

Reference Committee C (medical education)

YPS HOD Handbook Review Committee: Tina Brueschke, MD, Chair; Nita Kulkarni, MD; and John Ratliff, MD

Note: The text of all resolutions and reports can be viewed at <http://www.ama-assn.org/ama/pub/category/18588.html>.

HOD resolution/report	Action requested	Recommended AMA-YPS position	Final AMA-HOD action
B of T Report 19: Gender Disparities in Physician Income and Advancement	<p>Therefore, the Board of Trustees recommends that the following be adopted and the remainder of the report be filed:</p> <ol style="list-style-type: none"> 1) That our American Medical Association encourage medical associations and other relevant organizations to study gender differences in income and advancement trends, by specialty, experience, work hours and other practice characteristics, and develop programs to address disparities where they exist (Directive to Take Action); 2) That our AMA support physicians in making informed decisions on work-life balance issues through the continued development of informational resources on issues such as part-time work options, job sharing, flexible scheduling, reentry, and contract negotiations (Directive to Take Action); 3) That our AMA urge medical schools, hospitals, group practices and other physician employers to institute and monitor transparency in pay levels in order to identify and eliminate gender bias and promote gender equity throughout the profession (Directive to Take Action); and 4) That our AMA collect and publicize information on best practices in academic medicine and non academic medicine that foster gender parity in the profession. (Directive to Take Action) <p>Fiscal Note: Staff costs estimated at less than \$1000 to implement.</p>	Active Support	Adopted as amended; see http://www.ama-assn.org/ama1/pub/uploads/mm/471/annotateddc.doc for exact wording
CME Report 2: Council on Medical Education Sunset Review of 1998 House of Delegates Policies and Directives	The Council on Medical Education recommends that the House of Delegates policies that are listed in the Appendix to this report be acted upon in the manner indicated and the remainder of this report be filed.	Support	Adopted

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CME Report 3: Physician Lifelong Learning	<p>Therefore, the Council on Medical Education recommends that the following recommendations be adopted and that the remainder of this report be filed.</p> <ol style="list-style-type: none"> 1. That American Medical Association Policy H-300.958, "Support for Continuing Medical Education," be reaffirmed. (Reaffirm HOD Policy) 2. That our AMA, through its Initiative to Transform Medical Education, study the following and report back at the 2009 Annual Meeting: <ul style="list-style-type: none"> • The status of teaching the "basic science" of lifelong learning during medical school and residency training, including evidence-based medicine, information retrieval, and critical analysis of the literature. • The strategies that have been effective in teaching the skills of self-assessment among physicians-in-training and in practice, and in promoting their use. • The patterns of utilization of the various continuing medical education (lifelong learning) modalities by physicians, with the identification of those that are both efficient and effective for planning, tracking, and documenting learning experiences, as well as changing practice behavior. • The mechanisms that are effective in mitigating the actual and opportunity costs of participating in lifelong learning. (Directive to Take Action) 3. That our AMA, based on this study, work with other relevant bodies to develop and monitor the implementation of recommendations directed at the medical education community, including accrediting, certifying, and licensing bodies, as well as educational institutions and programs, aimed at assuring that physicians are prepared to engage in lifelong learning and report the results at the 2010 Annual Meeting. (Directive to Take Action) <p>Fiscal Note: \$7500 for staff time to engage in the proposed study, development of recommendations, and monitoring the outcomes.</p>	Support	Adopted as amended; see http://www.ama-assn.org/ama1/pub/uploadd/mm/471/annotatedcdc.doc for exact wording
CME Report 4: Educational Implications of the Medical Home Model	<p>Therefore, the Council on Medical Education recommends that the following be adopted and that the remainder of this report be filed.</p> <ol style="list-style-type: none"> 1. That our American Medical Association encourage the integration of medical education into Patient-Centered Medical Home (PC-MH) demonstration projects. (Directive 	Support	Adopted as amended; see http://www.ama-assn.org/ama1/pub/uploadd/mm/471/annotatedcdc.doc for exact wording

