**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-22

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| Subject: | Council on Medical Education Sunset Review of 2012 House of Delegates' Policies |
| Presented by: | Niranjan V. Rao, MD, Chair |
| Referred to: | Reference Committee C |

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:

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to the HOD or resolution to sunset a policy earlier than its 10-year horizon if it is no longer relevant, has been superseded by a more current policy, or has been accomplished.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

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 | Recommendation |
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| H-35.975 | Ratio of Physician to Physician Extenders | Our AMA endorses the principle that the appropriate ratio of physician to non-physician practitioners should be determined by physicians at the practice level, consistent with good medical practice, and state law where relevant, taking into consideration the physician's specialty, physician's panel size and disease burden of the patient case mix. (CME Rep. 10, I-98; Reaffirmed: CME Rep. 2, A-08; Reaffirmed: BOT Rep. 28, A-09; Modified: Joint CME-CMS Rep., I-12) | Retain; still relevant. |
| H-160.940 | Free Clinic Support | Our AMA supports: (1) organized efforts to involve volunteer physicians, nurses and other appropriate providers in programs for the delivery of health care to the indigent and uninsured and underinsured through free clinics; and (2) efforts to reduce the barriers faced by physicians volunteering in free clinics, including medical liability coverage under the Federal Tort Claims Act, liability protection under state and federal law, and state licensure provisions for retired physicians and physicians licensed in other United States jurisdictions. (Sub. Res. 113, I-96; Reaffirmed: BOT 17, A-04; CMS Rep. 1, A-09; Reaffirmed in lieu of Res. 105, A-12; Appended: CME Rep. 6, A-12) | Retain; still relevant. In addition, revise to incorporate relevant principles of H-160.953, "Free Clinics," which is rescinded through this report.<br><br>Our AMA supports: (1) organized efforts to involve volunteer physicians, nurses and other appropriate providers in programs for the delivery of health care to the indigent and uninsured and underinsured through free clinics, to include potential partnerships with state and county medical societies to establish a jointly sponsored free clinic pilot program; and (2) efforts to reduce the barriers faced by physicians volunteering in free clinics, including medical liability coverage under the Federal Tort Claims Act, liability protection under state and federal law, and state licensure provisions for retired physicians and physicians licensed in other United States jurisdictions, in partnership with state and county medical societies; medical liability insurance providers; and state, county, and local government. |
| H-160.953 | Free Clinics | The AMA: (1) encourages the establishment of free clinics as an immediate partial solution to providing access to health care for | Rescind and incorporate relevant principles into H-160.940, Free Clinic Support, as shown above. |

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| | | indigent and underserved populations; (2) will explore the potential for a partnership with state and county medical societies to establish a jointly-sponsored free clinic pilot program to provide health services and information to indigent and underserved populations; and (3) will develop strategies that will allow the AMA, along with one or more state or county medical societies, to join in partnership with private sector liability insurers and government - especially at the state, county, and local levels - to establish programs that will have appropriate levels of government pay professional liability premiums or indemnify physicians who deliver free services in free clinics or otherwise provide free care to the indigent. (BOT Rep. 27-A-94; Reaffirmed: BOT 17, A-04; Reaffirmed: CME Rep. 6, A-12) | Clause 1 is already reflected in H-160.940 (1), which reads:<br><br>Our AMA supports: (1) organized efforts to involve volunteer physicians, nurses and other appropriate providers in programs for the delivery of health care to the indigent and uninsured and underinsured through free clinics.<br><br>Relevant segments of clauses 2 and 3 are incorporated into clauses 1 and 2 of H-160.940, as shown above. |
| H-275.922 | Short-Term Physician Volunteer Opportunities Within the United States | Our AMA encourages the Federation of State Medical Boards to develop model policy for state licensure boards to streamline and standardize the process by which a physician who holds an unrestricted license in one state/district/territory may participate in physician volunteerism in another US state/district/territory in which the physician volunteer does not hold an unrestricted license. (Sub. Res. 915, I-10; Appended: CME Rep. 6, A-12) | Rescind and incorporate into D-275.984, "Licensure and Liability for Senior Physician Volunteers," as shown below. |
| D-275.984 | Licensure and Liability for Senior Physician Volunteers | Our AMA (1) and its Senior Physician Group will inform physicians about special state licensing regulations for volunteer physicians; and (2) will support and work with state medical licensing | Retain; still relevant. In addition, revise to append information from similar policy, H-275.922, "Short-Term Physician Volunteer Opportunities Within the United States," which is rescinded through this report. |

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| | | boards and other appropriate agencies, including the sharing of model state legislation, to establish special reduced-fee volunteer medical license for those who wish to volunteer their services to the uninsured or indigent.<br>(BOT Rep. 17, A-04; Reaffirmed: CCB/CLRPD Rep. 1, A-14) | Also, revise the title of this policy to remove references to senior physicians, as it now reflects all physician volunteers, regardless of age.<br><br>Licensure and Liability for Physician Volunteers<br><br>Our AMA will (1) inform physicians about special state licensing regulations for volunteer physicians providing their services to the uninsured or indigent; and (2) will support and work with state medical licensing boards and other appropriate agencies, including the Federation of State Medical Boards, to develop model policy and state legislation to (a) streamline and standardize the process by which a physician who holds an unrestricted license in one state/district/territory may participate in physician volunteerism in another U.S. state/district/territory in which the individual does not hold an unrestricted license and (b) establish special reduced-fee volunteer medical licenses for those who wish to volunteer their services to the uninsured or indigent. |
| H-210.991 | The Education of Physicians in Home Care | It is the policy of the AMA that: (1) faculties of the schools of medicine be encouraged to teach the science and art of home care as part of the regular undergraduate curriculum;<br>(2) graduate programs in the fields of family practice, general internal medicine, pediatrics, obstetrics, general surgery, orthopedics, physiatry, and psychiatry be encouraged to incorporate training in home care practice;<br>(3) the concept of home care as part of the continuity of patient care, rather than as an alternative care mode, be promoted to physicians and other health care professionals;<br>(4) assessment for home care be incorporated in all hospital discharge planning; | Retain; still relevant, with editorial revisions as shown to reflect the full (and current) names of the organizations in clause 6. |

