

## **REPORTS OF COUNCIL ON MEDICAL EDUCATION**

The following reports, 1-6, were presented by Sandra F. Olson, MD, Chair:

### **1. ENFORCEMENT OF ACGME DUTY HOURS STANDARDS**

#### **HOUSE ACTION: RECOMMENDATIONS ADOPTED AND REMAINDER OF REPORT FILED**

Recommendation 5 of Council on Medical Education Report 6-A-03, "Accreditation Council for Graduate Medical Education Enforcement of Duty Hour Standards," asked that our American Medical Association:

monitor the enforcement of ACGME standards on resident physician duty hours and report back to the House of Delegates as soon as possible, but no later than the 2004 Interim Meeting and regularly thereafter.

Resolution 322 (A-03), "Resident/Fellow Work and Learning Environment," was submitted by the Resident and Fellow Section and the Medical Student Section. Resolves 2 and 3, which were adopted by the House of Delegates, asked that our AMA:

study all options to address enforcement and compliance with the ACGME Duty Hour requirements (Joint Commission of Accreditation of Healthcare Organizations, legislation, private methods, etc) with a report back to the House of Delegates; and

study, develop, and promote a method of creating an environment for residents to safely report violations of resident duty hours without any repercussions.

Prior to the introduction of the ACGME duty hour standards, there is evidence that a significant number of resident physicians were working more than 80 hours per week, even in specialties that had an 80-hour limit. For example, a 1998-1999 study by Baldwin and colleagues showed that across 21 specialties, 35 % of 1868 reporting second-year resident physicians were working more than 80 hours per week (range 0% in preventive medicine to 100% in neurological surgery).

This report summarizes the steps taken by the ACGME to monitor compliance with its duty hour standards. The report also discusses other mechanisms that have been proposed to ensure adherence to duty hour limits, and highlights the complex issues surrounding resident reporting of duty hour violations.

#### **ACGME DUTY HOURS STANDARDS**

The ACGME duty hour standards that went into effect in July of 2003 require:

- An 80-hour weekly limit, averaged over four weeks;
- A 10-hour rest period between duty periods;
- A 24 hour limit on continuous duty, with up to six additional hours for continuity of care and education;
- One day in seven free from patient care and educational obligations, averaged over four weeks; and
- In-house call no more than once every three nights, averaged over four weeks.

These standards, as part of the Common Program Requirements, are included in the accreditation requirements of all specialties.

There is an option for programs in some, but not all, specialties to request an increase of up to eight weekly duty hours, with the approval of their sponsoring institution and the relevant Residency Review Committee (RRC).

## ACGME RESULTS AFTER ONE YEAR

### *Data Collection*

The ACGME has used several mechanisms to monitor resident duty hours since July 2003.

- *Program director survey* - Data have been collected from program directors using a web-based system and the data have been verified by the designated institutional official (DIO) at each institution. By the March 2004 deadline, responses had been received from 98% of ACGME-accredited programs.
- *Resident survey* - An online survey collected data from 25,176 residents (an 85% response rate) in 1489 programs.
- *Interviews during site visits* - During surveys of residency programs, ACGME site visitors interviewed between 11,000 and 13,000 residents, as well as program directors and faculty.
- *Document review* - During site visits, rotation and call schedules were reviewed.

### *Data on Compliance with Duty Hour Standards*

A total of 2019 full reviews of residency programs were conducted from July 2003 through June 2004. Of all programs reviewed, 99 programs (4.9%) received one or more citations of noncompliance with duty hours standards. The Appendix illustrates the number of programs cited across specialties and subspecialties.

A given program could be cited for one or more violations of duty hours standards. The number of programs cited for each duty hour standard is included in the Table.

Table - Duty Hour Citations

| Citation                            | Number of Programs |
|-------------------------------------|--------------------|
| 80 hours per week                   | 51                 |
| One day in seven free               | 27                 |
| Ten-hour rest period                | 11                 |
| Continuous duty of 24 +6 hours      | 27                 |
| Call no more than every third night | 8                  |

### *Permissions to Extend the Duty Hours Limit to 88 Hours*

A number of specialties (Allergy and Immunology, Anesthesiology, Emergency Medicine, Family Practice, Internal Medicine, Neurology, Nuclear Medicine, Pediatrics, Preventive Medicine, Psychiatry, Diagnostic Radiology) do not permit an increase to 88 hours per week. Of the 16 specialties that do permit an increase, a total of 92 programs in 7 specialties made such a request. The request was granted by the relevant RRC in 75 cases and denied in 17.

