REPORTS OF COUNCIL ON MEDICAL EDUCATION

The following reports, 1-9, were presented by Sandra F. Olson, MD, Chair:

1. ANNUAL REPORT ON AMA MEDICAL EDUCATION ACTIVITIES: 2004

HOUSE ACTION: FILED

This informational report summarizes the major activities of the Council on Medical Education and American Medical Association Medical Education Group during 2004. For more information on the Council on Medical Education, see *www.ama-assn.org/go/councilmeded*.

COUNCIL ON MEDICAL EDUCATION

The Council on Medical Education was founded in 1904 with the general goal of improving medical education in the United States. In 2004, the Council celebrated its 100th anniversary.

The Council now has four general goals:

- To propose policy on medical education to the AMA House of Delegates.
- To act as primary liaison between the AMA and other organizations with responsibility for medical education and physician performance.
- To collect and disseminate information about undergraduate, graduate, and continuing medical education/continuing professional development.
- To ensure the quality of medical education and the physician graduate.

Council activities during 2004-2005 can be classified into several areas.

Policy Development and Implementation

During 2004-2005, the Council submitted 14 reports for consideration by the House of Delegates, as well as one additional report for information. Reports typically are developed with advice and input from relevant areas of the AMA, especially the Section on Medical Schools, the Resident and Fellow Section, and the Medical Student Section.

In addition, the Council took major steps to enhance the AMA Physician's Recognition Award (PRA), by approving policy changes to allow continuing medical education credit to be awarded, in certain cases, for performance assessment activities. An initiative to develop guidelines for Internet-based, "just-in-time" education is nearing completion.

The Council on Medical Education, supported by staff from the Professional Standards Group of the AMA, has embarked on a major initiative to improve the quality of patient care by transforming medical education and training. A Leadership Group, with membership from the Board of Trustees, Council on Medical Education, Section on Medical Schools, Medical Student Section, and Resident and Fellow Section, will coordinate the activities of the initiative which will begin in the second half of 2005.

Liaison to Other Organizations

One of the major activities of the Council is to identify and recommend qualified nominees for various national medical education-related committees. The nominations are reviewed and finalized by the AMA Board of Trustees. During 2004-2005, the Council recommended new appointments to 14 Residency Review Committees (RRCs), the reappointment of 25 existing RRC members, and the nomination of individuals to four medical specialty boards. In addition, the Council recommended appointments or reappointments to accrediting bodies (the Accreditation Council for Continuing Medical Education [ACCME] and the ACCME Accreditation Review Committee). The nomination process ensures that the AMA appoints well-qualified individuals who will work to enhance US medical education.

Accreditation Activities

The Council on Medical Education reviewed and commented on new and revised program requirements submitted by individual RRCs for the following specialties/subspecialties: anesthesiology, geriatric medicine, nuclear medicine, obstetrics-gynecology, pediatrics, pediatric radiology, and vascular and interventional radiology.

Information Collection and Dissemination

The Council on Medical Education collects information under its own auspices and in conjunction with other units in the AMA and its Medical Education Group. For example, an e-mail survey was sent to state and specialty societies asking for information about their policies on physician supply and the physician workforce. This information is being collected as a follow-up to Council on Medical Education Report 2-I-03, "Proposed Revisions to AMA Policy on the Physician Workforce," which, in part, recommended that "our AMA collaborate with state and specialty societies to develop national consensus on physician workforce policy." As follow-up to Council on Medical Education Report 8-A-04, "Resident/Fellow Work and Learning Environment,"the Council is developing a national sample of medical schools and will survey their third-year medical students, resident physicians, and attending clinical faculty on the impact of Accreditation Council for Graduate Medical Education duty hours changes on the clinical teaching environment.

Data also are collected from medical schools through the Liaison Committee on Medical Education (LCME) Annual Medical School Questionnaire. This questionnaire collects information on medical students, faculty, curriculum, and student evaluation from the nation's 125 LCME-accredited medical schools. It is a successor to a survey done annually by the Council on Medical Education beginning in the early 1900s. The data are used for many purposes, including Council on Medical Education reports and an article on undergraduate medical education published annually in the *Journal of the American Medical Association*.

SECTION ON MEDICAL SCHOOLS

Established in 1976 by the House of Delegates to improve communication between practicing physicians and medical educators, the Section on Medical Schools (SMS) provides all US-accredited medical schools and their faculty a voice in House of Delegates deliberations and offers a forum for discussing and developing policies on medical education and national health care issues.

During the Annual and Interim Meetings, the Section provides educational programs on issues of importance to the academic community. For the 100th anniversary celebration of the AMA Council on Medical Education (CME), the SMS and CME cosponsored an educational program on June 11-12, 2004. The educational program brought together leaders in American medical education and health care to discuss issues of importance to the academic community.

The educational program featured presentations on the profession's historic role in ensuring quality medical education, challenges facing medical education and health care, what kinds and how many physicians will be needed in the future, and generational issues in the physician workforce. Nancy Dickey, MD, former AMA president, delivered the luncheon address, "Who Speaks for Medicine?"

At the 2004 Interim Meeting, the SMS featured a presentation on "New Approaches to Healthy Lifestyles and Changing Risky Behaviors." The participants heard about the behavioral and social interventions found to be effective in preventing and changing risky behaviors. They also discussed how physicians' health behaviors affect their patient counseling practices--doctors must practice what they preach. Another presentation covered professionalism. The featured speaker was Faith Fitzgerald, MD, who spoke on "The Vision of Physicians as Portrayed in Film." She explored the relationship between medicine and the movies and the influence on public attitudes, behavior, public policy, and physician humanism. Immediately following Dr. Fitzgerald's presentation was a reactor panel, highlighting professionalism issues, such as the hidden curriculum, service learning and professional development, and licensing and state board influences.

The Annual 2005 Meeting will offer a continuation of the dialogue stemming from the June 2004 meeting, taking an in-depth look at transforming medical education.

The Section's Governing Council recently completed a three-year strategic plan. Identified top priorities will be to (1) continue to influence AMA policy and directives, (2) develop a formal outreach program to encourage academic physicians to become AMA members and participate in Section activities, (3) partner with other AMA Sections, Councils, and Special Groups to make our AMA an effective agent for change in the US health care system, and (4) work with other organizations to pursue common initiatives.

At the 2005 Annual Meeting, the Section will again participate in the Medical Education Caucus--consisting of representatives from the Section as well as the Medical Student Section and Resident and Fellow Section--interviewing candidates for the Board of Trustees and the Council on Medical Education. This process ensures that issues of importance to the academic community are seen as a priority by the candidates.

MEDICAL EDUCATION GROUP ACTIVITIES

Office of the Vice President

Appointments to Other Organizations

Responsibilities of the Office of the Vice President include communicating and sending Council or staff representatives to physician credentialing organizations, such as the American Board of Medical Specialties (ABMS) and Federation of State Medical Boards (FSMB), where medical education issues are discussed. The Council serves as the critical link between these organizations and the AMA and obtains feedback from the representatives to assist in AMA policy development and implementation. Representation to physician assistant accrediting and certifying bodies and health professions accrediting organizations, such as the Commission on Accreditation of Allied Health Education Programs (CAAHEP), are overseen by the Office, with feedback provided to the Council. Good working relationships with these entities are essential to the continued production of several medical education books and CD-ROM products that serve as references for the Council.

The Office is monitoring the work of the Federation of State Medical Boards and state licensing boards as they develop a common licensure application, as specified in Resolution 324 (A-04), Simplifying the State Medical Licensure Process. FSMB staff report that New Hampshire has incorporated the common form into its licensure application process and that several other states have expressed interest. The FSMB is looking to do a pilot project with three to four states to put the form on the Internet so that physicians can complete and submit the form online.

AMA Membership Activities

The Office serves as the liaison to other membership-related groups within the AMA as well as other units within Professional Standards.

Medical School Representation/Outreach Program

This program was reinstated as part of the overall Board of Trustees' Representation Program. It involves participation by members of the Board of Trustees and is coordinated with other areas of the organization, such as Membership, Communications, and the student and resident sections.

The program was implemented on two levels (mini visit and full-day visit), with 10 and four visits, respectively, in 2004, allowing trustees the opportunity to meet with students, faculty, administrators, etc.

Undergraduate Medical Education Policy and Standards

Accrediting Activities

Ongoing Council involvement in undergraduate medical education includes sponsoring the Liaison Committee on Medical Education (LCME). The LCME, established in 1942 by the AMA and the Association of American Medical Colleges (AAMC), approves educational programs leading to the MD degree in the United States and Canada, the latter in cooperation with the Committee on Accreditation of Canadian Medical Schools. The LCME also serves as the deliberative body through which standards and procedures for accrediting educational programs are established.

During 2003-2004, the LCME conducted 18 full accreditation surveys, two of them for Canadian programs. The LCME conducted two visits to consider initial, provisional accreditation of a new MD-granting program in Canada. The LCME Secretariat staff from the AMA and AAMC conducted 14 consultation visits with medical schools, of which three were Canadian. The medical education programs leading to the MD degree at one medical school in Canada and one in the United States, are on probation. During the year, one program in the United States was removed from probationary status and another was placed on probation. The probationary status of the Canadian program was unchanged. The LCME awarded full accreditation to the Florida State University College of Medicine.

Career Information for Premedical and Medical Students

In response to the Council's interest in promoting careers in medicine, medical education staff developed a web site, "Becoming an MD" (*www.ama-assn.org/go/becominganmd*), which remains one of the more popular sites within Medical Education and on the AMA web site. The main page is visited more than 12,000 times per month and serves as a resource in responding to more than 5,000 requests from high school and college students seeking information about the medical profession.

Graduate Medical Education

Liaison Activities

The Council and division staff maintained active liaisons with the following organizations: AcademyHealth, Accreditation Council for Graduate Medical Education (including several Residency Review Committees, e.g., Internal Medicine, Pediatrics, and Psychiatry), American Academy of Family Practice (including its Commission on Education), Association of American Medical Colleges (including their Group on Residency Affairs), Association for Hospital Medical Education, Council on Graduate Medical Education, Council of Medical Specialty Societies (including their Organization of Program Directors Associations), Health Professions Network, Joint Commission on Accreditation of Healthcare Organizations (including their task force on Health Care Professional Education), and 22 allied health professions accrediting organizations.

Direct Communications

GME Program Directors E-letter - This monthly e-mail newsletter, with 13,000 subscribers, provides a forum for sharing and soliciting information on GME (and promoting the AMA's GME products/services). About 150 readers shared their thoughts with AMA staff via e-mail on the articles about work hours and requiring service learning in residency programs.

Medical Education Bulletin - The Bulletin, with a readership of over 11,000, is published twice a year, providing a review of the actions of the HOD of interest to medical educators and serving as a source of information about undergraduate and graduate medical education. The summer issue highlighted the Council's 100th Anniversary.

Bimonthly welcome letter to new program directors - A letter signed personally by the division director goes to all newly appointed program directors (more than 1,000 last year), informing them of the many medical education activities, services, and products provided by the AMA.

Health Professions Career and Education E-letter - This monthly e-mail newsletter, with 6,000 readers, helps reinforce and strengthen AMA relationships with allied health professions accrediting agencies/professional organizations and serves to promote AMA products and initiatives.

Research and Publication

The Department of Data Acquisition Services works closely with the AMA's Department of Census and Self Reported Data and the AAMC to administer the National GME Census. The Census collects information on all ACGME-accredited and combined GME programs, and on all 130,000 active and graduating residents and fellows. GME program information from the Census goes onto FREIDA Online® (see Product section, below), and resident information becomes part of the AMA's Physician Masterfile.

Program and resident information is also used in research studies conducted at the AMA and by health services researchers nationwide. Department staff licensed program and resident data for several research projects, after screening for data security and confidentiality. Furthermore, data were analyzed internally and presented in an article and appendix tables in the Medical Education issue of *JAMA*, published September 1, 2004. Another research study by staff was presented at the annual research meeting of AcademyHealth in June 2004.

Products/Services

FREIDA Online® - This Internet database provides easy access for medical students and residents to information about 8,200 ACGME-accredited and ABMS board-approved GME programs. Total searches by medical students and residents range from 28,000 to 82,000 per week.

Graduate Medical Education Directory - Now in its 90th edition, the 2005-2006 "Green Book" continues to be a key reference work for the GME community. It contains 8,042 ACGME-accredited programs and 208 ABMS board-approved combined programs, for a total of 8,250.

GMED Companion: An Insider's Guide to Selecting a Residency Program - This book features data on salary, hours of duty per week, call schedule, and other variables for 4,200 specialty programs, displayed in a grid format for quick comparison. The 2005-2006 edition includes listings of web sites/publications for information on nonaccredited fellowship opportunities.

Guidebook for GME Program Directors - Available online, this document provides pertinent and valuable information to residency directors/coordinators on all facets of AMA involvement in GME, as well as contact information for the ACGME, ABMS specialty boards, FSMB, state medical boards, and specialty societies that are part of the AMA Federation.

Health Professions Career and Education Directory - The 2005-2006 edition of this annual book includes 6,745 educational programs and 2,515 educational institutions in 65 health professions.

State Medical Licensure Requirements and Statistics - Published annually, this book provides updated information on licensing board requirements for the 54 allopathic and 13 osteopathic boards of medical examiners in the US and territories.

Continuing Physician Professional Development (CPPD)

The Division of CPPD pursues strategies, ongoing development and support for the Council in relation to CME. It also administers the AMA's status as an ACCME-accredited provider, which in 2004 was raised to "Accreditation with Commendation." In September 2004, Alejandro Aparicio, MD, became CPPD's new director. Well known in the Illinois CME community, Dr. Aparicio joins the AMA with extensive practical experience and fresh ideas for the AMA PRA.

Performance Improvement CME

In September 2004, the Council approved AMA PRA Category 1 credit rules for Performance Improvement (PI) activities. These guidelines enable CME providers and physicians to work on the design and implementation of structured PI interventions that capture learning from a retrospective assessment of practice, a prospective application of appropriate measurement sets, and a careful evaluation of the results. CPPD has worked with the ACCME to assist in their development of accreditor guidance for PI activities (available at: *www.ama-assn.org/go/cme*).

