

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 1-A-26

Subject: Council on Medical Education Sunset Review of 2016 House of Delegates' Policies

Presented by: Kelly Caverzagie, MD, MPH, Chair

Referred to: Reference Committee C

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2 Policy G-600.110, “Sunset Mechanism for AMA Policy,” calls for the decennial review of
3 American Medical Association (AMA) policies to ensure that our AMA’s policy database is
4 current, coherent, and relevant:
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6 1. As the House of Delegates adopts policies, a maximum ten-year time horizon shall exist. A
7 policy will typically sunset after ten years unless action is taken by the House of Delegates to
8 retain it. Any action of our AMA House that reaffirms or amends an existing policy position
9 shall reset the sunset “clock,” making the reaffirmed or amended policy viable for another ten
10 years.
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12 2. In the implementation and ongoing operation of our AMA policy sunset mechanism, the
13 following procedures shall be followed: (a) Each year, the Speakers shall provide a list of
14 policies that are subject to review under the policy sunset mechanism; (b) Such policies shall be
15 assigned to the appropriate AMA councils for review; (c) Each AMA council that has been
16 asked to review policies shall develop and submit a report to the House of Delegates identifying
17 policies that are scheduled to sunset; (d) For each policy under review, the reviewing council
18 can recommend one of the following actions: (i) retain the policy; (ii) sunset the policy; (iii)
19 retain part of the policy; or (iv) reconcile the policy with more recent and like policy; (e) For
20 each recommendation that it makes to retain a policy in any fashion, the reviewing council shall
21 provide a succinct, but cogent justification; and (f) The Speakers shall determine the best way
22 for the House of Delegates to handle the sunset reports.
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24 3. Nothing in this policy shall prohibit a report to the HOD or resolution to sunset a policy earlier
25 than its ten-year horizon if it is no longer relevant, has been superseded by a more current
26 policy, or has been accomplished.
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28 4. The AMA councils and the House of Delegates should conform to the following guidelines for
29 sunset: (a) when a policy is no longer relevant or necessary; (b) when a policy or directive has
30 been accomplished; or (c) when the policy or directive is part of an established AMA practice
31 that is transparent to the House and codified elsewhere such as the AMA Bylaws or the AMA
32 House of Delegates Reference Manual: Procedures, Policies and Practices.
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34 5. The most recent policy shall be deemed to supersede contradictory past AMA policies.
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36 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
5 filed.

Fiscal Note: Minimal

APPENDIX: RECOMMENDED ACTIONS

Policy Number	Title	Text	Recommendation
D-275.953	Protection of Physicians' Personal Information	<p>Our AMA will work with the Federation of State Medical Boards to standardize the publicly available data on the State Medical Boards' websites to protect the personal data of physicians to decrease the risk of identity theft.</p> <p>Policy Timeline: Res. 602, A-16</p>	<p>Rescind – accomplished.</p> <p>Update provided to HOD after A-16 stated that a letter was sent to the Federation of State Medical Boards (FSMB) to notify them of the House action. In part, the letter addressed the disclosure of multiple data elements about physicians on state medical board websites. The letter asked that state medical boards be encouraged to limit the personal information displayed on their websites to the minimum necessary to reduce the possibility of identity theft among physicians. The House action also was transmitted to medical school deans, residency program directors, directors of medical education at U.S. teaching hospitals, and those leading other interested groups via the AMA MedEd Update newsletter.</p> <p>There is currently no national standard for displaying physician information on websites. While states vary in their approaches given different priorities and state laws, there is convergence on not posting the most sensitive identifiers (e.g., full Social Security number, full date of birth, bank numbers, or tax numbers, etc.). These identifiers may be collected and stored in licensing records. FSMB does not collect comprehensive state-based data on this issue.</p>
D-295.949	Criminal Background Checks for Medical Students	<p>Our AMA will:</p> <p>(1) through relevant Councils and Sections, collaborate with other organizations working to develop policies and procedures for criminal background checks for applicants accepted to medical school and enrolled medical students, including the creation of guidelines for appropriate action related to individuals whose background checks raise concerns;</p> <p>(2) work to ensure that systems for criminal background checks for accepted applicants and medical students are standardized within and across institutions, as well as equitable, cost-</p>	<p>Retain clause 1 and amend by addition and deletion to read: Our AMA will: (1) through relevant Councils and Sections, collaborate with other organizations working to develop policies and procedures for encourages (1) criminal background checks for applicants accepted to medical school and enrolled medical students, including the creation of and (2) dissemination of guidelines for appropriate action related to individuals whose background checks raise concerns.</p> <p>Rescind clauses 2 and 3 – accomplished.</p> <p>Update provided to HOD after A-06 stated that the House action was transmitted to medical school deans, residency program</p>