## ALTERNATIVE ENFORCEMENT MECHANISMS

There have been questions raised by some groups, for example, the Committee of Interns and Residents (CIR) and the American Medical Student Association (AMSA) about the ACGME's ability to enforce its standards. The groups have combined to create a web site called "Hours Watch" to "serve as an independent 'watchdog,' monitoring and lobbying for enforcement mechanisms that offer better protection to residents."

One alternative enforcement mechanism that CIR and AMSA have suggested is based on New York State regulations that include unannounced as well as annual inspections of programs by an independent agency, coupled with the threat of fines to noncompliant institutions. While "Hours Watch" reports that this approach has brought many programs into compliance, no data are presented.

There have been attempts to utilize regulation or legislation at the federal level to address resident work hours and working conditions, but these have not been successful. A petition to the Occupational Safety and Health Administration, by the CIR, AMSA, and Public Citizen to limit resident work hours was rejected in 2002. Work hours legislation was last introduced in the Senate by Sen. Jon Corzine and in the House of Representatives by Rep. John Conyers, Jr. in 2003. No action was taken.

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) has been suggested as a private-sector entity that could monitor resident work hours and working conditions. JCAHO standards related to hospital accreditation were revised in 2004. The new standard related to graduate medical education requires that teaching hospitals have a defined process to ensure that each resident is supervised by a licensed independent practitioner with appropriate clinical privileges when he/she is carrying out his/her clinical responsibilities. Beyond this requirement for supervision, there currently are no references to the resident duty hours in JCAHO standards.

All the potential mechanisms to regulate duty hours described above would impact at the level of the institution, not the individual residency program, as is the case with ACGME accreditation.

#### ISSUES RELATED TO RESIDENT REPORTING OF DUTY HOURS VIOLATIONS

This complex set of issues revolves around two related questions:

- Are residents willing (and able) to report their programs' noncompliance with duty hours standards?
- Is there an environment within the residency program (and institution) that protects residents who report violations of duty hours standards?

##### *Mechanisms to Report Noncompliance*

In August of 2003, the ACGME communicated with resident physicians in accredited programs through administrators at their institutions. They were informed about the new duty hours standards, the mechanisms that would be used to monitor compliance, and the rights of residents to raise issues related to compliance.

In the current ACGME system, resident physicians can use several mechanisms to report violations of duty hours standards. First, there is an online survey of resident physicians. This survey is being phased in so that all programs with at least five active residents will be surveyed over a three-year period. A 70% response rate per program is expected and is required in order for program directors to get the results for their programs. The data from the one-third of programs that were surveyed in 2004 are available. Of the 25,176 residents who responded to the 2004 survey, 834 (3.3%) reported working more than 80 hours per week during the past four weeks. There were a few programs where the majority of residents worked beyond the duty hour limits, and the ACGME is following up with these programs. Since, for 2004, only one-third of programs participated in the survey, the data cannot be extrapolated to all programs.

The ACGME also has a procedure, which is included on its web site, that it uses for complaints related to potential areas of noncompliance with accreditation standards. The complaint process may keep the name of the complainant confidential, but complaints may not be submitted anonymously. Between July 2003 and June 2004, the ACGME received 53 complaints about work hours issues. Of these, 11 were dismissed as unfounded. The disposition of the remaining complaints was as follows:

- Issue to be monitored at next site visit (14 complaints)
- Site visit scheduled (10 complaints)
- Reviewed by RRC without a site visit (5 complaints)
- Progress report requested (4 complaints)
- Probation proposed (1 complaint)
- Probation confirmed (1 complaint)
- Program warned and time to next site visit shortened (1 program)
- Disposition pending (6 programs).

##### *Barriers to Reporting*

Any accreditation system is only as good as the quality of the data that are available for use in making decisions. In the enforcement of duty hour standards, it is essential that resident physicians be willing and able to accurately report their duty hours. Two main reasons exist as barriers to the accurate reporting of duty hours.

##### Concerns About Negative Consequences

Loss of accreditation has serious consequences for both programs and resident physicians. For programs, one result could be a loss of Medicare funding. Resident physicians' also could lose eligibility for licensure and board certification. In addition, even a probationary accreditation decision can negatively affect a program's ability to

recruit new residents. Although these serious consequences should stimulate programs to adhere to work hours standards, they may also make residents reluctant to report noncompliance. Pressure for resident physicians to falsely report that a program is in compliance with duty hour standards may be overt or subtle, and could arise from program directors, faculty, or their peers. International medical graduates may be especially vulnerable to pressure, since their visa status depends on their continuance in the program.

