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-23

Subject: Council on Medical Education Sunset Review of 2013 House of Delegates' Policies

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to the HOD or resolution to sunset a policy earlier than its 10-year horizon if it is no longer relevant, has been superseded by a more current policy, or has been accomplished.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

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1 RECOMMENDATION
2
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. (Directive to Take Action)

Fiscal Note: $1,000.

APPENDIX: RECOMMENDED ACTIONS

Policy Number	Title	Text	Recommendation
D-295.960	Clinical Skills Training in Medical Schools	Our AMA: (1) encourages medical schools to reevaluate their educational programs to ensure appropriate emphasis of clinical skills training in medical schools; (2) encourages medical schools to include longitudinal clinical experiences for students during the "preclinical" years of medical education; (3) will evaluate the cost/value equation, benefits, and consequences of the implementation of standardized clinical exams as a step for licensure, along with the barriers to more meaningful examination feedback for both examinees and US medical schools, and provide recommendations based on these findings; and (4) will evaluate the consequences of the January 2013 changes to the USMLE Step II Clinical Skills exam and their implications for US medical students and international medical graduates. (Res. 324, A-03; Appended: Res. 309, A-11; Appended: Res. 904, I-13)	Retain clause 2, which is still relevant and not superseded by other AMA policy, and sunset clauses 1, 3, and 4, to read as follows: "Our AMA encourages medical schools to include longitudinal clinical experiences for students during the "preclinical" years of medical education. The contents of clause 1 are required of medical school programs with accreditation from the Liaison Committee on Medical Education (LCME) and is reviewed periodically, and are reflected in H-295.995 (12) (17a) (17b), "Recommendations for Future Directions for Medical Education," which read: "(12) The curriculum of a medical school should be designed to provide students with experience in clinical medicine ranging from primary to tertiary care in a variety of inpatient and outpatient settings, such as university hospitals, community hospitals, and other health care facilities. Medical schools should establish standards and apply them to all components of the clinical educational program regardless of where they are conducted. Regular evaluation of the quality of each experience and its contribution to the total program should be conducted." "(17a) Faculties of medical schools should reevaluate the current elements of their fourth or final year with the intent of increasing the breadth of clinical experience through a more formal structure and improved faculty counseling. An appropriate number of electives or selected options should be included. (17b) Counseling of medical students by faculty and others should be directed toward increasing the breadth of clinical experience. Students should be encouraged to choose experience in disciplines that will not be an integral part of their projected graduate medical education."

			Clauses 3 and 4 have been accomplished and are reflected in other AMA policy, such as D-295.988, “Clinical Skills Assessment During Medical School,” which reads in part: “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. “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 schools, as they work to develop new and improved methods of assessing medical student competence for advancement into residency. . . . “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. "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."
D-295.982	Model Pain Management Program For Medical School Curricula	Our AMA will collect, synthesize, and disseminate information about effective educational programs in pain management and palliative care in medical schools and residency programs. (Res. 308, A-01; Reaffirmed: CME Rep. 2, A-11; Reaffirmed: CME Rep. 6, A-13)	Sunset; this directive has been accomplished.
D-300.999	Registration of Accredited CME Sponsors	1. Our AMA will continue cooperative efforts to assure that accredited sponsors of continuing medical education adhere to AMA Physician's Recognition Award (PRA) policy when designating AMA PRA credit. 2. Our AMA will remind all accredited CME providers of their responsibility, as stated in the AMA PRA requirements, to provide documentation to participating physicians of the credit awarded at the request of the physician. (CME Rep. 4, A-00; Reaffirmed: CME Rep. 2, A-10; Appended: CME Rep. 7, A-13)	Retain clause 1. Still relevant. Sunset clause 2. Accomplished though the publication of the PRA booklet in 2017. New version to read as follows: Our AMA will continue cooperative efforts to assure that accredited sponsors of continuing medical education adhere to AMA Physician's Recognition Award (PRA) policy when designating AMA PRA credit.
D-305.960	Loan Repayment for Physicians in State Designated Shortage Areas	Our AMA: (1) will educate membership about various opportunities surrounding loan repayment through mechanisms including but not limited to: a designated state contact, web resources, and informative meetings, so that residents can make an informed decision regarding employment; (2) will advocate equal tax benefits for physicians who practice in	Sunset; still relevant, but superseded by and reflected in other AMA policy, such as H-305.925, "Principles of and Actions to Address Medical Education Costs and Student Debt" and H-200.949 (16), "Principles of and Actions to Address Primary Care Workforce."

