REPORTS OF COUNCIL ON MEDICAL EDUCATION

The following reports, 1-4, were presented by Rebecca J. Patchin, MD, Chair:

1. INTERN AND RESIDENT WORKING HOURS (FOURTH RESOLVE OF SUBSTITUTE RESOLUTION 306, I-00)

HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS IN LIEU OF THE FOURTH RESOLVE OF SUBSTITUTE RESOLUTION 306 (I-00) AND REMAINDER OF REPORT FILED

Resolution 306, "Intern and Resident Work Standards," was submitted by the Resident and Fellow Section at the 2000 Interim Meeting. The first three resolves, which were adopted by the House of Delegates, proposed:

> That our American Medical Association support the various standards of Accreditation Council for Graduate Medical Education (ACGME) Residency Review Committees as a template for reasonable resident work conditions, pending further data; and be it further
>
> That our AMA stress the consideration of patterns and trends of program violations of ACGME requirements, and affirm the recommendations of Council on Medical Education Report 3-A-00 that recommended various alternatives to enforce compliance with requirements, including the shortening of the cycle for review of programs that receive unfavorable Institutional Reviews; and be it further
>
> That our AMA, through its Council on Medical Education, work with the American Academy of Sleep Medicine to convene a meeting during 2001 on the evidence available about the effect of chronic fatigue and acute sleep deprivation on medical education and physician performance and prepare a consensus statement on areas for further research and effective mechanisms to address identified concerns.

The following fourth resolve was referred to the Board of Trustees:

> That our AMA encourage the ACGME to release a regularly updated list in electronic form (i.e., the ACGME web site) of residency programs cited by their respective Residency Review Committee (RRC) for violations of the RRC's work-hour standards, with the opportunity for responses by the program directors.

The Reference Committee recognized the strong sentiment of medical students to have appropriate data available to be able to make informed judgments on the selection of residency programs for training. However, there was considerable testimony as to problems related to the quality and timeliness of the data requested. As a consequence, the fourth resolve was referred for further evaluation. The Board of Trustees assigned the evaluation to the Council on Medical Education.

BACKGROUND

The standards for the accreditation of general specialty and subspecialty graduate medical education programs are established independently for each of the 27 residency review committees that function within the ACGME. This includes the program requirements related to work hours and working conditions. In addition, the Institutional Review Committee has general standards relating to work hours that are applicable to all residency programs. For consistency, the term work hours as identified by the ACGME is used in this report.

The procedures for program accreditation include the preparation of documents by the program director that provide the program surveyor and the review committee with a comprehensive description of the program. A site visit is conducted to verify the information provided by the program director. Interviews are also conducted with administrators, faculty, and resident physicians to obtain additional information on the various aspects of the program. A report of the site visit and the program documents is submitted to the RRC for review.

Residency review committees meet two to four times each year to determine the accreditation status of the program and the timing of the next survey. In addition, the members of the RRC identify specific standards with which the program is not in compliance and produces a list of citations and requirements for reports on progress towards compliance. Programs have the opportunity to respond to the RRC and appeal individual citations. As a result, the interval from the time of a site visit until the final determination of a citation can extend to a full year.

The interval between surveys is one to five years, with shorter intervals indicating greater levels of concern about compliance with standards. Over the past year, two of the RRCs, Family Practice and Pediatrics, have instituted a process to deal with programs that are not in compliance with standards on work hours. This process requires an immediate progress report be submitted to the RRC addressing resolution of the citation related to work hour requirements. Other RRCs utilize this mechanism based on the severity or the duration of the problem.

The specific standards related to work hours for programs are listed in Appendix A. All programs require that, on average, call be no more frequent than every third night with one day off in seven with exceptions for the maintenance of continuity of patient care. The Institutional Requirements do not include specific schedule requirements but recognize that work hours must not be excessive and are to be structured to focus on the needs of the patient, continuity of care, and the educational needs of the resident.

EXISTING AMA POLICY

The AMA has a history of concern about resident supervision and work hours dating back to at least 1987. Policy H-310.961, (AMA Policy Database) "Residency/Fellowship Working Conditions and Supervision," directs that "the AMA will continue to work closely with the parties involved in the accreditation of graduate medical education programs to reaffirm the AMA's position on resident working conditions and supervision, to further clarify the various concerns related to resident working conditions, and to explain why specific language is essential to the general issue of working conditions...." Policy H-310.979, "Resident Physician Working Hours and Supervision," further indicates "...these problems should be addressed within the present system of graduate medical education, without regulation by agencies of government."

ACGME REPORTING OF NONCOMPLIANCE WITH WORK HOURS STANDARDS

The ACGME does not provide program specific information about citations for any standards including those related to supervision and work hours. The accreditation status of individual programs and the schedule of survey visits is available on the ACGME web site. In addition, an electronic version of a chart of the percent of programs surveyed in 1999 and 2000 by specialty that were cited for work hours and related requirements, Appendix B, can be obtained from the same web site.

Discussions were held with the ACGME Executive Director and the Director of the Department of RRC Activities to investigate the possibility of providing a regularly updated list in electronic form. Many of the same issues noted in the discussion before Reference Committee C at the 2000 Interim Meeting were revisited. In addition, concern was expressed that the issue of resident work hours was complex and could not be separated from other aspects of working conditions including the quality of patient care, patient and resident safety, and education.

The goal of posting program citations for noncompliance with work hour standards was to provide timely and accurate information to medical students so that they could make better decisions regarding the selection of training programs. As noted in the background information, the cycle of program review leading to a final determination of a citation could extend to a full year. Thus, a program with a sustained violation of work hour standards might not be posted until one year following the survey. Applicants would be unaware of the possible citation during that period. At the same time, programs cited for work hour violations that have corrected the problem and submitted a satisfactory progress report would remain on the list of violations for up to six months and not be afforded the benefit of their corrective actions. Finally, since the cycle for review varies from one to five years, it would be possible for a program to be in violation of the work hour standards and not discovered for up to five years.

