DISCLAIMER

The following is a preliminary report of actions taken by the House of Delegates at its 2013 Interim 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 (I-13)

## Report of Reference Committee K

Kenneth M. Certa, MD, Chair

---

Your Reference Committee recommends the following consent calendar for acceptance:

**RECOMMENDED FOR ADOPTION**

1. Council on Medical Education Report 1 – Update on Expanding Access to Clinical Training Sites for Medical Students
2. Council on Science and Public Health Report 2 – A Contemporary View of National Drug Control Policy
3. Resolution 916 – Support Stricter OSHA Silica Permissible Exposure Limit Standard
4. Resolution 922 – Examining the Changing Nature of U.S. Medical Residencies

**RECOMMENDED FOR ADOPTION AS AMENDED OR SUBSTITUTED**

5. Board of Trustees Report 3 – A More Uniform Approach to Assessing Patients for Controlled Substances for Pain Relief
6. Council on Science and Public Health Report 1 – Inclusion of Supplement Purchases in Nutritional Assistance Programs
7. Resolution 903 – Gun Safety Counseling in Undergraduate Medical Education
8. Resolution 904 – Evaluation of Standardized Clinical Skills Exams
9. Resolution 905 – Athlete Concussion Management and Chronic Traumatic Encephalopathy Prevention
10. Resolution 906 – Increasing Healthcare Access for the Underserved
11. Resolution 907 – Modern Chemical Controls Policy
12. Resolution 911 – Promoting Health Awareness and Preventive Screenings in Individuals with Disabilities
13. Resolution 912 – Crisis in Medication Shortages
14. Resolution 915 – Ask the Joint Commission to Reevaluate the Pain Scale of Patients
15. Resolution 917 – Culturally, Linguistically Competent Mental Health Care and Outreach for At-Risk Communities
16. Resolution 921 – Gun Violence

**RECOMMENDED FOR REFERRAL**

17. Resolution 913 – Pre-Medical School Shadowing

18. Resolution 914 – Change Rural and Off Site Rural Training Track Requirements in Order to Preserve and Encourage Interest in Rural Residency Programs
19. Resolution 923 – CMS Definition of “Resident Physician”

.

**RECOMMENDED FOR REAFFIRMATION IN LIEU OF**

20. Resolution 902 – Medical Ethics Guidelines for Undergraduate Medical Education
21. Resolution 919 – High Cost of Recertification
22. Resolution 920 – Telemedicine Licensure

Resolutions handled via the Reaffirmation Consent Calendar:
Resolution 908 – Hydraulic Fracturing
Resolution 918 – HIV Screening, Continuum of Care and Maintenance of Funding

(1) COUNCIL ON MEDICAL EDUCATION REPORT 1 - UPDATE ON EXPANDING ACCESS TO CLINICAL TRAINING SITES FOR MEDICAL STUDENTS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the recommendations in Council on Medical Education Report 1 be adopted and the remainder of the report filed.

**HOD ACTION: Council on Medical Education Report 1 adopted and the remainder of the report filed.**

Council on Medical Education Report 1 studies the issue of limiting international medical student clerkship rotations to a maximum of 12 weeks. It recommends that our AMA:

(1) reaffirm Policy H-255.988, "Foreign Medical Graduates," which supports the concept that the core curriculum of a foreign medical school should be provided by that school and that U.S. hospitals should not provide substitute core clinical experience for students attending a foreign medical school, and which states that the AMA does support US teaching hospitals and foreign medical educational institutions entering into appropriate relationships directed toward providing clinical educational experiences for advanced medical students who have completed the equivalent of US core clinical clerkships;

(2) reaffirm Policy D-295.931(1), "Update on the Availability of Clinical Training Sites for Medical Student Education," which directs the AMA to work with appropriate stakeholders to (a) study options to require that students from international medical schools who desire to take clerkships in U.S. hospitals come from medical schools that are approved by an independent or private organization, such as the Liaison Committee on Medical Education (LCME), using principles consistent with those used to accredit US medical schools; (b) advocate for regulations that will assure that international students taking clinical clerkships in U.S. medical schools come from approved medical schools that assure educational quality that promotes patient safety; and (c) advocate that any institution that accepts students for clinical placements be required to assure that all such students are trained in programs that meet requirements for curriculum, clinical experiences and attending supervision as expected for LCME and American Osteopathic Association accredited programs;

(3) reaffirm Policies D-295.931(4), "Update on the Availability of Clinical Training Sites for Medical Student Education," and D-295.320(4), "Factors Affecting the Availability of Clinical Training Sites for Medical Student Education," which direct the AMA to oppose any arrangements of U.S. medical schools or their affiliated hospitals that allow the presence of visiting students to disadvantage their own students educationally or financially, and to advocate for federal and state legislation or regulations to oppose any extraordinary compensation for clinical clerkship sites by medical schools or other clinical programs that would result in displacement or otherwise limit the training opportunities of U.S. LCME/Commission on Osteopathic College Accreditation (COCA) students in clinical rotations;

(4) reaffirm Policy D-295.320(2), "Factors Affecting the Availability of Clinical Training Sites for Medical Student Education," which directs the AMA to encourage medical schools and the rest of the medical community within states or geographic regions to engage in collaborative planning to create additional clinical education resources for their students;

and (5) rescind Policy D-295.320(6), "Factors Affecting the Availability of Clinical Training Sites for Medical Student Education," since that has been accomplished through this report.

Your Reference Committee heard testimony in favor of this report. The availability of clinical teaching sites and faculty to support the educational needs of medical students is a matter of ongoing and serious concern, especially as the number of U.S. medical school graduates continues to rise. Some non-U.S. medical schools pay U.S. hospitals to provide clinical training for their students; these monies are particularly attractive to financially distressed teaching hospitals. The educational experience of U.S. students, however, may be compromised by their having to compete for faculty attention and access to patients with students from non-U.S. schools. The report's recommendations support the AMA's continuing work to ensure appropriate availability of clinical resources for medical students. Some concern was expressed that the report reaffirms current AMA policy but does not address some deeper systemic issues. Therefore, future AMA reports on this issue should consider a number of concerns that were raised in the testimony, including transparency of payments by non-U.S. schools to U.S. teaching hospitals, availability of federal funding for U.S. citizens attending non-U.S. schools, the quality of non-U.S. versus that of U.S. medical schools, and attrition and graduation rates of non-U.S. students and their success rate in matching to U.S. residency programs and ultimately practicing in medicine.

(2) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT 2 - A CONTEMPORARY VIEW OF NATIONAL DRUG CONTROL POLICY

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the recommendations in Council on Science and Public Health Report 2 be adopted and the remainder of the report filed.

