HOD ACTION: Recommendations in Council on Medical Education Report 1 adopted and the remainder of the report filed.

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 1-A-24

Subject:	Council on Medical Education Sunset Review of 2014 House of Delegates' Policies
Presented by:	Cynthia Jumper, MD, MPH, Chair
Referred to:	Reference Committee C

Policy G-600.110, "Sunset Mechanism for AMA Policy," calls for the decennial review of American Medical Association (AMA) policies to ensure that our AMA's policy database is current, coherent, and relevant:

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to the HOD or resolution to sunset a policy earlier than its 10-year horizon if it is no longer relevant, has been superseded by a more current policy, or has been accomplished.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.

See Appendix for a table of 2014 policies and recommended actions.
RECOMMENDATION

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

Fiscal Note: $1,000.

APPENDIX: RECOMMENDED ACTIONS

Policy Number	Title	Text	Recommendations
D-275.958	USMLE Step 1 Timing	Our AMA will ask the appropriate stakeholders to track United States Medical Licensing Examination (USMLE) Step 1 Exam timing and subsequently publish aggregate data to determine the significance of advanced clinical experience on Step 1 Exam performance. (Res. 911, I-14)	**Sunset - accomplished.** After I-14, the Association of American Medical Colleges (AAMC), National Board of Medical Examiners (NBME), and Federation of State Medical Boards (FSMB) were notified of the HOD directive. It was also communicated via the *MedEd Update* newsletter to each medical school, residency program director, directors of medical education at U.S. teaching hospitals, and other interested groups.
D-275.981	Potential Impact of the USMLE Step 2 CS and COMLEX-PE on Undergraduate and Graduate Medical Education	Our AMA will: (1) continue to closely monitor the USMLE Step 2 CS and the COMLEX-USA Level 2-PE, collecting data on initial and final pass rates, delays in students starting residency training due to scheduling of examinations, economic impact on students, and the potential impact of ethnicity on passing rates; and (2) encourage residency program directors to proactively evaluate their access to resources needed to assist resident physicians who have not passed these examinations to remediate. (CME Rep. 4, A-04; Modified: CME Rep. 2, A-14)	**Sunset – no longer relevant.** USMLE Step 2 CS and the COMLEX-USA Level 2-PE were discontinued in 2021 and 2022 respectively.
D.275.983	Physicians? Right to Reasonable Privacy Protection and the Federation Credentials Verification Service	Our AMA will request the Federation Credentials Verification Service (FCVS) to (1) add to its "Affidavit and Release" and "Authorization for Release of Records" forms appropriate language that: (a) allows physicians to revoke a prior authorization to the FCVS at any time through an affirmative action on the part of the physician (e.g., written notice) and (b) informs physicians their authorization will remain in effect unless and until revoked by the physician in accordance with guidance provided by the FCVS; and (2) clarify its release does not extend to liability which arises from the gross negligence or willful misconduct of FCVS. (BOT Rep. 22, A-04; Reaffirmed: CMS Rep. 1, A-14)	**Retain – still relevant. Amend title to read as follows:** Physicians~~?~~ Right to Reasonable Privacy Protection and the Federation Credentials Verification Service After A-04, the FSMB was notified of this HOD directive. The current FCVS waiver does not contain language contained in the AMA policy. FSMB has shared this AMA policy with their FCVS department and legal staff for review and welcome any AMA language for consideration.

