**HOD ACTION: Council on Medical Education Report 1 adopted and the remainder of the report filed, with the exception of H-260.978, "Salary Equity for Laboratory Personnel," which is reaffirmed.**

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 1-JUN-21

Subject: Council on Medical Education Sunset Review of 2011 House Policies

Presented by: Liana Puscas, MD, MHS, Chair

Referred to: Reference Committee C
(x, MD, Chair)

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Policy G-600.110, "Sunset Mechanism for AMA Policy," calls for the decennial review of American Medical Association policies to ensure that our AMA's policy database is current, coherent, and relevant. This policy reads as follows, laying out the parameters for review and specifying the needed procedures:

1. As the House of Delegates adopts policies, a maximum ten-year time horizon shall exist. A policy will typically sunset after ten years unless action is taken by the House of Delegates to retain it. Any action of our AMA House that reaffirms or amends an existing policy position shall reset the sunset "clock," making the reaffirmed or amended policy viable for another 10 years.

2. In the implementation and ongoing operation of our AMA policy sunset mechanism, the following procedures shall be followed: (a) Each year, the Speakers shall provide a list of policies that are subject to review under the policy sunset mechanism; (b) Such policies shall be assigned to the appropriate AMA councils for review; (c) Each AMA council that has been asked to review policies shall develop and submit a report to the House of Delegates identifying policies that are scheduled to sunset; (d) For each policy under review, the reviewing council can recommend one of the following actions: (i) retain the policy; (ii) sunset the policy; (iii) retain part of the policy; or (iv) reconcile the policy with more recent and like policy; (e) For each recommendation that it makes to retain a policy in any fashion, the reviewing council shall provide a succinct, but cogent justification (f) The Speakers shall determine the best way for the House of Delegates to handle the sunset reports.

3. Nothing in this policy shall prohibit a report to the HOD or resolution to sunset a policy earlier than its 10-year horizon if it is no longer relevant, has been superseded by a more current policy, or has been accomplished.

4. The AMA councils and the House of Delegates should conform to the following guidelines for sunset: (a) when a policy is no longer relevant or necessary; (b) when a policy or directive has been accomplished; or (c) when the policy or directive is part of an established AMA practice that is transparent to the House and codified elsewhere such as the AMA Bylaws or the AMA House of Delegates Reference Manual: Procedures, Policies and Practices.

5. The most recent policy shall be deemed to supersede contradictory past AMA policies.

6. Sunset policies will be retained in the AMA historical archives.

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1 RECOMMENDATION
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3 The Council on Medical Education recommends that the House of Delegates policies listed in the
4 appendix to this report be acted upon in the manner indicated and the remainder of this report be filed.
5 (Directive to Take Action)

Fiscal Note: $1,000.

APPENDIX: RECOMMENDED ACTIONS

| Policy Number | Title | Text | Recommendation |
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| H-210.986 | Physicians and Family Caregivers - A Model for Partnership | Our AMA (1) encourages residency review committees and residency program directors to consider physician needs for training in evaluation of caregivers. Emphasis at both the undergraduate and graduate level is needed on the development of the physician's interpersonal skills to better facilitate assessment and management of caregiver stress and burden;<br>(2) supports health policies that facilitate and encourage home health care. Current regulatory and financing mechanisms favor institutionalization, often penalizing families attempting to provide lower cost, higher quality-of-life care;<br>(3) reaffirms support for reimbursement for physician time spent in education and counseling of caregivers and/or home care personnel involved in patient care; and<br>(4) supports research that identifies the types of education and support services that most effectively enhance the activities and reduce the burdens of caregivers. Further research is also needed on the role of physicians and others in supporting the family caregiver.<br>Citation: (CSA Rep. I, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11) | Rescind; duplicative of H-210.980, "Physicians and Family Caregivers: Shared Responsibility," which reads: "Our AMA: (1) specifically encourages medical schools and residency programs to prepare physicians to assess and manage caregiver stress and burden; (2) continues to support health policies that facilitate and encourage health care in the home; (3) reaffirm support for reimbursement for physician time spent in educating and counseling caregivers and/or home care personnel involved in patient care; (4) supports research that identifies the types of education, support services, and professional caregiver roles needed to enhance the activities and reduce the burdens of family caregivers, including caregivers of patients with dementia, addiction and other chronic mental disorders; and (5) (a) encourages partner organizations to develop resources to better prepare and support lay caregivers; and (b) will identify and disseminate resources to promote physician understanding of lay caregiver burnout and develop strategies to support lay caregivers and their patients." |