		<p>effective, and consistent with the requirements for background checks being required of resident physicians and practicing physicians; and</p> <p>(3) continue to monitor the requirement for criminal background checks for accepted applicants and medical students by medical schools, hospitals/health systems, and state laws.</p> <p>Policy Timeline: CME Rep. 9, A-06; Reaffirmed: CME Rep. 01, A-16</p>	<p>director, and directors of medical education at U.S. teaching hospitals via the AMA Medical Education Bulletin; and that the Council on Medical Education would work with other AMA Councils and Sections as well as the Association of American Medical Colleges (AAMC) to develop guidelines.</p> <p>Related information provided on AAMC and American Association of Colleges of Osteopathic Medicine websites.</p>
<p>D-295.313</p>	<p>Telemedicine in Medical Education</p>	<p>1. Our AMA encourages appropriate stakeholders to study the most effective methods for the instruction of medical students, residents, fellows and practicing physicians in the use of telemedicine and its capabilities and limitations.</p> <p>2. Our AMA will collaborate with appropriate stakeholders to reduce barriers to the incorporation of telemedicine into the education of physicians and other health care professionals.</p> <p>3. Our AMA encourages the Liaison Committee on Medical Education and Accreditation Council for Graduate Medical Education to include core competencies in telemedicine in undergraduate medical education and graduate medical education training.</p> <p>Policy Timeline: CME Rep. 06, A-16</p>	<p>Retain – still relevant; amend clauses 1 and 2 by addition and deletion to read:</p> <p>1. Our AMA encourages appropriate stakeholders <u>interested parties</u> to study the most effective methods for the instruction of medical students, residents, fellows and practicing physicians in the use of telemedicine and its capabilities and limitations.</p> <p>2. Our AMA will collaborate with appropriate stakeholders <u>interested parties</u> to reduce barriers to the incorporation of telemedicine into the education of physicians and other health care professionals.</p> <p>Update provided to HOD after A-16 stated that the Association of American Medical Colleges, American Osteopathic Association, American Association of Colleges of Osteopathic Medicine, Liaison Committee on Medical Education. and Accreditation Council for Graduate Medical Education were notified of the House action. It was also transmitted to medical school deans, residency program directors, directors of medical education at U.S. teaching hospitals, and leaders of other interested groups via the AMA MedEd update newsletter.</p>
<p>D-300.977</p>	<p>ACCME Proposed Changes in “Accreditation with Commendation” Continuing Medical Education Criteria Assessment Methodology</p>	<p>Our AMA will continue to monitor the proposed Accreditation Council for Continuing Medical Education (ACCME) “Accreditation with commendation” criteria, provide input to the ACCME Board of Directors, and report to the AMA HOD once the criteria are approved and implemented.</p> <p>Policy Timeline: Res. 313, A-16</p>	<p>Rescind – accomplished.</p> <p>Currently, a member of the AMA Council on Medical Education serves on the ACCME Board of Directors and provides updates to the Council.</p> <p>Update provided to HOD after A-16 stated that the Council on Medical Education prepared informational report CME 8-A-17 on this subject.</p>