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| | | (5) our AMA develop programs to increase physician awareness of and skill in the practice of home care;<br>(6) our AMA foster physician participation (and itself be represented) at all present and future home care organizational planning initiatives (e.g., ~~JCAHO, ASTM, FDA~~, The Joint Commission, ASTM International, Food and Drug Administration, etc.);<br>(7) our AMA encourage a leadership role for physicians as active team participants in home care issues such as quality standards, public policy, utilization, and reimbursement issues, etc.; and<br>(8) our AMA recognize the responsibility of the physician who is involved in home care and recommend appropriate reimbursement for those health care services. (Joint CSA/CME Rep., A-90; Reaffirmed: Sunset Report, I-00; Reaffirmation A-02; Modified: CSAPH Rep. 1, A-12) | |
| H-255.968 | Advance Tuition Payment Requirements for International Students Enrolled in US Medical Schools | Our AMA:<br>1. supports the autonomy of medical schools to determine optimal tuition requirements for international students;<br>2. encourages medical schools and undergraduate institutions to fully inform international students interested in medical education in the US of the limited options available to them for tuition assistance;<br>3. supports the Association of American Medical Colleges (AAMC) in its efforts to increase transparency in the medical school application process for international students by including school policy on tuition requirements in the | Retain; still relevant. |

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| | | Medical School Admission Requirements (MSAR); and 4. encourages medical schools to explore alternative means of prepayment, such as a letter of credit, for four years of medical school. (CME Rep. 5, A-12) | |
| H-255.987 | Foreign Medical Graduates | 1. Our AMA supports continued efforts to protect the rights and privileges of all physicians duly licensed in the US regardless of ethnic or educational background and opposes any legislative efforts to discriminate against duly licensed physicians on the basis of ethnic or educational background.<br>2. Our AMA will: (a) continuously study challenges and issues pertinent to IMGs as they affect our country's health care system and our physician workforce; and (b) lobby members of the US Congress to fund studies through appropriate agencies, such as the Department of Health and Human Services, to examine issues and experiences of IMGs and make recommendations for improvements. (Res. 56, A-86; Reaffirmed: Sunset Report, I-96; Reaffirmation A-00; Reaffirmed: CME Rep. 2, A-10; Reaffirmed: CME Rep. 11, A-10; Appended: Res. 303, A-10; Reaffirmation A-11; Reaffirmation A-12) | Still relevant; append to H-255.988, "AMA Principles on International Medical Graduates," as these are central tenets related to IMGs that should be reflected in that overarching policy:<br><br>Our AMA supports: …<br><br>23. Continued efforts to protect the rights and privileges of all physicians duly licensed in the U.S. regardless of ethnic or educational background and opposes any legislative efforts to discriminate against duly licensed physicians on the basis of ethnic or educational background.<br><br>24. Continued study of challenges and issues pertinent to IMGs as they affect our country's health care system and our physician workforce.<br><br>25. Advocacy to Congress to fund studies through appropriate agencies, such as the Department of Health and Human Services, to examine issues and experiences of IMGs and make recommendations for improvements. |
| H-275.949 | Discrimination Against Physicians Under Supervision of Their Medical Examining Board | 1. Our AMA opposes the exclusion of otherwise capable physicians from employment, business opportunity, insurance coverage, specialty board certification or recertification, and other benefits, solely because the physician is either presently, or has been in the past, under the supervision of a medical licensing board in a program | Rescind; superseded by D-405.984, "Confidentiality of Enrollment in Physicians (Professional) Health Programs:"<br><br>1. Our American Medical Association will work with other medical professional organizations, the Federation of State Medical Boards, the American Board of Medical Specialties, and the Federation of State Physician Health Programs, to seek and/or support rules and regulations or |

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| | | of rehabilitation or enrolled in a state-wide physician health program.<br>2. Our AMA will communicate Policy H-275.949 to all specialty boards and request that they reconsider their policy of exclusion where such a policy exists.<br>(Sub. Res. 3, A-92; Reaffirmed: BOT Rep. 18, I-93; Reaffirmed: CME Rep. 2, A-05; Appended: Res. 925, I-11; Reaffirmed in lieu of Res. 412, A-12; Reaffirmed: BOT action in response to referred for decision Res. 403, A-12) | legislation to provide for confidentiality of fully compliant participants in physician (and similar) health programs or their recovery programs in responding to questions on medical practice or licensure applications.<br><br>2. Our AMA will work with The Joint Commission, national hospital associations, national health insurer organizations, and the Centers for Medicare and Medicaid Services to avoid questions on their applications that would jeopardize the confidentiality of applicants who are compliant with treatment within professional health programs and who do not constitute a current threat to the care of themselves or their patients.<br><br>Also see H-275.978(6-9), "Medical Licensure:"<br><br>(6) urges licensing boards, specialty boards, hospitals and their medical staffs, and other organizations that evaluate physician competence to inquire only into conditions which impair a physician's current ability to practice medicine;<br>(7) urges licensing boards to maintain strict confidentiality of reported information;<br>(8) urges that the evaluation of information collected by licensing boards be undertaken only by persons experienced in medical licensure and competent to make judgments about physician competence. It is recommended that decisions concerning medical competence and discipline be made with the participation of physician members of the board;<br>(9) recommends that if confidential information is improperly released by a licensing board about a physician, the board take appropriate and immediate steps to correct any adverse consequences to the physician; |
| H-275.953 | The Grading Policy for Medical Licensure Examinations | 1. Our AMA's representatives to the ACGME are instructed to promote the principle that selection of residents should be based on a broad variety | Retain; still relevant, with the exception of clause 3, which was fulfilled through Council on Medical Education Report 5-I-19, "The Transition from Undergraduate Medical Education to Graduate Medical Education." |