Unfortunately, the current postings on the ACGME web site do not meet the goal of providing program-specific information. While the interval between survey visits is a reflection of the confidence of the ACGME in the program's ability to comply with the standards, it does not identify specific problems. The percentage of programs cited also fails to provide the necessary information. In fact, this information is even more difficult to interpret in that it is not a random sample of the programs in individual specialties but is heavily weighted toward programs that

require repeated, short-cycled inspections. The downward trend in the percent of programs cited in several specialties requires further investigation to determine if it is a true measure of increasing compliance or an artifact of the sampling or reporting by resident physicians.

To resolve the shortcomings noted above, the reporting of accurate information about work hours for individual programs could be separated from the reporting of violations of standards and would therefore not be constrained by the cycle of survey visits and could be updated frequently to provide timely information. These reports could then be posted on the ACGME web site and be available for review by medical students and resident physicians. This system would meet the intent of the fourth resolve of Substitute Resolution 306 (I-00).

RECOMMENDATIONS

Institutional and program compliance with ACGME standards for resident work hours is of critical importance. The Council on Medical Education has written to each AMA RRC representative stressing the importance of this issue and requested their assistance in monitoring the timely correction of each instance of noncompliance with work hour standards. The opportunity for the profession to regulate itself in the accreditation of graduate medical education is jeopardized by the extent of noncompliance with these standards.

The Council on Medical Education recommends that the following recommendations be adopted in lieu of the fourth resolve of Substitute Resolution 306 (I-00) and that the remainder of the report be filed:

1. That the Accreditation Council for Graduate Medical Education, through its Residency Review Committees and the Institutional Review Committee, enforce work hour guidelines rigorously and ensure compliance with work hour standards.

2. That the ACGME be requested to investigate mechanisms to provide readily accessible, timely and accurate information about work hours for individual programs that is not constrained by the cycle of survey visits.

APPENDIX A - SPECIFIC RRC STANDARDS RELATED TO WORK HOURS

Allergy and Immunology (Revised 1996)
- No more than 80 hours of hospital duties per week when averaged over 4 weeks
- On average at least 1 full day out of 7 free of hospital duties
- On call in hospital no more often than every third night

Anesthesiology (Revised 2000)
- 1 full day out of 7 free of program duties
- On average, on call no more than every third night

Colon Rectal Surgery (Revised 2000)
- On average, excluding exceptional patient care needs, residents have at least 1 day out of 7 free of resident responsibilities
- On call in the hospital no more often than every third night

Dermatology (Revised 1999)
- When averaged over 4 weeks, residents should spend no more than 80 hours per week in hospital duties
- On average, have the opportunity to spend at least 1 day out of 7 free of hospital duties
- On call no more often than every third night
- Opportunity to rest and sleep when on call for 24 hours or more

Emergency Medicine (Revised 2000)
- 1 full day in 7 days away from the institution and free of any clinical or academic responsibilities
- While on duty in the emergency department, residents may not work longer than 12 continuous scheduled hours
- There must be at least an equivalent period of continuous time off between scheduled work periods
- A resident should not work more than 60 scheduled hours per week seeing patients in the emergency department and no more than 72 duty hours per week (Duty hours comprise all assigned clinical duty time and conferences, whether spent within or outside the educational program, including on-call hours.)

Family Practice (Revised 2000)
- At least 1 day out of 7, averaged monthly, away from the residency program
- On-call duty no more frequently than every third night, averaged monthly

Internal Medicine (Revised 2000)
- When averaged over any 4-week rotation or assignment, residents must not spend more than 80 hours per week in patient care duties
- Residents must not be assigned on-call in-house duty more often than every third night
- When averaged over any 4-week rotation or assignment, residents must have at least 1 day out of 7 free of patient care duties
- During emergency medicine assignments, continuous duty must not exceed 12 hours
- Emergency medicine or night float assignments must be separated by at least 8 hours on non-patient-care duties

Internal Medicine Subspecialties (Revised 1998)
- When averaged over any 4-week rotation or assignment, residents must not spend more than 80 hours per week in patient care duties
- Residents must not be assigned on-call in-house duty more often than every third night
- When averaged over a year, excluding vacation, residents must be provided with a minimum of 48 days free of patient care duties, including home-call responsibilities

Medical Genetics (Revised 1999)
- On average, at least 1 full day out of 7 free of hospital duties
- On call no more often than every third night, except in the maintenance of continuity of care
- There should be adequate opportunity to rest and to sleep when on duty for 24 hours or more

Neurological Surgery (Revised 1999)
- On average, excluding exceptional patient care needs, residents have at least 1 day out of 7 free of routine responsibilities
- On-call in the hospital no more often than every third night

Neurology (Revised 2000) and Child Neurology (Editorial Rev 1999)
- Residents must be allowed to spend an average of at least 1 full day out of 7 away from the hospital
- Residents must provide on-call duty in the hospital, but no more frequently than an average of every third night

Nuclear Medicine (Revised 1998)
- All residents should have the opportunity to spend an average of at least 1 full day out of 7 free of hospital duties
- Assigned on-call duty in the hospital no more frequently than, on average, every third night

Obstetrics and Gynecology (Revised 2000)
- On the average, no more often than every third night
- On the average, at least 1 full day out of 7 away from program duties

Ophthalmology (Revised 1999)
- When averaged over 4 weeks, residents should spend no more than 80 hours per week in patient care activities
- On average, have the opportunity to spend at least 1 day out of 7 free of patient care activities
- No more often than every third night

