DISCLAIMER

The following is a preliminary report of actions taken by the House of Delegates at its 2016 Annual Meeting and should not be considered final. Only the Official Proceedings of the House of Delegates reflect official policy of the Association.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (A-16)

Report of Reference Committee C

Albert M. Kwan, MD, Chair

Your Reference Committee recommends the following consent calendar for acceptance:

1. **RECOMMENDED FOR ADOPTION**
   
   1. Council on Medical Education Report 2 – Update on Maintenance of Certification and Osteopathic Continuous Certification
   2. Resolution 303 – Research and Monitoring to Ensure Ethics of Global Health Programs
   3. Resolution 310 – Standardizing the Allopathic Residency Match System and Timeline
   4. Resolution 318 – Expansion of Public Service Loan Forgiveness
   5. Resolution 319 – Specialty-Specific Allocation of GME Funding
   6. Resolution 320 – Expanding GME Concurrently with UME

2. **RECOMMENDED FOR ADOPTION AS AMENDED OR IN LIEU OF**
   
   8. Council on Medical Education Report 3 – Addressing the Increasing Number of Unmatched Medical Students
   10. Council on Medical Education Report 5 – Accountability and Transparency in Graduate Medical Education Funding
   11. Council on Medical Education Report 6 – Telemedicine in Graduate Medical Education
   12. Resolution 301 – Recognizing the Actual Costs of Student Loans
   13. Resolution 309 – Continuing Medical Education Pathway for Recertification
   14. Resolution 311 – Transfer of Jurisdiction over Required Clinical Skills Examinations to LCME-Accredited and COCA-Accredited Medical Schools
   15. Resolution 316 – Transfer of Jurisdiction Over Required Clinical Skills Examinations to LCME-Accredited and COCA-Accredited Medical Schools
   16. Resolution 317 – Transfer of Jurisdiction Over Required Clinical Skills Examinations to U.S. Medical Schools
   17. Resolution 321 – Transfer of Jurisdiction over Required Clinical Skills Examinations to LCME-Accredited and COCA-Accredited Medical Schools
15. Resolution 313 – ACCME Proposed Changes in “Accreditation with Commendation” Continuing Medical Education (CME) Criteria Assessment Methodology

16. Resolution 314 – Addiction Medicine as a Multi-Specialty Subspecialty

RECOMMENDED FOR REFERRAL

17. Resolution 304 – Evaluation of Factors During Residency and Fellowship that Impact Routine Health Maintenance

RECOMMENDED FOR NOT ADOPTION

18. Resolution 312 – Specialty Board Report Cards

RECOMMENDED FOR REAFFIRMATION IN LIEU OF

19. Resolution 315 – Maintenance of Certification (MOC) and Licensure (MOL) vs Board Certification, CME and Life-Long Commitment to Learning

Resolutions handled via the Reaffirmation Consent Calendar:

20. 302 - Reform and Expand Graduate Medical Education Funding
21. 305 - Expanding GME Concurrently with UME
22. 306 - Maintenance of Certification / Licensure (MOC/MOL)
23. 307 - Diversity in the Health Care Workforce to Reduce Disparities
24. 308 - State Programs to Increase Residency Positions
(1) COUNCIL ON MEDICAL EDUCATION REPORT 2 - 
UPDATE ON MAINTENANCE OF CERTIFICATION AND 
OSTEOPATHIC CONTINUOUS CERTIFICATION 

RECOMMENDATION: 

Madam Speaker, your Reference Committee recommends 
that the recommendations in Council on Medical Education 
Report 2 be adopted and the remainder of the report 
be filed.

HOD ACTION: Council on Medical Education Report 2 adopted.

Council on Medical Education Report 2 asks that our AMA 1) a) examine the activities 
that medical specialty organizations have underway to review alternative pathways for 
board recertification, and b) determine if there is a need to establish criteria and 
construct a tool to evaluate if alternative methods for board recertification are equivalent 
to established pathways; 2) reaffirm Policy D-275.954 (9), Maintenance of Certification 
and Osteopathic Continuous Certification, which asks the American Board of Medical 
Specialties (ABMS) to ensure that all ABMS member boards provide full transparency 
related to the costs of preparing, administering, scoring and reporting maintenance of 
certification (MOC) and certifying examinations; 3) reaffirm Policy D-275.954 (4), which 
encourages the ABMS and its member boards to continue to explore other ways to 
measure the ability of physicians to access and apply knowledge to care for patients, 
and to continue to examine the evidence supporting the value of specialty board 
certification and MOC; and 4) ask the ABMS to encourage its member boards to review 
their MOC policies regarding the requirements for maintaining underlying primary or 
initial specialty board certification in addition to subspecialty board certification, if they 
have not yet done so, to allow physicians the option to focus on MOC activities relevant 
to their practice.

Your Reference Committee heard overwhelming support for this comprehensive report, 
which provides an update on the Council on Medical Education’s efforts with the 
American Board of Medical Specialties during the last year to improve the Maintenance 
of Certification (MOC) program. During testimony, it was noted that efforts to improve the 
MOC process are a work in progress. Therefore, your Reference Committee 
recommends adoption of Council on Medical Education Report 2.

(2) RESOLUTION 303 - RESEARCH AND MONITORING TO 
ENSURE ETHICS OF GLOBAL HEALTH PROGRAMS 

RECOMMENDATION: 

Madam Speaker, your Reference Committee recommends 
that Resolution 303 be adopted.

HOD ACTION: Resolution 303 adopted.

Resolution 303 asks that our American Medical Association amend Policy H-250.993 by 
addition to read as follows:

H-250.993 Overseas Medical Education Developed by US Medical Associations
The AMA will: (1) continue to focus its international activities on and through organizations that are multinational in scope; (2) encourage ethnic and other medical associations to assist medical education and improve medical care in various areas of the world; (3) encourage American medical institutions and organizations to develop relationships with similar institutions and organizations in various areas of the world; (4) work with the Association of American Medical Colleges (AAMC) and the American Association of Colleges of Osteopathic Medicine (AACOM) to ensure that medical students participating in global health programs, including but not limited to international electives and summer clinical experiences are held accountable to the same ethical standards as students participating in domestic service-learning opportunities; (5) work with the AAMC to ensure that international electives provide measureable and safe educational experiences for medical students, including appropriate learning objectives and assessment methods; and (6) communicate support for a coordinated approach to global health education, including information sharing between and among medical schools, and for activities, such as the AAMC Global Health Learning Opportunities (GHLO™), to increase student participation in international electives.

Your Reference Committee heard limited but favorable testimony in support of this item. The number of students participating in summer global health projects after completing their first year of medical school is increasing, but AMA policy does not explicitly address these projects. Your Reference Committee feels the proposed change to AMA policy is appropriate and recommends adoption of Resolution 303.

