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The following is a preliminary report of actions taken by the House of Delegates at its 2014 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-14)

Report of Reference Committee C

Kesavan Kutty, MD, Chair

Your Reference Committee recommends the following consent calendar for acceptance:

RECOMMENDED FOR ADOPTION

1. Board of Trustees Report 25 – CMS Definition of “Resident Physician”
3. CME Report 4 – Alignment of Accreditation Across the Medical Education Continuum
4. Resolution 304 – Graduate Medical Education Funding and Quality of Resident Education
5. Resolution 311 – Impact of Competency-based Medical Education Programs as Opposed to Time-based Programs
6. Resolution 314 – Compromising Lifetime Certifications Retroactively
7. Resolution 324 – Use of Unmatched Medical Students as “Assistant Physicians”

RECOMMENDED FOR ADOPTION AS AMENDED OR SUBSTITUTED

8. CME Report 3 – Competency-based Medical Education Across the Continuum of Education and Practice
9. CME Report 5 – AMA Duty Hours Policy
10. CME Report 6 – Update on Maintenance of Certification, Osteopathic Continuous Certification and Maintenance of Licensure
11. Resolution 316 – Moratorium on Maintenance of Certification
11. CME Report 7 – Physician Workforce Shortage: Approaches to GME Financing

Resolution 309 – Expansion of Graduate Medical Education Positions through Alternative Funding

12. Resolution 301 – Shared Decision Making in Medical Education

13. Resolution 302 – Providing Residency Applicants a Timely Response to Residency Application Outcome


15. Resolution 305 – Transparency on Maternity and Paternity Leave Policies for Trainees

16. Resolution 306 – Endorsing Standardized Core Curricula on Disability Education in Medical School

17. Resolution 307 – Practical Use of Advance Directives in Medical Education

18. Resolution 308 – Competency and the Aging Physician

19. Resolution 310 – Physician Reentry and Licensure

20. Resolution 312 – Assessing the Impact of Limited GME Residency Positions in the Match

21. Resolution 318 – Assisting Medical Students Applying for Away Rotations

22. Resolution 319 – Maintenance of Licensure

23. Resolution 322 – Maintaining and Developing High Quality Hospice and Palliative Care Physician Workforce in the New Millennium

24. Resolution 323 – Preservation of the Current Federal Student Aid Loan Forgiveness for Public Service Employees Program

RECOMMENDED FOR REFERRAL

25. CME Report 8 – Guidelines for Students Shadowing Physicians

26. Resolution 317 – Abolish Discrimination Against IMGs in Medical Licensing Requirements

RECOMMENDED FOR NOT ADOPTION

27. Resolution 315 – Certification of Methadone Education

28. Resolution 321 – Alternate Financing of Post Graduate Education for Physicians
RECOMMENDED FOR REAFFIRMATION IN LIEU OF

29. Resolution 313 – Opposition to the FSMB Maintenance of Licensure Program

30. Resolution 320 – Mandatory Board Re-Certification

(1) BOARD OF TRUSTEES REPORT 25 - CMS DEFINITION OF “RESIDENT PHYSICIAN”

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the recommendation in Board of Trustees Report 25 be adopted and the remainder of the report be filed.

HOD ACTION: Recommendation in Board of Trustees Report 25 adopted and the remainder of the report filed.

Resolution 923-I-13, “CMS Definition of “Resident Physician,” introduced by the Resident and Fellow Section, asked that our AMA “advocate, in conjunction with appropriate stakeholders, that the Centers for Medicare & Medicaid Services (CMS) use our AMA definition of Resident when formulating rules and regulations.”

Board of Trustees Report 25, CMS Definition of “Resident Physician,” recommends that Resolution 923-I-13 not be adopted and the remainder of the report be filed.

Your Reference Committee heard unanimous testimony in support of adopting this report. The nature of the roles and responsibilities of resident physicians versus fellow physicians are substantively different. In many fellowships, for example, fellows are afforded opportunities to participate in unsupervised activities and to bill accordingly—an opportunity not available to residents. If our AMA were to advocate for these changes in the CMS regulations, as proposed in Resolution 923-I-13, residents might be subject to attempts by the CMS to include them in the Physician Payment Sunshine Act (Open Payments). This unintended consequence makes the risk not worth the potential benefits (if any). Finally, it was noted that our AMA’s definition of a resident physician is intended for internal use. For these reasons, your Reference Committee recommends adoption of BOT Report 25.

(2) COUNCIL ON MEDICAL EDUCATION REPORT 2 - CME SUNSET REVIEW OF 2004 HOUSE POLICIES

RECOMMENDATION:

Mr. 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: Recommendations in Council on Medical Education Report 2 adopted and the remainder of the report filed.

Council on Medical Education Report 2, CME Sunset Review of 2004 House Policies, is a review of House of Delegates’ policies related to medical education last considered in 2004, and contains Council on Medical Education recommendations for retention or rescission of policies.

The Council on Medical Education 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 favorable testimony, and believes that this report should be adopted, to ensure the most accurate and up-to-date AMA policy on medical education matters.

(3) COUNCIL ON MEDICAL EDUCATION REPORT 4 - ALIGNMENT OF ACCREDITATION ACROSS THE MEDICAL EDUCATION CONTINUUM

RECOMMENDATION:

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

HOD ACTION: Recommendations in Council on Medical Education Report 4 adopted and the remainder of the report filed.

Council on Medical Education Report 4, Alignment of Accreditation Across the Medical Education Continuum, specifically examines the extent to which the current processes for accreditation are designed to facilitate an ideal medical education continuum. This report focuses on accreditation of undergraduate medical education (education leading to the MD or DO degrees) and graduate medical education (residency training).

This report recommends: (1) Our American Medical Association (AMA) supports the concept that accreditation standards for undergraduate and graduate medical education should adopt a common competency framework that is based in the Accreditation Council for Graduate Medical Education (ACGME) competency domains. (2) Our AMA recommends that the relevant associations, including the AMA, Association of American Medical Colleges (AAMC), American Osteopathic Association (AOA), and American Association of Colleges of Osteopathic Medicine (AACOM), along with the relevant accreditation bodies for undergraduate medical education (Liaison Committee on Medical Education, Commission on Osteopathic College Accreditation) and graduate medical education (ACGME, AOA) develop strategies to: a) Identify guidelines for the expected general levels of learners’ competencies as they leave medical school and enter residency training; b) Create a standardized method for feedback from medical
school to premedical institutions and from the residency training system to medical schools about their graduates’ preparedness for entry; c) Identify areas where accreditation standards overlap between undergraduate and graduate medical education (e.g., standards related to the clinical learning environment) so as to facilitate coordination of data gathering and decision-making related to compliance. All these activities should be codified in the standards or processes of accrediting bodies. (3) Our AMA encourages the development and implementation of accreditation standards or processes that support the utilization of tools (e.g., longitudinal learner portfolios) to track learners’ progress in achieving the defined competencies across the continuum.

Your Reference Committee heard limited testimony that was unanimously in favor of adoption of this report. Future study by our AMA will ensure additional evaluation of the evidence for and consideration of the consequences, challenges, and opportunities of the alignment of accreditation processes in undergraduate and graduate medical education.

(4) RESOLUTION 304 – GRADUATE MEDICAL EDUCATION FUNDING AND QUALITY OF RESIDENT EDUCATION

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 304 be adopted.

HOD ACTION: Resolution 304 adopted.

Resolution 304 asks our AMA to explore innovative funding models for incremental increases in funded residency positions related to quality of resident education and provision of patient care as evaluated by appropriate medical education organizations such as the Accreditation Council for Graduate Medical Education.

Your Reference Committee heard testimony in strong support for adoption of Resolution 304 and the need for new and innovative approaches to GME funding that are linked to quality and outcomes. The resolution is consistent with current AMA policy and allows our AMA to broaden its definitions of GME funding. For these reasons, your Reference Committee recommends adoption of Resolution 304.

(5) RESOLUTION 311 - IMPACT OF COMPETENCY-BASED MEDICAL EDUCATION PROGRAMS AS OPPOSED TO TIME-BASED PROGRAMS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 311 be adopted.

HOD ACTION: Resolution 311 adopted.

Resolution 311 asks that our American Medical Association (1) work with the National Resident Matching Program (NRMP) and Accreditation Council for Graduate Medical
Education (ACGME) to evaluate the challenges in moving from a time-based education framework toward a competency-based system, including a) analysis of time-based implications of the ACGME milestones for residency programs; b) the impact on the NRMP and entry into residency programs if medical education programs offer variable time lengths based on acquisition of competencies; c) the impact on financial aid for medical students with variable time lengths of medical education programs; d) the implications for interprofessional education and rewarding teamwork; and e) the implications for residents and students who achieve milestones earlier or later than their peers; and (2) work with the NRMP, ACGME and the 11 schools in the AMA’s Accelerating Change in Medical Education consortium to develop pilot projects to study the impact of competency-based frameworks on student graduation, the residency match process and off-cycle entry into residency programs.