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	<p>to Take Action).</p> <p>2. That our AMA ask the Liaison Committee on Medical Education and the Accreditation Council for Graduate Medical Education to review their accreditation standards to assure that the accreditation process facilitates education in and about the PC-MH model. (Directive to Take Action)</p> <p>3. That our AMA advocate for public (federal and state) and private payers to develop reimbursement systems to fit practice in the PC-MH model. (Directive to Take Action)</p> <p>4. That our AMA advocate for funding from all sources for medical schools and residency training programs to provide medical education in the context of PC-MH models. (Directive to Take Action)</p> <p>5. That our AMA monitor the evolution of the concept of the medical home and track the implementation by teaching programs, with a report back at the 2010 Annual Meeting. (Directive to Take Action)</p> <p>Fiscal Note: \$2500 for staff time associated with this activity.</p>		
<p>CME Report 5: Enforcement of Duty Hours Standards and Improving Resident, Fellow and Patient Safety</p>	<p>The Council on Medical Education, therefore, recommends that the following be adopted in lieu of Resolution 305 (A-07) and that the remainder of this report be filed.</p> <p>1. That our American Medical Association reaffirm support of the current Accreditation Council for Graduate Medical Education duty hour standards. (Directive to Take Action)</p> <p>2. That our AMA continue to monitor the enforcement and impact of the ACGME duty hour standards, as they relate to the larger issue of the optimal learning environment for residents, and monitor relevant research on duty hours, sleep, and resident and patient safety, with a report back at the 2010 Annual Meeting of the AMA House of Delegates. (Directive to Take Action)</p> <p>3. That our AMA, as part of its Initiative to Transform Medical Education strategic focus, utilize relevant evidence on patient safety and sleep to develop a learning environment model that optimizes balance between resident education, patient care, quality and safety,</p>	<p>Monitor/support</p>	<p>Adopted as amended in lieu of Resolution 318; see http://www.ama-assn.org/ama1/pub/upload/mm/471/annotatedc.doc for exact wording</p>

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	<p>with a report back at the 2010 Annual Meeting. (Directive to Take Action)</p> <p>4. That our AMA review, evaluate, and publicize the work of the ACGME Committee on Innovation, in particular its pilot projects related to duty hours, and encourage participation by ACGME Residency Review Committees and residency programs in these and other efforts towards innovation and improvement in graduate medical education and patient safety, to include the voluntary reduction or elimination of extended work shifts (>16 hours). (Directive to Take Action)</p> <p>5. That our AMA ask the ACGME to consider offering programs/institutions additional incentives, such as longer accreditation cycles or reduced accreditation fees, to ensure programmatic and institutional compliance with duty hour limits. (Directive to Take Action)</p> <p>6. That our AMA encourage publication of studies about the effects of duty hour standards, extended work shifts, and sleep deprivation and fatigue on patient safety, medical error, resident well-being, and resident learning outcomes, and disseminate study results to GME designated institutional officials (DIOs), program directors, resident/fellow physicians, attending faculty, and others. (Directive to Take Action)</p> <p>7. That our AMA communicate to all GME DIOs, program directors, resident/fellow physicians, and attending faculty about the importance of accurate, honest, and complete reporting of resident duty hours as an essential element of medical professionalism and ethics. (Directive to Take Action)</p> <p>8. That our AMA use the GME e-Letter, AMA Resident and Fellow Section publications, and other communications vehicles to raise awareness among residents (particularly first-year residents) of the ACGME and its role in monitoring and enforcing duty hours. (Directive to Take Action)</p> <p>9. That our AMA ask its Council on Medical Education to closely monitor the progress of the Institute of Medicine (IOM) committee studying resident duty hours and patient safety and to respond, and/or assist the AMA Washington Office in responding, to any legislative or regulatory initiatives that arise from the IOM or other bodies. (Directive to Take Action)</p> <p>Fiscal Note: Less than \$500.</p>		

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HOD resolution/report	Action requested	Recommended AMA-YPS position	Final AMA-HOD action
CME Report 6: Physician Reentry	<p>The Council on Medical Education recommends that the following be adopted and the remainder of the report be filed.</p> <ol style="list-style-type: none"> 1. That our American Medical Association continue to collaborate with other appropriate organizations on physician reentry issues including research on the need for and the effectiveness of reentry programs. (Directive to Take Action) 2. That our AMA work collaboratively with the American Academy of Pediatrics and other interested groups to convene a conference on physician reentry which will bring together key stakeholders to address the development of reentry programs as well as the educational needs of physicians reentering clinical practice. (Directive to Take Action) 3. That our AMA support efforts to establish a physician reentry program (PREP) information data base that is publicly accessible to physician applicants and which includes information pertaining to program characteristics. (Directive to Take Action) 4. That our AMA support efforts to ensure the affordability and accessibility, and to address the unique liability issues related to PREPs. (Directive to Take Action) 5. That our AMA make available to all interested parties the physician reentry program (PREP) system Guiding Principles for use as a basis for all reentry programs: <ol style="list-style-type: none"> a. Accessible: The PREP system is accessible by geography, time and cost. Reentry programs are available and accessible geographically across the United States and include national and regional pools of reentry positions. Reentering physicians with families or community ties are not burdened by having to relocate to attend a program. The length of time of reentry programs is standardized and is commensurate with the assessed clinical and educational needs of reentering physicians. The cost of reentry programs is not prohibitive to the physician, health care institutions or the health care system. b. Collaborative: The PREP system is designed to be collaborative to improve communication and resource sharing. Information and materials including evaluation instruments are shared across specialties, to the extent possible, to improve program and physician performance. A common nomenclature is used to maximize communication across specialties. Reentry programs share resources and create a common repository for such resources, which are easily accessible. c. Comprehensive: The PREP system is comprehensive to maximize program utility. 	Support	Adopted as amended; see http://www.ama-assn.org/ama1/pub/uploadd/mm/471/annotateddc.doc for exact wording