			ACCME's Accreditation with Commendation criteria were updated in 2016 and have been in effect for decisions made after November 2019. New Standards for Integrity and Independence in Accredited Continuing Education went into effect January 2022.
D-310.951	Mitigating Abusive Pre-Certification / Pre-Authorization Practices	Our AMA will work with the Accreditation Council for Graduate Medical Education to encourage residency programs to offer administrative resources to housestaff for practice-based support, including but not limited to pre-certification and pre-authorization of medications and services. Policy Timeline: Res. 716, A-16	Rescind – accomplished. Update provided to HOD after A-16 stated that the Accreditation Council for Graduate Medical Education was notified of the House action. It was also transmitted to medical school deans, residency program directors, directors of medical education at U.S. teaching hospitals, and leaders of other interested groups via the AMA MedEd Update newsletter.
H-275.936	Mechanisms to Measure Physician Competency	Our AMA: (1) continues to work with the American Board of Medical Specialties and other relevant organizations to explore alternative evidence-based methods of determining ongoing clinical competency; (2) reviews and proposes improvements for assuring continued physician competence, including but not limited to performance indicators, board certification and recertification, professional experience, continuing medical education, and teaching experience; and (3) opposes the development and/or use of “Medical Competency Examination” and establishment of oversight boards for current state medical boards as proposed in the fall 1998 Report on Professional Licensure of the Pew Health Professions Commission, as an additional measure of physician competency. Policy Timeline: Res. 320, I-98; Amended: Res. 817, A-99; Reaffirmed: CME Rep. 7, A-02; Reaffirmed: CME Rep. 7, A-07; Reaffirmed: CME Rep. 16, A-09; Reaffirmed in lieu of Res. 313, A-12; Modified: Res. 309, I-16	Rescind – addressed by H-275.916 , H-295.862 , H-275.924 , D-275.954 . Clause 3 is outdated. Update provided to HOD after A-16 stated that the American Board of Medical Specialties (ABMS) was notified of the House action. It was also transmitted to medical school deans, residency program directors, directors of medical education at U.S. teaching hospitals, and leaders of other interested groups via the AMA MedEd Update newsletter. The Council on Medical Education continues to engage with the ABMS on ways in which the continuing board certification (formerly maintenance of certification) process can be made more meaningful, relevant, and reflective of the ways that physicians actually practice.
H-275.979	Medicare Reporting of Adverse Incidents in Hospitals to State Agencies	The AMA opposes the sharing of information generated through the Medicare utilization process or other institutional review with state licensure bodies until hospital quality assurance committees have been notified and given a reasonable time to respond.	Retain – still relevant.

		<p>Policy Timeline: Res. 118, I-86; Reaffirmed: Sunset Report, I-96; Reaffirmed: CME Rep. 2, A-06; Reaffirmed: CME Rep. 01, A-16</p>	
H-275.980	Funding of State Medical Boards	<p>(1) The AMA urges state medical associations to recommend to their respective state legislatures that all fees and charges collected by the state licensing/disciplinary board(s), or on its behalf, be specifically designated for use of the board(s) in fulfilling its duties under the state’s medical practice act. (2) When such funds are inadequate to support such activities, state general funds should be used to support the board’s effective fulfillment of its duties mandated by the state’s medical practice act.</p> <p>Policy Timeline: Sub. Res. 23, I-86; Reaffirmed: Sunset Report, I-96; Reaffirmed: CME Rep. 2, A-06; Reaffirmed: CME Rep. 01, A-16</p>	Retain – still relevant.
H-275.997	Licensure by Specialty	<p>Experience with licensure by specialty is too limited to determine what the long-range effects will be in the provision of timely, safe and comprehensive medical care. However, the AMA does not consider licensure by specialty to be desirable even in unusual cases.</p> <p>Policy Timeline: CME Rep. F, A-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CME Rep. 2, A-10; Reaffirmed: BOT Rep. 05, I-16</p>	Rescind – addressed by H-275.978 clauses 2 and 16.
H-280.946	Policies on Intimacy and Sexual Behavior in Residential Aged Care Facilities	<p>Our AMA urges long-term care facilities and other appropriate organizations to:</p> <p>(1) adopt policies and procedures on intimacy and sexual behavior that preserve residents’ rights to pursue sexual relationships, while protecting them from unsafe, unwanted, or abusive situations; and (2) provide staff with in-service training to develop a framework to address intimacy in their patient population.</p> <p>Policy Timeline: Res. 403, A-16</p>	<p>Retain – still relevant.</p> <p>Notice provided to HOD after A-16 stated that the AMA Policy Database was updated.</p>
H-295.912	Education of Medical Students and Residents about Domestic	<p>Our American Medical Association will continue its support for the education of medical students and residents on domestic violence by advocating that medical schools and graduate medical</p>	Retain – still relevant.