(3) RESOLUTION 310 - STANDARDIZING THE ALLOPATHIC RESIDENCY MATCH SYSTEM AND TIMELINE

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 310 be adopted.

HOD ACTION: Resolution 310 referred.

Resolution 310 asks 1) That our American Medical Association support the movement toward a single United States residency match system and notification timeline for all non-military allopathic specialties; and 2) That our AMA work with the Association of University Professors in Ophthalmology, American Academy of Ophthalmology, the Society of University Urologists, the American Urological Association, and any other appropriate stakeholders to switch ophthalmology and urology to the National Resident Matching Program.

Your Reference Committee heard testimony both in support of and opposition to Resolution 310, but the preponderance of testimony favored adoption. Testimony focused on the difficulties of couples attempting to navigate both a specialty match and the National Resident Matching Program (NRMP) match; the observation that the NRMP is much more transparent about its data, which allows individuals in the NRMP match to better gauge their competitiveness than individuals participating in a specialty match; and a concern that specialties that run their own matches have a potential financial conflict of interest. Testimony offered in opposition to the resolution came mostly from the affected specialties, which expressed satisfaction with the current system and a reluctance to transition to a shared match and timeline. Although there were concerns,
your Reference Committee feels that the majority of students would benefit from an aligned match process and timeline, and therefore recommends that Resolution 310 be adopted.

(4) RESOLUTION 318 – EXPANSION OF PUBLIC SERVICE LOAN FORGIVENESS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 318 be adopted.

HOD ACTION: Resolution 318 adopted.

Resolution 318 asks that our AMA study mechanisms to allow residents and fellows working in for-profit institutions to be eligible for Public Service Loan Forgiveness.

Your Reference Committee heard limited but supportive testimony in favor of this item. The Public Service Loan Forgiveness program allows debt relief for medical professionals who work for a non-profit entity for 10 years. The National Resident Matching Program matching algorithm does not allow medical students the opportunity to choose a program based on non-profit status. Additionally, residents and fellows who match with a non-profit university-based residency or fellowship program are excluded if they are officially employees of an affiliated for-profit hospital or health system. A study of expanding the Public Service Loan Forgiveness program to residents and fellows working in for-profit institutions is appropriate. Therefore, your Reference Committee recommends adoption.

(5) RESOLUTION 319 – SPECIALTY-SPECIFIC ALLOCATION OF GME FUNDING

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 319 be adopted.

HOD ACTION: Resolution 319 adopted.

Resolution 319 asks that our AMA support specialty-specific enhancements to GME funding that neither directly nor indirectly reduce funding levels for any other specialty.

Your Reference Committee heard strong testimony in support of this resolution. Existing AMA policy is supportive of enhancing funding for GME, but does not call for specific specialties to receive funding at the expense of others. Some testimony was heard in support of preferred funding for first-certificate programs in order to promote specific workforce goals, but the majority did not agree with any degree of partiality. Additionally, your Reference Committee felt that the resolution as written does not preclude additional discussion regarding the importance of a national workforce plan that addresses population health needs. Therefore, your Reference Committee recommends that Resolution 319 be adopted.
Resolution 320 asks that our AMA study the effect of medical school expansion that occurs without corresponding graduate medical education expansion.

Your Reference Committee heard supportive and well-reasoned testimony overwhelmingly in favor of this resolution. Multiple individuals aptly noted that the number of new medical schools, and enrollment in existing institutions has expanded substantially of late, without a corresponding increase in the number of graduate medical education (GME) slots, and a concern was voiced that the number of U.S. medical graduates (both allopathic and osteopathic) likely will approach the number of U.S. GME positions within the next one to two decades. It was further acknowledged that the Accreditation Council for Graduate Medical Education (ACGME) is currently looking at this important issue. Additionally, a study on this topic could be linked to work underway by our AMA with respect to Resolution 902-I-15, related to a national campaign to educate Americans regarding GME. Some testimony requested the addition of a second resolve, to ask the AMA to advocate for expansion in resident and fellowship positions in proportion to expansions in medical school student populations and the needs of the populace. Other testimony discussed the need for a national workforce plan that appropriately addresses specialty and geographic shortages. Testimony in opposition to the addition of the proposed second resolve focused on concerns that advocating for U.S. medical schools to limit class sizes could be construed as restraint of trade. Both the Liaison Committee on Medical Education (LCME) and the Commission on Osteopathic College Accreditation (COCA) have the authority to set standards for schools, but they must approve any school that meets those standards; they cannot arbitrarily prohibit the establishment of new schools. While it may be a moral obligation for the medical schools themselves to consider the issue of the narrowing gap between the number of medical school graduates and the number of residency positions, it is not a legal obligation. For these reasons, your Reference Committee recommends that Resolution 320 be adopted.

Council on Medical Education Report 1 recommends that the recommendation in Council on Medical Education Report 1 be amended by addition, to read as follows:

Council on Medical Education Report 1 recommends that the House of Delegates policies that are listed in the Appendix to this report be acted upon in the manner
indicated, with the exception of H-295.912, Education of Medical Students and Residents about Domestic Violence Screening, which should be retained and the remainder of this report be filed. (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Council on Medical Education Report 1 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Council on Medical Education Report 1 adopted as amended.

Council on Medical Education Report 1 recommends that the House of Delegates policies that are listed in the Appendix to this report be acted upon in the manner indicated and the remainder of this report be filed.

Your Reference Committee heard limited but generally supportive testimony on this item, which represents the work of the Council on Medical Education to streamline and make more efficient our existing AMA policy, while not seeking to develop any new policy. Additional testimony was heard that questioned the rationale of a revision to Policy H-255.988, Report of the Ad Hoc Committee on Foreign Medical Graduates, specifically proposed item 12, where language is inserted from Policy H.310.962, Residency Programs Prejudiced Against Applicants with Ethnic Names. This policy, H.310-962, is being retained as still relevant and incorporated into Policy H-255.988, which now states: "Medical school admissions officers and directors of residency programs should select applicants on the basis of merit, without considering status as an IMG or an ethnic name as a negative factor." The phrase "status as an IMG or" was inserted into revised H-255.988, to incorporate the concept of the following phrase of H-255.988, which is being deleted: "In particular, these AMA representatives should emphasize that AMA policy does not prohibit the appointment of qualified graduates of foreign medical schools to residency training programs." Your Reference Committee believes this is an appropriate revision. Other testimony was heard in relation to D-480.981, Increasing Awareness of the Benefits and Risks Associated with Complementary and Alternative Medicine, which is marked for sunsetting in the report. The testimony requested addition of the following rationale to support sunsetting of this item: "Also superseded by H-480.973, Unconventional Medical Care in the United States, which reads, in part, '(1) encourages the Office of Alternative Medicine of the National Institutes of Health to determine by objective scientific evaluation the efficacy and safety of practices and procedures of unconventional medicine; and encourages its members to become better informed regarding the practices and techniques of such practices'." Your Reference Committee supports the intent of this addition, but believes it is superfluous, as it does not change the final action on this policy (i.e., sunsetting). Finally, testimony was heard in opposition to sunsetting of H-295.912, Education of Medical Students and Residents about Domestic Violence Screening, in that the policy that was cited as superseding this policy, H-60.992, Missing and Exploited Children, is not germane and does not fully reflect the issue of domestic abuse. Your Reference Committee concurs and therefore proffers the revised language as shown, and recommends adoption as amended.
COUNCIL ON MEDICAL EDUCATION REPORT 3 -
ADDRESSING THE INCREASING NUMBER OF
UNMATCHED MEDICAL STUDENTS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends
that the recommendations in Council on Medical Education
Report 3 be amended by addition of a new fourth
recommendation, to read as follows:

4. That our AMA encourage 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 (Directive to Take Action).

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends
that the recommendations in Council on Medical Education
Report 3 be adopted as amended and the remainder of the
report be filed.

