AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (A-15)

Report of Reference Committee C

Daniel B. Kimball, Jr., MD, Chair

Your Reference Committee recommends the following consent calendar for acceptance:

RECOMMENDED FOR ADOPTION

1. Council on Medical Education Report 4 – Guidelines for Students Shadowing Physicians
2. Council on Medical Education Report 7 – Enhancing the AMA's Role in Premedical Education
3. Council on Medical Education Report 9 – The Value of Graduate Medical Education
4. Council on Medical Education Report 10 – Aligning the Evaluation of Physicians Across the Medical Education Continuum
5. Resolution 303 – Autonomy in Utilization of CME Funds by Employed Physicians
6. Resolution 305 – Evaluation of DACA-Eligible Medical Students, Residents, and Physicians in Addressing Physician Shortages
7. Resolution 323 – Ensuring Equality in Loan Repayment Programs for Married Couples

RECOMMENDED FOR ADOPTION WITH CHANGE IN TITLE

8. Resolution 319 – Promoting Transparency in Medical Education and Access to Training in Settings Affiliated with Religious Health Care Organizations

RECOMMENDED FOR ADOPTION AS AMENDED OR SUBSTITUTED

9. Board of Trustees Report 25 – Abolish Discrimination Against IMGs in Medical Licensing Requirements
10. Council on Medical Education Report 1 – Council on Medical Education Sunset Review of 2005 House of Delegates' Policies
11. Council on Medical Education Report 2 – Update on Maintenance of Certification and Osteopathic Continuous Certification
12. Council on Medical Education Report 3 – An Update on Maintenance of Licensure
13. Council on Medical Education Report 5 – Competency and the Aging Physician
14. Council on Medical Education Report 6 – American Board of Medical Specialties Should Adhere to its Mission
15. Council on Medical Education Report 8 – Meaningful Access to Electronic Health Records for Medical Students
16. Resolution 304 – Addressing the Increasing Number of Unmatched Medical Students
17. Resolution 307 – Policy and Advocacy Opportunities for Medical Students
18. Resolution 308 – Reducing the Financial and Educational Costs of Residency Interviews

19. Resolution 310 – Mitigation of Physician Performance Metrics on Trainee Autonomy and Education
20. Resolution 313 – Human Trafficking Reporting and Education
21. Resolution 314 – Maintenance of Certification and Continuing Education
22. Resolution 315 – Obesity Education
    Resolution 326 – Obesity Education in Medical Schools and Residency Programs
23. Resolution 324 – Proposing Changes to Public Service Loan Forgiveness

RECOMMENDED FOR REFERRAL

24. Resolution 301 – Alerting Physicians to Deadlines for Maintenance of Certification
25. Resolution 302 – Re-Evaluating Knowledge Assessment in Maintenance of Certification
26. Resolution 312 – Model Guidelines for Expansion of Residency Programs
27. Resolution 318 – Maintenance of Certification
28. Resolution 321 – Value of Residents and Fellows to the Health Care System
    Resolution 327 – Achieving Transparency through Graduate Medical Education Funding
    Resolution 328 – Evaluation of Resident and Fellow Compensation Levels
    Resolution 329 – Principles of GME Funding Reform
29. Resolution 330 – Telemedicine in Graduate Medical Education

RECOMMENDED FOR NOT ADOPTION

30. Resolution 309 – Maintenance of Certification
31. Resolution 317 – Protect Physician Certification and Licensure
32. Resolution 320 – Post-Acute and Long-Term Care Education Requirement
33. Resolution 322 – Board of Medicine Sanctions and Fines
34. Resolution 325 – Broaden Conflict of Interest Disclosure

RECOMMENDED FOR REAFFIRMATION IN LIEU OF

35. Resolution 306 – Including Military History as Part of Standard History Taking
36. Resolution 311 – Selecting Residents to Better Reflect Patient Diversity

(1) COUNCIL ON MEDICAL EDUCATION REPORT 4 - GUIDELINES FOR STUDENTS SHADOWING PHYSICIANS

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.

Council on Medical Education Report 4 asks that our AMA 1) encourage physicians in both private practice and academic settings to provide shadowing opportunities to students interested in a career in medicine—particularly those from underrepresented populations—as part of the physician's commitment to the future of the profession; 2) encourage physicians to adopt the most appropriate shadowing model to the needs of the practice/institution and the student(s); and 3) endorse the clinical shadowing guidelines for students from the Association of American Medical Colleges as one model for such students and help disseminate this document to K-12 students, premedical students, health professions advisors, hospitals, and physicians.

Your Reference Committee heard unanimous testimony in favor of this item. Testimony reflected that this iteration addressed concerns from the earlier version, presented at the A-14 HOD meeting. The report's recommendations, while encouraging physicians to participate in shadowing as a professional responsibility, allow leeway for adaptation to meet local needs and circumstances. In addition, the report calls attention to the need to provide shadowing opportunities to minority populations that are under-represented in medicine. It was noted that hospital volunteering is preferable to shadowing as a true measure of interest in a career in medicine; this may be the topic of a future resolution or report. Your Reference Committee recommends adoption of this report.

(2) COUNCIL ON MEDICAL EDUCATION REPORT 7 - ENHANCING THE AMA'S ROLE IN PREMEDICAL EDUCATION

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the recommendations in Council on Medical Education Report 7 be adopted and the remainder of the report be filed.

Council on Medical Education Report 7 asks that our AMA 1) update its "Becoming a Physician" website with most relevant information to enhance usage and usability, and support the concept and explore the feasibility of enhancing current AMA online resources for premedical students; 2) explore the feasibility of developing innovative online "premedical" engagement activities that are affordable to students and cost-effective for our AMA and have value to medical school admissions personnel; and 3)

explore the feasibility of developing resources to enhance premedical student advising and mentoring by physicians and others.

Your Reference Committee heard unanimous testimony in favor of this item. This report calls on the AMA to increase exposure of undergraduates to values that are not typically emphasized in pre-medical education, particularly professionalism and humanism. While medical school admissions committees generally take a holistic approach to evaluating applicants, most guidance on admissions aimed at pre-medical students does not emphasize traits such as professionalism and humanism. This report is a timely and well-written effort to reemphasize these important values and ensure the continued high quality and ethical nature of our nation's medical professionals. Therefore, your Reference Committee recommends adoption.

(3) COUNCIL ON MEDICAL EDUCATION REPORT 9 - THE VALUE OF GRADUATE MEDICAL EDUCATION

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the recommendations in Council on Medical Education Report 9 be adopted and the remainder of the report be filed.

Council on Medical Education Report 9 asks that our AMA 1) utilize its resources to share its content expertise with policymakers and the public to ensure greater awareness of the significant societal value of graduate medical education (GME) in terms of patient care, particularly for underserved and at-risk populations, as well as global health, research and education; 2) revise Policy D-305.967, "The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education," to read as follows: "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 ~~payers)~~, to fund~~ing~~ both the direct and indirect costs of GME"; 3) 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; and 4) support 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.

Your Reference Committee heard unanimous testimony in favor of adopting CME Report 9. Dissemination of the information in this report may help the public better appreciate the value of graduate medical education to the common good and recognize all the contributions of resident/fellow physicians and residency programs to the community and society as a whole, through, for example, provision of care in underserved areas. Therefore, your Reference Committee recommends adoption of CME Report 9.

(4) COUNCIL ON MEDICAL EDUCATION REPORT 10 - ALIGNING THE EVALUATION OF PHYSICIANS ACROSS THE MEDICAL EDUCATION CONTINUUM

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the recommendations in Council on Medical Education Report 10 be adopted and the remainder of the report be filed.