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| | | of evaluative criteria, and to propose that the ACGME General Requirements state clearly that residency program directors must not use NBME or USMLE ranked passing scores as a screening criterion for residency selection.<br><br>2. Our AMA adopts the following policy on NBME or USMLE examination scoring: (a) Students receive "pass/fail" scores as soon as they are available. (If students fail the examinations, they may request their numerical scores immediately.) (b) Numerical scores are reported to the state licensing authorities upon request by the applicant for licensure. At this time, the applicant may request a copy of his or her numerical scores. (c) Scores are reported in pass/fail format for each student to the medical school. The school also receives a frequency distribution of numerical scores for the aggregate of their students.<br><br>~~3. Our AMA will co-convene the appropriate stakeholders to study possible mechanisms for transitioning scoring of the USMLE and COMLEX exams to a Pass/Fail system in order to avoid the inappropriate use of USMLE and COMLEX scores for screening residency applicants while still affording program directors adequate information to meaningfully and efficiently assess medical student applications, and that the recommendations of this study be made available by the 2019 Interim Meeting of the AMA House of Delegates.~~ | |

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| | | 34. Our AMA will: (a) promote equal acceptance of the USMLE and COMLEX at all United States residency programs; (b) work with appropriate stakeholders including but not limited to the National Board of Medical Examiners, Association of American Medical Colleges, National Board of Osteopathic Medical Examiners, Accreditation Council for Graduate Medical Education and American Osteopathic Association to educate Residency Program Directors on how to interpret and use COMLEX scores; and (c) work with Residency Program Directors to promote higher COMLEX utilization with residency program matches in light of the new single accreditation system.<br><br>45. Our AMA will work with appropriate stakeholders to release guidance for residency and fellowship program directors on equitably comparing students who received 3-digit United States Medical Licensing Examination Step 1 or Comprehensive Osteopathic Medical Licensing Examination of the United States Level 1 scores and students who received Pass/Fail scores.<br>(CME Rep. G, I-90; Reaffirmed by Res. 310, A-98; Reaffirmed: CME Rep. 3, A-04; Reaffirmed: CME Rep. 2, A-14; Appended: Res. 309, A-17; Modified: Res. 318, A-18; Appended: Res. 955, I-18; Appended: Res. 301, I-21) | |
| H-275.956 | Demonstration of Clinical Competence | It is the policy of the AMA to (1) support continued efforts to develop and validate | Rescind; superseded by D-295.988, "Clinical Skills Assessment During Medical School:" |

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| | | methods for assessment of clinical skills; (2) continue its participation in the development and testing of methods for clinical skills assessment; and (3) recognize that clinical skills assessment is best performed using a rigorous and consistent examination administered by medical schools and should not be used for licensure of graduates of Liaison Committee on Medical Education (LCME)- and American Osteopathic Association (AOA)-accredited medical schools or of Educational Commission for Foreign Medical Graduates (ECFMG)-certified physicians. (CME Rep. E, A-90; Reaffirmed: CME Rep. 5, A-99; Modified: Sub. Res. 821, I-02; Modified: CME Rep. 1, I-03; Reaffirmed: CME Rep. 16, A-09; Reaffirmed in lieu of Res. 313, A-12) | 1. Our AMA will encourage its representatives to the Liaison Committee on Medical Education (LCME) to ask the LCME to determine and disseminate to medical schools a description of what constitutes appropriate compliance with the accreditation standard that schools should "develop a system of assessment" to assure that students have acquired and can demonstrate core clinical skills.<br><br>2. Our AMA will work with the Federation of State Medical Boards, National Board of Medical Examiners, state medical societies, state medical boards, and other key stakeholders to pursue the transition from and replacement for the current United States Medical Licensing Examination (USMLE) Step 2 Clinical Skills (CS) examination and the Comprehensive Osteopathic Medical Licensing Examination (COMLEX) Level 2-Performance Examination (PE) with a requirement to pass a Liaison Committee on Medical Education-accredited or Commission on Osteopathic College Accreditation-accredited medical school-administered, clinical skills examination.<br><br>3. Our AMA will work to: (a) ensure rapid yet carefully considered changes to the current examination process to reduce costs, including travel expenses, as well as time away from educational pursuits, through immediate steps by the Federation of State Medical Boards and National Board of Medical Examiners; (b) encourage a significant and expeditious increase in the number of available testing sites; (c) allow international students and graduates to take the same examination at any available testing site; (d) engage in a transparent evaluation of basing this examination within our nation's medical schools, rather than administered by an external organization; and (e) include active participation by faculty leaders and assessment experts from U.S. medical |