HOD ACTION: Council on Medical Education Report
3 adopted as amended.

Council on Medical Education Report 3 asks that our AMA 1) reaffirm D-305.967 (4) and
(22), The Preservation, Stability and Expansion of Full Funding for Graduate Medical
Education: “4. Our AMA will strenuously advocate for increasing the number of GME
positions to address the future physician workforce needs of the nation” and “22. Our
AMA will advocate for the appropriation of Congressional funding in support of the
National Healthcare Workforce Commission, established under section 5101 of the
Affordable Care Act, to provide data and healthcare workforce policy and advice to the
nation and provide data that support the value of GME to the nation”; 2) reaffirm Policy
schools and residency programs to consider developing admissions policies and
practices and targeted educational efforts aimed at attracting physicians to practice in
underserved areas and to provide care to underserved populations; (5) encourages
medical schools and residency programs to continue to provide courses, clerkships, and
longitudinal experiences in rural and other underserved areas as a means to support
educational program objectives and to influence choice of graduates’ practice locations;
(6) encourages medical schools to include criteria and processes in admission of
medical students that are predictive of graduates’ eventual practice in underserved areas
and with underserved populations; (7) will continue to advocate for funding from public
and private payers for educational programs that provide experiences for medical
ges and (11), National
Resident Matching Program Reform: “Our AMA: ... (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."

Your Reference Committee heard overwhelming testimony in support of the report, although several comments expressed regret that data regarding osteopathic graduates and international medical graduates were not included in the report’s overall scope, and requested that the Council on Medical Education address these issues in a separate report. A request was made to change the title of the report to “Addressing the Increasing Number of Unmatched Eligible Individuals,” in order to address content related to non-U.S. trained physicians, but your Reference Committee believes that the title accurately reflects the report’s substance and intent. Support was also expressed for adding a recommendation that calls for our AMA to encourage stakeholders to identify best practices, including career counseling, to facilitate matches and reduce the number of individuals who do not match. In addition, interest was expressed in the Council on Medical Education’s planned report for A-17, which will further examine the plight of unmatched medical students and study ways to reengage in medicine those individuals who do not match. For these reasons, your Reference Committee recommends that Council on Medical Education Report 3 be adopted as amended.

COUNCIL ON MEDICAL EDUCATION REPORT 4 - RESIDENT AND FELLOW COMPENSATION AND HEALTH CARE SYSTEM VALUE

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Recommendation 1 in Council on Medical Education Report 4 be amended by addition and deletion to read as follows:

1. That American Medical Association (AMA) Policy H-305.988 be amended by addition and deletion, to read as follows:

(10) supports AMA monitoring of trends that may lead to a reduction in stipends compensation and benefits provided paid to resident physicians. (Amend HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Recommendation 3 in Council on Medical Education Report 4 be amended by addition and deletion to read as follows:

3. That our AMA encourage teaching institutions to provide benefits to residents and fellows that will reduce personal cost of living expenditures, such as allowances for housing, childcare, and transportation. (New HOD Policy)
RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the recommendations in Council on Medical Education Report 4 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Council on Medical Education Report 4 adopted as amended.

Council on Medical Education Report 4 asks that our AMA 1) reaffirm Policy H-305.988, which states that our AMA (10) supports AMA monitoring of trends that may lead to a reduction in stipends paid to resident physicians; (12) will advocate that resident and fellow trainees should not be financially responsible for their training; 2) modify Policy H-310.922 by addition and deletion to read as follows: “Our AMA encourages that residents’ level of training, cost of living, and other factors relevant to appropriate compensation be considered by graduate training programs when establishing salaries for residents. Our AMA encourages teaching institutions to base residents' salaries on the resident's level of training as well as local economic factors, such as housing, transportation, and energy costs, that affect the purchasing power of wages, with appropriate adjustments for changes in cost of living”; 3) encourage teaching institutions to provide benefits to residents and fellows that will reduce personal cost of living expenditures, such as allowances for housing, childcare, and transportation; 4) collaborate with other stakeholder organizations to evaluate and work to establish consensus regarding the appropriate economic value of resident and fellow services; 5) monitor ongoing pilots and demonstration projects, and explore the feasibility of broader implementation of proposals that show promise as alternative means for funding physician education and training while providing appropriate compensation for residents and fellows; and 6) continue to explore, with the Accelerating Change in Medical Education initiative and with other stakeholder organizations, the implications of shifting from time based to competency-based medical education on residents’ compensation and lifetime earnings.

Your Reference Committee heard significant testimony in support of this report, which explores complex issues around resident compensation and the significant value that residents provide to patients and the health care system. Using the phrase, “compensation and benefits” rather than the word “stipend” in Recommendation 1 addresses residents’ concerns about their total compensation packages. Replacing the word “provide” in Recommendation 3 with the word “explore” avoids mandating action on the part of residency programs. With these changes, your Reference Committee recommends adoption of CME Report 4 as amended.

(10) COUNCIL ON MEDICAL EDUCATION REPORT 5 - ACCOUNTABILITY AND TRANSPARENCY IN GRADUATE MEDICAL EDUCATION FUNDING

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Recommendation 6 of Council on Medical Education Report 5 be amended by addition and deletion, to read as follows:
6. That our AMA monitor the status of the House Energy and Commerce Committee's response to public comments solicited regarding the 2014 IOM report, Graduate Medical Education That Meets the Nation's Health Needs, as well as results of ongoing studies, including that requested of the GAO, in order to formulate new advocacy strategy for GME funding, and that our AMA report back to the House of Delegates, as needed, regularly on important changes in the landscape of GME funding. (Directive to Take Action).

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the recommendations in Council on Medical Education Report 5 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Council on Medical Education Report 5 adopted as amended.

