

REPORTS OF COUNCIL ON MEDICAL EDUCATION

The following reports, 1-11, were presented by Emmanuel G. Cassimatis, MD, Chair:

1. ANNUAL REPORT ON AMA MEDICAL EDUCATION ACTIVITIES: 2003

HOUSE ACTION: FILED

This informational report summarizes the major activities of the Council on Medical Education and American Medical Association Medical Education Group during 2003. 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 is celebrating its 100th anniversary with a variety of special events, including a program held in conjunction with the 2004 Annual Meeting of the AMA House of Delegates. The program brings together leaders in American medicine and medical education to address current challenges and issues of importance in American medical education.

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 2003-2004 can be classified into several areas.

Policy Development and Implementation

During 2003-2004, the Council submitted 12 reports for consideration by the House of Delegates, as well as two additional reports for information. These reports addressed issues of national importance, including a revision of AMA policy on physician workforce and strategies to decrease medical student debt. 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. The Council on Medical Education also is starting a comprehensive examination of medical education financing, including a review of the utility and feasibility of current AMA policy.

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 manuscript review and the development of test items for national examinations.

In addition, several pilot projects are under way to develop guidelines for awarding AMA PRA credit for new models of continuing physician professional development (for example, "just-in-time" education using the Internet and quality review activities).

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 2003-2004, the Council recommended new appointments to 14 Residency Review Committees, the reappointment of 22 existing Residency Review Committee members, and the nomination of individuals to two medical specialty boards. In addition, the Council recommended appointments or reappointments to accrediting

bodies (the Liaison Committee on Medical Education [LCME] and the Accreditation Council for Graduate Medical Education [ACGME]) and to other national organizations (for example, the Educational Commission for Foreign Medical Graduates [ECFMG]). 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 accreditation requirements submitted by the ACGME and individual Residency Review Committees for the following specialties/subspecialties: Urology, Otolaryngology, Ophthalmology, Emergency Medicine, Neurology, Sleep Medicine, Interventional Radiology, Nuclear Radiology, and six subspecialties of Pathology (Cytopathology, Hematology, Forensic Pathology, Chemical Pathology, Blood Banking/Transfusion Medicine, and Pediatric Pathology).

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 medical societies under the auspices of Federation Relations asking about sponsorship of scholarship and loan repayment programs. This information is being used as part of a comprehensive review of strategies to decrease medical student debt. Data also are collected from medical schools through the LCME Annual Medical School Questionnaire. This questionnaire collects information on medical students, faculty, curriculum, and student evaluation from the nation's 126 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 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 on Medical Schools provides educational programs on issues of importance to the academic community. At the 2003 Annual Meeting, Jordan J. Cohen, MD, president of the Association of American Medical Colleges, spoke on the need for medical schools to increase diversity awareness in medical education and advance health care equity in the US. At the 2003 Interim Meeting, Floyd Bloom, MD, board chair of the American Association for the Advancement of Science, spoke on the need for a comprehensive restructuring of the US health care system and how to translate new biomedical knowledge into clinical practice. This Annual Meeting will be devoted to celebrating the 100th anniversary of the Council on Medical Education (see Council on Medical Education, above) and the challenges facing medical education and health care.

The section's Governing Council recently completed a three-year strategic plan. The 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 2004 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 AMA 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.

The Section on Medical Schools E-letter (www.ama-assn.org/go/sms) is sent via e-mail each month, providing news/updates of interest to US and Canadian medical school administrators as well as information about section activities and relevant AMA products/services. The newsletter's 1,000 readers include medical school deans, appointed section representatives, and others interested in undergraduate medical education.

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), regarding medical education issues. The Council serves as the critical link between these external organizations and the AMA and obtains feedback from the representatives to assist in 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.

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 - Trustees who are already in the area of the medical school will have a visit arranged to meet with students, faculty, administrators, etc. Approximately 11 secondary visits occurred in 2003.
- Full-day visit - These visits are more extensive and require an invitation from the medical school. Additional planning on the part of the schools and the AMA is necessary. Three such visits occurred in 2003.

Undergraduate Medical Education Policy and Standards

Accrediting Activities

Ongoing Council involvement in undergraduate medical education includes sponsoring the 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 2002-2003, the LCME conducted 29 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 and conducted one Secretariat visit. Two medical schools participated in consultation visits with the Secretariat staff. The medical education programs leading to the MD degree at two medical schools, one in Canada and one in the United States, were placed on probation. The LCME continued the provisional accreditation for 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 asking for information about the medical profession.

Graduate Medical Education

Liaison Activities

The Council and division staff maintained active liaisons with the following organizations: AcademyHealth, ACGME (including several Residency Review Committees, e.g., Internal Medicine, Pediatrics, and Psychiatry), American Academy of Family Physicians (including its Commission on Education), AAMC (including its Group on Residency Affairs), Association for Hospital Medical Education, Council on Graduate Medical Education, Council of Medical Specialty Societies (including its Organization of Program Directors Associations), Health Professions Network, Joint Commission on Accreditation of Healthcare Organizations (including its 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 (www.ama-assn.org/go/gmenews), with nearly 13,000 readers among GME program personnel, hospital administrators, and medical school deans and educators, provides a forum for sharing and soliciting information on GME (and promoting the AMA's GME products/services) through such features as the "Question of the Month" and the Calendar of Events. Residency coordinators are playing a larger role in the E-letter's popularity; their input led to the development of the Residency Coordinators Information Page on FREIDA Online™.

Medical Education Bulletin - The Bulletin, with a readership of over 10,500, 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.

Monthly welcome letter to new program directors - Each month, a letter signed by the division director goes to all newly appointed program directors, informing them to the many activities of the AMA in medical education, especially GME, including the *Guidebook for GME Program Directors* (see Products/Services, below).

Health Professions Career and Education E-letter - This monthly e-mail newsletter (www.ama-assn.org/go/hpe-letter), with 6,000 readers, helps reinforce and strengthen AMA relationships with allied health professions accrediting agencies and 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 Data Collection 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 Products/Services 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 procedures for data security and confidentiality. Furthermore, data were analyzed internally and presented in an article and appendix tables in the Medical Education theme issue of *JAMA*, published September 3, 2003. Another research study by staff was presented at the annual research meeting of AcademyHealth in June 2003.

Products/Services

FREIDA Online™ - This Internet database provides easy access for medical students and residents to information about 8,000 ACGME-accredited and ABMS board-approved GME programs. Total searches for the program information by medical students and residents range from 28,000 to 70,000 per week.

Graduate Medical Education Directory - Now in its 89th edition, the 2004-2005 "Green Book" continues to be a key reference work for the GME community. It lists 7,940 ACGME-accredited programs in 27 specialties and 97 subspecialties (124 total) and 212 ABMS board-approved combined programs, for a total of 8,152.

GMED Companion: An Insider's Guide to Selecting a Residency Program - This book features data on salary, hours of duty per week, call schedule, curricula, and other variables for more than 4,000 specialty programs, displayed in a grid format for quick comparison. The 2004-2005 edition includes listings of web sites/publications for information on nonaccredited fellowship opportunities.

Guidebook for GME Program Directors - This 107-page document, now available via the "Program Directors Only" section of FREIDA Online™, provides pertinent and valuable information to 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 Federation.

Health Professions Career and Education Directory - The 2004-2005 edition of this annual book includes information about 6,554 educational programs and 2,443 educational institutions in 64 different allied health professions. New this year are dance therapy and massage therapy.

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

The Division of Continuing Physician Professional Development (CPPD) continues to pursue long-term strategic planning as well as ongoing development and support for the Council relating to continuing medical education (CME) and continuing professional development (CPD). CPPD drafted Council on Medical Education Reports 4, "Enduring Materials for Continuing Medical Education," and 5, "Web-based System for Registering CME Credit," for the 2003 Annual Meeting and Report 9, "CME Validation Criteria (Resolution 312, A-02)," for the 2004 Annual Meeting.

PRA Certificate with Commendation

The AMA PRA certificate program has recently expanded to include a Certificate with Commendation. This certificate has more rigorous requirements than the regular certificate and is intended to recognize physicians who go above and beyond what is required or expected in CME. The AMA PRA certificate anchors the AMA PRA credit system with more than 60,000 active certificates.

New Guidelines

In 2003, the Division of CPPD developed guidelines on two new activities that are now recognized for AMA PRA category 1 credit: test item writing and manuscript review. Both activities are provider-driven and based on recommendations of high-level committees representing our constituents. The guidelines are available at www.ama-assn.org/go/cme.

Pilot Projects

Progress continues for the two Pilot Projects staffed by CPPD, one focusing on Self-Directed, Self-Initiated (SDSI) Internet CME and the other on Performance Measurement activities. Each project will expand and redefine how AMA PRA category 1 credit is earned and awarded, with an increased emphasis on physician-centered learning and point-of-care CME. Information from these pilot projects will also help to inform our development of a refined credit metric, with an increased focus on quality of education rather than actual time spent. Recommendations from these pilot projects will be the basis for new guidelines that will be forwarded to the Council for approval in 2004.

International Activity Approval

In February 2003, CPPD launched a new process for allowing CME providers to award AMA PRA credit to physicians licensed outside the United States. As our international discussions increase, this mechanism allows CPPD an important opportunity to review what types of activities target international audiences and how our credit is being used. We continue to increase awareness of this program and expect that the activity will continue to expand in 2004. Information and applications can be found at www.ama-assn.org/go/intlpracredit.

14th Annual Task Force Conference

CPPD hosted the 14th Annual Conference of the National Task Force on CME Industry/Provider Collaboration, titled "Partners in Progress: Serving the Profession and the Public," in September 2003. This conference, held in Chicago, welcomed almost 450 participants from 37 states, representing education and communication companies, medical specialty societies, academic medical centers, and pharmaceutical and device industries. The conference focused on new regulations that affect the industry/provider relationship and explored the value and challenges to this partnership in the context of a continuously changing environment. We look forward to returning next year to the Baltimore Inner Harbor for the 15th Annual Conference, titled "Effective CME and Industry Collaboration: Understanding Boundaries," to be held September 27-30, 2004.

Gifts to Physicians

CPPD continues to administer a major national initiative, "What You Should Know About Gifts to Physicians from Industry," to encourage medical students, residents, physicians, and industry representatives to adhere to ethical guidelines on promotional gifts from industry. In April, in addition to the modules that were already available for downloading, the AMA launched an interactive online version of the four 1-hour modules, which physicians can take for AMA PRA category 1 credit. Physician interest has been very high, with over 500,000 hits on the web site since April. A summary report is currently in progress and will be available in 2004.