Council on Medical Education Report 10 asks that our AMA 1) support the concept that evaluation of physicians as they progress along the medical education continuum should include the following: a) Assessments of each of the six competency domains of patient care, medical knowledge, interpersonal and communication skills, professionalism, practice-based learning and improvement, and systems-based practice; and b) Use of assessment instruments and tools that are valid and reliable and appropriate for each competency domain and stage of the medical education continuum; 2) encourage study of competency-based progression within and between medical school and residency: a) through its Accelerating Change in Medical Education initiative, study models of competency-based progression within the medical school; and b) work with the Accreditation Council for Graduate Medical Education (ACGME) to study how the Milestones of the Next Accreditation System support competency-based progression in residency; 3) encourage research on innovative methods of assessment related to the six competency domains of the ACGME/American Board of Medical Specialties that would allow monitoring of performance across the stages of the educational continuum; and 4) encourage ongoing research to identify best practices for workplace-based assessment that allow performance data related to each of the six competency domains to be aggregated and to serve as feedback to physicians in training and in practice.

Your Reference Committee heard unanimous testimony in favor of this item. 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 assessment processes of practicing physicians. Therefore, your Reference Committee recommends adoption.

(5) RESOLUTION 303 - AUTONOMY IN UTILIZATION OF CME FUNDS BY EMPLOYED PHYSICIANS

RECOMMENDATION:

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

Resolution 303 asks that our AMA support physician autonomy by partnering with relevant organizations to encourage medical organizations or institutions that employ physicians and offer financial support towards continuing medical education (CME) to avoid prioritizing institutional goals over individual physician educational needs in the choice of CME coursework.

Your Reference Committee heard unanimous testimony in favor of this item. Testimony noted that more physicians are working as employees, so this may become an increasingly common concern going forward. Physicians need to maintain the autonomy to get the education they need, as one of the key components of physician professional competence. The individual doctor should be the arbiter of the relevance of a given educational program, rather than his/her employer or institution. In short, the specific needs of a given physician should be the priority in allocation of CME funding. Therefore, your Reference Committee recommends adoption of Resolution 303.

(6) RESOLUTION 305 - EVALUATION OF DACA-ELIGIBLE MEDICAL STUDENTS, RESIDENTS, AND PHYSICIANS IN ADDRESSING PHYSICIAN SHORTAGES

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 305 be adopted.

Resolution 305 asks that our AMA study the issue of Deferred Action for Childhood Arrivals-eligible medical students, residents, and physicians and consider the opportunities for their participation in the physician profession and report its findings to the House of Delegates.

Your Reference Committee heard unanimous testimony in favor of Resolution 305. A total of 1.8 million undocumented immigrants are eligible under DACA, which allows individuals who came to the U.S. as children and meet several guidelines to apply for deferred deportation and be eligible for work authorization. Many DACA-eligible medical students want to meet the needs of their communities and have the potential to increase the physician workforce, particulary for underserved populations and in underserved areas. This issue should be studied by the AMA. Therefore, your Reference Committee recommends adoption.

(7) RESOLUTION 323 - ENSURING EQUALITY IN LOAN REPAYMENT PROGRAMS FOR MARRIED COUPLES

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 323 be adopted.

Resolution 323 asks that our AMA oppose any stipulations in loan repayment programs that place greater burdens upon married couples than for similarly-situated couples who are cohabitating.

Your Reference Committee heard unanimous testimony in favor of this item and significant concern about a “marriage penalty” for married couples wiith signficant student loans and disparate incomes. Such a penalty is not incurred by couples that co-habit but are not legally married. Therefore, your Reference Committee recommends adoption as amended.

(8) RESOLUTION 319 - PROMOTING TRANSPARENCY IN MEDICAL EDUCATION AND ACCESS TO TRAINING IN SETTINGS AFFILIATED WITH RELIGIOUS HEALTH CARE ORGANIZATIONS

RECOMMENDATION A:

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

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the title of Resolution 319 be changed, to read as follows:

PROMOTING TRANSPARENCY IN MEDICAL EDUCATION AND ACCESS TO TRAINING

Resolution 319 asks that our AMA 1) strongly encourage medical schools and graduate medical education training programs to communicate with current and prospective medical students, residents and fellows how affiliations and mergers among health care organizations may impact health care delivery, medical education and training opportunities at their respective institutions; and 2) work with the Accreditation Council for Graduate Medical Education and other appropriate stakeholders to support transparency within medical education, recommending that medical schools and graduate medical education training programs communicate with current and prospective medical students, residents and fellows how affiliations and mergers among health care organizations may impact health care delivery, medical education and training opportunities.

Your Reference Committee heard testimony in favor of this item and broadening its scope beyond affiliations and mergers involving religious health care organizations—hence the suggested title change. A resident's training may be impacted by a health care facility discontinuing a particular service for financial or other reasons. Therefore, your Reference Committee recommends adoption of Resolution 319.

(9) BOARD OF TRUSTEES REPORT 25 - ABOLISH DISCRIMINATION AGAINST IMGS IN MEDICAL LICENSING REQUIREMENTS

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Recommendation 1 of Board of Trustees Report 25 be amended by addition on lines 19-20, to read as follows:

3) Discrimination against physicians solely on the basis of national origin and/or the country in which they completed their medical education is inappropriate.

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Recommendation 4 of Board of Trustees Report 25 be amended by addition, to read as follows:

4. That our AMA work with ~~interested~~ state medical societies in states with discriminatory licensure requirements between IMGs and graduates of U.S. and Canadian medical schools to advocate for parity in licensure requirements, using the AMA International Medical Graduate Section ~~model~~ licensure parity model resolution as a resource. (Directive to Take Action)

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that Board of Trustees Report 25 be adopted as amended.

RECOMMENDATION D:

Mr. Speaker, your Reference Committee recommends that the title of Board of Trustees Report 25 be changed, to read as follows:

ABOLISH DISCRIMINATION IN LICENSURE OF IMGS

Board of Trustees Report 25 asks that our AMA adopt the following policy, Medical Licensure of International Medical Graduates: Our AMA supports the following principles related to medical licensure of international medical graduates (IMGs): 1) State medical boards should ensure uniformity of licensure requirements for IMGs and graduates of U.S. and Canadian medical schools, including eliminating any disparity in the years of graduate medical education (GME) required for licensure and a uniform standard for the allowed number of administrations of licensure examinations; 2) All physicians seeking licensure should be evaluated on the basis of their individual education, training, qualifications, skills, character, ethics, experience and past practice; 3) Discrimination against physicians on the basis of national origin and/or the country in which they completed their medical education is inappropriate; 4) U.S. states and territories retain the right and responsibility to determine the qualifications of individuals applying for licensure to practice medicine within their respective jurisdictions; 5) State medical boards should be discouraged from a) using arbitrary and non-criteria-based lists of approved or unapproved foreign medical schools for licensure decisions and b) requiring an interview or oral examination prior to licensure endorsement. More effective methods for evaluating the quality of IMGs' undergraduate medical education should be pursued with the Federation of State Medical Boards and other relevant organizations. When available, the results should be a part of the determination of eligibility for licensure. It also asks that our AMA continue to work with the Federation of State Medical Boards to encourage parity in licensure requirements for all physicians, whether U.S. medical school graduates or international medical graduates; continue to work with the

Educational Commission for Foreign Medical Graduates and other appropriate organizations in developing effective methods to evaluate the clinical skills of IMGs; work with interested state medical societies to advocate for parity in licensure requirements, using the AMA International Medical Graduate Section model licensure parity resolution as a resource; and that the House of Delegates policies listed in Appendix B of this report be acted upon in the manner indicated.