**HOD ACTION: Council on Science and Public Health Report 2 adopted and the remainder of the report filed.**

Council on Science and Public Health Report 2 evaluates individual, societal, and public health related issues around federal drug control policies, the so-called "war on drugs," state-based cannabis activities, drug decriminalization/legalization, and the intersection of illicit and prescription drug abuse. It recommends:

(1) that Policies H-95.995 and H-95.977 be amended by addition and deletion to read as follows:

H-95.995 ~~Health Aspects of~~ Cannabis ~~Marijuana~~ Use

Our AMA (1) discourages cannabis ~~marijuana~~ use, especially by persons vulnerable to the drug's effects and in high-risk situations; (2) supports the determination of the consequences of long-term cannabis ~~marijuana~~ use through concentrated research, especially among youth and adolescents; and (3) supports the modification of state and federal laws to emphasize public health based strategies to address and reduce cannabis use ~~reduce the severity of penalties for possession of marijuana; (4) urges that educational efforts on the harms of cannabis use be extended to all segment of the population~~.

H-95.997 ~~Marijuana~~ Cannabis Intoxication as a Criminal Defense
Our AMA: ~~(1) recommends personal possession of insignificant amounts of that substance be considered a misdemeanor with commensurate penalties applied;~~ (~~21~~) believes a plea of cannabis intoxication not be a defense in any criminal proceedings~~; and (32) urges that educational efforts be expanded to all segments of the population.~~ (BOT Rep. J, A-72; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CSAPH Rep. 1, A-10);

(2) that Policy H-95.981 be amended by addition and deletion to read as follows:

H-95.981 Federal Drug Policy ~~Drug Abuse~~ in the United States ~~- A Policy Report~~
The AMA, in an effort to reduce personal and public health risks of drug abuse, urges the formulation of a comprehensive national policy on drug abuse, specifically advising that the federal government and the nation should: (1) ~~encourage recognition that~~ acknowledge that federal efforts to address illicit drug use via ~~at~~ supply reduction and enforcement have been ineffective ~~should be accompanied by increased efforts to reduce the demand for illicit drugs; (2) renew and expand federal leadership to reduce the demand for illicit drugs; (3~~2) expand the availability and reduce the cost of treatment programs for substance use disorders, including addiction~~, including treatment on demand for intravenous drug abusers~~; (~~4~~3) lead a coordinated approach to adolescent drug education; (~~5~~4) develop community-based prevention programs for youth at risk; (~~6~~5) continue to fund the Office of National Drug Control Policy ~~appoint a high ranking official of the Executive Branch~~ to coordinate federal drug policy; (~~7) encourage a variety of private initiatives and carefully evaluate the use of limited workplace drug testing; (8~~6) extend greater protection against discrimination in the employment and provision of services to drug abusers; (~~9~~7) make a long-term commitment to expanded research and data collection; (~~10~~8) broaden the focus of national and local policy from drug abuse to substance abuse; and (~~11~~10) recognize the complexity of the problem of substance abuse and oppose drug legalization. (BOT Rep. NNN, A-88; Reaffirmed: CLRPD 1, I-98; Reaffirmed: CSAPH Rep. 2, A-08);

(3) that Policy H-95.954 be amended by addition and deletion to read as follows:

H-95.954 The Reduction of Medical and Public Health Consequences of Drug Abuse
Our AMA: (1) encourages national policy-makers to pursue an approach to the problem of drug abuse aimed at preventing the initiation of drug use, aiding those who wish to cease drug use, and diminishing the adverse consequences of drug use; (2) encourages policy-makers to recognize the importance of screening for alcohol and other drug use in a variety of settings, and to broaden their concept

of addiction treatment to embrace a continuum of modalities and goals, including appropriate measures of harm reduction, which can be made available and accessible to enhance positive treatment outcomes for patients and society; (3) encourages the expansion of opioid maintenance programs so that opioid maintenance therapy can be available for any individual who applies and for whom the treatment is suitable. Training must be available so that an adequate number of physicians are prepared to provide treatment. Program regulations should be strengthened so that treatment is driven by patient needs, medical judgment, and drug rehabilitation concerns. Treatment goals should acknowledge the benefits of abstinence from drug use, or degrees of relative drug use reduction; (4) encourages the extensive application of needle and syringe exchange and distribution programs and the modification of restrictive laws and regulations concerning the sale and possession of needles and syringes to maximize the availability of sterile syringes and needles, while ensuring continued reimbursement for medically necessary needles and syringes. The need for such programs and modification of laws and regulations is urgent, considering the contribution of injection drug use to the epidemic of HIV infection; (5) encourages a ~~the undertaking of~~ comprehensive review of the risks and benefits of U.S. state-based drug legalization initiatives, ~~research into the potential effects, both positive and adverse, of relaxing existing drug prohibitions and controls~~ and, that, until the findings of such reviews ~~such research~~ can be adequately assessed, the AMA reaffirm its opposition to drug legalization; (6) strongly supports the ability of physicians to prescribe syringes and needles to patients with injection drug addiction in conjunction with addiction counseling in order to help prevent the transmission of contagious diseases; and (7) encourages state medical associations to work with state regulators to remove any remaining barriers to permit physicians to prescribe needles for patients. (CSA Rep. 8, A-97; Reaffirmed: CSA Rep. 12, A-99; Appended: Res. 416, A-00; Reaffirmation I-00; Reaffirmed: CSAPH Rep. 1, A-10);

(4) that Policy H-95.998 be amended by addition and deletion to read as follows:

H-95.998 AMA Policy Statement on Cannabis ~~(Marijuana)~~

Our AMA believes that (1) cannabis is a dangerous drug and as such is a public health concern; (2) sale ~~and possession~~ of ~~marijuana~~ cannabis should not be legalized; (3) public health based strategies, rather than incarceration, should be utilized in the handling of individuals possessing cannabis for personal use~~handling of offenders should be individualized~~; and (4) additional research should be encouraged. (BOT Rep. K, I-69; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CSAPH Rep. 1, A-10; Reaffirmed in lieu of Res. 202, I-12);

and (5) that Policy H-95.952, “Cannabis for Medicinal Use,” be reaffirmed.