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| D-295.322 | Increasing Demographically Diverse Representation in Liaison Committee on Medical Education Accredited Medical Schools | Our AMA will continue to study medical school implementation of the Liaison Committee on Medical Education (LCME) Standard IS-16 and share the results with appropriate accreditation organizations and all state medical associations for action on demographic diversity. (Res. 313, A-09; Modified: CME Rep. 6, A-11) | Retain; remains relevant, especially due to increased attention to the need for diversity in medical education and practice. |
| H-295.888 | Progress in Medical Education: the Medical School Admission Process | 1. Our AMA encourages: (A) research on ways to reliably evaluate the personal qualities (such as empathy, integrity, commitment to service) of applicants to medical school and support broad dissemination of the results. Medical schools should be encouraged to give significant weight to these qualities in the admissions process; (B) premedical coursework in the humanities, behavioral sciences, and social sciences, as a way to ensure a broadly-educated applicant pool; and (C) dissemination of models that allow medical schools to meet their goals related to diversity in the context of existing legal requirements, for example through outreach to elementary schools, high schools, and colleges.<br><br>2. Our AMA: (A) will continue to work with the Association of American Medical Colleges (AAMC) and other relevant organizations to encourage improved assessment of personal qualities in the recruitment process for medical school applicants including types of information to be solicited in applications to medical school; (B) will work with the AAMC and other relevant organizations to explore the range of measures used to assess personal qualities among applicants, including those used by related fields; (C) encourages the development of innovative methodologies to assess personal qualities among medical school applicants; (D) will work with medical schools and other relevant stakeholder groups to review the ways in which medical schools communicate the importance of personal qualities among applicants, including how and when specified personal qualities will be assessed in the admissions process; (E) encourages continued research on the personal qualities most pertinent to success as a medical student and as a physician to assist admissions committees to adequately assess applicants; and (F) encourages continued research on the factors that impact negatively on humanistic and empathetic traits of medical students during medical school. (CME Rep. 8, I-99; Reaffirmed: CME Rep. 2, A-09; Appended: CME Rep. 3, A-11) | Retain; remains relevant, as the AMA's Accelerating Change in Medical Education initiative and other activities seek to improve the selection process for medical students (and change the composition and diversity of the future physician workforce). |

| H-305.962 | Taxation of Federal Student Aid | Our AMA opposes legislation that would make medical school scholarships or fellowships subject to federal income or social security taxes (FICA). (Res. 210, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CME Rep. 2, A-11) | Retain; remains relevant. |
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| H-305.997 | Income Tax Exemption for Medical Student Loans and Scholarships | The AMA supports continued efforts to obtain exemption from income tax on amounts received under medical scholarship or loan programs. (Res. 65, I-76; Reaffirmed: Sunset Report, I-98; Reaffirmation A-01; Reaffirmed: CME Rep. 2, A-11) | Rescind; superseded by H-305.962, "Taxation of Federal Student Aid," which reads: "Our AMA opposes legislation that would make medical school scholarships or fellowships subject to federal income or social security taxes (FICA)." |
| H-40.994 | Military Physicians in Graduate Medical Education Programs | Our AMA opposes any arbitrary attempt to limit the percentage of resident physicians in military graduate education or training programs. (Res. 71, I-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CME Rep. 2, A-11) | Rescind; superseded by H-40.995, "Graduate Medical Education in the Military," which reads, in part: "Our AMA: (1) strongly supports and endorses the graduate medical education programs of the military services and recognizes the potential benefit to the military services of recruitment, retention and readiness programs; (2) is gravely concerned that closures of military medical centers and subsequent reduction of graduate medical education programs conducted therein will not only impede the health care mission of the Department of Defense, but also harm the health care of the nation by increasing the drain on trained specialists available to the civilian sector; … 5) oppose any reductions to military GME residency or fellowship positions without dedicated congressional funding for an equal number of civilian residency positions in addition to any other planned increases to civilian GME to avoid further exacerbating the United States' physician shortage." |