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| | | | schools, as they work to develop new and improved methods of assessing medical student competence for advancement into residency.<br><br>4. Our AMA is committed to assuring that all medical school graduates entering graduate medical education programs have demonstrated competence in clinical skills.<br><br>5. Our AMA will continue to work with appropriate stakeholders to assure the processes for assessing clinical skills are evidence-based and most efficiently use the time and financial resources of those being assessed.<br><br>6. Our AMA encourages development of a post-examination feedback system for all USMLE test-takers that would: (a) identify areas of satisfactory or better performance; (b) identify areas of suboptimal performance; and (c) give students who fail the exam insight into the areas of unsatisfactory performance on the examination.<br><br>7. Our AMA, through the Council on Medical Education, will continue to monitor relevant data and engage with stakeholders as necessary should updates to this policy become necessary.<br><br>Also superseded by D-275.950, "Retirement of the National Board of Medical Examiners Step 2 Clinical Skills Exam for US Medical Graduates: Call for Expedited Action by the American Medical Association:"<br><br>Our AMA: (1) will take immediate, expedited action to encourage the National Board of Medical Examiners (NBME), Federation of State Medical Boards (FSMB), and National Board of Osteopathic Medical Examiners (NBOME) to eliminate centralized clinical skills examinations used as a part of state licensure, including the USMLE Step 2 Clinical Skills Exam and the Comprehensive Osteopathic Medical Licensing Examination (COMLEX) Level 2 - Performance Evaluation Exam; (2) in collaboration |

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| | | | with the Educational Commission for Foreign Medical Graduates (ECFMG), will advocate for an equivalent, equitable, and timely pathway for international medical graduates to demonstrate clinical skills competency; (3) strongly encourages all state delegations in the AMA House of Delegates and other interested member organizations of the AMA to engage their respective state medical licensing boards, the Federation of State Medical Boards, their medical schools and other interested credentialling bodies to encourage the elimination of these centralized, costly and low-value exams; and (4) will advocate that any replacement examination mechanisms be instituted immediately in lieu of resuming existing USMLE Step 2-CS and COMLEX Level 2-PE examinations when the COVID-19 restrictions subside. |
| D-275.974 | Depression and Physician Licensure | Our AMA will (1) recommend that physicians who have major depression and seek treatment not have their medical licenses and credentials routinely challenged but instead have decisions about their licensure and credentialing and recredentialing be based on professional performance; and (2) make this resolution known to the various state medical licensing boards and to hospitals and health plans involved in physician credentialing and recredentialing. (Res. 319, A-05; Reaffirmed: BOT action in response to referred for decision Res. 403, A-12) | Rescind; superseded by H-275.970, "Licensure Confidentiality," which reads:<br><br>1. The AMA (a) encourages specialty boards, hospitals, and other organizations involved in credentialing, as well as state licensing boards, to take all necessary steps to assure the confidentiality of information contained on application forms for credentials; (b) encourages boards to include in application forms only requests for information that can reasonably be related to medical practice; (c) encourages state licensing boards to exclude from license application forms information that refers to psychoanalysis, counseling, or psychotherapy required or undertaken as part of medical training; (d) encourages state medical societies and specialty societies to join with the AMA in efforts to change statutes and regulations to provide needed confidentiality for information collected by licensing boards; and (e) encourages state licensing boards to require disclosure of physical or mental health conditions only when a physician is suffering from any condition that currently impairs his/her judgment or that would otherwise |

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| | | | adversely affect his/her ability to practice medicine in a competent, ethical, and professional manner, or when the physician presents a public health danger.<br><br>2. Our AMA will encourage those state medical boards that wish to retain questions about the health of applicants on medical licensing applications to use the language recommended by the Federation of State Medical Boards that reads, "Are you currently suffering from any condition for which you are not being appropriately treated that impairs your judgment or that would otherwise adversely affect your ability to practice medicine in a competent, ethical and professional manner? (Yes/No)." |
| D-275.992 | Unified Medical License Application | Our AMA will request the Federation of State Medical Boards to examine the issue of a standardized medical licensure application form for those data elements that are common to all medical licensure applications. (Res. 308, I-01; Reaffirmed: CME Rep. 2, A-11; Reaffirmed: CME Rep. 6, A-12) | Rescind; this directive has been accomplished. Currently, 28 licensing jurisdictions use the Uniform Application for Physician State Licensure from the Federation of State Medical Boards. |
| D-295.934 | Encouragement of Interprofessional Education Among Health Care Professions Students | 1. Our AMA~~: (A)~~ recognizes that interprofessional education and partnerships are a priority of the American medical education system~~; and (B) will explore the feasibility of the implementation of Liaison Committee on Medical Education and American Osteopathic Association accreditation standards requiring interprofessional training in medical schools~~.<br>2. Our AMA supports the concept that medical education should prepare students for practice in physician-led interprofessional teams.<br>3. Our AMA will encourage health care organizations that engage in a collaborative care model to provide access to an | Retain in part, with edits to clauses 1 and 4, as these directives have been accomplished. |

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| | | appropriate mix of role models and learners.<br>4. ~~Our AMA will encourage the Liaison Committee on Medical Education, Commission on Osteopathic College Accreditation, American Osteopathic Association, and Accreditation Council for Graduate Medical Education to facilitate the incorporation of physician-led interprofessional education into the educational programs for medical students and residents in ways that support high quality medical education and patient care.~~<br>~~5.~~ Our AMA will encourage the development of skills for interprofessional education that are applicable to and appropriate for each group of learners.<br>(Res. 308, A-08; Appended: CME Rep. 1, I-12) | |
| D-295.942 | Patient Safety Curricula in Undergraduate Medical Education | 1. Our AMA will explore the feasibility of asking the Liaison Committee on Medical Education to encourage the discussion of basic patient safety and quality improvement issues in medical school curricula.<br>2. Our AMA will encourage the Liaison Committee on Medical Education to include patient safety and quality of patient care curriculum within the core competencies of medical education in order to instill these fundamental skills in all undergraduate medial students.<br>(Res. 801, I-07; Appended: Res. 320, A-12) | Rescind; superseded by H-295.864, "Systems-Based Practice Education for Medical Students and Resident/Fellow Physicians."<br><br>Our AMA: (1) supports the availability of educational resources and elective rotations for medical students and resident/fellow physicians on all aspects of systems-based practice, to improve awareness of and responsiveness to the larger context and system of health care and to aid in developing our next generation of physician leaders; (2) encourages development of model guidelines and curricular goals for elective courses and rotations and fellowships in systems-based practice, to be used by state and specialty societies, and explore developing an educational module on this topic as part of its Introduction to the Practice of Medicine (IPM) product; and (3) will request that undergraduate and graduate medical education accrediting bodies consider incorporation into their requirements for systems-based practice education such topics as health care policy and |