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HOD resolution/report	Action requested	Recommended AMA-YPS position	Final AMA-HOD action
	<p>Physician reentry programs prepare physicians to return to clinical activity in the discipline in which they have been trained or certified and in the practice settings they expect to work including community-based, public health, and hospital-based or academic practice.</p> <p>d. Ethical: The PREP system is based on accepted principles of medical ethics. Physician reentry programs will conform to physician licensure statues. The standards of professionalism, as stated in the AMA Code of Medical Ethics, must be followed.</p> <p>e. Flexible: The PREP system is flexible in structure in order to maximize program relevancy and usefulness. Physician reentry programs can accommodate modifications to program requirements and activities in ways that are optimal to the needs of reentering physicians.</p> <p>f. Modular: Physician reentry programs are modularized, individualized and competency-based. They are tailored to the learning needs of reentering physicians, which prevents the need for large, expensive, and standardized programs. Physicians should only be required to take those modules that allow them to meet an identified educational need.</p> <p>g. Innovative: Innovation is built into a PREP system allowing programs to offer state of the art learning and meet the diverse and changing needs of reentry physicians. Physician reentry programs develop and utilize learning tools including experimenting with innovative and novel curricular methodologies such as distance learning technologies and simulation.</p> <p>h. Accountable: The PREP system has mechanisms for assessment and is open to evaluation. Physician reentry programs have an evaluation component that is comparable among all specialties. Program assessments use objective measures to evaluate physician's competence at time of entry, during the program and at time of completion. Program outcomes are measured. Reliability and validity of the measures are established. Standardization of measures exist across programs to assess whether or not national standards are being met.</p> <p>i. Stable: A funding scheme is in place to ensure the PREP system is financially stable over the long-term. Adequate funding allows physician reentry programs to operate at sufficient and appropriate capacity.</p> <p>j. Responsive: The PREP system makes refinements, updates and other changes when necessary. Physician reentry programs are equipped to address systemic changes such as changes in regulations. Additionally, the PREP system is prepared to respond efficiently to urgent health care needs within society including mobilizing clinically inactive physicians temporarily into the workforce to attend to an acute public health crisis, such as a terrorist, biological, chemical, or natural disaster. (Directive to Take Action)</p>		

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	<p>6. That our AMA, as part of its Initiative to Transform Medical Education strategic focus and in support of its members and Federation partners, develop model program standards utilizing PREP system Guiding Principles with a report back at the 2009 Interim Meeting. (Directive to Take Action)</p> <p>Fiscal Note: \$30,000 to convene a conference and conduct research.</p>		
<p>CME Report 7: Diversity in the Physician Workforce and Access to Care</p>	<p>Therefore, the Council on Medical Education recommends that the following be adopted and that the remainder of this report be filed.</p> <p>1. That American Medical Association Policies H-200.951, “Strategies for Enhancing Diversity in the Physician Workforce,” and H-200.054, “US Physician Shortage” be reaffirmed. (Reaffirm HOD Policy)</p> <p>2. That our AMA continue to advocate for programs that promote diversity in the US medical workforce, such as pipeline programs to medical schools. (Directive to Take Action)</p> <p>3. That our AMA continue to advocate for adequate funding for federal and state programs that promote interest in practice in underserved areas, such as those under Title VII of the Public Health Service Act, scholarship and loan repayment programs under the National Health Services Corps and state programs, state Area Health Education Centers, and Conrad 30, and also encourage the development of a centralized database of scholarship and loan repayment programs. (Directive to Take Action)</p> <p>4. That our AMA continue to study the factors that support and those that act against the choice to practice in an underserved area, and report the findings and solutions at the 2008 Interim Meeting. (Directive to Take Action)</p> <p>Fiscal Note: \$7,500 for staff time to research the indicated issues and to advocate as directed.</p>	<p>Support</p>	<p>Adopted</p>
<p>CME Report 8: One-Year Public Health Training Options for All Specialties</p>	<p>The Council on Medical Education recommends that the following be adopted and that the remainder of the report be filed.</p> <p>1. That our American Medical Association offer its participation in the future planning to implement the recommendations in the Institute of Medicine report, Training Physicians for Public Health Careers. (Directive to Take Action)</p>	<p>Support</p>	<p>Adopted as amended; see http://www.ama-assn.org/ama1/pub/upload/mm/471/annotateddc.doc for exact wording</p>