Council on Medical Education Report 5 asks that our AMA 1) endorse the following principles of social accountability and promote their application to GME funding: a. Adequate and diverse workforce development; b. Primary care and specialty practice workforce distribution; c. Geographic workforce distribution; and d. Service to the local community and the public at large; 2) encourage transparency of GME funding through models that are both feasible and fair for training sites, affiliated medical schools and trainees; 3) believes that financial transparency is essential to the sustainable future of GME funding and therefore, regardless of the method or source of payment for GME or the number of funding streams, institutions should publically report the aggregate value of GME payments received as well as what these payments are used for, including: a. Resident salary and benefits; b. Administrative support for graduate medical education; c. Salary reimbursement for teaching staff; d. Direct educational costs for residents and fellows; and e. Institutional overhead; 4) reaffirm Policy D-305.967 (8) (22) (23), The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education: “(8), Our AMA will vigorously advocate for the continued and expanded contribution by all payers for health care (including the federal government, the states, and local and private sources) to fund both the direct and indirect costs of GME.” “(22), Our AMA will advocate for the appropriation of Congressional funding in support of the National Healthcare Workforce Commission, established under section 5101 of the Affordable Care Act, to provide data and healthcare workforce policy and advice to the nation and provide data that support the value of GME to the nation.” “(23) Our AMA supports recommendations to increase the accountability for and transparency of GME funding and continue to monitor data and peer-reviewed studies that contribute to further assess the value of GME”; 5) reaffirm Policy H-305.988 (12), Cost and Financing of Medical Education and Availability of First-Year Residency Positions: “Our AMA...(12) will advocate that resident and fellow trainees should not be financially responsible for their training”; 6) monitor the status of the House Energy and Commerce Committee's response to public comments solicited regarding the 2014 IOM report, Graduate Medical Education That Meets the Nation's Health Needs, as well as results of ongoing studies, including that requested of the GAO, in order to formulate new advocacy strategy for
GME funding, and that our AMA report back to the House of Delegates, as needed, on important changes in the landscape of GME funding.

Your Reference Committee heard universal support for this report. Testimony highlighted the importance of transparency and its role in appropriate geographic distribution of physicians, especially in specialties of need, and acknowledgment that the report correctly calls attention to a public good that is consistently underfunded when examined in the context of societal need. The authors of the report were also complimented for summarizing a complex topic in a relatable and relevant manner. A request was made that the report be updated annually; however, your Reference Committee recognizes that, in the absence of necessary data or any noteworthy changes in the GME funding climate, our AMA would be better served by updating the report regularly, as required. Therefore, your Reference Committee recommends that Council on Medical Education Report 5 be adopted as amended.

(11) COUNCIL ON MEDICAL EDUCATION REPORT 6 -
TELEMEDICINE IN GRADUATE MEDICAL EDUCATION

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Recommendation 1 of Council on Medical Education Report 6 be amended by addition and deletion, to read as follows:

1. That our AMA support incorporating the appropriate use of telemedicine into the education of medical students, residents, fellows and practicing physicians. (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the recommendations in Council on Medical Education Report 6 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Council on Medical Education Report 6 adopted as amended with a change in title.

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the title of Council on Medical Education Report 6 be changed to read as follows:

TELEMEDICINE IN MEDICAL EDUCATION

Council on Medical Education Report 6 asks that our AMA 1) support incorporating telemedicine into the education of medical students, residents, fellows and practicing physicians; 2) encourage appropriate stakeholders to study the most effective methods for the instruction of medical students, residents, fellows and practicing physicians in the
use of telemedicine and its capabilities and limitations; 3) collaborate with appropriate
stakeholders to reduce barriers to the incorporation of telemedicine into the education of
physicians and other health care professionals; 4) encourage the Liaison Committee on
Medical Education (LCME) and Accreditation Council for Graduate Medical Education
(ACGME) to include core competencies in telemedicine in undergraduate medical
education and graduate medical education training; and 5) reaffirm policies H-480.946,
H-480.974, D-480.970, and H-480.968, which can reduce some of the barriers to
telemedicine education, which have been identified.

Your Reference Committee heard overwhelming testimony in support of this report,
which was felt to be timely and relevant, due to the increased, and increasingly valuable,
implementation of this technological enhancement to medical practice. Testimony
reflected the value of teaching and learning the appropriate use of telemedicine in
training and practice, and noted the importance of issues related to teleprecepting.
Some testimony noted that the scope of the report extends beyond graduate medical
education, and recommended that the title be modified to reflect the entirety of its
content. Testimony also reflected a concern that the first resolve, as written, could be
construed as a curricular mandate, and support was voiced to amend this
recommendation in a way that stresses the importance of methodology and care
delivery. Online testimony expressed concern that the term “telemedicine,” as used in
the report, would not encompass other, related terms such as telehealth or mHealth;
however, your Reference Committee felt that the report adequately addressed the
reasoning for the use of the term “telemedicine” and does not believe change is needed
in this regard. Therefore, your Reference Committee recommends adoption of Council
on Medical Education Report 6 as amended.

(12) RESOLUTION 301 - RECOGNIZING THE
ACTUAL COSTS OF STUDENT LOANS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends
that the fourth Resolve of Resolution 301 be amended by
addition and deletion, to read as follows:

RESOLVED, That our American Medical Association consider the total cost of
loans including loan origination fees and benefits of federal loans such as tax

HOD ACTION: Resolution 301 adopted as amended.
deductibility or loan forgiveness when advocating for a reduction in student loan interest rates; 2) That our AMA amend Policy D-305.984 by addition to include Grad-PLUS loans, as follows:

Reduction in Student Loan Interest Rates D-305.984
1. Our American Medical Association will actively lobby for legislation aimed at establishing an affordable student loan structure with a variable interest rate capped at no more than 5.0%.
2. Our AMA will work in collaboration with other health profession organizations to advocate for a reduction of the fixed interest rate of the Stafford student loan program and the Graduate PLUS loan program.
3) That our AMA advocate for policies which lead to equal or less expensive loans (in terms of loan benefits, origination fees, and interest rates) for Grad-PLUS loans as this would change the status quo of high-borrowers paying higher interest rates and fees in addition to having a higher overall loan burden; and 4) That our AMA ask the Association of American Medical Colleges to collect data and report student indebtedness that includes total loan costs at time of graduation.

Your Reference Committee heard overwhelming support for this item. The fourth Resolve calls on our AMA to ask the Association of American Medical Colleges (AAMC) to collect data and report on student indebtedness, using methodology that includes total loan costs at the time of graduation. The AAMC already collects and reports on these data, but there was significant concern that the debt acquired in the process of becoming a physician is actually under-reported, because interest that accumulates during residency or fellowship is not reflected in these data. The recommended change incorporates these concerns. Accordingly, your Reference Committee recommends adoption of Resolution 301 as amended.