Your Reference Committee heard testimony largely in favor of this item. Your AMA Board of Trustees has developed an excellent report that analyzes this issue in depth and, refines AMA policy in this regard, and highlights the work of the AMA International Medical Graduates Section to provide model legislation for states seeking to address this issue. Because of the variability of training requirements in various countries, a change to Recommendation 1 (3) is suggested. Also, a minor editorial change was proposed by the IMG Section in Recommendation 4. In addition, a title change was suggested to clarify the meaning and intent of the report. Licensure of physicians is a public protection issue, and states and territories retain the right to take action against any unqualified or disreputable physicians practicing within their borders. That said, our AMA encourages parity of licensing requirements for U.S. and international medical graduates in each state/jurisdiction. Therefore, your Reference Committee recommends adoption of BOT Report 25 as amended.

(10) COUNCIL ON MEDICAL EDUCATION REPORT 1 - COUNCIL ON MEDICAL EDUCATION SUNSET REVIEW OF 2005 HOUSE OF DELEGATES' POLICIES

RECOMMENDATION A:

Mr. Speaker, your Reference Committee 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 and the remainder of this report be filed, with the exception of H-310.988, Adequate Resident Compensation, which should be retained. (Directive to Take Action)

RECOMMENDATION B:
Mr. Speaker, your Reference Committee recommends that the recommendation in Council on Medical Education Report 1 be adopted as amended and the remainder of the report be filed.

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 favorable testimony in favor of this item. Testimony from the Resident and Fellow Section requested that Policy H-310.988, Adequate Resident Compensation, be retained, as it encompasses resident compensation, which is broader in scope than just salary. Therefore, your Reference Committee recommends adoption of CME Report 1, with this exception.

(11) COUNCIL ON MEDICAL EDUCATION REPORT 2 - UPDATE ON MAINTENANCE OF CERTIFICATION AND OSTEOPATHIC CONTINUOUS CERTIFICATION

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Recommendation 3 in Council on Medical Education Report 2 be amended by addition on lines 19 and 20, to read as follows:

3. That our AMA encourage AMA members to be proactive in shaping Maintenance of Certification (MOC) and Osteopathic Continuous Certification by seeking leadership positions on the ABMS member boards, American Osteopathic Association specialty certifying boards and MOC Committees. (Directive to Take Action)

RECOMMENDATION B:

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

Council on Medical Education Report 2 asks that our AMA 1) advocate that the American Board of Medical Specialties (ABMS) develop fiduciary standards for its member boards that are consistent with AMA Policy D-275.960 (4), An Update on Maintenance of Certification (MOC), Osteopathic Continuous Certification and Maintenance of Licensure, which states that our AMA encourages the ABMS to ensure that all ABMS specialty boards provide full transparency related to the costs of preparing, administering, scoring and reporting MOC and certifying/recertifying examinations and ensure that MOC and certifying/recertifying examinations do not result in significant financial gain to the ABMS specialty boards; 2) reaffirm Policy H-275.924 (15), Maintenance of Certification (MOC), which states that actively practicing physicians should be well-represented on specialty boards developing MOC; 3) encourage AMA members to be proactive in shaping Maintenance of Certification (MOC) by seeking leadership positions on the ABMS member boards' and MOC Committees; 4) continue to monitor the actions of professional societies regarding recommendations for modification to Maintenance of Certification; and 5) rescind Policy D-275.960 (6) (9), An Update on Maintenance of Certification, Osteopathic Continuous Certification, and Maintenance of Licensure, since that has been accomplished through this report.

Your Reference Committee heard much testimony in favor of this comprehensive report, which provides an update on AMA efforts with the American Board of Medical Specialties to improve the Maintenance of Certification program. Your Reference Committee understands concerns about participation in MOC and/or MOC status potentially being used to promote policy initiatives (with punitive intent) and recommends reaffirmation of H-275.924, Maintenance of Certification, to reinforce that the MOC program should not be a mandated requirement for licensure, credentialing, reimbursement, network participation, or employment. The changes outlined in Appendix B of the report show how the ABMS is addressing the issues that have been raised by AMA members to reduce the administrative burden and cost of MOC, improve accountability and transparency, decrease learning redundancies, and explore a number of innovations being tested to streamline the MOC Part III high-stakes secured exam and make it relevant to practice. The report also acknowldeges that the AMA will continue to work with the ABMS, the American Osteopathic Association (AOA), and their respective member boards to identify and suggest improvements to the MOC and OCC programs and ensure that MOC and OCC support physicians' ongoing learning and practice improvement. Therefore, your Reference Committee recommends adoption of Report 2 as amended.

(12) COUNCIL ON MEDICAL EDUCATION REPORT 3 - AN UPDATE ON MAINTENANCE OF LICENSURE

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Recommendation 1 in Council on Medical Education Report 3 be amended by addition and deletion on lines 5-6, to read as follows:

b) Any MOL educational activity under consideration should be developed in collaboration with physicians, should be evidence-based, and should be practice-~~specialty~~-specific. Accountability for physicians should be led by physicians;

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.

Council on Medical Education Report 3 asks that our AMA 1) establish 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 specialty-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) support the FSMB Guiding Principles for MOL, 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) work with interested state medical societies and support collaboration with state specialty medical societies and state medical boards on establishing criteria and regulations for the implementation of MOL that reflect AMA guidelines for implementation of state MOL programs and the FSMB's Guiding Principles for MOL; and 4) explore the feasibility of developing, in collaboration with other stakeholders, AMA products and services that may be helpful tools to shape and support MOL for physicians.

Your Reference Committee heard testimony in support of this report. MOL programs will recognize activities that physicians currently use or should use for continuing professional development. Medical licensure is not based on a physician's specialty, so it should follow that any MOL educational activities should not be based on one's specialty. Using the term "practice" rather than "specialty" will help ensure that state MOL programs are more likely to be tailored to individual physician's needs and relevant to their practice. With this change, your Reference Committee recommends adoption of CME Report 2 as amended.

(13) COUNCIL ON MEDICAL EDUCATION REPORT 5 - COMPETENCY AND THE AGING PHYSICIAN

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Recommendation 1 in Council on Medical Education Report 5 be amended by addition and deletion, to read as follows:

1. That our American Medical Association (AMA) identify organizations that should participate in the development of guidelines and methods of screening and assessment to assure that senior~~aging~~/late career physicians remain able to provide safe and effective care for patients. (Directive to Take Action)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Recommendation 2 in Council on Medical Education Report 5 be amended by addition and deletion, to read as follows:

2. That our AMA convene~~encourage~~ organizations identified by the AMA to work together to develop preliminary guidelines for assessment of the senior~~aging~~/late career physician and develop a research agenda that could guide those interested in this field and serve as the basis for guidelines more grounded in research findings. (Directive to Take Action)

RECOMMENDATION C:

Mr. 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.

RECOMMENDATION D:

Mr. Speaker, your Reference Committee recommends that the title of Council on Medical Education Report 5 be changed, to read as follows:

ASSURING SAFE AND EFFECTIVE CARE FOR PATIENTS BY SENIOR/LATE CAREER PHYSICIANS

Council on Medical Education Report 5 asks that our AMA 1) identify organizations that should participate in the development of guidelines and methods of screening and assessment to assure that aging/late career physicians remain able to provide safe and effective care for patients; 2) encourage organizations identified by the AMA to work together to develop preliminary guidelines for assessment of the aging/late career physician and develop a research agenda that could guide those interested in this field and serve as the basis for guidelines more grounded in research findings; and 3) rescind Policy D-275.959, Competency and the Aging Physician, since this directive has been accomplished through this report.