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	<p>2. That our AMA, in the context of its Initiative to Transform Medical Education (ITME), study opportunities for integrating content related to public health and preventive medicine across the medical education continuum and report back at the 2009 Annual Meeting. (Directive to Take Action)</p> <p>Fiscal Note: \$5000 for staff time to conduct the recommended study.</p>		
<p>CME Report 10: Independent Regulation of Physician Licensing Exams</p>	<p>The Council on Medical Education therefore recommends that the following be adopted, and that the remainder of the report be filed.</p> <ol style="list-style-type: none"> 1. That our American Medical Association reaffirm Policy H-295.893 “Voting Rights for AMA-MSS NBME Representatives.” (Reaffirm HOD Policy) 2. That our AMA continue to work with the National Board of Medical Examiners to ensure that the AMA is given appropriate advance notice of any major potential changes in the examination system in support of Policy H-295.893, “Voting Rights for AMA-MSS NBME Representatives.” (Directive to Take Action) 3. That our AMA continue to collaborate with the organizations who create, validate, monitor, and administer the United States Medical Licensing Examination. (Directive to Take Action) 4. That our AMA continue to promote and disseminate the rules governing USMLE in its publications. (Directive to Take Action) 5. That our AMA continue its dialog with and be supportive of the process of the Committee to Evaluate the USMLE Program (CEUP). (Directive to Take Action) <p>Complete references for this report are available from the Medical Education Group.</p> <p>Fiscal Note: Less than \$500</p>	<p>Support</p>	<p>Adopted as amended; see http://www.ama-assn.org/ama1/pub/upload/mm/471/annotatedcdc.doc for exact wording</p>

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HOD resolution/report	Action requested	Recommended AMA-YPS position	Final AMA-HOD action
CME Report 11: Independent Regulation of Physician Licensing Exams	<p>The Council of Medical Education, therefore, recommends the following be adopted in lieu of Resolution 303 (A-07), and the remainder of this report be filed.</p> <ol style="list-style-type: none"> 1. That our American Medical Association encourage the Accreditation Council for Graduate Medical Education to study the feasibility of requiring training institutions to offer paid maternity leave for residents of no less than six weeks' duration, and to permit unpaid maternity leave of an additional six weeks. (Directive to Take Action) 2. That our AMA propose to the American Board of Medical Specialties member boards that they standardize their policies regarding parental leave, absence from training, and the timing of entrance into the board certification examination process, so that at a minimum, all residents are allowed six weeks' absence of training for parental leave per academic year without disproportionately increasing the length of training, or postponing certification. (Directive to Take Action) 3. That our AMA oppose requiring residents to serve any more service time than they took in leave that qualifies under the federal Family and Medical Leave Act. (New HOD Policy) 4. That our AMA convene a group of appropriate interested parties, including the ACGME and the ABMS, to discuss options for standardization of parental leave policies that would not disproportionately increase length of training or result in postponement of certification. (Directive to Take Action) <p>Fiscal Note: \$1500 to convene a meeting of appropriate parties.</p>	Monitor	Adopted as amended in lieu of Resolution 316; see http://www.ama-assn.org/ama1/pub/uploadd/mm/471/annotatedcdc.doc for exact wording
CME Report 12: Observerships for International Medical Graduates	<p>The Council on Medical Education, therefore, recommends that the following be adopted in lieu of Resolution 308 (A-07) and that the remainder of this report be filed.</p> <p>That our American Medical Association, through its relevant Sections, work with internal and external groups to develop guidelines for observership programs for International Medical Graduates (IMGs) who have received certification by the Educational Commission for Foreign Medical Graduates, including the following:</p> <ul style="list-style-type: none"> • Development of a set of educational objectives and a model curriculum outline; • Identification of educational/informational materials to address the objectives; and 	Support	Adopted as amended; see http://www.ama-assn.org/ama1/pub/uploadd/mm/471/annotatedcdc.doc for exact wording