Internet Point of Care CME

In March 2005, the Division plans to conclude five years of work with a presentation, for Council approval, of AMA PRA credit system rules governing how Category 1 credit can be awarded for interactive, physician-directed use of clinical databases at the point of care (PoC). Learners will be asked to review their inquiry, identify relevant sources consulted, and describe the application of their search to practice. CPPD has worked with the ACCME on provider guidance for this new modality. Once approved, the guidelines will be available at *www.ama-assn.org/go/cme*.

Designation Statement Study

The ACCME in 2003 began collecting from providers an attestation that they would comply with all AMA PRA credit system requirements. ACCME also agreed to secure, on behalf of CPPD, a representative sample of certified CME activities. CPPD will evaluate the data for compliance with the required AMA PRA designation statement. So far, 100% of providers have attested to their willingness to comply with AMA PRA requirements. Approximately two-thirds of the activity files sampled had minor discrepancies in the use of the designation statement. This effort will help direct educational initiatives that support CME provider compliance with the AMA PRA.

Conjoint Committee on CME

CPPD has actively participated in the Conjoint Committee on CME, a group hosted by the Council of Medical Specialty Societies. The Committee focuses on galvanizing action toward the evolution of CME. It seeks to accomplish this through consensus recommendations that would guide CME into more documented and effective forms of continuing professional development. This effort will help advance adoption of the AMA PRA's new interactive, practice-based, learning modalities (see first two items in this section). James L. Borland, Jr., MD, has represented the Council on the Conjoint Committee, which is leveraging input from thirteen of the principal stakeholders in CME (ACCME, ACGME, ACME, AAFP, ABMS, AHA, AMA, AOA, AHME, CMSS, FSMB, NBME, and the Society of Academic Continuing Medical Education (SACME).

15th Annual Task Force Conference

In September, CPPD hosted the 15th Annual Conference of the National Task Force on CME Provider/Industry Collaboration: "Effective CME and Industry Collaboration: Understanding Boundaries." The event had its largest audience ever, with over 500 participants representing all areas of the CME enterprise. The CPPD looks forward to returning to the Baltimore Marriott Waterfront Hotel on October 24-26 for the 16th Annual Conference, "Practical Strategies for Survival in the Guideline-rich Environment of 2005." Additional information available at *www.ama-assn.org/go/cmetaskforce*.

Regional Meetings

The Division of CPPD held its first regional conference on CME, "New Directions in Physician Learning," on November 18, 2004, in Hoffman Estates, outside Chicago. This conference provided a unique focus on the AMA PRA credit system, particularly highlighting new developments such as the recently approved AMA PRA performance improvement guidelines. The AMA planned and marketed this event in collaboration with the Illinois Alliance for CME, and CPPD plans to partner with state and regional organizations for additional regional conferences in summer and fall 2005. Additional information is available at *www.ama-assn.org/go/regionalcme*.

Communications and Resources

CPPD continuously explores new ways to connect with the CME community. The CPPD web site includes the applications for the AMA PRA certificate and for international activities, an AMA PRA tutorial, and other AMA PRA materials. CPPD also delivers updates through presentations at conferences and meetings, both at the national and state level. The *CPPD Report*, published three times per year, reaches nearly 5,000 subscribers in both print and online versions. CPPD also contributes columns in the Society for Academic CME's *Intercom* and the Alliance's *Almanac*. The AMA continues active participation with multiple collaborative efforts, including the Physician Consortium for Performance Improvement and the Coalition for Physician Enhancement.

2. COUNCIL ON MEDICAL EDUCATION SUNSET REVIEW OF 1995 AND OTHER SELECTED HOUSE OF DELEGATIONS POLICIES

HOUSE ACTION: RECOMMENDATION ADOPTED AND REMAINDER OF REPORT FILED

At its 1984 Interim Meeting, the House of Delegates established a sunset mechanism for House policies (Policy G-600.110, AMA Policy Database). Under this mechanism, a policy established by the House ceases to be viable after 10 years unless action is taken by the House to retain it.

The objective of the sunset mechanism is to help ensure that the AMA Policy Database is current, coherent, and relevant. By eliminating outmoded, duplicative, and inconsistent policies, the sunset mechanism contributes to the ability of the AMA to communicate and promote its policy positions. It also contributes to the efficiency and effectiveness of House of Delegates deliberations.

At its 2002 Annual Meeting, the House modified Policy G-600.110 to change the process through which the policy sunset review is conducted. The process now includes the following steps:

- In the spring of each year, the House policies that are subject to review under the policy sunset mechanism are identified.
- Using the areas of expertise of the AMA Councils as a guide, the staffs of the AMA Councils determine which policies should be reviewed by which Councils.
- For the Annual Meeting of the House, each Council develops a separate policy sunset report that recommends how each policy assigned to it should be handled. For each policy it reviews, a Council may recommend one of the following actions: (a) retain the policy; (b) rescind the policy; or (c) retain part of the policy. A justification must be provided for the recommended action on each policy.
- The Speakers assign each policy sunset report for consideration by the appropriate Reference Committee.

Although the policy sunset review mechanism may not be used to change the meaning of AMA policies, minor editorial changes can be accomplished through the sunset review process.

Staff review of the AMA Policy Database this year found several policies that are over 10 years old, but were inadvertently overlooked in previous sunset reviews. These policies are included this year along with the 1995 policies.

The Council on Medical Education's recommendations on the disposition of the House policies that were assigned to it are included in the Appendix to this report.

RECOMMENDATION

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.

APPENDIX - RECOMMENDED ACTIONS ON 1995 AND OTHER SELECTED HOUSE OF DELEGATES POLICIES

Policy Number	*Title*	*Recommended Action and Rationale*
H-35.987	Medical Acts by Unlicensed Individuals	Retain. The policy still is relevant.
H-45.993	Support of Residencies in Aerospace Medicine	Retain. Although there only are four existing programs in Preventive Medicine/Aerospace, the policy still is relevant.
H-200.966	Federal Financial Incentives and Medical Student Career Choice	Retain. The policy still is relevant.

Policy Number	*Title*	*Recommended Action and Rationale*
H-220.989	Physician Credentialing	Retain. The policy still is relevant.
H-225.969	Disputes Between Medical Supervisors and Trainees	Retain. The policy still is relevant.
H-230.964	Physician Credentialing and Privileging	Retain. The policy still is relevant. Throughout, the term “sponsor” should be replaced by “provider,” as this is the currently-accepted terminology.
H-250.993	Overseas Medical Education Developed by U.S. Medical Associations	Retain. The policy still is relevant.
H-255.989	A Program for Exchange Visitor Physicians	Retain. The policy still is relevant.
H-255.991	Education for Foreign Physicians	Retain. The policy still is relevant.
H-255.994	Physician Exemption from Medical School Standards and Performance Requirements	Retain. The policy still is relevant.
H-275.949	Discrimination Against Physicians Under Supervision of their Medical Examining Board	Retain. The policy still is relevant.
H275.985	Graduate Medical Education Requirement for Medical Licensure	Retain. The policy still is relevant.
H-295.918	Strengthening Education in Geriatrics	Retain. The policy still is relevant.
H-295.920	Academic Freedom	Retain. The policy still is relevant.
H-295.926	Support for Development of Continuing Education Programs for Primary Care Physicians in Non-academic Settings	Retain. The policy still is relevant.
H-295.929	Faculty/Staff Appointments at More Than One Medical School	Retain. The policy still is relevant.
H-295.977	Socioeconomic Education for Medical Students	Retain. The policy still is relevant.
H-295.980	Clinical Training in STD for Medical Students/Physicians in Training	Retain. The policy still is relevant.
H-300.959	25th Anniversary of the AMA PRA	Retain. The policy still is relevant. The title should be changed to reflect the content of the policy: “~~25th Anniversary of the AMA PRA~~ Physician Participation in the AMA Physician’s Recognition Award”
H-300.967	Continuing Medical Education Learning Assessment Form	Rescind. The policy no longer is relevant. The “Learning Assessment Form” has been superseded by a procedure “PRA credit certificate language for new procedures” that is included in the “Physician’s Recognition Award Requirements for Accredited Providers” (version 3.2, pages 25-26).
H-300.970	Continuing Medical Education for Expanded Hospital Privileges	Rescind. The policy no longer is relevant. The “Learning Assessment Form” has been superseded by a procedure “PRA credit certificate language for new procedures” that is included in the “Physician’s Recognition Award Requirements for Accredited Providers” (version 3.2, pages 25-26).
H-300.983	Community Hospital Continuing Medical Education	Retain. The policy still is relevant.
H-300.984	Abuses of the Continuing Medical Education System	Retain in part. The terminology used in the policy is out of date. “The AMA urges accredited ~~sponsors~~ providers of continuing medical education to accept the responsibility for careful compliance with the ~~“Essentials and Guidelines for Accreditation of Sponsors of Continuing Medical Education”~~ “ACCME’s Essential Areas and Elements” in order to prevent abuses of the continuing medical education system.

Policy Number	*Title*	*Recommended Action and Rationale*
H-305.948	Direct Loan Consolidation Program	Retain. The policy still is relevant.
H-305.981	Funding of Graduate Medical Education	Rescind. The reason for the deletion is that the policy is being incorporated into a consolidated policy as part of Council on Medical Education Report 7-A-05, Proposed Revision to Policy on Medical Education Financing.
H-305.982	Student Loan Repayment Defaults	Retain. The policy still is relevant.
H-305.983	Proposed Cuts in Student Aid	Retain. The policy still is relevant.
H-305.990	AMA ERF Student Assistance Funds	Retain in part. The title of the program has changed. "AMA ~~ERF Student Assistance Funds~~ Foundation Scholars Fund The AMA urges that all student recipients of monies from the AMA ~~ERF Student Assistance Fund~~ Foundation Scholars Fund be made aware of the course of these funds, and that medical school financial aid offices and medical students be informed of the existence and activities of the AMA and the Medical Student Section."
H-305.991	Repayment of Educational Loans	Retain. The policy still is relevant.
H-305.998	Health Professions Scholarship Program	Retain. The policy still is relevant.
H-310.945	Graduate Medical Education Faculty Evaluations	Retain in part. The ACGME Common Program Requirements (VI B) require the evaluation of faculty, so encouragement of the Residency Review Committees no longer is necessary. "~~The AMA will request its representatives to the ACGME to encourage the Residency Review Committees that do not have explicit procedures for the evaluation of faculty, including evaluation by residents, to develop procedures and implement them.~~ The AMA recommends that evaluations of residency program faculty should be done in a confidential manner, at least annually, and the areas evaluated should include teaching ability, clinical knowledge, scholarly contributions, attitudes, interpersonal skills, communication ability and commitment. Residency program directors should provide faculty members with a written summary of the evaluations."
H-310.987	Resident Physician Training	Retain. The policy still is relevant.
H-310.988	Adequate Resident Compensation	Retain. The policy still is relevant.
H-310.991	Assistance in Completion of Residency Programs	Retain. The policy still is relevant.
H-310.992	Revision of "General Requirements" for Graduate Medical Education	Rescind. The "General Requirements" no longer exist. The current ACGME Institutional Requirements clearly state eligibility requirements (III A.1).
H-310.993	Resident Participation on Hospital Committees	Retain in part. The intent of item #1 has been accomplished, through the ACGME Institutional Requirements. "The AMA ~~(1) encourages the inclusion in residency programs of education about hospital staff organization, the function of hospital committees and the several responsibilities of attending staff membership and (2)~~ encourages hospitals with graduate medical education programs to include residents on hospital executive, fiscal and other committees."
H-310.994	Curriculum Orientation of Medical Staff Membership in Teaching Programs	Retain. The policy still is relevant.
H-310.995	Anonymity for Resident Inquiries to Residency Review Committees	Retain. The policy still is relevant.
H-365.995	Competence in Occupational Medicine of Hospital-Based Physicians Assigned to Occupational Medicine Practice	Retain. The policy still is relevant.

Policy Number	*Title*	*Recommended Action and Rationale*
H-405.995	Administration and Supervision of Rehabilitation Units	Retain. The policy still is relevant.
H-425.982	Training in the Principles of Population-Based Medicine	Retain. The policy still is relevant.
H-425.988	The Guide to Clinical Preventive Services	Retain in part. The name of the guide has changed and some of the elements of the policy (#2, 3, and 5) already have been accomplished. "The US Preventive Services Task Force Guide to Clinical Preventive Services "It is the policy of the AMA: (1) that our AMA continue to work with the federal government, specialty societies, and others to develop guidelines for, and effective means of delivery of, clinical preventive services; ~~(2) that AMA representatives to the Liaison Committee on Medical Education alert the committee to the Guide's availability as a resource for curricular development in preventive medicine; (3) that AMA representatives to the ACGME urge the ACGME to include preventive medicine content in the General Essentials and alert the ACGME to the Guide's availability as a resource for assessing compliance with this essential;~~ and ~~(4)~~ (2) that our AMA continue its efforts to develop and encourage continuing medical education programs in preventive medicine~~; and (5) that the Guide be expanded to include the appropriate preventive health services of children and women~~.
H-450.990	Physician Information for Credentialing	Retain. The policy still is relevant.
H-460.989	Animals as Experimental Subjects	Retain. The policy still is relevant.
H-480.988	Allocation of Privileges to Use Health Care Technologies	Retain. The policy still is relevant.

3. IMPLICATIONS OF THE NOVEMBER 2003 EMERGENCY MEDICAL TREATMENT AND LABOR ACT (EMTALA) FINAL RULE

HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS IN LIEU OF RESOLUTIONS 212, 234, AND 235 AND REMAINDER OF REPORT FILED

Resolution 234 (A-04), which was submitted by the Section on Medical Schools and adopted by the House of Delegates, asks that our American Medical Association study the impact that the new EMTALA regulations will have on patient care particularly at academic medical centers and at facilities in less populous regions, and report back to the House of Delegates at the 2005 Annual Meeting.

This report first will provide a history of the Emergency Medical Treatment and Labor Act (EMTALA) and summarize the Final Rule that went into effect on November 10, 2003. Then, the report will highlight some concerns and unresolved issues that require ongoing attention by our AMA.