Your Reference Committee heard strong support for CME Report 5, which addresses a complex and sensitive topic. Many organizations expressed strong interest in working with our AMA to develop preliminary guidelines for assessment of the senior/late career physician, and to develop a research agenda that could guide those interested in this field and serve as the basis for guidelines more grounded in research findings. Therefore, your Reference Committee recommends that CME Report 5 be adopted as amended.

(14) COUNCIL ON MEDICAL EDUCATION REPORT 6 - AMERICAN BOARD OF MEDICAL SPECIALTIES SHOULD ADHERE TO ITS MISSION

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the recommendation in Council on Medical Education Report 6 be amended by addition and deletion, to read as follows:

That our American Medical Association (AMA) work with the American Board of Medical Specialties (ABMS) to ensure that ABMS member boards avoid attempts at restricting the legitimate scope of practice of board-certified physicians ~~who have received appropriate training and have demonstrated competency in additional areas, particularly if such restrictions could decrease access to health care services for specific patient populations~~. This is not meant to restrict the ability of ABMS member boards from deliberating on and issuing guidelines on the legitimate scope of practice within that board's specialty. (Directive to Take Action)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the recommendation in Council on Medical Education Report 6 be adopted as amended.

Council on Medical Education Report 6 asks that our AMA work with the American Board of Medical Specialties (ABMS) to ensure that ABMS member boards avoid attempts at restricting the legitimate scope of practice of board-certified physicians who have received appropriate training and have demonstrated competency in additional areas, particularly if such restrictions could decrease access to health care services for specific patient populations.

Your Reference Committee heard limited but supportive testimony on this item. The Council on Medical Education noted in its testimony that this could be a larger issue going forward, such that the AMA's developing policy on this issue is warranted. A friendly amendment was offered by the plastic surgery caucus, as noted. Your Reference Committee concurs and recommends adoption as amended.

(15) COUNCIL ON MEDICAL EDUCATION REPORT 8 - MEANINGFUL ACCESS TO ELECTRONIC HEALTH RECORDS FOR MEDICAL STUDENTS

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Recommendation 5 in Council on Medical Education Report 8 be amended by addition on lines 23-27, to read as follows:

5. That our AMA work with the Liaison Committee for Medical Education (LCME), AOA Commission on Osteopathic College Accreditation (COCA) and the Accreditation Council for Graduate Medical Education (ACGME) to encourage the nation's medical schools and residency and fellowship training programs to teach students and trainees effective methods of utilizing electronic devices in the exam room and at the bedside to enhance rather than impede the physician-patient relationship and improve patient care. (Directive to Take Action)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the recommendations in Council on Medical Education Report 8 be adopted as amended and the remainder of the report be filed.

Council on Medical Education Report 8 asks that our AMA 1) reaffirm Policy H-315.969, Medical Student Access to Electronic Health Records, which recognizes the benefits of medical students' access to electronic health record systems as part of their clinical training; 2) support medical student acquisition of hands-on experience in documenting patient encounters and entering clinical orders into patients' electronic health records (EHRs), with appropriate supervision, as was the case with paper charting; 3) (1) research the key elements recommended for an educational Electronic Health Record (EHR) platform; and (2) based on the research—including the outcomes from the Accelerating Change in Medical Education initiatives to integrate EHR-based instruction and assessment into undergraduate medical education—determine the characteristics of an ideal software system that should be incorporated for use in clinical settings at medical schools and teaching hospitals that offer EHR educational programs; 4) encourage efforts to incorporate EHR training into undergraduate medical education, including the technical and ethical aspects of their use, under the appropriate level of supervision; and 5) work with the Liaison Committee (LCME) and the Accreditation Council for Graduate Medical Education (ACGME) to encourage the nation's medical schools and residency and fellowship training programs to teach students and trainees effective methods of utilizing electronic devices in the exam room and at the bedside to enhance rather than impede the physician-patient relationship and improve patient care.

Your Reference Committee heard testimony, live and online, in strong support of this report, which provides an update on the current level of student involvement with EHRs in undergraduate and graduate medical education. There is a need to explore best practices and opportunities to assure that students and residents have ample opportunities to have access to and meaningful experiential clinical experiences with EHRs. Given the testimony in favor of this item, your Reference Committee recommends adoption of CME Report 8 as amended.

(16) RESOLUTION 304 - ADDRESSING THE INCREASING NUMBER OF UNMATCHED MEDICAL STUDENTS

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the first resolve of Resolution 304 be amended by addition, to read as follows:

RESOLVED, That our American Medical Association study, in collaboration with the Association of American Medical Colleges, the National Resident Matching Program, and the American Osteopathic Association, the common reasons for failures to match (Directive to Take Action); and be it further

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the second resolve of Resolution 304 be amended by substitution, to read as follows:

RESOLVED, that our AMA discuss with the National Resident Matching Program, Association of American Medical Colleges, American Osteopathic Association, Liaison Committee on Medical Education, Accreditation Council for Graduate Medical Education, and other interested bodies potential pathways for reengagement in medicine following an unsuccessful match and report back on the results of those discussions. (Directive to Take Action)

RECOMMENDATION C:

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

Resolution 304 asks that our AMA 1) study, in collaboration with the Association of American Medical Colleges and the American Osteopathic Association, the common reasons for failures to match; and 2) study potential pathways for reengagement in the medical field for applicants to the National Resident Matching Program who fail to match.

Your Reference Committee heard testimony in support of the principle of Resolution 304. The resolution author noted that this problem is becoming more dire, with the continued growth in enrollments in medical schools as well as the imminent unification of the accreditation systems for allopathic and osteopathic residency programs. Indeed, this was the topic of a Section on Medical Schools' educational session at this Annual Meeting, to ensure that medical students obtain needed guidance and counseling pre-Match and assistance with any post-Match problems, including advice on alternative career options, as needed. The Council on Medical Education voiced support for this item but with the substitution of a new Resolve 2, to ensure adequate collaboration with other key stakeholder organizations. Other testimony called for the addition of the National Resident Matching Program to Resolve 1, to ensure their involvement in any study of Match issues. Your AMA will continue to study and closely monitor this issue—through the efforts of the Council on Medical Education and Section on Medical Schools, among others—to ensure the highest possible return on the nation's investment in our future medical workforce. Therefore, your Reference Committee recommends adoption as amended.

(17) RESOLUTION 307 - POLICY AND ADVOCACY OPPORTUNITIES FOR MEDICAL STUDENTS

RECOMMENDATION A:

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

RESOLVED, That our American Medical Association establish health policy and advocacy elective rotations based in Washington, DC for medical students, residents, and fellows.

RECOMMENDATION B:

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

RESOLVED, That our AMA support and encourage ~~internal~~institutional, state and specialty organizations to offer health policy and advocacy opportunities for medical students, residents, and fellows.

RECOMMENDATION C:

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

RECOMMENDATION D:

Mr. Speaker, your Reference Committee recommends that the title of Resolution 307 be changed, to read as follows:

POLICY AND ADVOCACY OPPORTUNITIES FOR MEDICAL STUDENTS, RESIDENTS AND FELLOWS

Resolution 307 asks that our AMA (1) establish health policy and advocacy elective rotations based in Washington, DC for medical students; and (2) support and encourage internal, state, and specialty organizations to offer health policy and advocacy opportunities for medical students.