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| | | | patient care advocacy; insurance, especially pertaining to policy coverage, claim processes, reimbursement, basic private insurance packages, Medicare, and Medicaid; the physician's role in obtaining affordable care for patients; cost awareness and risk benefit analysis in patient care; inter-professional teamwork in a physician-led team to enhance patient safety and improve patient care quality; and identification of system errors and implementation of potential systems solutions for enhanced patient safety and improved patient outcomes. |
| D-295.964 | Pharmaceutical Federal Regulations -- Protecting Resident Interests | Our AMA shall continue to evaluate and oppose, as appropriate, federal regulations on the pharmaceutical industry that would curtail educational and/or research opportunities open to residents and fellows that are in compliance with current AMA ethical guidelines. (Res. 921, I-02; Reaffirmed: CCB/CLRPD Rep. 4, A-12) | Retain; still relevant. |
| D-295.966 | Pain Management Standards and Performance Measures | Our AMA, through the Council on Medical Education, shall continue to work with relevant medical specialty organizations to improve education in pain management in medical schools, residency programs, and continuing medical education programs. (CSA Rep. 4, A-02; Reaffirmed: CCB/CLRPD Rep. 4, A-12) | Rescind; superseded by D-160.981 (1), "Promotion of Better Pain Care:"<br><br>1. Our AMA: (a) will express its strong commitment to better access and delivery of quality pain care through the promotion of enhanced research, education and clinical practice in the field of pain medicine; and (b) encourages relevant specialties to collaborate in studying the following: (i) the scope of practice and body of knowledge encompassed by the field of pain medicine; (ii) the adequacy of undergraduate, graduate and post graduate education in the principles and practice of the field of pain medicine, considering the current and anticipated medical need for the delivery of quality pain care; (iii) appropriate training and credentialing criteria for this multidisciplinary field of medical practice; and (iv) convening a meeting of interested parties to review all pertinent matters scientific and socioeconomic. |

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| | | | Also superseded by D-120.985(3), "Education and Awareness of Opioid Pain Management Treatments, Including Responsible Use of Methadone:"<br><br>3. Our AMA will work in conjunction with the Association of American Medical Colleges, American Osteopathic Association, Commission on Osteopathic College Accreditation, Accreditation Council for Graduate Medical Education, and other interested professional organizations to develop opioid education resources for medical students, physicians in training, and practicing physicians. |
| D-295.970 | HIV Postexposure Prophylaxis for Medical Students During Electives Abroad | Our AMA: (1) recommends that US medical schools ensure that medical students who engage in clinical rotations abroad have immediate access to HIV postexposure prophylaxis; and (2) encourages medical schools to provide information to medical students regarding the potential health risks of completing a medical rotation abroad, and on the appropriate precautions to take to minimize such risks. (Res. 303, A-02; Reaffirmed: CCB/CLRPD Rep. 4, A-12) | Retain; still relevant, with minor edit as shown so that the policy content matches the title. |
| D-295.972 | Standardized Advanced Cardiac Life Support (ACLS) Training for Medical Students | Our AMA shall: (1) encourage standardized Advanced Cardiac Life Support (ACLS) training for medical students prior to clinical clerkships; and (2) strongly encourage medical schools to fund ACLS training for medical students. (Res. 314, A-02; Reaffirmed: CCB/CLRPD Rep. 4, A-12) | Retain by rescission and appending to related Policy H-300.945, "Proficiency of Physicians in Basic and Advanced Cardiac Life Support," to read as follows:<br><br>Our AMA: (1) believes that all licensed physicians should become proficient in basic CPR and in advanced cardiac life support commensurate with their responsibilities in critical care areas; (2) recommends to state and county medical associations that programs be undertaken to make the entire physician population, regardless of specialty or subspecialty interests, proficient in basic CPR; and (3) encourages training of cardiopulmonary resuscitation and basic life support be funded by medical schools and provided to first-year |

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| | | | medical students, preferably during the first term or prior to clinical clerkships. |
| H-295.876 | Equal Fees for Osteopathic and Allopathic Medical Students | 1. Our AMA, in collaboration with the American Osteopathic Association, discourages discrimination against medical students by institutions and programs based on osteopathic or allopathic training.<br><br>2. Our AMA encourages equitable access to and equitable fees for clinical electives for allopathic and osteopathic medical students.<br><br>~~3. Our AMA will work with relevant stakeholders to explore reasons behind application barriers that result in discrimination against osteopathic medical students when applying to elective visiting clinical rotations, and generate a report with the findings by the 2020 Interim Meeting.~~<br><br>3~~4~~. Our AMA: (a) encourages the Association of American Medical Colleges to request that its member institutions promote equitable access to clinical electives for allopathic and osteopathic medical students and charge equitable fees to visiting allopathic and osteopathic medical students; and (b) encourages the Accreditation Council for Graduate Medical Education to require its accredited programs to work with their respective affiliated institutions to ensure equitable access to clinical electives for allopathic and osteopathic medical students and charge equitable fees to visiting allopathic and osteopathic medical students. (Res. 809, I-05; Appended: CME Rep. 6, A-07; Modified: CCB/CLRPD Rep. | Retain; still relevant, with the exception of clause 3, which has been fulfilled through Council on Medical Education Report 5-N-21, "Investigation of Existing Application Barriers for Osteopathic Medical Students Applying for Away Rotations." |