Communications and Resources

CPPD is continuously developing new ways to reach out to the CME community, providing regular updates on the latest developments from CPPD. The CPPD web site is always growing and adapting to physician and provider needs, and now includes an online application for the AMA PRA certificate, online applications for international activities, and an interactive tutorial for individuals who are new to CME. CPPD also provides regular updates for the AMA PRA through representation at several conferences and meetings, both at the national and state level. In addition, the *CPPD Report*, a newsletter published three times per year, reaches nearly 5,000 subscribers in both print and online versions, and CPPD also contributes columns in the Society for Academic Continuing Medical Education's *Intercom* and the Alliance's *Almanac*.

2. COUNCIL ON MEDICAL EDUCATION SUNSET REVIEW OF 1994 HOUSE OF DELEGATES POLICIES

HOUSE ACTION: RECOMMENDATIONS ADOPTED AND REMAINDER OF REPORT FILED

At its 1984 Interim Meeting, the House of Delegates established a sunset mechanism for House policies (Policy H-600.110, AMA Policy Database). Under this mechanism, a policy established by the House of Delegates 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 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 H-600.110 to change the process through which the policy sunset review is conducted. The general process used for the review of 1994 House of Delegates policies was as follows:

- The House policies subject to review under the policy sunset mechanism are identified.
- An assignment of relevant policies is made to each Council.
- 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 the policy sunset reports from each Council to the appropriate Reference Committee.

Although the policy sunset review mechanism is not used to change the meaning of AMA policies, minor editorial changes can be accomplished through the sunset review process. In this report, the Council on Medical Education presents its recommendations on the disposition of its assigned 1994 House policies.

RECOMMENDATION

The Council on Medical Education recommends that the 1994 policies 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 1994 HOUSE OF DELEGATES POLICIES

(New language is underlined; deletions are ~~struck through~~)

<i>Policy Number</i>	<i>Title</i>	<i>Recommended Action and Rationale</i>
H-200.965	Health Education Loan Exchange (HELEX) Plan	Rescind. The HELEX plan did not become operational. There are other policies that support the availability of loan repayment programs (for example, H-200.978, "Loan Repayment for Primary Care Careers").
H-255.993	Evaluation of Foreign Medical Schools	Retain. The policy still is relevant.
H-275.945	Self-incriminating Questions on Applications for Licensure and Specialty Boards	Retain. The policy still is relevant.
H-275.970	Licensure Confidentiality	Retain. The policy still is relevant.
H-275.988	Identifying Persons with Illegally Obtained Medical Degrees	Retain. The policy still is relevant.
H-295.923	Medical Training and Termination of Pregnancy	Retain. The policy still is relevant.
H-295.924	Future Directions for Socioeconomic Education	Retain-in-part. Item #3 is a "Directive to Take Action" that has been addressed, in part, through the collection of data on the LCME Annual Medical School Questionnaire and the publication of results on socioeconomic education (for example, in the Sept 2003 Medical Education Issue of <i>JAMA</i>). "The AMA:(1) asks medical schools and residencies to encourage that basic content related to the structure and financing of the current health care system, including the organization of Health care delivery, modes of practice, practice settings, cost effective use of diagnostic and treatment services, practice management, risk management, and utilization review/quality assurance, is included in the curriculum. (2) asks medical schools to ensure that content related to the environment and economics of medical practice in fee-for service, managed care and other financing systems is presented in didactic sessions and reinforced during clinical experiences, in both inpatient and ambulatory settings, at educationally appropriate times during undergraduate and graduate medical education. (3) will survey medical schools, specialty societies, and other groups and collect curricula that have been developed on the environment and economics of medical practice. From this comprehensive data collection, a curriculum outline should be developed, including a list of topics to be presented, recommendations for placement of the topic in the continuum of undergraduate and graduate medical education, and suggested modes of presentation. This curriculum outline should be made widely available to medical schools and other interested organizations. (4) (3) will encourage representatives to the Liaison Committee on Medical Education (LCME) to ensure that survey teams pay close attention during the accreditation process to the degree to which "socioeconomic" subjects are covered in the medical curriculum."
H-295.925	Restriction of Medical Staff Appointments	Retain. The policy still is relevant.
H-295.983	Extramural Clerkships and Early Career Decisions	Retain. The policy still is relevant.

<i>Policy Number</i>	<i>Title</i>	<i>Recommended Action and Rationale</i>
H-295.985	Humanism in Graduate Medical Education	Retain. The policy still is relevant.
H-295.987	Impairment Prevention and Treatment in the Training Years	Retain. The policy still is relevant.
H-295.988	Alcohol and Substance Abuse Education of Medical Students and Residents	Retain. The policy still is relevant.
H-295.989	Computer and Information Systems in Medical Education	Retain. The policy still is relevant.
H-295.990	Work-study Programs in Medical Education	Retain. The policy still is relevant.
H-300.956	Practice Management Training	Retain. The policy still is relevant.
H-300.957	Promoting Primary Care Services Through Continuing Medical Education	Retain. The policy still is relevant.
H-305.950	Fairness in Publication of Names of Loan Defaulters	Retain. The policy still is relevant.
H-305.986	Student Loan Consolidation	Retain-in-part. There is no impending reauthorization. The Student Loan Marketing Association is a principal operating subsidiary of Sallie Mae, which now is a private organization. “The AMA supports reauthorization of the availability of opportunities for student loan consolidation, for example, through the Student Loan Marketing Association or a similar organization for student loan consolidation. ”
H-310.942	Training Physicians in Nontraditional Sites	Retain. The policy still is relevant.
H-310.989	Information on Shared Residency Positions	Retain-in part. The policy should be amended to read as follows, because publication in the “Directory of Residency Training Programs” is no longer possible, but publication can occur in AMA FREIDA online and the “GMED Companion”: “The AMA supports the continued collection <u>and publication</u> of data on shared schedule positions in the Directory of Residency Training Programs. ”
H-310.990	Support of Shared Schedule Residency Positions	Retain. The policy still is relevant.
H-365.994	Funding of Educational Resource Center Programs	Retain- in-part. The name of the program has changed, and the sponsoring unit is the National Institute for Occupational Safety and Health. “The AMA supports adequate federal funding for the NIH’s Educational Resource -NIOSH’s <u>Education and Research Centers</u> program, as an appropriate means to help ensure that a sufficient number of physicians trained in occupational medicine will be available to meet future needs.”
H-405.969	Definition of a Physician	Retain-in-part. A correction is being made to terminology. “The AMA affirms that a physician is an individual who has received a “Doctor of Medicine” or a “ Doctor of Osteopathy <u>Osteopathic Medicine</u> ” degree of an equivalent degree following successful completion of a prescribed course of study from a school of medicine or osteopathy <u>osteopathic medicine.</u> ”
H-420.984	Paternity Leave	Retain-in-part. The ACGME Institutional Requirements currently include the requirement that there be policies on parental leave. “The AMA <u>supports the requirement</u> encourages the development by the Accreditation Council for Graduate Medical Education (ACGME) for of maternity and paternity leave guidelines to assist residency program directors in the administration of their educational programs. ”

<i>Policy Number</i>	<i>Title</i>	<i>Recommended Action and Rationale</i>
H-420.987	Maternity Leave for Residents	Retain-in-part. The ACGME Institutional Requirements currently include the requirement that there be policies on parental leave, and this requirement is supported in H-420.984. “The AMA believes that: (1) Residency program directors should review federal law concerning maternity leave and note that for policies to be in compliance, pregnant residents must be allowed the same sick leave or disability benefits as other residents who are ill or disabled. (2) The duration of disability leave should be determined by the pregnant resident’s physicians, based on the individual’s condition and needs. (3) The “Essentials of Accredited Residencies” should be amended to include maternity leave policies in the list of items includes in the written agreement between the resident and the program. (4) (3) All residency programs should develop a written policy on maternity and paternity leave for residents that addresses:.... (5)-(4) Manpower levels <u>Resident numbers</u> and scheduling are encouraged to be flexible enough to allow coverage without creating intolerable increases in other residents’ work loads. (6)-(5) Residents should be able to return to their training program after disability leave without loss of training status.

3. RATIONAL ROLE FOR USMLE STEP EXAMS

HOUSE ACTION: RECOMMENDATIONS ADOPTED AND REMAINDER OF REPORT FILED

Resolution 303 (A-03), “Developing Rational Role for USMLE Step Exams,” which was submitted by the Medical Student Section and adopted by the House of Delegates in lieu of Resolution 321 (A-03), asked that:

Our American Medical Association, with appropriate partners, study what role, if any, scaled and scored national, standardized examinations like the USMLE Steps 1 and 2 should have in evaluation of applicants for residency, and propose changes to the examination(s) in order to serve that role.

BACKGROUND

Adequate performance on all steps of the United States Medical Licensing Examination (USMLE) is required in all jurisdictions for licensure of medical school graduates with the MD degree in the United States. The standards for the three steps are established and monitored by committees that are responsible for the individual Step examinations.

The process of setting the standards is focused on defining the characteristics of a borderline examinee, someone who, based upon skills and knowledge exhibited in the academic and clinical setting, is performing at a level that is minimally acceptable for continued progress through the educational system and for the safe and effective care of patients. An individual meeting these criteria should receive the lowest passing score on the examination. This judgment also takes into account information regarding the impact of score reliability on the accuracy of pass/fail decision and the likelihood of false positive and false negative decisions. This approach to scoring gives the most accurate result at the pass/fail cut score.

Scores for Step 1, Step 2 Clinical Knowledge (Step 2 CK), and Step 3 are reported on a three-digit scale with most scores falling between 160 and 240. A two-digit score is also derived from the three-digit score in such a way that 75 always corresponds to the minimum passing score. The two-digit score does not represent a percentile score. The reporting of percentile information was discontinued as of May 1999. For Step 2 Clinical Skills (Step 2 CS), performance will be reported as pass or fail, with no numerical score. The current minimum three-digit passing scores are 182 for Step 1, 182 for Step 2 CK, and 182 for Step 3. The mean score for first-time examinees from LCME-accredited medical schools in the United States varies between 200 and 220 with a standard deviation of approximately 20.

Official USMLE transcripts for providing scores to third parties include the complete results for all Step examinations that were taken including any examinations for which no results were reported and an indication of whether previous examinations, National Board of Medical Examiners (NBME) certifying examinations Parts I, II, or III or the Federation Licensing Examination (FLEX) were taken. The report also contains annotations related to test accommodations, indeterminate scores, and documentation of irregular behavior. In addition, the transcript includes notation of any actions taken against the individual by medical licensing authorities or other credentialing entities that have been reported to the Federation of State Medical Boards' (FSMB) Board Action Databank. Graphical performance profiles are not included in the USMLE transcript.