Orthopaedic Surgery (Revised 1997)
- On average, excluding exceptional patient care needs, residents have at least 1 day out of 7 free of routine responsibilities
- On call in the hospital no more often than every third night

Otolaryngology (Revised 1996)
- On average, at least 1 full day out of 7 free of hospital duties
- On call in the hospital no more than every third night, except in the maintenance of continuity of care
- Adequate opportunity to rest and to sleep when on duty for 24 hours or more

Pathology (Revised 1989)
- On average, have the opportunity to spend at least 1 full day out of 7 free from hospital duties
- On call no more often than every third night

Pediatrics (Revised 2000)
- A monthly average of every third to fourth night for inpatient rotations requiring call
- Call may be less frequent for outpatient or elective rotations
- Call-free rotations should not exceed 4 months during the 3 years of training
- A monthly average of at least 1 day out of 7 without assigned duties
- Emergency department shifts should not exceed 12 hours, with consecutive shifts separated by at least 8 hours

Physical Medicine and Rehabilitation (Revised 2000)
- Residents at all levels, on the average, should have the opportunity to spend 1 full day out of 7 free on inpatient and outpatient care duties
- On average, should be on night call no more often than every third night

Plastic Surgery (Revised 1994)
- On average, excluding exceptional patient care needs, residents have at least 1 day out of 7 free of routine responsibilities
- On call in the hospital no more often than every third night

Preventive Medicine (Revised 2000)
- When averaged over 4 weeks, residents should spend no more than 80 hours per week in all duties
- On average, have the opportunity to spend at least 1 day out of 7 free of hospital duties
- On call no more often than every third night
- Adequate opportunity to rest and sleep when on call for 24 hours or more

Psychiatry (Revised 2000)
- One day out of 7 free of program duties
- On average, on-call duty no more than every third night

Radiology-Diagnostic (Revised 1998) and Subspecialties (Revised 1994)
- Allowed to spend at least 1 full day out of 7 away from the hospital
- Assigned on-call duty in the hospital no more than, on average, every third night

Radiation Oncology (Revised 2000)
- Residents be allowed to spend, on average, at least 1 full day out of 7 away from the hospital
- Not be assigned on-call duty in the hospital more frequently than every third night

General Surgery (Revised 1998) and Subspecialties (Revised 1996)
- On average, excluding exceptional patient care needs, residents have at least 1 day out of 7 free of routine responsibilities
- Be on call in the hospital no more often than every third night
- Distinction must be made between on-call time in the hospital and no-call availability at home and their relation to actual hours worked

Thoracic Surgery (Revised 1992)
- Duty hours and night and weekend call for residents must reflect this concept of longitudinal responsibility for patients by providing for adequate continuity of patient care. At the same time, duty assignments must not regularly be of such excessive length and frequency that they cause undue fatigue and sleep deprivation
- On average, excluding exceptional patient care needs, residents have at least 1 day out of 7 free of routine responsibilities
- On call in the hospital no more often than every third night

Urology (Revised 1996) and Pediatric Urology (Revised 1998)
- On average, have the opportunity to spend at least 1 full day out of 7 free of scheduled hospital duties
- On call in the hospital no more often than every third night, except for the maintenance of continuity of care

Transitional Year (Revised 1999)

- In-hospital duty hours shall correspond to the program requirements of the categorical programs to which the transitional year resident is assigned
- Distinction must be made between on-call time in the hospital and on-call availability at home vis-à-vis actual hours worked
- On average, excluding exceptional patient care needs, residents have at least 1 day out of 7 free of routine responsibilities
- On call in the hospital no more often than every third night

Source: *Graduate Medical Education Directory, 2000-2001*

APPENDIX B - NUMBER OF PRORAMS AND INSTITUTIONS CITED FOR WORK HOURS AND RELATED REQUIREMENTS FOR YEARS 1999 AND 2000

Specialty	*Percent of Programs Cited - 1999*	*Percent of Programs Cited - 2000*
INSTITUTIONAL REVIEW	20.0	8.0
Allergy and Immunology	22.0	8.0
Anesthesiology	2.0	2.0
Colon and Rectal Surgery	33.0	6.0
Dermatology	7.0	0.0
Emergency Medicine	10.0	6.0
Family Practice	13.0	8.0
Internal Medicine (Core)	30.0	10.0
Subpecialties	4.0	2.0
Medical Genetics	6.0	0.0
Neurological Surgery	10.0	5.0
Neurology	14.0	14.0
Nuclear Medicine	0.0	0.0
Obstetrics and Gynecology	19.0	5.0
Ophthalmology	13.0	0.0
Orthopaedic Surgery	29.0	10.0
Subspecialties	10.0	4.0
Otolaryngology	10.0	3.0
Anatomic and Clinical Pathology	20.0	2.0
Subspecialties	6.0	2.0
Pediatrics	21.0	16.0
Physical Medicine and Rehabilitation	12.0	12.0
Plastic Surgery	10.0	10.0
Preventive Medicine	0.0	0.0
Psychiatry	0.0	0.0
Radiology-Diagnostic	0.0	1.5
Radiation Oncology	0.0	0.0
Surgery-General	36.0	35.0
Vascular	17.0	9.0
Pediatric	53.0	44.0
Thoracic Surgery	16.0	21.0
Urology	8.0	2.7
Transitional Year	24.0	23.0

Source: www.acgme.org, accessed June 25, 2001

2. REPORT ON THE FIFTH PATHWAY

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

BACKGROUND

During the 1960s, the number of applicants to US medical schools increased from 14,397 for the entering class in 1960 to 24,987 for the 1970 entering class (a 73% rise). The number of available first-year places, however, increased only 38% (from 8069 in 1960 to 11,169 in 1970). The interest in medicine as a career continued to escalate during the 1970s. By the mid-1970s, there were more than 40,000 applicants per year, with only 14,000-15,000 first-year places. As a result, many US citizens chose to study medicine outside of the United States. In the mid-1970s, it was estimated that between 4,000 and 6,000 US citizens were studying medicine in other countries, the majority of them in Mexico.