Testimony on Council on Science and Public Health Report 2 reflected the complex individual, societal, and public health issues around federal drug control policies, the potential legalization of cannabis, and state-based cannabis activities. Support was offered for the philosophical position that addressing illicit drug use, especially for cannabis, is best achieved by employing a public-health based approach that reduces individual harm from drug use while preserving the state’s interest in protecting the public from the adverse consequences of individual drug use. Other testimony supported

the view that the Council had not gone far enough, and that policy should at least be neutral on the issue of cannabis legalization given the shifts in state-based policies and public attitudes. Additionally, the term "criminal penalties" was offered as a substitute for "incarceration" in Recommendation 4, a change supportive of decriminalization. Your Reference Committee supports the general approach advocated by the Council on Science and Public Health and recommends adoption.

(3) RESOLUTION 916 - SUPPORT STRICTER OSHA SILICA PERMISSIBLE EXPOSURE LIMIT STANDARD

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 916 be adopted.

**HOD ACTION: Resolution 916 adopted.**

Resolution 916 asks that our American Medical Association (1) support the Department of Labor's Occupational Safety and Health Administration's (OSHA's) proposed rule to establish a stricter permissible exposure limit (PEL) for respirable crystalline silica; (2) support OSHA's proposed rule to establish a stricter standard of exposure assessment and medical surveillance requirements to identify adverse health effects in exposed populations of workers; and (3) submit comments, in collaboration with respiratory and occupational health medical societies, in support of a stricter silica PEL.

Testimony urged that the AMA formally support OSHA's proposed rule to reduce exposure to respirable crystalline silica in an effort to protect the health of workers. Your Reference Committee believes the health of workers is an important public health priority, and therefore supports adoption.

(4) RESOLUTION 922 - EXAMINING THE CHANGING NATURE OF U.S. MEDICAL RESIDENCIES

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 922 be adopted.

**HOD ACTION: Resolution 922 adopted.**

Resolution 922 asks that our AMA continue to study the effect of ever increasing match participants and the stagnant growth of U.S. residency positions with a report back at 2014 Annual Meeting. (Directive to Take Action)

Your Reference Committee heard testimony in support of this resolution and was informed that the Council on Medical Education is currently working on a report for A-14 regarding GME financing, which will also address this issue. Therefore, your Reference Committee recommends adoption so that this issue can be considered in the Council's A-14 report.

(5) BOARD OF TRUSTEES REPORT 3 - A MORE UNIFORM APPROACH TO ASSESSING PATIENTS FOR CONTROLLED SUBSTANCES FOR PAIN RELIEF

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Recommendation 1 in Board of Trustees Report 3 be amended by addition on line 7, to read as follows:

1. That our AMA consult with relevant Federation partners and consider developing by consensus a set of best practices to help inform the appropriate clinical use of opioid analgesics, including risk assessment and monitoring for substance use disorders, in the management of persistent pain.

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the recommendations in Board of Trustees Report 3 be adopted as amended and the remainder of the report filed.

**HOD ACTION: Board of Trustees Report 3 adopted as amended and the remainder of the report filed.**

Board of Trustees Report 3 reviews recent trends in patient harms attributed to prescription opioid analgesics, briefly addresses the issue of opioid associated overdoses and deaths, and reviews relevant American Medical Association (AMA) policy. It recommends (1) that our AMA consult with relevant Federation partners and consider developing by consensus a set of best practices to help inform the appropriate clinical use of opioid analgesics in the management of persistent pain; (2) that our AMA urge the Centers for Disease Control and Prevention to take the lead in promoting a standard approach to documenting and assessing unintentional poisonings and deaths involving prescription opioids, including obtaining more complete information on other contributing factors in such individuals, in order to develop the most appropriate solutions to prevent these incidents; and (3) that Policy H-120.960 be reaffirmed.

Testimony favored the recommendations in the report, noting the importance of efforts to develop best practices for the management of persistent pain, including conducting risk assessments for substance use disorders, including addiction. Additionally, it is essential that a public health-based approach be used to improve the management of patients with persistent pain in order to assure their safety and provide appropriate access to controlled substances while minimizing diversion and misuse. The Centers for Disease Control and Prevention is the chief reporting agency for data on unintentional doses and deaths attributable to opioid analgesics. A standard approach to documentation and assessment of presumed opioid-related poisonings and deaths is needed in order to craft solutions. Many contributory factors exist, including concomitant use of anxiolytics, sedative-hypnotics, drugs that influence cardiac conduction, etc. Your Reference

Committee believes the Board's recommendations are a step in the right direction, and recommends adoption as amended.

(6) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT 1 - INCLUSION OF SUPPLEMENT PURCHASES IN NUTRITIONAL ASSISTANCE PROGRAMS

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the recommendations in Council on Science and Public Health Report 1 be amended by the addition of second and third recommendations, to read as follows:

1. That our American Medical Association support improvements to the Supplemental Nutrition Assistance Program (SNAP) and Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) that are designed to promote adequate nutrient intake and reduce food insecurity and obesity. (New HOD Policy)

2. That our AMA reaffirm Policy D-150.985, which urges fortification of all grain products, including those that are corn-based, as a means to increase folic acid intake in all women of child-bearing age. (Reaffirm HOD Policy)

3. That our AMA reaffirm Policy H-440.898, which encourages education of women on the need to achieve adequate folic acid intake. (Reaffirm HOD Policy)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the recommendations in Council on Science and Public Health Report 1 be adopted as amended and the remainder of the report filed.

**HOD ACTION: Council on Science and Public Health Report 1 adopted as amended and the remainder of the report filed.**

Council on Science and Public Health Report 1 examines the potential inclusion of vitamin and mineral supplements as eligible items under the Supplemental Nutrition Assistance Program and the Special Supplemental Nutrition Program for Women, Infants, and Children. It recommends that our American Medical Association support improvements to the Supplemental Nutrition Assistance Program (SNAP) and Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) that are designed to promote adequate nutrient intake and reduce food insecurity and obesity.

Testimony was mostly supportive of the Council's recommendation, though testimony strongly underscored the importance of folic acid intake and the need to ensure that low-income women of child-bearing age are consuming the recommended daily dosage. The Council noted that the SNAP program has experienced recent funding cuts and that emphasis should be placed on maintaining the program's essential benefits for those who need them. The Council also stated that recent evidence suggests that fortification programs appear to be more effective than supplementation in increasing folic acid levels, and that current AMA policy, adopted as a result of its 2006 report, urges fortification of all grains products, including those that are corn-based. Existing AMA policy also supports education of women on the need to achieve adequate folate intake. Your Reference Committee supports the Council's current recommendation as well as an additional recommendation reaffirming policy urging fortification of all grain products.