Your Reference Committee heard supportive testimony on Resolution 311. This item is timely in light of the trend towards competency-based versus time-based medical education and measures of competency across the continuum. However, as this trend continues to accelerate in undergraduate medical education, the current time-based assessments and processes for advancement into graduate medical education may lead to issues for medical students. These include graduation timing and its effect on the Match, start date for residencies, and status of Federal loans. In addition, variable educational lengths may increase the logistical complexity of a variety of worthy and important curricular efforts, such as interprofessional education. Pilot programs to explore these issues are needed, in concert with our AMA’s strategic focus work in Accelerating Change in Medical Education. Therefore, your Reference Committee recommends adoption of Resolution 311.

(6) RESOLUTION 314 - COMPROMISING LIFETIME CERTIFICATIONS RETROACTIVELY

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 314 be adopted.

HOD ACTION: Resolution 314 adopted.

Resolution 314 asks our AMA to adopt policy stating that no qualifiers or restrictions should be placed on lifetime certifications recognized by the American Board of Medical Specialties.

Your Reference Committee heard testimony that supported the principle of this resolution, that all physicians should be given the opportunity to maintain their competency through high quality educational activities. However, it is inappropriate to place qualifiers on lifetime certification. Your Reference Committee recommends that Resolution 314 be adopted.
(7) RESOLUTION 324 - USE OF UNMATCHED MEDICAL
STUDENTS AS “ASSISTANT PHYSICIANS”

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that
Resolution 324 be adopted.

HOD ACTION: Resolution 324 be adopted.

Resolution 324 asks that our AMA oppose special licensing pathways for physicians who
are not currently enrolled in an Accreditation Council for Graduate Medical Education or
American Osteopathic Association training program, or have not completed at least one
year of accredited post-graduate U.S. medical education.

Your Reference Committee heard strong support for adoption of Resolution 324. This
recommendation is in line with AMA Policies H-270.958, Need for Active Medical Board
Oversight of Medical Scope-of-Practice Activities by Mid Level Practitioners, H-405.969,
Definition of a Physician, and H-160.949, Practicing Medicine by Non-Physicians.
Accordingly, your Reference Committee recommends that Resolution 324 be adopted.

(8) COUNCIL ON MEDICAL EDUCATION REPORT 3 -
COMPETENCY-BASED MEDICAL EDUCATION ACROSS
THE CONTINUUM OF EDUCATION AND PRACTICE

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that
Recommendation 2 in Council on Medical Education
Report 3 be amended by addition and deletion, to read as
follows:

2. That our AMA Council on Medical Education work to
establish a framework of consistent vocabulary and
definitions across the continuum of health sciences
education that will facilitate competency-based
curriculum, andragogy, pedagogy and assessment
implementation. (Directive to Take Action)

RECOMMENDATION B:

Mr. 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: Recommendations in Council on Medical
Education Report 3 adopted as amended and the
remainder of the report filed.
Council on Medical Education Report 3, Competency-Based Medical Education Across the Continuum of Education and Practice, summarizes information from a review of the literature regarding the current state of competency-based medical education (CBME) in the health professions. CBME focuses on the skills and progression of learning of an individual, promoting greater learner centeredness and potentially allowing greater flexibility in the time required for training.

The report recommends: (1) That our American Medical Association (AMA) Council on Medical Education continue to study and identify challenges and opportunities and critical stakeholders in achieving a competency-based curriculum across the medical education continuum and other health professions that provides significant value to those participating in these curricula and their patients. (2) That our AMA Council on Medical Education work to establish a framework of consistent vocabulary and definitions across the continuum of health sciences education that will facilitate competency-based curriculum, pedagogy and assessment implementation.

Your Reference Committee heard limited but favorable testimony in favor of adoption of CME Report 3. An editorial change was noted in that pedagogy is a teacher-focused model of learning, whereas andragogy moves the learner from dependency to independence and self-directed learning, a model more appropriate for medical student and physician learners. There was some testimony noting the report’s connection to Resolution 311, but your Reference Committee believes the report and resolution stand on their own, as separate items, and urges adoption of CME Report 3 as amended.

(9) COUNCIL ON MEDICAL EDUCATION REPORT 5 - AMA DUTY HOURS POLICY

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Recommendation 4 in Council on Medical Education Report 5 be amended by addition and deletion, to read as follows:

4) Our AMA endorses the future study of innovative models of duty hour requirements and, pending the outcomes of ongoing and future research, should consider endorses the evolution of specialty and rotation-specific duty hours requirements that are evidence-based and will optimize patient safety and competency-based learning opportunities.

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Recommendation 7 in CME Report 5 be amended by addition and deletion, to read as follows:

g) Resident physicians should be ensured a sufficient duty-free interval of at least 10 hours prior to returning to duty.
RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that the recommendations in CME Report 5 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Recommendations in CME Report 5 adopted as amended and the remainder of the report filed.

Council on Medical Education Report 5, AMA Duty Hours Policy, builds on information provided in three previous Council reports to the House of Delegates on this topic in 2011, 2009, and 2008, reviews recent research on duty hours and related concerns and outlines potential areas for further research. A second goal of this report is to review and consolidate existing AMA policy on duty hours.

This report recommends: (1) That our AMA adopts the following Principles of Resident/Fellow Duty Hours, Patient Safety, and Quality of Physician Training: 1) Our AMA reaffirms support of the 2003 Accreditation Council for Graduate Medical Education (ACGME) duty hour standards. 2) Our AMA will continue to monitor the enforcement and impact of duty hour standards, in the context of the larger issues of patient safety and the optimal learning environment for residents. 3) Our AMA encourages publication and supports dissemination of studies in peer-reviewed publications and educational sessions about all aspects of duty hours, to include such topics as: Extended work shifts, handoffs, in-house call and at-home call, level of supervision by attending physicians, workload and growing service demands, moonlighting, protected sleep periods, sleep deprivation and fatigue, patient safety, medical error, continuity of care, resident well-being and burnout, development of professionalism, resident learning outcomes, and preparation for independent practice. 4) Our AMA endorses the future study of innovative models of duty hour requirements and, pending the outcomes of ongoing and future research, endorses the evolution of specialty- and rotation-specific duty hours requirements that will optimize patient safety and competency-based learning opportunities. 5) Our AMA encourages the ACGME to: a) Decrease the barriers to reporting of both duty hour violations and resident intimidation. b) Ensure that readily accessible, timely and accurate information about duty hours is not constrained by the cycle of ACGME survey visits. c) Use, where possible, recommendations from respective specialty societies and evidence-based approaches to any future revision or introduction of resident duty hour rules. d) Broadly disseminate aggregate data from the annual ACGME survey on the educational environment of resident physicians, encompassing all aspects of duty hours. 6) Our AMA recognizes the ACGME for its work in ensuring an appropriate balance between resident education and patient safety, and encourages the ACGME to continue to: a) Offer incentives to programs/institutions to ensure compliance with duty hour standards. b) Ensure that site visits include meetings with peer-selected or randomly selected residents and that residents who are not interviewed during site visits have the opportunity to provide information directly to the site visitor. c) Collect data on at-home call from both program directors and resident/fellow physicians; release these aggregate data annually; and develop standards to ensure that appropriate education and supervision are maintained, whether the setting is in-house or at-home. d) Ensure that resident/fellow physicians receive education on sleep deprivation and fatigue. 7) Our AMA supports the following statements related to duty hours: a) Resident physician total duty hours must not exceed
80 hours per week, averaged over a four-week period (Note: “Total duty hours” includes
providing direct patient care or supervised patient care that contributes to meeting
educational goals; participating in formal educational activities; providing administrative
and patient care services of limited or no educational value; and time needed to transfer
the care of patients). b) Scheduled on-call assignments should not exceed 24 hours.
Residents may remain on-duty for an additional 4 hours to complete the transfer of care,
patient follow-up, and education; however, residents may not be assigned new patients,
cross-coverage of other providers’ patients, or continuity clinic during that time. c) Time
spent in the hospital by residents on at-home call must count towards the 80-hour
maximum weekly hour limit and on-call frequency must not exceed every third night
averaged over four weeks. The frequency of at-home call is not subject to the every-
third-night limitation, but must satisfy the requirement for one-day-in-seven free of duty,
when averaged over four weeks. d) At home call must not be so frequent or taxing as to
preclude rest or reasonable personal time for each resident. e) Residents are permitted
to return to the hospital while on at-home call to care for new or established patients.
Each episode of this type of care, while it must be included in the 80-hour weekly
maximum, will not initiate a new “off-duty period.” f) Given the different education and
patient care needs of the various specialties and changes in resident responsibility as
training progresses, duty hour requirements should allow for flexibility for different
disciplines and different training levels to ensure appropriate resident education and
patient safety; for example, allowing exceptions for certain disciplines, as appropriate, to
the 16-hour shift limit for first-year residents, or allowing a limited increase to the total
number of duty hours when need is demonstrated. g) Resident physicians should be
ensured a duty-free interval of at least 10 hours prior to returning to duty. h) Duty hour
limits must not adversely impact resident physician participation in organized educational
activities. Formal educational activities must be scheduled and available within total duty
hour limits for all resident physicians. i) Scheduled time providing patient care services of
limited or no educational value should be minimized. j) Accurate, honest, and complete
reporting of resident duty hours is an essential element of medical professionalism and
ethics. k) The medical profession maintains the right and responsibility for self-regulation
(one of the key tenets of professionalism) through the ACGME and its purview over
graduate medical education, and categorically rejects involvement by the Centers for
Medicare & Medicaid Services, The Joint Commission, Occupational Safety and Health
Administration, and any other federal or state government bodies in the monitoring and
enforcement of duty hour regulations, and opposes any regulatory or legislative
proposals to limit the duty hours of practicing physicians. l) Increased financial
assistance for residents/fellows, such as subsidized child care, loan deferment, debt
forgiveness, and tax credits, may help mitigate the need for moonlighting. At the same
time, resident/fellow physicians in good standing with their programs should be afforded
the opportunity for internal and external moonlighting that complies with ACGME policy.
m) Program directors should establish guidelines for scheduled work outside of the
residency program, such as moonlighting, and must approve and monitor that work such
that it does not interfere with the ability of the resident to achieve the goals and
objectives of the educational program. n) The costs of duty hour limits should be borne
by all health care payers. o) The general public should be made aware of the many
contributions of resident/fellow physicians to high-quality patient care and the importance
of trainees’ realizing their limits (under proper supervision) so that they will be able to
competently and independently practice under real-world medical situations. 8) Our AMA
is in full support of the collaborative partnership between allopathic and osteopathic