THE PATHWAYS FOR ENTRY TO US MEDICAL EDUCATION

In the 1970s, there were various routes by which US citizens studying medicine in other countries could return to complete their medical education. Transfer during medical school was facilitated by the Coordinated Transfer Application System (COTRANS), which was a joint project of the Association of American Medical Colleges and the National Board of Medical Examiners. Organized in 1970, COTRANS provided information about transfer and access to Part I of the National Board of Medical Examiners (NBME) examination. After passing the NBME Part I, COTRANS-sponsored students then applied to the medical schools of their choice. In 1972, COTRANS had 1750 application requests, and deemed 807 of these eligible to take the NBME Part I examination. Of the 676 students who actually took the test that year, 215 passed. In the same year, 46 US medical schools reported accepting COTRANS students. A total of 214 transfer students were admitted in 1972 through COTRANS, the great majority into the third year. COTRANS continued to assist a relatively small number of students to transfer into US medical schools (for example 153 in 1973, 262 in 1974, 244 in 1975).

In the 1970s, after graduation from a medical school that was not accredited by the Liaison Committee on Medical Education (LCME), US citizens could return for residency training by obtaining certification by the Educational Commission for Foreign Medical Graduates (ECFMG). This required passing the ECFMG examination and meeting other ECFMG requirements, including possessing a valid MD degree. Access to US residency training could also be achieved in two additional ways. An individual might obtain a full and unrestricted license to practice medicine issued by a US licensing jurisdiction. Also, an individual who had met the requirements of the ECFMG might pass a licensing examination in a jurisdiction that granted a license after completion of an internship or residency.

These four routes of entry into US medical education did not meet the needs of the many US citizens who were studying medicine in some countries. For example, medical students in Mexico who had completed the four years of medical training were required to do a fifth year of internship/community service before the medical degree was awarded. These students and their supporters were looking for a new pathway to return to the US that would allow them to avoid Mexico's fifth-year requirement. The fifth year in Mexico was not available for all non-Mexican students and was believed to be of minimal educational value.

THE CREATION OF THE FIFTH PATHWAY

In 1970, the Commission on Foreign Medical Graduates (CFMG) was asked by the American Medical Association (AMA) to consider the problem of how best to reabsorb American citizens studying medicine abroad into US graduate medical education. The CFMG was sponsored by the major organizations involved in medical education: The Advisory Board for Medical Specialties, Inc. (precursor to the American Board of Medical Specialties), American Hospital Association, American Medical Association, Association of American Medical Colleges, Association for Hospital Medical Education, Educational Council for Foreign Medical Graduates (precursor to the Educational Commission for Foreign Medical Graduates), and the Federation of State Medical Boards of the US. The CFMG Task Force studying the issue was led by an individual who also was the chair of the AMA Council on

Medical Education. The Task Force developed a set of options, one of which was that a student could, after four years in a Mexican medical school, return to the US for a structured clinical program. At its November 1970 meeting, the AMA Council on Medical Education approved the concept that:

> American citizens, after completing the four-year academic program at Guadalajara and passing either Part I of the National Board Examination or the ECFMG Examination, could enter specifically structured clinical clerkships under the auspices of American medical schools.

At its June 23, 1971 meeting, the Council on Medical Education adopted a policy statement on "American Students in Foreign Medical Schools." It modified existing AMA policy to create a "new pathway" for entry into AMA approved internships and residencies and eligibility for state licensure without the required MD degree. The new "Fifth Pathway" was directed at US citizens who had completed their collegiate education in the US; had studied medicine at a medical school outside the US, Puerto Rico, and Canada; and had completed all the formal requirements of the foreign medical school except for internship and/or social service. Such students could substitute the foreign internship with an academic year of supervised clinical education at an LCME-accredited medical school. Entry into a Fifth Pathway program should be based on passing a screening examination, such as Part I of the NBME, the ECFMG examination, or the Federation Licensing Examination (FLEX). Students who successfully completed a Fifth Pathway program were eligible to enter the first year of an AMA-approved graduate medical education program. During this period, the AMA was responsible for accreditation of residency training programs, so could set such eligibility criteria. Fifth Pathway graduates later became eligible to enter graduate medical education programs accredited by the Accreditation Council for Graduate Medical Education if they met the requirements specified in the Fifth Pathway Statement.

The number of students participating in a Fifth Pathway program increased during the 1970s (see Table). In 1980, one-fourth of US medical schools sponsored students in a Fifth Pathway program. Students entering the Fifth Pathway mainly took their medical education in Mexico, but some studied in France, Italy, the Philippines, and elsewhere. The majority of Fifth Pathway students enrolled in programs in New York and New Jersey.

The Fifth Pathway program does not result in the awarding of an MD degree. Rather, it allows American students from foreign medical schools to enter a graduate medical education training program and seek state licensure. In New York, however, an accommodation was made. In the mid-1970s, a state law was passed that allowed the New York State Board of Regents to confer an MD degree on Fifth Pathway graduates after they completed three years of graduate medical education and passed the state licensing examination.

In the mid-1970s, 31 states and Puerto Rico accepted completion of the Fifth Pathway as a basis for licensure. Currently, 48 licensing jurisdictions accept the Fifth Pathway certificate. Alaska, Indiana, Michigan, Utah, Vermont, and Guam will not accept Fifth Pathway graduates for licensure.