Your Reference Committee heard unanimous testimony in favor of this item. Students value these types of opportunities for the professional experience, and the AMA can benefit from the leadership skills that students gain. There also was significant testimony about the value of expanding these programs to residents and fellows, and to reflect the types of organizations (including institutions) that could sponsor such programs. Therefore, your Reference Committee recommends adoption as amended.

(18) RESOLUTION 308 - REDUCING THE FINANCIAL AND EDUCATIONAL COSTS OF RESIDENCY INTERVIEWS

RECOMMENDATION A:

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

RESOLVED, That our American Medical Association work with appropriate stakeholders, such as the Association of American Medical Colleges and the Accreditation Council for Graduate Medical Education, in consideration of ~~consider~~ the following strategies to address the high cost of interviewing for residency/fellowship: a) establish a method of collecting data on interviewing costs for medical students and resident physicians of all specialties for study, and b) support further study of residency/fellowship interview strategies aimed at mitigating costs associated with ~~residency~~ such interviews. (Directive to Take Action)

RECOMMENDATION B:

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

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that the title of Resolution 308 be changed, to read as follows:

REDUCING THE FINANCIAL AND EDUCATIONAL COSTS OF RESIDENCY/FELLOWSHIP INTERVIEWS

Resolution 308 asks that our AMA consider the following strategies to address the high cost of interviewing for residency: a) establish a method of collecting data on interviewing costs for medical students of all specialties for study, and b) support further study of residency interview strategies aimed at mitigating costs associated with residency interviews.

Your Reference Committee heard positive testimony on this item. The resolution's authors noted that costs for interviews are skyrocketing, and students are applying more broadly than ever before, particularly in more competitive specialties. Some individuals may apply to over 100 programs, visit 20, and spend $10,000 on travel costs. In its testimony, the Council on Medical Education expressed its support for these sentiments and the principle behind the resolution, but noted that our AMA alone may not be the appropriate organization to study these costs and strategies to mitigate them, and suggested revised language, so that the Association may work with other stakeholders to accomplish these tasks in a more effective and efficient manner. Finally, testimony noted that such costs apply to interviews for fellowships as well, so a language and title change is recommended to reflect this aspect. Accordingly, your Reference Committee recommends adoption of Resolution 308 as amended.

(19) RESOLUTION 310 - MITIGATION OF PHYSICIAN PERFORMANCE METRICS ON TRAINEE AUTONOMY AND EDUCATION

RECOMMENDATION:

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

MITIGATION OF PHYSICIAN PERFORMANCE METRICS ON TRAINEE EDUCATION

RESOLVED, That our AMA ask the Accreditation Council for Graduate Medical Education and other organizations to use data to evaluate the impact of supervising physicians' performance metrics on trainees' learning experience. (Directive to Take Action)

Resolution 310 asks that our AMA assess ways to mitigate the negative effects of physician performance metrics on trainee autonomy and clinical experience during residency and fellowship training.

Your Reference Committee heard limited but favorable testimony on this item. To ensure the highest quality of medical practice, resident/fellow physicians need to obtain adequate clinical experiences in supervised settings so that they are ready to practice independently upon graduation from residency. The Council on Medical Education was supportive of the resolution, but called for substitute language, due to variation in residency/fellowship programs. For those programs accredited by the Accreditation Council for Graduate Medical Education, the applicable ACGME Residency Review Committee would be the appropriate entity to ensure trainees' experiences are not negatively affected by performance metrics. This would not be the case, however, for non-ACGME-accredited fellowship programs. Therefore, your Reference Committee recommends adoption of Substitute Resolution 310.

(20) RESOLUTION 313 - HUMAN TRAFFICKING REPORTING AND EDUCATION

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 313 be amended by deletion of the first resolve.

~~RESOLVED, That our American Medical Association work with the Association of American Medical Colleges and the Liaison Committee on Medical Education on the formal education of medical professionals on identifying and managing victims of human trafficking as they enter the healthcare system that will cover the role of the medical professional in: i) the social impact of human trafficking, ii) screening and identifying victims, iii) first response to identified victims, iv) communication and trust building skills with victims, v) understanding the effects of trauma on the brain including PTSD and trauma bonding, vi) current state and federal laws in place for victims, vii) visa status for victims, and viii) community and national resources to help victims receive proper care during the process of reintegration into society (Directive to Take Action); and be it further~~

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the second resolve of Resolution 313 be amended by addition and deletion, to read as follows:

RESOLVED, that our AMA help encourage the education of physicians about human trafficking and how to report cases of suspected human trafficking to appropriate~~local law enforcement~~ authorities ~~and national hotlines in consultation with their institutional guidelines in order~~ to

provide a conduit to resources to address the victim's medical, legal and social needs. (Directive to Take Action)

RECOMMENDATION C:

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

Resolution 313 asks that our AMA 1) work with the Association of American Medical Colleges and the Liaison Committee on Medical Education on the formal education of medical professionals on identifying and managing victims of human trafficking as they enter the healthcare system that will cover the role of the medical professional in: i) the social impact of human trafficking, ii) screening and identifying victims, iii) first response to identified victims, iv) communication and trust building skills with victims, v) understanding the effects of trauma on the brain including PTSD and trauma bonding, vi) current state and federal laws in place for victims, vii) visa status for victims, and viii) community and national resources to help victims receive proper care during the process of reintegration into society; and 2) help encourage the education of physicians about how to report cases of suspected human trafficking to local law enforcement authorities and national hotlines in consultation with their institutional guidelines in order to provide a conduit to resources to address the victim's medical, legal and social needs.

Your Reference Committee heard unanimous testimony in support of increased awareness among physicians of human trafficking, a $32 billion global industry, but there were significant concerns that the actions in the first resolve were outside the purview of physicians, and that this resolve constitutes a curricular mandate. Therefore, your Reference Committee recommends adoption as amended.

(21) RESOLUTION 314 - MAINTENANCE OF CERTIFICATION AND CONTINUING EDUCATION

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Substitute Resolution 314 be adopted in lieu of Resolution 314.

RESOLVED, That our AMA encourage medical specialty societies' leadership to work with the ABMS, and their member specialty boards, to identify those specialty organizations that have developed an appropriate and relevant MOC process for its members (Directive to Take Action).

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Policy H-275.924 be amended, to read as follows:

H-275.924 Maintenance of Certification
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 each 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 permit 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 would not be 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. The AMA affirms the current language regarding continuing medical education (CME): "By 2011, each Member Board will document that diplomates are meeting the CME and Self-Assessment requirements for MOC Part 2. 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 Physician’s Recognition Award (PRA) Category 1, American Academy of Family Physicians Prescribed, American College of Obstetricians and Gynecologists, and or American Osteopathic Association Category 1A)." 10. MOC is an essential but not sufficient component to promote patient-care safety and quality.

Health care is a team effort and changes to MOC should not create an unrealistic expectation that failures in patient safety are primarily failures of individual physicians. 11. 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. 12. The MOC process should be evaluated periodically to measure physician satisfaction, knowledge uptake and intent to maintain or change practice. 13. MOC should be used as a tool for continuous improvement. 14. The MOC program should not be a mandated requirement for licensure, credentialing, reimbursement, network participation, or employment. 15. Actively practicing physicians should be well-represented on specialty boards developing MOC. 16. MOC activities and measurement should be relevant to clinical practice. 17. The MOC process should not be cost prohibitive or present barriers to patient care. 18. Any assessment tests should be used to guide physicians' self-directed CME study, and should never be punitive. 19. Specific content-based feedback after any assessment tests should be provided to physicians in a timely manner so physicians know what they got wrong and why, and utilize the information in a beneficial manner. 20. There should be multiple options for how an assessment could be structured to accommodate different learning styles.

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that Policy H-274.924 be adopted as amended.