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	<ul style="list-style-type: none"> Creation of informational materials related to legal, organizational, and operational issues related to program implementation. (Directive to Take Action) <p>Fiscal Note: \$10,500 for staff time to develop objectives and a curriculum plan, identify and create educational and informational materials, and convene a group of relevant stakeholders to review the materials.</p>		
CME Report 13: Financial Conflicts in CME	<p>Therefore, the Council on Medical Education recommends that the following be adopted in lieu of Resolution 310 (A-07) and that the remainder of this report be filed.</p> <p>That our American Medical Association continue to monitor the implementation of the Accreditation Council for Continuing Medical Education 2004 Standards for Commercial Support and report to the House of Delegates any major evidence that these requirements are not effective in ensuring the independence of or adversely impact the availability of continuing medical education. (Directive to Take Action)</p> <p>Complete references for this report are available from the Medical Education Group.</p> <p>Fiscal Note: Less than \$500</p>	Support	Adopted as amended; see http://www.ama-assn.org/ama1/pub/upload/mm/471/annotatedc.doc for exact wording
CME Report 14: Employment Benefits for Residents and Fellows	<p>The Council on Medical Education, therefore, recommends that the following be adopted in lieu of Resolution 309 (A-07), and that the remainder of the report be filed.</p> <p>That our American Medical Association, through its appropriate sections, study the status of employment benefits offered to residents and fellows and report back at the 2010 Annual Meeting. (Directive to Take Action)</p> <p>Fiscal Note: \$7500 for data gathering and analysis.</p>	Support	Adopted in lieu of Resolution 309 (A-07)

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Resolution 301: Support for the Epidemic Intelligence Service (EIS) Program and Preventive Medicine Residency Expansion	<p>RESOLVED, That our American Medical Association work to support increased federal funding for training of public health physicians through the Epidemic Intelligence Service program and work to support increased federal funding for preventive medicine residency training programs. (Directive to Take Action)</p> <p>Fiscal Note: Implement accordingly at estimated staff cost of \$1,859.</p>	Support	Adopted
Resolution 302: Recognition of Osteopathic Education and Training	<p>RESOLVED, That our American Medical Association recognize the current similarities in the accreditation and certification systems for allopathic and osteopathic physicians and encourage greater collaboration between and mutual recognition of education, training, and board certification systems. (New HOD Policy)</p> <p>Fiscal Note: Staff cost estimated at less than \$500 to implement.</p>	Support	Referred
Resolution 303: Protection of the Titles "Doctor," "Resident" and "Residency" MOVED TO B	<p>RESOLVED, That our American Medical Association adopt that the title "Doctor," in a medical setting, apply only to physicians licensed to practice medicine in all its branches, dentists and podiatrists (New HOD Policy); and be it further</p> <p>RESOLVED, That our AMA adopt policy that the title "Resident" apply only to individuals enrolled in physician, dentist or podiatrist training programs (New HOD Policy); and be it further</p> <p>RESOLVED, That our AMA adopt policy that the title "Residency" apply only to physician, dentist or podiatrist training programs (New HOD Policy); and be it further</p> <p>RESOLVED, That our AMA serve to protect, through legislation, the titles "Doctor," "Resident" and "Residency." (Directive to Take Action)</p> <p>Fiscal Note: Staff cost estimated at less than \$500 to implement.</p>	Support	MOVED TO B (Resolution 232)

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Resolution 304: Medical Student Debt Crisis	<p>RESOLVED, That our American Medical Association pursue long-term solutions to the student debt crisis by hiring an economic consulting firm to analyze the feasibility of novel solutions including 1) competency-based curriculums that shorten the length of undergraduate education and medical school, 2) work-study opportunities, 3) paid rotating internships for fourth-year students who have passed initial licensing exams and have the training equivalents of mid-level providers, 4) financial investment funds that match parental savings, 5) relief for dual degrees not covered by the National Institute of Health, 6) pursuit of government Medicare funding for undergraduate medical education funding, and 7) implementing international medical student tuition models, among other viable options. (Directive to Take Action)</p> <p>Fiscal Note: Estimated cost of \$25,000 for professional fees.</p>	Support	Referred
Resolution 305: Oppose Discrimination in Residency Selection Based on Location of Medical School	<p>RESOLVED, That our American Medical Association lobby the Accreditation Council for Graduate Medical Education to include international medical graduates in its list of prohibited discriminations. (Directive to Take Action)</p> <p>Fiscal Note: Staff cost estimated at less than \$500 to implement.</p>	Monitor	Substitute Resolution 305 adopted with a change in title. See http://www.ama-assn.org/ama1/pub/uploadd/mm/471/annotatedcdc.doc for exact wording.
Resolution 306: Waiver of US Medical Licensing Examination Step 2-CS Requirements	<p>RESOLVED, That our American Medical Association lobby the United States Medical Licensing Examination to allow the Educational Commission for Foreign Medical Graduates certificate holders who started their residency training before January 1, 2005, to be eligible to sit for Step 3 without having to take Step 2-CS. (Directive to Take Action)</p> <p>Fiscal Note: Staff cost estimated at less than \$500 to implement.</p>	Monitor	Not adopted
Resolution 307: Student Loan Empowerment	<p>RESOLVED, That our American Medical Association support legislation that requires medical schools to inform students of all government loan opportunities along with private loans, and requires disclosure of reasons that preferred lenders were chosen. (New HOD Policy)</p> <p>Fiscal Note: Implement accordingly at estimated staff cost of \$1,859.</p>	Support	Adopted as amended; see http://www.ama-assn.org/ama1/pub/uploadd/mm/471/annotatedcdc.doc for exact wording