HISTORY AND PROVISIONS OF EMTALA

EMTALA was passed in 1986 as part of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) in response to reports that hospital emergency rooms were refusing to accept or treat individuals with emergency conditions who did not have health insurance. Found under sections of the Social Security Act [1866(a)(1)(I), 1866(a)(1)(N), and 1867)], EMTALA places certain requirements on Medicare-participating hospitals that offer emergency services. The requirements are in force whether or not the patient is a beneficiary of any federal program under the Social Security Act (e.g., Medicare). Also known as the "patient anti-dumping statute," EMTALA, in general, requires:

- That medical screening examinations and, if an emergency situation exists, necessary stabilization or appropriate transfer, occur for all patients who come to the emergency department requesting an examination or treatment for a medical condition or present on hospital property requesting an examination or treatment for an emergency medical condition, and

- That there be no delay in providing screening or stabilization to inquire into a patient's ability to pay or to seek "prior authorization" for the provision of services from an insurer.

Additional regulations under EMTALA include a hospital's obligation to report receipt of inappropriately transferred patients; to post signs in the emergency department indicating the right to emergency treatment; and to maintain on-call logs and emergency room logs.

Civil monetary penalties may be imposed on hospitals or physicians for negligent failure to provide appropriate screening for an individual seeking medical care, negligent failure to provide appropriate stabilization for an emergency condition, and inappropriate transfer of an individual, among other violations. On September 9, 2003, the Centers for Medicare and Medicaid Services (CMS) issued a "Final Rule" (42 CFR Parts 413, 482, and 489) clarifying policies related to the responsibilities of Medicare-participating hospitals in treating individuals with emergency conditions. The Final Rule, effective November 10, 2003, includes the following key provisions:

- *Definition of Emergency Department.* The definition of an emergency department was expanded to include any department or facility of the hospital, on or off the main hospital campus, that is licensed by the state as an emergency department, or is believed by the public to provide care for emergency conditions without needing an appointment, or that provided emergency care during at least one-third of its outpatient visits in the previous calendar year.

- *On-call Schedules.* Hospitals can develop their on-call lists in ways that best meet community needs, as in accordance with hospital resources. Physicians are permitted to be on-call at more than one hospital simultaneously and to schedule elective surgery or other procedures during on-call times. Hospitals are permitted to maintain a level of on-call coverage that is within their capability, and physicians are not required to be on-call at all times. Hospitals must have policies and procedures that they must follow when a particular specialty or on-call physician is not available. For example, rural hospitals with limited availability of specialist physicians can have procedures in place to ensure access through other means.

- *Ambulance Service.* Hospital-owned ambulances may comply with local or citywide protocols for responding to emergencies.

EMTALA obligations end when an individual is stabilized, transferred (appropriately) to another hospital/facility, or admitted in good faith as an inpatient.

AMERICAN MEDICAL ASSOCIATION POLICY

Our AMA has a number of existing policies related to EMTALA. A number of policies and directives (H-130.950, D-130.989, and D-130.994, AMA Policy Database), in part, oppose expansion of EMTALA and recommend a return to the original congressional intent (i.e., preventing emergency departments from turning away or transferring patients without insurance). Directives also recommend that our AMA develop educational guidelines to inform medical staff physicians about on-call requirements under EMTALA (D-130.996) and participate in the creation of options for on-call coverage in the context of EMTALA (D-130.998). A set of principles for emergency department on-call coverage are contained in Policy H-130.948.

The AMA worked in partnership with several medical specialty societies to provide input to CMS prior to the adoption of the Final Rule.

ISSUES AND REMAINING CONCERNS

There are several general issues that remain either unresolved or uncertain related to EMTALA.

EMTALA as an Unfunded Mandate - EMTALA has been deemed to be an "unfunded mandate," since hospitals are not permitted to take into account the insurance status or ability to pay of patients presenting to emergency departments. There had been no explicit provision for funding the services provided under EMTALA. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (PL 108-173 or MMA) now provides the possibility of reimbursement for EMTALA-related "medically necessary" screening and stabilization provided to undocumented and other specified groups of aliens (Section 944). Funding will be based on information available at the time services are ordered or furnished. It is unclear, however, to what degree the funding will compensate for costs incurred by hospitals and physicians that are fulfilling EMTALA mandates.

Emergency Department Crowding and On-Call Issues - Emergency department crowding is reported to be a national problem. For example, in a random sample of emergency departments, 91% of respondents reported overcrowding as a problem, at least at some points in time. About one-third of emergency departments can be classified high safety-net providers (have a high proportion of uninsured/underinsured patients), with disproportionate share funding not always available or sufficient to cover costs. EMTALA can place a large financial burden on such hospitals and on the physicians who are staffing and on call at the emergency department.

There is evidence that there is, at least in some locations and specialties, difficulty in obtaining on-call coverage. For example, a recent survey in California representing most of the state's emergency departments showed that 38% of emergency departments had difficulty obtaining specialty response in plastic surgery, 36% in otolaryngology, 23% in neurosurgery, and 18% in orthopedics. About three-quarters of emergency departments experienced problems with specialty response at night and on weekends. The majority of hospitals did not pay specialists for call. Various commentaries note that while EMTALA requires hospitals to have call panels, it does not, itself, require physicians to be available for call and does not mandate a particular level of minimum on-call coverage. Lack of specialist physician availability and/or willingness to take call at some institutions may place additional pressure on other facilities, for example, academic health centers and trauma centers, which are more likely to have a range of physician specialists available for on-call coverage. Trauma centers, for example, report receiving patients who have low severity injuries or who need non-injury-related emergency surgery because of the availability at those facilities of on-call surgeons, especially at night and on weekends.

In May 2004, CMS announced the creation of a technical advisory group (TAG) to review hospital responsibilities under EMTALA. The TAG was mandated under the MMA (Section 945) and is charged to help CMS "develop rules that will protect individual rights while minimizing unnecessary burdens on hospitals and physicians." The TAG consists of 19 members, including 2 agency members specified by the MMA and 17 to be appointed by the Secretary of HHS from nominations submitted by interested groups, including 4 hospital representatives, 7 practicing physicians from defined specialties, and 2 patient representatives. The AMA was active, in collaboration with medical specialty societies, in the nominations process for the TAG and a member of the Organized Medical Staff Governing Council was appointed as a TAG member. Unless extended by Congress, the charter of the TAG is due to expire 30 months from the date of its first meeting.

SUMMARY AND RECOMMENDATIONS

The most recent EMTALA Final Rule addressed some areas of concern, including creating more flexibility for hospitals to develop on-call schedules. However, this flexibility may be negatively impacting certain categories of hospitals, including trauma centers and academic health centers. These types of facilities often bear the cost of patients transferred from other institutions that do not have a range of specialists available. It is critical that all categories of hospitals and that emergency department and on-call physicians be fairly compensated for providing EMTALA-mandated services. Therefore, the Council on Medical Education recommends that the following be adopted and that the remainder of this report be filed:

1. That our American Medical Association ask the Emergency Medical Treatment and Labor Act (EMTALA) Technical Advisory Group (TAG) and the Centers for Medicare and Medicaid Services (CMS) for assistance in ameliorating the differential economic and staffing burdens on certain categories of facilities, including but not limited to academic health centers, trauma centers, critical access hospitals, and safety net hospitals, which are likely to receive high volumes of patients as a result of the EMTALA regulations.

2. That our AMA work with the EMTALA TAG and CMS to ensure that physicians staffing emergency departments and on-call emergency services be appropriately compensated for providing EMTALA mandated services.

3. That our AMA initiate additional advocacy strategies to implement H-130.970[5] that states: "All health payers should be required to cover emergency services provided by physicians and hospitals to plan enrollees, as required under Section 1867 of the Social Security Act (i.e., medical screening examination and further examination and treatment needed to stabilize and "emergency medical condition" as defined in the Act) without regard to prior authorization or the emergency care physician's contractual relationship with the payer" and report back at the 2005 Interim Meeting.

4. That our AMA, with input from all interested Federation members, coordinate an effort to educate the membership about emergency department coverage issues and the efforts to resolve them.

5. That our AMA seek to require all insurers, both public and private, to pay promptly and fairly all claims for services mandated by EMTALA for all plans they offer, or face fines and penalties comparable to those imposed on providers.

6. That our AMA seek to have CMS require all states participating in Medicaid, as a condition of continued participation, establish and adequately fund state Emergency Medical Services funds which physicians providing EMTALA-mandated services may bill, and from which those physicians shall receive prompt and fair compensation.

(References pertaining to Report 3 of the Council on Medical Education are available from the Medical Education Group.)

4. NATIONAL RESIDENT MATCHING PROGRAM REFORM (RESOLUTION 309, A-04)

HOUSE ACTION: RECOMMENDATIONS ADOPTED AND REMAINDER OF REPORT FILED

Resolution 309 (A-04), "National Residency Match Program Reform," which was submitted by the California Delegation and referred to the Board of Trustees, contained four major resolves with multiple subsections and asked that:

Our American Medical Association work with the National Residency Match Program (NRMP) to seek reforms to the NRMP to include the following basic principles:
1. Rank ordering must continue to prefer student, not program choices;
2. Programs and students must continue to be able to get second, third and lower choices;
3. Couples must continue to be able to apply dually;
4. Antitrust laws must be followed;
5. Transaction costs must be kept to reasonable levels;
6. Residents must continue to be recognized as "labor";
7. Training and education must be dominant vs. "scut work" in any realignment of work hours;
8. Programs must be able to continue their "safety net" function; and
9. All solicitations must avoid "exaggeration of interest."

Our AMA work with the NRMP to seek reforms to the NRMP to include the following requirements:
1. The Match should be continued, not abolished;
2. The Match should continue to be held in March;
3. Programs should not be permitted to remove positions from the Match once they have committed these positions to it. Students should not be permitted to withdraw from the Match after the deadline for submission of the "rank order" to the Match;

4. Students should be allowed to "opt out" of the NRMP Match without penalty when there are extenuating circumstances;
5. Programs should pay all the costs of the Match, i.e., no cost to students;
6. Solicitation of students by programs should not begin before October 1;
7. Programs should provide a "draft" contract to students on request, anytime after October 1, and it should be negotiable up until the student submits their rank-order for program preference;
8. Programs must make all information they share with other programs available to students, i.e., "transparent"; and
9. The Osteopathic Match should be incorporated into a single all-student Match.

Our AMA support working with the NRMP to seek reforms to the NRMP that should include the following requirements:
1. Non-US medical school graduates should not be treated the same as US graduates by the Match;
2. Programs should be allowed to provide "commentary" about their programs referable to other programs, e.g., regional averages for salary; and
3. The US Military Residency Selection process should not be incorporated into the Match.

Our AMA address the following issues, for which there has not been consensus, in any modification of the NRMP:
1. The Match should not allow short (less than 7 days) deadlines for responses to position offerings;
2. If any revised Match allows a student the option to refuse the program with which the student matches, then all programs the student applied to must give the student a sufficient amount of time (not less than 7 days, not more than 30 days) to respond to the offers tendered;
3. Programs should be allowed to offer some positions outside of the Match;
4. Programs should be permitted to continue to set aside a specified portion of available positions (__ %) for students they recruit outside of the Match. Some or all of these positions can be re-entered into the Match, but no later than (___) weeks before the Match;
5. Students should be allowed to "opt out" of their matched residency if they want to try for another position via a secondary Match;
6. Students should not be allowed to "opt out" without penalty after the Match, i.e., seek other program opportunities than the ones with which they have matched;
7. Students should continue to have access, secured and confidential, to the FREIDA database, and programs should not be able to access the data of the other programs;
8. The Accreditation Council for Graduate Medical Education should continue to review only such program data as necessary to set standards that assure proper residency educational experience, workload and program viability; and
9. There should be a body that oversees and recommends fair salaries for residents.

BACKGROUND

The resolves noted above were developed as the result of a report of the Resident Match Technical Advisory Committee of the California Medical Association that was presented on March 12, 2004. The advisory committee had been established in response to concerns about the consequences of an antitrust lawsuit that had been filed against the NRMP on May 7, 2002 and the results of a 2003 survey in which almost one-half of the respondents indicated that there was a need to reform the NRMP Match.

The first resolve identifies general principles of policy that were deemed to be necessary for the effective continuation of the Match. The second resolve lists consensus statements of the advisory committee for the structure and operation of the Match. However, the members of the advisory committee were unable to reach agreement of the definition of "extenuating circumstances" cited in item 4. The third resolve addressed specific items that should not be considered in any proposed reforms. The final resolve included items for which no consensus could be reached and are identified as reform issues for consideration.

In the fall of 2003, the AMA Medical Student Section (MSS) Governing Council created an ad-hoc committee on the NRMP in response to the antitrust lawsuit. A report from the committee that was adopted by the MSS directed that the section survey its members to define specific aspects of the NRMP Match that required improvement. The survey consisting of 29 questions was emailed to students and residents in the AMA Masterfile on May 3, 2004. More than 32,000 surveys were distributed. Valid responses were received from 2,418 third- and fourth-year students and 1,557 residents. The report of the survey was presented to the MSS Assembly in MSS Governing Council Report F (I-04). Overall, students surveyed either did not know enough about the Match to form an opinion or were satisfied with the Match, but had specific suggestions for its improvement. In addition, applicants expressed frustration with the interview process. Students but not residents believed that applicants should be permitted to hold multiple offers for a short period of time before having to make a final decision. There was agreement that there should be a set date on which offers are made to applicants. Survey respondents believed that it was important for applicants to be able to engage in frank discussions with residency programs in regards to working conditions. While the respondents support the concept of the Match, the committee believed that significant concerns should be conveyed to the NRMP to ensure that the Match meets the needs of its applicants.

The recommendations of the report included many items supporting the current NRMP Match as well as suggestions to improve student knowledge and the interview process. Additional specific recommendations dealt with the findings of the survey, some of which did not directly relate to the NRMP Match but focused on working conditions and salary. Most importantly, the report recommended that the findings of the survey be used to inform future discussions and policy decisions regarding the NRMP. The AMA Resident and Fellow Section supported all of the recommendations of the MSS Governing Council report in its own Assembly at the 2004 Interim Meeting.

MODIFICATIONS IN THE NRMP POLICIES AND PROCEDURES

Several events related to the NRMP have transpired since Resolution 309 (A-04) was discussed at Reference Committee C and referred by the House of Delegates that impact the timeliness and necessity of many of the resolves. The Pension Funding Equity Act of 2004 that was signed into law in April 2004 included language that stated that federal antitrust laws "do not prohibit sponsoring, conducting, or participating in a graduate medical education residency matching program, or agreeing to do so." On August 12, 2004, the US District Court for the District of Columbia ruled that this applied to the pending antitrust lawsuit and dismissed the antitrust claims against 27 teaching hospitals and two medical organizations. Claims against the AMA had been dismissed in February 2004. Motions to reconsider and amend the August 2004 dismissal were denied in early 2005. Appeals from the prior dismissal are pending and a NRMP motion to compel arbitration is also pending.