Resolution 314 asks that AMA Policy H-275.924, Principles on Maintenance of Certification (MOC), be amended by addition to include the following: Board Certification once attained, should be "lifelong" for physicians; Testing organizations' Boards should be constituted with, at a minimum, 50% of their members being physicians engaged in active practice - defined as actively seeing patients for more than 50% of their professional time in practice; Minimum CME requirements should be reasonably set and used as a replacement for the current proposed modules, enabling physicians to self-direct their learning; Any assessment tests should be used to guide physicians' self-directed CME study, and should never be punitive, thereby eliminating the need for a "secure exam"; Specific content-based feedback after any assessment tests should be provided to physicians in a timely manner so physicians know what they got wrong and why, and utilize the information in a beneficial manner; There should be multiple options for how an assessment could be structured to accommodate different learning styles. The resolution also asks that our AMA directly communicate all of the Principles in AMA Policy H-275.924, as amended, to the American Board of Medical Specialties (ABMS), and all member specialty boards, and actively seek their support thereof; that our AMA work with the ABMS and collectively

become actively engaged in the monitoring of board/testing stakeholder organizations to assure they are supporting physician practices not impeding it; that our AMA encourage state medical societies' leadership to work with the ABMS, and their member specialty boards, to identify those specialty organizations that have developed an appropriate and relevant MOC process for its members; and that our AMA communicate its belief that American Board of Internal Medicine Foundation funds should be mobilized for use by the physicians that funded it.

Your Reference Committee heard mixed testimony regarding Resolution 314. Our AMA has extensive policy to support the principles of MOC, and the Council on Medical Education is working with the ABMS and its member boards to streamline the MOC Part III high-stakes secured exam and make it relevant to practice. CME Report 2, Update on Maintenance of Certification and Osteopathic Continuous Certification, provides an update on a number of innovations being tested by the ABMS member boards to improve this process. The report also reviews how the member boards are working with medical specialty societies to develop educational curricula and provide resources to support physician professional development. The Council will continue to work with the ABMS, the American Osteopathic Association, and their respective member boards to identify and suggest improvements to the MOC and OCC programs and ensure that MOC and OCC support physicians' ongoing learning and practice improvement. Your Reference Committee therefore recommends that Substitute Resolution 314 be adopted in lieu of Resolution 314.

(22) RESOLUTION 315 - OBESITY EDUCATION
RESOLUTION 326 - OBESITY EDUCATION IN MEDICAL SCHOOLS AND RESIDENCY PROGRAMS

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Substitute Resolution 315 be adopted in lieu of Resolutions 315 and 326.

OBESITY EDUCATION

RESOLVED, That our American Medical Association (AMA) study and report back on the current state of obesity education in medical schools. (Directive to Take Action)

RESOLVED, That our AMA, through this report, identify organizations that currently provide educational resources/toolkits regarding obesity education for physicians in training. (Directive to Take Action)

Resolution 315 asks that our AMA 1) with the AAMC, COCA, the LCME and other interested parties, study and report back on the current state of obesity education in medical schools; 2) with the AAMC, COCA, the LCME, and other interested parties, research and define a minimum recommended knowledge base for a physician in

training to be consider competent in regards to obesity; and 3) with appropriate interested parties, create a toolkit regarding obesity education for physicians in training.

Resolution 326 asks that our AMA 1) create a report on the current state of obesity education in medical schools; 2) research and define a minimum recommended knowledge base for a physician in training to be considered competent in the prevention, diagnosis and treatment of disease; and 3) create a model curriculum regarding obesity for medical schools to ensure that all individuals receive the same standard of care, regardless of their weight.

Your Reference Committee heard testimony in support of educating physicians on the topic of obesity. AMA policy recognizes obesity as a disease and as a major public health problem. However, many medical societies, such as the American Academy of Pediatrics, already make toolkits available to physicians. Furthermore, our AMA (Council on Medical Education and Section on Medical Schools) generally oppose curricular mandates. Therefore, your Reference Committee recommends Substitute Resolution 315 be adopted in lieu of Resolutions 315 and 326.

(23) RESOLUTION 324 - PROPOSING CHANGES TO PUBLIC SERVICE LOAN FORGIVENESS

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the second resolve of Resolution 324 be amended by addition and deletion, to read as follows:

RESOLVED, That our AMA work with the United States Department of Education to ensure that any cap on loan forgiveness under the Public Service Loan Forgiveness program be at least equal to the principal amount borrowed~~; leaving any accrued interest the responsibility of the borrower~~; (Directive to Take Action); and be it further

RECOMMENDATION B:

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

Resolution 324 asks that our AMA (1) advocate for maintaining a variety of student loan repayment options to fit the diverse needs of graduates; (2) work with the United States Department of Education to ensure that any cap on loan forgiveness under the Public Service Loan Forgiveness program be equal to the principal amount borrowed; and (3) ask the United States Department of Education to include all terms of Public Service Loan Forgiveness in the contractual obligations of the Master Promissory Note.

Your Reference Committee heard testimony in favor of this item. The author of the resolution noted that the Department of Education currently offers a number of loan repayment options, each with specific advantages and disadvantages, but these

different options are in danger of being consolidated into one plan through the administrative rulemaking process, which is under way. This could have negative repercussions for nontraditional medical students. Accordingly, it is timely that this issue is being considered now, and wise for our AMA to have policy on this topic. Other testimony raised concerns about Resolve 2 and the amount of "skin in the game" for a given loan recipient. Your Reference Committee believes its proferred revisions would address these concerns and therefore recommends adoption of Resolution 324 as amended.

(24) RESOLUTION 301 - ALERTING PHYSICIANS TO DEADLINES FOR MAINTENANCE OF CERTIFICATION

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 301 be referred.

Resolution 301 asks that our AMA 1) continue to work with the American Board of Medical Specialties (ABMS) to ensure that physicians are clearly informed of the maintenance of certification requirements for their specific board and the timelines for accomplishing those requirements; and 2) encourage the ABMS and its member boards to develop a system to actively alert physicians to the due dates of the multi-stage requirements of continuous professional development and performance in practice, thereby assisting them with maintaining their board certification.

Your Reference Committee heard mixed testimony on this item. It is important that MOC participants be informed about the due dates of the multi-stage requirements of MOC. However, ABMS standards state that the individual ABMS member boards have the responsibility of using "reasonable means" to inform diplomates of the timelines for accomplishing specific MOC requirements, and in most cases they provide notifications. The Council on Medical Education will explore this issue and provide an update in its next mandated update report to the House of Delegates. Therefore, your Reference Committee recommends that Resolution 301 be referred for further study.

(25) RESOLUTION 302 - RE-EVALUATING KNOWLEDGE ASSESSMENT IN MAINTENANCE OF CERTIFICATION

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 302 be referred.

Resolution 302 asks that our AMA work with the American Board of Medical Specialties to streamline and improve the Cognitive Expertise (Part III) component of Maintenance of Certification, including the exploration of alternative formats, in ways that effectively evaluate acquisition of new knowledge while reducing or eliminating the burden of a high-stakes examination.

Your Reference Committee heard mixed testimony regarding this item. As noted in CME Report 2, Update on Maintenance of Certification and Osteopathic Continuous Certification, the Council on Medical Education has been working with the ABMS and its member boards to explore alternatives to the secure, high-stakes examination for assessing knowledge and cognitive skills. The Council will continue to explore this issue and provide an update in their next mandated update report to the House of Delegates. Therefore, your Reference Committee recommends that Resolution 302 be referred for further study.