(13) RESOLUTION 309 - CONTINUING MEDICAL EDUCATION PATHWAY FOR RECERTIFICATION

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Resolve of Resolution 309 be amended by addition and deletion, to read as follows:

RESOLVED, That our American Medical Association call for the immediate end of any mandatory, recertifying examination by continue to work with the American Board of Medical Specialties (ABMS) to encourage the development by and the sharing between specialty boards of alternative ways to assess medical knowledge other than by a secure exam or other certifying organizations as part of the recertification process (Directive to Take Action); and be it further

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the fourth Resolve of Resolution 309 be deleted.
RESOLVED, That the AMA voice this policy directly to the ABMS and other certifying organizations (Directive to Take Action); and be it further

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the fifth Resolve of Resolution 309 be deleted.

RESOLVED, That there be a report back to the AMA HOD by the 2017 Annual Meeting. (Directive to Take Action)

RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends that Resolution 309 be adopted as amended.

HOD ACTION: Original language of the first Resolve adopted as amended, with addition of fourth and fifth Resolves, to read as follows:

RESOLVED, That our American Medical Association call for the immediate end of any mandatory, secured recertifying examination by the American Board of Medical Specialties (ABMS) or other certifying organizations as part of the recertification process for all those specialties that still require a secure, high-stakes recertification examination.

RESOLVED, That our AMA continue to work with the American Board of Medical Specialties (ABMS) to encourage the development by and the sharing between specialty boards of alternative ways to assess medical knowledge other than by a secure exam.

RESOLVED, That our AMA continue to support the requirement of Continuing Medical Education (CME) and ongoing, quality assessments of physicians, where such CME is proven to be cost-effective and shown by evidence to improve quality of care for patients.

Resolution 309 asks 1) That our American Medical Association call for the immediate end of any mandatory, recertifying examination by the American Board of Medical Specialties (ABMS) or other certifying organizations as part of the recertification process; 2) That our AMA support a recertification process based on high quality, appropriate CME material directed by the AMA recognized specialty societies covering the physician’s practice area, in cooperation with other willing stakeholders, that would be completed on a regular basis as determined by the individual medical specialty, to ensure lifelong learning; 3) That our AMA reaffirm Policies H-275.924 and D-275.954; 4)
That the AMA voice this policy directly to the ABMS and other certifying organizations; and 5) That there be a report back to the AMA HOD by the 2017 Annual Meeting.

Your Reference Committee heard testimony in support of Resolution 309. Our AMA, through the Council on Medical Education, works with the American Board of Medical Specialties (ABMS) to encourage the sharing of best practices between specialty boards about all aspects of Maintenance of Certification (MOC), including Part III, the secured, high-stakes examination, for some but not all of the boards. The ABMS member boards are independent entities, and it is not within the purview of the ABMS to mandate the cessation of the secure examination. However, the Council will continue to work collaboratively with the ABMS and, when appropriate, with specific boards regarding alternative models for the secure exam. In addition, the Council continues to maintain an active dialogue with the ABMS, and Council members and AMA staff meet regularly with ABMS leaders to communicate questions and concerns about MOC. Policy D-275.954 calls on our AMA to continue to monitor the evolution of MOC, continue its active engagement in discussions regarding their implementation, encourage specialty boards to investigate and/or establish alternative approaches for MOC and prepare a yearly report to the HOD regarding the MOC process. For these reasons, your Reference Committee recommends that Resolution 309 be adopted as amended.

RESOLUTION 311 - TRANSFER OF JURISDICTION
OVER REQUIRED CLINICAL SKILLS EXAMINATIONS TO LCME-ACCREDITED AND COCA-ACCREDITED MEDICAL SCHOOLS

RESOLUTION 316 - TRANSFER OF JURISDICTION
OVER REQUIRED CLINICAL SKILLS EXAMINATIONS TO LCME-ACCREDITED AND COCA-ACCREDITED MEDICAL SCHOOLS

RESOLUTION 317 - TRANSFER OF JURISDICTION
OVER REQUIRED CLINICAL SKILLS EXAMINATIONS TO U.S. MEDICAL SCHOOLS

RESOLUTION 321 - TRANSFER OF JURISDICTION
OVER REQUIRED CLINICAL SKILLS EXAMINATIONS TO LCME-ACCREDITED AND COCA-ACCREDITED MEDICAL SCHOOLS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the following resolution be adopted in lieu of Resolutions 311, 316, 317, and 321.

TRANSFER OF JURISDICTION OVER REQUIRED CLINICAL SKILLS EXAMINATIONS TO LCME-ACCREDITED AND COCA-ACCREDITED MEDICAL SCHOOLS

RESOLVED, That our American Medical Association work with the Federation of State Medical Boards, National Board of Medical Examiners, 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) as a requirement for Liaison Committee on Medical
Education-accredited and Commission on Osteopathic
College Accreditation-accredited medical school graduates
who have passed a school-administered, clinical skills
examination (Directive to Take Action); and be it further

RESOLVED, That our AMA work to: 1) 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; 2)
encourage a significant and expeditious increase in the
number of available testing sites; 3) engage in a
transparent evaluation of basing this examination within
our nation’s medical schools, rather than administered by
an external organization; and, 4) 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 (New HOD
Policy).

HOD ACTION: Alternate Resolution 311 adopted as
amended in lieu of Resolutions 311, 316, 317, and 321 to
read as follows:

RESOLVED, That our American Medical Association 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) as with a
requirement for to pass a Liaison Committee on Medical
Education-accredited and/or Commission on Osteopathic
College Accreditation-accredited medical school
graduates who have passed a school-administered,
clinical skills examination.
RESOLVED, That our AMA work to: 1) 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; 2) encourage a significant and expeditious increase in the number of available testing sites; 3) allow international students and graduates to take the same examination at any available testing site; 4) engage in a transparent evaluation of basing this examination within our nation’s medical schools, rather than administered by an external organization; and, 5) 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.

Resolution 311 asks 1) That our American Medical Association work with the Federation of State Medical Boards and state medical licensing boards to advocate for the elimination of the United States Medical Licensing Examination (USMLE) Step 2 Clinical Skills (CS) exam and the COMLEX Level 2-PE (Performance Evaluation) as a requirement for Liaison Committee on Medical Education-accredited and Commission on Osteopathic College Accreditation-accredited medical school graduates who have passed a school-administered, clinical skills examination; and 2) That our American Medical Association amend AMA Policy D-295.998 by addition to read as follows: Required Clinical Skills Assessment During Medical School D-295.988

Our AMA will encourage its representatives to the Liaison Committee on Medical Education (LCME) to ask the LCME to 1) 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, and 2) require that medical students attending LCME-accredited or American Osteopathic Association Commission on Osteopathic College Accreditation (COCA)-accredited institutions pass a school-administered clinical skills examination to graduate from medical school.