		either state-designated or federally-designated shortage areas; and (3) acknowledges and continues to support initiatives that facilitate recruitment of physicians to designated shortage areas. (Res. 328, A-09; Reaffirmation A-13)	
D-305.973	Proposed Revisions to AMA Policy on the Financing of Medical Education Programs	Our AMA will work with: (1) the federal government, including the Centers for Medicare and Medicaid Services, and the states, along with other interested parties, to bring about the following outcomes: (a) ensure adequate Medicaid and Medicare funding for graduate medical education; (b) ensure adequate Disproportionate Share Hospital funding; (c) make the Medicare direct medical education per-resident cost figure more equitable across teaching hospitals while assuring adequate funding of all residency positions; (d) revise the Medicare and Medicaid funding formulas for graduate medical education to recognize the resources utilized for training in non-hospital settings; (e) stabilize funding for pediatric residency training in children's hospitals; (f) explore the possibility of extending full direct medical education per-resident payment beyond the time of first board eligibility for specialties/subspecialties in shortage/defined need; (g) identify funding sources to increase the number of graduate medical education positions, especially in or adjacent to physician shortage/underserved areas and in undersupplied specialties; and (h) act on existing policy by seeking federal legislation requiring all health insurers to	Retain; still relevant, with name change as shown below: Financing of Medical Education Programs

		support graduate medical education through an all-payer trust fund created for this purpose; and (2) other interested parties to ensure adequate funding to support medical school educational programs, including creating mechanisms to fund additional medical school positions. (CME Rep. 7, A-05; Reaffirmation I-06; Reaffirmation I-07; Reaffirmed: Res. 921, I-12; Reaffirmation A-13; Reaffirmed: CME Rep. 5, A-13)	
D-305.986	Recognizing Spouse and Dependent Care Expenses in Determining Medical Education Financial Aid	Our AMA will: (1) work with the Liaison Committee on Medical Education to require, as part of the accreditation standards for medical schools, that dependent health insurance, dependent care, and dependent living expenses be included both as part of the "cost of attendance" and as an educational expense for the purposes of student budgets and financial aid in medical schools; and (2) encourage medical schools to include spouse and dependent health insurance, dependent care, and dependent living expenses as part of the "cost of attendance" and as an educational expense for the purposes of student budgets and financial aid. (Res. 301, A-03; Modified: CME Rep. 2, A-13)	Sunset. The LCME does not mandate school policies at this level of specificity. Further, elements included in defining "cost of attendance" are relevant to and guided by lenders and financial aid rules.
D-310.953	Exploring the Feasibility of Clinic-Based Residency Programs	Our AMA: (1) advocates that key stakeholders, such as the Accreditation Council for Graduate Medical Education, explore the feasibility of extending residency programs through a pilot study placing medical graduates in integrated physician-led practices in order to expand training positions and increase the number of physicians providing healthcare access; and (2) encourages that	Sunset; this directive has been accomplished.

		pilot studies of clinic-based residency program expansion be funded by private sources. (Res. 906, I-13)	
D-310.954	Training in Reproductive Health Topics as a Requirement for Accreditation of Family Residencies	Our AMA: (1) will work with the Accreditation Council for Graduate Medical Education to protect patient access to important reproductive health services by advocating for all family medicine residencies to provide comprehensive women's health including training in contraceptive counseling, family planning, and counseling for unintended pregnancy; and (2) encourages the ACGME to ensure greater clarity when making revisions to the educational requirements and expectations of family medicine residents in comprehensive women's health topics. (Res. 317, A-13)	Retain; still relevant, but rescind and append to H-295.890, "Medical Education and Training in Women's Health," to read as follows. Also, note editorial changes to clauses 6 and 7: "Our AMA: (1) encourages the coordination and synthesis of the knowledge, skills, and attitudinal objectives related to women's health/gender-based biology that have been developed for use in the medical school curriculum. Medical schools should include attention to women's health throughout the basic science and clinical phases of the curriculum; (2) does not support the designation of women's health as a distinct new specialty; (3) that each specialty should define objectives for residency training in women's health, based on the nature of practice and the characteristics of the patient population served; (4) that surveys of undergraduate and graduate medical education, conducted by the AMA and other groups, should periodically collect data on the inclusion of women's health in medical school and residency training; (5) encourages the development of a curriculum inventory and database in women's health for use by medical schools and residency programs; (6) encourages physicians to include continuing education in women's health/gender-based biology as part of their continuing professional development; (7) encourages its representatives to the Liaison Committee on Medical Education, the Accreditation Council for Graduate Medical Education (ACGME), and the various ACGME Review Committees to promote attention to women's health in accreditation standards; (8) will work with the ACGME to protect patient access to important reproductive health services by advocating for all family medicine residencies to provide