Policies recommended for reaffirmation:

D-150.985 Folic Acid Fortification of Grain Products
Our AMA will: (1) urge the Food and Drug Administration to recommend folic acid fortification of all grains marketed for human consumption, including grains not carrying the "enriched" label; and (2) write letters to domestic and international producers of corn grain products, including masa, nixtamal, maize, and pozole, to advocate for folic acid fortification of such products. (CSAPH Rep. 6, A-06)

H-440.898 Recommendations on Folic Acid Supplementation
Our AMA will: (1) encourage the Centers for Disease Control and Prevention (CDC) to continue to conduct surveys to monitor nutritional intake and the incidence of neural tube defects (NTD); (2) continue to encourage broad-based public educational programs about the need for women of child-bearing potential to consume adequate folic acid through nutrition, food fortification, and vitamin supplementation to reduce the risk of NTD; (3) encourage the CDC and the National Institutes of Health to fund basic and epidemiological studies and clinical trials to determine causal and metabolic relationships among homocysteine, vitamins B12 and B6, and folic acid, so as to reduce the risks for and incidence of associated diseases and deficiency states; (4) encourage research efforts to identify and monitor those populations potentially at risk for masking vitamin B12 deficiency through routine folic acid supplementation of enriched food products; (5) urge the Food and Drug Administration to increase folic acid fortification to 350 µg per 100 g of enriched cereal grain; and (6) encourage the FDA to require food, food supplement, and vitamin labeling to specify milligram content, as well as RDA levels, for critical nutrients, which vary by age, gender, and hormonal status (including anticipated pregnancy); and (7) encourage the FDA to recommend the folic acid fortification of all refined grains marketed for human consumption, including grains not carrying the "enriched" label. (CSA Rep. 8, A-99; Modified: CSAPH Rep. 6, A-06)

(7) RESOLUTION 903 - GUN SAFETY COUNSELING IN UNDERGRADUATE MEDICAL EDUCATION

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 903 be amended by addition and deletion on lines 16-33, to read as follows:

(1) amend Policy H-145.976 by insertion as follows:

H-145.976 Censorship of Physician Discussion of Firearm Risk
Our AMA: (1) will oppose any restrictions on physicians' and other members of the physician-led health care team's ~~and medical students~~ ~~being able~~ ability to inquire and talk about firearm safety issues and risks with their patients; and (2) will oppose any law restricting physicians' and other members of the physician-led health care team's ~~and medical students'~~ discussions with patients and their families about ~~guns~~ firearms as an intrusion into medical privacy (Modify current HOD Policy); and be it further

~~RESOLVED, That our AMA advocate for the inclusion of strategies for counseling patients on safe gun use and storage in undergraduate medical education (New HOD Policy); and be it further~~

RESOLVED, That our AMA encourage dissemination of ~~advocate that the Association of American Medical Colleges, Agency for Health, Research and Quality, and other relevant professional medical societies develop gun~~ educational materials related to firearm safety ~~counseling modules~~ to be used in undergraduate medical education. (New HOD Policy)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 903 be adopted as amended.

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that the title of Resolution 903 be changed to read as follows:

**HOD ACTION: Resolution 903 adopted as amended with a title change.**

FIREARM SAFETY COUNSELING IN PHYSICIAN-LED HEALTH CARE TEAMS

Resolution 903 asks that our American Medical Association (1) amend Policy H-145.976 by insertion as follows:

> H-145.976 Censorship of Physician Discussion of Firearm Risk
> Our AMA: (1) will oppose any restrictions on physicians and medical students being able to inquire and talk about firearm safety issues and risks with their patients; and (2) will oppose any law restricting physicians' and medical students' discussions with patients and their families about guns as an intrusion into medical privacy (Modify current HOD Policy);

(2) advocate for the inclusion of strategies for counseling patients on safe gun use and storage in undergraduate medical education; and (3) advocate that the Association of American Medical Colleges, Agency for Health, Research and Quality, and other relevant professional medical societies develop gun safety counseling modules to be used in undergraduate medical education.

Your Reference Committee heard extensive testimony on Resolution 903 generally in favor of Resolve 1 but with concerns about the second and third Resolves. Our AMA has been a strong supporter of the right of physicians to discuss gun safety with their patients (as contained in Policy H-145.976), and our AMA would be opposed to any legislation that would restrict a physician's ability to inquire about firearm risk factors or to initiate a discussion about appropriate gun safety precautions with a patient. Testimony noted that it would be more inclusive, and more reflective of actual practice, to add language to this policy encompassing all members of the health care team versus solely medical students. As for Resolve 2, our AMA is reluctant to specify content that must be included in the medical curriculum. Testimony also raised questions about the practicality and advisability of adding this element to an already packed medical school curriculum. Related to Resolve 3, it was noted that the proposed language would be more flexible by not specifying particular organizations and advocating instead for dissemination of gun safety educational materials by the appropriate organizations. For these reasons, your Reference Committee recommends adoption of Resolution 903 as amended.

(8) RESOLUTION 904 - EVALUATIONS OF STANDARDIZED CLINICAL SKILLS EXAMS

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolve 1 of Resolution 904 be amended by addition on lines 21-23, to read as follows:

RESOLVED, That our American Medical Association evaluate the cost/value equation, benefits, and consequences of the implementation of standardized clinical exams as a step for licensure, along with the barriers to more meaningful examination feedback for both examinees and U.S. medical schools, and provide recommendations based on these findings (Directive to Take Action); and be it further

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolve 2 of Resolution 904 be amended by addition on line 26, to read as follows:

RESOLVED, That our American Medical Association evaluate the consequences of the January 2013 changes to the USMLE Step II Clinical Skills exam and their implications for U.S. medical students and international medical graduates. (Directive to Take Action)

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that Resolution 904 be adopted as amended.

**HOD ACTION: Resolution 904 adopted as amended.**

Resolution 904 asks that our American Medical Association (1) evaluate the benefits and consequences of the implementation of standardized clinical exams as a step for licensure and provide recommendations based on these findings; and (2) evaluate the consequences of the January 2013 changes to the USMLE Step II Clinical Skills exam and their implications for US medical students.

Your Reference Committee heard extensive testimony on Resolution 904. Supporters of the resolution noted concerns about costs of the clinical skills examination, which include travel to one of only five testing centers nationwide. They also cited the exam's questionable utility as a filter for student preparedness for practice, given that approximately 98 percent of U.S. medical school students pass on their first attempt. It was expressed that the examination is essentially a poor value proposition, with a low return on investment. In addition, examinees obtain little feedback on their exam performance, other than a pass/fail grade. Your Reference Committee therefore asks that Resolution 904 be adopted as amended.