D-275.995	Licensure and Credentialing Issues	Our AMA will: (1) support recognition of the Federation of State Medical Boards' (FSMB) Credentials Verification Service by all licensing jurisdictions; and (2) encourage the National Commission on Quality Assurance (NCQA) and all other organizations to accept the Federation of State Medical Boards' Credentials Verification Service, the Educational Commission for Foreign Medical Graduates' Certification Verification Service, and the AMA Masterfile as primary source verification of credentials. Res. 303, I-00; Reaffirmation A-04; Modified: (CCB/CLRPD Rep. 2, A-14; Reaffirmed: BOT Rep. 3, I-14)	**Retain - still relevant. Amend policy with change in title to read as follows**: ~~Licensure and Credentialing Issues~~ Primary Source Verification of Credentials Our AMA ~~will~~: (1) supports recognition of the Federation of State Medical Boards' (FSMB) Credentials Verification Service by all licensing jurisdictions; and (2) encourages ~~the National Commission on Quality Assurance (NCQA) and all other organizations to accept~~ recognition of the Federation of State Medical Boards' Credentials Verification Service, the Educational Commission for Foreign Medical Graduates' Certification Verification Service, and the AMA Masterfile as primary source verification of credentials.
D-300.984	Physician Reentry	Our AMA: 1. Will continue to collaborate with other appropriate organizations on physician reentry issues including research on the need for and the effectiveness of reentry programs. 2. Will work collaboratively with the American Academy of Pediatrics and other interested groups to convene a conference on physician reentry which will bring together key stakeholders to address the development of reentry programs as well as the educational needs of physicians reentering clinical practice. 3. Will work with interested parties to establish a physician reentry program (PREP) information data base that is publicly accessible to physician applicants and which includes information pertaining to program characteristics. 4. Will support efforts to ensure the affordability and accessibility, and to address the unique liability issues related to PREPs. 5. Will make available to all interested parties the physician reentry program (PREP) system Guiding Principles for use as a basis for all reentry programs: a. Accessible: The PREP system is accessible by geography, time and cost. Reentry programs are available and accessible geographically across the United States and include national and regional pools of reentry positions. Reentering physicians with families or community ties are not burdened by having to relocate to attend a program. The length of time of reentry programs is standardized and is	**Retain – in part. Sunset clauses (2) and (3) as having been accomplished and (6) as no longer relevant. Amend policy to read as follows:** Our AMA: 1. Will continue to collaborate with other appropriate organizations on physician reentry issues including research on the need for and the effectiveness of reentry programs. ~~2. Will work collaboratively with the American Academy of Pediatrics and other interested groups to convene a conference on physician reentry which will bring together key stakeholders to address the development of reentry programs as well as the educational needs of physicians reentering clinical practice.~~ ~~3. Will work with interested parties to establish a physician reentry program (PREP) information data base that is publicly accessible to physician applicants and which includes information pertaining to program characteristics.~~ ~~4~~2. Will support efforts to ensure ~~the~~ affordability and accessibility and to address the unique liability issues related to ~~PREPs~~ physician reentry programs. ~~5~~3. Will ~~make available to all interested parties the~~ continue to support ~~physician reentry program (PREP) system~~ these guiding principles for use as a basis for all reentry programs: (a)~~.~~ Accessible: ~~The PREP system is accessible~~ Obtainable by geography, time, and cost. Reentry programs are available and accessible geographically across the United States and include national and regional pools of reentry positions. Reentering physicians with families or community ties are not burdened by having to relocate to attend a program. The length of time of reentry programs is standardized and is commensurate with the assessed clinical and

		commensurate with the assessed clinical and educational needs of reentering physicians. The cost of reentry programs is not prohibitive to the physician, health care institutions or the health care system. b. Collaborative: The PREP system is designed to be collaborative to improve communication and resource sharing. Information and materials including evaluation instruments are shared across specialties, to the extent possible, to improve program and physician performance. A common nomenclature is used to maximize communication across specialties. Reentry programs share resources and create a common repository for such resources, which are easily accessible. c. Comprehensive: The PREP system is comprehensive to maximize program utility. Physician reentry programs prepare physicians to return to clinical activity in the discipline in which they have been trained or certified and in the practice settings they expect to work including community-based, public health, and hospital-based or academic practice. d. Ethical: The PREP system is based on accepted principles of medical ethics. Physician reentry programs will conform to physician licensure statues. The standards of professionalism, as stated in the AMA Code of Medical Ethics, must be followed. e. Flexible: The PREP system is flexible in structure in order to maximize program relevancy and usefulness. Physician reentry programs can accommodate modifications to program requirements and activities in ways that are optimal to the needs of reentering physicians. f. Modular: Physician reentry programs are modularized, individualized and competency-based. They are tailored to the learning needs of reentering physicians, which prevents the need for large, expensive, and standardized programs. Physicians should only be required to take those modules that allow them to meet an identified educational need. g. Innovative: Innovation is built into a PREP system allowing programs to offer state of the art learning and meet the diverse and changing needs of reentry physicians. Physician reentry programs develop and utilize learning tools including experimenting with innovative and novel curricular methodologies such as distance learning technologies and simulation. h.	educational needs of reentering physicians. The cost of reentry programs is not prohibitive to the physician, health care institutions, or the health care system. (b)~~.~~ Collaborative: ~~The PREP system is~~ ~~d~~Designed to be collaborative to improve communication and resource sharing. Information and materials including evaluation instruments are shared across specialties, to the extent possible, to improve program and physician performance. A common nomenclature is used to maximize communication across specialties. Reentry programs share resources and create a common repository for such resources, which are easily accessible. (c)~~.~~ Comprehensive: ~~The PREP system is comprehensive~~ Broad to maximize program utility. Physician reentry programs prepare physicians to return to clinical activity in the discipline in which they have been trained or certified and in the practice settings they expect to work including community-based, public health, and hospital-based or academic practice. (d)~~.~~ Ethical: ~~The PREP system is b~~Based on accepted principles of medical ethics. Physician reentry programs will conform to physician licensure statues. The standards ofstat professionalism, as stated in the AMA Code of Medical Ethics, must be followed. (e)~~.~~ Flexible: ~~The PREP system is flexible~~ Pliable in structure in order to maximize program relevancy and usefulness. Physician reentry programs can accommodate modifications to program requirements and activities in ways that are optimal to the needs of reentering physicians. (f)~~.~~ Modular: Physician reentry programs are modularized, individualized, and competency-based. They are tailored to the learning needs of reentering physicians, which prevents the need for large, expensive, and standardized programs. Physicians should only be required to take those modules that allow them to meet an identified educational need. (g)~~.~~ Innovative: ~~Innovation is built into a PREP system allowing~~ Allows programs to offer state of the art learning and meet the diverse and changing needs of reentry physicians. Physician reentry programs develop and utilize learning tools including experimenting with innovative and novel curricular methodologies such as distance learning technologies and simulation. (h)~~.~~ Accountable: ~~The PREP system~~ Has mechanisms for assessment and is open to evaluation. Physician reentry programs have an evaluation component that is comparable among all specialties. Program assessments use objective measures to evaluate physician's competence at time of entry, during the program and at time of completion. Program outcomes are measured. Reliability and validity of