			comprehensive women's health, including training in contraceptive counseling, family planning, and counseling for unintended pregnancy; and (9) encourages the ACGME to ensure clarity when making revisions to the educational requirements and expectations of family medicine residents in comprehensive women's health topics."
D-35.980	Primary Care Physician Supply	Our AMA will continue to work with interested stakeholders to gather and disseminate data regarding the primary care physician supply. (Res. 217, I-13)	Sunset; still relevant, but already reflected in H-200.949 (25), "Principles of and Actions to Address Primary Care Workforce," which reads as follows: "Research: Analysis of state and federal financial assistance programs should be undertaken, to determine if these programs are having the desired workforce effects, particularly for students from disadvantaged groups and those that are underrepresented in medicine, and to gauge the impact of these programs on elimination of geographic, racial, and other health care disparities. Additional research should identify the factors that deter students and physicians from choosing and remaining in primary care disciplines. Further, our AMA should continue to monitor trends in the choice of a primary care specialty and the availability of primary care graduate medical education positions. The results of these and related research endeavors should support and further refine AMA policy to enhance primary care as a career choice."
H-200.992	Designation of Areas of Medical Need	The AMA urges the federal government to: (1) consolidate the federal designation process for identifying areas of medical need; (2) coordinate the federal designation process with state agencies to obviate duplicative activities; and (3) ask for state and local medical society approval of said designated underserved areas. (Res. 24, A-82; CLRPD Rep. A, I-92; CME Rep. 2, A-03; CME Rep. 2, A-13)	Sunset. Accomplished through the Health Resources and Services Administration's consolidation of federal shortage area designations.
H-200.994	Health Workforce	The AMA endorses the following principle on health manpower: Both physicians and allied health professionals	Sunset; still relevant, but reflected in other, more recent policies, including H-160.950, "Guidelines for Integrated Practice of Physician and Nurse

		have legal and ethical responsibilities for patient care, even though ultimate responsibility for the individual patient's medical care rests with the physician. To assure quality patient care, the medical profession and allied health professionals should have continuing dialogue on patient care functions that may be delegated to allied health professionals consistent with their education, experience and competency. (BOT Rep. C, I-81; Reaffirmed: Sunset Report, I-98; Modified: CME Rep. 2, I-03; Reaffirmed: CME Rep. 2, A-13)	Practitioner"; H-160.906, "Models / Guidelines for Medical Health Care Teams"; and "Code of Medical Ethics 10.5."
H-255.970	Employment of Non-Certified IMGs	Our AMA will: (1) oppose efforts to employ graduates of foreign medical schools who are neither certified by the Educational Commission for Foreign Medical Graduates, nor have met state criteria for full licensure; and (2) encourage states that have difficulty recruiting doctors to underserved areas to explore the expanded use of incentive programs such as the National Health Service Corps or J1 or other visa waiver programs. (Res. 309, A-03; Reaffirmed: CME Rep. 2, A-13)	Retain; still relevant, with editorial changes as shown below. All physicians practicing medicine should be licensed. The ECFMG (a member of Intealth) is the organization that evaluates the credentials of international physicians, so it is important that all physicians training in non-U.S.-based medical schools be vetted through the ECFMG. "Our AMA will: (1) oppose efforts to employ graduates of foreign medical schools who are neither certified by the ECFMG (a member of Intealth) nor have met state criteria for full licensure; and "(2) encourage states that have difficulty recruiting doctors to underserved areas to explore the expanded use of incentive programs such as the National Health Service Corps or J-1 or other visa waiver programs."
H-255.976	Speech Tests for International Medical Graduates	The AMA encourages state licensing boards to accept ECFMG certification in satisfaction of requirements for demonstrating English language competence. (CME Rep. B, A-93; Reaffirmed: CME Rep. 2, A-03; Reaffirmed: CME Rep. 2, A-13)	Retain, as state medical boards have differing policies. Note editorial change below, to ensure congruence in terminology with the policy above: "The AMA encourages state licensing boards to accept certification by the ECFMG (a member of Intealth) as satisfying the requirements for demonstrating English language competence."
H-255.985	Graduates of Foreign Health	(1) Any United States or alien graduate of a foreign health professional education program	Sunset. Still relevant, but already reflected in other policy, such as H-255.988, "AMA Principles on