(26) RESOLUTION 312 - MODEL GUIDELINES FOR EXPANSION OF RESIDENCY PROGRAMS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 312 be referred.

Resolution 312 asks that our AMA facilitate a working group that includes the International Medical Graduates Section, Medical Student Section, Resident and Fellow Section, Section on Medical Schools, Council on Medical Education and other stakeholders, with the charge for creating model guidelines for expansion of existing residency programs, with funding support from non-federal donors.

Your Reference Committee heard testimony in favor of referral of Resolution 312. The Council on Medical Education described its work on a report for the I-15 meeting, stemming from referral of Resolution 931-I-14, which will summarize existing funding streams for graduate medical education, provide examples of and new models for alternative funding sources, and outline principles to ensure quality of training and patient safety. Because this work is already in process, and can be modified to reflect the intent of Resolution 312, your Reference Committee recommends referral.

(27) RESOLUTION 318 - MAINTENANCE OF CERTIFICATION

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 318 be referred.

Resolution 318 asks that our AMA 1) congratulate the American Board of Medical Specialties (ABMS) and its member Boards on their century of service to our profession and our patients; and 2) engage the ABMS and member Boards to conduct an independent, external review process to examine the performance and impact of Board policies, procedures, organizational structure and governance.

Your Reference Committee heard limited testimony regarding this resolution. It is not our AMA's role to oversee the ABMS member boards, and as such our AMA should not be involved in any process to review ABMS member board policies, procedures, organizational structure, and governance processes. There are also concerns about an

external reviewer outside the medical profession; this type of action is not warranted at this time, and furthermore, this is the purview of the ABMS. The Council on Medical Education will continue to explore this issue and provide an update in its next mandated update report to the House of Delegates. Therefore, your Reference Committee recommends that Resolution 318 be referred for further study.

(28) RESOLUTION 321 - VALUE OF RESIDENTS AND FELLOWS TO THE HEALTH CARE SYSTEM
RESOLUTION 327 - ACHIEVING TRANSPARENCY THROUGH GRADUATE MEDICAL EDUCATION FUNDING
RESOLUTION 328 - EVALUATION OF RESIDENT AND FELLOW COMPENSATION LEVELS
RESOLUTION 329 - PRINCIPLES OF GME FUNDING REFORM

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolutions 321, 327, 328, and 329 be referred.

Resolution 321 asks that our AMA 1) advocate that resident and fellow trainees should not be financially responsible for their training; and 2) evaluate and work to establish consensus regarding the appropriate value of resident and fellow services, and address this in upcoming reports regarding graduate medical education financing.

Resolution 327 asks that our AMA 1) reaffirm D-305.967 and continue to advocate for the preservation, stability and expansion of full funding for the direct and indirect costs of graduate medical education (GME) positions; 2) support combining Indirect Graduate Medical Education into the Direct Graduate Medical Education payments into a single, transparent funding stream; 3) support that Medicare's Graduate Medical Education funding be a per-resident federal allocation that is adjusted according to solely geographic measures, such as cost-of-living; and 4) support that the payment of Graduate Medical Education funding being directed to the designated residency GME office, in lieu of the hospital system, to be allocated across the department(s), sites and other specialties to provide comprehensive training.

Resolution 328 asks that our AMA 1) develop recommendations for appropriate protections and increases to resident and fellow compensation and benefits with input from residents, fellows, and other involved parties including residency and fellowship programs; 2) advocate that resident and fellow trainees should not be financially responsible for their training; and 3) evaluate and work to establish consensus regarding the appropriate economic value of resident and fellow services, and address this in upcoming reports regarding graduate medical education financing.

Resolution 329 asks that our AMA 1) supports that federal funding for Graduate Medical Education should be based on the actual costs to train and educate a resident/fellow (including but not limited to salary and benefits and institutional support for training and education) including yearly adjustments for geographic and inflation-based cost-of-living;

2) supports that the allocation of Graduate Medical Education funds within an institution should be transparent and accountable to all stakeholders; 3) support that federal funding for Graduate Medical Education should strive to meet the health needs of the public including but not limited to size of the training program, geographic distribution, and specialty mix; 4) support that federal funding for Graduate Medical Education from the Centers for Medicare/Medicaid Services or any federal successors should be disbursed through a single transparent funding stream while maintaining opportunities for a multi-payor system; and 5) support additional federal funding for Graduate Medical Education that provides flexibility for innovation in training and education above and beyond current levels of funding.

Your Reference Committee heard mixed testimony on these four items, which are inter-related and cover similar topics. This highlights the complexity of the issues they raise and the potential unintended consequences they may present (i.e., a "slippery slope" that moves the dialogue on GME away from an educational focus to a service and bottom-line focus). It is inarguable that the substantial and still rising debt load on graduating medical students and resident/fellow physicians is reaching crisis proportions, and our AMA should formulate a feasible, long-range solution that takes into account all the moving parts of this complex puzzle. The first step would be to quantify the extent of the problem, and the true value of resident/fellow services (one estimate cited in testimony pegs the number at approximately $150,000 per year, according to a fall 2014 *Health Affairs* study). Adoption of policy through these resolutions, three of which were immediately forwarded to this Annual Meeting, may ultimately be less helpful than a more reasoned, circumspect approach, through referral to the appropriate AMA organ for a full review and subsequent report. Indeed, a considerable amount of the testimony on these items urged referral, including that of the Council on Medical Education. Due to the many questions raised in consideration of these items, and uncertainty as to how these broad changes might impact GME funding and related issues, your Reference Committee believes that these issues must be studied in more detail before being adopted as new policy, and therefore recommends referral.

(29) RESOLUTION 330 - TELEMEDICINE IN GRADUATE MEDICAL EDUCATION

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 330 be <u>referred</u>.

Resolution 330 asks that our AMA 1) advocate for educating resident and fellow physicians during their training on the use of telehealth technology in their future practices, and 2) study the barriers to optimizing the use of telehealth technology for the purposes of tele-education and specifically tele-precepting in Graduate Medical Education and the solutions to overcoming these barriers.

Your Reference Committee heard testimony in favor of studying the barriers to optimizing the use of telehealth technology for the purposes of tele-education and, especially, tele-precepting in graduate medical education, but also heard testimony opposed to creating a curricular mandate in GME on the subject. In addition, aspects of

this topic are outside the purview of the AMA, such that collaboration with an outside stakeholder(s) may be appropriate. Therefore, your Reference Committee recommends referral.

(30) RESOLUTION 309 - MAINTENANCE OF CERTIFICATION

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 309 not be adopted.

Resolution 309 asks that our AMA advocate for a moratorium on the maintenance of certification requirements of all medical and surgical specialties until it has been reliably shown that these programs significantly improve patient care.

Your Reference Committee heard limited but mixed testimony on this item. The process of MOC contains many elements, and suspension of the entire program would include removal of components such as continuing medical educaton and the fulfillment of licensing requirements. Also, a moratorium would affect all 24 ABMS member boards, even though a number of these boards are not the source of the problem. Further, as noted in the testimony, there are studies that show the process can and should be improved, but “reliably shown” and “significantly improve patient care” are terms that are too vague to provide appropriate direction for ongoing MOC research and process improvement. Therefore, your Reference Committee recommends that Resolution 309 not be adopted.

(31) RESOLUTION 317 - PROTECT PHYSICIAN CERTIFICATION AND LICENSURE

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 317 not be adopted.

Resolution 317 asks that our AMA seek legislation that would prohibit hospitals, all employers, regulatory agencies, all third-party payers, insurers, Medicare, Medicaid and other entities, from requiring physicians to participate in prescribed corporate programs including Maintenance of Certification or expiration of time-limited Maintenance of Certification, and from discriminating against physicians economically through various fee schedules.