EXISTING AMA POLICY

Concerns have been raised in the past about the inappropriate use of numerical scores on licensing examinations. As a result, the AMA has existing policy promoting the principle that selection of residents should be based on a broad variety of evaluative criteria and that the Accreditation Council for Graduate Medical Education (ACGME) Program Requirements should state clearly that residency program directors must not use NBME or USMLE ranked passing scores as a screening criterion for residency selection (Policy H-275.953, AMA Policy Database). This policy further suggests a reporting system that would only report numerical scores to state licensing authorities and pass/fail scores to medical schools. A similar policy (Policy H-275.957) supports the development of mechanisms to ensure confidentiality of results of licensure examinations to ensure the use of such results only in an appropriate fashion.

DISCUSSION

As noted above, the procedures for setting standards for scoring of Steps 1, 2 CK, and 3 yield the most reliable results at the pass/fail point. The farther removed from that point, the comparative reliability and accuracy diminishes. Based on the range and standard deviation of scores, differences of 5 points on the three-digit score represent approximately 0.25 standard deviations and are probably not significant. Thus using numerical scores to screen or to rank applicants for residency positions is unscientific and problematic.

Studies in the past attempting to relate performance of medical school graduates in residency training with performance on licensure examinations failed to demonstrate any or significant correlations. A more recent study did demonstrate a low to moderate statistically significant correlation but concluded that other factors besides USMLE Step 1 and Step 2 scores were the major contributors to successful performance in the first year of residency.

In a study designed to evaluate the influences on ranking decisions made by an intern selection committee compared to evaluations of resident performance, it was found that members of the selection committee overemphasized the predictive value of performance on the first part of the licensing examination compared with medical student performance on the relevant clerkship. This finding was confirmed in a more recent study comparing the value of clerkship ratings with USMLE Step 1 scores in predicting performance in residency training. Another study supported the finding that performance on the first part of the licensure examination did not correlate with faculty rating scores of residents.

Irrespective of this data, in a survey of internal medicine program directors USMLE scores ranked highest as being useful for deciding to grant interviews and second highest for making decisions for ranking applicants. This was more pronounced for community programs compared to university programs.

Since it is apparently difficult to dissuade residency program directors and intern selection committees from using the numerical data provided in the USMLE transcript in the ranking of residency program applicants, the most direct approach to eliminate this problematic practice is to remove the information from the transcript. At the same time, it must be noted that some state licensing boards require a numerical score to be reported for licensure. A reporting system that is able to meet both needs should be developed.

The issue of reporting pass/fail scores for USMLE results has been explored by the NBME. The results of the most recent study on the subject were reported in 2000. In that study, all of the medical boards, the members of the Council of Medical Specialty Societies, the deans, education deans, and student affairs deans of all of the LCME-accredited US medical education schools and a sampling of examinees and residency directors were surveyed. The

student responses strongly supported reporting pass/fail scores to schools and program directors while desiring numeric scores for personal feedback. Residency program directors overwhelmingly desired numeric score reporting and indicated that the score was important in the evaluation of applicants. Student affairs deans and to a lesser extent education deans favored the student position of reporting pass/fail scores. Based on this information and a thorough discussion of the implication of converting to a pass/fail score report, the Composite Committee decided to retain the reporting of numeric scores. Now that Step 2 CS scores will be reported as pass/fail, it is timely to revisit the entire score reporting policies of the USMLE.

SUMMARY AND RECOMMENDATIONS

Existing AMA policy (Policy H-275.953) proposed a system for reporting USMLE examination scores that would eliminate the reporting of scores to medical schools and residency program directors but would retain the ability to report numerical scores for licensure. In addition, this policy afforded the opportunity for a student who failed the examination to request a numerical score in addition to the performance profile. Medical schools would also receive a frequency distribution of numerical scores for the aggregate of their students. The USMLE transcript would continue to include the full record of all previous examinations, including previous failures, and all annotations.

Therefore, the Council on Medical Education recommends that the following recommendations be adopted and the remainder of this report be filed:

1. That our American Medical Association reaffirm Policy H-275.953, "The Grading Policy for Medical Licensure Examinations."
2. That our AMA work with the National Board of Medical Examiners and the Federation of State Medical Boards to implement the recommendations in Policy H-275.953.

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

4. POTENTIAL IMPACT OF THE USMLE STEP 2 CS AND COMLEX-PE ON UNDERGRADUATE AND GRADUATE MEDICAL EDUCATION

HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS AND REMAINDER OF REPORT FILED

Resolve 5 of Resolution 324 (A-03), "Clinical Skills Assessment Exam and College of Osteopathic Medicine Licensing Exam-Physical Exam Implementation," which was submitted by the Medical Student Section and adopted as amended by the House of Delegates in lieu of Resolution 315 (A-03), asked that

Our American Medical Association in conjunction with the National Resident Matching Program, the American Osteopathic Association, the Accreditation Council for Graduate Medical Education, and other interested organizations study the potential impact of the CSAE and the COMLEX-PE on undergraduate and graduate medical education and report back at the 2004 Annual Meeting.

BACKGROUND

The United States Medical Licensing Examination (USMLE) Step 2 examination has been divided into two segments, the USMLE Step 2 Clinical Knowledge (Step 2 CK) and the Step 2 Clinical Skills (Step 2 CS). The sections of the Step 2 examination can be taken in any sequence. The USMLE Step 2 CS examination is scheduled for implementation in June 2004. Students and graduates of LCME or AOA-accredited medical schools will be required to pass both components of USMLE Step 2 as part of the eligibility criteria for USMLE Step 3 if they have graduation dates in 2005 or later or have graduation dates prior to 2005 and have not passed the Step 2 CK component taken on or before June 30, 2005. All international medical graduates who have not passed the ECFMG Clinical Skills Examination by April 17, 2004, will be required to pass the Step 2 CS examination. Testing for the Step 2 CS will be scheduled throughout the year at five regional sites. It is projected that the five test centers will be able to test approximately 30,000 examinees annually. This would accommodate the approximately 25,000 to

27,000 US medical students and international examinees estimated to take the examination during the first year. If an individual fails the Step 2 CS he or she cannot reschedule for sooner than 60 days after the last attempt. The excess capacity is considered by the USMLE Composite Committee to be adequate to manage repeat examinees.

The National Board of Osteopathic Medical Examiners (NBOME) will incorporate a clinical skills component into the Comprehensive Osteopathic Medical Licensure Examination (COMLEX-USA) as part of the Level 2 examination during the 2004-2005 academic year. This examination has been designated the Level 2 Performance Evaluation (Level 2-PE). Testing is scheduled to be available as early as September 15, 2004. The written/cognitive component of the Level 2 examination will be renamed Level 2-CE. As of July 1, 2004, all candidates for COMLEX-USA Level 3 will be required to pass COMLEX-USA Level 2-PE, in addition to all other requirements presently in place. Candidates who graduated prior to 2005 will be exempt from this requirement if they have passed COMLEX-USA Level 2-CE prior to June 30, 2005. All members of the class of 2005 will be required to take and pass COMLEX-USA Level 2-PE. Testing for Level 2-PE will be at the NBOME Center for Clinical Skills Testing in Philadelphia and will be scheduled throughout the year.

DISCUSSION

The potential impact of the implementation of these components of the licensure examinations must be considered at two levels. The first relates to medical school curricula and graduation requirements and the second to requirements for acceptance into residency training programs.

While licensure examinations should not dictate medical school curriculum, it is evident that the content and structure of those examinations do directly influence medical student education and evaluation. In 2002-2003, 97 medical schools used one or more clinical skills examinations in their introductory skills course. A clinical skills assessment examination was included as part of required clerkships in family medicine in 57 schools, medicine in 56 schools, obstetrics and gynecology in 48 schools, pediatrics in 47 schools, psychiatry in 43 schools, and surgery in 43 schools. In 82 schools there was a third or fourth-year comprehensive clinical skills assessment examination. Of those schools 53 or 65% require a passing grade for graduation.

It can be anticipated that those medical schools that do not provide adequate experience for their students in standardized patient examinations similar in format and grading to the USMLE Step 2 CS or COMLEX-USA Level 2-PE will be under intense pressure to do so during the 2004-2005 academic year. Further, the medical schools will most likely be the site for the remediation of students who fail the clinical skills licensing examination. Medical schools will have to develop consortia or invest major resources to deliver this experience, because not all currently have facilities for clinical skills assessment. In 2002-2003, 65 schools used a dedicated facility for clinical skills teaching with standardized patients that was owned by the medical school, 31 used existing clinic space, 15 used a facility that was owned by another institution or a consortium, and 15 had no facilities available.

Concerns have also been raised regarding the scoring of the examination. In a high-stakes performance evaluation such as the USMLE Step 2 CS and the COMLEX-USA Level 2-PE, evaluators may harbor prejudices or stereotypes that can adversely impact the scores of minority medical students. Similar concerns have led states such as California to ban the use of oral examinations for licensure. The USMLE Composite Committee needs to carefully monitor the examination to ensure that all medical students are treated fairly on the examination and to immediately address any problems that may arise. Data collection on performance and pass rates by the race and ethnicity of examinees is an essential part of the monitoring and should be made available to appropriate agencies.

In regard to graduation requirements for LCME-accredited medical education programs in the United States, in 2003, 106/125 schools required students to take USMLE Step 2 and 79/125 schools required passing USMLE Step 2 for graduation and all 19 of the AOA Bureau of Professional Education-accredited medical schools require passing COMLEX-USA Level 2 for graduation. Although the exact reasoning by which each medical school determined its policy for this requirement is not known, it can be concluded that this requirement for graduation ensures eligibility of graduates to continue the licensing examination sequence and is a national measure of performance of graduates. Based on this assumption, it is likely that these schools will include passing USMLE Step 2 CS or COMLEX-USA Level 2-PE as part of the graduation requirement. However, a recent survey of colleges of osteopathic medicine reported that only 4 of 16 schools responding would require passing COMLEX-USA Level 2-PE for graduation and the other 12 would require students to take the examination. The number of MD-schools requiring Step 2 for graduation has been increasing. The requirement for passing the Step 2 CS is being monitored in the LCME annual survey of medical schools, and the first data will be available in the summer of 2004.

The passing rate for USMLE Step 2 in 2001-2002 for first-time takers who were examinees from US and Canadian medical schools that grant the MD degree was 97%. During the same period the passing rate on repeat examinations for the same group was 70%. The ultimate passing rate is expected to increase to approximately 99%. Passing rates for first-time takers of COMLEX-USA Level 2 for 2002 were approximately 91% and for repeat examinations approximately 61%. Observed correlations between clinical skills examination scores and USMLE Step 2 scores for international medical graduates tested for the first time from June 2001 to June 2002 were consistently low. This indicates that the clinical skills examination measures a set of skills that is different from that measured in the USMLE Step 2 CK. Because the clinical skills examinations have not yet been given to graduates of US medical schools as a high-stakes examination, a passing rate can only be estimated. Despite a passing rate of only 85.2% on a pilot test of the USMLE Step 2 CS administered to medical students in LCME-accredited medical education programs in the US, the NBME anticipates that the initial passing rate for graduates of US medical schools on the USMLE Step 2 CS will be approximately 95%, with an ultimate passing rate of 98-99%.