	Professional Schools	must, as a requirement for entry into graduate education and/or practice in the United States, demonstrate entry-level competence equivalent to that required of graduates of United States' programs. Agencies recognized to license or certify health professionals in the United States should have mechanisms to evaluate the entry-level competence of graduates of foreign health professional programs. The level of competence and the means used to assess it should be the same or equivalent to those required of graduates of U.S. accredited programs. (2) All health care facilities, including governmental facilities, should adhere to the same or equivalent licensing and credentialing requirements in their employment practices. (BOT Rep. NN, A-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: Res. 320 and Res. 305, A-03; Reaffirmed: CME Rep. 1, I-03; Reaffirmed: CME Rep. 2, A-13)	International Medical Graduates," which reads in part: "6. Working with the Accreditation Council for Graduate Medical Education (ACGME) and the Federation of State Medical Boards (FSMB) to assure that institutions offering accredited residencies, residency program directors, and U.S. licensing authorities do not deviate from established standards when evaluating graduates of foreign medical schools." "8. The AMA continues to support the activities of the ECFMG related to verification of education credentials and testing of IMGs." Also superseded by H-255.966, "Abolish Discrimination in Licensure of IMGs," which reads in part as shown (also note editorial change to clause 3, below): "A. State medical boards should ensure uniformity of licensure requirements for IMGs and graduates of U.S. and Canadian medical schools, including eliminating any disparity in the years of graduate medical education (GME) required for licensure and a uniform standard for the allowed number of administrations of licensure examinations. . . ." "2. Our AMA will continue to work with the FSMB to encourage parity in licensure requirements for all physicians, whether U.S. medical school graduates or international medical graduates. "3. Our AMA will continue to work with the Educational Commission for Foreign Medical Graduates (a member of Intealth) and other appropriate organizations in developing effective methods to evaluate the clinical skills of IMGs. "4. Our AMA will work with state medical societies in states with discriminatory licensure requirements between IMGs and graduates of U.S. and Canadian medical schools to advocate for parity in licensure requirements, using the AMA International Medical Graduate Section licensure parity model resolution as a resource."

H-275.959	Cognitive Exams	It is the policy of the AMA to oppose the use of cognitive exams as the major means of evaluating a physician's clinical competence. (Sub. Res. 205, A-90; Modified: Sunset Report, I-00; Reaffirmed: CME Rep. 2, A-10; Reaffirmed: CME Rep. 2, A-13)	Sunset; still relevant, but superseded by H-275.916, "Guiding Principles and Appropriate Criteria for Assessing the Competency of Physicians Across the Professional Continuum."
H-275.998	Physician Competence	Our AMA urges: (1) The members of the profession of medicine to discover and rehabilitate if possible, or to exclude if necessary, the physicians whose practices are incompetent. (2) All physicians to fulfill their responsibility to the public and to their profession by reporting to the appropriate authority those physicians who, by being impaired, need help, or whose practices are incompetent. (3) The appropriate committees or boards of the medical staffs of hospitals which have the responsibility to do so, to restrict or remove the privileges of physicians whose practices are known to be incompetent, or whose capabilities are impaired, and to restore such physicians to limited or full privileges as appropriate when corrective or rehabilitative measures have been successful. (4) State governments to provide to their state medical licensing boards resources adequate to the proper discharge of their responsibilities and duties in the recognition and maintenance of competent practitioners of medicine. (5) State medical licensing boards to discipline physicians whose practices have been found to be incompetent. (6) State medical licensing boards to report all disciplinary actions promptly to the Federation of State Medical	Retain; still relevant.