Table - Enrollment in the Fifth Pathway

Academic Year	Number of Individuals who:		
	Applied	Were Admitted	Completed the Program
1973-74	130	110	110
1976-77	948	350	338
1979-80	2774	598	558
1982-83	1676	388	392
1985-86	1345	208	199
1988-89	721	133	136
1991-92	181	56	50

Source: Medical Education issues of *JAMA*

The number of Fifth Pathway programs dwindled during the latter part of the 1980s and 1990s. In 1984-85, 19 medical schools had a Fifth Pathway program. The number of schools that sponsored programs decreased to seven by 1989-90 and four in 1991-92. AMA records show that more than 7,000 individuals have completed the Fifth Pathway in the 30 years since the program was initiated. Currently, there is one active Fifth Pathway program at the New York Medical College that graduated 140 students in 2000. A single student also is participating in a program at the University of Utah.

In summary, Fifth Pathway students complete the following educational steps prior to entering practice:

- four years of study at a non LCME-accredited, non-US medical school, where the medical degree is not awarded until a year of social service or internship;
- one year of supervised clinical clerkships in an accredited US medical school; and
- graduate medical education in the specialty of choice.

As noted previously, most, but not all, licensing jurisdictions accept the Fifth Pathway certificate in lieu of a medical degree as a prerequisite for licensure. Fifth Pathway students, once matriculated at the sponsoring institution, are eligible for active student membership in the AMA.

REVISIONS TO THE "FIFTH PATHWAY" STATEMENT

The Fifth Pathway Statement adopted in 1971 was modified in 1973, 1975, 1979, and 1981. Since that last modification, there have been changes in medical education. For example, a single examination for licensure, the three-step United States Medical Licensing Examination, has taken the place of the examinations mentioned in previous versions of the statement. Therefore, at its March 12, 2001 meeting, the Council on Medical Education approved the following revised statement.

AMERICAN STUDENTS IN FOREIGN MEDICAL SCHOOLS
The "Fifth Pathway" Statement

1. A pathway for entrance to approved programs of graduate medical education, other than those existing under previous policies, became available as of July 1, 1971 for students who have fulfilled the following conditions:
   (a) Have completed, in an accredited American college or university, undergraduate premedical work of the quality acceptable for matriculation in an accredited United States medical school, evaluated by measures such as college grade point average and scores on the Medical College Admission Test.
   (b) Have studied medicine at a medical school located outside the US, including Puerto Rico, and Canada that is listed in the *World Directory of Medical Schools*, published by the World Health Organization.
   (c) Have completed all of the formal requirements of the foreign medical school except internship and/or social service. Those who have completed all of the requirements, including internship and/or social service, and are, consequently, eligible to apply for ECFMG certification, are not eligible for the Fifth Pathway.

2. Students who have completed the academic curriculum at a foreign medical school and who have fulfilled the above conditions may be offered the opportunity to substitute an academic year of supervised clinical training for the internship/social service required by the foreign medical school. The supervised training should consist of the clinical education provided in the third year of a US medical school or in appropriate clinical subinternships. The supervised clinical training must be provided by faculty of a program in medical education accredited by the Liaison Committee on Medical Education and should be conducted in its affiliated hospitals, so as to assure that individuals who complete Fifth Pathway programs are reasonably comparable to the school's regularly-graduated students. The medical school should insure that resources are adequate for the conduct of the Fifth Pathway program, without jeopardizing its other academic programs. Fifth Pathway education should be provided only with the written approval of the dean or other appropriate official of the medical school.

3. Students must pass Step 1 of the United States Medical Licensing Examination (USMLE) in order to be eligible for admission to a Fifth Pathway program.

4. Students must successfully complete clinical training, on the judgment of the medical school's faculty based on a final evaluation comparable to that used to judge regularly-enrolled students. With the approval of the faculty, and upon passing Step 2 of the USMLE, Fifth Pathway students are eligible to enter the first year of approved graduate medical education, without completing the social service and/or internship required by the foreign country and without obtaining ECFMG certification.

5. Fifth Pathway certificates must be provided only with the approval of the dean or other medical school official and must be recorded with the registrar. The medical school must notify the American Medical Association that a student has successfully completed the Fifth Pathway program.

6. The Council on Medical Education recommends that all state medical licensing boards consider for licensure all candidates who have successfully completed a Fifth Pathway program on the same basis as they consider candidates who have received ECFMG certification.

THE FUTURE OF THE FIFTH PATHWAY

In the late 1980s and 1990s, interest in the Fifth Pathway declined because other options became available for American citizens choosing to study medicine abroad. A number of medical schools opened in the Caribbean that granted the MD degree after four years of study. Students then could seek certification by the Educational Commission for Foreign Medical Graduates, which would confer eligibility to apply for US graduate medical education. Now, however, interest in the Fifth Pathway may be reviving. Inquiries are being received at the AMA from schools thinking of starting small programs.

Little is know about the general outcomes of the Fifth Pathway in recent years. Research from the 1970s and early 1980s has examined such things as the specialty choice of individuals completing Fifth Pathway programs and their performance in graduate medical education compared to regular medical school graduates. Such data about the Fifth Pathway in recent years would be useful.

CONCLUSIONS AND RECOMMENDATIONS

The Fifth Pathway has served an important function during its 30-year history and there still are individuals who can benefit from such programs. It is important, therefore, for the American Medical Association to ensure that the requirements for conducting a Fifth Pathway program be widely understood and adhered to.

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

1. That the "Fifth Pathway Statement" (2001 revision) be disseminated to existing and developing programs, prospective students, and others on request and that adherence to its requirements continue to be monitored.