At its meeting of October 25, 2004, the NRMP Board of Directors voted to expand its membership and for the first time designated slots for residency program directors, resident physicians, and a public member. The NRMP Board of Directors will consider the bylaws changes in May 2005. Each of the current five sponsors of the NRMP will continue to nominate individuals for two seats to be elected by the Board. The two program director positions will be filled through one nomination from the Organization of Program Director Associations and the other from an at-large call for nominations. The three resident physician positions must include at least one international medical graduate and will come from an at-large call. One public member will be elected by the Board. In addition, the number of voting positions for medical students will be increased from two to three with designated nominations from the AMA Medical Student Section, the Association of American Medical Colleges (AAMC) Organization of Student Representatives, and the American Medical Student Association (AMSA). It is anticipated that these changes will become effective in 2006.

The Match Participation Agreement that is signed by each participating institution now requires each of the institution's programs to provide "complete and accurate information to interviewees, including a copy of the contract the applicant will be expected to sign if matched to the program and the institution's policies on visa status and eligibility for appointment to a residency or fellowship position." The information must be communicated in writing to interviewees prior to the rank order list certification deadline.

The NRMP is considering a proposal for a second or two-phased match. The proposal has been made available for comment to applicants, program directors, medical school officials, and institutional officials registering for the 2005 Main Residency Match. Feedback to date on the proposal has varied based on the particular constituency.

Institutions, medical schools, and program directors have been generally opposed to the proposal while applicants favor the concept of a second match. However, various details of the proposal, such as making phase-one matched applicants wait until after phase two to receive their match results, are opposed by all constituents. A decision by the NRMP Board is expected in May 2005.

EXISTING AMA POLICY

The AMA has limited but supportive policy regarding the National Resident Matching Program. Current policy is directed at making medical students more aware of the NRMP policies and procedures and evaluating the number and type of violations of the NRMP Match Participation Agreement. Policy also seeks to have greater involvement of residency program directors in discussion of violations of NRMP policies and procedures and that program directors have designated seats on the NRMP Board. (See D-310.997, "Compliance with National Resident Matching Program Requirements by Residency Program Directors," and H-295.891, "Governance of the National Resident Matching Program," AMA Policy Database.)

DISCUSSION

Many of the components of the first and second resolves of Resolution 309 (A-04) support the policies and procedures of the current NRMP Match. Included in these items is the matching algorithm, schedule of the matching process, matching of couples, controlling costs, listing of programs, and providing appropriate program information. The NRMP reviews the issue of "opting out" without penalty and determines on an individual basis the validity of the circumstances.

Other components of the second and third resolves suggest alternatives that are currently part of the NRMP Match or might be considered for inclusion. At the present time, international applicants are subject to different rules than are US graduates and the US Military Residency Selection process occurs prior to the NRMP Match as does the Osteopathic Match. Any effort to include the Osteopathic Match in the NRMP Match would require the cooperation of both organizations and could have a negative impact on osteopathic medicine.

Several components of the resolutions do not deal with issues related to the Match but address general graduate medical education and health care delivery issues. While laudable, items dealing with the recognition of resident physicians as "labor," training and education, and the "safety net" function of health care institutions need to be addressed in other contexts.

The components of the fourth resolve are difficult to address since a consensus was not reached on these items by the Resident Match Technical Advisory Committee of the California Medical Association (CMA) or by the CMA. Some items are based on the presumption of a two-phased Match while others are refinements of agreed upon components of the second resolve. In addition, the last three items do not relate to the Match. It would seem most prudent to consider these items as possible alternative suggestions to be discussed should further input be requested.

AMA-MSS GOVERNING COUNCIL SURVEY

The findings of the MSS survey and the subsequent recommendations adopted by the AMA-MSS Assembly and the AMA-RFS Assembly also support the policies and procedures of the current NRMP Match. These include support for the schedule of the matching process, the strict enforcement of penalties and the requirement to provide future contracts and appropriate program information. In addition, the medical students and resident physicians have offered suggestions for the modification of the Match and requested that all organizations with a vested interest in the process be included in the evaluation of any such proposals. One of these proposals to subject US medical student seniors and international applicants to the same rules is in direct opposition to a resolve proposed by the CMA.

Suggestions for modification of the current Match, such as the interest of students to bargain with residency program directors on terms of employment and the potential for applicants to hold multiple offers of employment, are identified for further study. Several of the recommendations do not deal with issues related to the Match but address terms of employment such as equal pay for residents in the same program at the same level of training, opposition to reduced salaries for stronger rank placement, or requirements to pay for enrollment in residency training. Another item in this category is the request that programs offer multiple interview dates and appropriate advance notice.

Most importantly, the medical students and residents have requested that the results of the MSS Governing Council survey be used to inform future discussions and policy decisions in regards to the NRMP. These two groups have also called for the development of an educational program regarding the Match process.

NRMP STATISTICS

The NRMP Match continues to be an efficient and effective placement system for filling positions in graduate medical education in the US. In 2004 there were 25,246 active applicants in the Match that included 14,609 US senior students. The number of US senior students is at the highest level recorded in the past ten years. During this same time period more than 85% of US senior students have matched to one of their top three choices with about 60% getting their first choice. Participation of couples in the Match has also increased with 641 paired applicants in 2004. The number of first-year residency positions offered in the Match reached a record high of 21,192 this past year. This level of participation by both students and residency programs suggests a reasonable degree of overall satisfaction with the program that is supported by the findings of the MSS survey.

SUMMARY AND RECOMMENDATIONS

Based on the events that have occurred since the development and referral of Resolution 309 (A-04) and the complexity of the various suggestions for modifying the NRMP Match, the Council on Medical Education recommends that the following recommendations be adopted in lieu of Resolution 309 (A-04) and that the remainder of this report be filed.

1. That our American Medical Association support the National Resident Matching Program (NRMP) as an efficient and effective placement system for filling positions in graduate medical education in the US.

2. That our AMA work with the NRMP to develop and distribute educational programs to better inform applicants about the NRMP matching process.

3. That our AMA actively participate in the evaluation of, and provide timely comments about, all proposals to modify the NRMP Match.

4. That our AMA request that the NRMP explore the possibility of including the Osteopathic Match in the NRMP Match.

5. That our AMA continue to review the NRMP's policies and procedures and make recommendations for improvements as the need arises.

6. That our AMA work with the Accreditation Council for Graduate Medical Education and other appropriate agencies to assure that the terms of employment for resident physicians are fair and equitable and reflect the unique and extensive amount of education and experience acquired by physicians.

5. INTERNATIONAL MEDICAL GRADUATES ON ACCREDITATION COUNCIL FOR GRADUATE MEDICAL EDUCATION (RESOLUTION 316, A-04)

HOUSE ACTION: RECOMMENDATIONS ADOPTED AND REMAINDER OF REPORT FILED

Resolution 316 (A-04), "International Medical Graduates on Accreditation Council for Graduate Medical Education," which was submitted by the Michigan Delegation and referred to the Board of Trustees, asked that our American Medical Association nominate International Medical Graduate (IMG) physicians to the Accreditation Council for Graduate Medical Education Board of Directors.

AMA'S ROLE IN GRADUATE MEDICAL EDUCATION (GME)

Throughout the 20th century, the AMA through its Council on Medical Education (CME), has played a significant role in the evaluation and accreditation of GME training programs. In 1912 (two years after the Flexner report which reformed undergraduate medical education), the Council conducted the first survey of hospitals for the training of interns. In 1917 the Council established the "Essentials for Approved Internships" and ten years later promulgated the "Essentials for Registered Hospitals and Approved Residencies and Fellowships." Over the years other organizations collaborated with the AMA in the accreditation process and in1972 five organizations sponsored the Liaison Committee on Graduate Medical Education. The other four organizations were the American Board of Medical Specialties, American Hospital Association, Association of American Medical Colleges, and Council of Medical Specialty Societies. In 1981, the LCGME was succeeded by the Accreditation Council for Graduate Medical Education (ACGME) and the same five member organizations incorporated the ACGME as a separate, private, not-for-profit council in 2000. Each member organization nominates four members to the ACGME Board of Directors. In addition to these twenty members, the Board of Directors includes two resident physician members (one is the Chair of the ACGME Resident Council, the other is nominated by the AMA's Resident and Fellow Section), the Chair of the Council of Review Committee Chairs and three public members.

ACGME'S MISSION

The ACGME's mission is to improve the quality of health care by ensuring and improving the quality of graduate medical education in the United States. There are currently more than 100,000 residents and fellows in more than 8,000 residency programs which the ACGME evaluates and accredits. The ACGME accomplishes residency program accreditation through a peer review process based upon established standards and guidelines. The ACGME has 28 review committees (RCs), one for each of the 26 specialties, one for one-year transitional year general clinical programs, and one for institutional review. Each review committee comprises 6 to 15 volunteer physicians. The AMA is one of the appointing organizations to all residency RCs (RRCs).

AMA appointments to the RRCs and AMA nominations to the ACGME Board are initiated by the Council on Medical Education and finalized by the Board of Trustees. Becoming a member of a Review Committee or the ACGME Board of Directors is considered prestigious and offers physicians an opportunity to make a meaningful contribution to graduate medical education.

INTERNATIONAL MEDICAL GRADUATES IN GME

Graduates from medical schools outside of the US and Canada are referred to as International Medical Graduates. More than 26% of residents and fellows in ACGME accredited programs are IMGs. Issues of particular concern to this important AMA constituency include potential discrimination in selection for residency and evaluation during training. Since most IMGs are pursuing training on a J-1 visa, dismissal from a training program could result in loss of their visa status. Because of their vulnerability, IMGs must be provided due process protections and confidential reporting mechanisms so that IMGs are comfortable in reporting violations of residency standards to the ACGME. In addition, the ACGME is in a unique position to take an advocacy role in opposing discrimination against IMGs.

DISCUSSION AND RECOMMENDATIONS

The Council on Medical Education concurs that well qualified IMGs would be excellent candidates for appointment to the ACGME Board of Directors and that their participation would give the ACGME a broader perspective on residency issues. However, the Council does not support the creation of "slotted seats" (board positions to be filled specifically by IMGs or other interested groups). The Council encourages participation by IMGs in its own activities and has a history of nominating well-qualified IMGs to serve on Residency Review Committees.

The Council on Medical Education, therefore, recommends that the following be adopted in lieu of Resolution 316 (A-04) and that the remainder of this report be filed.

1. That our American Medical Association encourage the candidacy of well qualified International Medical Graduates for the Council on Medical Education.

2. That our AMA strongly consider well qualified International Medical Graduates for nomination to the Accreditation Council for Graduate Medical Education Board of Directors.

6. FELLOWSHIP APPLICATION REFORM (RESOLUTION 323, A-04)

HOUSE ACTION: RECOMMENDATIONS ADOPTED IN LIEU OF RESOLUTION 323 (A-04) AND REMAINDER OF REPORT FILED

Resolution 323 (A-04), which was introduced by the Resident and Fellow Section and referred by the House of Delegates to the Board of Trustees, asks that our American Medical Association: (1) working with specialty societies, support the development of a standardized application and selection process for each fellowship training specialty, specifically to simplify the process of application for subspecialty training; and (2) encourage that residents are allowed adequate exposure to subspecialty training prior to the initiation of the fellowship application process.

The rationale for reforming the fellowship application process is based on perceived deficiencies and inequities in the current system. Specifically, applying for and being accepted in a fellowship is a rolling process which lacks uniform subspecialty timelines and does not utilize a uniform, electronic system like the Electronic Residency Application System (ERAS). Furthermore, fellowship selections do not employ a consistent match process and timeline such as the National Resident Matching Program (NRMP) utilizes for first- and second-year residency positions.

Due to timing issues, resident physicians applying for fellowships are compelled to begin the fellowship application process before they have had sufficient exposure to all areas within their core specialty; as a result, they may not be able to make an informed decision. Furthermore, resident physicians may make hasty commitments to programs out of fear of not receiving other offers. These factors may limit the time resident physicians have to visit and compare multiple programs before signing a contract. Likewise, some fellowship programs may feel pressured into making premature commitments in order to fill their programs.

The current situation and its inherent problems are very similar to those experienced by medical students seeking initial residency training positions before the inception of the National Resident Matching Program. In 1952, the AMA joined four other organizations to sponsor the NRMP. Since then, the NRMP has served as a fair and efficient process to match applicants and programs. Before the "Match" was introduced, many students were pressured to pick a specialty before they had finished their primary clinical rotations. The Match eliminated two other practices that created serious problems for both students and programs: "exploding offers" that required students to respond within 24 or 48 hours and "bottlenecks" that resulted when students held open offers while hoping for better ones.

CURRENT SERVICES OF THE NATIONAL RESIDENT MATCHING PROGRAM (NRMP)

In addition to the Match for first- and second-year residency positions, the NRMP's Specialty Matching Services (SMS) conducts matches for advanced residency or fellowship positions. Those specialty matches occur throughout the year and each requires its own registration process with the NRMP. Fellowship positions generally begin in July.

The SMS is provided by the NRMP to organizations of training program directors whose entry level positions require applicants to have completed one or more years of graduate medical education. To qualify for matching services, sponsoring organizations must identify an individual to represent the organization in negotiating the terms of the services to be provided by the SMS. Organizations receiving matching services are expected to identify eligible programs and to assist the NRMP in communicating with the member programs.

Beginning in July 2001 and every year thereafter, in order for the NRMP to provide a matching service, each specialty is requested to:

- verify that at least 75% of the programs with available positions in a given year will be registered for the Match;
- encourage programs to actively participate by submitting a rank order list; and
- have at least 75% of the available positions within the specialty registered with the NRMP.

According to the National Resident Matching Program web site, the following specialty matches are currently managed by the NRMP. The dates in parenthesis indicate the year when the match started.