		Accountable: The PREP system has mechanisms for assessment and is open to evaluation. Physician reentry programs have an evaluation component that is comparable among all specialties. Program assessments use objective measures to evaluate physician's competence at time of entry, during the program and at time of completion. Program outcomes are measured. Reliability and validity of the measures are established. Standardization of measures exist across programs to assess whether or not national standards are being met. i. Stable: A funding scheme is in place to ensure the PREP system is financially stable over the long-term. Adequate funding allows physician reentry programs to operate at sufficient and appropriate capacity. j. Responsive: The PREP system makes refinements, updates and other changes when necessary. Physician reentry programs are equipped to address systemic changes such as changes in regulations. Additionally, the PREP system is prepared to respond efficiently to urgent health care needs within society including mobilizing clinically inactive physicians temporarily into the workforce to attend to an acute public health crisis, such as a terrorist, biological, chemical, or natural disaster. 6. Our AMA encourages each state which does not grant a full and unrestricted license to physicians undergoing reentry to develop a non-disciplinary category of licensure for physicians during their reentry process. (CME Rep. 6, A-08; Reaffirmed: CME Rep. 11, A-12; Modified: CCB/CLRPD Rep. 2, A-14; Appended: Res. 310, A-14)	the measures are established. Standardization of measures exists across programs to assess whether or not national standards are being met. (i)~~.~~ Stable: A funding scheme is in place to ensure ~~the PREP system is~~ financial~~ly~~ ~~stable~~ stability over the long-term. Adequate funding allows physician reentry programs to operate at sufficient and appropriate capacity. (j) Responsive: ~~The PREP system m~~Makes refinements, updates, and other changes when necessary. Physician reentry programs are equipped to address systemic changes such as changes in regulations. ~~Additionally, the PREP system~~It is prepared to respond efficiently to urgent health care needs within society including mobilizing clinically inactive physicians temporarily into the workforce to attend to an acute public health crisis, such as a terrorist, biological, chemical, or natural disaster. ~~6. Our AMA~~ Will ~~encourages each states~~ that ~~which does not grant a full and unrestricted license to physicians undergoing reentry to develop a non-disciplinary category of licensure for physicians during their reentry process.~~ Sunset clause (2) as having been accomplished. Records indicate the AMA and the American Academy of Pediatrics hosted joint conferences in 2008 and 2011. They also launched the National Inactive Physicians Survey, which was published in 2011. Plans are underway for a similar study that will ask many of the same questions as the previous study. Sunset clause (3) as having been accomplished. FSMB developed a directory of physician assessment and remedial education programs. Regarding clause (6), state board requirements for reentry are listed on the FSMB website. FSMB's Workgroup on Reentry to Practice developed a draft report that discusses difficulties obtaining licensure based on time away from practice and speaks to differing reentry requirements when absences from practice result from disciplinary action or criminal conviction. Open comment period ended Feb 16, 2024. Remove references to "PREP" as it does not reflect current nomenclature.
D-300.988	Implications of the "Stark II" Regulations for Continuing Medical Education	Our AMA will (1) request that the Centers for Medicare & Medicaid Services develop an explicit exception within the regulations for Section 1877 of the Social Security Act (Stark law) that permits physician compensation without financial limit in the form of continuing medical education that is	**Retain – in part. Amend policy to read as follows:** Our AMA will ~~(1) request that the Centers for Medicare & Medicaid Services develop an explicit exception within the regulations for Section 1877 of the Social Security Act (Stark law) that permits~~