2. That our American Medical Association explore ways to collect and disseminate information on the general outcomes of the Fifth Pathway, including such things as graduate specialty choice, performance in residency training, board certification status, and record of disciplinary actions.

(References pertaining to Report 2 of the Council on Medical Education are available from the Medical Education Group.)

3. MEDICAL SCHOOL FINANCING AND STUDENT DEBT - A PROGRESS REPORT

HOUSE ACTION: FILED

Recommendation 9 of Council on Medical Education Report 2-I-00, "Medical School Financing, Tuition, and Student Debt," asked our American Medical Association to work with other concerned organizations to promote legislation and regulation with the aims of increasing loan deferment through the period of residency, promoting the expansion of subsidized loan programs, eliminating taxes on aid from service-related programs, and restoring tax deductibility of interest on educational loans. Recommendation 10 asked that Policy H-310.934 (AMA Policy Database), which states that the AMA elevate the issue of medical students debt to one of the top legislative priorities on its agenda, and that Policy H-305.946, which states that the AMA encourage society and payors for health care to recognize the cost of medical education and develop a stable funding source specifically dedicated to support the education of medical students, be reaffirmed. The recommendation asked that a report on the measures taken by the AMA to implement these policies be developed for the 2001 Interim Meeting. This informational report responds to that directive.

There has been activity by the AMA and other organizations related to medical student debt relief and medical school financing. Federal legislation has resulted in some positive outcomes, and additional opportunities are pending.

REDUCING THE COST OF LOAN PAYBACK

In the winter of 2001, bills were introduced in the House and Senate that allow individuals with higher incomes to deduct the interest paid on student debt. A February 14, 2001, AMA press release thanked the sponsors of this legislation and stated that the issue of debt relief was a "high priority for the AMA." In support of this and other legislation, medical students, resident physicians, and fellows visited with members of Congress during the March 2001 National Leadership Conference. Residents were given talking points on the issue of debt relief by the Resident and Fellow Section and were briefed by staff from the AMA Washington Office. On June 7, President Bush signed the bill "Restoring Earnings to Lift Individuals and Empower Families Act of 2001," now Public Law 107-16, which raised the income level for eligibility to deduct the interest from student loans. For single taxpayers, the income level was raised from $50,000 to $65,000 and for married taxpayers filing joint returns, the level was raised from $100,000 to $130,000. The income phase-out ranges will be adjusted for inflation after 2002. The bill also repealed the five-year limit on the length of time that interest on a qualified educational loan can be deducted and repealed the restriction that voluntary interest payments are not tax deductible.

The staff of the AMA's Washington Office has prepared draft legislation on loan deferment, which has been reviewed by the Council on Legislation. A legislative sponsor for this bill is actively being sought. The bill would allow more individuals to defer, rather than forbear, payments on their loans. During the deferment period, the borrower is not required to make payments on a loan and, for subsidized loans, interest will be paid by the government. During forbearance, payments are not required or are reduced, but interest accrues.

Public Law 107-16 also addresses the tax deductibility of financial aid under the National Health Service Corps (NHSC) Scholarship Program. Payments made to individuals for tuition, fees, and related expenses will no longer be included in their gross income for tax purposes.

In June 2001, reauthorization legislation was introduced for the NHSC that would eliminate taxation of payments made under the NHSC loan repayment program. The NHSC program provides funding to be used for repayment of the loans of physicians in selected specialties (and some other health professionals) who provide care in underserved areas.

Additional loan repayment programs recently have been introduced by the federal government. For example, the National Institutes of Health announced the Extramural Clinical Research Loan Repayment Program, which is for health professionals from disadvantaged backgrounds who agree to engage in clinical research for at least two years. The Loan Repayment Program for Health Disparities Research is for individuals who agree to conduct research on minority health disparities, or other health disparities, for at least two years. These programs will repay up to $35,000 per year of student loan principal and interest.

SUPPORT OF MEDICAL EDUCATION AND TEACHING HOSPITALS

Various bills are pending that would provide enhanced funding for medical education. In April 2001, Senator Reed (Rhode Island), along with Senators Clinton and Schumer from New York, introduced S. 743, "Medical Education Trust Fund Act of 2001." This legislation would create a Medical Education Trust Fund that would be supported by contributions from all payors for health care (Medicare, Medicaid, private payors). Private payor funding would come from a 1.5% assessment on all accident and health insurance premiums. The bill creates five separate funding "accounts": the Medical School Account, the Medicare Teaching Hospital Direct Account, the Medicare Teaching Hospital Indirect Account, the Non-Medicare Teaching Hospital Direct Account, and the Non-Medicare Teaching Hospital Indirect Account. The Medical School Account and would be used to maintain and develop quality educational programs. The concept of a trust fund in support of medical education that receives contributions from all payors is consistent with AMA Policy H-305.935.

S. 839, "The American Hospital Preservation Act," was introduced in the Senate in May of 2001, with a companion bill (H.R. 1556) in the House. The bill would amend title XVIII (Medicare) of the Social Security Act to maintain the indirect medical education adjustment (IME) to 6.5%. The IME is a modifier to DRG payments in teaching

hospitals. The Balanced Budget Act of 1997 had reduced the IME from 7.7% to 5.5%, to be phased in over a four-year period. Legislation in 2000 froze the IME at 6.5% for FY2001 and 2002, before reducing it to 5.5% in FY2003. As of July 2001, S. 839 had 24 cosponsors and H.R. 1556 had 94 cosponsors.

In June 2001, Representative Cardin (Maryland) and 11 cosponsors introduced the "All-Payer Graduate Medical Education (GME) Act" (H.R. 2178). The bill creates an all payor fund through a 1% tax on premiums. Medicare's contribution to support GME would be reduced based on the availability of funds from the all payor pool.