- Abdominal Transplant Surgery (2005)
- Child & Adolescent Psychiatry (1995)
- Colon & Rectal Surgery (1984)
- Combined Musculoskeletal Matching Program (CMMP)
  - Hand Surgery (1990)
- Medical Specialties Matching Program (MSMP)
  - Cardiovascular Disease (1986)
  - Pulmonary and Critical Medicine (1986)
  - Infectious Disease (1986-1990; rejoined in 1994)
  - Rheumatology (2005)
- Minimally Invasive and Gastrointestinal Surgery (2003)
- Obstetrics/Gynecology
  - Reproductive Endocrinology (1991)
  - Gynecologic Oncology (1993)
  - Maternal-Fetal Medicine (1994)
  - Female Pelvic Medicine & Reconstructive Surgery (2001)
- Ophthalmic Plastic & Reconstructive Surgery (1991)
- Pediatric Cardiology (1999)
- Pediatric Critical Care Medicine (2000)
- Pediatric Emergency Medicine (1994)
- Pediatric Hematology/Oncology (2001)
- Pediatric Rheumatology (2004)
- Pediatric Surgery (1992)
- Primary Care Sports Medicine (1994)
- Radiology
  - Abdominal Radiology (2003)
  - Breast Imaging/Women's Imaging (2003)
  - Interventional Radiology (2002)
  - MRI (2003)
  - Musculoskeletal Radiology (2003)
  - Neuroradiology (2001)
  - Pediatric Radiology (2003)
  - Special/Combined Programs in Radiology (2003)
  - Thoracic Radiology (2003)
  - Ultrasound (2003)
- Spine Surgery (2002)
- Surgical Critical Care (2004)
- Thoracic Surgery (1988)
- Vascular Surgery (1988)

Although this is a long list, it is not comprehensive and the process is voluntary for both specialties and applicants. Furthermore, since the process allows for as many as one-quarter of the positions in a specialty to be offered outside of the Match, it is almost impossible to identify exceptions or violations.

CURRENT SERVICES OF THE ELECTRONIC RESIDENCY APPLICATION SERVICE (ERAS)

ERAS Fellowships is a part of the Electronic Residency Application Service of the Association of American Medical Colleges (AAMC) and is specifically aimed at fellowship positions. It is commonly used by residents or fellowship applicants to apply for specialization training beyond completion of the initial residency training. The specialties that are currently eligible to participate in ERAS are listed below:

- Colon and Rectal Surgery, Start Date: July 2004
- Critical Care Medicine, Start Date: December 2004
- Pulmonary Medicine, Start Date: December 2004
- Pulmonary and Critical Care Medicine, Start Date: December 2004
- Vascular Surgery, Start Date: December 2004
- Rheumatology, Start Date: December 2004
- Infectious Diseases, Start Date: December 2004
- General Surgery-Pediatric Surgery, Start Date: December 2004

Fellowship applications to programs participating in the July cycle could be submitted beginning on July 15, 2004. These applications culminated in a November/December Match for positions that begin July 1, 2005. Fellowship applicants to programs participating in the December cycle could begin selecting and applying to programs on November 15, 2004. These applications will culminate in a May/June Match for positions starting July 1, 2006.

Starting in 2006, ERAS Fellowships will provide application services for the following nine specialties (to fill 2007 positions):

- Cardiology
- Endocrinology
- Hematology
- Hematology/Oncology
- Nephrology
- Oncology
- Pediatric Emergency Medicine
- Pediatric Nephrology
- Thoracic Surgery

CURRENT SERVICES OF THE SAN FRANCISCO MATCHING PROGRAM (SF MATCH)

The SF Match provides support services to applicants and programs to facilitate the application and selection process for residency and fellowship positions. In addition to residency positions in Neurological Surgery, Neurology, Ophthalmology, Otolaryngology and Plastic Surgery, the SF Match provides application and selection services for the following fellowship positions:

- Child Neurology
- Spine Surgery
- Craniofacial Surgery
- Facial Plastic Surgery
- Mohs Surgery
- Neurosurgery (all subspecialties)
- Ophthalmology (all subspecialties)
- Otology/Neurotology
- Pediatric Otolaryngology

DISCUSSION AND RECOMMENDATIONS

The percentage of resident physicians pursuing fellowships continues to grow. Currently, almost one-third of resident physicians continue training beyond their initial residency program. A uniform, electronic-based system like ERAS would make the application process easier and more orderly. Therefore, it seems to be an opportune time to simplify and bring order to the process of applying for and being accepted into fellowship training.

In addition to ERAS, the NRMP, and the SF Match, the medical specialty societies and the medical specialty boards are major stakeholders in this process. The Council of Medical Specialty Societies (CMSS) could provide a forum to discuss this issue with its member organizations. Likewise, the American Board of Medical Specialties (ABMS) could provide a venue to approach its member boards.

The Council on Medical Education, therefore, recommends the following be adopted in lieu of Resolution 323 (A-04) and that the remainder of this report be filed.

1. That our American Medical Association support the concept of a standardized application and selection process for fellowship training positions.

2. That our AMA encourage the Electronic Residency Application Service; the National Resident Matching Program; the San Francisco Matching Program; the Council on Medical Specialty Societies and its member organizations; and the American Board of Medical Specialties and its member medical specialty boards to develop a plan to standardize the application and selection process for each specialty. The plan should assure that:

   (a) the process provides adequate time for the resident to be exposed to all subspecialties within a specialty before he/she must apply to a fellowship training program;
   (b) a consistent application and match process and timeline is adopted across all available subspecialties within each specialty; and
   (c) a process is developed which gives both applicants and programs ample time to evaluate each other before generating their ranking lists.

3. That our AMA report back to the House of Delegates at the 2007 Annual Meeting on progress toward achieving a standardized application and selection process for fellowship training positions.

7. PROPOSED REVISIONS TO AMA POLICY ON THE FINANCING OF MEDICAL EDUCATION PROGRAMS (RESOLUTION 319, A-04; RESOLVES 2 AND 3)

HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS IN LIEU OF RESOLUTIONS 305 AND 322 AND RESOLVES 2 AND 3 OF RESOLUTION 319 (A-04) AND REMAINDER OF REPORT FILED

This report responds to the following resolutions and recommendations from previous reports.

Resolves 2 and 3 of Resolution 319 (A-04), "Medicare Graduate Medical Education and Medicaid Disproportionate Share Funding," which was submitted by the Texas Delegation and referred to the Board of Trustees, asked that our American Medical Association work with the Centers for Medicare and Medicaid Services and other appropriate entities to:

- work for increased and geographically equitable Medicare graduate medical education funding, and
- stabilize Medicare graduate medical education and Medicaid Disproportionate Share Hospital Funding.

Recommendation 2 of Council on Medical Education Report 1-I-02, "Preserving Medicaid Funding of Graduate Medical Education," asked that our AMA continue to monitor the status of funding for graduate medical education by state Medicaid programs and report back to the House of Delegates.

Resolves 5 and 7 of Resolution 848 (I-03), which was submitted by the Medical Student Section and adopted by the House of Delegates, asked that our AMA study and report back at the 2005 Annual Meeting on:

- the feasibility of earmarking federal funds to undergraduate medical education for the purpose of reducing medical school tuition at public and private universities, and
- appropriate methods for calculating the value of clinical work performed by medical students and taking such calculations into account when determining the cost of educating a medical student.

Recommendation 6 of Council on Medical Education Report 3-I-03, "Strategies to Combat Mid-year and Retroactive Tuition Increases," which was adopted by the House of Delegates, asks that our AMA study the funding of medical education to identify:

- the status of revenue sources used to support undergraduate and graduate medical education programs, including current constraints on these revenue sources;
- strategies to reduce these financial constraints; and
- mechanisms to ensure that funding for undergraduate and graduate medical education programs is maintained, so as to reduce the financial burden on medical students and resident physicians.

This report responds to the resolutions and report recommendations listed above in the context of the study of medical education financing called for in Council on Medical Education Report 3-I-03. The study of medical education financing, in turn, prompted a review of current AMA policy on the financing of undergraduate and graduate medical education programs. In order to engage in proactive advocacy or to respond to pending legislation or regulations, AMA policy must be coherent, consistent, and up-to-date. Policy review and revision will support the AMA's ability to participate in initiatives at the national and state levels to ensure adequate and appropriate funding for medical education programs. This report (1) summarizes the current mechanisms for financing medical schools and residency training programs; (2) describes a scheme to categorize current policy; and (3) presents recommended revisions to policy and proposals for action.

The Council on Medical Education also is reviewing policy on the financing of medical student education, especially mechanisms to reduce medical student debt. That report will be presented to the House of Delegates in December 2005, and will specifically address the issue of calculating the value of clinical work performed by medical students (Resolve 7 of Resolution 848, I-03).

CURRENT SOURCES OF MEDICAL EDUCATION PROGRAM FINANCING

Medical schools and residency training programs are funded from a variety of public and private sources.

Medical School Funding

The Table illustrates the sources of medical school revenue.

Table - Sources of Funding for Public and Private Medical Schools

Revenue Source	Percent of Total Funding (2002-2003)	
	Public Schools	Private Schools
Tuition and Fees	2.7	3.8%
State Appropriations	12.8	0.6
Parent University	1.0	0.4
Grants and Contracts (direct)	25.2	25.8
Indirect Cost Recoveries	6.2	7.9
Faculty Practice (Practice Plan)	32.8	38.8
Transfers from Hospitals	12.1	12.5
Gifts and Endowments	3.2	5.4
Other Revenue Sources	4.1	5.1

Source: Association of American Medical Colleges. LCME Annual Financial Questionnaire/2002-2003

In recent years, state support to public medical schools has, in general, either remained constant or decreased. Across all schools (public and private) state funding accounted for about 6.5% of total revenue in 2003, but was an important source of unrestricted revenue. Tuition increases at many medical schools have been in response, at least in part, to declining state support. While tuition accounts for only about 3-4% of total revenue, it also is an important source of discretionary (uncommitted) funding.

The major source of total medical school revenue comes from faculty practice, accounting for an average of 36% of total revenue in 2002-2003. Most of this funding goes toward practice expenses, including salaries. It is customary, however, for a percentage of revenue from faculty practice to be contributed to the central administration of the medical school. This "dean's tax" is used to support medical education or other programmatic activities.

Grant and contract funding from the federal government and other sources contributes about 25% of total revenue. While this funding is committed to cover research costs, including faculty salaries, it also generates indirect cost recoveries (about 7% of total funding). Indirect costs are handled variably across universities, but the medical school may receive a portion of these funds. In some schools, this funding helps support the educational program.

There is no indication that the federal government would be willing to "earmark" funds to support medical school operations, with the goal of reducing medical student tuition. Based on past history, in order to achieve this result a specific national need would have to be demonstrated. The federal government has not directly funded medical schools, except for specific purposes. For example, federal funding in the past was provided for workforce expansion. In the 1960s-1970s, the federal government provided capitation grants to medical schools tied to increases in class size and also supported the development of new schools. With the emerging shortage of physicians, federal or other targeted funding for expanded medical school enrollment or for the development of new medical schools is warranted. The Council on Medical Education, along with other interested groups, will continue to explore other targeted purposes for federal funding.

Medical schools have multiple missions, including education, research, and patient care. At most medical schools, it has been difficult to isolate the revenue sources that support each mission. Cross-subsidization has been common. For example, revenue from clinical practice has contributed to medical student education explicitly, such as through the "dean's tax" on faculty clinical earnings, and implicitly, such as through faculty paid from clinical earnings contributing time to teaching. Now, however, a number of medical schools have begun to budget specifically for the educational mission. In 2003-2004, 35 medical schools (28% of MD-granting schools) had implemented a system to distribute funding to departments or faculty based on their contributions to education and 40 schools (32% of the total) were developing such a system. This funding often comes from tuition and state support (in public schools), though other funding sources also may contribute. An explicit funding stream for medical education can help in assuring faculty availability to teach, because departments and/or individual faculty are receiving at least some compensation for lost clinical income.

There have been various attempts to calculate the cost of educating a medical student. The instructional costs (costs of adding medical students to an environment in which graduate medical education, research, and patient care already exist), when adjusted to the base year of 1996, averaged $40,000-50,000 per student per year. Total educational resource costs (costs for developing an educational program with necessary research and patient care) were calculated to be around $71,000-93,000 per student per year. A number of studies, mostly in the ambulatory setting, indicated that the presence of medical students decreases physician productivity. In a national study, including resident physicians, medical students, and/or allied health/nursing students, the operating costs of ambulatory teaching sites increased by 24-36%. However, medical students also can contribute to the work of a hospital or ambulatory unit, by providing ancillary services and performing other needed tasks. The value of these services would be difficult to quantify, as requested in Resolution 848 (I-03). For example, there is an expectation that medical students be supervised, so that their work also has an associated cost.

Graduate Medical Education Funding

Sources of funding for residency training (graduate medical education) can be identified but many are difficult to quantify. Graduate medical education is financed by direct payments for that purpose (explicit support) and also by payments provided for other purposes (implicit support).

<u>Federal and State Government Funding</u>

Medicare is the single largest explicit payer for graduate medical education (GME), covering 30-40% of the estimated total costs. Medicare paid almost $8 billion dollars to teaching hospitals in 2004. Currently, Medicare supports GME in hospital-based specialties. Medicare funding to hospitals comes in two segments:

1. The "direct" funding reimbursement (about $2.6 billion in 2004) is meant to support a proportion of resident salaries, the costs of resident supervision, and other direct costs of the teaching program. It is calculated based on the number of residents in training, a "per resident" cost figure, and the percentage of Medicare patients at the given hospital. For historic reasons, there is wide variation among hospitals in the "per resident" cost. Medicare direct funding is reduced for residents (fellows) who are past their first board certification or in GME beyond the time required for first-board certification (e.g., fellows are counted as 0.5 FTE in most cases).

2. The "indirect" medical education adjustment (about $5.3 billion in 2004) is paid to teaching hospitals. It is calculated based on a formula that uses a legislatively-determined multiplier and the resident to bed ratio. The calculated result is an adjustment to the amount paid for each Diagnosis-Related Group (DRG). The indirect medical education adjustment (IMEA) is meant to address the higher costs that teaching hospitals incur, but is not solely tied to teaching activity. The Balanced Budget Act (BBA) of 1997 began the process of cutting the IMEA by reducing the multiplier, but some amelioration was granted by the Balanced Budget Refinement Act (BBRA) of 1999 and the Medicare Prescription Drug, Improvement and Modernization Act of 2003.

There currently is a cap in the current number of Medicare-funded GME positions. With the existing or predicted shortage of physicians in many regions and specialties, this cap serves as a disincentive to growth in the physician workforce.