Another factor that may lead to underreporting of extended work hours is the need for patient care responsibilities to be covered. If the work is not done by resident physicians, it will fall to others, including attending physicians. This may be an additional incentive for pressure to be exerted for resident physicians to exceed duty hour limits.

#### Cultural Norms Within Residency Programs

Some resident physicians do not support work hour limits because they consider them as equivalent to “shift work” and contrary to medical professionalism. Many resident physicians feel a strong commitment to meeting the needs of patients under their care and are reluctant to leave when they reach a duty hour limit. This norm within their residency program may be fostered by faculty who themselves worked many hours during their training. In this case, sleep deprivation may be viewed as a lesser evil than discontinuity of care. Evidence about the negative effects of sleep deprivation and fatigue on patient safety and on resident learning may not be widely known by residents and their supervisors, even though the Common Program Requirements state that “faculty and residents must be educated to recognize the signs of fatigue....”

While concerns have been raised that both the above barriers exist, there is no comprehensive evidence either to support or refute these assertions or to document the extent of the problem. Examples exist of negative consequences, including ostracism by their peers, for individuals who have reported violations. The ACGME Institutional Requirements state that the Sponsoring Institution and its ACGME-accredited programs must provide an educational environment in which residents may raise and resolve issues without fear of intimidation or retaliation.” The responsibility to create such an environment, however, also exists at the program level. It is unlikely that the institutional-level standard, as it currently exists, is perceived by resident physicians as an adequate protection.

#### DISCUSSION AND RECOMMENDATIONS

The ACGME is acting to comprehensively monitor adherence to its duty hour standards. Examples of noncompliance have been identified and are being addressed. Uncertainty remains in some quarters, however, about the accuracy of the data used to determine compliance. Council on Medical Education Report 8-A-04, “Resident/Fellow Work and Learning Environment,” recommended that the AMA conduct a survey of resident physicians (as well as medical students and attending faculty) during 2005 to determine the effects of ACGME duty hour changes. This survey will be used to collect independent data about duty hours and related issues.

There is a need for steps to overcome barriers to accurate reporting as part of the review process. This means ensuring that: (1) comprehensive and unbiased data are collected and (2) resident physicians feel free and are given opportunities to provide information without fear of retaliation.

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

1. That our American Medical Association continue to monitor the enforcement of the Accreditation Council for Graduate Medical Education duty hour standards, including the consistency, accuracy, and validity of reporting, with a report back at the 2006 Annual Meeting of the AMA House of Delegates.
2. That our AMA work with other interested groups to assist residency programs in educating resident physicians and attending faculty about the adverse effects of sleep deprivation and fatigue on patient safety and resident well-being.
3. That our AMA strongly encourage Residency Review Committees to ensure that site visits include meetings with peer-selected or randomly-selected residents and that residents who are not interviewed during site visits have the opportunity to provide information directly to the site visitor.

4. That our AMA recommend to the ACGME that the Common Program Requirements be amended to charge program directors, along with the designated institutional official, with the responsibility of creating an environment where resident physicians, without fear of retaliation, may make complaints and report noncompliance with ACGME standards, including duty hours.
5. That our AMA investigate ways to protect resident physicians who file a complaint to the ACGME, with a report back at the 2006 Annual Meeting of the AMA House of Delegates.
6. That our AMA encourage and disseminate the results of studies that link compliance with duty hour standards to patient care quality outcomes and patient safety.

(References pertaining to Report 1 of the Council on Medical Education are available from the Medical Education Group.)