		Boards and to the AMA Physician Masterfile. (Failure to do so simply allows the incompetent or impaired physician to migrate to another state, even after disciplinary action has been taken against him, and to continue to practice in a different jurisdiction but with the same hazards to the public.) (CME Rep. G, A-79; Reaffirmed: CLRPD Rep. B, I-89; Reaffirmed: Sunset Report, A-00; Reaffirmation I-03; Reaffirmed: CME Rep. 2, A-13)	
H-295.900	Creating an Effective Environment for Medical Student Education	1. The AMA encourages the development of a model student orientation program that includes workshops that address health awareness for students and standards of behavior for teachers and learners. 2 .Our AMA will: (A) ask the Liaison Committee on Medical Education to ensure that medical schools have policies to protect medical students from retaliation based on reporting incidents of mistreatment; and (B) through the Learning Environment Study, conduct research and disseminate findings on the medical education learning environment including the positive and negative elements of that environment that impact the teacher-learner relationship; and (C) encourage the Association of American Medical Colleges and the American Association of Colleges of Osteopathic Medicine to identify best practices and strategies to assure an appropriate learning environment for medical students. (CME Rep. 9, A-98; Reaffirmed: CME Rep. 2, A-08; Appended: CME Rep. 9, A-13)	Sunset. This has already been accomplished, and clause 2 is an LCME requirement, as stipulated in LCME standard 3.6, Student Mistreatment: "A medical school develops effective written policies that define mistreatment, has effective mechanisms in place for a prompt response to any complaints, and supports educational activities aimed at preventing mistreatment. Mechanisms for reporting mistreatment are understood by medical students, including visiting medical students, and ensure that any violations can be registered and investigated without fear of retaliation."

H-295.927	Medical Student Health and Well-Being	The AMA encourages the Association of American Medical Colleges, Liaison Committee on Medical Education, medical schools, and teaching hospitals to address issues related to the health and well-being of medical students, with particular attention to issues such as HIV infection that may have long-term implications for health, disability and medical practice, and consider the feasibility of financial assistance for students with disabilities. (BOT Rep. 1, I-934; Modified with Title Change: CSA Rep. 4, A-03; Reaffirmed: CME Rep. 2, A-13)	Sunset. LCME Element 12.8, “Student Exposure Policies/Procedures,” (see below) addresses this policy, except for “feasibility of financial assistance” (in this regard, LCME requires disability insurance for medical students). “A medical school has policies in place that effectively address medical student exposure to infectious and environmental hazards, including the following: - The education of medical students about methods of prevention - The procedures for care and treatment after exposure, including a definition of financial responsibility - The effects of infectious and environmental disease or disability on medical student learning activities “All registered medical students (including visiting students) are informed of these policies before undertaking any educational activities that would place them at risk.”
H-295.933	Medical School Affiliations With VA Medical Centers	The AMA will work to ensure that the successful relationships between VA academic medical centers and the nation's medical schools are maintained. (Sub. Res. 313, A-93; Modified: CME Rep. 2, A-03; Reaffirmed: CME Rep. 2, A-13)	Retain, still relevant, with editorial change to title and policy to specify the acronym “VA,” as shown below: Medical School Affiliations With Veterans Affairs (VA) Medical Centers “The AMA will work to ensure that the successful relationships between Veterans Affairs (VA) academic medical centers and the nation's medical schools are maintained.”
H-295.940	Recruiting Students of Medicine at the Elementary and High School Levels	The AMA will work with state and local medical societies to encourage teachers at primary and secondary schools to alert their students to the potential for professional and personal satisfaction from service to others through a career in medicine. (Res. 319, A-92; Reaffirmed: CME Rep. 2, A-03; Reaffirmed: CME Rep. 2, A-13)	Retain; still relevant, as reflected in the AMA’s Doctors Back to School program.
H-295.984	Family Medicine as a Fundamental Subject in Medical Schools	The AMA recommends that U.S. medical schools include family medicine as a clinical subject.	Retain; still relevant. As of the 2021-22 academic year, 23 (15 percent) of the 155 LCME-accredited schools did not report that they offered family medicine as a