Medicaid is the second-largest explicit payer for GME, contributing about $2.5-2.7 billion to teaching hospitals in 2002. These payments are optional, in that there is no explicit national requirement for states to support GME. However, in 2002, 47 states and the District of Columbia provided GME funding under their Medicaid programs. With the budgetary constraints on states, a few have considered reducing or have eliminated or curtailed Medicaid payments for GME. While 2002 data about levels of state support are the latest available, a number of strategies are being used by states. These include:

- carving out GME payments under Medicaid managed care and channeling them directly to teaching hospitals;
- creating a medical education "trust fund" supported by multiple payers (three states have or are planning such a program); and/or
- using special Medicaid financing strategies, such as intergovernmental transfers, to increase the availability of funds to support GME.

Pediatric residency programs in children's hospitals receive funding from annual appropriations. These appropriations come from the Health Resources and Services Administration, not the Centers for Medicare and Medicaid Services.

Hospitals that treat a significant percentage of poor/uninsured patients are eligible to receive disproportionate share (DSH) funding. Though not directed to the support of graduate medical education, DSH funding is an important revenue source for teaching hospitals, since they provide a large proportion of the nation's uncompensated care. DSH funding is allocated through an adjustment to the reimbursement rates for each Medicare case. DSH payments were cut by the BBA and partially restored by the BBRA.

In some states, there are line items in the state budget to support residency training in family medicine. The federal government also offers training grants and research grants that support educational programs, as well as individual residents and fellows.

Private Sector Funding

There is little explicit funding of GME by the private health insurance sector. However, implicit funding may come from the higher charges of teaching hospitals (payment over 100% of costs), though this is difficult to quantify. Funding for GME also may come from grants/contracts, faculty practice plans (based in patient care revenue), philanthropy, and subsidies from sponsoring or affiliated managed care plans.

Direct Patient Care Revenue

Residency programs in subspecialties (fellowships) may be funded, in part, from patient care revenue that the fellow, as a licensed physician, can generate.

SUMMARY OF CURRENT AMA POLICY

The Council found 32 existing policies or parts of policies related to the funding of undergraduate (medical school) and graduate medical education in the following sections of the AMA Policy Database: H-165 (Health Care System Reform), H-200 (Health Workforce), H-295 (Medical Education), H-305 (Medical Education: Financing and Support), H-310 (Medical Education: Graduate), and H-460 (Research).

In addition to being scattered among many sections of the policy database, there was considerable redundancy among policies and some addressed different aspects of the same issue. Therefore, as a first step, policies and parts of policies covering the same issue were grouped into categories. Since some policies addressed multiple issues, a given policy was included in as many categories as relevant. Then summary statements were created to capture the intent of the policies in a category, while not necessarily quoting the policies verbatim. No topic area contained in the cited policies or parts of policies was lost in creating the categories.

Policies or parts of policies related to undergraduate and graduate medical education funding could be grouped into eight summary policy categories. The summary statements for each category are as follows:

1. *Medical Education as a Public Good.* The health and well-being of the American public benefit from undergraduate and graduate medical education. For this reason, there should be public support of academic health centers and of medical schools and graduate medical education programs.
   Relevant Policies/Parts of Policies: 295.898, 305.936[1], 305.981[1]

2. *Consider Medical Education in Health System Planning.* In any plan to modify the health system or to change health system funding, the impact on medical education should be considered so that educational quality and faculty responsibility for education are not compromised.
   Relevant Policies/Parts of Policies: 165.933, 165.935, 165.961, 295.885

3. *Adequate and Stable Medical Education Funding.* There should be adequate and stable funding for medical education (undergraduate and/or graduate). The AMA and members of the Federation should advocate for medical education funding.
   Relevant Policies/Parts of Policies: 165.897, 200.983[3], 305.935[5,8], 305.936[2, 3], 305.946[1], 305.971[2], 305.976, 305.995[2], 310.987, 460.922

4. *Medical School Funding.* The current pluralistic system for support of medical schools should be maintained, with funding coming from a variety of sources including the federal government and the states.
   Relevant Policies/Parts of Policies: 295.955[13], 305.973, 305.988[12, 13], 305.995[4]

5. *Sources of GME Funding.* Ideally, graduate medical education (GME) should be funded by support from all payers for health care. If an all-payer pool is not feasible, GME funding should continue to be linked to the financing of patient care services. There should continue to be funding for GME from Medicare and Medicaid, and private payers (including managed care companies) also should contribute.
   Relevant Policies/Parts of Policies: 165.987, 295.898, 305.933, 305.935[4], 305.945, 305.956, 305.968[3], 305.977[1-5], 305.981[2-8], 305.988[17] 310.936, 310.942

6. *Length of GME Funding.* Full Medicare direct medical education funding should be available for the number of years required for initial board certification. For combined residencies, funding should be available for the longest of the individual programs plus one additional year.
   Relevant Policies/Parts of Policies: 305.944, 305.977[6], 310.931

7. *Reimbursement for Teaching.* Faculty should be explicitly reimbursed for teaching, based on a "CPT code" for teaching activities. Faculty compensation and academic reward should be based on fulfillment of expected teaching duties.
   Relevant Policies/Parts of Policies: 305.946[2, 3], 305.947

8. *Funding Should Follow the Resident.* There should be funding to train residents in a variety of settings. Funding for graduate medical education should follow the resident (be allocated) to the sites where training occurs.
   Relevant Policies/Parts of Policies: 295.907[1], 305.935[7], 305.943, 305.945, 305.968[3], 305.981[3], 310.940, 310.942[1-3]

PROPOSED CHANGES TO CURRENT AMA POLICY

In order to obtain broad-based feedback from the Federation and Councils/Sections of the AMA, the Council on Medical Education held a public hearing during the 2004 Interim Meeting of the House of Delegates to discuss the current policies and also to suggest new policy positions. A number of comments were received during the session and submitted in writing afterward. These have been considered and incorporated into the revisions to policy and recommendations for action.

The following revised policy statements are presented, along with a rationale. Although many do not represent significant changes from current policy, there has been an attempt to simplify the language and clarify the main subject of each policy category.

1. Medical Education as a Public Good

Since quality medical education directly benefits the American people, there should be public support for medical schools and graduate medical education programs and for the teaching institutions in which medical education occurs. Such support is required to ensure that there is a continuing supply of well-educated, competent physicians to care for the American public.

Rationale: The public benefits from both the production of future physicians and from the clinical service provided by teaching institutions. Teaching hospitals and medical school faculty provide a large percentage of the nation's uncompensated care, intensive and specialized services, and complex care.1 These services are costly to maintain. In the late 1990s, more than one-third of teaching hospitals were operating in the red.8 Financial support is needed to ensure their viability.

2. Consideration of Medical Education in Health System Planning

Planning to modify health system organization or financing should include consideration of the effects on medical education, with the goal of ensuring that the quality of medical education and the quality of and access to care in teaching institutions are preserved.

Rationale: The education of medical students and resident physicians is based in institutions that deliver health care. In addition, the financing of undergraduate and graduate medical education, for example through faculty practice, is integrally linked to reimbursement from public and private payers. Changes in how health care is organized and financed will likely have major effects on the ability of teaching institutions to deliver training. Therefore, care must be taken that any health system changes not have the potential to lessen the quality of medical education and patient care in teaching institutions.

3. Adequate and Stable Medical Education Funding

Adequate and stable funding should be available to support quality undergraduate and graduate medical education programs. Our AMA and the Federation should advocate for medical education funding.

Rationale: Medical education is a long-term process. Educating a physician prepared for independent practice takes at least seven years. In addition, medical schools and teaching hospitals must make substantive infrastructure investments to support medical education. Stable funding is necessary to ensure that appropriate long-term investments can be made. Unfortunately, many of the funding sources currently supporting medical student and resident physician education are under threat. This has led to uncertainty and the need to replace reductions in one funding source with increases from another. For example, cuts in state funding have led to medical school tuition increases, sometimes imposed retroactively due to the timing of state legislative decision-making. Legislation also has changed the Indirect Medical Education Adjustment multiplier a number of times, making it difficult for teaching hospitals to anticipate the amount of Medicare GME funding they will receive. Medical schools and teaching hospitals must have the ability to plan based on a knowledge of the funding that they will have available. This will not be possible unless mechanisms are put in place to normalize funding for medical schools and residency training programs.

4. Sources of Medical School Funding

Diversified sources of funding should be available to support medical schools' multiple missions, including education, research, and clinical service. Reliance on any particular revenue source should not jeopardize the balance among a medical school's missions.

Rationale: It could be detrimental to the attainment of all medical school missions if funding from a particular source were to drive faculty activity excessively. For example, medical schools rely heavily on revenue from clinical service and research as sources of faculty support. In many cases, medical schools have introduced incentive and other compensation systems that tie part of faculty compensation to success in these areas. This has, in some cases, created disincentives for faculty to participate in the educational program. It also is sound fiscal policy to not depend on a limited number of funding sources.

5. Sources of Graduate Medical Education Funding

All payers for health care, including the federal government, the states, and private payers, benefit from graduate medical education and should directly contribute to its funding.

Rationale: Medical education is a public good from which all payers benefit. The federal government and, in many cases, the states explicitly support the training of resident physicians. Private payers may contribute in several ways, including paying teaching hospitals over 100% of their costs. This "implicit subsidy" for GME is vulnerable in a competitive market. With many teaching hospitals in a precarious financial situation, additional revenue sources are needed. All payers who benefit from physician services should directly contribute to GME.

6. Length of Full Federal GME Funding

Full Medicare direct medical education funding should be available for the number of years required for initial board certification. For combined residency programs, funding should be available for the longest of the individual programs plus one additional year. There should be opportunities to extend the period of full direct medical education funding for specialties or subspecialties where there is a documented need, including a physician shortage.

Rationale: Residents in the period leading to eligibility for initial board certification should be counted as one full time equivalent (FTE) for purposes of calculating the Medicare direct medical education payment. However, there also should be opportunities to count residents/fellows who are past first board certification as one FTE if there is documented need, such as a physician shortage in the specialty/subspecialty. There is a precedent for this recommendation. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 allows an exception to the limitations on full direct medical education funding for geriatric residency or fellowship programs. Full funding is allowed for approved geriatric residency programs where a resident is required to complete two years of training to initially become board eligible in the specialty.

7. Budgeting for the Educational Mission

Medical schools should develop systems to explicitly document and reimburse faculty teaching activity, so as to facilitate faculty participation in medical student and resident physician education and training.

Rationale: In order to ensure that faculty are available to participate in teaching, there is a need to bring education into parity with other medical school missions that have associated funding streams.

8. Funding for Training Residents in Both Hospital and Non-hospital Settings

Funding for graduate medical education should support the training of resident physicians in both hospital and non-hospital (ambulatory) settings. Federal and state funding formulas must take into account the resources, including volunteer faculty time and practice expenses, needed for training residents in all specialties in non-hospital, ambulatory settings. Funding for GME should be allocated to the sites where teaching occurs.

Rationale: The Balanced Budget Act of 1997 allowed teaching hospitals to claim Medicare reimbursement for the time residents spend in non-hospital settings only as long as the hospital pays all (or substantially all) of the training costs. This did not take into account the fact that community physicians often volunteer their time to participate in teaching. As a result, a moratorium was imposed that prevented fiscal intermediaries from disallowing medical education payments based on the fact that the hospital did not incur the costs of physician time in non-hospital settings. The moratorium only applies to family practice residents. In December 2004, the Inspector General of the Department of Health and Human Services issued a report recommending that the moratorium as currently structured be extended and that more work be done on mechanisms to pay the costs of training residents in non-hospital settings. Our AMA, along with other groups, has written to the Administrator of the Centers for Medicare and Medicaid Services (CMS) asking CMS to "recognize volunteer supervisory physicians in non-hospital sites for purposes of direct graduate medical education and indirect medical education payment policy." This policy should apply to all training in non-hospital sites, not just family medicine.

9. Funding for Workforce Expansion

New funding should be made available to support increases in the number of medical school and residency training positions, preferably in or adjacent to physician shortage/underserved areas and in undersupplied specialties.

Rationale: There is evidence that physician shortages currently exist in some specialties and regions, and more are predicted. Significant increases in the number of medical school and residency training positions would be facilitated by new funding from federal, state and, perhaps, private payers. For example, the current cap on the number of Medicare-funded GME positions should be removed and new determinations made about the number of funded positions. Ideally, new positions should be created in or close to areas or specialties of need, to encourage new physicians to practice in underserved areas or undersupplied specialties.

SUMMARY AND RECOMMENDATIONS

The funding of undergraduate and graduate medical education is complex and often lacks the stability needed for long-term planning at the national, regional, and institutional levels. Multiple funders make decisions in isolation and on schedules that may not be congruent with educational program/teaching institution needs. Decreases in one funding source must be balanced by increases in another, which has the potential to seriously impact members of the academic community, including faculty and medical students. For example, decreases in state funding often result in medical school tuition increases. The following revisions to policy and proposed directives for action will prepare our AMA to work with other interested groups to rationalize this unstable situation.

The Council on Medical Education recommends that the following be adopted in lieu of Resolves 2 and 3 of Resolution 319 (A-04) and that the remainder of this report be filed:

1. That our American Medical Association adopt the following policy positions:

    (a) Since quality medical education directly benefits the American people, there should be public support for medical schools and graduate medical education programs and for the teaching institutions in which medical education occurs. Such support is required to ensure that there is a continuing supply of well-educated, competent physicians to care for the American public.
    (b) Planning to modify health system organization or financing should include consideration of the effects on medical education, with the goal of preserving and enhancing the quality of medical education and the quality of and access to care in teaching institutions are preserved.
    (c) Adequate and stable funding should be available to support quality undergraduate and graduate medical education programs. Our AMA and the Federation should advocate for medical education funding.
    (d) Diversified sources of funding should be available to support medical schools' multiple missions, including education, research, and clinical service. Reliance on any particular revenue source should not jeopardize the balance among a medical school's missions.
    (e) All payers for health care, including the federal government, the states, and private payers, benefit from graduate medical education and should directly contribute to its funding.
    (f) Full Medicare direct medical education funding should be available for the number of years required for initial board certification. For combined residency programs, funding should be available for the longest of the individual programs plus one additional year. There should be opportunities to extend the period of full funding for specialties or subspecialties where there is a documented need, including a physician shortage.