		offered for the purpose of ensuring quality patient care; and (2) monitor the impact of the Section 1877 (Stark II) regulations on the ability of health care institutions to provide continuing medical education to their medical staffs. (CME Rep. 6, I-04; Reaffirmed: CME Rep. 2, A-14)	~~physician compensation without financial limit in the form of continuing medical education that is offered for the purpose of ensuring quality patient care; and (2)~~ monitor the impact of the Section 1877 (Stark II) regulations on the ability of health care institutions to provide continuing medical education to their medical staffs. Sunset clause (1) as having been accomplished. After I-04, Centers for Medicare & Medicaid Services was notified of this HOD directive. Retain clause (2) as there remain situations where health care institutions seek guidance on whether providing certain types of continuing medical education violates section 1877.
D-300.994	Reduced Continuing Medical Education (CME) Fees for Retired Physicians	Our AMA supports reduced registration fees for retired physicians at all continuing medical education (CME) programs and encourages CME providers to consider a reduced fee policy for retired physicians. (Res. 302, I-01; Reaffirmed: CME Rep. 2, A-11; Modified: CME Rep. 2, A-14)	**Retain - still relevant.**
D-310.967	Resident Pay During Orientation	Our AMA will advocate that all resident and fellow physicians should be compensated, and receive benefits, at a level commensurate with the pay that they will receive while in their training program, for all days spent in required orientation activities prior to the onset of their contractual responsibilities. (Res. 302, A-07; Modified: CCB/CLRPD Rep. 2, A-14)	**Retain - still relevant.**
D-310.980	Increase in ACGME Fees	Our AMA will work with the Accreditation Council for Graduate Medical Education to limit the increase of the ACGME fees. (Res. 311, A-04; Reaffirmed: CME Rep. 2, A-14)	**Sunset – not practical.** ACGME has limited increases for many years. It is incumbent on organizations to be able to control their own fees.
D-310.982	Protecting the Privacy of Physician Information Held by the ACGME	Our AMA will request the Accreditation Council for Graduate Medical Education and any other organization with a similar case and procedure log for resident physicians to (1) develop and implement a system to remove or sufficiently protect identifying data from individual physicians? data logs; and (2) adopt a policy not to disseminate any data specific to individual physicians without the written consent of the physician. (Res. 301, A-04; Reaffirmed: CME Rep. 2, A-14)	**Sunset – accomplished.** After A-04, ACGME was notified of this HOD directive. Records of the correspondence state that "in discussing this issue last week with John Nylen, he assured me this is already ACGME policy." The ACGME data systems include the Accreditation Data System (ADS), the Case Log System, the Medical School Portal, and ACGME surveys. Public-facing data is available here. The majority of data are available only to individuals with login credentials. Logins are provided to