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| D-180.995 | Physician Privileges Application -Timely Review by Managed Care | Our AMA will work with the American Association of Health Plans (AAHP), the American Hospital Association (AHA), the National Committee on Quality Assurance (NCQA), and other appropriate organizations to allow residents who are within six months of completion of their training to apply for hospital privileges and acceptance by health plans. (Res. 708, A-01; Reaffirmed: CME Rep. 2, A-11) | Retain; still relevant. |
| D-255.982 | Oppose Discrimination in Residency Selection Based on International Medical Graduate Status | Our AMA:<br><br>1. Will request that the Accreditation Council for Graduate Medical Education include in the Institutional Requirements a requirement that will prohibit a program or an institution from having a blanket policy to not interview, rank or accept international medical graduate applicants.<br><br>2. Recognizes that the assessment of the individual international medical graduate residency and fellowship applicant should be based on his/her education and experience.<br><br>3. Will disseminate this new policy on opposition to discrimination in residency selection based on international medical graduate status to the graduate medical education community through AMA mechanisms. (Sub. Res. 305, A-08; Reaffirmation I-11) | Rescind.<br><br>Clause 1 is reflected in ACGME Institutional Requirement IV.1.5, “Discrimination: The Sponsoring Institution must have policies and procedures, not necessarily GME-specific, prohibiting discrimination in employment and in the learning and working environment, consistent with all applicable laws and regulations. (Core)”<br><br>Clause 2 is superseded by H-255.988 (11), “AMA Principles on International Medical Graduates,” which reads, “That AMA representatives to the ACGME, residency review committees and to the ECFMG should support AMA policy opposing discrimination. Medical school admissions officers and directors of residency programs should select applicants on the basis of merit, without considering status as an IMG or an ethnic name as a negative factor.”<br><br>Also reflected in H-255.983, “Graduates of Non-United States Medical Schools,” which reads, “The AMA continues to support the policy that all physicians and medical students should be |

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| | | | evaluated for purposes of entry into graduate medical education programs, licensure, and hospital medical staff privileges on the basis of their individual qualifications, skills, and character."<br><br>Clause 3 was accomplished at the time of adoption of the resolution. |
| D-275.993 | Reporting of Resident Physicians | Our AMA will: (1) work with appropriate groups, including the Federation of State Medical Boards, to attempt to increase the standardization of information about resident physicians that is reported to state medical licensing boards to obtain or renew the limited educational permit~~, consistent with existing AMA Policy H-265.934 (#4)~~; (2) encourage state medical societies to act as a link between state medical licensing boards and medical schools/residency programs to ensure that educational programs are familiar with and have the opportunity to comment on proposed changes in reporting requirements for resident physicians; and (3) make relevant groups-- for example, medical schools, state medical societies, resident physicians--aware of what types of information must be supplied in order for resident physicians to obtain and renew a limited educational permit. (CME Rep. 4-I-01; Reaffirmed CME Rep. 2-A-11) | Retain in part.<br><br>Policy H-265.934 is no longer AMA policy, hence the deletion in clause 1. |
| D-305.992 | Accounting for GME Funding | Our AMA will encourage: (1) department chairs and residency program directors to learn effective use of the information that is currently available on Medicare funding accounting of GME at the level of individual hospitals to assure appropriate support for their training programs, and publicize sources for this information, including placing links on our AMA web site; and (2) hospital administrators to share with residency program directors and department chairs, accounting and budgeting information on the disbursement of Medicare education funding within the hospital to ensure the appropriate use of those funds for Graduate Medical Education. (Sub. Res. 302, I-00; Reaffirmed: CME Rep. 2, A-10; Reaffirmation A-11) | Retain; remains relevant.<br><br>See also H-305.929, "Proposed Revisions to AMA Policy on the Financing of Medical Education Programs":<br>"4. Our AMA believes that financial transparency is essential to the sustainable future of GME funding and therefore, regardless of the method or source of payment for GME or the number of funding streams, institutions should publically report the aggregate value of GME payments received as well as what these payments are used for, including: (a) Resident salary and benefits; (b) |

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| | | | Administrative support for graduate medical education; (c) Salary reimbursement for teaching staff; (d) Direct educational costs for residents and fellows; and (e) Institutional overhead.” |
| H-310.911 | ACGME Allotted Time Off for Health Care Advocacy and Health Policy Activities | Our AMA: 1) urges the Accreditation Council for Graduate Medical Education (ACGME) to acknowledge that “activities in organized medicine” facilitate competency in professionalism, interpersonal and communication skills, practice-based learning and improvement, and systems-based practice; 2) encourages residency and fellowship programs to support their residents and fellows in their involvement in and pursuit of leadership in organized medicine; and 3) encourages the ACGME and other regulatory bodies to adopt policy that resident and fellow physicians be allotted additional time, beyond scheduled vacation, for scholarly activity time and activities of organized medicine, including but not limited to, health care advocacy and health policy. (Res. 317, A-11) | Retain; remains relevant. See also H-310.905, “Scholarly Activity by Resident and Fellow Physicians.” |
| H-310.959 | In-Service Training Examinations - Final Report | It is the policy of the AMA ~~(1)~~ to encourage entities responsible for in-service examinations and the ACGME to recognize that in-service training examinations should not be used in decisions concerning acceptance, denial, advancement, or retention in residency or fellowship training positions; should not be used by outside regulatory agencies for the purpose of assessing resident knowledge or the quality of training programs; and should not be used as a pretest to sit for specialty boards~~; (2) to encourage residency program directors to use the results of in-training examinations to counsel residents and as the basis for developing appropriate programs of remediation and also for the purpose of educational program evaluation; and (3) to urge that evaluation of residents for promotion or retention be based on valid and reliable measures of knowledge, skills, and behaviors, applied sequentially over time. In-training examinations should be administered under appropriate testing conditions. Residents should be relieved of on-call duty the night prior to and during the administration of the examination. The results, if used at all, should not be the sole factor in evaluation of residents~~. (CME Rep. A, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CME Rep. 2, A-11) | Retain in part.<br><br>Clause 1 is still relevant.<br><br>For clauses 2 and 3, the Accreditation Council for Graduate Medical Education is using Milestones and multiple measures of evaluation. Relying on one metric is frowned upon. (see Sections V.A.1 Resident Feedback and Evaluation and V.A.2 Resident Final Evaluation.) |
| H-310.960 | Resident Education in Laboratory Utilization | Our AMA endorses the concept of practicing physicians devoting time with medical students and resident physicians for chart reviews focusing on appropriate test ordering in patient care. (Res. 84, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CME Rep. 2, A-11) | Retain; remains relevant. |