In summary, there is pending legislation in support of medical education that is consistent with AMA policy. The Council on Legislation discussed S. 743 and its June meeting and H.R. 2178 at its meeting in September.

PLANS FOR THE FUTURE

As described in the original Council on Medical Education Report 2-I-00, "Medical School Financing, Tuition, and Student Debt," a multifaceted approach is needed: (1) to limit the debt burden incurred by medical students and carried by young physicians during residency and into practice; and (2) to ensure a stable funding stream for medical education programs. The American Medical Association will continue to implement the recommendations in CME Report 2-I-00, including taking the following actions:

- Advocate for legislation and regulation to decrease the costs of medical education (for example, programs that provide financial aid in return for service) and the costs of loan repayment.
- Collect and disseminate information on successful strategies used by medical schools to reduce or cap tuition and on available opportunities for medical students and resident physicians to obtain financial aid for emergency and other related purposes.
- Monitor the provision of financial planning/debt management counseling for medical students and resident physicians.
- Advocate for stable sources of medical education funding.

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

4. REPORTING OF RESIDENT PHYSICIANS

HOUSE ACTION: RECOMMENDATIONS ADOPTED AND REMAINDER OF REPORT FILED

The Council on Medical Education continues to be concerned about the reporting of resident physicians. "Reporting" is defined as supplying information about resident physicians to federal and state entities as required by law or regulation. Specifically, this report describes the types of information about resident physicians that must be reported to the National Practitioner Data Bank (NPDB) and to state medical licensing boards. Current American Medical Association policy on the reporting of residents also is reviewed. This report recommends expanded AMA policy and actions to ensure information about resident physicians that is reported to federal and state agencies is appropriate, and not prejudicial to the resident's future career.

NATIONAL PRACTITIONER DATA BANK

The Health Care Quality Improvement Act of 1986 established the NPDB and defined the types of actions that must be reported to it. The NPDB is administered for the Health Resources and Services Administration (HRSA) by an independent contractor. Reports must be sent to the NPDB when payment is made on behalf of a physician as a result of a verdict or a settlement by the payor (e.g., an insurance company) in a malpractice claim. Actions by a state medical licensing board, a hospital or self insured health care organization, or health plan which restrict a physician's clinical privileges for more than 30 days due to professional competence or conduct must also be reported. Professional societies, such as the AMA, must report actions based on reasons relating to professional competence or conduct that adversely affect a physician's membership.

Since 1990, 76% of the reports to the NPDB (about 173,000 out of a total of about 228,000 reports) were related to malpractice claims. The guidelines of the NPDB state that reports must be submitted when medical malpractice payments are made on behalf of "residents or interns," but that payments made on behalf of medical students are not reportable. A study examining malpractice judgements and settlements between 1994 and 1998 identified a total of 66,107 reports representing 50,396 physicians. Of all payments, only about 4% were from judgments. Eighty-two percent of payments were settlements and the rest (14%) were made before settlement or were of unknown type. Of total physicians with payments, less than 1% were resident physicians (including physicians defined as interns). Of the reports involving resident physicians, the payment in about 70% of cases was made for a single individual (that is, the resident's supervisors were not named).

In 2000, the Office of the Inspector General of the Department of Health and Human Services (OIG DHHS) released a discussion paper that recommended HRSA pursue the introduction of legislation requiring hospitals to report to the NPDB residents who had been dismissed from training programs "for cause" when "cause" is not necessarily related to professional competence. The AMA expressed concerns about this proposal in a January 2001 letter to the OIG DHHS. Such legislation has not, to date, been introduced.

AMA policy seeks to limit reports to the NPDB about residents to only final adverse actions taken by a medical licensing jurisdiction (Policy H-355.983, AMA Policy Database). Existing policy opposes the inclusion in the NPDB of information on liability payments made on behalf of residents named in malpractice suits for incidents that occur during the required supervised activities of residency training (Policy H-355.980).

REPORTING TO STATE MEDICAL LICENSING BOARDS

In various ways, most resident physicians come under the jurisdiction of a state medical licensing board. Individuals in residency training may have a full and unrestricted license to practice medicine from a state medical licensing board, may have a limited/temporary educational permit from a licensing board that restricts them to supervised practice within their residency program, or may be unlicensed. The table shows the number of years of graduate medical education required to obtain a full and unrestricted license to practice medicine. Many resident physicians, especially graduates of US medical schools, will obtain a license to practice medicine while they are in residency training. The information that must be reported for these resident physicians will be identical to the information for all physicians, since all come under the same licensing law and regulations.

Table: Years of Graduate Medical Education Required for Licensure

Location of Medical School	Number of Licensing Jurisdictions* Requiring		
	1 year	2 years	3 years
US	37	14	1
Non-US	5	20	27

* - 50 states plus Puerto Rico and Washington, DC

Resident physicians without an unrestricted medical license may come under the jurisdiction of a medical board through a limited educational permit. AMA Policy H-275.934[3] supports the concept that there be a training permit for all resident physicians who do not yet have a full and unrestricted license to practice. Forty-seven of the 52 MD-licensing jurisdictions require that resident physicians have a limited educational permit in order to participate in supervised practice during their residency program. In this case, information may be required about resident physicians that is not required of physicians (including resident physicians) with a full, unrestricted license to practice.

There is variation among licensing jurisdictions in the type of information that must be reported to state medical licensing boards about resident physicians who are applying for or renewing a limited educational permit. States consistently require that medical conditions affecting practice, substance abuse, violations of the law, loss/denial of a license or of medical staff privileges be reported (as for fully licensed physicians). The examples that follow illustrate some of the variability that now exists in other areas.