(9) RESOLUTION 905 - ATHLETE CONCUSSION MANAGEMENT AND CHRONIC TRAUMATIC ENCEPHALOPATHY PREVENTION

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 905 be amended by addition and deletion on line 29, to read as follows:

RESOLVED, that our American Medical Association support ~~collegiate and professional athletic organizations adopting~~ the adoption of evidence-based guidelines for the evaluation and management of concussions by all athletic organizations (New HOD Policy); and be it further

RESOLVED, That our American Medical Association encourage further research in the diagnosis, treatment, and prevention of chronic traumatic encephalopathy. (New HOD Policy)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 905 be adopted as amended.

**HOD ACTION: Resolution 905 adopted as amended.**

Resolution 905 asks that our American Medical Association (1) support collegiate and professional athletic organizations adopting evidence-based guidelines for the evaluation and management of concussions; and (2) encourage further research in the diagnosis, treatment, and prevention of chronic traumatic encephalopathy.

Testimony overwhelmingly underscored the serious problems of concussions and other repetitive brain injuries that can result in chronic traumatic encephalopathy, as well as the impact on both males and females at all age levels to include K-12. Support was strongly voiced for more rigorous actions to prevent such injuries and for research into the causes and prevention. Concern about the need for certified athletic trainers was also raised (see Policy H-470.995). Your Reference Committee recommends adopting the resolution as amended.

(10) RESOLUTION 906 - INCREASING HEALTHCARE ACCESS FOR THE UNDERSERVED

RECOMMENDATION

Mr. Speaker, your Reference Committee recommends that Substitute Resolution 906 be adopted.

**HOD ACTION: Substitute Resolution 906 adopted with a title change.**

EXPLORING THE FEASIBILITY OF CLINIC-BASED RESIDENCY PROGRAMS

RESOLVED, That our American Medical Association advocate that key stakeholders, such as the Accreditation Council for Graduate Medical Education, explore the feasibility of extending residency programs through a pilot study placing medical graduates in integrated physician-led practices in order to expand training positions and increase the number of physicians providing healthcare access. (Directive to Take Action).

RESOLVED, That our AMA encourage that pilot studies of clinic-based residency program expansion be funded by private sources. (New HOD Policy)

Resolution 906 asks that our American Medical Association advocate to key stakeholders to establish and fund pilot clinic-based residency programs at diverse underserved sites, employing medical graduates in integrated physician-led practices to expand training positions utilizing dedicated funding and increase the number of physicians providing healthcare access to those with the greatest medical need.

Your Reference Committee heard testimony noting concerns with the wording of the original resolution and potential issues with program accreditation and medical licensure. The majority of testimony, however, was in favor of the spirit of the resolution and the need to explore any and all possible sources for expanded residency program slots. The revised language proffered by the authors emphasizes the exploratory nature of the request, and was supported by most of those providing testimony. Accordingly, your Reference Committee recommends that Substitute Resolution 906 be adopted.

(11) RESOLUTION 907 - MODERN CHEMICAL CONTROLS POLICY

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Policy D-135.976 be amended to read as follows:

D-135.976 Modernization of the Federal Toxic Substances Control Act (TSCA) of 1976
Our AMA will: (1) ~~support~~ collaborate with relevant stakeholders to advocate for modernizing the Toxic Substances Control Act (TSCA) to require chemical manufacturers to provide adequate safety information on all chemicals and give federal regulatory agencies reasonable authority to regulate hazardous chemicals in order to protect the health of all individuals, especially

vulnerable populations; (2) support the public disclosure of chemical use, exposure and hazard data in forms that are appropriate for use by medical practitioners, workers, and the public; and (3) work with members of the Federation to promote a reformed TSCA that is consistent with goals of Registration, Evaluation, Authorisation, and Restriction of Chemicals (REACH). (Res. 515, A-12)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Policy D-135.976 be adopted as amended in lieu of Resolution 907.

**HOD ACTION: Policy D-135.976 be adopted as amended in lieu of Resolution 907.**

Resolution 907 asks that our American Medical Association (AMA) (1) lobby Congress to amend the Toxic Substances Control Act of 1976 to require protecting the health of vulnerable populations and communities; (2) work with the National Medical Association and the Safer Chemicals Healthy Families Campaign to advocate for health protective chemical policy on a federal and state level; and (3) reaffirm our commitment to AMA Policy D-135.976, Modernization of the Federal Toxic Substances Control Act (TSCA) of 1976."

Your Reference Committee received mostly supportive testimony on this resolution. While the special risks among vulnerable populations to toxic chemicals were emphasized, others noted that all populations should be protected. Testimony also supported working with relevant stakeholders to more actively advocate for changes to TSCA that would protect vulnerable populations. Your Reference Committee believes that current AMA policy could be amended to achieve the requests of the resolution.

(12) RESOLUTION 911 - PROMOTING HEALTH AWARENESS AND PREVENTIVE SCREENINGS IN INDIVIDUALS WITH DISABILITIES

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 911 be amended by addition and deletion on lines 23-26, to read as follows:

RESOLVED, That our American Medical Association ~~continue to~~ work closely with relevant stakeholders ~~with the National Council on Disability, the US Department of Health and Human Services, the World Health Organization, and related agencies~~ to advocate for equitable access to health promotion and preven~~ta~~tative screenings for individuals with disabilities. (Directive to Take Action)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 911 be adopted as amended.

**HOD ACTION: Resolution 911 adopted as amended.**

Resolution 911 asks that our American Medical Association continue to work closely with the National Council on Disability, the US Department of Health and Human Services, the World Health Organization, and related agencies to advocate for equitable access to health promotion and preventive screenings for individuals with disabilities.

Your Reference Committee received supportive testimony on this item. Several commenters underscored the disparities in health promotion and preventive screenings experienced by individuals with disabilities, citing specific examples. Online testimony expressed concern that it may not be appropriate to encourage physicians of every specialty to perform such screenings, nor would it be appropriate for every individual patient with a disability to undergo them. Your Reference Committee favors modification of the resolution so that it is supportive of access to health promotion and prevention activities for disabled individuals who need them without being prescriptive as to which organization should be carrying out such activities.

(13) RESOLUTION 912 - CRISIS IN MEDICATION SHORTAGES

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Policy H-100.956(6) be amended by addition and deletion, to read as follows:

6. The Council on Science and Public Health shall continue to evaluate the drug shortage issue and report back at least annually to the House of Delegates on progress made in addressing drug shortages ~~as appropriate~~.

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Policy H-100.956 be adopted as amended in lieu of Resolution 912.