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| H-310.996 | Residency Review Committee Representation | Our AMA: (1) supports resident membership on Residency Review Committees; (2) requests that the resident representatives to the Residency Review Committees (RRCs) of the Accreditation Council for Graduate Medical Education (ACGME) serve for at least a one-year term as a full and voting participant at all RRC meetings; (3) requests that the resident members of the RRCs be peer-selected; and (4) will advocate for diversity of appointees to RRCs. (Res. 67, I-82; Reaffirmed: Sub. Res. 186, A-87; Reaffirmed: CLRPD Rep. A, I-92; Appended: Res. 306, I-98; Reaffirmed: CME Rep. 2, A-08; Appended: Res. 304, A-11) | Rescind; is now reflected in ACGME documents, including ACGME Policies and Procedures, Subject: 9.00 Review Committees and Recognition Committee:<br>"(8) Member Appointment – Nominating organizations should submit to the ACGME administration the names of two candidates for each vacancy at least 12 months before the date of the appointment. Nominating organizations should consider professional qualifications, geographic distribution, and diversity in nominating their candidates."<br><br>Also reflected in Committees and Members Selection Process: "Review Committees have physician members, at least one of whom is a resident at the time of appointment, and a public member.<br>"Appointment of Resident Members to Review Committees<br>"The process takes approximately 12 months from the call for nominations until the member's term begins. The Review Committee Executive Director requests nominations through the ACGME e-Communication and/or via letter to the specialty-specific professional organizations that have resident groups." |
| H-410.986 | Resident Involvement in Practice Parameters | Our AMA urges national medical specialty societies to work with resident physicians within their specialty in developing practice parameters. (Res. 52, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CME Rep. 2, A-11) | Rescind. The intent of this policy is being met, as many specialty societies include residents/fellows on committees on development of guidelines for physician practice. |

| D-140.981 | Ethical Guidelines on Gifts to Physicians from Industry | Our AMA shall: (1) communicate to all medical school deans and residency program directors the importance of including education on ethical guidelines regarding gifts to physicians from industry within the ethics curriculum of their medical student and housestaff education programs; (2) communicate to all medical school deans and residency program directors the content of CEJA Opinion E-8.061 and shall recommend that it or another nationally-recognized ethical guideline be used as the basis for educational content on this issue; (3) recommend to all medical school deans and residency program directors that appropriate policies be developed for medical students, housestaff and faculty in their respective institutions regarding the issue of gifts to physicians from industry; (4) work with the Association of American Medical Colleges (AAMC) and the American Association of Colleges of Osteopathic Medicine (AACOM) to encourage the Liaison Committee on Medical Education and the American Osteopathic Association Commission on Osteopathic College Accreditation to require all medical schools to make known to students the existence of the physician-industry financial disclosure databases that exist or will be created by 2013 as required by the Patient Protection and Affordable Care Act; and (5) work with AAMC and AACOM to encourage all medical school faculty to model professional behavior to students by disclosing the existence of financial ties with industry, in accordance with existing disclosure policies at each respective medical school. (Res. 13, A-02; Reaffirmed: Res. 303, A-05; Appended: Res. 308, A-11) | Rescind. This directive has been accomplished. |
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| H-275.993 | Examinations for Medical Licensure | Our AMA affirms its recommendation that medical school faculties continue to exercise the responsibilities inherent in their positions for the evaluation of students and residents, respectively. (CME Rep. B, I-81; Reaffirmed: CLRPD Rep. F, I-91; Modified: Sunset Report, I-01; Reaffirmed: CME Rep. 2, A-11) | Rescind. This is in essence the role of medical school faculties, and the essence of medical school accreditation. |
| H-295.868 | Education in Disaster Medicine and Public Health Preparedness During Medical School and Residency Training | 1. Our AMA recommends that formal education and training in disaster medicine and public health preparedness be incorporated into the curriculum at all medical schools and residency programs.<br>2. Our AMA encourages medical schools and residency programs to utilize multiple methods, including simulation, disaster drills, interprofessional team-based learning, and other interactive formats for teaching disaster medicine and public health preparedness.<br>3. Our AMA encourages public and private funders to support the development and implementation of education and training opportunities in disaster medicine and public health preparedness for medical students and resident physicians.<br>~~4. Our AMA supports the National Disaster Life Support (NDLS) Program Office's work to revise and~~ | Retain in part. Still timely, with deletion of clauses 4-7, as these are no longer relevant. |