		(Res. 14, I-84; Reaffirmed: CMS Rep. L, A-93; Reaffirmed: CME Rep. 2, A-03; Reaffirmed: CME Rep. 2, A-13)	separate required clerkship or as part of a longitudinal integrated clerkship. Family medicine is a required element of all COCA-accredited medical schools.
H-300.964	Medical Ethics and Continuing Medical Education	The AMA encourages accredited continuing medical education sponsors to plan and conduct programs and conferences emphasizing ethical principles in medical decision making. (Res. 323, I-92; Reaffirmed: CME Rep. 2, A-03; Reaffirmed: CME Rep. 2, A-13)	Retain. Still relevant.
H-300.966	Continuing Medical Education for Physicians in the Hospital Setting	It is the policy of the AMA that the continuing medical educational programs offered physicians in the hospital setting be the responsibility of the hospital medical staff and directed by the medical staff as defined in the hospital bylaws. (Res. 318, A-92; Reaffirmed: CME Rep. 2, A-03; Reaffirmed: CME Rep. 2, A-13)	Retain. Still relevant.
H-300.983	Community Hospital Continuing Medical Education	1. The AMA believes that quality, patient-centered, cost-effective continuing medical education is important for hospital medical staffs, and that the cooperative efforts of hospitals, state and county medical societies, and academic medical centers contribute to achieving this goal. 2. Our AMA will advocate for the availability of accessible, affordable, high-quality continuing medical education for small rural and community hospitals. (CME Rep. D, A-85; Reaffirmed by CLRPD Rep. 2, I-95; Reaffirmed: CME Rep. 2, A-05; Appended: Res. 316, A-13)	Retain; still relevant.
H-310.908	Support for Residents and Fellows During Family and Medical Leave Time	Our AMA encourages specialty boards, the Accreditation Council for Graduate Medical Education and residency review committees to study alternative mechanisms and pathways	Sunset; still relevant, but superseded by and reflected in H-405.960, “Policies for Parental, Family and Medical Necessity Leave.”

		based on competency evaluation to ensure that individuals who have taken family and medical leave graduate as close to their original completion date as possible. (Res. 307, A-13)	
H-310.913	Physician Extenders	1. In academic environments, our AMA will only support payment models for non-physician practitioners that do not interfere with graduate medical training. 2. Our AMA supports the concept that procedural training is a critical portion of resident education and the augmentation of patient care by non-physician practitioners should not interfere with a resident's ability to achieve competence in the performance of required procedures. (Res. 208, I-10; Appended: CME Rep. 8, A-13)	Retain; still relevant.
H-310.946	Training Physicians in Non-Traditional Sites	It is the policy of the AMA to promote and support the training of physicians in non-traditional sites, including nursing homes. (Res. 301, I-93; Reaffirmed: CME Rep. 2, A-03; Reaffirmed: CME Rep. 2, A-13)	Retain, still relevant, but incorporate into the more expansive Policy H-200.949 (13), "Principles of and Actions to Address Primary Care Workforce," which reads: "13. The curriculum in primary care residency programs and training sites should be consistent with the objective of training generalist physicians. Our AMA will encourage the Accreditation Council for Graduate Medical Education to (a) support primary care residency programs, including community hospital-based programs and those in non-traditional sites, including nursing homes, and (b) develop an accreditation environment and novel pathways that promote innovations in graduate medical education, using progressive, community-based models of integrated care focused on quality and outcomes (such as the patient-centered medical home and the chronic care model)."
H-310.952	Housestaff Input During the ACGME Review Process	The AMA asks its representatives to the Accreditation Council for Graduate Medical Education to support a requirement that site	Sunset; this has been accomplished and is in place at the ACGME, through resident surveys during program site visits.

		visitors to both residency training programs and institutions conduct interviews with residents, including peer-selected residents, as well as with administrators and faculty. (Res. 314, I-92; Reaffirmed: CME Rep. 2, A-03; Reaffirmed: CME Rep. 2, A-13)	
H-310.976	Gender-Based Questioning in Residency Interviews	The AMA (1) opposes gender-based questioning during residency interviews in both public and private institutions for the purpose of sexual discrimination; (2) supports inclusion in the AMA Fellowship and Residency Interactive Database Access (FREIDA) system information on residency Family and Medical Leave policies; and (3) supports monitoring the Accreditation Council for Graduate Medical Education as it proposes changes to the "Common Requirements" and the "Institutional Requirements" of the "Essentials of Accredited Residencies," to ensure that there is no gender-based bias. (Res. 125, I-88; Reaffirmed: Sunset Report, I-98; Modified and Reaffirmed: CME Rep. 2, A-08; Reaffirmed: CCB/CLRPD Rep. 4, A-13)	Retain clause 1; still relevant, and sunset clauses 2 and 3 for the reasons noted below. Updated version to read: "The AMA opposes gender-based questioning during residency interviews in both public and private institutions for the purpose of sexual discrimination." Sunset clause 2, as this has been accomplished, with FREIDA including program data on the maximum number of paid and unpaid days for family/medical leave as well as a hyperlink to programs' leave policies. Sunset clause 3, as the Council on Medical Education reviews all proposed changes to program and institutional requirements and provides feedback as needed. The ACGME has also placed significant emphasis on equity, including the elimination of bias across the board.
H-310.997	Accreditation of Graduate Medical Education Programs	(1) The AMA believes that (a) accreditation and certification programs in graduate medical education should be designed and operated to objectively evaluate the educational quality and content of such programs and to assure a high level of professional training, achievement, and competence; (b) accreditation and certification programs in graduate medical education should not be administered as a means of regulating or restricting the number of physicians entering any specialty or field of medical	Retain, still relevant, with editorial changes as shown below, in that (1)(b) and (2) are essentially the same. "The AMA believes that (a) accreditation and certification programs in graduate medical education should be designed and operated to objectively evaluate the educational quality and content of such programs and to assure a high level of professional training, achievement, and competence; (b) accreditation and certification programs in graduate medical education should not be administered as a means of regulating or restricting the number of physicians entering any specialty or field of medical practice; and (c) qualified physicians who