**HOD ACTION: Policy H-100.956 adopted as amended in lieu of Resolution 912.**

Resolution 912 asks that our American Medical Association (AMA) adopt the policy that the Council on Science and Public Health will render a report at each and every Annual

and Interim Meeting of the AMA on the "Crisis in Medication Shortages" until the House of Delegates deems otherwise.

Drug shortages continue to be a critical issue affecting patient management. The Council on Science and Public Health has generated three reports on drug shortages and will be providing another update at A-14. These reports have reviewed existing trends and progress in addressing drug shortages, pertinent emerging or existing legislation, and recommendations to address drug shortages that have emerged from relevant stakeholders. Current policy allows the Council to determine if and when additional reports on drug shortages will provide added value. Your Reference Committee believes that a report should be offered at least annually for the foreseeable future.

(14) RESOLUTION 915 - ASK THE JOINT COMMISSION TO REEVALUATE THE PAIN SCALE OF PATIENTS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Substitute Resolution 915 be adopted.

**HOD ACTION: Substitute Resolution 915 adopted.**

JOINT COMMISSION ACCREDITATION STANDARD FOR PAIN ASSESSMENT

RESOLVED, That our American Medical Association urge The Joint Commission to reevaluate its accreditation standard for pain assessment, including evidence on whether the standard improves pain management practices, in order to ensure that the standard supports physician's abilities to select the most appropriate treatment options for their patients. (Directive to Take Action)

RESOLVED, That Policy H-220.931, which asks that standards and performance measures set forth by The Joint Commission be supported by the best available evidence, be reaffirmed. (Reaffirm HOD Policy)

Resolution 915 asks that our American Medical Association ask the Joint Commission to reevaluate the mandate for pain assessment and subsequent implied treatment of all patients with opioids based on a subjective pain scale reported by the patient; and that the Joint Commission desist in referring to pain assessment scores as "the fifth vital sign."

Testimony reflected continuing concern about The Joint Commission (TJC) standard on pain assessment, as well as patient satisfaction surveys that include pain management as a metric. These are two important but separate issues, and the use of patient satisfaction surveys was discussed in Board of Trustees Report 9-A-13. Some testimony

reflected the belief that existing TJC standards for pain assessment and the use of patient satisfaction surveys are driving a trend toward overuse of opioid analgesics. The pain assessment process is often performed at the same time a patient's vital signs are taken. Because of this, pain is sometimes called "the fifth vital sign." This is not a term that was created by TJC, and it does not require or advocate that pain be the "fifth vital sign." Testimony also noted that TJC has evolved into an organization that has an educational function as well as an accrediting function. Accordingly, some sentiment was expressed for referral of this resolution. Your Reference Committee is aware that TJC is currently in the process of updating its pain standards. The substitute resolution appropriately emphasizes the need to adopt an evidence-based approach to this and other standards-setting processes.

Policy recommended for reaffirmation
H-220.931 Evidence-Based Value of Joint Commission Standards and Measures
Our AMA asks The Joint Commission that all present and future standards and performance measures set forth by The Joint Commission be supported by the best available evidence.

(15) RESOLUTION 917 - CULTURALLY, LINGUISTICALLY COMPETENT MENTAL HEALTH CARE AND OUTREACH FOR AT-RISK COMMUNITIES

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolve 1 of Resolution 917 be amended by addition and deletion on line 17 to read as follows:

RESOLVED, That our American Medical Association support adequate attention and funds being ~~appropriated~~ directed towards culturally and linguistically competent mental health direct services for the diverse, multi-ethnic communities at greatest risk (New HOD Policy); and be it further

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolve 2 of Resolution 917 be amended by addition and deletion on lines 21-24 to read as follows:

RESOLVED, That our AMA encourage greater cultural and linguistic-competent outreach to ethnic communities ~~that goes beyond in-language print materials to include~~ including partnerships with ethnic community~~-based ethnic~~ organizations, health care advocates, and respected ~~ethnic~~ media outlets ~~(e.g. print, radio, television and social media) that are well-respected and utilized by the members of these respective ethnic communities~~. (New HOD Policy)

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that Resolution 917 be adopted as amended.

**HOD ACTION: Resolution 917 adopted as amended.**

Resolution 917 asks that our American Medical Association (1) support adequate attention and funds being appropriated towards culturally and linguistically competent mental health direct services for the diverse, multi-ethnic communities at greatest risk; and (2) encourage greater cultural and linguistic-competent outreach to ethnic communities that goes beyond in-language print materials to include partnerships with community-based ethnic organizations, health care advocates, and ethnic media outlets (e.g. print, radio, television and social media) that are well-respected and utilized by the members of these respective ethnic communities.

Supportive testimony was received for this item, underscoring the need for increased attention to mental health services and the disparity in access to services among some communities. It was noted that increased attention to cultural and linguistic factors can result in better communication between health care providers and patients, and concomitantly, better mental health care. Some concern was expressed about the focus of Resolve 2, so your Reference Committee recommends amending it so that it retains the same meaning but is simplified.

(16) RESOLUTION 921 - GUN VIOLENCE

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 921 be amended by addition and deletion on line 21, to read as follows:

RESOLVED, That our American Medical Association strongly urge U.S. legislators to fund ~~support~~ further research into the epidemiology of risks related to gun violence on a national level. (Directive to Take Action)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 921 be adopted as amended.

**HOD ACTION: Resolution 921 adopted as amended.**

Resolution 921 asks that our American Medical Association strongly urge U.S. legislators to support further research into the epidemiology of risks related to gun violence on a national level.

Supportive testimony emphasized the importance of research into the epidemiology of gun violence, especially for the development of programs that could reduce its

prevalence. Your Reference Committee points out that a Presidential Executive Order has re-established the ability of researchers to investigate gun violence, and that funding is needed in order to conduct such research. The Reference Committee therefore recommends adopting the resolution with an amendment to include such language.

(17) RESOLUTION 913 – PRE-MEDICAL SCHOOL SHADOWING

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 913 be referred.

**HOD ACTION: Resolution 913 referred.**

Resolution 913 asks that our American Medical Association (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.

Your Reference Committee heard testimony on Resolution 913 in support of the availability of appropriate guidelines for providing pre-medical school shadowing opportunities. It was also noted that increased opportunities for shadowing can help increase diversity in medicine (through the AMA Doctors Back to School program, for example) and make the dream of a career in medicine a reality. Further testimony noted that shadowing should be available to all interested in a medical career, especially underprivileged individuals. In addition, questions were raised as to the responsibility of medical schools to offer shadowing opportunities. Such programs may contribute to improved matriculation and lower attrition rates. Guidelines recently released by the Association of American Medical Colleges offer recommended practices for clinical shadowing, as requested by Resolve 1. In addition, the Council on Medical Education will review the AAMC guidelines in a report on shadowing scheduled for the A-14 Meeting. Your Reference Committee believes that the planned Council report would be the best method in which to fully examine shadowing and ensure effective AMA policy on this critical issue to the future of medicine.