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| | | ~~enhance the NDLS courses and supporting course materials, in both didactic and electronic formats, for use in medical schools and residency programs.~~<br>~~5. Our AMA encourages involvement of the National Disaster Life Support Education Consortium's adoption of training and education standards and guidelines established by the newly created Federal Education and Training Interagency Group (FETIG).~~<br>~~6. Our AMA will continue to work with other specialties and stakeholders to coordinate and encourage provision of disaster preparedness education and training in medical schools and in graduate and continuing medical education.~~<br>~~7. Our AMA encourages all medical specialties, in collaboration with the National Disaster Life Support Educational Consortium (NDLSEC), to develop interdisciplinary and inter-professional training venues and curricula, including essential elements for national disaster preparedness for use by medical schools and residency programs to prepare physicians and other health professionals to respond in coordinated teams using the tools available to effectively manage disasters and public health emergencies.~~<br>4~~8~~. Our AMA encourages medical schools and residency programs to use community-based disaster training and drills as appropriate to the region and community they serve as opportunities for medical students and residents to develop team skills outside the usual venues of teaching hospitals, ambulatory clinics, and physician offices.<br>5~~9~~. Our AMA will make medical students and residents aware of the context (including relevant legal issues) in which they could serve with appropriate training, credentialing, and supervision during a national disaster or emergency, e.g., non-governmental organizations, American Red Cross, Medical Reserve Corps, and other entities that could provide requisite supervision.<br>6~~10~~. Our AMA will work with the Federation of State Medical Boards to encourage state licensing authorities to include medical students and residents who are properly trained and credentialed to be able to participate under appropriate supervision in a national disaster or emergency.<br>7~~11~~. Our AMA encourages physicians, residents, and medical students to participate in disaster response activities through organized groups, such as the Medical Response Corps and American Red Cross, and not as spontaneous volunteers.<br>8~~12~~. Our AMA encourages teaching hospitals to develop and maintain a relocation plan to ensure that educational activities for faculty, medical students, and residents can be continued in times of national disaster and emergency. (CME Rep. 15, A-09; Reaffirmed: CME Rep. 7, A-10; Appended: CME Rep. 7, A-10; Reaffirmed and Appended: CME Rep. 1, I-11) | |

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| H-310.970 | Mandatory Helicopter Flight for Emergency Medical Residents in Training | Our AMA urges residency training programs that require helicopter transport as a mandatory part of their residency to notify applicants of that policy prior to and during the interview process. (Res. 239, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CME Rep. 2, A-10; Reaffirmed: CME Rep. 01, A-20) | Rescind; superseded by H-295.943, "Issues Regarding Patient and/or Donor Transports by Resident Physicians and Medical Students." |
| H-295.943 | Issues Regarding Patient and/or Donor Transports by Resident Physicians and Medical Students | Our AMA (1) urges medical schools not to require medical students to participate in the air or ground transport of patients or organs during required clinical rotations; and (2) encourages all teaching institutions where medical students or resident physicians participate (compulsorily or voluntarily) in the air or ground transport of patients or organs (a) to notify prospective students and residents of all program requirements related to transports; (b) to include accident, disability, and life insurance as part of an available package for participating medical students and resident physicians, and to provide such insurance where participation is mandatory; (c) to include in the educational curriculum formal training on general and safety issues pertaining to emergency transport before students or residents participate in such activity; and (d) to adhere to the Association of Air Medical Services (AAMS) Minimum Quality Standards and Safety Guidelines for transport. (CME Rep. E, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CME Rep. 2, A-11) | Retain; remains relevant. See also H-310.970, "Mandatory Helicopter Flight for Emergency Medical Residents in Training," which is being rescinded through this report, as it is superseded by H-295.943. |
| D-305.990 | Impact of Health System Changes on Medical Education | Our AMA wil continue to monitor the financial status of academic medical centers and the availability of faculty and patients to support the clinical education of medical students and resident physicians. This should both include collecting information and synthesizing information from other sources on these issues. (CME Rep. 4, A-01; Reaffirmed: CME Rep. 2, A-11) | Rescind; remains relevant, but superseded by H-305.942, "The Ecology of Medical Education: The Infrastructure for Clinical Education," which reads: "The AMA recommends the following to ensure that access to appropriate clinical facilities and faculty to carry out clinical education is maintained: (1) That each medical school and residency program identify the specific resources needed to support the clinical education of trainees, and should develop an explicit plan to obtain and maintain these resources. This planning should include identification of the types of clinical facilities and the number and specialty distribution of full-time and volunteer clinical |