		practice; and (c) qualified physicians who possess the essential prerequisites are entitled to compete for training and subsequently to practice in the specialty or type of practice of their choice upon successful completion of their training. (2) The AMA opposes use of the accreditation and certification process as a means of controlling the number of physicians in any specialty or field of medical practice. (Res. 14, A-82; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmed: CME Rep. 2, A-03; Reaffirmed: CME Rep. 2, A-13)	possess the essential prerequisites are entitled to compete for training and subsequently to practice in the specialty or type of practice of their choice upon successful completion of their training."
H-330.950	Post-Licensure Assessment as a Condition for Physician Participation in Medicare	The AMA opposes proposals for periodic post-licensure assessment as a condition for physician participation in the Medicare program or other health-related entitlement program. (Res. 231, I-93; Reaffirmed: BOT Rep. 28, A-03; Reaffirmed: CME Rep. 2, A-13)	Retain; still relevant. The AMA continues to oppose extraneous evaluations of physicians that create burdens and are not based on evidence that they will improve care quality or patient safety. In addition, physicians are already subject to multiple assessments of their competence and ability to practice medicine, through maintaining licensure, certification, and credentials/privileges, such that any additional assessment would be duplicative. Finally, imposing an assessment as a requirement for Medicare participation may create additional burden that would drive some physicians to end their Medicare participation, threatening access to care for some of the nation's most vulnerable populations.
H-35.978	Education Programs Offered to, for or by Allied Health Professionals Associated with a Hospital	The AMA encourages hospital medical staffs to have a process whereby physicians will have input to and provide review of education programs provided by their hospital for the benefit of allied health professionals working in that hospital, for the education of patients served by that hospital, and for outpatient educational programs provided by that hospital. (BOT Rep. B, A-93; Adopts Res. 317, A-92; Reaffirmed: CME Rep. 2, A-03; Reaffirmed: CME Rep. 2, A-13)	Retain; still relevant.

H-360.997	Nursing Education	The AMA (1) supports all levels of nursing education, including baccalaureate, diploma, associate degree and practical nursing in order that individuals may be able to choose from a number of alternatives, each of which legitimately fulfills the purpose of meeting the health care needs of the nation; (2) affirms that there is no substitute for bedside teaching and practical learning in any education program for nurses; and (3) recommends strong support of multiple levels of nursing education in order to make available career ladders in the various levels of nursing education without dead-ends or repetitions of education. (Res. 4, A-82; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmed: CME Rep. 2, A-03; Reaffirmed: CME Rep. 2, A-13)	Retain; still relevant.

D-630.974	Health Care Recovery Fund	Our AMA will: (1) convey to the AMA Foundation its desire that medical students, resident physicians and fellows, and young physicians be given special consideration and priority, along with all other physicians, beyond rebuilding medical practices, based on their degree of need, in distributions from any special disaster recovery funds; and (2) work with interested state and national medical specialty societies to publicize the existence of any special AMA Foundation disaster recovery funds and to identify and encourage applications from deserving recipients, especially among those who are medical students, resident physicians and fellows, and young physicians, and that these names be shared with the AMA Foundation as it considers grants from such funds. (Res. 605, A-06; Reaffirmed: CCB/CLRPD Rep. 3, A-12)	Sunset; this has been accomplished.