Resolution 316 asks 1) That our American Medical Association, working with the state medical societies, advocate for the Federation of State Medical Boards (FSMB) and state medical boards to eliminate the United States Medical Licensing Examination (USMLE) Step 2 Clinical Skills (CS) and the Comprehensive Osteopathic Licensing Examination (COMLEX) Level 2-Performance Examination (PE) as a requirement for Liaison Committee on Medical Education (LCME)-accredited and Committee on Osteopathic College Accreditation (COCA)-accredited medical school graduates who have passed a school-administered, clinical skills examination; 2) That our AMA advocate for medical schools and medical licensure stakeholders to create standardizing a clinical skills examination that would be administered at each Liaison Committee on Medical Education (LCME)-accredited and Committee on Osteopathic College Accreditation (COCA)-accredited medical school in lieu of United States Medical Licensing Examination (USMLE) Step 2 Clinical Skills (CS) and Comprehensive Osteopathic Licensing Examination (COMLEX) Level 2-Performance Examination (PE) and that would be a substitute prerequisite for future licensure exams; and 3) That AMA to amend Policy D-295.998 by addition and deletion as follows:
Required Clinical Skills Assessment During Medical School D-295.998

Our AMA will encourage its representatives to the Liaison Committee on Medical Education (LCME) to ask the LCME to 1) 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, and 2) require that medical students attending LCME-accredited institutions pass a school-administered, clinical skills examination to graduate from medical school.

Resolution 317 asks 1) That our American Medical Association work with the Federation of State Medical Boards and state medical licensing boards to advocate for the elimination of the United States Medical Licensing Examination (USMLE) Step 2 Clinical Skills (CS) exam as a requirement for Liaison Committee on Medical Education-accredited graduates who have passed a school-administered, clinical skills examination; and 2) That our AMA amend Policy D-295.998 by addition and deletion to read as follows:

Resolution 321 asks 1) That our AMA, working with the state medical societies, advocate for the Federation of State Medical Boards (FSMB) and state medical boards to eliminate the United States Medical Licensing Examination (USMLE) Step 2 Clinical Skills (CS) and the Comprehensive Osteopathic Licensing Examination (COMLEX) Level 2-Performance Examination (PE) as a requirement for Liaison Committee on Medical Education (LCME)-accredited and Committee on Osteopathic College Accreditation (COCA)-accredited medical school graduates who have passed a school administered, clinical skills examination; and 2) That our AMA amend D-295.998 by insertion and deletion as follows:

Your Reference Committee heard extensive and impassioned testimony on both sides of this item, but the substantial preponderance of testimony was in favor of adoption of these resolutions. A number of key and compelling points were made, including the significant costs and burden to medical students associated with this examination; the lack of meaningful feedback provided for learning and improvement; and questions
regarding the predictive ability of the exam for success or enhanced patient safety in clinical practice. The less extensive yet equally reasoned testimony in opposition to this resolution focused on the importance of physician self-regulation; maintenance of the public trust; and a concern expressed by international medical graduates (IMGs) that if this resolution is adopted, they would be held to a different, unequal standard than their U.S.-trained peers. Strong arguments were made that the responsibility for clinical skills testing should be maintained by medical schools, despite some concerns that asking schools to evaluate their own students could lead to inflated assessments through a lack of neutrality; that there could be a lack of standardization in assessments; and that not all schools had the resources to perform this particular function. These concerns were furthered by a discussion of whether the issue at hand is the nature or the cost of the examination. While acknowledging concerns, others stressed that referral would allow this important matter to be appropriately studied, and would also permit identification of a valid transition plan which could address immediate concerns of cost and lack of transparency while engaging appropriate stakeholders in the identification of concrete steps toward the return of responsibility for clinical skills assessment to the direct purview of medical schools. Your Reference Committee carefully and deliberately considered this testimony and its associated implications, and recommends adoption of the proposed resolution in lieu of the original items.

RESOLUTION 313 - ACCME PROPOSED CHANGES IN "ACCREDITATION WITH COMMENDATION" CONTINUING MEDICAL EDUCATION (CME) CRITERIA ASSESSMENT METHODOLOGY

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 313 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association study the validity, reliability and equivalency application practicality of the proposed ACCME changes in its method for assessing compliance with criteria for "Accreditation with Commendation" with a report back to the AMA House of Delegates by the 2016 Interim Meeting. Continue to monitor the proposed Accreditation Council for Continuing Medical Education (ACCME) "Accreditation with commendation" criteria, provide input to the ACCME Board of Directors, and report to the AMA HOD once the criteria are approved and implemented. (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 313 be adopted as amended.

HOD ACTION: Resolution 313 adopted as amended.

Resolution 313 asks that our American Medical Association study the validity, reliability and equivalency application practicality of the proposed ACCME changes in its method
for assessing compliance with criteria for “Accreditation with Commendation” with a
report back to the AMA House of Delegates by the 2016 Interim Meeting.

Your Reference Committee heard support for Resolution 313. The Accreditation Council
for Continuing Medical Education (ACCME) has proposed new Accreditation with
Commendation Criteria, and there may be changes to these criteria in late summer
based on comments provided to the ACCME earlier this year. The issue is complex and
requires study by the Council on Medical Education. However, these changes may
impact the Council’s ability to conduct a study by November. For these reasons, your
Reference Committee recommends that Resolution 313 be adopted as amended.

(16) RESOLUTION 314 - ADDICTION MEDICINE AS A
MULTI-SPECIALTY SUBSPECIALTY

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends
that Resolve 2 in Resolution 314 be amended by addition
and deletion to read as follows:

RESOLVED, That our AMA encourage the ABPM to offer
the first ABMS-approved certification examination in
addiction medicine in the year 2017 expeditiously in order
to improve access to care to treat addiction. (New HOD
Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends
that Resolution 314 be adopted as amended.

HOD ACTION: Resolution 314 adopted as amended.

Resolution 314 asks 1) That our American Medical Association commend the American
Board of Preventive Medicine (ABPM) for its successful application to the American
Board of Medical Specialties (ABMS) to establish the new ABMS-approved
multispecialty subspecialty of addiction medicine, which will be able to offer certification
to qualified physicians who are diplomates of any of the 24 ABMS member boards; and
2) That our AMA encourage the ABPM to offer the first ABMS-approved certification
examination in addiction medicine in the year 2017 in order to improve access to care to
treat addiction.

Your Reference Committee heard testimony in support of Resolution 314. On March 14,
the American Board of Medical Specialties (ABMS) announced the recognition of
Addiction Medicine as a new subspecialty under the American Board of Preventive
Medicine (ABPM). ABPM applied to the ABMS for recognition of the new subspecialty
and will be the administering board for Addiction Medicine. This new subspecialty field
will be open to any physician certified by any of the 24 Member Boards of the ABMS.
However, no date has yet been determined for the first examination. The examination
needs to be developed by experts in addiction medicine, and this process will take some
time. The second resolve asks the AMA to encourage the ABPM to offer the
examination in 2017, due to the large number of physicians interested in attaining
certification status in addiction medicine and the pressing need for physicians to help address the opioid crisis that our nation faces. Rather than indicating a time certain, it may be more politic and appropriate to encourage development of an examination in a timely fashion, while also ensuring that the exam is well-constructed and is an accurate gauge of the qualifications of a physician to practice addiction medicine. Therefore, your Reference Committee recommends that Resolution 314 be adopted as amended.