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| | | | faculty members needed. (2) That affiliated health care institutions and volunteer faculty members be included in medical school and residency program resource planning for clinical education when appropriate. (3) That medical school planning for clinical network development include consideration of the impact on the education program for medical students and resident physicians. (4) That accrediting bodies for undergraduate and graduate medical education be encouraged to adopt accreditation standards that require notification of changes in clinical affiliations, in order to ensure that changes in the affiliation status of hospitals or other clinical sites do not adversely affect the education of medical students and resident physicians." |
| D-405.987 | Debilitating Accidents and Accidental Deaths of Physicians in Training | Our AMA: 1) requests modification in the annual survey distributed to medical schools in order to assess the topic of serious accidents and accidental deaths; 2) requests modification of other annual surveys of medical schools, residency directors, and other medical educators in order to assess the topic of serious accidents and accidental deaths among physicians in training. (Res. 323, A-11) | Rescind; this directive was accomplished. |
| H-435.997 | Medical School Malpractice Risk Prevention Curriculum | Our AMA (1) acknowledges the continuing and growing severity of the problem of physician professional liability insurance nationwide and (2) urges medical schools and directors of residency programs to assist students and residents to understand and apply the determinants of sound risk management to clinical practice. (Sub. Res. 48, A-81; Reaffirmed: CLRPD Rep. F, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CMS Rep. 7, A-11) | Rescind; superseded by H-295.924, "Future Directions for Socioeconomic Education," which reads: "The AMA: (1) asks medical schools and residencies to encourage that basic content related to the structure and financing of the current health care system, including the organization of health care delivery, modes of practice, practice settings, cost effective use of |

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| | | | diagnostic and treatment services, practice management, risk management, and utilization review/quality assurance, is included in the curriculum; (2) asks medical schools and residencies to ensure that content related to the environment and economics of medical practice in fee-for-service, managed care and other financing systems is presented at educationally appropriate times during undergraduate and graduate medical education; and (3) will encourage the Liaison Committee on Medical Education (LCME) to ensure that survey teams pay close attention during the accreditation process to the degree to which 'socioeconomic' subjects are covered in the medical curriculum." |
| G-615.060 | CME Activities | Our AMA supports intensified efforts of the Council on Medical Education and other bodies within our AMA to initiate meetings and encourage continuing dialogue with medical students, interns, and residents. (Sub. Res. 22, I-69; CME Rep. I, I-77; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Consolidated: CLRPD Rep. 3, I-01; Modified: CC&B Rep. 2, A-11) | Rescind; this work is already reflected in multiple AMA activities and initiatives, including the Medical Student Section and Resident and Fellow Section (neither of which were in existence in 1969, when this policy was adopted). |
| H-300.946 | Inappropriate Use of Social Security Numbers in CME Accreditation | Our AMA opposes the use of Social Security numbers as: (1) a requirement to obtain continuing medical education credit and strongly encourage the use of the AMA Medical Education number for such educational activities; and (2) file identifiers by providers of continuing medical education, certification boards and similar entities, suggesting instead the use of the AMA Medical Education number where such a unique identifier is required and applicable. (Res. 306, A-00; Appended Res. 301, A-01; Reaffirmed: CME Rep. 2, A-11) | Retain; remains relevant.<br><br>See also H-190.963, "Identity Fraud," which reads: "Our AMA policy is to discourage the use of Social Security numbers to identify insureds, patients, and physicians, except in those situations where the use of these numbers is required by law and/or regulation." |