Your Reference Committee heard mixed testimony that was, however, largely in favor of the report. Concerns were raised about ongoing and troubling deficiencies in the competencies of newly practicing physicians, particularly in the surgical fields, and the potential for reduced quality of care. In addition, the endorsement of the duty hour standards of the Accreditation Council for Graduate Medical Education (ACGME) was seen as problematic. The 10-hour time-off period was also cited as a non-evidence-based regulation and as contributing to more handoffs and the potential for patient safety lapses. The proposed edits to the report reflect the need for an evidence-based solution. Overall, concerning duty hours, flexibility and specialty-specific solutions are needed due to the range of educational and training needs among the specialties/subspecialties of medicine. This extends to the individual level, with variations in sleep patterns and susceptibility to fatigue from one person to the next—which relates to the ongoing and accelerating trend of medical education moving towards competency-based versus time-based measures of achievement. Other testimony, which was in favor of the report’s adoption, noted that two large studies looking at duty hour revisions for first-year interns and surgical residents, respectively, are currently under way. When completed, these randomized, controlled studies should provide additional insight into the large-scale impacts of duty hours. In any event, the Council on Medical Education will continue to closely monitor duty hours and report back to the House of Delegates as needed. In the interim, this report will help to solidify and simplify our AMA’s multiple policies on duty hours. Therefore, your Reference Committee recommends adoption of CME Report 5 as amended.
COUNCIL ON MEDICAL EDUCATION REPORT 6 - UPDATE ON MAINTENANCE OF CERTIFICATION, OSTEOPATHIC CONTINUOUS CERTIFICATION, AND MAINTENANCE OF LICENSURE

RESOLUTION 316 – MORATORIUM ON MAINTENANCE OF CERTIFICATION

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that CME Report 6 be amended by addition of a new Recommendation 5, to read as follows:

5. That the AMA oppose mandatory MOC as a condition of medical licensure, and encourage physicians to strive constantly to improve their care of patients by the means they find most effective.

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the recommendations in Council on Medical Education Report 6 be adopted in lieu of Resolution 316 and the remainder of the report be filed.

HOD ACTION: Recommendations in Council on Medical Education Report 6 adopted as amended in lieu of Resolution 316 and the remainder of the report filed.

Council on Medical Education Report 6, Update on Maintenance of Certification (MOC), Osteopathic Continuous Certification (OCC) and Maintenance of Licensure (MOL), includes a comprehensive summary of AMA’s ongoing efforts with the American Board of Medical Specialties to improve MOC to address concerns about the time, administrative burden and costs (monetary and other) associated with participation, the relevance of the secure, high-stakes Part III examination, and need to lessen the burden for physicians with multiple board certifications. The report also addresses the evidence to support the value of MOC. An update on OCC and the development of the MOL framework are included in the report. The report also summarizes the preliminary steps undertaken to explore the feasibility of engaging an independent entity to study the impact of MOC, OCC and MOL on the physician workforce which would require a fairly complex research effort.

This report recommends: 1) That our AMA Council on Medical Education continue to review published literature and emerging data as part of the Council’s ongoing efforts to critically review maintenance of certification (MOC), osteopathic continuous certification (OCC), and maintenance of licensure (MOL) issues. 2) That our AMA continue to explore with independent entities the feasibility of conducting a study to evaluate the impact that MOC requirements and the principles of MOL have on physicians’ practices, including, but not limited to physician workforce, physicians’ practice costs, patient
outcomes, patient safety, and patient access. 3) That our AMA work with the American Board of Medical Specialties (ABMS) and the ABMS Member Boards to collect data on why physicians choose to maintain or discontinue their board certification. 4) That our AMA work with the ABMS and the Federation of State Medical Boards to study whether MOC and the principles of MOL are important factors in a physician’s decision to retire and have a direct impact on the US physician workforce.

Resolution 316 asks our AMA to work with the American Board of Medical Specialties (ABMS) and individual specialty boards to put a moratorium on maintenance of certification (MOC) until all of the following occur: 1. Pilot studies have shown the efficacy of MOC in physician care and patient outcomes; 2. An assessment of the cost of time and money on the profession per year is completed; and 3. An assessment of the impact of MOC on worsening physician shortages by the adverse effect of tying the MOC program to state licenses (i.e., estimation of physicians that would leave or be removed from the physician pool of practicing doctors) is completed.

Your Reference Committee heard mixed testimony that included differences of opinion and misunderstanding on this complex item. There was a lack of understanding of the details of MOC, especially regarding the relationship between MOC and MOL and the value of MOC. Based on the testimony, it is clear that the issues of administrative burden and costs need to be addressed, that the Council needs to be more thorough about interpreting the evidence to show the efficacy of MOC in physician care and patient outcomes and encouraging increased financial transparency among the specialty boards. More than 200 study annotations focusing on best practices in CME and the ABMS Program for MOC Part II, Lifelong Learning and Self-Assessment, are available online (evidencelibrary.abms.org). In addition, lifelong learning and self-assessment, integral parts of MOC, OCC and MOL, were reviewed in the December 13, 2013 supplement of the Journal of Continuing Education in the Health Professions. The Council also must continue to review the literature to assess the impact of MOC and MOL on the physician workforce as studies become available.