(18) RESOLUTION 914 - CHANGE RURAL AND OFF SITE RURAL TRAINING TRACK REQUIREMENTS IN ORDER TO PRESERVE AND ENCOURAGE INTEREST IN RURAL RESIDENCY PROGRAMS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 914 be referred.

**HOD ACTION: Resolution 914 referred.**

Resolution 914 asks that our American Medical Association (1) work with the Centers for Medicare and 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.

Your Reference Committee heard testimony in favor of Resolution 914 as a mechanism to encourage interest in rural residency programs. Our AMA is supportive of efforts to improve the viability of rural training opportunities, which help increase the likelihood of physician practice in underserved rural areas. Testimony noted, however, that the resolution had some issues with language and terminology—for example, the first Resolve refers to the ABMS as the accreditor of residency programs, rather than the Accreditation Council of Graduate Medical Education. More substantively, several individuals providing testimony asked for the resolution to be expanded to cover other fields of medicine, including general surgery, psychiatry, and obstetrics-gynecology. The Council on Medical Education is developing a report on GME funding and workforce issues for the A-14 meeting; the details of this resolution can be further explored and delineated in the planned report. Accordingly, your Reference Committee urges referral.

(19) RESOLUTION 923 - CMS DEFINITION OF "RESIDENT PHYSICIAN"

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 923 be <u>referred with report back to the House of Delegates at the 2014 Annual Meeting</u>.

**HOD ACTION: Resolution 923 <u>referred with report back to the House of Delegates at the 2014 Annual Meeting.</u>**

Resolution 923 asks that our AMA advocate, in conjunction with appropriate stakeholders, that the Centers for Medicare & Medical Services use our AMA definition of Resident when formulating rules and regulations. (New HOD Policy)

Your Reference Committee heard testimony urging referral of this item. It was noted that this resolution is more complex than it appears and could have unforeseen consequences. In particular, if physicians in fellowships are defined as residents, this could compromise their ability to bill for services. Timely exploration of this issue is critical due to the requirements of the Sunshine Act; therefore, your Reference Committee urges referral with a report back at A-14.

(20) RESOLUTION 902 - MEDICAL ETHICS GUIDELINES FOR UNDERGRADUATE MEDICAL EDUCATION

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Policy H-295.961 be reaffirmed in lieu of Resolution 902.

**HOD ACTION: Policy H-295.961 reaffirmed in lieu of Resolution 902.**

Resolution 902 asks that our American Medical Association (AMA) (1) recognize the importance of addressing the disparity between current outcomes and the ideal status of undergraduate medical education in bioethics and humanities; (2) in partnership with the AMA Medical Student Section, leverage its internal resources and its relationships with professional society stakeholders to create suggested guidelines for undergraduate medical education of bioethics and humanities guided by LCME requirements and the American Society for Bioethics and Humanities Task Force; and (3) advocate for the national adoption of a set of suggested guidelines for undergraduate medical education in bioethics and humanities by allopathic and osteopathic medical schools.

Your Reference Committee heard extensive testimony on Resolution 902. It was noted by the resolution's authors that medical school accreditation requirements for developing professionalism among students lack specificity, which has led to significant variability of medical school curricula in ethics, as stated in the first Resolve. In its virtual testimony, the Council on Medical Education, however, points to data from an annual questionnaire of all graduating medical students showing that the great majority of respondents believe that their instruction in ethical decision making, bioethics, and professionalism was adequate. Our AMA is addressing ethical issues from the perspective of medical students and residents/fellows, through its Virtual Mentor online journal, for example, and encourages education related to ethics, but does not believe in mandating medical curriculum; this is better left to the faculty of medical schools. Finally, existing AMA policy reflects the intent of this resolution. Policy H-295.961, for example, calls for "attention to subject matter related to ethics and to the doctor-patient relationship at all levels of medical education." For these reasons, your Reference Committee recommends reaffirmation of Policy H-295.961 in lieu of this resolution.

Policy recommended for reaffirmation:
H-295.961 Medicolegal, Political, Ethical and Economic Medical School Course
(1) The AMA urge every medical school and residency program to teach the legal, political, ethical and economic issues which will affect physicians. (2) The AMA will work with state and county medical societies to identify and provide speakers, information sources, etc., to assist with the courses. (3) An assessment of professional and ethical behavior, such as exemplified in the AMA Principles of Medical Ethics, should be included in internal evaluations during medical school and residency training, and also in evaluations utilized for licensure and certification. (4) The Speaker of the HOD shall determine the most appropriate way for assembled physicians at the opening sessions of the AMA House of Delegates Annual and Interim Meetings to renew their commitment to the standards of conduct which define the essentials of honorable behavior for the physician, by reaffirming or reciting the seven Principles of Medical Ethics which

constitute current AMA policy. (5) There should be attention to subject matter related to ethics and to the doctor-patient relationship at all levels of medical education: undergraduate, graduate, and continuing. Role modeling should be a key element in helping medical students and resident physicians to develop and maintain professionalism and high ethical standards. (6) There should be exploration of the feasibility of improving an assessment of ethical qualities in the admissions process to medical school. (7) Our AMA pledges support to the concept that professional attitudes, values, and behaviors should form an integral part of medical education across the continuum of undergraduate, graduate, and continuing medical education. (Res. 189, A-90; Modified by CME Rep. 1, I-95; Appended: Res. 318, I-98; Reaffirmed: CME Rep. 2, A-08)

(21) RESOLUTION 919 - HIGH COST OF RECERTIFICATION

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Policies D-275.971, D-275.969, H-275.923, and H-275.924 be reaffirmed in lieu of Resolution 919.

**HOD ACTION: Policies D-275.971, D-275.969, H-275.923, and H-275.924 reaffirmed in lieu of Resolution 919.**

Resolution 919 asks that our American Medical Association request an investigation into the high cost of recertification and, if such investigation warrants reduction of recertification fees, that our AMA urge/advocate for a reduction by the ABMS of recertification fees.