APPENDIX - NUMBER OF PROGRAMS WITH DUTY HOURS CITATIONS, BY SPECIALTY, JULY 1, 2003-MAY 1, 2004

| <i>Specialty</i>                   | <i>Number of Programs Reviewed</i> | <i>Number (%) of Reviewed Programs Cited</i> |
|------------------------------------|------------------------------------|--|
| Allergy/Immunology                 | 21                                 | 3 (14%)                                      |
| Allergy/Immunology Subspecialties  | 10                                 | 0 (0%)                                       |
| Anesthesiology                     | 41                                 | 2 (5%)                                       |
| Anesthesiology Subspecialties      | 53                                 | 5 (9%)                                       |
| Colon and Rectal Surgery           | 10                                 | 0 (0%)                                       |
| Dermatology                        | 26                                 | 0 (0%)                                       |
| Dermatology Subspecialties         | 14                                 | 0 (0%)                                       |
| Emergency Medicine                 | 29                                 | 1 (3%)                                       |
| Emergency Medicine Subspecialties  | 35                                 | 0 (0%)                                       |
| Family Practice                    | 154                                | 26 (17%)                                     |
| Family Practice Subspecialties     | 35                                 | 0 (0%)                                       |
| Internal Medicine                  | 73                                 | 10 (14%)                                     |
| Internal Medicine Subspecialties   | 322                                | 9 (3%)                                       |
| Medical Genetics                   | 12                                 | 1 (8%)                                       |
| Molecular Genetic Pathology        | 4                                  | 0 (0%)                                       |
| Neurological Surgery               | 17                                 | 0 (0%)                                       |
| Neurology                          | 29                                 | 2 (7%)                                       |
| Neurology Subspecialties           | 50                                 | 0 (0%)                                       |
| Nuclear Medicine                   | 13                                 | 0 (0%)                                       |
| Obstetrics-Gynecology              | 68                                 | 4 (6%)                                       |
| Ophthalmology                      | 20                                 | 0 (0%)                                       |
| Orthopaedic Surgery                | 29                                 | 3 (10%)                                      |
| Orthopaedic Surgery Subspecialties | 32                                 | 0 (0%)                                       |
| Otolaryngology                     | 29                                 | 0 (0%)                                       |
| Otolaryngology Subspecialties      | 6                                  | 0 (0%)                                       |
| Pathology                          | 41                                 | 0 (0%)                                       |
| Pathology Subspecialties           | 88                                 | 2 (2%)                                       |
| Pediatrics                         | 41                                 | 2 (5%)                                       |
| Pediatrics Subspecialties          | 124                                | 4 (3%)                                       |
| Physical Medicine & Rehabilitation | 19                                 | 0 (0%)                                       |
| PM&R Subspecialties                | 8                                  | 0 (0%)                                       |
| Plastic Surgery                    | 44                                 | 2 (5%)                                       |
| Plastic Surgery Subspecialties     | 9                                  | 0 (0%)                                       |
| Preventive Medicine                | 18                                 | 1 (6%)                                       |
| Preventive Medicine Subspecialties | 3                                  | 0 (0%)                                       |
| Psychiatry                         | 44                                 | 1 (2%)                                       |
| Psychiatry Subspecialties          | 57                                 | 1 (2%)                                       |

| <i>Specialty</i>                    | <i>Number of Programs Reviewed</i> | <i>Number (%) of Reviewed Programs Cited</i> |
|-------------------------------------|------------------------------------|--|
| Radiation Oncology                  | 21                                 | 0 (0%)                                       |
| Diagnostic Radiology                | 52                                 | 0 (0%)                                       |
| Diagnostic Radiology Subspecialties | 98                                 | 0 (0%)                                       |
| General Surgery                     | 73                                 | 5 (7%)                                       |
| General Surgery Subspecialties      | 71                                 | 1 (1%)                                       |
| Thoracic Surgery                    | 31                                 | 3 (10%)                                      |
| Transitional Year                   | 30                                 | 9 (30%)                                      |
| Urology                             | 27                                 | 2 (7%)                                       |
| Urology Subspecialties              | 4                                  | 0 (0%)                                       |
| <b>TOTAL</b>                        | <b>2019</b>                        | <b>99 (5%)</b>                               |

## **2. THE IMPLICATIONS OF THE HEALTH CARE PERSONNEL DELIVERY SYSTEM**

### **HOUSE ACTION: RECOMMENDATIONS ADOPTED AND REMAINDER OF REPORT FILED**

Resolution 703 (I-03), which was submitted by the Medical Student Section and adopted by the House of Delegates, asked that our American Medical Association study the Health Care Personnel Delivery System and its implications for physicians and other health care professionals as well as the civilian health care system and report its findings with any recommendations for change.

#### **BACKGROUND**

The most recent conscription of health care personnel was initiated in 1950 as the Doctor's Draft Law, which remained in effect until 1973. There were 30,000 health care professionals brought into the military through this draft. Of those drafted, 78% were physicians. The President's Commission on an All-Volunteer Armed Forces stated that the medical profession had borne the heaviest burden of military service of any group in our society. With the advent of the all-volunteer force in 1973, the Doctor's Draft Law expired.

The Health Care Personnel Delivery System (HCPDS) is a standby plan developed for the Selective Service System that would draft physicians and other health care professionals in an emergency that requires more health care personnel than the volunteer military can supply. The HCPDS is not yet law and would require Congress and the President to pass and sign legislation to enact it. The HCPDS is not designed to be enacted during peacetime, but rather during a time of national emergency. In uncertain times such an emergency could arise rapidly with little time for national debate or discussion.

Despite more than three decades without an immediate mission, the Selective Service System continues to promulgate policies and procedures. Documents describing the HCPDS are contained in a several-hundred-page manual titled: Health Care Personnel Delivery System Manual and Guide: DRAFT April 1999. Although each page contains the disclaimer "Selective Service System - Predecisional Document - NOT Releasable under FOIA," the entire manual and guide was sent to an interested medical student last year following his Freedom of Information Act request.