The first-year enrollment for the entering class of 2001 in LCME-accredited medical schools in the US was almost 17,000. Considering the two passing rates cited above the number of initial failures would range between 850 and 2,500 students. Based on the assumptions about the examination being required for graduation, this could result in between 537 and 1,590 students not being able to graduate. While reexaminations will lower the number of students who are unable to graduate, the final count is uncertain. Using the projections of the NBME for the ultimate passing rate, between 110 and 215 students will not graduate from medical school.

Students who are not able to graduate on time will not be able to honor their commitments for residency programs. The failure of these individuals to start their residency training could effect at least one position in between 4% and 59% of ACGME-accredited graduate medical education programs in the US offering entry-level positions. This is of particular concern for small residency programs in which the absence of even a single entry-level resident could seriously compromise the quality of the educational program and clinical experiences.

Although international medical graduates already have been required to pass the Clinical Skills Assessment examination offered by the Educational Commission for Foreign Medical Graduates (ECFMG) as a requirement for ECFMG certification, it should also be noted that delays in obtaining visas to take the USMLE Step 2 CS could produce additional problems. Inability to take the examination could limit the number of international medical graduates eligible to enter ACGME-accredited residency training programs.

From the standpoint of the residency program director, the implementation of the clinical skills examination could add an additional condition for entry into residency training. At the present time, some residency programs have as a condition of initial employment the requirement that residents have passed USMLE Step 2 or COMLEX-USA Level 2. In such circumstances, medical school graduates who have not passed those examinations are denied employment. Applicants must be made aware of this requirement before submitting their rank order lists to the National Resident Matching Program. Based on the understanding that the clinical skills examination is purported to assess whether the examinee can demonstrate the fundamental clinical skills essential for safe and effective patient care under supervision, there may be an increase in the number of residency programs adding the requirement to pass the examination prior to employment. The trend in this requirement will be monitored through the AMA-AAMC Annual GME Census.

Residency program directors must also consider the complexities of providing remediation for resident physicians who are unsuccessful at passing USMLE Step 2 CS prior to entering their program. The educational program of a particular residency may not provide the broad-based experiences tested in the examination. Many programs are offered at sites that do not have dedicated clinical skills testing facilities. Faculty resources may not be available within the graduate medical education environment to provide the necessary assistance for the mastery of tested clinical skills.

In addition to the issues discussed above it must also be noted that the cost of the USMLE Step 2 CS is \$975 for June 1, 2004-June 30, 2005 with additional expenditures for travel and lodging for many medical students. The cost of the COMLEX-USA Level 2-PE is anticipated to be \$965 in 2004 plus expenses for travel and lodging. Since more than 82% of graduates of LCME-accredited medical schools in the US have some educational debt, it can be expected that these costs will be added to the debt burden of the students.

The AMA has suggested that the number of testing sites be increased immediately so as to be available on July 1, 2004. The current number of test sites (2) and the proposed number of test sites (5) are inadequate and create a burden on the students who may have to travel to the test site. Of particular concern is the northeast region, which has the highest concentration of medical schools. The closest test site is in Philadelphia. A list of recommended texts should be provided for examinee preparation. This should include not only NBME products, but also recommended general texts and materials that will form the basis of the USMLE Step 2 CS. The logistics of retesting are also of great concern in that there may not be an opportunity for students to retake the examination in time for graduation and starting in a residency. Finally, adequate feedback needs to be provided to the students who do not pass the examination so that they can properly direct their remediation efforts.

Further, the AMA has already taken action to mitigate the potential consequences of the implementation of the USMLE Step 2 CS and the COMLEX-USA Level 2-PE examinations. Medical schools have been encouraged to avoid linking passage of the examination to graduation requirements for at least five years after the implementation of the examination and to develop mechanisms to assist medical students to meet the financial obligations associated with the requirements for participation in the examination. Further, the NBME and the NBOME have been strongly encouraged to develop policies to ensure adequate capacity for registration and administration of the examinations and for retesting of students who fail the examination (Directive D-275.985, AMA Policy Database).

Other suggestions from the AMA to limit any adverse impact of the USMLE Step 2 CS and the COMLEX-USA Level 2-PE have been to encourage residency program directors not to require passage of the examinations for entry into residency and to assist residents who must retake the examination to prepare for retesting. Medical schools have been encouraged to implement objective structured clinical examinations (OSCEs) as part of their evaluation of medical students if the schools do not already use such tools. The AMA has also requested the opportunity to monitor blinded performance data to corroborate the validity of the USMLE Step 2 CS.

SUMMARY AND RECOMMENDATIONS

The AMA is deeply concerned about the potential negative impact of the implementation of the clinical skills examination as part of the USMLE and COMLEX-USA licensure sequence on medical students and on graduate medical education. In the interim, it is important to avoid using the examination as an absolute requirement for graduation. The effect of the examination on graduate medical education will depend on whether passing the examination is a condition for employment. There may be external pressure not to hire medical school graduates who are unable to demonstrate fundamental clinical skills essential for safe and effective patient care under supervision. Residency training programs may be ill-equipped to remediate individuals who have been unsuccessful in passing the examination. The hiring of such individuals might also increase the liability risk for the residency program. The financial burden of the examination to medical students must also be considered. In all instances, action should be taken to ameliorate these conditions and to yield the most positive result.

Therefore, the Council on Medical Education recommends that the following recommendations be adopted and the remainder of this report be filed:

1. That our American Medical Association continue to closely monitor the implementation of the USMLE Step 2 CS and the COMLEX-USA Level 2-PE, collecting data on initial and final pass rates, delays in students starting residency training due to scheduling of examinations, economic impact on students, and the potential impact of ethnicity on passing rates.
2. That our AMA inform residency program directors of the potential impact of the implementation of the USMLE Step 2 CS and the COMLEX-USA Level 2-PE by distributing copies of this report to all program directors.
3. That our AMA encourage residency program directors to proactively evaluate their access to resources needed to assist resident physicians who have not passed these examinations to remediate.

(References pertaining to Report 4 of the Council on Medical Education are available from the Medical Education Group.)

5. REVIEW OF POLICY H-255.995, "FOREIGN MEDICAL GRADUATES"

HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS AND REMAINDER OF REPORT FILED

During the 2003 "sunset" review of 1982 and 1983 American Medical Association House of Delegates' policies, the House of Delegates voted to refer the recommendation on Policy H-255.995, "Foreign Medical Graduates," to the Board of Trustees. The recommended change to Policy H-255.995 (AMA Policy Database) was as follows (suggested deletions from the original policy are stricken through):

The AMA believes that (1) ~~preferential immigration policies for foreign medical graduates should be terminated and~~ existing immigration laws should be enforced ~~more strictly~~; and (2) reduced requirements for licensure should not be applied under any circumstances to graduates of foreign medical schools.

Policy H-255.995 was originally adopted in 1982, at a time when there were emerging perceptions of an impending physicians surplus and, as a consequence, preferential immigration policies for foreign-trained physicians were beginning to be eliminated. The rationale for the proposed change in policy was that most preferential immigration policies now have disappeared, so that the deleted portion of the policy no longer is relevant.

HISTORICAL BACKGROUND

Entry into the US of foreign-trained physicians was facilitated by legislation beginning in the 1940s. The 1946 Fulbright amendments (PL 79-584) authorized international educational and cultural programs. The US Information and Educational Exchange Act of 1948 (Smith-Mundt Act, PL 80-402) established the exchange visitor (J) visa program. Taking effect in 1949, the US exchange-visitor program allowed any foreign student to enroll in a US government-approved program and remain until the program was completed. In 1965, the Immigration Act (PL 89-236) abolished national quotas and gave preference to individuals with occupations designated by the Department of Labor as being in short supply. This included physicians.

By the mid-1970s, however, this permissive climate began to change. The Health Professions Education Act (HPEA) of 1976 (PL-94-484) declared an end to the physician shortage, thereby eliminating the granting of preferences to international medical graduates (IMGs) for exchange visitor visas or immigration. In addition, a series of examinations was put in place to assess the knowledge of IMGs desiring to enter graduate medical education in the US. The HPEA established the Visa Qualifying Examination (VQE), which was similar to Parts I and II of the National Board of Medical Examiners (NBME) examination required for licensure of US medical graduates. In 1984, the VQE was replaced by the Foreign Medical Graduate Examination in the Medical Sciences (FMGEMS). International medical graduates began taking the Part I and II examinations of the NBME in 1989, and the United States Medical Licensing Examination sequence was implemented for licensure of US graduates and IMGs in 1994.

CURRENT IMMIGRATION/VISA STATUS OF IMGs

In 2001, of the 25,403 physicians in residency training who were IMGs, 3000 (11.8%) were native US citizens, 2404 (9.5%) were naturalized US citizens, 6823 (26.9%) were permanent residents, 5473 (21.5%) held the J-1/J-2 visa, 1591 (6.2%) held another type of visa and 6109 (24%) had another or unknown citizenship/visa status. Currently, the Educational Commission for Foreign Medical Graduates (ECFMG) serves as the visa sponsor for all J-1 exchange visitor physicians in clinical training programs. The ECFMG acts as the visa sponsor in accordance with a Memorandum of Understanding between it and the US Department of State and with the federal regulations developed to implement the 1948 legislation setting up the exchange visitor visa program.

CURRENT AMA POLICY

There are other existing policies related to entry of international medical graduates into the US for training. Policy H-255.986 supports the position that IMGs who plan to return to their country of origin should have the opportunity to obtain graduate medical education in the US. Policy H-255.988 reaffirms support for the current US visa and immigration requirements applicable to foreign national physicians who are IMGs and continues to support current

regulations governing the issuance of exchange visitor visas. Policy H-255.975 states that the AMA will work to correct problems of inconsistency, lack of accountability, and noncompliance in the administration of the J-1 Visa Exchange Program that had been identified in a 1996 study by the US General Accounting Office.

There is some policy that relates to the concept in Policy H-255.995 that there should not be reduced requirements for licensure of IMGs. AMA policy (H-255.985) affirms that any graduate of a foreign health professions educational program must, as requirement for entry into graduate medical education and/or practice in the US, demonstrate entry-level competence equivalent to that required of graduates of US programs.