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| | | 2, A-14; Appended: Res. 303, I-19; Modified: CME Rep. 5, I-21) | |
| H-295.882 | Proposed Consolidation of Liaison Committee on Medical Education | (1) Our AMA reaffirms its ongoing commitment to excellence in medical education and its continuing responsibility for accreditation of undergraduate medical education.<br>(2). Our AMA supports a formal recognition of the organizational relationships among the AMA, the AAMC, and the LCME through a memorandum of understanding.<br>(3) Consistent with United States Department of Education regulations and its historic role, the LCME should remain the final decision-making authority over accreditation matters, decisions, and policies for undergraduate medical education leading to the MD degree.<br>(4) The LCME will have final decision-making authority regarding the establishment, adoption and amendment of accreditation standards, through a defined process that allows the sponsors an opportunity to review, comment, and recommend changes to, and refer back for further consideration, new or amended standards proposed by the LCME.<br>(5) A new entity will be formed to support communications, flexibility and planning among the AMA, the AAMC and the LCME on medical school accreditation, with membership, authority and additional parameters to be defined within the new memorandum of understanding.<br>(6) The AMA Council on | Rescind; this policy was accomplished in 2012, implemented in 2013, and remains in effect through the LCME Council and other activities of the AMA, AAMC, and LCME. |

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| | | Medical Education will be the entity within the AMA to determine policy relating to the organization or structure of the LCME.<br>(CME Rep. 7, A-03; Modified and Appended: BOT Rep. 16, A-12) | |
| D-300.996 | Voluntary Continuing Education for Physicians in Pain Management | Our AMA will encourage appropriate organizations to support voluntary continuing education for physicians based on effective guidelines in pain management.<br>(Res. 308, A-01; Modified: CME Rep. 2, A-11; Reaffirmed: CME Rep. 6, A-1) | Rescind; superseded by D-160.981(1), "Promotion of Better Pain Care:"<br><br>1. Our AMA: (a) will express its strong commitment to better access and delivery of quality pain care through the promotion of enhanced research, education and clinical practice in the field of pain medicine; and (b) encourages relevant specialties to collaborate in studying the following: (i) the scope of practice and body of knowledge encompassed by the field of pain medicine; (ii) the adequacy of undergraduate, graduate and post graduate education in the principles and practice of the field of pain medicine, considering the current and anticipated medical need for the delivery of quality pain care; (iii) appropriate training and credentialing criteria for this multidisciplinary field of medical practice; and (iv) convening a meeting of interested parties to review all pertinent matters scientific and socioeconomic.<br><br>Also superseded by D-120.985(3), "Education and Awareness of Opioid Pain Management Treatments, Including Responsible Use of Methadone:"<br><br>3. Our AMA will work in conjunction with the Association of American Medical Colleges, American Osteopathic Association, Commission on Osteopathic College Accreditation, Accreditation Council for Graduate Medical Education, and other interested professional organizations to develop opioid education resources for medical students, physicians in training, and practicing physicians. |
| D-310.974 | Policy Suggestions to Improve the | Our AMA will: | Rescind as a number of aspects of this directive have been accomplished, and incorporate the remaining relevant and |

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| | National Resident Matching Program | (1) request that the National Resident Matching Program review the basis for the extra charge for including over 15 programs on a primary rank order list and consider modifying the fee structure to minimize such charges;<br><br>(2) work with the NRMP to increase awareness among applicants of the existing NRMP waiver and violations review policies to assure their most effective implementation;<br><br>(3) request that the NRMP continue to explore measures to maximize the availability of information for unmatched applicants and unfilled programs including the feasibility of creating a dynamic list of unmatched applicants;<br><br>(4) ask the National Resident Matching Program (NRMP) to publish data regarding waivers and violations with subsequent consequences for both programs and applicants while maintaining the integrity of the match and protecting the identities of both programs and participants;<br><br>(5) advocate that the words "residency training" in section 8.2.10 of the NRMP Match agreement be added to the second sentence so that it reads, "The applicant also | timely segments into D-310.977 (1) and (4), "National Resident Matching Program Reform," as shown below.<br><br>Clause 1: Rescind; this runs counter to the current approach of encouraging medical students to be judicious in the number of match applications, as this increases the burden on residency program personnel and does not appreciably help the applicant, after a certain threshold of program applications is reached.<br><br>Clause 2: Retain through insertion of relevant language into Clause 1 of D-310.977, as shown below.<br><br>Clause 3: Rescind; this request is reflected in the NRMP's Supplemental Offer and Acceptance Program (SOAP).<br><br>Clause 4: Rescind; the NRMP has published two articles in this regard, on applicant non-compliance and program non-compliance, respectively.<br><br>Clause 5: Rescind; reflected in NRMP policy on match violations, section 6.E.b.iii, which states that sanctions for a confirmed violation by an applicant include "being barred for one year from accepting an offer of a position or a new training year, regardless of the start date (or renewing a training contract for a position at a different level or for a subsequent year), in any residency or fellowship training program sponsored by a Match-participating institution and/or starting a position or a new training year in any program sponsored by a Match-participating institution if training would commence within one year from the date of issuance of the Final Report."<br><br>Clause 6: Retain through insertion of relevant language into Clause 4 of D-310.977, as shown below. The phrase "and using a thorough process in declaring that a violation has occurred" is not included in the edits below, as it is reflected in the NRMP policy noted above on match violations. |