			designated institutional officials (DIOs), program directors, program coordinators, residents, fellows, and designated medical school users. Users have access to the following systems: • Program directors: ADS, including Case Logs for viewing reports. • DIOs: ADS, including Case Logs for viewing reports. • Residents and fellows: Case Logs and ACGME Surveys. • Faculty members: ACGME Surveys • Medical school users: Medical School Portal. • Others: ADS Public.
D-310.992	Limits on Training Opportunities for J-1 Residents	Our AMA will request that the Bureau of Educational and Cultural Affairs, Accreditation Council for Graduate Medical Education (ACGME), American Board of Medical Specialties and the Educational Commission for Foreign Medical Graduates develop criteria by which J-1 exchange visitor physicians could seek extension of the length of their visa beyond the 7-year limit in order to participate in fellowship or subspecialty programs accredited by the ACGME. (Res. 303, A-01; Reaffirmed: CME Rep. 2, A-11; Reaffirmation A-14)	**Sunset – accomplished.** After A-01, the Bureau of Educational and Cultural Affairs and the Educational Commission for Foreign Medical Graduates were notified of this HOD directive. It was also communicated to each residency program director and directors of medical education at U.S. teaching hospitals via the *Medical Education Bulletin*. According to ECFMG's (now a member of Intealth) Exchange Visitor Sponsor Program (EVSP), "any international medical graduate seeking to extend his/her participation in ECFMG-sponsored training beyond seven years must file a formal extension request with the Department of State (DOS) through ECFMG." In addition to the ECFMG fee and DOS fee, documentation must include: complete application for ECFMG sponsorship, letter of support from applicant's current and proposed program directors, statement of educational objectives from applicant, and letter of "exceptional need" from the home country government; this letter must be signed by either the home country's ambassador to the United States or the home country's minister of health confirming an "exceptional need" for the applicant to be trained in the field of medicine being pursued.
D-373.999	Informed Patient Choice and Shared Decision Making	1. Our AMA will work with state and specialty societies, medical schools, and others as appropriate to educate and communicate to medical students and to physicians about the importance of shared decision-making guidance through publications and other educational methods and assist the medical community in moving towards patient-centered care. (Res. 817, I-08; Modified: Res. 301, A-14)	**Retain - still relevant.**

D-480.999	State Authority and Flexibility in Medical Licensure for Telemedicine	Our AMA will continue its opposition to a single national federalized system of medical licensure. (CME Rep. 7, A-99; Reaffirmed and Modified: CME Rep. 2, A-09; Reaffirmed in lieu of Res. 920, I-13; Reaffirmed: BOT Rep. 3, I-14)	**Retain - still relevant.** This policy is central to Advocacy's work on telehealth licensure.
G-620.065	Dues Exemption/ Adjustment for Physicians Unable to Attain Residency Training Program	Our AMA urges state societies to offer membership at significantly discounted rates for example, equal to the charge for medical students or residents, to physicians who have graduated from American medical schools or who have successfully completed Educational Commission on Foreign Medical Graduate (ECFMG) and United States Medical Licensing Examination (USMLE) examinations but have been unable to obtain American residency positions. (Res. 611, A-14)	**Retain - still relevant.**
H-40.977	Pay Equity for Physicians in Active and Reserve Uniformed Services	For reservists called to active duty or on short-term mobilization assignments, the AMA supports the adjustment of pay and allowances upwards to approach pay and allowances for those with similar rank and qualifications in regular and long-term reserve status. (Sub. Res. 233, I-92; Reaffirmed: CMS Rep. 10, A-03; Reaffirmed: CME Rep. 2, I-04; Reaffirmed: CMS Rep. 1, A-14)	**Retain - still relevant.**
H-40.983	Active and Reserve Physicians and Physicians-In-Training	(1) Our AMA requests the Residency Review Committees and Specialty Boards to develop flexible policies to ensure that (a) resident physicians and fellows who are members of the active or reserve components of the uniformed services of the United States retain their academic and training status within their respective training programs during periods of reserve activation or active duty with the uniformed services; and (b) active duty or deployment time with the uniformed services during a residency or fellowship should be credited toward the usual training period for eligibility for matriculation and Board examinations when the trainee's experiences have been educationally appropriate. (2) Our AMA strongly encourages state licensing boards to waive requirements for continuing medical education credits for	**Retain – still relevant.** ACGME works closely with the Department of Defense around issues with deployment of both residents and faculty. The institutional review group is revising their requirements, which will likely be released in fall 2024 with an open comment period.