SUMMARY AND RECOMMENDATIONS

In summary, the preferential immigration policies developed in the 1940s-1960s to address a perceived undersupply of physicians have disappeared. Our AMA has other existing policy that supports enforcement of existing visa and immigration policies. There is, however, no other specific policy that our AMA oppose reduced requirements for licensure for IMGs. The Council on Medical Education, therefore, recommends that the following recommendations be adopted and the remainder of this report be filed:

1. That Policy H-255.995, "Foreign Medical Graduates," be modified to read as follows:

The AMA believes that ~~(1) preferential immigration policies for foreign medical graduates should be terminated and existing immigration laws should be enforced more strictly and (2) reduced requirements for licensure should not be applied under any circumstances to graduates of foreign medical schools.~~

2. That the title of Policy H-255.995 be changed to "International Medical Graduates."

(References pertaining to Report 5 of the Council on Medical Education are available from the Medical Education Group.)

6. RECOGNIZING SPOUSE AND DEPENDENT CARE EXPENSES IN DETERMINING MEDICAL EDUCATION FINANCIAL AID

HOUSE ACTION: FILED

Resolution 301 (A-03), which was submitted by the Medical Student Section and adopted as amended by the House of Delegates, asked our American Medical Association to:

(1) work with the Liaison Committee on Medical Education to require that dependent health insurance, dependent care, and dependent living expenses be included both as part of the "cost of attendance" and as an educational expense for purposes of student budgets and financial aid; (2) encourage medical schools to include spouse and dependent health insurance, dependent care, and dependent living expenses as part of the "cost of attendance" and as an educational expense for the purposes of student budgets and financial aid; (3) ask its Council on Medical Education, Section on Medical Schools, and Women Physicians Congress to consider options to carry out the intention of current House of Delegates policy on the issue of spouse and dependent health insurance, dependent care, and dependent living expenses; and (4) report back on actions taken at the 2004 Annual Meeting.

This informational report discusses actions taken to implement the resolution.

BACKGROUND

In the 2001-2002 LCME Annual Medical School Questionnaire, Part II, an item was included asking whether dependent care expenses are included when calculating a student's financial aid budget. The questionnaire was sent to all LCME-accredited US medical schools and had a 100% response rate. Seventy-six schools (61%) responded that dependent care expenses were included. Twenty-five schools (20%) also reported having a program to assist students in obtaining financial assistance to care for their children (to meet the costs of food, clothing, child care, or health care).

SUMMARY OF ACTIONS TAKEN IN RESPONSE TO RESOLUTION 301 (A-03)

The adopted resolved clauses in Resolution 301 (A-03) were published in the Summer 2003 issue of the "Medical Education Bulletin," prepared by the Medical Education Group of the AMA. The Bulletin was sent to all medical school deans and to each medical school's representatives to the Section on Medical Schools.

Members of the Medical Education Group serve as the AMA Secretariat staff of the LCME, and, therefore, were given the responsibility of bringing the matter to the LCME's attention. To collect background information, staff contacted medical school financial aid administrators. This investigation revealed that the issue of how dependent care expenses are included in preparing a financial aid budget is a "gray area." According to a 1993 guidance document from the National Association of Student Financial Aid Administrators, there is an expected contribution from a student's working spouse that is used in the calculation of the financial aid budget. The spouse also is expected to cover dependent care expenses, such as medical or dental insurance. Based on this, the expected contribution from the spouse is decreased in calculating the budget, so that the amount of the aid that the student can receive is increased. If there is a non-working spouse or a single-parent household, the student's budget may be raised accordingly to cover dependent care expenses. This determination, however, is made on an individual basis. The federal government has not explicitly agreed that the process described above is allowable in the development of the student budget. Forcing the federal government to rule on the issue might lead to more rigid requirements that would not allow dependent care expenses to be considered at all in calculating the student's financial aid budget. The resolution, along with the background information, will be included on the agenda of the June 2004 LCME meeting.

In addition, the Higher Education Act is due to be reauthorized during 2004 or 2005. The AMA also will work to favorably resolve the current ambiguity related to the inclusion of dependent care expenses in financial aid budgets.

7. MEASURE EFFECTIVENESS OF AMA ANTI-DISCRIMINATION POLICY

HOUSE ACTION: RECOMMENDATIONS ADOPTED AND REMAINDER OF REPORT FILED

Resolution 308 (A-03), "Measure Effectiveness of AMA Anti-Discrimination Policy," which was introduced by the Michigan Delegation and adopted by the House of Delegates, asked that:

Our American Medical Association utilize the existing Graduate Medical Education Census, with the assistance of the International Medical Graduates Section, to examine trends and patterns in the selection of international medical graduates by residency program directors, and report back to the House of Delegates at the 2004 Annual Meeting; and that

Our AMA utilize the GME E-letter to communicate its policies of anti-discrimination to all residency program directors

AMA POLICY AGAINST DISCRIMINATION

AMA policies have long supported the concept that there be no discrimination against International Medical Graduates (IMGs). For example, Policy H-255.983 (AMA Policy Database) states that the AMA continues to support the policy that all physicians and medical students should be evaluated for purposes of entry into graduate medical education programs, licensure, and hospital staff privileges on the basis of their individual qualifications, skills, and character. Policy H-255.982 affirms that it is inappropriate to discriminate against any physician because of national origin or geographical location of medical education. The Division of Graduate Medical Education in the AMA Medical Education Group monitors accreditation standards, licensing requirements, immigration policies, and trends which affect IMGs to identify any signs of discrimination and then acts in concert with other groups within the AMA to take appropriate action.

DATA COLLECTION TO MONITOR IMG ENTRY INTO GRADUATE MEDICAL EDUCATION

The AMA monitors trends through the National GME Census. This survey is sent yearly to about 8000 residency program directors and has about an 85% response rate. The survey asks questions about current residents and fellows, as well as about program characteristics. Aggregate results of the census have been typically published in the yearly Medical Education Issue of the *Journal of the American Medical Association*.

In summary, the number (about 25,000) and percentage (26% of the total) of residents who are IMGs has been stable for at least the past 6 years. Analysis of trends in specialty selection of first-year residents has demonstrated a broadening distribution of IMGs into various specialties. The numbers and percentages of IMGs entering emergency medicine, general surgery, family medicine, obstetrics and gynecology, internal medicine/pediatrics, and orthopaedic surgery have steadily risen in the past 6 years, whereas the number and percentage entering internal medicine have been stable.

The stability in the number of IMGs in graduate medical education has occurred in the context of decreasing numbers of individuals seeking and receiving certification by the Educational Commission for Foreign Medical Graduates (ECFMG) (see Table).

Table - ECFMG Certificates and IMG Registrations for the USMLE

Year	ECFMG Certificates Issued	Number of IMG Registrants	
		Step 1	Step 2
1995	9,525	36,982	31,151
1997	10,297	36,231	30,614
1999	5,653	13,491	16,965
2001	5,934	16,828	12,122

In 2003, however, due to enhanced scrutiny for national security reasons, IMGs from some countries encountered significant delays in obtaining approval for J-1 visas. This, in turn, imposed a delay in the start of their residency training. The situation is being monitored closely by the ECFMG and the National Residency Matching Program to determine whether it was a short-term condition or is becoming a persistent problem.

COMMUNICATION WITH RESIDENCY PROGRAM DIRECTORS

The Division of Graduate Medical Education communicates with residency program directors monthly through the AMA's *GME E-letter*. This letter is sent electronically to 13,000 program directors and coordinators, and provides them with up-to-date information and appropriate contacts to help them discharge their many responsibilities. In February 2004, for example, the *GME E-letter* solicited information regarding potential delays for IMGs entering US residencies. The ECFMG has been closely tracking this concern and provided the AMA new information from ECFMG's ongoing surveys. This data has already been posted to the *GME E-letter* web site and will be published in the March 2004 issue of the *GME E-letter*. Future issues of the *GME E-letter* will continue to reinforce the AMA's anti-discrimination policy while providing residency directors and coordinators with appropriate tools to navigate an increasingly complex immigration, certification, and licensing environment.

CONCLUSION AND RECOMMENDATIONS

Data indicate that IMGs are gaining widening access to opportunities to participate in graduate medical education across specialties. This pattern should be monitored. The Council on Medical Education also believes that discrimination against any physician based on site of education should not occur. Therefore, the Council on Medical Education recommends that the following recommendations be adopted and the remainder of this report be filed:

1. That our American Medical Association continue to collect data on international medical graduate participation in graduate medical education, monitor trends, and disseminate the findings widely, for example, through publication in the annual Medical Education Issue of the *Journal of the American Medical Association*.

2. That our AMA reaffirm Policy H-255.982, which states that it is inappropriate to discriminate against any physician because of national origin or geographical location of medical education, and Policy H-255.983, which states that all physicians should be evaluated for purposes of entry into graduate medical education programs, licensure, and hospital staff privileges on the basis of their individual qualifications, skills, and character.

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

8. RESIDENT/FELLOW WORK AND LEARNING ENVIRONMENT (RESOLVE 7 OF RESOLUTION 322, A-03)

HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS IN LIEU OF RESOLVE 7 OF RESOLUTION 322 (A-03) AND REMAINDER OF REPORT FILED

Resolution 322 (A-03) was submitted by the Resident and Fellow Section and the Medical Student Section. Resolve 7 of Resolution 322 (A-03), which was referred to the Board of Trustees, asks that:

Our AMA conduct a 10-year survey to capture the attitudes and changes of residents on duty hours after the new ACGME guidelines to determine the effect on working conditions for residents and fellows.

BACKGROUND

In July 2003, the comprehensive new Accreditation Council for Graduate Medical Education (ACGME) duty hours and working environment requirements went into effect. The requirements include the need for residents to be supervised by qualified faculty at all times and for limitations on duty hours to be imposed. Duty hours must be limited to 80 hours per week, averaged over 4 weeks, and residents must be provided with 1 day in 7 free from educational and clinical responsibilities, averaged over 4 weeks. A 10-hour time period for rest and personal activities should be provided between daily duty periods and after in-house call. In-house call must occur no more frequently than every third night, averaged over 4 weeks. Continuous on-site duty (such as in-house call) must not exceed 24 hours, with an additional 6 hours permitted for didactic activities, transfer of care, outpatient clinics, and continuity of care.

Data from a comprehensive multi-specialty survey of residents by Baldwin and colleagues for the 1998-1999 training year showed that many residents were working above the 80-hour limit, with considerable variation among and within specialties (see Table 1).