	Violence Screening	<p>education programs educate students and resident physicians to sensitively inquire about family abuse with all patients, when appropriate and as part of a comprehensive history and physical examination, and provide information about the available community resources for the management of the patient.</p> <p>Policy Timeline: Res. 303, I-96; Reaffirmed: CME Rep. 2, A-06; Reaffirmed: CME Rep. 01, A-16</p>	
H-295.915	Residency Program Responsibility for Resident Education	<p>Our American Medical Association affirms that the basic skills and competencies for the practice of medicine and its specialties must be determined solely by the medical profession.</p> <p>Policy Timeline: Res. 313, A-96; Reaffirmed: CME Rep. 2, A-06; Reaffirmed: CME Rep. 01, A-16</p>	Rescind – addressed by policies H-275.916 and Opinion 8.13 .
H-295.969	Nondiscrimination Toward Residency Applicants	<p>Our American Medical Association urges the Accreditation Council for Graduate Medical Education to amend its Institutional Requirements to read: “In assessing and selecting applicants for residency/fellowship programs, ACGME-accredited programs must not discriminate on the basis of sex, age, race, creed, national origin, gender identity, or sexual orientation.”</p> <p>Policy Timeline: Res. 12, A-89; Reaffirmed: Sunset Report, A-00; Modified: BOT Rep. 11, A-07; Reaffirmed: CCB/CLRPD Rep. 1, A-14; Modified: CME Rep. 01, A-16</p>	<p>Retain; amend by addition and deletion to read:</p> <p>Our American Medical Association urges the Accreditation Council for Graduate Medical Education to amend its Institutional Requirements to read: “In assessing and selecting applicants for residency/fellowship programs, ACGME-accredited programs must not discriminate on the basis of sex, age, race, creed, national origin, gender identity, or sexual orientation.”</p> <p><u>Our American Medical Association encourages that Accreditation Council for Graduate Medical Education-accredited programs should not discriminate on the basis of an individual’s sex, age, race, creed, national origin, gender identity, or sexual orientation.</u></p> <p>Discrimination is addressed by the ACGME in the 2025 Institutional Requirements, specifically:</p> <ul style="list-style-type: none"> ● (3.2.f.4) addresses all discrimination, while not articulating the types. ● (4.2) addresses recruitment, selection, eligibility, and appointment ● (4.9.e) directs institutional policies prohibiting discrimination in employment and in the learning and working environment.
H-295.981	Geriatric Medicine	<p>1. Our AMA reaffirms its support for: (a) the incorporation of geriatric medicine</p>	Retain – still relevant.

		<p>into the curricula of medical school departments and its encouragement for further education and research on the problems of aging and health care of the aged at the medical school, graduate and continuing medical education levels; and (b) increased training in geriatric pharmacotherapy at the medical student and residency level for all relevant specialties and encourages the Accreditation Council for Graduate Medical Education and the appropriate Residency Review Committees to find ways to incorporate geriatric pharmacotherapy into their current programs.</p> <p>2. Our AMA recognizes the critical need to ensure that all physicians who care for older adults, across all specialties, are competent in geriatric care, and encourages all appropriate specialty societies to identify and implement the most expedient and effective means to ensure adequate education in geriatrics at the medical school, graduate, and continuing medical education levels for all relevant specialties.</p> <p>Policy Timeline: Res. 137, A-85; Reaffirmed by CLRPD Rep. 2, I-95; Appended: CSA Rep. 5, A-02; Appended: Res. 301, A-10; Reaffirmed: BOT Rep. 05, I-16</p>	
<p>H-300.951</p>	<p>Credit for Reading Medical Journals</p>	<p>The AMA continues to support appropriate credit for medical journal study and make every effort to simplify the process by which this is accomplished.</p> <p>Policy Timeline: Res. 315, I-96; Reaffirmed: CME Rep. 2, A-06; Reaffirmed: CME Rep. 01, A-16</p>	<p>Rescind – accomplished.</p> <p>AMA Physician’s Recognition Award and credit system booklet describes “journal-based CME” on page 4.</p>
<p>H-300.952</p>	<p>Dissemination of Information Regarding CME Activities</p>	<p>The AMA will continue to support the current system of Continuing Medical Education accreditation in which the Accreditation Council for Continuing Medical Education accredits sponsors whose mission and intended audience are on a regional or national level and state medical societies accredit sponsors whose mission and intended audience are physicians within state and contiguous states, following the guidelines enunciated by the ACCME.</p>	<p>Retain – still relevant.</p>