(17) RESOLUTION 304 - EVALUATION OF FACTORS DURING RESIDENCY AND FELLOWSHIP THAT IMPACT ROUTINE HEALTH MAINTENANCE

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 304 be referred.

HOD ACTION: Resolution 304 referred.

Resolution 304 asks that our American Medical Association study ways to improve access and reduce barriers to seeking preventive and routine physical and mental health care for trainees in graduate medical education programs.

Your Reference Committee heard significant testimony on this timely issue, as the epidemic of physician burnout and suicide continues unabated. Testimony noted the attention of our AMA to exploring and disseminating solutions, through the work of its Professional Satisfaction and Practice Sustainability strategic focus area, for example, and educational sessions on the topic (as were featured prior to the opening of this House of Delegates). Similarly, testimony was also expressed that a task force of the Accreditation Council for Graduate Medical Education is actively addressing the issues of physician burnout, wellness and resiliency. Additional testimony noted issues of confidentiality in accessing needed care, especially in smaller cities and towns; the reluctance among trainees to seek care due to fear of burdening their residency colleagues with having to cover for their absence; and the need to change the culture of medicine to enhance physician well-being and work-life balance. The Council on Medical Education testified that this resolution could be added to a planned report for the 2016 Interim Meeting on this topic, which addresses a number of resolutions referred at the Interim 2015 meeting. Accordingly, your Reference Committee recommends referral.

(18) RESOLUTION 312 - SPECIALTY BOARD REPORT CARDS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 312 not be adopted.

HOD ACTION: Resolution 312 not adopted.

Resolution 312 asks 1) That our American Medical Association evaluate and prepare for distribution to the House of Delegates by the June 2017 Annual Meeting (A-17) an analysis report card comparing ABIM and NBPAS to the standards codified within AMA Policy H-275.924 (AMA Principles on Maintenance of Certification); and 2) That each
succeeding year the AMA evaluate and annually prepare for distribution to the House of Delegates an Analysis Report Card comparing two separate and additional specialty boards, to be selected on a rotating and inclusive basis, from those Specialty Boards operating under the auspices of the American Board of Medical Specialties (ABMS) to the standards codified within AMA Policy H-275.924 (AMA Principles on Maintenance of Certification).

Minimal testimony was offered for Resolution 312. The sponsor called on our AMA to develop a report card to evaluate certifying boards against our AMA’s Principles of Maintenance of Certification (MOC). However, it was noted that the requirements for MOC are changing rapidly, so that by the time a report on an individual board could be prepared it is likely to be out of date. In addition, the specialty societies are having considerable success in achieving appropriate modification of requirements for all the steps of MOC. It was also noted that the Council on Medical Education’s continued work with the American Board of Medical Specialties has helped to encourage appropriate flexibility with meeting MOC requirements. Therefore, your Reference Committee recommends that Resolution 312 not be adopted.

(19) RESOLUTION 315 - MAINTENANCE OF CERTIFICATION (MOC) AND LICENSURE (MOL) VS BOARD CERTIFICATION, CME AND LIFE-LONG COMMITMENT TO LEARNING

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Policies H-275.924, H-275.926, and H-275.917 be reaffirmed in lieu of Resolution 315.

HOD ACTION: Resolution 315 referred.

Resolution 315 asks that the American Medical Association oppose discrimination by any hospital or employer, state board of medical licensure, insurers, Medicare, Medicaid, and other entities, which results in the restriction of a physician’s right to practice medicine without interference (including discrimination by varying fee schedules) due to lack of recertification or participation in a Maintenance of Licensure, Maintenance of Certification program, or due to a lapse of a time-limited board certification

Your Reference Committee heard testimony in support of Resolution 315. Maintenance of Certification (MOC) is a career-long process of learning, assessment and performance improvement that is meant to demonstrate proficiency within a chosen discipline, but is separate and not required for licensure, employment or reimbursement. Your Reference Committee believes that current AMA policy covers the intent of Resolution 315. Policy H-275.924 states that the MOC program should not be a mandated requirement for licensure, credentialing, reimbursement, network participation, or employment. Policy H-275.926 states that our AMA opposes discrimination against physicians based solely on lack of ABMS or equivalent AOA-BOS board certification, or where board certification is one of the criteria considered for purposes of measuring quality of care, determining eligibility to contract with managed care entities, eligibility to receive hospital staff, or other clinical privileges, ascertaining competence to practice medicine, or for other purposes. Policy H-275.917 states that our AMA will advocate that if state medical boards move forward with a more intense or
rigorous MOL program, each state medical board be required to accept evidence of
successful ongoing participation in the ABMS MOC and AOA-Bureau of Osteopathic
Specialists Osteopathic Continuous Certification to have fulfilled all three components of
the MOL, if performed. Therefore, your Reference Committee recommends that Policies

Policy recommended for reaffirmation:

Maintenance of Certification H-275.924
AMA Principles on Maintenance of Certification (MOC)
1. Changes in specialty-board certification requirements for MOC programs should be
longitudinally stable in structure, although flexible in content.
2. Implementation of changes in MOC must be reasonable and take into consideration
the time needed to develop the proper MOC structures as well as to educate physician
diplomates about the requirements for participation.
3. Any changes to the MOC process for a given medical specialty board should occur no
more frequently than the intervals used by that specialty board for MOC.
4. Any changes in the MOC process should not result in significantly increased cost or
burden to physician participants (such as systems that mandate continuous
documentation or require annual milestones).
5. MOC requirements should not reduce the capacity of the overall physician workforce.
It is important to retain a structure of MOC programs that permits physicians to complete
modules with temporal flexibility, compatible with their practice responsibilities.
6. Patient satisfaction programs such as The Consumer Assessment of Healthcare
Providers and Systems (CAHPS) patient survey are neither appropriate nor effective
survey tools to assess physician competence in many specialties.
7. Careful consideration should be given to the importance of retaining flexibility in
pathways for MOC for physicians with careers that combine clinical patient care with
significant leadership, administrative, research and teaching responsibilities.
8. Legal ramifications must be examined, and conflicts resolved, prior to data collection
and/or displaying any information collected in the process of MOC. Specifically, careful
consideration must be given to the types and format of physician-specific data to be
publicly released in conjunction with MOC participation.
9. Our AMA affirms the current language regarding continuing medical education (CME):
"Each Member Board will document that diplomates are meeting the CME and Self-
Assessment requirements for MOC Part II. The content of CME and self-assessment
programs receiving credit for MOC will be relevant to advances within the diplomate's
scope of practice, and free of commercial bias and direct support from pharmaceutical
and device industries. Each diplomate will be required to complete CME credits (AMA
PRA Category 1 Credit™, American Academy of Family Physicians Prescribed,
American College of Obstetricians and Gynecologists, and/or American Osteopathic
Association Category 1A).
"
10. In relation to MOC Part II, our AMA continues to support and promote the AMA
Physician's Recognition Award (PRA) Credit system as one of the three major credit
systems that comprise the foundation for continuing medical education in the U.S.,
including the Performance Improvement CME (PICME) format; and continues to develop
relationships and agreements that may lead to standards accepted by all U.S. licensing
boards, specialty boards, hospital credentialing bodies and other entities requiring
evidence of physician CME.
11. MOC is but one component to promote patient safety and quality. Health care is a
team effort, and changes to MOC should not create an unrealistic expectation that
lapses in patient safety are primarily failures of individual physicians.
12. MOC should be based on evidence and designed to identify performance gaps and unmet needs, providing direction and guidance for improvement in physician performance and delivery of care.