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Resolution 308: Encouragement of Interprofessional Education Among Health Care Professions Students	<p>RESOLVED, That our American Medical Association recognize that interprofessional education and partnerships are a top priority of the American medical education system (New HOD Policy); and be it further</p> <p>RESOLVED, That our AMA explore the feasibility of the implementation of Liaison Committee on Medical Education and American Osteopathic Association accreditation standards requiring interprofessional training in medical schools. (Directive to Take Action)</p> <p>Fiscal Note: Staff cost estimated at less than \$500 to implement.</p>	Monitor	Adopted as amended; see http://www.ama-assn.org/ama1/pub/upload/mm/471/annotatedc.doc for exact wording
Resolution 309: Increasing Medical School Class Sizes	<p>RESOLVED, That our American Medical Association support increasing the number of medical students, provided that such expansion would not jeopardize the quality of medical education. (New HOD Policy)</p> <p>Fiscal Note: Staff cost estimated at less than \$500 to implement.</p>	Monitor	Adopted
Resolution 310: Solutions to Tackling the Increasing Cost of Medical Education	<p>RESOLVED, That our American Medical Association support policies that ensure that funding gained by medical schools from all future increases to medical school tuition and fees be allocated directly to improve the education of medical students (New HOD Policy); and be it further</p> <p>RESOLVED, That our AMA support policies that ensure that all information related to the allocation of funds from tuition and fee increases be disclosed to all prospective and current medical students for each respective medical school campus. (New HOD Policy)</p> <p>Fiscal Note: Staff cost estimated at less than \$500 to implement.</p>	Oppose	Substitute Resolution 310 adopted with a change in title; see http://www.ama-assn.org/ama1/pub/upload/mm/471/annotatedc.doc for exact wording

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HOD resolution/report	Action requested	Recommended AMA-YPS position	Final AMA-HOD action
<p>Resolution 311: Credentialing Materials: Timely Submission by Residency and Fellowship Programs</p>	<p>RESOLVED, That our American Medical Association encourage residency programs and fellowship programs to properly complete and promptly submit verification of resident education/training on credentialing and re-credentialing forms to the requesting agency within thirty days of the request (Directive to Take Action); and be it further</p> <p>RESOLVED, That our American Medical Association encourage the Accreditation Council for Graduate Medical Education to add to the accreditation standards for residency and fellowship programs and to the Institutional Program Requirements the requirement of the proper completion and prompt submission of verification of resident education/training on credentialing and re-credentialing forms to the requesting agency within thirty days of the request. (Directive to Take Action)</p> <p>Fiscal Note: Staff cost estimated at less than \$500 to implement.</p>	<p>Support</p>	<p>Adopted</p>
<p>Resolution 312: Study of the Impact of Medical Education on Patient Safety</p>	<p>RESOLVED, That our American Medical Association work with the federal government to update the 1986 study by the US Congressional Office of Technology Assessment on the impact of physician education versus nurse practitioner or physician assistant education on patient welfare and safety. (Directive to Take Action)</p> <p>Fiscal Note: Implement accordingly at estimated cost of \$41,035 to hire a half-time research assistant for eight months to conduct a meta-analysis of the literature, with staff and legal oversight.</p>	<p>Monitor</p>	<p>Not adopted</p>

Reference Committee C (medical education)

YPS HOD Handbook Review Committee: Tina Brueschke, MD, Chair; Nita Kulkarni, MD; and John Ratliff, MD