		physicians during periods of reserve or national guard activation or active duty with the uniformed services. (3) Our AMA supports the position that, at the time of national emergency, residents and fellows called to support their country in military service should be placed, when possible, in positions consistent with their specialty and level of training. (Res. 187, I-90; Modified: Sunset Report, I-00; Reaffirmed: CME Rep. 2, I-04; Modified: CME Rep. 2, A-14)	
H-95.943	MDs/DOs as Medical Review Officers	Our AMA: (1) reaffirms its policy that only licensed MDs/DOs with knowledge of substance use disorders should serve as Medical Review Officers (MROs); (2) reaffirms its policy that all MDs/DOs who serve as MROs should obtain continuing medical education credit in this subject area; (3) vigorously advocates that any legislation concerning drug testing in the workplace include a provision for a Medical Review Officer (MRO) who will review all positive test results and further that only a licensed physician may serve as the MRO and further that this physician MRO has knowledge of substance abuse disorders and has appropriate medical training to interpret and evaluate an individual's positive test results together with his or her medical history and any other relevant biomedical information ; and (4) vigorously opposes legislation that is inconsistent with these policies. (CCB/CLRPD Rep. 3, A-14)	**Retain – still relevant**. **Amend policy to read as follows:** Our AMA: (1) ~~reaffirms its policy~~ affirms that only licensed MDs/DOs with knowledge of substance use disorders should serve as Medical Review Officers (MROs); (2) ~~reaffirms its policy~~ affirms that all MDs/DOs who serve as MROs should obtain continuing medical education credit in this subject area; (3) ~~vigorously advocates~~ affirms that any legislation concerning drug testing in the workplace include a provision for a Medical Review Officer (MRO) who will review all positive test results ~~and further that only a licensed physician may serve as the MRO~~ and further that this physician MRO ~~has knowledge of substance abuse disorders and~~ has appropriate medical training to interpret and evaluate an individual's positive test results together with their medical history and any other relevant biomedical information~~-~~; and (4) ~~vigorously~~ opposes legislation that is inconsistent with these policies. Clauses (1) and (2) are consistent with ACOEM's MRO training. Language in clause (3) is redundant.
H-275.929	Additions to United States Medical Licensure Examination and Comprehensive Osteopathic Medical Licensure Examination	Our AMA opposes additions to the United States Medical Licensing Examination and Comprehensive Osteopathic Medical Licensure Examination that lack predictive validity for future performance as a physician. (Res. 308, A-04; Reaffirmed: CME Rep. 2, A-14)	**Retain - still relevant. Amend policy with change in title to read as follows:** Oppose Additions to United States Medical Licensure Examination and Comprehensive Osteopathic Medical Licensure Examination
H-275.930	Opposition to Clinical Skills Examinations	Our AMA: (1) opposes clinical skills examinations for the purpose of physician medical relicensure; (2) reaffirms its	**Retain- in part. Amend policy to read as follows:**

	for Physician Medical Relicensure	support for continuous quality improvement of practicing physicians, and supports research into methods to improve clinical practice, including practice guidelines; and (3) continues to support the implementation of quality improvement through local professional, non-governmental oversight. (Res. 307, A-04; Reaffirmed: CME Rep. 2, A-14)	Our AMA: (1) opposes clinical skills examinations for the purpose of physician medical relicensure; and (2) ~~reaffirms its supports for continuous quality improvement of practicing physicians, and supports; research into methods to improve clinical practice, including practice guidelines; and (3) continues to~~ supports the implementation of quality improvement through local professional, non-governmental oversight. Retain clause (1) as still relevant. Sunset clause (2) which is addressed in policies H-450.970, H-450.965, and D-478.984. Retain clause (3) and append to H-450.970 where it better aligns with the content and title.
H-275.945	Self-Incriminating Questions on Applications for Licensure and Specialty Boards	The AMA will: (1) encourage the Federation of State Medical Boards and its constituent members to develop uniform definitions and nomenclature for use in licensing and disciplinary proceedings to better facilitate the sharing of information; (2) seek clarification of the application of the Americans with Disabilities Act to the actions of medical licensing and medical specialty boards; and (3) until the applicability and scope of the Americans with Disabilities Act are clarified, will encourage the American Board of Medical Specialties and the Federation of State Medical Boards and their constituent members to advise physicians of the rationale behind inquiries on mental illness, substance abuse or physical disabilities in materials used in the licensure, reregistration, and certification processes when such questions are asked. (BOT Rep. 13, I-93; Reaffirmed: CME Rep. 10-I-94; Reaffirmed: CME Rep. 2, A-04; Reaffirmed: CME Rep. 2, A-14)	**Sunset – accomplished.** Sunset clause (1) as having been accomplished. FSMB Physician Data Center (PDC) and Disciplinary Alert Service (DAS) foster the appropriate sharing of information and uniformity of definitions and nomenclature. Sunset clause (2) as having been accomplished. FSMB adopted policy Physician Wellness and Burnout (2018) that addresses the ADA related to licensing. Sunset clause (3), as it is addressed in policy H-275.970.
H-275.973	State Control of Qualifications for Medical Licensure	(1) The AMA firmly opposes the imposition of federally mandated restrictions on the ability of individual states to determine the qualifications of physician candidates for licensure by endorsement. (2) The AMA actively opposes the enactment of any legislation introduced in Congress that promotes these objectives. (Res. 84, I-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CME Rep. 2, A-07; Reaffirmed: BOT Rep. 3, I-14)	**Retain - still relevant. Amend policy with change in title to read as follows:** Support State Control of Qualifications for Medical Licensure