(g) Medical schools should develop systems to explicitly document and reimburse faculty teaching activity, so as to facilitate faculty participation in medical student and resident physician education and training.
(h) Funding for graduate medical education should support the training of resident physicians in both hospital and non-hospital (ambulatory) settings. Federal and state funding formulas must take into account the resources, including volunteer faculty time and practice expenses, needed for training residents in all specialties in non-hospital, ambulatory settings. Funding for GME should be allocated to the sites where teaching occurs.
(i) New funding should be available to support increases in the number of medical school and residency training positions, preferably in or adjacent to physician shortage/underserved areas and in undersupplied specialties.

2. That the following House of Delegates policies be rescinded: H-165.897, H-165.933, H-165.935, H-165.961, H-200.983[3], H-295.885, H-295.898, H-295.907[1], H-295.995[13], H-305.933, H-305.935[4-8], H-305.936, H-305.943, H-305.944, H-305.945, H-305.946, H-305.947, H-305.956, H-305.968[3], H-305.971[2], H-305.973, H-305.976, H-305.977, H-305.981, H-305.988[12-13, 17], H-305.995[1-2, 4], H-310.931, H-310.936, H-310.940, H-310.942, H-310. 987, and H-460.922.

3. That our AMA work with the federal government, including the Centers for Medicare and Medicaid Services, and the states, along with other interested parties, to bring about the following outcomes:

   (a) ensure adequate Medicaid and Medicare funding for graduate medical education;
   (b) ensure adequate Disproportionate Share Hospital funding;
   (c) make the Medicare direct medical education per-resident cost figure more equitable across teaching hospitals while assuring adequate funding of all residency positions;
   (d) revise the Medicare and Medicaid funding formulas for graduate medical education to recognize the resources utilized for training in non-hospital settings;
   (e) stabilize funding for pediatric residency training in children's hospitals;
   (f) explore the possibility of extending full direct medical education per-resident payment beyond the time of first board eligibility for specialties/subspecialties in shortage/defined need;
   (g) identify funding sources to increase the number of graduate medical education positions, especially in or adjacent to physician shortage/underserved areas and in undersupplied specialties; and
   (h) act on existing policy by seeking federal legislation requiring all health insurers to support graduate medical education through an all-payer trust fund created for this purpose.

4. That our AMA work with other interested parties to ensure adequate funding to support medical school educational programs, including creating mechanisms to fund additional medical school positions.

(References pertaining to Report 7 of the Council on Medical Education are available from the Medical Education Group.)

8. THE PHYSICIAN WORKFORCE: RECOMMENDATIONS FOR POLICY IMPLEMENTATION (RESOLUTIONS 312, A-04; RESOLUTION 319, A-04, RESOLVE 1)

HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS IN LIEU OF RESOLUTION 312 (A-04) AND RESOLVE 1 OF RESOLUTION 319 (A-04) AND REMAINDER OF REPORT FILED

A number of resolutions and report recommendations ask our AMA to develop and implement policy positions directed at increasing the number of physicians and reducing geographic maldistribution.

Resolution 312 (A-04), "Graduate Medical Education Position Increase," which was submitted by the Wisconsin Delegation and referred to the Board of Trustees, asks our AMA to work with the Centers for Medicare and Medicaid Services and the Veterans Administration to increase the number of graduate medical education (residency and fellowship) positions by at least 10%.

The first Resolve of Resolution 319 (A-04), "Medicare Graduate Medical Education and Medicaid Disproportionate Share Funding," which was submitted by the Texas Delegation and referred to the Board of Trustees, asks that our AMA work with the Centers for Medicare and Medicaid Services and other appropriate entities to eliminate the current outdated caps on funded graduate medical education training slots.

Resolution 807 (I-03), "US Physician Shortage," which was submitted by the American Thoracic Society, the American College of Cardiology, the American College of Chest Physicians, and the Society of Critical Care Medicine and adopted as amended, asks that our AMA: (1) direct the Council on Medical Education and Council on Medical Service to draft a report outlining policy options to address the US physician supply shortage; (2) explicitly recognize the existing shortage of physicians in many specialties and areas of the US; (3) support efforts to quantify the geographic maldistribution and physician shortage in many specialties; (4) support current programs to alleviate the shortages in many specialties and the maldistribution of physicians in the US; and (5) draft a report outlining policy options to address the US physician supply.

Recommendation 12 in Council on Medical Education Report 2-I-03, "Proposed Revisions to AMA Policy on the Physician Workforce," asks that our AMA collaborate with state and specialty societies and other interested groups to develop a national consensus on physician workforce policy.

This report addresses the issues raised in Resolutions 312, 319, and 807 in the context of developing a national consensus about: (1) the adequacy of physician supply and distribution and (2) appropriate implementation strategies to address any perceived deficiencies.

BACKGROUND: NATIONAL RESPONSE TO CONCERNS ABOUT A PROJECTED SHORTAGE OF PHYSICIANS

Over the past 5 years, there has been an increasing number of published commentaries and studies concluding that there is, or soon will be, a shortage of physicians in general or in specific specialty areas. In response to these concerns, there has been a number of proposals for an increase in the number of physicians produced in US training programs. For example, in July 2004, the federal Council on Graduate Medical Education (COGME) concluded that there would be a significant shortage of physicians over the next 15 years and recommended a 15% increase in medical school enrollment and an increase of 3000 entry-level residency positions. These recommended increases are based on workforce projections adopted by COGME, and do not represent, in COGME's opinion, a complete solution to impending physician shortages. This is a reversal of previous COGME policy that predicted a significant physician surplus. In February 2005, the Association of American Medical Colleges (AAMC) also recommended a 15% increase in US medical school enrollment by 2015 and a removal of the restriction on the number of Medicare-funded GME positions.

In addition to overall physician supply, there also are large variations among states in numbers of physicians, as well as in numbers of medical students and resident physicians. This variation has been associated with differential access to physician services. COGME has recommended expansion of programs directed at reducing geographic maldistribution and at meeting the needs of the underserved.

DATA COLLECTION AND RESULTS

A first step in the creation of a consensus on workforce policy is to determine how consistent the existing perceptions are about physician supply among physician stakeholder groups. Two mechanisms were used to collect such information: (1) a literature search was conducted to identify published reports/documents related to the physician workforce in states and medical specialties and (2) a request was sent to state medical societies and medical specialty societies in the House of Delegates asking for any policy documents/position statements and/or data-based reports related to the current or projected availability of physicians.

Information on workforce policies or documents/published studies on workforce were identified related to 14 states and 16 medical specialties. In addition, two state medical societies and two medical specialty societies reported that they were in the process of conducting studies or developing policies. There were 11 states and 5 specialty societies that responded to the survey with the information that they had no current policy and had conducted no workforce studies.

A synopsis of information obtained from the literature and the survey is included in the Appendix.

Medical Specialty Society Responses - A number of national medical specialty societies reported inadequacies in their current and projected physician supply. These included:

- Critical Care;
- Dermatology;
- Radiology;
- Endocrinology;
- Allergy and Immunology;
- Psychiatry;
- Cardiology; and
- Geriatrics.

State Responses - Some responding states indicated concerns about the total physician supply in their states and about the adequacy of the physician supply in one or more of the following specialties:

- Medical subspecialties (Cardiology, Gastroenterology, Endocrinology, Oncology, Rheumatology, Dermatology) and Pediatric subspecialties;
- General Surgery and Surgical subspecialties (Urology, Orthopaedics, Neurosurgery, Plastic Surgery);
- Hospital-based specialties (Anesthesiology, Radiology);
- Psychiatry and Neurology; and
- Primary care (regionally).

Since this summary is based on responses from a small number of specialties and states, the actual number of regions and specialties that currently are or soon will be in shortage may be greater. These data, even though limited, indicate that there is reason to be concerned about the adequacy of the future physician supply.

SUMMARY OF RELEVANT AMA PHYSICIAN WORKFORCE POLICY

In December 2003, the AMA House of Delegates adopted Council on Medical Education Report 2, "Proposed Revisions to AMA Policy on the Physician Workforce," which included the following new House of Delegates policy statements (H-200.955, AMA Policy Database) related to physician supply and distribution:

- That in order to enhance access to care, our AMA collaborate with the public and private sectors to ensure an adequate supply of physicians in all specialties and to develop strategies to mitigate the current geographic maldistribution of physicians.

- That there should be no decrease in the number of funded graduate medical education (GME) positions. Any increase in the number of funded GME positions, overall or in a given specialty, and in the number of US medical students should be based on demonstrated regional or national need.

STRATEGIES TO INCREASE THE PHYSICIAN SUPPLY

The data collected by the Council on Medical Education indicate that there is both national and regional justification for expanding the physician supply. The following discussion addresses mechanisms that have been proposed to increase the number of physicians entering practice.

Expand Medical School Enrollment - The first-year enrollment in MD-granting medical schools has remained relatively constant at about 17,000 per year over the past 20 years. The 15% increase in enrollment recommended by COGME and the AAMC would result in about 2,500 new MD graduates per year. Since average first-year enrollment in the nation's MD-granting schools is about 150, an increase of 2,500 students is equivalent to 16 new medical schools. While there are planned increases in enrollment in a number of schools and some new medical schools may be created over the next several years, such a significant increase in capacity will have major financial implications.

There already have been significant increases in the enrollment of colleges of osteopathic medicine. Between 1993 and 2002, the number of students entering osteopathic medical schools rose from 2,162 to 3,079. If the 15% increase is applied to both MD- and DO-granting schools, there would be almost 3,000 new graduates per year (or the equivalent of about 20 new schools).

Expand the Number of Graduate Medical Education Positions - A period of accredited graduate medical education (GME) is required for physicians to obtain a license to practice medicine in all US licensing jurisdictions. Therefore, the number of available GME positions is the rate-limiting step in increasing the number of new physicians in practice.

Unless the number of residency training positions is expanded, increasing medical school enrollment will not itself have a significant impact on the size of the physician workforce. In 2003-2004, there were almost 24,000 resident physicians in Accreditation Council for Graduate Medical Education and combined first-year graduate medical education positions. Of the 8,000 excess of resident physicians over US MD-graduates, about 75% (slightly over 6,000) were international medical graduates (IMGs). Of the first-year IMGs, almost one-half were US citizens or permanent residents. About 75% of IMGs will have gained citizenship or permanent resident status by the end of residency, and so will be eligible to remain in the US. The remainder of first-year residents (about 2,000) were graduates of DO-granting schools, graduates of Canadian medical schools, or physicians who previously graduated from a US (LCME-accredited) medical school. Therefore, most individuals in graduate medical education already are able to remain in the US for practice. Replacing IMGs with US graduates, which could occur if the number of US medical school graduates increased and the number of residency positions remained the same, would have only a minor effect on the number of available physicians in the US.

An increase in the number of resident physicians entering GME has been inhibited by limits on the number of federally-funded GME positions. The 1997 Balanced Budget Act (BBA) capped the number of residency positions supported by Medicare at 1996 levels for an institution. There has been some (minor) loosening of the restrictions. The 1999 Balanced Budget Refinement Act allowed rural hospitals to increase their cap by 30% and the Medicare Prescription Drug, Improvement and Modernization Act of 2003 allowed redistribution of unused residency positions. However, the BBA limits preclude the level of increases needed to significantly expand the number of physicians entering practice. This cap must be removed as one mechanism to expand physician supply.

Attend to Regional Needs in Increasing Medical School and Residency Training Positions - An overall increase in the numbers of medical school and residency program positions may not be sufficient to address regional shortages unless position increases are targeted to areas of need and training actually occurs in shortage areas (for example, in non-metropolitan areas). For example, there is evidence that the site of residency training has a strong influence on where physicians will begin their practice. The creation of training opportunities in or adjacent to specific shortage areas will not only address future physician workforce needs, but also will provide underserved populations with a source of immediate care provided by attending faculty and trainees.

It would be difficult to ensure that new medical schools and residency training programs are located in areas of need without additional and targeted funding. Funding sources for this expansion will have to be identified. In addition, mechanisms are needed to develop consensus on what regions would be eligible for funding and to make funding awards (for example, a specific “request for proposals” system).

Move Toward National Self-Sufficiency in Physician Supply - Physician supply is an international issue. For example, the US depends heavily on international medical graduates to fill graduate medical education positions and to provide care to the population. Many developing countries are concerned that they bear the initial expense of educating physicians, only to lose them to the US and other developed countries. Some countries that export physicians now face their own shortages. As a response, there have been calls for “global self-sufficiency” in physician training and supply. Recommendations include expanding the health workforce globally and addressing the issue of out-migration, which is exacerbating maldistribution. Each country has been encouraged to invest in and manage its workforce more strategically. As a consequence, the US should consider options for producing a physician workforce that is scaled to our aggregate national needs.

SUMMARY AND RECOMMENDATIONS

Increasing the number of US medical school and residency program positions and locating new positions or full programs in areas of physician shortage would help our nation address current and projected physician shortages. However, this desirable outcome will require a number of changes in current funding mechanisms for medical schools and residency programs.

The Council on Medical Education, therefore, recommends that the following be adopted in lieu of Resolution 312 (A-04) and Resolve 1 of Resolution 319 (A-04) and that the remainder of this report be filed:

1. That our American Medical Association adopt the policy position that there is now a shortage of physicians, at least in some regions and specialties, and that evidence exists for additional shortages in the future.

2. That to address current and predicted physician shortages, our AMA work with members of the Federation and national and regional policymakers to develop mechanisms, including identification of funding sources, to create medical school and residency positions in or adjacent to physician shortage/underserved areas and in undersupplied specialties.

(References pertaining to Report 8 of the Council on Medical Education are available from the Medical Education Group.)