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| | | may be barred from accepting or starting a position in any residency training program sponsored by a match-participating institution that would commence training within one year from the date of issuance of the Final Report" and specifically state that NRMP cannot prevent an applicant from maintaining his or her education through rotating, researching, teaching, or otherwise working in positions other than resident training at NRMP affiliated programs; and<br><br>(6) work with the Educational Commission for Foreign Medical Graduates, Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, and other graduate medical education stakeholders to encourage the NRMP to make the conditions of the Match agreement more transparent while assuring the confidentiality of the match and to use a thorough process in declaring that a violation has occurred.<br>(CME Rep. 15, A-06; Appended: Res. 918, I-11; Appended: CME Rep. 12, A-12) | Also, note editorial change below to the end of Clause 8 (adding an "s" to "applicant").<br><br>Our AMA:<br>(1) will work with the National Resident Matching Program (NRMP) to develop and distribute educational programs to better inform applicants about the NRMP matching process, including the existing NRMP waiver and violations review policies;<br>(2) will actively participate in the evaluation of, and provide timely comments about, all proposals to modify the NRMP Match;<br>(3) will request that the NRMP explore the possibility of including the Osteopathic Match in the NRMP Match;<br>(4) will continue to review the NRMP's policies and procedures and make recommendations for improvements as the need arises, to include making the conditions of the Match agreement more transparent while assuring the confidentiality of the match;<br>(5) will work with the Accreditation Council for Graduate Medical Education (ACGME) and other appropriate agencies to assure that the terms of employment for resident physicians are fair and equitable and reflect the unique and extensive amount of education and experience acquired by physicians;<br>(6) does not support the current the "All-In" policy for the Main Residency Match to the extent that it eliminates flexibility within the match process;<br>(7) will work with the NRMP, and other residency match programs, in revising Match policy, including the secondary match or scramble process to create more standardized rules for all candidates including application timelines and requirements;<br>(8) will work with the NRMP and other external bodies to develop mechanisms that limit disparities within the residency application process and allow both flexibility and standard rules for applicants;<br>(9) encourages the National Resident Matching Program to study and publish |

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| | | | the effects of implementation of the Supplemental Offer and Acceptance Program on the number of residency spots not filled through the Main Residency Match and include stratified analysis by specialty and other relevant areas;<br>(10) will work with the NRMP and ACGME to evaluate the challenges in moving from a time-based education framework toward a competency-based system, including: a) analysis of time-based implications of the ACGME milestones for residency programs; b) the impact on the NRMP and entry into residency programs if medical education programs offer variable time lengths based on acquisition of competencies; c) the impact on financial aid for medical students with variable time lengths of medical education programs; d) the implications for interprofessional education and rewarding teamwork; and e) the implications for residents and students who achieve milestones earlier or later than their peers;<br>(11) will work with the Association of American Medical Colleges (AAMC), American Osteopathic Association (AOA), American Association of Colleges of Osteopathic Medicine (AACOM), and National Resident Matching Program (NRMP) to evaluate the current available data or propose new studies that would help us learn how many students graduating from US medical schools each year do not enter into a US residency program; how many never enter into a US residency program; whether there is disproportionate impact on individuals of minority racial and ethnic groups; and what careers are pursued by those with an MD or DO degree who do not enter residency programs;<br>(12) will work with the AAMC, AOA, AACOM and appropriate licensing boards to study whether US medical school graduates and international medical graduates who do not enter residency programs may be able to serve unmet national health care needs;<br>(13) will work with the AAMC, AOA, AACOM and the NRMP to evaluate the feasibility of a national tracking |

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| | | | system for US medical students who do not initially match into a categorical residency program;<br>(14) will discuss with the National Resident Matching Program, Association of American Medical Colleges, American Osteopathic Association, Liaison Committee on Medical Education, Accreditation Council for Graduate Medical Education, and other interested bodies potential pathways for reengagement in medicine following an unsuccessful match and report back on the results of those discussions;<br>(15) encourages the Association of American Medical Colleges to work with U.S. medical schools to identify best practices, including career counseling, used by medical schools to facilitate successful matches for medical school seniors, and reduce the number who do not match;<br>(16) supports the movement toward a unified and standardized residency application and match system for all non-military residencies;<br>(17) encourages the Educational Commission for Foreign Medical Graduates (ECFMG) and other interested stakeholders to study the personal and financial consequences of ECFMG-certified U.S. IMGs who do not match in the National Resident Matching Program and are therefore unable to get a residency or practice medicine; and<br>(18) encourages the AAMC, AACOM, NRMP, and other key stakeholders to jointly create a no-fee, easily accessible clearinghouse of reliable and valid advice and tools for residency program applicants seeking cost-effective methods for applying to and successfully matching into residency. |
| H-310.909 | ACGME Residency Program Entry Requirements | Our AMA supports entry into Accreditation Council on Graduate Medical Education (ACGME) accredited residency and fellowship programs from either ACGME-accredited programs or American Osteopathic Association-accredited programs.<br>(Res. 920, I-12) | Rescind; the number of formerly AOA-accredited but not ACGME-accredited programs is small, and none are accepting new residents. Therefore, this policy is not needed after the unification of graduate medical education residency program accreditation through the ACGME's Single Accreditation System. |

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| H-350.981 | AMA Support of American Indian Health Career Opportunities | AMA policy on American Indian health career opportunities is as follows:<br>(1) Our AMA, and other national, state, specialty, and county medical societies recommend special programs for the recruitment and training of American Indians in health careers at all levels and urge that these be expanded.<br>(2) Our AMA support the inclusion of American Indians in established medical training programs in numbers adequate to meet their needs. Such training programs for American Indians should be operated for a sufficient period of time to ensure a continuous supply of physicians and other health professionals.<br>(3) Our AMA utilize its resources to create a better awareness among physicians and other health providers of the special problems and needs of American Indians and that particular emphasis be placed on the need for additional health professionals to work among the American Indian population.<br>(4) Our AMA continue to support the concept of American Indian self-determination as imperative to the success of American Indian programs, and recognize that enduring acceptable solutions to American Indian health problems can only result from program and project beneficiaries having initial and continued contributions in planning and program operations.<br>(CLRPD Rep. 3, I-98; Reaffirmed: Res. 221, A-07; Reaffirmation A-12) | Retain; still relevant. |