Online testimony was received expressing concern that our AMA not be perceived as being against the current processes that the medical profession has in place to maintain and improve the competence of physicians and to retain the public trust. The CME has been successful in shaping ABMS standards on behalf of AMA membership. Our AMA has provided input that is reflected in the ABMS Updated Standards for 2015. Our AMA also sponsored a meeting with the ABMS that brought together subject matter experts in physician assessment and representatives from the Council, AMA sections, and the ABMS Member Boards to further discuss practice-relevant and innovative MOC Part III activities. Your Reference Committee expects that our AMA will continue to monitor these issues closely and report back to the House of Delegates as appropriate. Resolution 316 raises important issues that need to be addressed as part of the monitoring process. On that front, your Reference Committee Recommends that CME Report 6 be adopted in lieu of Resolution 316.
Mr. Speaker, your Reference Committee recommends that Recommendation 1 of CME Report 7 be amended by addition, to read as follows:

1. That our American Medical Association continue to strongly advocate that Congress fund additional graduate medical education (GME) positions for the most critical workforce needs, especially considering the current and worsening maldistribution of physicians. (Directive to Take Action)

Mr. Speaker, your Reference Committee recommends that Recommendation 5 of CME Report 7 be amended by addition, to read as follows:

5. That our AMA work with interested state and national medical specialty societies and other appropriate stakeholders to share and support legislation to increase GME funding, enabling a state to accomplish one or more of the following: (1) train more physicians to meet state and regional workforce needs; (2) train physicians who will practice in physician shortage/underserved areas; or (3) train physicians in undersupplied specialties and subspecialties in the state/region. (Directive to Take Action)

Mr. Speaker, your Reference Committee recommends that Recommendation 7 of CME Report 7 be amended by addition and deletion, to read as follows:

7. That our AMA continue to work with stakeholders such as Association of American Medical Colleges (AAMC), ACGME, AOA, American Academy of Family Physicians, and American College of Physicians, and other specialty organizations to analyze the changing landscape of future physician workforce needs as well as the number
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and variety of GME positions necessary to provide that workforce. (Directive to Take Action)

RECOMMENDATION D:

Mr. Speaker, your Reference Committee recommends that the Recommendations in CME Report 7 be adopted as amended in lieu of Resolution 309 and the remainder of the report be filed.

HOD ACTION: Recommendations in CME Report 7 adopted as amended in lieu of Resolution 309 and the remainder of the report filed.

Resolution 914-I-13, “Change Rural and Off Site Rural Training Track Requirements in order to Preserve and Encourage Interest in Rural Residency Programs,” introduced by the Mississippi Delegation, asks our AMA to 1) work with the Centers for Medicare & Medicaid Services to allow for up to one month in the second post graduate year and one month in the third post graduate year of an ABMS/AOA approved Family Medicine, General Internal Medicine or General Pediatric residency to occur in the office of a primary care physician who is listed and meets the qualifications for adjunct faculty of the sponsoring institution; and 2) work with the Accreditation Council of Graduate Medical Education Residency Review Committee for Family Medicine and other specialties to adjust GME program requirements so that the patient encounters during this experience may count toward the continuity requirements for the completion of a residency.

Council on Medical Education Report 7, Physician Workforce Shortage: Approaches to GME Financing, recommends that our AMA: 1) Continue to strongly advocate that Congress fund graduate medical education (GME) positions for the most critical workforce needs, especially considering the current and worsening maldistribution of physicians. 2) Advocate that the Centers for Medicare & Medicaid Services allow for rural and other underserved rotations in Accreditation Council for Graduate Medical Education (ACGME)-accredited residency programs, in disciplines of particular local/regional need, to occur in the offices of physicians who meet the qualifications for adjunct faculty of the residency program’s sponsoring institution. 3) Encourage the ACGME to reduce barriers to rural and other underserved community experiences for graduate medical education programs that choose to provide such training, by adjusting as needed its program requirements, such as continuity requirements or limitations on time spent away from the primary residency site. 4) Encourage the ACGME and the American Osteopathic Association (AOA) to continue to develop and disseminate innovative methods of training physicians efficiently that foster the skills and inclinations in a health care system that rewards team-based care and social accountability. 5) Work with interested state and national medical specialty societies to share and support legislation to increase GME funding, enabling a state to accomplish one or more of the following: (1) train more physicians to meet state and regional workforce needs; (2) train physicians who will practice in physician shortage/underserved areas; or (3) train physicians in undersupplied specialties and subspecialties in the state/region. 6) Support the ongoing efforts by states to identify and address changing physician workforce needs within the GME landscape and continue to
broadly advocate for innovative pilot programs that will increase the number of positions and create enhanced accountability of GME programs for quality outcomes. 7) Continue to work with stakeholders such as Association of American Medical Colleges (AAMC), ACGME, AOA, American Academy of Family Physicians, and American College of Physicians (ACP) to analyze the changing landscape of future physician workforce needs as well as the number and variety of GME positions necessary to provide that workforce. and 8) Rescind Policies H-200.954 (12), “U.S. Physician Shortage,” and D-305.967 (13), “The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education,” since that has been accomplished through this report.

Resolution 309 asks our AMA 1) and other graduate medical education stakeholders, such as the Accreditation Council for Graduate Medical Education and the Council on Graduate Medical Education, work towards the expansion of graduate medical education positions by creating community-funded graduate medical education positions for the existing and new graduate medical education programs and 2) in collaboration with its International Medical Graduates Section and other stakeholders within the AMA, create a Graduate Medical Education Working Group to work on a guiding principles document for the expansion of existing residency programs by utilizing alternative/community and philanthropic funding.

Your Reference Committee heard testimony largely in favor of adopting CME Report 7. Concerns were raised by representatives of specific specialties that the report’s recommendations, while correctly identifying shortages in primary care fields, do not highlight similar deficits in the specialties. Language changes in, for example, Recommendation 7 help address these concerns by specifically listing specialty organizations. The insertion of “additional” in Recommendation 1 ensures that any such GME funding is supplemental to existing funding and is targeted to the most critical workforce and access to care needs. With the Institute of Medicine soon releasing a report on graduate medical education financing, it was noted that our AMA needs strong and up-to-date workforce policy to respond appropriately to the IOM’s recommendations. Finally, there was testimony that Recommendation 8 suggested that our AMA had actually accomplished the goals in those policies; this was simply a misinterpretation of the language, which calls for rescission of these policies, which called for the writing of this report by the 2014 Annual Meeting. Your Reference Committee also recommends adoption of this report in lieu of Resolution 309, which would create another GME-oriented working group that would be in competition with the Council on Medical Education and its GME subcommittee. Further, the Council already has representation from our AMA Medical Student Section and Resident/Fellow Section and is pursuing the work outlined in Resolution 309.

(12) RESOLUTION 301 - SHARED DECISION MAKING IN MEDICAL EDUCATION

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the second resolve of Resolution 301 be amended by substitution, to read as follows:
RESOLVED, That our AMA collaborate with the appropriate medical education organizations to identify resources for undergraduate and graduate medical education programs to help ensure proficiency among medical students and resident/fellow physicians in shared decision-making and effective use of shared decision-making tools, such as patient decision aids. (Directive to Take Action)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 301 be adopted as amended.

HOD ACTION: Resolution 301 adopted as amended.

Resolution 301 asks our AMA to 1) amend policy D-373.999, Informed Patient Choice and Shared Decision Making, by addition as follows: Our AMA will work with state and specialty societies, medical schools, and others as appropriate to educate and communicate to medical students and to physicians about the importance of shared decision-making guidance through publications and other educational methods and assist the medical community in moving towards patient-centered care. and 2) collaborate with the appropriate medical education organizations to develop undergraduate medical education recommendations that ensure proficiency in shared decision making and effective use of shared decision-making tools, such as patient decision aids.

Your Reference Committee heard testimony against adoption of the second resolve as currently worded. Curriculum development should be the purview of medical schools; it is not appropriate for our AMA to impose curricular mandates on shared decision-making or any other topics in undergraduate medical education. This is consistent with our AMA’s past actions in respecting the autonomy of medical schools. In addition, concerns were expressed about the wording of the resolution. Accordingly, your Reference Committee recommends adoption of Resolution 301 with the amended language as shown.

(13) RESOLUTION 302 - PROVIDING RESIDENCY APPLICANTS A TIMELY RESPONSE TO RESIDENCY APPLICATION OUTCOME

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 302 be amended by addition and deletion, to read as follows:

RESOLVED, That our American Medical Association Policy H-310.998 Residency Interview Schedules be amended by addition and deletion as below: (Modify Current HOD Policy)
Our The AMA encourages accredited residency and fellowship programs to incorporate in their residency interview dates increased flexibility, whenever possible, to accommodate applicants’ schedules. Our The AMA encourages the ACGME and other accrediting bodies to require residency programs to provide, by electronic or other means, representative contracts to applicants prior to the interview. Our The AMA encourages residency and fellowship programs to inform applicants in a timely manner confirming receipt of application and ongoing changes in the status of consideration of the application of their application materials and timely notification of when an applicant is no longer under consideration for an interview, about their interview status and provide a time frame of notification dates in the application materials.

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 302 be adopted as amended.

HOD ACTION: Resolution 302 adopted as amended.

Resolution 302 ask that our AMA amend Policy H-310.998, Residency Interview Schedules, by addition and deletion as follows: The AMA encourages accredited residency and fellowship programs to incorporate in their residency interview dates increased flexibility, whenever possible, to accommodate applicants’ schedules. The AMA encourages the ACGME and other accrediting bodies to require residency programs to provide, by electronic or other means, representative contracts to applicants prior to the interview. The AMA encourages residency and fellowship programs to inform applicants in a timely manner confirming receipt of their application materials and timely notification of when an applicant is no longer under consideration for an interview, about their interview status and provide a time frame of notification dates in the application materials.