Table 1 - Mean Weekly Duty Hours by Specialty, 1998-1999

Specialty	Mean PGY1 Hours (% over 80 hr limit)	Mean PGY2 Hours (% over 80 hr limit)
Emergency Medicine	80 (18%)	71 (14%)
Family Practice	78 (39%)	68 (18%)
Internal Medicine	84 (52%)	77 (36%)
Obstetrics-Gynecology	92 (70%)	91 (71%)
Orthopaedic Surgery	95 (76%)	94 (71%)
Pediatrics	81 (44%)	78 (36%)
General Surgery	102 (89%)	106 (93%)

The move to a standard duty hour limit for residents has raised concern that other groups within the teaching hospital (especially medical students and attending physicians) will be expected to assume some of the workload. As a result of these concerns, the Medical Student Section introduced Resolution 304 (A-02) which was adopted by the House of Delegates. This resolution asked that:

Our American Medical Association work with the Liaison Committee on Medical Education to develop standards addressing appropriate medical student training hours and training conditions during clinical clerkships.

In response to this resolution, the Liaison Committee on Medical Education (LCME) collected data from all LCME-accredited medical schools on the requirement that medical students participate in night call. Data from 2002-2003 are shown in Table 2.

Table 2 - Frequency of Night Call in Required Clinical Clerkships, 2002-2003

Clerkship	Number of Schools Where Night Call:		
	Required	Optional	Does Not Occur
Family Practice	20	19	77
Internal Medicine	101	16	9
Obstetrics-Gynecology	117	4	5
Pediatrics	102	10	14
Psychiatry	67	9	51
Surgery	113	8	5

The most common frequency of night call was every fourth night. Only 20 schools reported having a formal policy on medical student work hours.

These data indicated to the LCME that medical students were being expected to work long hours and that there was little central oversight or control.

At its February 2004 meeting, the LCME adopted an annotation to one of its existing accreditation standards. The standard states that “the committee [responsible for the curriculum] should give careful consideration to the impact on students of the amount of work required, including the frequency of examinations and their scheduling.” The annotation, which serves to explain the meaning of the standard and to assist survey teams in judging compliance, reads as follows:

In addition to monitoring the amount of classroom time and examination frequency, attention should be paid to the hours that medical students work during the clinical years and the educational value of their clinical activities. Student duty hours should take into account the effects of fatigue and sleep deprivation on learning and patient care. In general, medical students should not be required to work longer hours than residents.

In addition, Resolution 314 (A-03), submitted by the Young Physicians Section and adopted by the House of Delegates, asked that:

Our American Medical Association actively participate in ongoing efforts to monitor the impact of resident duty hour limitations to ensure that patient safety and physician well-being are not jeopardized by excessive demands on post-residency physicians.

Many groups, therefore, have an interest in the effects of the ACGME duty hours standards on patient care and on teaching and learning in the hospital. The Council on Medical Education shares this concern and proposes to expand the scope of data gathering to include resident physicians, medical students, and attending physicians.

OTHER CURRENT SURVEYS

Both the Resident and Fellow Section and the Medical Student Section currently are collecting data on hospital work hours and on the learning environment from the perspective of their constituencies. There are some limitations in the distribution of these surveys due to resources, but they are providing useful background information. The results of these surveys can inform the development of the comprehensive set of surveys proposed in this report.

The ACGME is initiating a web-based resident survey in February 2004. Over the next three years, residents in all specialty and subspecialty programs that have more than five active residents will be expected to complete the survey, which covers duty hours, resident and faculty evaluation, and aspects of the learning environment. Program directors will receive the results, with some of the aggregate responses flagged if they indicate non-compliance with accreditation standards. In addition, the survey results will be available to site visitors and to members and staff of Residency Review Committees. The results may not be available, however, to the general medical education community.

PLANS FOR DESIGN OF AMA SURVEY

The Council on Medical Education concurs that an assessment of the impact of the ACGME resident duty hours standards is warranted. Collecting data about the current clinical work and learning environment would provide useful normative information to the medical education community. However, care must be taken that the survey results meet standards of reliability.

Content

As described previously, there will parallel surveys for medical students, resident physicians, and attending physicians (at a minimum, residency program and clerkship directors) that address similar topics from the perspective of the responding group. The survey by Baldwin and colleagues conducted during 1998-1999 will be used as a model, since the results of that survey provide baseline data from before the ACGME duty hours standards were enacted. The proposed surveys will include items in the following general areas:

- Duty hours and amount of sleep
- The perceived quality of clinical education and the availability of supervision for medical students and resident physicians, including opportunities for study and independent learning;
- The adequacy of institutional resources, including the availability of support staff to perform routine, non-educational activities;
- Perceptions of personal health and well-being, stress, and interpersonal conflict;
- Interactions with members of the health care team;
- Issues related to medical errors and patient safety; and
- Perceived satisfaction with the work and learning environment.

Respondents and Mode of Questionnaire Delivery

A randomized sample from each of the responding groups (medical students, resident physicians, attending physicians) will be selected and invited to participate in the relevant survey. For resident physicians and faculty, the sample will be stratified to include multiple specialties. Sample sizes will be large enough to ensure that the results will be credible and that statistical analysis will be possible. The survey will be web-based to ensure easy access.

Timeline for Survey Development

The specific survey instruments will be developed during the latter half of 2004, in collaboration with the Medical Student Section, Resident and Fellow Section, Section on Medical Schools, and Young Physicians Section. In addition, outside groups with interests in graduate medical education will be consulted during survey development and review.

The surveys will first be conducted in early 2005, approximately 18 months after the ACGME duty hour requirements went into effect. Based on the results of the initial surveys, the content and timing of future survey will be determined. At a minimum, comprehensive surveys should be conducted every five years.

RECOMMENDATIONS

The ACGME duty hours changes have the potential to impact the hospital environment in many ways. It is important to monitor the effects to ensure that opportunities for learning, including the ability of medical students and resident physicians to participate as part of the health care team, are not being compromised. Therefore, the Council on Medical Education recommends that the following recommendations be adopted in lieu of Resolve 7 of Resolution 322 (A-03) and the remainder of this report be filed:

1. That our American Medical Association, with the input of other relevant groups involved in medical education, pursue the creation and dissemination of a survey in 2005 to medical students, resident physicians, and attending faculty to determine the effects of the 2003 Accreditation Council for Graduate Medical Education duty hours standards on the clinical learning environment.
2. That the scope of future surveys on the learning environment be determined based on the results of the 2005 survey.
3. That our AMA and other relevant groups offer to work with the ACGME in the design and analysis of the ACGME resident survey.

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

9. CME VALIDATION CRITERIA (RESOLUTION 312, A-02)

HOUSE ACTION: RECOMMENDATIONS ADOPTED IN LIEU OF RESOLUTION 312 (A-02) AND REMAINDER OF REPORT FILED

This report responds to Resolution 312 (A-02), introduced by the Georgia Delegation, that asked our American Medical Association to adopt policy recognizing the importance of physician experience, observation, and insight, and to acknowledge generally accepted and customary medical practice as appropriate criteria for continuing medical education (CME) content. Further, the resolution directed our AMA to communicate this policy to the Accreditation Council for Continuing Medical Education (ACCME), and to prevent any CME content criteria from being adopted that do not recognize these elements. The resolution was referred for further study, because both the American Academy of Family Physicians (AAFP), through its evidence-based (EB) CME initiative and the ACCME, through its Task Force on Content Validation and Eligibility for Accreditation, had undertaken a critical appraisal of how better use of the professional literature could strengthen the content of CME on clinical topics.

POLICIES OF THE AMA'S PHYSICIAN'S RECOGNITION AWARD (PRA) PROGRAM

The AMA PRA program, which encompasses not just the AMA PRA credit system but also the AMA PRA certificate on which it is based, has since 1982 relied on a broad and robust definition of CME:

CME consists of educational activities that serve to maintain, develop, or increase the knowledge, skills, and professional performance and relationships a physician uses to provide services for patients, the public, or the profession. CME represents that body of knowledge and skills generally recognized and accepted by the profession as within the basic medical sciences, the discipline of clinical medicine, and the provision of health care to the public.

The AMA shares this definition with the ACCME, and opens both of the AMA PRA information booklets with it (physician and CME provider versions, www.ama-assn.org/go/pr). With regard to content validity, this profession-driven definition of CME has never overlooked individual physician proficiency as a cornerstone of "that body of knowledge and skills generally recognized and accepted by the profession." Nevertheless, physician insight based

on experience will be shaped by the evolution of clinical and biomedical science. The AMA PRA program directs “CME providers [to] ensure that the content of the educational activities they designate for AMA PRA category 1 credit is scientifically based, accurate, current, and objectively presented [Provider information booklet, p. 5, v. 3.2].”

Further, in relation to alternative therapies, AMA PRA guidance specifies that CME teaching “how to perform such procedures, without evidence or *general acceptance in the profession* that supports their efficacy and safety, cannot be designated for AMA PRA category 1 credit [emphasis added, Provider information booklet, p. 6, v. 3.2].” The AMA PRA, in keeping with the general, non-specialty-specific language that has informed the credit system since its inception, recognizes the tension which informs the art and science of medicine: a physician should continuously apply the best available clinical knowledge through the speculum of his or her own experience. That said, the Council also notes that CME has grown to embrace more than strictly clinical areas; thus the AMA has migrated to a concept of continuing physician professional development in order to address topics such as leadership and communication skills.

AAFP EVIDENCE-BASED (EB) CME

In September of 2000 the AAFP’s Congress of Delegates launched its effort to integrate a category of CME within the overall construct of its prescribed credit system. Materials for EB CME were piloted in 2001 among 18 representative organizations, with a formal release in January 2002. Although adoption of EB CME has been slow among providers other than the AAFP, this ambitious and high-stakes effort pursues the worthy goal of combining (1) current best research evidence with (2) clinical expertise and (3) patient values (Sackett’s standard definition for EB medicine). Ongoing concerns, both public and within the profession, about quality and variations in care, accountability, cost-effectiveness, and outcomes impelled the Academy to set aside a specific standard for this category of CME.

While EB CME continues to be refined and challenged on matters ranging from how to address complementary and alternative medicine (CAM), reviewing and then identifying a fixed universe of approved EB sources, to establishing standards for strength of evidence and linking them to clinical recommendations--perhaps its most salutary impact has been to ignite discussion among the profession on exactly what is the most effective way to translate evidence into practice. Throughout this process, however, the AAFP has taken great pains to communicate to both the physician and CME provider communities that faculty should rely on their expertise to evaluate the best available evidence, *and to present it from their own perspective as practicing physicians*. Likewise, physician learners must be trusted (and expected) to employ their critical faculties to determine how to apply these recommendations in a manner that fits their patients’ best interests.

ACCME’S VALIDATION OF THE CLINICAL CONTENT OF CME

The ACCME has historically focused on the process and organizational concerns that define an appropriate CME provider. Due to pressure from licensing bodies and others, the ACCME took steps to more explicitly define what constitutes valid clinical content in CME activities (“CME that counts for maintenance of licensure”). The ACCME Task Force on Content Validation and Eligibility for Accreditation was formed, called for public comment and in July of 2002 issued formal guidance.