| D-300.980 | Opposition to Increased CME Provider Fees | 1. Our AMA will ~~(a) communicate its appreciation to the Accreditation Council for Continuing Medical Education (ACCME) Board of Directors for their responsiveness to AMA's requests this past year~~; (a~~b~~) continue to work with the ACCME to: (i) reduce the financial burden of institutional accreditation and state recognition; (ii) reduce bureaucracy in these processes, (iii) improve continuing medical education, and (iv) encourage the ACCME to show that ~~the updated~~ accreditation criteria improve patient care; and (b~~e~~) continue to work with the ACCME to (i) mandate meaningful involvement of state medical societies in the policies that affect recognition and (ii) reconsider the fee increases to be paid by the state-accredited providers to ACCME.<br>2. Our AMA will continue to work with the ACCME to accomplish the directives in policy D-300.980, "Opposition to Increased Continuing Medical Education (CME) Provider Fees."<br>~~3. Our AMA, in collaboration with the ACCME, will do a comprehensive review of the CME process on a national level, with the goal of decreasing costs and simplifying the process of providing CME.~~ (CME Rep. 14, A-10; Appended: CME Rep. 9, A-11; Modified: CCB/CLRPD Rep. 4, A-12; Modified: CCB/CLRPD Rep. 2, A-14; Appended: Res. 302, A-17) | Retain in part. Delete 1.(a) and 3, which have been accomplished, and delete "updated" in 1.(b)(iv), in that these criteria were revised in the past.<br>As stated in Council on Medical Education Report 7-A-12, the Council monitored results of the recommendations from Policy D-300.980 for the prior three years, and the Accreditation Council for Continuing Medical Education has been amenable to discussing AMA concerns. In December 2009, the ACCME created a task force to explore strategies for clarifying the requirements, eliminating redundancies, and reducing the documentation requirements for providers. This Task Force reported back to the ACCME Board in November 2010. The ACCME reports that it continues to be actively engaged in ongoing discussions and that some of the "simplification" changes associated with the Task Force's work have already been implemented. For the past three years, the AMA has advocated for reduced fees and changes to the existing ACCME accreditation system. The Council on Medical Education will continue to monitor the activities and fees of the ACCME. |
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| H-300.973 | Promoting Quality Assurance, Peer Review, and Continuing Medical Education | Our AMA: (1) reaffirms that it is the professional responsibility of every physician to participate in voluntary quality assurance, peer review, and continuing medical education activities; (2) to encourage hospitals and other organizations in which quality assurance, peer review, and continuing medical education activities are conducted to provide recognition to physicians who participate voluntarily; | Retain; remains relevant. |

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| | | (3) to increase its efforts to make physicians aware that participation in the voluntary quality assurance and peer review functions of their hospital medical staffs and other organizations provides credit toward the AMA’s Physicians’ Recognition Award; and (4) to continue to study additional incentives for physicians to participate in voluntary quality assurance, peer review, and continuing medical education activities. (BOT Rep. SS, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CME Rep. 2, A-11) | |
| H-300.974 | Unification of Continuing Education Credits | Our AMA accepts American Academy of Family Physicians prescribed credit hours and American College of Obstetricians and Gynecologists cognate credit hours for formal learning, as equivalent to *AMA PRA Category 1 Credit*™. (CME Rep. C, I-91; Reaffirmed: Sunset Report, I-01; Modified: CME Rep. 2, A-11) | Retain; remains relevant. |
| H-300.975 | Fraudulent/ Legitimate Continuing Medical Education Activities | Our AMA supports the development and publication of guidelines to assist physicians in identifying continuing medical education of high quality, responsive to their needs, and supports the promulgation of ethical principles regarding the responsibilities of physicians to participate in continuing medical education programs which they claim for continuing medical education recognition, credit or other purposes. (Sub. Res. 64, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CME Rep. 2, A-11) | Retain; remains relevant. |
| D-300.979 | Suggested Revision in ACCME Evaluations | ~~1.~~ Our AMA will: ~~(1) strongly encourage the Accreditation Council for Continuing Medical Education to recognize the value of gaining knowledge outside a physician’s specialty and change the activity evaluation to reflect this; and (2)~~ communicate to the Accreditation Council for Continuing Medical Education that programs on the history of medicine have relevance for improvements in physicians’~~?~~ knowledge and competence. (Sub. Res. 310, A-10; Appended: Res. 320, A-11) | Retain in part with the deletion of (1) and editorial change to (2), along with the number 1., which is unneeded. Both (1) and (2) have been accomplished, but (2) is still relevant. |
| H-300.992 | National Accreditation of AMA as Provider of Continuing Medical Education | Our AMA assigns to the ~~CME~~ Council on Medical Education the responsibility to be the unit of the AMA to become accredited for continuing medical education. (BOT Rep. NN, A-81; CLRPD Rep. F, I-91; Modified: Sunset Report, I-01; Reaffirmed: CME Rep. 2, A-11) | Retain; remains relevant, with editorial change to specify the “Council on Medical Education,” to avoid confusion with “continuing medical education.” |