		<p>Policy Timeline: CME Rep. 7, I-96; Reaffirmed: CME Rep. 2, A-06; Reaffirmed: CME Rep. 01, A-16</p>	
H-300.955	Restructuring of Continuing Medical Education Credits	<p>The AMA encourages state licensing boards with CME reporting requirements to allow <i>AMA PRA Category 1 Credit</i>™ and <i>AMA PRA Category 2 Credit</i>™ toward reregistration of the license to practice medicine; and all state licensing boards be urged to accept a current and valid AMA Physician’s Recognition Award as evidence of completion of these requirements.</p> <p>Policy Timeline: CME Rep. 7, A-96; Reaffirmed: CME Rep. 2, A-06; Reaffirmed: CME Rep. 01, A-16</p>	Retain – still relevant.
H-310.906	Improving Residency Training in the Treatment of Opioid Dependence	<p>Our AMA: (1) encourages the expansion of residency and fellowship training opportunities to provide clinical experience in the treatment of opioid use disorders, under the supervision of an appropriately trained physician; and (2) supports additional funding to overcome the financial barriers that exist for trainees seeking clinical experience in the treatment of opioid use disorders.</p> <p>Policy Timeline: Res. 301, I-16</p>	<p>Retain – still relevant.</p> <p>Notice provided to HOD after I-16 stated that the AMA Policy Database was updated.</p>
H-310.982	Reevaluation of Residency Selection Process	<p>Our American Medical Association supports continued cooperation with the Association of American Medical Colleges in the evaluation of the residency selection process, with emphasis on the reduction of pressures that induce premature specialty decisions within the undergraduate medical curriculum.</p> <p>Policy Timeline: Sub. Res. 112, I-86; Amended by Sunset Report, I-96; Modified and Reaffirmed: CME Rep. 2, A-06; Reaffirmed: CME Rep. 01, A-16</p>	Retain – still relevant.
H-310.983	Residency Positions for Sale	<p>Our American Medical Association reaffirms its position that selection of residents should be based on the academic and personal qualifications of applicants and that monetary considerations should never compromise the selection process.</p>	<p>Retain – still relevant. Append to H-305.925; amend by addition and deletion to read:</p> <p>27. Our American Medical Association reaffirms its position Upholds that selection of residents should be based on the academic and personal qualifications of applicants and</p>

		<p>Policy Timeline: CME Rep. A, A-86; Reaffirmed: Sunset Report, I-96; Reaffirmed: CME Rep. 2, A-06; Reaffirmed: CME Rep. 01, A-16</p>	<p>that monetary considerations should never compromise the selection process.”</p>
H-345.970	<p>Improving Mental Health Services for Undergraduate and Graduate Students</p>	<p>Our AMA supports: (1) strategies that emphasize de-stigmatization and enable timely and affordable access to mental health services for undergraduate and graduate students, in order to improve the provision of care and increase its use by those in need; (2) colleges and universities in emphasizing to undergraduate and graduate students and parents the importance, availability, and efficacy of mental health resources; and (3) collaborations of university mental health specialists and local public or private practices and/or health centers in order to provide a larger pool of resources, such that any student is able to access care in a timely and affordable manner.</p> <p>Policy Timeline: Res. 904, I-16</p>	<p>Retain – still relevant.</p> <p>Notice provided to HOD after I-16 stated that the AMA Policy Database was updated.</p>
H-345.973	<p>Medical and Mental Health Services for Medical Students and Resident and Fellow Physicians</p>	<p>Our AMA promotes the availability of timely, confidential, accessible, and affordable medical and mental health services for medical students and resident and fellow physicians, to include needed diagnostic, preventive, and therapeutic services. Information on where and how to access these services should be readily available at all education/training sites, and these services should be provided at sites in reasonable proximity to the sites where the education/training takes place.</p> <p>Policy Timeline: Res. 915, I-15; Revised: CME Rep. 01, I-16</p>	<p>Retain – still relevant.</p> <p>Notice provided to HOD after I-15 stated that the AMA Policy Database was updated.</p>
H-405.962	<p>The Practice of Public Health by Physicians</p>	<p>Our AMA: (1) recognizes the practice of public health by physicians as the practice of medicine; (2) opposes specialty-specific license restrictions for American Board of Medical Specialties (ABMS)-recognized specialties; and (3) encourages the ABMS and the Federation of State Medical Boards to adopt similar policies recognizing the practice of public health by physicians as a legitimate practice of medicine and opposing specialty-specific license restrictions for ABMS-recognized specialties.</p> <p>Policy Timeline: Res. 815, I-06; Reaffirmed: CME Rep. 01, A-16</p>	<p>Retain clause 1 – still relevant. Rescind clauses 2 and 3 – accomplished.</p> <p>Public health is recognized by the ABMS: Specialties - The American Board of Preventive Medicine. All certifications offered by ABMS Member Boards are endorsed by the ABMS and require approval when they offer a new certification or focused practice designation.</p> <p>No state requires any certification (ABMS or otherwise) to obtain a license to practice medicine. ABMS and FSMB have long held that ABMS certification is voluntary and should not be tied to requirements to obtain a</p>

			state medical license, which aligns with other AMA policy.
H-405.966	Resident Physician Licenses	<p>Our American Medical Association supports the option of limited educational licenses in all states for resident physicians to provide care within their residency programs; and supports reduced licensure fees for resident physicians for participation solely in graduate medical education training programs when full medical licensure is required by a state.</p> <p>Policy Timeline: Sub. Res. 312, A-96; Reaffirmed: CME Rep. 2, A-06; Reaffirmed: CME Rep. 01, A-16</p>	Retain – still relevant.