The ACCME, due to its mission, must speak not only to the scientific foundation of clinical CME delivered by their accredited providers, but also to the issue of freedom from bias (commercial support firewalls). One way for providers to mitigate bias is through an adherence to the principles of EB medicine.

The key to understanding the first recommendation produced by the Task Force rests with how the term “evidence” is used:

“All the recommendations involving clinical medicine in a CME activity must be based on *evidence that is accepted within the profession of medicine* as adequate justification for their indications and contraindications in the care of patients.”

The Task Force in its strategy statement asserted that the ACCME will seek “to raise the general awareness among providers, physicians, and faculty about the principles of EBM and clinical practice.” This brings us back to Sackett’s definition, which with its focus on clinical expertise and patient values cannot possibly function without linking to the analytic skills of the individual practicing physician.

CONCLUSIONS

The AMA PRA has always valued the skills acquired through experience by the individual practicing physician, and important efforts by other organizations to formally connect use of the professional literature in CME have not abandoned this component of how a physician delivers care. However, set against the history of CME, these initiatives do represent a change in how physicians are expected to leverage clinical science in CME, both as faculty and learners. If anything, physicians are being asked to think even more critically, through their own experience, about how they use the scientific literature. Ultimately, a command of the current science is necessary but not sufficient: all facets of a physician’s professional skill set must be in play to develop (and successfully participate in) quality CME activities.

The Council believes the AMA should support these efforts, collaborate with other stakeholders, and monitor the results on behalf of the AMA PRA credit system. In order to address the concerns behind Resolution 312 (A-02), the Council believes this support should be communicated to both the AAFP and the ACCME, emphasizing that EB CME and standards for valid clinical content should continue to integrate individual physician expertise as an essential facet of CME content and its delivery.

RECOMMENDATIONS

The Council on Medical Education recommends that the following be adopted in lieu of Resolution 312 (A-02) and the remainder of this report be filed:

1. That our American Medical Association express its support to the American Academy of Family Physicians for its evidence-based continuing medical education initiative and to the Accreditation Council for Continuing Medical Education for its valid clinical content standards.
2. That the AMA PRA program continue to monitor the use of evidence-based standards for CME, reporting back to the House of Delegates as major changes occur.

10. MECHANISMS TO REDUCE MEDICAL STUDENT DEBT

HOUSE ACTION: RECOMMENDATIONS ADOPTED AND REMAINDER OF REPORT FILED

Recommendation 8 of Council on Medical Education Report 2-I-02 asked that progress in limiting medical school tuition and in developing mechanisms to reduce student debt be reported to the House of Delegates at regular intervals, beginning with the 2004 Annual Meeting. This report provides current data on medical student debt levels and financial aid programs and summarizes strategies that have been proposed in the past to limit debt. Additional initiatives to limit student debt burden also are discussed. The report draws from the work of the 2003 Medical Student Section Task Force on Student Debt, which the Council in Medical Education gratefully acknowledges.

MEDICAL STUDENT DEBT

The average debt of graduating medical students has been rising steadily (see Table 1). Between 2002 and 2003, the average debt of indebted public medical school graduates increased 6.4%, of private school graduates increased 4.5%, and of all indebted students increased 5.4%.

Table 1 - Average Educational Debt of Indebted Graduates*

Year	Public Schools	Private Schools	All Schools
1985	\$25,718	\$36,417	\$29,943
1990	38,167	57,836	46,220
1995	58,276	84,946	93,000
2003	97,275	129,392	109,457

* - Includes premedical and medical school educational debt

Source: Association of American Medical Colleges

Of medical school graduates in 2003, 16.9% had no educational debt, but almost 3% of public school graduates and 15% of private school graduates had debt in excess of \$200,000.

FACTORS CONTRIBUTING TO MEDICAL STUDENT DEBT

Increases in medical school tuition and fees are a major factor contributing to increased debt levels. For 2003-2004, the average tuition and fees for in-state residents at public medical schools was \$16,172 (an 11% increase from 2002-2003) and for private medical schools was \$32,488 (a 4.9% increase from 2002-2003). There is a wide range across schools, however, in the amount of tuition and fees. Resident tuition and fees in public medical schools ranged from \$4922 to \$26,422 and in private schools ranged from \$9558 to \$40,459 in 2003-2004.

Total educational debt also is, however, influenced by other factors. These include college debt, which averaged \$22,095 for the 38% of students with premedical debt. Average premedical debt increased 30% between 2000 (when 35% of medical school graduates had such debt) and 2003.

SOURCES OF FINANCIAL AID

There are a variety of sources of financial aid. Most common are loans (from public and private sources) and scholarships. Of 2003 graduates, 81.4% had outstanding loans that they will be required to repay and 48% had received some scholarship support. The following summarizes sources of financial aid in addition to federal and commercial loan programs, and institutional (medical school and university) scholarships.

Federal and State Service-Related Programs

There are public scholarship and loan repayment programs that provide funding in return for a specific period of service. One of the most longstanding is the National Health Service Corps (NHSC), which offers both scholarship and loan-repayment programs in return for service in an underserved area. Awards for physicians are limited to specific specialty areas. A parallel federal program exists through the Indian Health Service and a number of states have loan repayment programs, most often with characteristics similar to the NHSC. The National Institutes of Health has several loan repayment programs, both intramural and extramural, for individuals pursuing research in targeted areas, including clinical, pediatric, contraception/infertility, and health disparities. Military programs also exist, including the Health Professions Scholarship Program offered by the Army, Navy, and Air Force, and the Health Professions Loan Repayment Program.

Programs from Private Sources

There are many scholarship programs both at the national and local levels. Medical students often depend on the financial aid office at their schools to inform them of these opportunities.

One potential source of funding is the physician community. In order to determine whether certain members of the Federation (state and county medical societies) provide financial aid, an e-mail survey was sent to the directors of all state and county medical societies in the winter of 2003. Responses were received from 27 state medical societies and 45 county societies. The results are shown in Table 2. Funding for the programs came, in general, from private sources and from endowment/dues/reserves.

In three of the states, the loan repayment program was limited to individuals selecting a generalist specialty. Four of the county societies limited access to individuals from or attending medical school in a specific location (e.g., a county).

Table 2 - Financial Aid Programs of State and County Medical Societies

Financial Aid Offered	State Medical Societies	County Medical Societies
Scholarships	12 (44%)	28 (62%)
Loan repayment programs	4 (15%)	3 (7%)
Low/no interest loans	2 (7%)	2(4%)

AMA POLICY RELATED TO LIMITING STUDENT DEBT

The AMA has adopted policy raising the issue of medical education debt to one of the top several legislative priorities (Policy H-310.934, AMA Policy Database). In previous reports and resolutions, the AMA has recommended a number of strategies to limit the amount of debt that medical students must eventually discharge. These strategies can be grouped into several categories.

Reducing the Cost of Medical Education

The AMA has pledged to work with appropriate bodies to study how the cost to students of medical education can be reduced (Policy H-305.959).

Making the Cost of Medical Education Transparent and Predictable

This includes expecting medical schools to publicize the costs of attending to prospective students and college faculty advisors (Policy H-305.995) and opposing mid-year and retroactive tuition increases (Policy H-305.934).

Making Financial Aid Available

The AMA supports working with the federal government and other parties to increase financial aid opportunities, such as loan repayment options (Policy H-305.954). The availability of financial aid opportunities through the National Health Services Corps (for example, Policies H-200.959, 20.984) and other Title VII programs (Policy H-305.952) should specifically be sustained.

Decreasing the Cost of Loan Payback

There is considerable policy related to restoring the tax deductibility of interest on educational loans (for example, Policies H-305.955, H-305.963, H-305.978) and the tax exemption of funds from federal scholarship (Policy H-305.940) and loan repayment (Policy H-305.937) programs. Deferral of loans until the completion of residency also is supported (for example, Policies H-305.961, H-305.965).

Supporting Debt Counseling

The AMA supports medical schools assisting students to find available funds and manage debt responsibly (Policy H-305.995).

STRATEGIES FOR ACTION

The elimination of medical student debt would require a comprehensive overhaul of the system of medical school financing. While this is an important goal to work toward, there are a number of areas where actions could be taken more immediately to reduce debt burden. Many of these areas depend upon partnerships between the AMA and members of the Federation.

Advocacy at the Federal Level

The Higher Education Act (HEA) is due to be reauthorized in 2004 or 2005. There are a number of provisions that should specifically be supported for inclusion, including:

- *Eliminating the single holder rule.* The single holder rule stipulates that the borrower must refinance loans through the same lender when all loans are through a single lender. This prohibits borrowers from searching for the best loan terms.

- *Making the availability of loan deferment more flexible, including broadening the definition of economic hardship and expanding the period for loan deferment to include the entire length of residency and fellowship training (and retaining the option of loan forbearance if there are residents ineligible for loan deferment).* In loan deferment, the borrower is allowed to postpone repaying the loan. In subsidized loans, the federal government pays the interest charges during the deferment period; in an unsubsidized loan, the borrower is responsible for the interest that accrues during the deferment period. In loan forbearance, the borrower may temporarily postpone repaying the principal, but interest charges continue to accrue and must be paid during the forbearance period.
- *Including dependent care expenses in the definition of “cost of attendance.”* While medical schools may include dependent care expenses in the student’s budget, there is not explicit permission in the HEA and accompanying regulations to allow this to regularly be done.
- *Supporting the ability to refinance Federal Consolidation Loans.* The 1998 amendments to the HEA state that a borrower is ineligible to reconsolidate student loans if she/he has a Federal Consolidation Loan. The ability to refinance Federal Consolidation Loans could lower the cost of loan payback, thereby reducing overall debt level.

Advocacy at the State Level

The AMA should continue to work with state medical societies to advocate for sufficient funding for medical schools so that drastic and unplanned increases in tuition are not required.

Increased Availability of Financial Aid

Additional sources of financial aid, especially scholarship and loan repayment opportunities, should be made available. This includes expanding scholarship and loan repayment options in the public sector. There should be increases in the number of awards in existing programs (such as the National Health Service Corps and state loan repayment programs). In addition, new, targeted programs should be created, for example, directed at clinical investigators, clinical teachers, and other areas of need.

The private sector, especially the federation, also should take a larger role in providing financial aid opportunities. For example, state medical societies and specialty societies should expand or create financial aid programs for targeted groups of medical students. For example, the survey of state medical societies was undertaken based on the request of a state society that expressed interest in starting a financial aid program, but wanted more information about the types of programs that already existed.