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HOD resolution/report	Action requested	Recommended AMA-YPS position	Final AMA-HOD action
Resolution 313: Alternative Approaches to Dealing with Medical School Tuition Costs and Student Indebtedness	<p>RESOLVED, That our American Medical Association, through the Council on Medical Education and the Initiative to Transform Medical Education, study the applicability of novel models such as using endowment funds to lessen the impact of educational costs on medical students, develop policy recommendations, and suggest a work plan for how these models can be implemented by medical schools, with a report back at 2009 Annual Meeting (Directive to Take Action); and be it further</p> <p>RESOLVED, That our AMA work with stakeholders such as the Liaison Committee on Medical Education, Association of American Medical Colleges, and all US medical schools, to implement solutions based on novel models such as using endowment funds to minimize student indebtedness, and provide an update on the status of these efforts at the 2010 Annual Meeting and periodically thereafter. (Directive to Take Action)</p> <p>Fiscal Note: Implement accordingly at estimated staff cost of \$1,500.</p>	Monitor	Referred
Resolution 314: Physician Scientist Benefit Equity	<p>RESOLVED, That our American Medical Association support the concept that all resident and fellow physicians who function in a role as physician scientists are provided with benefits packages comparable to those provided to their peers in clinical residencies or fellowships, to include disability insurance, life insurance, HIV indemnity, malpractice insurance including tail coverage, retirement benefits, health, sick leave and wages commensurate with their education and experience, and if a given benefit or salary is provided to some residents within a given program at the same postgraduate level, then that benefit must be provided to all residents. (New HOD Policy)</p> <p>Fiscal Note: Staff cost estimated at less than \$500 to implement.</p>	Monitor	Referred
Resolution 315: Evaluation of Increasing Resident Review Committee Requirements	<p>RESOLVED, That our American Medical Association study residency/fellowship documentation requirements for program accreditation and the impact of these documentation requirements on program directors and residents with recommendations for improvement. (Directive to Take Action)</p> <p>Fiscal Note: Estimated cost of \$38,602 to visit between 10 to 20 GME sponsoring institutions and analyze work effort involved by a representative sample of program directors and Designated Institutional Officers to respond to ACGME accreditation requirements.</p>	Monitor	Adopted as amended; see http://www.ama-assn.org/ama1/pub/uploadd/mm/471/annotateddc.doc for exact wording

Reference Committee C (medical education)

YPS HOD Handbook Review Committee: Tina Brueschke, MD, Chair; Nita Kulkarni, MD; and John Ratliff, MD

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HOD resolution/report	Action requested	Recommended AMA-YPS position	Final AMA-HOD action
Resolution 316: Loss of Status Following Family Medical Leave Act Qualified Leave During Residency Training	<p>RESOLVED, That our American Medical Association oppose requiring residents to repeat a year of training when returning to work following a leave that qualifies under the federal Family Medical Leave Act (FMLA) (New HOD Policy); and be it further</p> <p>RESOLVED, That our AMA urge the American Board of Medical Specialties and its member boards to be in compliance with the FMLA and to retract any policies that do not comply. (Directive to Take Action)</p> <p>Fiscal Note: Staff cost estimated at less than \$500 to implement.</p>	Support	CME Report 11 adopted as amended in lieu of Resolution 316; see http://www.ama-assn.org/ama1/pub/upload/mm/471/annotatedcdc.doc for exact wording
Resolution 317: Telemedicine and Medical Licensure	<p>RESOLVED, That our American Medical Association study how guidelines regulating medical licenses are affected by telemedicine and medical technological innovations that allow for physicians to practice outside their states of licensure. (Directive to Take Action)</p> <p>Fiscal Note: Estimated cost of \$135,128 to develop instrument and conduct survey and follow up.</p>	Oppose	Adopted as amended; see http://www.ama-assn.org/ama1/pub/upload/mm/471/annotatedcdc.doc for exact wording
Resolution 318: Protecting Patients and Residents by Reducing Extended Work Shifts	<p>RESOLVED, That our American Medical Association reaffirm support of the current Accreditation Council for Graduate Medical Education (ACGME) duty hour restrictions (Reaffirm HOD Policy); and be it further</p> <p>RESOLVED, That our AMA encourage the voluntary reduction or elimination of extended work shifts (greater than 16 hours) for residents and fellows by academic medical centers and teaching hospitals while opposing a new ACGME mandate at this time (Directive to Take Action); and be it further</p> <p>RESOLVED, That our AMA continue to evaluate outcomes-based research on the impact of reductions in extended work shifts on (1) Patient Safety, (2) Resident Education, (3) Resident Safety, (4) Resident Quality of Life and (5) Professionalism in Transfer of Care (Directive to Take Action); and be it further</p> <p>RESOLVED, That our AMA develop specific prioritized research questions/objectives to further evaluate issues related to resident duty-hour reforms, such as best practices for signing out patients and organizing patient care teams. (Directive to Take Action)</p> <p>Fiscal Note: Staff cost estimated at less than \$500 to implement.</p>	Monitor	CME Report 5 adopted as amended in lieu of Resolution 318; see http://www.ama-assn.org/ama1/pub/upload/mm/471/annotatedcdc.doc for exact wording

Reference Committee C (medical education)

YPS HOD Handbook Review Committee: Tina Brueschke, MD, Chair; Nita Kulkarni, MD; and John Ratliff, MD

Note: The text of all resolutions and reports can be viewed at <http://www.ama-assn.org/ama/pub/category/18588.html>.