13. The MOC process should be evaluated periodically to measure physician satisfaction, knowledge uptake and intent to maintain or change practice.

14. MOC should be used as a tool for continuous improvement.

15. The MOC program should not be a mandated requirement for licensure, credentialing, reimbursement, network participation or employment.

16. Actively practicing physicians should be well-represented on specialty boards developing MOC.

17. Our AMA will include early career physicians when nominating individuals to the Boards of Directors for ABMS member boards.

18. MOC activities and measurement should be relevant to clinical practice.

19. The MOC process should not be cost prohibitive or present barriers to patient care.

20. Any assessment should be used to guide physicians' self-directed study.

21. Specific content-based feedback after any assessment tests should be provided to physicians in a timely manner.

22. There should be multiple options for how an assessment could be structured to accommodate different learning styles.

23. Physicians with lifetime board certification should not be required to seek recertification.

24. No qualifiers or restrictions should be placed on diplomates with lifetime board certification recognized by the ABMS related to their participation in MOC.

25. Members of our House of Delegates are encouraged to increase their awareness of and participation in the proposed changes to physician self-regulation through their specialty organizations and other professional membership groups.

Medical Specialty Board Certification Standards H-275.926

Our AMA:

1. Opposes any action, regardless of intent, that appears likely to confuse the public about the unique credentials of American Board of Medical Specialties (ABMS) or American Osteopathic Association Bureau of Osteopathic Specialists (AOA-BOS) board certified physicians in any medical specialty, or take advantage of the prestige of any medical specialty for purposes contrary to the public good and safety.

2. Continues to work with other medical organizations to educate the profession and the public about the ABMS and AOA-BOS board certification processes. It is AMA policy that when the equivalency of board certification must be determined, accepted standards, such as those adopted by state medical boards or the Essentials for Approval of Examining Boards in Medical Specialties, be utilized for that determination.

3. Opposes discrimination against physicians based solely on lack of ABMS or equivalent AOA-BOS board certification, or where board certification is one of the criteria considered for purposes of measuring quality of care, determining eligibility to contract with managed care entities, eligibility to receive hospital staff or other clinical privileges, ascertaining competence to practice medicine, or for other purposes. Our AMA also opposes discrimination that may occur against physicians involved in the board certification process, including those who are in a clinical practice period for the specified minimum period of time that must be completed prior to taking the board certifying examination.
4. Advocates for nomenclature to better distinguish those physicians who are in the board certification pathway from those who are not.

5. Encourages member boards of the ABMS to adopt measures aimed at mitigating the financial burden on residents related to specialty board fees and fee procedures, including shorter preregistration periods, lower fees and easier payment terms.


H-275.917

AMA Principles on Maintenance of Licensure (MOL):

1. Our American Medical Association (AMA) established the following guidelines for implementation of state MOL programs:
   A. Any MOL activity should be able to be integrated into the existing infrastructure of the health care environment.
   B. Any MOL educational activity under consideration should be developed in collaboration with physicians, should be evidence-based and should be practice-specific. Accountability for physicians should be led by physicians.
   C. Any proposed MOL activity should undergo an in-depth analysis of the direct and indirect costs, including physicians' time and the impact on patient access to care, as well as a risk/benefit analysis, with particular attention to unintended consequences.
   D. Any MOL activity should be flexible and offer a variety of compliance options for all physicians, practicing or non-practicing, which may vary depending on their roles (e.g., clinical care, research, administration, education).
   E. Any MOL activity should be designed for quality improvement and lifelong learning.
   F. Participation in quality improvement activities, such as chart review, should be an option as an MOL activity.

2. Our AMA supports the Federation of State Medical Boards Guiding Principles for MOL (current as of June 2015), which state that:
   A. Maintenance of licensure should support physicians' commitment to lifelong learning and facilitate improvement in physician practice.
   B. Maintenance of licensure systems should be administratively feasible and should be developed in collaboration with other stakeholders. The authority for establishing MOL requirements should remain within the purview of state medical boards.
   C. Maintenance of licensure should not compromise patient care or create barriers to physician practice.
   D. The infrastructure to support physician compliance with MOL requirements must be flexible and offer a choice of options for meeting requirements.
   E. Maintenance of licensure processes should balance transparency with privacy protections (e.g., should capture what most physicians are already doing, not be onerous, etc.).

3. Our AMA will:
   A. Continue to support and promote the AMA Physician's Recognition Award (PRA) Credit system as one of the three major CME credit systems that comprise the foundation for continuing medical education in the U.S., including the Performance Improvement CME (PICME) format, and continue to develop relationships and agreements that may lead to standards accepted by all U.S. licensing boards, specialty boards, hospital credentialing bodies, and other entities requiring evidence of physician CME as part of the process for MOL.
   B. Advocate that if state medical boards move forward with a more intense or rigorous MOL program, each state medical board be required to accept evidence of successful ongoing participation in the ABMS MOC and AOA-Bureau of Osteopathic Specialists
Osteopathic Continuous Certification to have fulfilled all three components of the MOL, if performed,

C. Advocate that state medical boards accept programs created by specialty societies as evidence that the physician is participating in continuous lifelong learning and allow physicians to choose which programs they participate in to fulfill their MOL criteria.

D. Oppose any MOL initiative that creates barriers to practice, is administratively unfeasible, is inflexible with regard to how physicians practice (clinically or not), does not protect physician privacy, or is used to promote policy initiatives about physician competence.

Madam Speaker, this concludes the report of Reference Committee C. I would like to thank Peter Aran, MD; Sharon Douglas, MD; C. Blair Harkness, MD; Laura Shea, MD; Sarah Smith; J. Mack Worthington, MD; our AMA staff, including Catherine Welcher, Fred Lenhoff, Richard Hawkins, MD, Alejandro Aparicio, MD, Carrie Radabaugh, Victoria Stagg-Elliott; and all those who testified before the Committee.

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