Your Reference Committee heard limited mixed testimony regarding this resolution. Our AMA has extensive policy opposing mandated board certification, recertification, specialty recertification, and maintenance of certification for licensure, reimbursement, credentialing, network participation, or employment. Seeking federal legislation to enforce existing policy would divert AMA focus and resources away from strategic issues such as funding of graduate medical education, improving public health, standards of care in telemedicine, coordinated care and new delivery models, medical liability reform,

and expanding coverage for the uninsured. Therefore, your Reference Committee recommends that Resolution 317 not be adopted.

(32) RESOLUTION 320 - POST-ACUTE AND LONG-TERM CARE EDUCATION REQUIREMENT

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 320 not be adopted.

Resolution 320 asks that our AMA support a mandatory minimum exposure to the post-acute and long-term care setting in undergraduate and graduate medical education.

Your Reference Committee heard limited testimony in opposition to this item, despite its importance as a topic area, because it constitutes a curricular mandate, which the AMA generally opposes. Your Reference Committee therefore recommends that our AMA not adopt Resolution 320.

(33) RESOLUTION 322 - BOARD OF MEDICINE SANCTIONS AND FINES

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 322 not be adopted.

Resolution 322 asks that our AMA work with the Federation of State Medical Boards to study the various sanctions, fines, and monitoring procedures applied on a state-by-state basis to physicians under investigation and/or disciplinary action.

Your Reference Committee heard unanimous testimony in opposition of this item (with the exception of the resolution's author). Testimony reflected that the results of such a study might be interesting, but it is unclear what purpose these data would serve. This work might also be seen as an attempt to usurp state roles in this regard, and the AMA has policy against national licensure. Therefore, your Reference Committee recommends that Resolution 322 not be adopted.

(34) RESOLUTION 325 - BROADEN CONFLICT OF INTEREST DISCLOSURE

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 325 not be adopted.

Resolution 325 asks that our AMA work with the Accreditation Council for Continuing Medical Education and the American Osteopathic Association pertaining to any continuing medical education programming to broaden their required conflict of interest

disclosure and management of conflict of interest to include all forms of funding, including, but not limited to: employers, corporations, drug companies, governmental entities (e.g., National Institutes of Health), foundations, speakers' bureaus, speaking engagements, and universities.

Your Reference Committee heard nearly unanimous testimony in opposition to this item (with the exception of the author). Testimony was appreciative of the intent of this item, and appropriate reporting of conflict is needed, but it was strongly felt that this resolution was overly broad, such that physicians might be loath to undertake a CME program. Further, data on funding from many of the entities named in the resolution are already publicly available. Therefore, your Reference Committee recommends that Resolution 325 not be adopted.

(35) RESOLUTION 306 - INCLUDING MILITARY HISTORY AS PART OF STANDARD HISTORY TAKING

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Policy H-295.874 be reaffirmed in lieu of Resolution 306.

Resolution 306 asks that our AMA (1) encourage the universal inclusion of military history in the standard history taking of all adults in civilian healthcare settings; and (2) support the addition of military history training to undergraduate, graduate, and continuing medical education and the continued refinement of existing screening resources.

Your Reference Committee heard mixed testimony on this item. There was general support for physicians asking about a patient's military history, and a military history is viewed as an element of a good social history. Significant questions were raised, however, about whether it was necessary to develop policy on this matter. For this reason, your Reference Committee recommends reaffirmation of Policy H-295.874.

Policy recommended for reaffirmation:

H-295.874 Educating Medical Students in the Social Determinants of Health and Cultural Competence
Our AMA: (1) Supports efforts designed to integrate training in social determinants of health and cultural competence across the undergraduate medical school curriculum to assure that graduating medical students are well prepared to provide their patients safe, high quality and patient-centered care. (2) Supports faculty development, particularly clinical faculty development, by medical schools to assure that faculty provide medical students' appropriate learning experiences to assure their cultural competence and knowledge of social determinants of health. (3) Supports medical schools in their efforts to evaluate the effectiveness of their social determinants of health and cultural competence teaching of medical students, for example by the AMA serving as a convener of a consortium of interested medical schools to develop Objective Standardized Clinical Exams for use in evaluating medical students' cultural competence. (4) Will conduct ongoing data gathering, including interviews with medical

students, to gain their perspective on the integration of social determinants of health and cultural competence in the undergraduate medical school curriculum. (5) Recommends studying the integration of social determinants of health and cultural competence training in graduate and continuing medical education and publicizing successful models. (CME Rep. 11, A-06; Reaffirmation A-11; Modified in lieu of Res. 908, I-14)

(36) RESOLUTION 311 - SELECTING RESIDENTS TO BETTER REFLECT PATIENT DIVERSITY

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Policy H-350.960, H-350.969, and H-350.970 be reaffirmed in lieu of Resolution 311.

Resolution 311 asks that our AMA advocate that the criteria used for selecting residents have greater emphasis and consideration placed on qualitative and demographic characteristics of resident candidates in order to train a more diverse and culturally, competent physician workforce that better reflects the diversity of the U.S. patient population.

Your Reference Committee heard testimony in favor of the sentiment of this item, but that the residency selection process is too late in the pipeline to have any real impact on the diversity of the physician workforce. Residency program directors cannot be responsible for increasing the diversity of the physician workforce single-handedly, as they can only select from the product before them; further, the structure of the Match doesn't ensure that the applicant they want is the one they will get. Efforts in the premedical arena are where work to increase physician diversity should be focused (for example, through the AMA's Doctors Back to School program). The AMA already has significant policy in this regard, so your Reference Committee recommends reaffirmation of these policies in lieu of Resolution 311.

Policy recommended for reaffirmation:

H-350.960 Underrepresented Student Access to US Medical Schools
Our AMA: (1) recommends that medical schools should consider in their planning: elements of diversity including but not limited to gender, racial, cultural and economic, reflective of the diversity of their patient population; and (2) supports the development of new and the enhancement of existing programs that will identify and prepare underrepresented students from the high-school level onward and to enroll, retain and graduate increased numbers of underrepresented students. (Res. 908, I-08)

H-350.969 Medical Education for Members in Underserved Minority Populations
Our AMA: (1) actively opposes the reduction of resources and opportunities used to increase the number of minority medical and premedical students in training; (2) uses its influence in states and local communities to increase the representation of minority group members in medical education, as long as domestic health care disparities exist between minority populations and the greater population at-large; and (3) supports the need for an increase in the participation of under-represented minorities as investigators,

trainees, reviewers, and subjects in peer review biomedical research at all levels. (Sub. Res. 316, A-99; Reaffirmed CME Rep. 8, I-99; Reaffirmed: CME Rep. 2, A-09)

H-350.970 Diversity in Medical Education
Our AMA will: (1) request that the AMA Foundation seek ways of supporting innovative programs that strengthen pre-medical and pre-college preparation for minority students; (2) support and work in partnership with local state and specialty medical societies and other relevant groups to provide education on and promote programs aimed at increasing the number of minority medical school admissions; applicants who are admitted; and (3) encourage medical schools to consider the likelihood of service to underserved populations as a medical school admissions criterion. (BOT Rep. 15, A-99; Reaffirmed: CME Rep. 2, A-09)

Mr. Speaker, this concludes the report of Reference Committee C. I would like to thank Ricardo Correa, MD, Ben Durkee, MD, Gary R. Figge, MD, Lynn LC Jeffers, MD, Cynthia Jumper, MD, Thomas G. Peters MD, and all those who testified before the Committee.

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