APPENDIX - PHYSICIAN WORKFORCE ADEQUACY: STATE/SPECIALTY DATA

Specialties	*Conclusions about Physician Workforce Adequacy*
Dermatology	Based on surveys that asked about waiting times for appointments, the current supply was deemed to be inadequate.
Critical Care	Based on a practice analysis considered against need, there is a current and projected shortage.
Radiology	The shortage previously recognized has eased somewhat, but still exists.
Otolaryngology	There has been a geographic and proportionate increase in the number of otolaryngologists.
Clinical Endocrinology	The supply of endocrinologists is limited and limitations will get worse, based on information about current delays in obtaining appointments and projections based on a workforce model.
Allergy and Immunology	The demand has been increasing and the numbers of physicians in the specialty area is declining.
Emergency Medicine	In the late 1990s, when a comprehensive review was conducted, the need/demand for emergency medicine physicians was stable.
General Pediatics	The number of general pediatricians is expanding in relation to the general population.
Psychiatry	In looking at numbers of psychiatrists, demographic trends, and practice patterns, the projected number of psychiatrists may not keep pace with the future demand.
Cardiology	While the supply has not declined, the demand has increased. There is considerable dependence on international medical graduates.
Geriatrics	There is large variability in availability across states. Not enough geriatricians exist or are anticipated to meet the needs of the aging population.
Family Medicine	The number of residency positions is adequate and the supply of family physicians is adequate for the projected need. Steps should be taken to decrease dependence on international medical graduates in residency training.
Neurosurgery	There are unfilled job openings and an overall current shortage. Regional variations exist in numbers of neurosurgeons.
States	*Conclusions about Physician Workforce Adequacy*
Alaska	It has been concluded that there is a shortage of 25-30%, based on physician to population ratios in the state as compared with nationally. Acute shortages have been identified in many specialties, including general internal medicine, psychiatry, neurosurgery, neurology, and rheumatology.

States, cont.	*Conclusions about Physician Workforce Adequacy*
Georgia	The growth in the physician workforce has stalled. The number of family physicians is beginning to erode, and there is a maldistribution of the primary care workforce. An overall shortage in the number of physicians is anticipated as demographic changes in the physician workforce indicate a decline in the ability to meet demand in the future. Shortages are emerging in certain areas: diagnostic radiology, gastroenterology, oncology, endocrinology, rheumatology, and urologic surgery.
Kentucky	There has been a net loss of physicians in the state between 2000 and 2002. The loss was differential across specialties, with significant decreases in some specialties. During the period, 36% of practicing neurosurgeons retired or left the state.
Maryland	There are regional shortages of both primary care and specialist physicians.
Massachusetts	The physician labor market is under extreme stress. Based on trend data, neurosurgery is in critical shortage and anesthesiology, cardiology, general surgery, orthopaedics, and radiology are in severe shortage. Gastroenterology currently is significantly stressed.
Oregon	One-half of respondents to a statewide survey of physicians have restrictions on accepting new patients. Only about one-third of primary care physicians and about two-thirds of medical and surgical specialists were open to all patients. About 20% of physicians plan to retire in the next five years.
Rhode Island	The physician supply is fragile. General surgery is in short supply in some counties. There is a shortage of anesthesiologists and neurosurgery and obstetrics are of concern (the latter two specialties based, in part, on medical liability concerns). The practices of one-third of psychiatrists are closed to new patients. Radiology, gastroenterology, urology, otolaryngology, cardiology, endocrinology, and reconstructive plastic surgery are in short supply.
Texas	There are shortages and increased demand, especially in anesthesiology, gastroenterology, pediatric subspecialties, orthopaedics, radiology, urology. A shortage in most surgical subspecialties is anticipated. There are regional shortages of primary care physicians.

9. UPDATE ON THE AMERICAN BOARD OF MEDICAL SPECIALTIES PROGRAM ON MAINTENANCE OF CERTIFICATION

HOUSE ACTION: RECOMMENDATIONS ADOPTED AND REMAINDER OF REPORT FILED

At the American Medical Association 2002 Annual Meeting, the House of Delegates adopted Council on Medical Education Report 7-A-02, "Internal Medicine Board Certification Report - Interim Report." This report responded to several resolutions addressing recertification, specifically within the internal medicine practice community. The report summarized the implementation of the Maintenance of Certification (MOC) program, which had been initially proposed by the American Board of Medical Specialties (ABMS) in 2000. The American Board of Internal Medicine (ABIM) had been the first ABMS member board to develop and implement the MOC concept as part of a more comprehensive approach on evaluation of physician performance. CME Report 7 called for a follow-up report to be drafted at a later date, to document progress in the implementation of MOC. This report is in response to that request.

RELEVANT POLICY

CME Report 7-A-02 established new AMA policy H-275.932 (AMA Policy Database) which opposes the use of recertification or MOC as a condition of employment, licensure or reimbursement. In fact, the ABMS does not endorse the use of certification, recertification or MOC for employment, licensure or reimbursement and has specific policy that opposes the use of board certification for the delineation of clinical privileges, as well as for initial state licensure and licensure re-registration.

BACKGROUND

The ABMS has long supported the concept of recertification for professional maintenance, and has guidelines and policies going back to 1936. By 1973, the existing 22 medical specialty boards had adopted the principle of recertification and by 1998 all 24 boards had adopted time-limited certificates requiring recertification at intervals of seven to ten years. In March 2000, the ABMS and its 24 member boards became committed to evolve their current or planned programs of recertification into MOC, a process designed to document that physician specialists have maintained the necessary competencies to provide quality patient care. By March 2002, the four components of MOC were approved, as follows:

Part I - Professional Standing - Physicians must hold an unrestricted license to practice medicine in at least one jurisdiction in the United States or Canada and if licenses are held in more than one jurisdiction, all licenses should meet this requirement. This requirement has been adopted and is consistent across all 24 boards.

Part II - Lifelong Learning and Self-Assessment - There is an expectation that board requirements be designed to encourage lifelong learning and self-assessment. Boards currently are requiring participation in specialty specific continuing medical education as well as self-assessment activities.

Part III - Cognitive Expertise - There must be a secure examination that tests fundamental knowledge, practice related knowledge, and knowledge of the practice environment. Testing should occur at intervals of no more than ten years. Most of the certifying boards have chosen 10 years as the interval, while a few continue to use 7 years and one board has a 6-year cycle.

Part IV - Practice Performance Assessment - This component consists of an evaluation process which will address individual physician performance, patient factors, and practice site factors that influence performance. The assessment may include review by patients and peers, practice improvement modules, office record review, case or clinic logs, all as part of a quality improvement initiative. Several major projects were started to assist with Part IV: patient and physician peer surveys to assess communication skills and professionalism, and web-based education/improvement modules including a patient safety program. The ABMS member boards, in an effort to get reliable and valid data, as well as reduce cost and duplication, have partnered with the Agency for Healthcare Research and Quality in an effort to develop patient surveys that would meet some of the Part IV MOC requirements.

The MOC program of each specialty must go through an approval process that begins with committee review and concludes with approval from all members of the ABMS organization. The AMA has a seat and one vote within the ABMS assembly and participates in this review process. Currently, 23 of the 24 boards have received initial approval of their MOC (Parts I-III) programs. Twenty-two boards met the December 31, 2004 deadline for submission of the entire MOC plan, including Part IV (two boards asked for and received an extension), which had a first reading at the March 2005 ABMS meeting. All boards have been cooperative with the development of the Part IV process, though some content is still under development or revision. The ABMS prepared a blueprint to aid the boards in the development of Part IV and a “help team” has been assembled.

New committees were established to assist with the MOC program. The first is the Committee on Oversight and Monitoring of MOC (COMMOC). This committee has been charged to receive and review reports from the individual member boards with respect to the progress, development, and implementation of their MOC programs. They will verify and document compliance with the established MOC guidelines. A member of the AMA Council on Medical Education is the AMA delegate to the ABMS and is a member of this committee. The second committee is the MOC Task Force which will look at issues of implementation requirements and timelines, uniformity between the boards, evaluation methods, and overall effectiveness of the program. The MOC Task Force will also look at establishing recommendations for diplomates who are retired or not in active clinical practice, including requirements for return to active clinical practice. A discussion paper on this topic was presented and discussed by the ABMS Assembly in March 2005 with specific recommendations on these issues. These two new committees will complement the work of the already existing Committee on Certification, Subcertification, Recertification and Maintenance of Certification (COCERT) whose responsibility is to review all MOC applications, with input from all interested parties, and to recommend acceptance to the governing bodies of the ABMS, the board of directors, and the assembly.

SPECIALTY SOCIETY/ABMS MEMBER BOARD COLLABORATION

The MOC application to the ABMS must describe the nature and extent of the involvement of specialty society(ies) in preparation for the actual MOC process. CME Report 7-A-02 stressed that there must be a shared relationship between the specialty society and its respective board as MOC is developed and implemented. The focus of that report was primarily the specialty of internal medicine. Since that time, the American College of Physicians (ACP) and the ABIM have collaborated to help internists achieve ongoing certification through completion of an ABIM practice improvement module. The ACP-ABIM collaboration links educational resources developed by ACP with the ABIM practice improvement module for diabetes care. In addition, at the request of ABIM diplomates who complete practice improvement modules, the Board will send data to the National Committee for Quality Assurance (NCQA) that will allow physicians to simultaneously renew their ABIM certificate and seek recognition from NCQA. Many boards have close working relationships with their specialty societies with regard to Parts II and IV of MOC.

The ABMS has joined with the Council of Medical Specialty Societies (CMSS) to form a Joint Planning Committee which provides a forum for the exchange of information between the organizations and for the development of joint ideas and projects. Its primary goal is to enhance the effectiveness of the certifying boards and the specialty societies in their work in improving the public's health care and the profession's commitment to quality of care.

INCLUSION OF PRACTICING PHYSICIANS/RELEVANCE TO PRACTICE

CME Report 7-A-02 encouraged the ABMS to include practicing physicians and physicians with time-limited board certificates in designing and evaluating the MOC process and also to make the process relevant. The ABMS Executive Committee discussed the necessity for physicians holding leadership positions on the boards to participate in MOC programs even if they hold a lifetime certificate (February 11, 2003). It was the feeling of the Executive Committee that this was a necessary step in order to establish consistency and credibility for the ABMS MOC process with the general public and board diplomates. The Executive Committee then voted that it would be highly desirable that new ABMS and Member Board appointees, committee members, examiners and directors participate in the MOC process of their boards. When presented to the ABMS Assembly the next month, the consensus was that the statement should be strengthened and brought back to the next Assembly meeting for discussion and possible approval. At the September 2003 ABMS Interim meeting, the following two statements were approved: (1) as member boards move to advance the MOC process, their nominees for director/trustee should participate in the MOC process, (2) as the ABMS moves to advance the MOC process, physician nominees for ABMS Executive Committee membership should participate in the MOC process of their respective boards.

The 24 ABMS member boards were surveyed as to the inclusion of directors holding time-limited certificates and participating in the MOC process. With 20 of the 24 boards responding, 11 boards currently have one or more directors holding time-limited certificates. In addition, four of the boards have directors that are voluntarily participating in the MOC process. Steps are being taken to assure that the MOC process, including the secure examination, is relevant to physicians in practice. The closed-book examination of the ABIM contains no questions that an experienced clinician would be expected to research and all questions have been pretested for clinical relevance. The other ABMS member boards have or will be developing a similar approach in their cognitive examinations. These actions have provided some assurances to practicing physicians, since most agree that their competence should be assessed periodically through a secure examination and self-assessment process.

ETHICAL DIMENSIONS

CEJA Report 10-A-03 addressed the ethical implications of the MOC program including the patient assessment component as related to the doctor-patient relationship and the peer review component as related to the practice environment. That report stressed that the methods used for peer and patient assessments needed to strive for objectivity and fairness. Patient confidentiality must be preserved and patients need to understand the educational nature of the assessment, so that a poor physician evaluation is not interpreted as a referral for a disciplinary action. Boards need to explicitly specify how results will be used and be prepared to address instances where an assessment reveals conduct that places patients at risk of harm. The report concluded that the use of patient and physician assessment represents an evaluation method that may provide physicians with valuable information but that the role of the patient as assessor could impact the therapeutic alliance.

A recent publication presented general findings from a Gallup public opinion poll which revealed that patients highly value certification as an indicator of quality. Nearly all the patients surveyed said it was important for practicing physicians to be evaluated on a frequent basis by an independent board of physicians. This survey points out that patients do seem to understand the meaning of board certification, and that they see it as an indicator of quality. The survey did not address the use of patient assessment as part of the physician evaluation process.

ROLE OF THE AMA IN PERFORMANCE MEASUREMENT FOR QUALITY IMPROVEMENT

Existing AMA-sponsored activities have the potential to contribute significantly to the portion of the MOC process related to practice assessment. The AMA convened the Physician Consortium for Performance Improvement (the Consortium) in recognition of physicians' professional responsibility to provide quality health care and in response to the multiplicity and variability of performance evaluation mechanisms in existence. The Consortium is committed to developing performance measures by physicians for physicians. It is comprised of methodological experts, clinical experts representing more than 60 national medical specialty societies, state medical associations, and other organizations engaged in health care quality evaluation. The vision of the Consortium is to fulfill the responsibility of physicians to patient care, public health, and safety by becoming the leading source organization for evidence-based clinical performance measure and outcomes reporting tools for physicians. By the end of 2005, the Consortium will have adopted performance measures for 19 clinical conditions or topics.

The Consortium seeks endorsement and use of its performance measures by multiple stakeholders. At The Consortium's March 2004 meeting, representatives from the CMSS, the ABMS, the Accreditation Council for Graduate Medical Education and the Association of American Colleges participated in a panel discussion on the use of performance measures by these organizations and their perspectives of the Consortium's products.

SUMMARY

The Maintenance of Certification process has slowly begun to evolve and will eventually replace recertification as part of ABMS board certification. The ABMS has established several committees to monitor and evaluate this process as it evolves. Shared collaboration between the boards and their respective specialty societies has enabled the process to be more acceptable to practicing physicians and more representative of the practice community. The AMA has been encouraged that physicians participating in the process will be included as board members or members of the MOC planning committees. It is hoped that The AMA Physician Consortium for Performance Improvement will become an invaluable resource for Part IV of MOC.

RECOMMENDATIONS

1. That our American Medical Association continue to monitor the progress of Maintenance of Certification (MOC) and its ultimate impact on the practice community.

2. That our AMA encourage the Physician Consortium for Performance Improvement, the American Board of Medical Specialties, and the Council of Medical Specialty Societies to work together toward utilizing Consortium performance measures in Part IV of MOC.

3. That our AMA encourage the ABMS Maintenance of Certification Task Force to develop and adopt recommendations for re-entry into clinical practice and entry into Step IV of MOC for diplomates not involved in direct patient care.

4. That our AMA reaffirm Policy D-275.987[5], which encourages the ABMS to include practicing physicians and physicians with time-limited board certificates to assist in designing and evaluating the MOC process for each of the ABMS member boards.

(References pertaining to Report 9 of the Council on Medical Education are available from the Medical Education Group.)