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| D-300.995 | Reducing Burdens of CME Accreditation and Documentation | Our AMA will work with the Accreditation Council for Continuing Medical Education to simplify the requirements for documentation and administration of accredited CME programs. (Res. 304, I-01; Reaffirmed: CME Rep. 2, A-11) | Rescind; accomplished. In 2017, the AMA and ACCME completed a multi-year process of simplification and alignment of the credit and accreditation systems. The process included multiple avenues of input from the CME community, culminating in a call for comment regarding proposed changes. The recommendations of the AMA/ACCME bridge committee were approved by the AMA Council on Medical Education and the ACCME Board of Directors. |
| D-300.998 | Attendance of Non-Physicians at Courses Teaching Complex Diagnostic, Therapeutic or Surgical Procedures | Our AMA will encourage the Accreditation Council for Continuing Medical Education, the American Academy of Family Physicians, and other groups that accredit providers of continuing medical education to adopt the principle that continuing medical education should be focused on physicians (MDs/DOs). Courses teaching complex diagnostic, therapeutic or surgical procedures should be open only to those practitioners and/or sponsored members of the practitioner's care team who have the appropriate medical education background and preparation to ensure patient safety. This should not be construed to limit access to or apply to programs leading to life support certification, e.g. ATLS, ACLS (CME Rep. 2, A-01; Reaffirmed: CME Rep. 2, A-11) | Retain; remains relevant. |
| H-250.996 | Enhancing Young Physicians' Effectiveness in International Health | It is the policy of the AMA to work with national medical specialty societies and other organizations in preparing materials which guide young physicians in the development of skills necessary for effectively promoting the health of poor populations both in the United States and abroad. (Res. 407, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CME Rep. 2, A-11) | Retain; remains relevant. |
| H-260.978 | Salary Equity for Laboratory Personnel | It is the policy of the AMA to promote adequate compensation for medical technologists, cytotechnologists and other medical laboratory personnel and to promote increased funding for their educational programs. (Sub. Res. 39, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CME Rep. 2, A-11) | Retain and reaffirm. |

| D-275.964 | Principles of Due Process for Medical License Complaints | 1. Our AMA will explore ways to establish principles of due process that must be used by a state licensing board prior to the restriction or revocation of a physician’s medical license, including strong protections for physicians’~~?~~ rights.<br><br>2. Our AMA takes the position that: A) when a state medical board conducts an investigation or inquiry of a licensee applicant’s quality of care, that the standard of care be determined by physician(s) from the same specialty as the licensee applicant, and B) when a state medical board conducts an investigation or inquiry regarding quality of care by a medical licensee or licensee applicant, that the physician be given: (i) a minimum of 30 days to respond to inquiries or requests from a state medical board, (ii) prompt board decisions on all pending matters, (iii) sworn expert review by a physician of the same specialty, (iv) a list of witnesses providing expert review, and (v) exculpatory expert reports, should they exist. (Res. 238, A-08; Appended: Res. 301, A-11) | Retain; still relevant. Note editorial change to clause 1 to fix error. |
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| D-275.989 | Credentialing Issues | ~~1. Our AMA shall: (A) continue to encourage the Federation of State Medical Boards (FSMB) and its licensing jurisdictions to widely disseminate information about the Federation Credentials Verification Service; and (B) encourage the FSMB and the Educational Commission for Foreign Medical Graduates to work together to develop a system for the prompt and reliable verification of the medical education credentials of international medical graduates and to serve as a repository and a body for primary source verification of credentials.~~<br><br>~~2.~~ Our AMA encourages state medical licensing boards, the Federation of State Medical Boards, and other credentialing entities to accept the Educational Commission for Foreign Medical Graduates certification as proof of primary source verification of an IMG’s international medical education credentials. (CME Rep. 3, A-02; Appended: CME Rep. 10, A-11) | Rescind in part.<br><br>Clause 1 has been accomplished through work by the FSMB and ECFMG to replace paper-based processes with an electronic portal for medical school transmission of diplomas and transcripts for IMGs. These technological advances have reduced turnaround time for credentials verification for the majority of applicants.<br><br>Clause 2 should be retained, in that states should be encouraged to accept the ECMG certification as proof of primary source verification of an IMG’s international medical education credentials, to ensure efficiency and reduced processing time for IMGs seeking licensure while protecting the public. |