HOD resolution/report	Action requested	Recommended AMA-YPS position	Final AMA-HOD action
Resolution 319: Medical Education in Disaster Response	<p>RESOLVED, That our American Medical Association study the current status of disaster education and training in medical schools, with a report back to the House of Delegates at the 2009 Annual Meeting. (Directive to Take Action)</p> <p>Fiscal Note: Implement accordingly at estimated staff cost of \$1,613.</p>	Active Support	Adopted as amended; see http://www.ama-assn.org/ama1/pub/upload/mm/471/annotateddc.doc for exact wording
Resolution 320: Tax Deductibility of Medical Education	<p>RESOLVED, That our American Medical Association advocate that payments for medical education tuition or medical education loans be deductible for US federal income tax purposes (New HOD Policy); and be it further</p> <p>RESOLVED, That our AMA continue to work to make medical education affordable for and accessible to all qualified and interested individuals. (Directive to Take Action)</p> <p>Fiscal Note: Staff cost estimated at less than \$500 to implement.</p>	<p>Active Support with Amendment in Resolved 1</p> <p>Support Resolved 2</p>	Referred
Resolution 321: Promotion of Better Pain Care	<p>RESOLVED, That our American Medical Association express its strong commitment to better access and delivery of quality pain care through the promotion of enhanced research, education and clinical practice in the field of pain medicine (Directive to Take Action); and be it further</p> <p>RESOLVED, That our AMA undertake a study and report back by the 2009 Annual Meeting about the following: (1) the scope of practice and body of knowledge encompassed by the specialty of pain medicine; (2) the adequacy of undergraduate, graduate and post graduate education in the principles and practice of the specialty of pain medicine, considering the current and anticipated medical need for the delivery of quality care for pain; and (3) the advisability of pursuing primary board certification in pain medicine available to physicians qualified by training and examination. (Directive to Take Action)</p> <p>Fiscal Note: Implement accordingly at estimated cost of \$162,651.</p>	Oppose	Adopted as amended; see http://www.ama-assn.org/ama1/pub/upload/mm/471/annotateddc.doc for exact wording

Reference Committee C (medical education)

YPS HOD Handbook Review Committee: Tina Brueschke, MD, Chair; Nita Kulkarni, MD; and John Ratliff, MD

Note: The text of all resolutions and reports can be viewed at <http://www.ama-assn.org/ama/pub/category/18588.html>.

HOD resolution/report	Action requested	Recommended AMA-YPS position	Final AMA-HOD action
Resolution 322: Non-ABMS Boards	<p>RESOLVED, That our American Medical Association, through its Council on Medical Education, prepare a report on the status of non-ABMS boards, which represent current medical specialties, including the role they play in the delivery of health care (Directive to Take Action); and be it further</p> <p>RESOLVED, That such a report be brought back by the 2009 Annual Meeting. (Directive to Take Action)</p> <p>Fiscal Note: Implement accordingly at estimated cost of \$304,698.</p>	Oppose	
Resolution 323: Improvements to the Maintenance of Certification Process	<p>RESOLVED, That, by September 15, 2008, our American Medical Association Board of Trustees write a letter to the American Board of Medical Specialties (ABMS) asking that it work with its 24 member boards to:</p> <ul style="list-style-type: none"> A. Coordinate with each other, the ABMS, specialty societies and the AMA to ensure that the demands of MOC are reasonable; B. Educate physicians and increase their understanding of the MOC process and its requirements; C. Solicit physician input and feedback regarding MOC implementation; D. Make transparent all recertification-related costs; E. Work to minimize the disruption of physician practice due to MOC requirements; F. Ensure that the number of MOC-related testing dates and the location of testing sites are ample enough to minimize the burden on physician practices and their time away from clinical care; and G. Coordinate with the Accreditation Council for Continuing Medical Education (ACCME) to develop continuing medical education (CME) credits for MOC preparation activities. (Directive to Take Action) <p>Fiscal Note: Staff cost estimated at less than \$500 to implement.</p>	Active Support	Adopted as amended; see http://www.ama-assn.org/ama1/pub/uploads/mm/471/annotateddc.doc for exact wording