H-275.977	Verifying Physicians' Credentials	The AMA endorses the use of pluralistic approaches to the verification and validation of physicians' credentials. The AMA will seek legislation that managed care companies be required to request credentialing information in a uniform standardized format which all groups involved in credentialing would accept. (Sub. Res. 91, A-87; Amended by Res. 736, A-97; Reaffirmed: Sunset Report, I-97; Reaffirmed: CME Rep. 2, A-07; Reaffirmed: BOT Rep. 3, I-14)	**Sunset – duplicative.** Sunset the first sentence as superseded by policy D-275.995 that supports primary source verification of credentials via the AMA Masterfile, FSMB's Federation Credentials Verification Service, and the Educational Commission for Foreign Medical Graduates' Certification Verification Service. Sunset the second sentence, which is already addressed by policy H-285.979.
H-275.988	Identifying Persons with Illegally Obtained Medical Degrees	The AMA supports appropriate efforts of private and governmental agencies in identification of persons possessing illegally obtained medical degrees. (Res. 43, A-84; Reaffirmed by CLRPD Rep. 3 - I-94; Reaffirmed: CME Rep. 2, A-04; Reaffirmed: CME Rep. 2, A-14)	**Retain- still relevant.**
H-275.996	Physician Competence	Our AMA: (1) urges the American Board of Medical Specialties and its constituent boards to reconsider their positions regarding recertification as a mandatory requirement rather than as a voluntarily sought and achieved validation of excellence; (2) urges the Federation of State Medical Boards and its constituent state boards to reconsider and reverse their position urging and accepting specialty board certification as evidence of continuing competence for the purpose of re-registration of licensure; and (3) favors continued efforts to improve voluntary continuing medical education programs, to maintain the peer review process within the profession, and to develop better techniques for establishing the necessary patient care data base. (CME Rep. J, A-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CME Rep. 7, A-02; Reaffirmed: CME Rep. 7, A-07; Reaffirmed: CME Rep. 16, A-09; Reaffirmed in lieu of Res. 302, A-10; Reaffirmed in lieu of Res. 320, A-14)	**Sunset – accomplished.** Sunset clause (1) as having been accomplished. According to the ABMS, "member board certification is a voluntary specialty credential that indicates a physician or medical specialist's proficiency in a particular specialty area of medicine." Sunset clause (2) as having been accomplished, given the FSMB was notified of this policy after A-80. In 2012, the FSMB House of Delegates adopted a policy that states "The Federation of State Medical Boards (FSMB) supports the use of, and encourages state boards to recognize, a licensee's participation in an ABMS MOC and/or AOA BOS OCC program as an acceptable means of meeting CME requirements for license renewal." FSMB is aware of a small but growing number of state medical boards that accept participation in continuing certification as evidence of substantive compliance with CME requirements. Sunset clause (3) as duplicative. Addressed in AMA policy Support for Continuing Medical Education H-300.958.
H-295.863	Impairment Prevention and Treatment in the Training Years	Our AMA: (1) reaffirms the importance of preventing and treating psychiatric illness, alcoholism and substance abuse in medical students, residents and fellows; (2) strongly encourages medical schools and teaching	**Retain - still relevant. Amend policy to read as follows:** Our AMA: (1) ~~re~~affirms the importance of preventing and treating psychiatric illness,