In addition, medical schools should be encouraged to increase their efforts to raise scholarship funding from philanthropy. As of 2002, about two-thirds of schools were involved in a fundraising campaign directed, at least in part, in attracting funding for scholarships. The results of these efforts are not yet generally observable, but have potential for the future. These efforts should be supported by medical students and alumni should be encouraged to participate actively.

Medical schools also should be encouraged to adopt innovative financial aid programs. One example used successfully by some schools is the revolving loan fund. These are low or no-interest loans from a pool, originally from institutional funding or philanthropy, that is replenished when the loans are repaid by graduates.

Increased Availability of Financial Planning/Debt Management Services for Medical Students and Resident Physicians

Medical students should be provided with financial planning/debt management counseling throughout their medical school years. They also should be informed of the existing online tools, such as the Association of American Medical Colleges program “Monetary Decisions for Medical Doctors” (MD²) and advised early about the implications of their borrowing. Resident physicians also should have access to financial planning/debt management services.

Study of Medical Education Financing

The Council on Medical Education has begun a comprehensive review of the financing of undergraduate and graduate medical education. The goal is to develop policy recommendations directed at stable sources of funding for medical schools and graduate medical education teaching institutions. Stable funding streams could, for example, reduce the need for regular tuition increases, thereby limiting the debt burden that medical school graduates accrue.

SUMMARY AND RECOMMENDATIONS

Student debt continues to rise at a significant rate, due to increasing medical school tuition and other factors. A single, comprehensive remedy is not imminent. This requires, therefore, that a variety of actions be taken to mitigate, as far as possible, the negative pressures on medical students of a high debt burden. The Council on Medical Education, therefore, recommends that the following recommendations be adopted and the remainder of this report be filed:

1. That our American Medical Association take an active advocacy role during the upcoming reauthorization of the Higher Education Act and other pending legislation, to achieve the following goals:
 - Eliminating the single holder rule;
 - Making the availability of loan deferment more flexible, including broadening the definition of economic hardship and expanding the period for loan deferment to include the entire length of residency and fellowship training;
 - Retaining the option of loan forbearance for residents ineligible for loan deferment;
 - Including, explicitly, dependent care expenses in the definition of the “cost of attendance;”
 - Including room and board expenses in the definition of tax-exempt scholarship income;
 - Continuing the loan consolidation program, including the ability to “lock in” a fixed interest rate; and
 - Adding the ability to refinance Federal Consolidation Loans.
2. That our AMA continue to work with state and county medical societies to advocate for adequate levels of medical school funding and to oppose legislative or regulatory provisions that would result in significant or unplanned tuition increases.
3. That our AMA encourage members of the federation to develop or enhance financial aid opportunities for medical students.
4. That our AMA continue to monitor the availability of financial aid opportunities and financial planning/debt management counseling at medical schools, and share innovative approaches with the medical education community.
5. That our AMA continue to collect and disseminate information to assist members of the federation (state medical societies and specialty societies) and medical schools to establish or expand financial aid programs.
6. That our AMA continue to study medical education financing, so as to identify long-term strategies to mitigate the debt burden of medical students.

(References pertaining to Report 10 of the Council on Medical Education are available from the Medical Education Group.)

11. PLAN FOR THE IMPLEMENTATION OF A NATIONAL DISASTER LIFE SUPPORT (NDLS) EDUCATIONAL PROGRAM

HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS AND REMAINDER OF REPORT FILED

This report proposes a plan for our American Medical Association to work with a national consortium of experts and key stakeholders, including members of the Federation, to update and disseminate the National Disaster Life Support (NDLS) program, a comprehensive national disaster management education and training program for physicians and other health professionals. The NDLS program would be managed at the AMA through a newly-created National Program Office.

BACKGROUND

There is evidence supporting the need for a national educational initiative in disaster preparedness. The amount of information about biological and chemical terrorism presented during medical school is variable, but, in general, limited. A 2002-2003 survey of medical schools found that, while about two-thirds of schools included such content as part of the required curriculum, on average only six hours were devoted to the subject. As a result, most physicians believe themselves unprepared to deal with a disaster situation. For example, a 2003 article in the journal *Health Affairs* reported that 80% of respondents to a national survey of physicians were willing to care for patients in a potential bioterrorist attack, but only about 20% believed that they were well prepared to play a role.

An AMA commitment to the implementation of a national training effort in disaster preparedness has existed for some time. At the 2001 AMA Interim Meeting, the House of Delegates approved the creation of a major initiative to assist physicians in responding to the medical consequences of disasters. This resulted in the formation of the Center for Disaster Preparedness and Emergency Response within the Group on Science, Quality, and Public Health.

As part of its national initiative, our AMA signed a Memorandum of Understanding with four organizations (Medical College of Georgia, University of Georgia, University of Texas Southwestern Medical Center at Dallas, and University of Texas at Houston School of Public Health) in 2003. This partnership has been expanded to include the National Association of EMS Physicians, National Association of State EMS Directors, and the American Public Health Association. A National Executive Committee (NEC), which the AMA chairs, was formed representing the partner organizations. The goal of the NEC is to develop and disseminate the NDLS educational program for physicians and other health professionals. The NEC has been working with the larger National Disaster Life Support Education Consortium (NDLSEC), which was formed with support from the Centers for Disease Control and Prevention. The Consortium consists of a multidisciplinary group of national experts and organizations involved in disaster medicine and emergency response. As the program develops, the NDLSEC will expand to include all interested members of the Federation.

The general goals of the NDLS program were articulated in Council on Scientific Affairs Report 1-I-03, "AMA National Disaster Life Support Program." This report amended Policy H-130.946 (AMA Policy Database) to add that the AMA would:

Work collaboratively with the Federation in the development, disseminations, and evaluation of a national education and training initiative, called the National Disaster Life Support Program, to provide physicians, medical students, other health professionals, and other emergency responders with a fundamental understanding and working knowledge of their integrated roles and responsibilities in disaster management and response efforts.

THE CURRENT NDLS PROGRAM

NDLS follows the model of the national advanced cardiac life support (ACLS) and advanced trauma life support (ATLS) programs, in that it provides stand-alone training with "certification" for successful completion. Currently, NDLS is composed of three courses, aimed at different segments of the health professions community. The current target audiences and formats of the three courses are described below.

- Core Disaster Life Support (CDLS) provides an overview aimed at producing general preparedness for traditional first responders and other non-medical personnel. The half-day course is presented mainly through didactic lectures.
- Basic Disaster Life Support (BDLS) is a comprehensive introduction for health professionals covering 8 topic areas: the DISASTER paradigm, natural disasters, traumatic and explosive events, nuclear and radiological events, biological events, chemical events, public health implications of disasters, psychosocial aspects, and evaluation and testing. The course can be offered over one day or multiple days. It currently utilizes a lecture-based format and is appropriate for medical students and resident physicians, as well as practicing physicians.
- Advanced Disaster Life Support (ADLS) is designed to provide hands-on skills for physicians, nurses, and paramedics. The 2-day course allows learners to demonstrate competencies in a number of areas, such as simulated all-hazards scenarios and mass casualty incidents.

Courses, especially BDLS already have been offered in a number of locations, including at the 2003 Interim Meeting of the AMA House of Delegates.

PROJECTED ENHANCEMENTS TO THE NDLS PROGRAM

To update and enhance the NDLS course sequence, a number of changes are being implemented for the on-site courses, including the:

- Identification of a core set of competencies;
- Creation of a core text for use in both BDLS and ADLS;
- Revision of the BDLS course format to be more interactive and allow more communication among participants;
- Introduction of training programs for instructors, course coordinators, and course directors, as part of a network of training centers based at the state level;
- Development of pre- and post-tests for each course linked to the specific program competencies; and
- Creation of standardized teaching materials, including slide sets and course syllabi.

In addition, plans are being developed for a modular online version of the CDLS and BDLS courses. This will allow for easy dissemination of the information and permit learners to access the content at their own pace. Each stand-alone module will include objectives, a pre- and post-test, and relevant content presented in an interactive format.

A verification system also is in development by the AMA that will lead to a central voluntary database or registry of individuals who have successfully completed course requirements. The database will permit rapid identification of a pool of medically trained individuals, by location, who could be called upon to respond in case of a terrorist emergency or other disaster.

CREATION OF A NATIONAL PROGRAM OFFICE

The proposed National Program Office, which will be housed at the AMA, will serve a variety of functions. Currently, staff from the existing Center for Disaster Preparedness and Emergency Response provide support for the NDLS and the Executive Committee and serve to link all members of the national network. The Center also is the locus of planning to revise the NDLS training program and to create the national registry of certified providers.

As the NDLS program grows, there is a need to develop a formal National Program Office. The current Center complement of 3 FTEs is insufficient for the expanded roles of the National Program Office, in addition to carrying out their other job responsibilities. These new roles include coordination of training of instructors for NDLS deployment and administration, which effort will, similar to the ATLS model, be based at the state level.

Some of the expense of the National Program Office would be offset by revenue from sales of the BDLS/ADLS core text through the AMA Press. The development and maintenance of the national registry will be supported, in part, by revenue from course registration.

BENEFITS OF NDLS TO AMA MEMBERS AND THE FEDERATION

NDLS offers a number of benefits to AMA members and to the Federation in general. For members, NDLS training would be made available at a discount, as will participation in the national registry of NDLS-certified physicians. The Federation will be included in NDLS in several ways. The national network for NDLS training will draw heavily in the infrastructure of the Federation, for example, regional centers could be based in or associated with state medical societies. It is expected that NDLS program faculty and trainers will be recruited from state and specialty societies, as well as from medical schools.

AMA involvement in NDLS also should enhance membership by bringing the AMA into contact with a large physician audience. This visible program will reach a national group of physicians, medical students, and resident physicians.

SUMMARY AND RECOMMENDATIONS

The NDLS allows physicians and physicians-in training, as well as other health professionals and first responders, to acquire understanding of and ability to contribute in disaster and other public health emergency situations. Our AMA is uniquely situated to play a central role in the development and national dissemination of NDLS. Therefore, the Council on Medical Education recommends that the following be adopted and the remainder of this report be filed:

1. That our AMA actively pursue the creation of a National Training Network for the National Disaster Life Support (NDLS) program, based at the state level and coordinated through a newly-developed AMA-based NDLS National Program Office.
2. That our AMA support the NDLS National Program Office at a level that permits the following enhancements to the NDLS program:
 - Revision of the NDLS course sequence, including creation of online Core Disaster Life Support and Basic Disaster Life Support courses;
 - Creation of a voluntary electronic registry of NDLS-trained individuals; and
 - Outreach to other members of the National Disaster Life Support Education Consortium, to encompass individuals from many specialties and disciplines within the Federation.

(References pertaining to Report 11 of the Council on Medical Education are available from the Medical Education Group.)