Your Reference Committee heard limited testimony predominantly in favor of adoption of Resolution 302. Although support was expressed for the guiding concepts and spirit of this resolution (as a mechanism to assist residency program applicants), concerns were expressed about the overly prescriptive nature of the language and potential burdens on program directors. The phrase “timely notification of when an applicant is no longer under consideration for an interview” could have the unintended impact of eliminating some applicants for consideration who might otherwise have been ultimately selected. In addition, ERAS is the preferred means of communication between residency programs and applicants for notification of completeness of the residency application package. Your Reference Committee therefore recommends the insertion of less prescriptive language that would nonetheless accomplish the overarching goals of this resolution.
(14) RESOLUTION 303 - PROTECTING RESIDENTS AGAINST AVOIDABLE FINANCIAL CONSTRAINT RELATED TO REIMBURSED WORK-RELATED EXPENSES

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that second resolve of Resolution 303 be amended by addition, to read as follows:

RESOLVED, That our AMA encourage a system of expedited repayment for purchases of $200 or less (or an equivalent institutional threshold), for example through payment directly from their residency and fellowship programs (in contrast to following traditional workflow for reimbursement) (New HOD Policy); and be it further

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the third resolve of Resolution 303 be amended by addition and deletion, to read as follows:

RESOLVED, That our AMA encourage training programs to develop a budget and strategy for planned expenses versus unplanned expenses, where planned expenses should be estimated using historical data, and should include trainee reimbursements for items such as educational materials, attendance at conferences, and entertaining applicants. Payment in advance or within one month of document submission is strongly recommended in advance but at a minimum, reimbursement should be completed at 2 weeks and not to exceed 1 month after submission of relevant reimbursement documents; and unplanned expenses which includes money spent collectively above the planned amount by trainees is strongly recommended to be reimbursed by 1 month after submission of relevant reimbursement documents, with a period not to exceed 6 weeks. (New HOD Policy)

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that Resolution 303 be adopted as amended.

HOD ACTION: Resolution 303 adopted as amended.
Resolution 303 asks our AMA to 1) promote residency and fellowship training programs to evaluate their own institution’s process for repayment and develop a leaner approach. This includes disbursement of funds by direct deposit as opposed to a paper check and an online system of applying for funds; 2) encourage a system of expedited repayment for purchases of $200 or less, for example through payment directly from their residency and fellowship programs (in contrast to following traditional workflow for reimbursement); and 3) encourage training programs to develop a budget and strategy for planned expenses versus unplanned expenses, where planned expenses should be estimated using historical data, and should include trainee reimbursements for items such as educational materials, attendance at conferences, and entertaining applicants. Payment is strongly recommended in advance but at a minimum, reimbursement should be completed at 2 weeks and not to exceed 1 month after submission of relevant reimbursement documents; and unplanned expenses which includes money spent collectively above the planned amount by trainees is strongly recommended to be reimbursed by 1 month after submission of relevant reimbursement documents, with a period not to exceed 6 weeks.

Your Reference Committee heard testimony in support of the spirit of the resolution and the need to ensure that resident/fellow physicians are not unduly burdened by delays in work-related reimbursement. At the same time, it was expressed that the current language was too prescriptive and could be difficult to implement at an institutional level. Your Reference Committee therefore believes that the revised recommendations reflect the overarching goals of the resolution while allowing for flexibility at the ground level.

(15) RESOLUTION 305 - TRANSPARENCY ON MATERNITY AND PATERNITY LEAVE POLICIES FOR TRAINEES

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 305 be amended by deletion, to read as follows:

RESOLVED, That American Medical Association House of Delegates Policy H-405.960, Policies for Maternity, Family and Medical Necessity Leave, be amended by insertion as below (Modify Current HOD Policy):

AMA adopts as policy the following guidelines for, and encourage the implementation of, Maternity, Family and Medical Necessity Leave for Medical Students and Physicians:

(1) The AMA urges medical schools, residency training programs, medical specialty boards, the Accreditation Council for Graduate Medical Education, and medical group practices to incorporate and/or encourage development of written and publicly available leave policies, including parental, family, and medical leave
policies, as part of the physician’s standard benefit agreement;

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 305 be amended by addition on page 2, to read as follows:

14) These policies as above should be freely available online and in writing to all applicants to medical school, residency or fellowship.

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends the title of Policy H-405.960 be amended by addition, to read as follows:

Policies for Maternity, Paternity, Family and Medical Necessity Leave

RECOMMENDATION D:

Mr. Speaker, your Reference Committee recommends the Resolution 305 be adopted as amended.

HOD ACTION: Resolution 305 adopted as amended.

Resolution 305 asks our AMA to amend Policy H-405.960, Policies for Maternity, Family and Medical Necessity Leave, as follows: AMA adopts as policy the following guidelines for, and encourage the implementation of, Maternity, Family and Medical Necessity Leave for Medical Students and Physicians: (1) The AMA urges medical schools, residency training programs, medical specialty boards, the Accreditation Council for Graduate Medical Education, and medical group practices to incorporate and/or encourage development of written and publicly available leave policies, including parental, family, and medical leave policies, as part of the physician’s standard benefit agreement; (2) Recommended components of maternity leave policies for medical students and physicians include: (a) duration of leave allowed before and after delivery; (b) category of leave credited; (c) whether leave is paid or unpaid; (d) whether provision is made for continuation of insurance benefits during leave, and who pays the premium; (e) whether sick leave and vacation time may be accrued from year to year or used in advance; (f) how much time must be made up in order to be considered board eligible; (g) whether make-up time will be paid; (h) whether schedule accommodations are allowed; (i) leave policy for adoption; and (j) leave policy for paternity. (3) AMA policy is expanded to include physicians in practice, reading as follows: (a) residency program directors and group practice administrators should review federal law concerning maternity leave for guidance in developing policies to assure that pregnant physicians are allowed the same sick leave or disability benefits as those physicians who are ill or disabled; (b) staffing levels and scheduling are encouraged to be flexible enough to
allow for coverage without creating intolerable increases in other physicians' workloads, particularly in residency programs; and (c) physicians should be able to return to their practices or training programs after taking maternity leave without the loss of status. (4) Our AMA encourages residency programs, specialty boards, and medical group practices to incorporate into their maternity leave policies a six-week minimum leave allowance, with the understanding that no woman should be required to take a minimum leave; (5) Residency program directors should review federal and state law for guidance in developing policies for parental, family, and medical leave; (6) Medical students and physicians who are unable to work because of pregnancy, childbirth, and other related medical conditions should be entitled to such leave and other benefits on the same basis as other physicians who are temporarily unable to work for other medical reasons; (7) Residency programs should develop written policies on parental leave, family leave, and medical leave for physicians. Such written policies should include the following elements: (a) leave policy for birth or adoption; (b) duration of leave allowed before and after delivery; (c) category of leave credited (e.g., sick, vacation, parental, unpaid leave, short term disability); (d) whether leave is paid or unpaid; (e) whether provision is made for continuation of insurance benefits during leave and who pays for premiums; (f) whether sick leave and vacation time may be accrued from year to year or used in advance; (g) extended leave for resident physicians with extraordinary and long-term personal or family medical tragedies for periods of up to one year, without loss of previously accepted residency positions, for devastating conditions such as terminal illness, permanent disability, or complications of pregnancy that threaten maternal or fetal life; (h) how time can be made up in order for a resident physician to be considered board eligible; (i) what period of leave would result in a resident physician being required to complete an extra or delayed year of training; (j) whether time spent in making up a leave will be paid; and (k) whether schedule accommodations are allowed, such as reduced hours, no night call, modified rotation schedules, and permanent part-time scheduling; (8) Our AMA endorses the concept of paternity leave for birth and adoption as a benefit for resident physicians, medical students, and physicians in practice; (9) Staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in the workloads of other physicians, particularly those in residency programs; (10) Physicians should be able to return to their practices or training programs after taking parental leave, family leave, or medical leave without the loss of status; (11) Residency program directors must assist residents in identifying their specific requirements (for example, the number of months to be made up); because of leave for eligibility for board certification and must notify residents on leave if they are in danger of falling below minimal requirements for board eligibility. Program directors must give these residents a complete list of requirements to be completed in order to retain board eligibility; (12) Our AMA encourages flexibility in residency training programs, incorporating maternity leave and alternative schedules for pregnant house staff; and (13) In order to accommodate leave protected by the federal Family and Medical Leave Act, our AMA encourages all specialties within the American Board of Medical Specialties to allow graduating residents to extend training up to 12 weeks after the traditional residency completion date while still maintaining board eligibility in that year. (14) These policies as above should be available in writing to all applicants to medical school, residency or fellowship.