Your Reference Committee heard limited but supportive testimony on this issue. Our AMA continues to closely monitor the development of maintenance of certification (MOC), including MOC fees, and the Council on Medical Education has written several reports on this topic, and will report again on this issue at the A-14 Meeting. As stated in extensive AMA policy on this topic, our AMA advocates for balancing the requirements of MOC with a sensitivity to physicians' valuable time and resources, ensuring physician input into the ongoing development of MOC, and making this process as efficient, effective, and evidence-based as possible. Your Reference Committee therefore recommends reaffirmation of Policies D-275.971, D-275.969 (4), H-275.923 (3), and H-275.924 (4) in lieu of Resolution 919.

Policy recommended for reaffirmation:
D-275.971 American Board of Medical Specialties - Standardization of Maintenance of Certification Requirements
1. Our AMA will work with the American Board of Medical Specialties to streamline Maintenance of Certification (MOC) to reduce the cost, inconvenience, and the disruption of practice due to MOC requirements for all of their member boards, including subspecialty requirements. 2. Our AMA will actively work to enforce existing policies to reduce current costs and effort required for the maintenance of certification and to work to control future charges and expenses. (Sub. Res. 313, A-06; Reaffirmed: CME Rep. 7, A-07; Reaffirmed: CME Rep. 16, A-09; Appended: Res. 319, A-12; Reaffirmed in lieu of Res. 313, A-12)

D-275.969 Specialty Board Certification and Recertification
1. Our AMA will continue to monitor the progress by the ABMS and its member boards on implementation of Maintenance of Certification (MOC) and encourage ABMS to report its research findings on the issues surrounding certification, recertification and MOC on a periodic basis. 2. An update report will be prepared for the AMA House of Delegates no later than 2010. 3. Our AMA will encourage dialogue between the ABMS and its respective specialty societies to work on development, implementation, and monitoring of MOC that meets the needs of practicing physicians and improves patient care. 4. Our AMA will exercise its full influence to protect physicians from undue burden and expense in the Maintenance of Certification process. (CME Rep. 7, A-07; Reaffirmed: CME Rep. 16, A-09)

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)

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. (CME Rep. 16, A-09; Reaffirmed: CME Rep. 11, A-12; Reaffirmed: CME Rep. 10, A-12; Reaffirmed in lieu of Res. 313, A-12; Reaffirmed: CME Rep. 4, A-13)

(22) RESOLUTION 920 - TELEMEDICINE LICENSURE

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Policies H-480.969 and D-480.999 be reaffirmed in lieu of Resolution 920.

**HOD ACTION: Policies H-480.969 and D-480.999 reaffirmed in lieu of Resolution 920.**

Resolution 920 asks that our American Medical Association support the continuation of telemedicine licensure by individual states and opposes efforts to change such to federal licensure of telemedicine.

Your Reference Committee heard mixed testimony on this resolution which raised concern for the evolving issue of telemedicine. Our AMA examined the issues related to telemedicine at its A-13 HOD Meeting with BOT Report 22-A-13, which included a review of extensive existing AMA policy on telemedicine and licensure. AMA policy (H-480.969) supports telemedicine licensure at the state level, and opposes federal regulation of telemedicine licensure (D-480.999). Your Reference Committee recommends reaffirmation of Policies H-480.969 and D-480.999 in lieu of Resolution 920.

Policy recommended for reaffirmation:

H-480.969 The Promotion of Quality Telemedicine
(1) It is the policy of the AMA that medical boards of states and territories should require a full and unrestricted license in that state for the practice of telemedicine, unless there are other appropriate state-based licensing methods, with no differentiation by specialty, for physicians who wish to practice telemedicine in that state or territory. This license category should adhere to the following principles: (a) application to situations where there is a telemedical transmission of individual patient data from the patient's state that results in either (i) provision of a written or otherwise documented medical opinion used for diagnosis or treatment or (ii) rendering of treatment to a patient within the board's state; (b) exemption from such a licensure requirement for traditional informal physician-to-physician consultations ("curbside consultations") that are provided without expectation of compensation; (c) exemption from such a licensure requirement for telemedicine practiced across state lines in the event of an emergent or urgent circumstance, the definition of which for the purposes of telemedicine should show substantial deference to the judgment of the attending and consulting physicians as well as to the views of the patient; and (d) application requirements that are non-burdensome, issued in an expeditious manner, have fees no higher than necessary to cover the reasonable costs of administering this process, and that utilize principles of reciprocity with the licensure requirements of the state in which the physician in question practices. (2) The AMA urges the FSMB and individual states to recognize that a physician practicing certain forms of telemedicine (e.g., teleradiology) must sometimes perform necessary functions in the licensing state (e.g., interaction with patients, technologists, and other physicians) and that the interstate telemedicine approach adopted must accommodate these essential quality-related functions. (3) The AMA

urges national medical specialty societies to develop and implement practice parameters for telemedicine in conformance with: Policy 410.973 (which identifies practice parameters as "educational tools"); Policy 410.987 (which identifies practice parameters as "strategies for patient management that are designed to assist physicians in clinical decision making," and states that a practice parameter developed by a particular specialty or specialties should not preclude the performance of the procedures or treatments addressed in that practice parameter by physicians who are not formally credentialed in that specialty or specialties); and Policy 410.996 (which states that physician groups representing all appropriate specialties and practice settings should be involved in developing practice parameters, particularly those which cross lines of disciplines or specialties). (CME/CMS Rep., A-96; Amended: CME Rep. 7, A-99; Reaffirmed: CME Rep. 2, A-09; Reaffirmed: CME Rep. 6, A-10; Reaffirmed: CME Rep. 6, A-12; Reaffirmed in lieu of Res. 805, I-12; Reaffirmed: BOT Rep. 22, A-13)

D-480.999 State Authority and Flexibility in Medical Licensure for Telemedicine
Our AMA will continue its opposition to a single national federalized system of medical licensure. (CME Rep. 7, A-99; Reaffirmed and Modified: CME Rep. 2, A-09)

Mr. Speaker, this concludes the report of Reference Committee K. I would like to thank Paul D. Bozyk, MD, David A. Hexter, MD, Ajoy Kumar, MD, Brandi N. Ring, MD, Ryan Van Woerkom, MD, L. Samuel Wann, MD, all those who testified before the Committee, and staff members Katie Johansen Taber, Barry Dickinson, Amber Ryan, and Fred Lenhoff.

Paul D. Bozyk, MD (Alternate)
Michigan

Brandi N. Ring, MD
Resident and Fellow Section

David A. Hexter, MD (Alternate)
Maryland

Ryan C. Van Woerkom, MD (Alternate)
American College of Physicians

Ajoy Kumar, MD
American Academy of Family Physicians

L. Samuel Wann, MD
American College of Cardiology

Kenneth M. Certa, MD
American Psychiatric Association
Chair