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| H-460.982 | Availability of Professionals for Research | (1) In its determination of personnel and training needs, major public and private research foundations, including the Institute of Medicine of the National Academy of Sciences, should consider the future research opportunities in the biomedical sciences as well as the marketplace demand for new researchers. (2) The number of physicians in research training programs should be increased by expanding research opportunities during medical school, through the use of short-term training grants and through the establishment of a cooperative network of research clerkships for students attending less research-intensive schools. Participation in research training programs should be increased by providing financial incentives for research centers, academic physicians, and medical students. (3) The current annual production of PhDs trained in the biomedical sciences should be maintained. (4) The numbers of nurses, dentists, and other health professionals in research training programs should be increased. (5) Members of the industrial community should increase their philanthropic financial support to the nation's biomedical research enterprise. Concentration of support on the training of young investigators should be a major thrust of increased funding. The pharmaceutical and medical device industries should increase substantially their intramural and extramural commitments to meeting postdoctoral training needs. A system of matching grants should be encouraged | Rescind; this policy, first adopted in 1987, is superseded by two more recently amended policies.<br><br>H-460.930, "Importance of Clinical Research"<br><br>(1) Given the profound importance of clinical research as the transition between basic science discoveries and standard medical practice of the future, the AMA will a) be an advocate for clinical research; and b) promote the importance of this science and of well-trained researchers to conduct it.<br><br>(2) Our AMA continues to advocate vigorously for a stable, continuing base of funding and support for all aspects of clinical research within the research programs of all relevant federal agencies, including the National Institutes of Health, the Agency for Healthcare Research and Quality, the Centers for Medicare & Medicaid Services, the Department of Veterans Affairs and the Department of Defense.<br><br>(3) The AMA believes it is an inherent obligation of capitation programs and managed care organizations to invest in broad-based clinical research (as well as in health care delivery and outcomes research) to assure continued transition of new developments from the research bench to medical practice. The AMA strongly encourages these groups to make significant financial contributions to support such research.<br><br>(4) Our AMA continues to encourage medical schools a) to support clinical research; b) to train and develop clinical researchers; c) to recognize the contribution of clinical researchers to academic medicine; d) to assure the highest quality of clinical research; and e) to explore innovative ways in which clinical researchers in academic health centers can actively involve practicing physicians in clinical research.<br><br>(5) Our AMA encourages and supports development of community and practice-based clinical research networks. |

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| | | in which private industry would supplement the National Institutes of Health and the Alcohol, Drug Abuse and Mental Health Administration sponsored Career Development Awards, the National Research Service Awards and other sources of support. (6) Philanthropic foundations and voluntary health agencies should continue their work in the area of training and funding new investigators. Private foundations and other private organizations should increase their funding for clinical research faculty positions. (7) The National Institutes of Health and the Alcohol, Drug Abuse and Mental Health Administration should modify the renewal grant application system by lengthening the funding period for grants that have received high priority scores through peer review. (8) The support of clinical research faculty from the National Institutes of Health Biomedical Research Support Grants (institutional grants) should be increased from its current one percent. (9) The academic medical center, which provides the multidisciplinary research environment for the basic and clinical research faculty, should be regarded as a vital medical resource and be assured adequate funding in recognition of the research costs incurred.<br>(BOT Rep. NN, A-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CSA Rep. 13, I-99; Reaffirmed: CME Rep. 4, I-08; Modified: Res. 305, A-12; Modified: CME Rep. 2, A-12) | (CSA Rep. 2, I-96; Reaffirmed: CSA Rep. 13, I-99; Reaffirmation A-00; Reaffirmed: CME Rep. 4, I-08; Modified: CSAPH Rep. 01, A-18)<br><br>H-460.971, "Support for Training of Biomedical Scientists and Health Care Researchers"<br><br>Our AMA: (1) continues its strong support for the Medical Scientists Training Program's stated mission goals;<br><br>(2) supports taking immediate steps to enhance the continuation and adequate funding for stipends in federal research training programs in the biomedical sciences and health care research, including training of combined MD and PhD, biomedical PhD, and post-doctoral (post MD and post PhD) research trainees;<br><br>(3) supports monitoring federal funding levels in this area and being prepared to provide testimony in support of these and other programs to enhance the training of biomedical scientists and health care research;<br><br>(4) supports a comprehensive strategy to increase the number of physician-scientists by: (a) emphasizing the importance of biomedical research for the health of our population; (b) supporting the need for career opportunities in biomedical research early during medical school and in residency training; (c) advocating National Institutes of Health support for the career development of physician-scientists; and (d) encouraging academic medical institutions to develop faculty paths supportive of successful careers in medical research; and<br><br>(5) supports strategies for federal government-sponsored programs, including reduction of education-acquired debt, to encourage training of physician-scientists for biomedical research. |

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| H-480.950 | Diagnostic Ultrasound Utilization and Education | Our AMA affirms that ultrasound imaging is a safe, effective, and efficient tool when utilized by, or under the direction of, appropriately trained physicians and supports the educational efforts and widespread integration of ultrasound throughout the continuum of medical education. (Res. 507, A-12) | Retain; still relevant. |
| D-630.972 | AMA Race/ Ethnicity Data | Our American Medical Association will continue to work with the Association of American Medical Colleges to collect race/ethnicity information through the student matriculation file and the GME census including automating the integration of this information into the Masterfile. (BOT Rep. 24, I-06; Modified: CCB/CLRPD Rep. 3, A-12) | Retain; still relevant. |