Your Reference Committee heard lengthy testimony in support of adoption of Resolution 305. It was noted in testimony that such policies should be freely available online as well as in writing, to ensure that applicants are afforded assurance that leave will be available.
as needed due to personal circumstances. The minor editorial edits as shown reflect these sentiments. In addition, it was cited that the title mentions paternity leave, but the policy being amended does not include paternity leave in the title, although it is mentioned in the body of the policy. Consistency would be helpful. This may take the form of an additional amendment of a modification of the resolution title. Similarly, the title of the resolution refers to “trainees” (generally understood to refer to post-medical school trainees), but the body refers to students also. Your Reference Committee therefore urges adoption of Resolution 305.

(16) RESOLUTION 306 – ENDORSING STANDARDIZED CORE CURRICULA ON DISABILITY EDUCATION IN MEDICAL SCHOOL

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the first resolve of Resolution 306 be amended by addition and deletion, to read as follows:

RESOLVED, That our American Medical Association continue to work with medical schools and their accrediting/licensing bodies to encourage require disability related competencies/objectives in medical school curricula so that medical professionals are able to effectively communicate with patients and colleagues with disabilities, and are able to provide the most clinically competent and compassionate care for patients with disabilities. (Directive to Take Action)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 306 be adopted as amended.

HOD ACTION: Resolution 306 be adopted as amended with a title change.

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that the title of Resolution 306 be changed, to read as follows:

INCLUDING DISABILITY RELATED COMPETENCIES AND OBJECTIVES IN MEDICAL SCHOOL CURRICULUM

Resolution 306 asks our AMA to continue to work with medical schools and their accrediting/licensing bodies to require disability related competencies/objectives in medical school curricula so that medical professionals are able to effectively communicate with patients and colleagues with disabilities, and are able to provide the most clinically competent and compassionate care for patients with disabilities.
Your Reference Committee heard testimony on the need that all medical professionals be well-versed in understanding the needs of people with disabilities. While sympathetic to the needs of this population, particularly in regards to their health care needs and the appropriate education of future physicians, our AMA is opposed to mandates for additional content areas in an already distended undergraduate medical education curriculum. However, a change in the title and a wording change (from “require” to “encourage”) is seen by your Reference Committee as edits that reflect less a mandate and more a suggestion. Accordingly, your Reference Committee recommends that Resolution 306 be adopted as amended.

(17) RESOLUTION 307 – PRACTICAL USE OF ADVANCE DIRECTIVES IN MEDICAL EDUCATION

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the first and second resolves of Resolution 307 be amended by addition and deletion, to read as follows:

RESOLVED, Our AMA work with medical schools, graduate medical education programs and other interested groups to increase the awareness and the creation of personal advance directives for all medical students and physicians (Directive to Take Action); and be it further That our American Medical Association recommend that all Liaison Committee on Medical Education (LCME) and Commission on Osteopathic College Accreditation (COCA) accredited medical schools provide students the opportunity to complete an advance directive and learn to further address advance care planning in the course of their medical ethics curricula (Directive to Take Action); and be it further

RESOLVED, That our AMA encourage the LCME and COCA to include in their current accreditation standards opportunities for personal completion of advance directives by medical students and opportunities to further address advance care planning in the course of the curricula (Directive to Take Action); and be it further

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 307 be adopted as amended.

HOD ACTION: Resolution 307 adopted as amended.

Resolution 307 asks our AMA to 1) recommend that all Liaison Committee on Medical Education (LCME) and Commission on Osteopathic College Accreditation (COCA)
accredited medical schools provide students the opportunity to complete an advance
directive and learn to further address advance care planning in the course of their
medical ethics curricula, 2) encourage the LCME and COCA to include in their current
accreditation standards opportunities for personal completion of advance directives by
medical students and opportunities to further address advance care planning in the
course of the curricula, and 3) encourage development of a model educational module
for the teaching of advance directives and advance care planning.

Your Reference Committee heard testimony that reflected issues with the resolution’s
language as written. Similar to views expressed on other resolutions related to the
medical education curriculum, a significant portion of the testimony focused on the issue
of curricular mandates. We believe that the proposed edits address these concerns.
Your Reference Committee therefore recommends adoption of Resolution 307 as
amended.

RESOLUTION 308 - COMPETENCY AND THE AGING PHYSICIAN

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that
the first resolve of Resolution 308 be amended by addition
and deletion, to read as follows:

RESOLVED, That our AMA study the issue of competency
in aging physicians and develop guidelines, if the study
supports such a need, for appropriate mechanisms of
assessment to assure that America’s physicians remain
able to provide optimal best care for their patients
(Directive to Take Action); and be it further

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that
Resolution 308 be adopted as amended.

HOD ACTION: Resolution 308 adopted as amended.

Resolution 308 asks 1) That our AMA study the issue of competency in aging physicians
and develop guidelines, if the study supports such a need, for appropriate mechanisms
of assessment to assure that America’s physicians remain able to best care for their
patients, and 2) That there be a report back to the House of Delegates.

Your Reference Committee heard significant testimony in favor of adoption of Resolution
308—a timely item of business, in that a large western state is working on a report on
this topic. In testimony, concern was expressed about the use of the word “aging”; competency of all physicians needs to be assured for patient safety, and the aging
process affects different individuals in different ways and at different speeds. A minor
editorial change was made, which your Reference Committee agrees is appropriate.
(19) RESOLUTION 310 - PHYSICIAN REENTRY AND LICENSURE

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the first resolve of Resolution 310 be amended by deletion, to read as follows:

RESOLVED, That our American Medical Association work with the Federation of State Medical Boards to establish a definition of “active practice of medicine” that is evidence-based and includes the practice of population-based medicine (Directive to Take Action);

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 310 be adopted as amended.

HOD ACTION: Resolution 310 adopted as amended.

Resolution 310 asks our AMA to 1) work with the Federation of State Medical Boards to establish a definition of “active practice of medicine” that is evidence-based, and 2) encourage each state which does not grant a full and unrestricted license to physicians undergoing reentry to develop a non-disciplinary category of licensure for physicians during their reentry process.

Your Reference Committee heard testimony that was uniformly in favor of Resolution 310. With a growing physician shortage, all available physicians are needed, and licensure barriers to workforce reentry should be eased, while still ensuring protection of the public. One of the key challenges is defining clinical inactivity and elucidating the needs of a reentering physician versus one who needs remediation or retraining. Our AMA Council on Medical Education expressed its willingness to collaborate with the Federation of State Medical Boards and other appropriate entities to establish a definition of “active practice of medicine.” This is in accord with current Council work on the topic of reentry, including a forum on the topic with a number of key stakeholders during the A-14 meeting. Your Reference Committee believes that these facts support adoption of Resolution 310 as amended.

(20) RESOLUTION 312 – ASSESSING THE IMPACT OF LIMITED GME RESIDENCY POSITIONS IN THE MATCH

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the first resolve of Resolution 312 be amended by addition, to read as follows:
RESOLVED, That our American Medical Association 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;

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 312 be adopted as amended.

HOD ACTION: Resolution 312 adopted as amended.

Resolution 312 asks our AMA to 1) 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; and what careers are pursued by those with an MD or DO degree who do not enter residency programs; 2) work with the AAMC, AOA, AACOM and appropriate licensing boards to study whether US medical school graduates and international medical graduates who do not enter residency programs may be able to serve unmet national health care needs; and 3) work with the AAMC, AOA, AACOM and the NRMP to evaluate the feasibility of a national tracking system for US medical students who do not initially match into a categorical residency program.

Your Reference Committee heard supportive testimony on Resolution 312, which seeks to address concerns about the growing number of unmatched students. Further study is required to document the prevalence of the issue and further elucidate what career alternatives these individual pursue. An additional phrase is proposed for addition to the report to reflect the need for focused analysis on the possible disproportionate effects of unsuccessful matching on individuals from racial and ethnic groups. Your Reference Committee therefore recommends adoption of Resolution 312 as amended.
(21) RESOLUTION 318 - ASSISTING MEDICAL STUDENTS APPLYING FOR AWAY ROTATIONS

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 318 be amended by addition and deletion, to read as follows:

RESOLVED, That our American Medical Association encourage appropriate work with stakeholders to develop, promulgate, and have adopted a uniform immunization form for medical students seeking to do rotations at hospitals away from their home institutions.

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 318 be adopted as amended.