		hospitals to develop and maintain impairment prevention and treatment programs with confidential services for medical students, residents and fellows; (3) urges medical schools, hospitals with graduate medical education programs, and state and county medical societies to initiate active liaison with local impaired physician committees in order to more effectively diagnose and treat medical student and resident substance abuse; (4) advocates (a) further study (and continued monitoring of other studies) concerning the problem of substance abuse among students, residents, and faculty in U.S. medical schools, and (b) development of model policy and programmatic guidelines which might assist in the establishment of programs for medical students, residents and faculty and which could significantly impact this problem and potentially reduce the risk of future impairment among physicians. (CCB/CLRPD Rep. 3, A-14)	alcoholism, and substance ~~abuse~~ use in medical students, residents, and fellows; (2) ~~strongly~~ encourages medical schools and teaching hospitals to develop and maintain impairment prevention and treatment programs with confidential services for medical students, residents, and fellows; (3) urges medical schools, hospitals with graduate medical education programs, and state and county medical societies to initiate active liaison with local impaired physician committees in order to more effectively diagnose and treat medical student and resident substance ~~abuse~~ use; (4) advocates (a) further study (and continued monitoring of other studies) concerning the problem of substance ~~abuse~~ use among students, residents, and faculty in U.S. medical schools, and (b) development of model policy and programmatic guidelines which might assist in the establishment of programs for medical students, residents, and faculty and which could significantly impact this problem and potentially reduce the risk of future impairment among physicians. Change from "abuse to "use" in keeping with policy Destigmatizing the Language of Addiction H-95.917.
H-295.880	Service Learning in Medical Education	Our AMA will support the concept of service learning as a key component in medical school and residency curricula, and that these experiences should include student and resident collaboration with a community partner to improve the health of the population. (Res. 321, A-04; Reaffirmed: CME Rep. 2, A-14)	**Retain - still relevant.**
H-295.929	Faculty/Staff Appointments at More Than One Medical School	The AMA encourages medical schools that currently do not permit volunteer faculty members to hold appointments at more than one medical school to review this policy, to ensure that it is in the best interests of medical education and program integrity. Nonsalaried faculty members of medical schools should be allowed to hold concurrent appointments at more than one medical school as long as the individual physician agrees to carry out all responsibilities assigned by each medical school. (CME Rep. 3, I-93; Reaffirmed: CME Rep. 2, A-05; Modified: CME Rep. 2, A-14)	**Retain - still relevant.**
H-295.983	Extramural Clerkships and	The AMA (1) recognizes the essential role of the medical school faculty in the	**Retain - still relevant.**

	Early Career Decisions	determination of the core clinical education of medical students; and (2) opposes resident recruitment practices which would interfere with scheduled core clinical clerkships at the student's medical school. (Res. 77, I-84; CLRPD Rep. 3 - I-94; Reaffirmed: CME Rep. 2, A-04; Reaffirmed: CME Rep. 2, A-14)	
H-295.985	Humanism in Graduate Medical Education	The AMA encourages medical schools and teaching hospitals to strengthen educational programs for undergraduates and resident physicians in recognizing and meeting the emotional needs of patients and their families. (Sub. Res. 154, A-84; Reaffirmed by CLRPD Rep. 3 - I-94; Reaffirmed: CME Rep. 2, A-04; Reaffirmed: CME Rep. 2, A-14)	**Retain - still relevant.**
H-305.950	Fairness in Publication of Names of Loan Defaulters	The AMA opposes the selective publication of names of defaulters on federally funded student loans. (Res. 309, A-94; Reaffirmed: CME Rep. 2, A-04; Reaffirmed: CME Rep. 2, A-14)	**Retain - still relevant.**
H-310.990	Shared Residency Positions	The AMA supports the concept of shared residency positions and the continued collection and publication of data on these positions, and encourages residency program directors to offer such positions where feasible. (Res. 81, I-84; Reaffirmed by CLRPD Rep. 3 - I-94; Reaffirmed: CME Rep. 2, A-04; Modified: CME Rep. 2, A-14)	**Retain – still relevant. Amend policy to read as follows:** The AMA supports the concept of shared residency positions and the continued collection and publication of data on these positions~~, and encourages residency program directors to offer such positions where feasible~~.
H-355.977	Reporting of Resident Physicians to the National Practitioner Data Bank	1. Our AMA: (A) seeks opportunities to limit reports concerning residents to the National Practitioner Data Bank to only those situations where a final adverse action has been taken by a medical licensing jurisdiction; (B) opposes attempts to extend reports concerning residents to the National Practitioner Data Bank beyond those covered in Item 1 of this policy; and (C) advocates for legislation amending, as appropriate, the NPDB reporting requirements regarding resident physicians to be consistent with this policy, and opposes the expansion of existing reporting requirements. (CCB/CLRPD Rep. 3, A-14)	**Retain - still relevant. Amend policy to read as follows:** ~~1.~~ Our AMA: (A) ~~seeks opportunities to~~ supports the limiting of reports concerning residents to the National Practitioner Data Bank to only those situations where a final adverse action has been taken by a medical licensing jurisdiction; and (B) opposes attempts to extend reports concerning residents to the National Practitioner Data Bank ~~beyond those covered in Item 1 of this policy; and (C) advocates for legislation amending, as appropriate, the NPDB reporting requirements regarding resident physicians to be consistent with this policy, and opposes the expansion of existing reporting requirements~~.