In order to obtain a limited educational permit in Massachusetts, the applicant must inform the board whether he/she has taken more than four years to complete medical school (for a US medical graduate); has had to repeat a year of residency training; has been subject to any disciplinary action since enrollment in college; has been granted a leave of absence by a medical school or residency program; or has left, transferred from, or withdrawn from a medical school or residency program. Individuals responding "yes" to these items must supply information from the medical school or residency program. These requirements could affect a considerable number of individuals. For example, data from US medical schools show that almost 14% of all medical school graduates during 1999-2000 took more four years to complete the MD program. This finding is due to many reasons, including study for an additional degree, leave of absence for personal or academic reasons, or academic difficulty leading to deceleration of the individual's academic program.

Also, to obtain or renew a limited educational permit in Massachusetts, an evaluation form must be completed by the chief of service or program director. This form rates, on a scale of superior to poor, the individual's clinical knowledge, clinical competence, professional judgment, character and ethics, technical skills, relationships with staff and patients, and cooperativeness of the applicant. The application for renewal also asks whether the applicant has had to repeat a year or taken a leave of absence since the last renewal.

The Ohio application for a training certificate (limited educational permit) asks whether the applicant has ever resigned from withdrawn from, been warned by, censured by, disciplined by, been put on probation by, been requested to withdraw from, dismissed from, been refused renewal of a contract by, or expelled from a medical school, clinical clerkship, externship, preceptorship, or residency.

For renewal of the training permit, the Texas State Board of Medical Examiners requires that a yearly evaluation of each resident physician be submitted. The evaluation of the resident physician must be completed by the chief of staff, training director, medical director, or department chair. The evaluation asks whether the resident physician is reliable, ethical, and of good character and also asks the respondent to rate the resident's professional ability, attention to duties, breadth of education, and personality on a scale ranging from excellent to poor.

In Oklahoma, the state medical licensing board requires annual reporting of all resident physicians with a limited educational permit. The information that must be provided includes any disciplinary actions taken against the resident physician, failure to advance in the program or practice restriction due to performance or behavioral reasons, any leave of absence from the program in excess of two weeks, and dismissal or resignation from the program. Failure to comply with reporting requirements is grounds for disciplinary action by the board against the program director and/or the designated reporting physician.

In February 1999, the AMA Council on Medical Education held an open hearing in response to the Federation of State Medical Boards (FSMB) "Recommendations on Licensure." Adopted in 1998, the FSMB Recommendations supported annual reporting of all resident physicians to the relevant state medical licensing board. There was concern among hearing participants about the broad nature of the reporting requirements. Council on Medical Education Report 8-A-99, "Alternatives to the Federation of State Medical Boards Recommendations on Licensure," recommended instead that residency program directors report only those actions to state medical licensing boards that are reported for all licensed physicians. This was adopted as AMA policy (H-275.934[4]).

There is considerable variability in current reporting requirements by state. Some areas that must be reported for resident physicians, such as violation of a law, medical conditions that impair the ability to practice, or impairment due to substance abuse, are also reportable for all physicians across licensing jurisdictions. In other cases, areas that must be reported for resident physicians are also reportable for all physicians in that specific state. For example, in Massachusetts, the same evaluation form used to rate applicants for new and renewed educational licenses is used in the application for a new unrestricted license. Finally, there are some things that are reportable for resident physicians that are not reportable for fully-licensed physicians in that state (for example, the Oklahoma requirement to report more than a two-week absence during residency training).

CONCLUSIONS

The NPDB was established as a central source of information about physicians (and other health care professionals) to prevent practitioners from moving from state to state without disclosure or discovery of events related to their professional competence. However, the majority of reports to the NPDB relate to settlements of malpractice claims where there may be no evidence that any standard of care has been breached. The reporting of residents independently, without any indication that they would have been providing care under supervision, is especially troublesome. Most state medical licensing boards require an educational permit for resident physicians who do not yet have a full and unrestricted license to practice medicine. The ultimate goal of bringing resident physicians under the jurisdiction of the medical licensing board is the protection of the public. There is, however, variability among licensing jurisdictions in the type of information that must be reported and the relevance of some items (for example, the absence from a program for at least two weeks) can be questioned.

RECOMMENDATIONS

The Council on Medical Education recommends that the following recommendations be adopted and that the remainder of this report be filed.

1. That American Medical Association Policy H-355.983, which asks that reports about resident physicians to the National Practitioner Data Bank (NPDB) be limited to final actions taken by a medical licensing jurisdiction, and Policy H-275.934[4], which states that residency program directors should report only those actions to state medical licensing boards that are reported for all physicians, be reaffirmed.

2. That our AMA continue to monitor the types of information reported about resident physicians to federal and state agencies, especially the National Practitioner Data Bank and state medical licensing boards.

3. That our AMA draft and advocate for legislation amending, as appropriate, the NPDB reporting requirements regarding resident physicians to be consistent with Policy H-355.983, and oppose the expansion of existing reporting requirements.

4. That our AMA work with appropriate groups, including the Federation of State Medical Boards, to attempt to increase the standardization of information about resident physicians that is reported to state medical licensing boards to obtain or renew the limited educational permit, consistent with existing AMA Policy H-275.934[4].

5. That our AMA encourage state medical societies to act as a link between state medical licensing boards and medical schools/residency programs to ensure that educational programs are familiar with and have the opportunity to comment on proposed changes in reporting requirements for resident physicians.

6. That our AMA make relevant groups--for example, medical schools, state medical societies, resident physicians--aware of what types of information must be supplied in order for resident physicians to obtain and renew a limited educational permit.

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