HOD ACTION: Resolution 318 adopted as amended.

Resolution 318 asks our AMA to work with the Association of American Medical Colleges and other stakeholders to develop, promulgate, and have adopted a uniform immunization form for medical students seeking to do rotations at hospitals away from their home institutions.

Your Reference Committee heard limited but supportive testimony for Resolution 318. It was noted in testimony that the American Hospital Association may be the more relevant organization in this instance than the Association of American Medical Colleges. Accordingly, the language has been revised, and your Reference Committee urges acceptance of the resolution as amended.

(22) RESOLUTION 319 - MAINTENANCE OF LICENSURE

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the first resolve of Resolution 319 be amended by deletion, to read as follows:
RESOLVED, That our American Medical Association oppose any efforts to require the Federation of State Medical Boards maintenance of licensure (MOL) program as a condition of medical licensure (New HOD Policy); and be it further

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the second resolve of Resolution 319 be amended by addition and deletion, to read as follows:

RESOLVED, That our AMA oppose any MOL initiative that creates barriers to practice, is administratively unfeasible, is inflexible with regard to how physicians practice (clinically or not), that does not protect physician privacy, and that is used to promote policy initiatives (rather than above physician competence) such as participation in health plans, subscription to data exchanges, and specialty board certification. (New HOD Policy)

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that Policy H-275.923 be reaffirmed.

RECOMMENDATION D:

Mr. Speaker, your Reference Committee recommends that Resolution 319 be adopted as amended.

HOD ACTION: Resolution 319 adopted as amended.

Resolution 319 asks our AMA to 1) oppose any efforts to require the Federation of State Medical Boards maintenance of licensure (MOL) program as a condition of medical licensure and 2) oppose any MOL initiative that creates barriers to practice, is administratively unfeasible, is inflexible with regard to how physicians practice (clinically or not), that does not protect physician privacy, and that is used to promote policy initiatives (rather than competence) such as participation in health plans, subscription to data exchanges, and specialty board certification.

Your Reference Committee heard testimony to strike the first resolve and support for revising the second resolve. Existing AMA policy reflects the intent of the second resolve. Policy H-275.923 asks our AMA to continue to work with the FSMB to establish and assess MOL principles with our AMA to assess the impact of MOC and MOL on the practicing physician and the FSMB to study the impact on licensing boards. For this reason, your Reference Committee recommends reaffirmation of Policy H-275.923 and adoption of Resolution 319 as amended.
Policy recommended for reaffirmation:

H-275.923 Maintenance of Certification / Maintenance of Licensure

Our AMA will: 1. Continue to work with the Federation of State Medical Boards (FSMB) to establish and assess maintenance of licensure (MOL) principles with the AMA to assess the impact of MOC and MOL on the practicing physician and the FSMB to study the impact on licensing boards. 2. Recommend that the American Board of Medical Specialties (ABMS) not introduce additional assessment modalities that have not been validated to show improvement in physician performance and/or patient safety. 3. Encourage rigorous evaluation of the impact on physicians of future proposed changes to the MOC and MOL processes including cost, staffing, and time. 4. Review all AMA policies regarding medical licensure; determine if each policy should be reaffirmed, expanded, consolidated or is no longer relevant; and in collaboration with other stakeholders, update the policies with the view of developing AMA Principles of Maintenance of Licensure in a report to the HOD at the 2010 Annual Meeting. 5. Urge the National Alliance for Physician Competence (NAPC) to include a broader range of practicing physicians and additional stakeholders to participate in discussions of definitions and assessments of physician competence. 6. Continue to participate in the NAPC forums. 7. Encourage members of our House of Delegates to increase their awareness of and participation in the proposed changes to physician self-regulation through their specialty organizations and other professional membership groups. 8. 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 post graduate medical education in the US, including the Performance Improvement CME (PICME) format; and continue to develop relationships and agreements that may lead to standards, accepted by all US licensing boards, specialty boards, hospital credentialing bodies, and other entities requiring evidence of physician CME. 9. Collaborate with the American Osteopathic Association and its eighteen specialty boards in implementation of the recommendations in CME Report 16-A-09, Maintenance of Certification / Maintenance of Licensure. 10. Continue to support the AMA Principles of Maintenance of Certification (MOC). 11. Monitor MOL as being led by the Federation of State Medical Boards (FSMB), and work with FSMB and other stakeholders to develop a coherent set of principles for MOL. 12. Our AMA will 1) advocate that if state medical boards move forward with the more intense MOL program, each state medical board be required to accept evidence of successful ongoing participation in the American Board of Medical Specialties Maintenance of Certification and American Osteopathic Association-Bureau of Osteopathic Specialists Osteopathic Continuous Certification to have fulfilled all three components of the MOL if performed, and 2) also advocate to require state medical boards accept programs created by specialty societies as evidence that the physician is participating in continuous lifelong learning and allow physicians choices in what programs they participate to fulfill their MOL criteria. (CME Rep. 16, A-09; Appended: CME Rep. 3, A-10; Reaffirmed: CME Rep. 3, A-10; Appended: Res. 322, A-11; Reaffirmed: CME Rep. 10, A-12; Reaffirmed in lieu of Res. 313, A-12; Reaffirmed: CME Rep. 4, A-13; Reaffirmed in lieu of Res. 919, I-13)
(23) RESOLUTION 322 - MAINTAINING AND DEVELOPING HIGH QUALITY HOSPICE AND PALLIATIVE CARE PHYSICIAN WORKFORCE IN THE NEW MILLENNIUM

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Substitute Resolution 322 be adopted.

RESOLVED, That our AMA work with relevant national medical specialty organizations to petition the American Board of Medical Specialties and relevant specialty boards to support development of innovative fellowship models that would qualify physicians for board certification in the fields of hospice and palliative medicine as well as geriatrics. (Directive to Take Action)

HOD ACTION: Substitute Resolution 322 adopted.

Resolution 322 asks our AMA to work with the various national medical specialty organizations to petition the American Board of Medical Specialties to develop alternative pathways to board certification for physicians with high quality experience and additional education to sit for the boards in hospice and palliative care, and geriatric medicine.

Your Reference Committee heard testimony that was in favor of Resolution 322. The American Academy of Hospice and Palliative Medicine, supported by the American Geriatrics Society and the Pain and Palliative Medicine Section Council, provided alternate language, as shown above. Your reference committee urges adoption as amended.

(24) RESOLUTION 323 - PRESERVATION OF THE CURRENT FEDERAL STUDENT AID LOAN FORGIVENESS FOR PUBLIC SERVICE EMPLOYEES PROGRAM

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 323 be amended by addition and deletion, to read as follows:

RESOLVED, That our American Medical Association advocate lobbying against putting a monetary cap of $57,500 on federal loan forgiveness programs, through the Federal Student Aid Loan Forgiveness for Public Service Employees Program as proposed by President Obama in the 2015 fiscal year budget. (Directive to Take Action)
Resolution 323 asks our AMA to lobby against putting a cap of $57,500 on loan forgiveness through the Federal Student Aid Loan Forgiveness for Public Service Employees Program as proposed by President Obama in the 2015 fiscal year budget.

**HOD ACTION:** Resolution 323 be amended by addition and deletion.

Your Reference Committee heard strong support for Resolution 323. Minor changes were made to the resolve, based on the testimony, because specific legislation, bill numbers, and/or presidential administrations are subject to change. Your Reference Committee therefore asks that Resolution 323 be adopted as amended.

(25) **COUNCIL ON MEDICAL EDUCATION REPORT 8 - GUIDELINES FOR STUDENTS SHADOWING PHYSICIANS**

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that CME Report 8 be referred.

**HOD ACTION:** CME Report 8 referred.

Resolution 310-A-13, “Medical Facility Regulations for Students Shadowing Physicians,” introduced by the Georgia delegation, asked that our AMA develop standard criteria for students to shadow physicians in medical facilities. Resolution 913-I-13, “Pre-Medical School Shadowing,” submitted by the Washington delegation, asked that our AMA (1) promote the development of programs that assist physicians in providing pre-medical shadowing opportunities; and (2) communicate to the Association of American Medical Colleges that for medical schools which have the pre-medical shadowing requirement, aiding these underprivileged students in getting their shadowing is an obligation of the medical school.

CME Report 8 recommends 1. That our American Medical Association encourage wide dissemination of the Association of American Medical Colleges’ clinical shadowing guidelines to interested parties, including K-12 students, pre-medical students, health professions advisors, hospitals, medical schools and physicians; 2. That our AMA encourage all physicians to provide shadowing opportunities to pre-medical students; and 3. That AMA Policy D-295.941, “Facilitating Access to Health Care Facilities for Training,” be amended by addition to state that the AMA “work with the Association of American Medical Colleges and other national organizations to expedite, wherever possible, the standardization of requirements in regards to training on HIPAA, drug screening, and health requirements for pre-medical and medical students, and resident and fellow physicians who are being educated in hospitals and other health care settings.” The report focuses on areas common to Resolutions 310-A-13 and 913-I-13, namely concerns and strategies around pre-medical students shadowing physicians.

Your Reference Committee heard mixed testimony on CME Report 8. Some individuals noted that the amount of paperwork required of physicians to offer a shadowing opportunity is onerous. Your Reference Committee recommends referral of CME Report
8 to ensure a more thorough review of physician shadowing and mechanisms to ensure that individuals from underprivileged and under-represented minority groups are afforded the equal opportunity to participate in shadowing.

(26) RESOLUTION 317 - ABOLISH DISCRIMINATION AGAINST IMGS IN MEDICAL LICENSING
RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 317 be referred.

HOD ACTION: Resolution 317 referred.

Resolution 317 asks our AMA to 1) advocate that state medical societies in states that require unequal amounts of graduate medical education (GME) for International Medical Graduates (IMGs) versus LCME graduates seek legislation in their state legislatures to make GME requirements the same for IMGs and LCME graduates and also to eliminate any other discriminatory requirements mandated for IMGs alone, and 2) lobby the Federation of State Medical Boards (FSMB) to vigorously promote its policy of equal requirements for International Medical Graduates (IMGs) and LCME graduates and to ask the FSMB to seek changes in laws in each state to eliminate unequal graduate medical education (GME) requirements that discriminate against IMGs.

Your Reference Committee heard testimony in favor of the need for parity between U.S. and international medical graduates in the requirements for licensure. It was noted that this is a state-based issue, and requires changes to individual states’ medical practice acts, but the disparity and discrimination inherent in this discrepancy among many states need to be addressed through an equitable, evidence-based solution. Other testimony reflected the variations in quality among foreign medical schools, and the trends in graduate medical education towards achievement of milestones versus a rigid, time-based requirement. In addition, it is critical to ascertain the number of states that have discrepant regulations in this regard. Further, the resolution’s language calling on our AMA to “lobby” the FSMB to seek changes in state laws is problematic; more appropriate would be for our AMA to work with the FSMB to determine the scope of the problem and the rationale (if any) for the continued existence of such laws. Due to the complexity of these issues and the need for additional study, your Reference Committee recommends referral of Resolution 317.

(27) RESOLUTION 315 - CERTIFICATION OF METHADONE EDUCATION
RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 315 not be adopted.

HOD ACTION: Resolution 315 not adopted.
Resolution 315 asks: 1) our AMA to bring together interested experts in the use of Methadone (and other extended release opioids) in chronic pain patients to create or designate a certifying body (such as the American Board of Pain Medicine or American Board of Anesthesiology) to oversee a certification process regarding the use of Methadone; 2) that the certifying body be charged with creating a test aimed at the demonstration of expertise in the use of Methadone in chronic pain patients; 3) that our AMA work with the DEA or other regulatory bodies to require providers to have this certification starting by June 2016; and 4) that experts already certified in the subspecialty of Pain Medicine by an ABMS specialty or by the American Board of Pain Medicine be exempt from this new certification requirement.

Your Reference Committee heard testimony that highlighted major concerns with this resolution. These include the following: 1) Certification by one of the certifying boards is not the optimal approach; special certification in the use of a single medication would be unique and set a precedent restricting scope of practice. 2) Many other drugs are dangerous and require specific training to use safely; these include extended release narcotic medications. 3) The FDA has established risk reduction training requirements for the use of extended release pain medications—theese should be sufficient for methadone as well. 4) Patient safety should be adequately addressed with the use of the FDA Risk Evaluation and Mitigation Strategy (REMS) mechanism. 5) Specialties other than pain medicine are trained in the safe use of methadone—hospice and palliative medicine, for example—and should also be exempted from such a requirement if it were to be created with an exemption for pain medicine. 6) Finally, further restriction of the availability of long-acting narcotic analgesics to the hands of such pain medication specialists would exacerbate the already severely limited availability of physicians able and willing to manage severe pain in the terminally ill and in oncology patients. The point was also made that requiring special consideration and certification for a particular drug is unwieldy and sets an unfortunate precedent. Your Reference Committee concurs with this testimony and believes that there are better avenues for addressing some of the emerging concerns with regard to methadone use in chronic pain. We therefore urge that Resolution 315 not be adopted.

Resolution 321 asks our AMA to 1) work with the Congress to earmark funds from the federal higher education budget to increase graduate medical education (GME) training positions, and 2) explore funding from private sources for graduate medical education (GME) training positions and prepare a report for the House of Delegates.

Your Reference Committee heard testimony that was in opposition to this item. The potential unintended consequences of redirecting funds were noted; such actions could move GME funding into general appropriations and place the future sustainability of this
funding stream in jeopardy. Concern was also expressed about use of private sources; this could lead to possible conflicts of interest for physicians in the public eye. Your Reference Committee therefore recommends that our AMA not adopt Resolution 321.

(29) RESOLUTION 313 - OPPOSITION TO THE FSMB MAINTENANCE OF LICENSURE PROGRAM

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that H-275.920 be reaffirmed in lieu of Resolution 313.

HOD ACTION: H-275.920 reaffirmed in lieu of Resolution 313.

Resolution 313 asks our AMA to 1) oppose any efforts by the Federation of State Medical Boards, Inc. (FSMB) to implement a “maintenance of licensure (MOL)” program in any state and 2) oppose any maintenance of certification (MOC) or recertification by a specialty medical board as a condition of licensure in any state.

Your Reference Committee heard mixed testimony, with support for deleting the first resolve and for reaffirming existing Policy H-275.920, in lieu of the second resolve. This policy calls for our AMA to develop alternatives for physicians who are not certified/recertified, and asks that MOC or OCC not be the only pathway to MOL for physicians. For this reason, your Reference Committee recommends reaffirmation of Policy H-275.920 in lieu of this resolution.

Policy recommended for reaffirmation:

H-275.920 Impact of Maintenance of Certification, Osteopathic Continuous Certification, Maintenance of Licensure on the Physician Workforce

1. Our AMA encourages the Federation of State Medical Boards to continue to work with state licensing boards to accept physician participation in maintenance of certification (MOC) and osteopathic continuous certification (OCC) as meeting the requirements for MOL and to develop alternatives for physicians who are not certified/recertified, and that MOC or OCC not be the only pathway to MOL for physicians. 2. Our AMA encourages the American Board of Medical Specialties to use data from maintenance of certification to track whether physicians are maintaining certification and share this data with the AMA. (CME Rep. 11, A-12)

(30) RESOLUTION 320 - MANDATORY BOARD RECERTIFICATION

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Policy H-275.996 be reaffirmed in lieu of Resolution 320.

HOD ACTION: Policy H-275.996 reaffirmed in lieu of Resolution 320.
Resolution 320 asks our AMA to urge the mandatory recertification to be replaced with a specialty-specific continuing medical education alternative.

Your Reference Committee heard testimony to reaffirm existing AMA policy that currently reflects the intent of this resolution in lieu of Resolution 320. For example, Policy H-275.996 asks our AMA to urge the FSMB and its constituent state boards to reconsider and reverse the position urging and accepting specialty board certification as evidence of continuing competence for the purpose of re-registration of licensure. Your Reference Committee recommends that Policy H-275.996 be reaffirmed in lieu of Resolution 320.

Policy recommended for reaffirmation:

H-275.996 Physician Competence
Our AMA: (1) urges the American Board of Medical Specialties and its constituent boards to reconsider their positions regarding recertification as a mandatory requirement rather than as a voluntarily sought and achieved validation of excellence; (2) urges the Federation of State Medical Boards and its constituent state boards to reconsider and reverse their position urging and accepting specialty board certification as evidence of continuing competence for the purpose of re-registration of licensure; and (3) favors continued efforts to improve voluntary continuing medical education programs, to maintain the peer review process within the profession, and to develop better techniques for establishing the necessary patient care data base. (CME Rep. J, A-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CME Rep. 7, A-02; Reaffirmed: CME Rep. 7, A-07; Reaffirmed: CME Rep. 16, A-09; Reaffirmed in lieu of Res. 302, A-10)
Mr. Speaker, this concludes the report of Reference Committee C. I would like to thank Sharon Douglas, MD, Aaron George, DO, Zachary N. Litvack, MD, John J. Wernert, MD, MHA, John P. Williams, MD, Cameron Paterson, and all those who testified before the Committee.

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