#### **HEALTH CARE PERSONNEL DELIVERY SYSTEM**

In 1987, Congress authorized the Selective Service System to develop a conscription program "for registration and classification of persons qualified for practice or employment in a health care occupation essential to the Armed Forces." The HCPDS is the result.

Registration for possible induction would occur only when approved by the President and Congress. Emergency registration would happen in two phases: a seven-day mass registration within two weeks of a Presidential Proclamation, and then a continuous registration beginning two weeks after that. Initially, only qualified individuals

between 20 and 44 years of age would be required to register and the maximum age for registration and service is 55. Active duty military personnel and nonimmigrant aliens would be exempted from registering. Resident physicians in a program of graduate medical education would not be required to register unless they were already qualified in a specialty. ("Qualified in a specialty" means having obtained licensing, certification, registration, credentials, diploma, or otherwise becoming eligible for practice or employment in one or more of the specialties to be determined by Presidential Proclamation.) All eligible physicians would be required to register in that specialty with the highest education, training or experience requirements. (For example, if a doctor were qualified both as a family practitioner and a neurosurgeon, he/she would be drafted as a neurosurgeon.) Failure to register within 15 days of becoming qualified in a specialty could result in a \$250,000 fine and/or 5 years in prison.

Year of registration, age, and random number sequences would be used to sequence potential inductees. As a first step, a series of priority selection groups (PSGs) would be created by the date of registration. Registrants from the first year of registration (PSG1s) would be the most vulnerable to induction, followed by registrants from the second year (PSG2s), and so on. Within each PSG, registrants would be ranked by year of birth and selection would begin with the youngest cohort. Within each age cohort, final selection would be by random number sequence.

Once selected for induction the registrant would report to a Military Entrance Processing Station (MEPS) for a physical examination. After being examined, mobilization could be immediate or delayed, depending on the severity of the crisis.

As in previous drafts, various classifications would exist which could preclude military service. Exempt and deferred classifications include categories for conscientious objectors, hardship on dependent(s), prior military service, essential civilian occupations, and aliens.

#### EXISTING AMA POLICY

There is existing AMA policy in support of physicians called to active duty in the military. Policy H-40.983 (AMA Policy Database) requests that Residency Review Committees and medical specialty boards "develop flexible policies" to ensure that resident physicians called to active duty retain their academic and training status within their residency programs and that educationally appropriate time spent on active duty be credited toward board eligibility. The policy also encourages state medical licensing boards to waive the requirement for continuing medical education credits during periods of active duty. Policy H-40.979 supports the position that residents called to active duty be placed, whenever possible, in positions consistent with their specialty and level of training. The pay and allowances of physicians called to active duty should match those for physicians with similar rank and qualifications who are in regular and long-term reserve status (Policy H-40.977).

#### ANALYSIS AND RECOMMENDATIONS

Although a general draft is not immediately imminent, a physician draft could be more likely and the current conflict in Iraq may have increased this possibility. Since many health professionals in the reserve components (including the National Guard) were activated recently and suffered financial losses in their civilian practices while they were mobilized, they may leave the military after completing their current assignments. If this occurs, a physician draft may be the only option to assure the health of our men and women in the military.

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

1. That our American Medical Association continue to monitor the Health Care Personnel Delivery System (HCPDS) and initiate communication with the Selective Service System and other relevant governmental bodies to address questions and concerns related to the implementation of the HCPDS.
2. That Policies H-40.983, "Active and Reserve Physicians," H-40.979, "Reserve Physicians in Training," and H-40.977, "Pay Equity for Physicians in Active and Reserve Uniformed Services," be reaffirmed.

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

### 3. LONG-TERM SOLUTIONS TO MEDICAL STUDENT DEBT

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

Resolves 3, 4, and 6 of Resolution 848 (I-03), which was submitted by the Medical Student Section and adopted by the House of Delegates, asked our American Medical Association to study and report back at the 2004 Interim Meeting on:

- Potential new sources of graduate medical education funding and ways to increase resident salaries;
- Feasible strategies for creating new and/or expanded loan programs specifically for the health professions; and
- The need for non-primary care physicians in underserved areas, with a focus on showing how the National Health Service Corps and similar loan repayment programs could feasibly be expanded to cover specialties beyond primary care.

Resolve 6 of Resolution 847 (I-03), which was submitted by the Medical Student Section and adopted as amended by the House of Delegates, asked that our AMA study the merits of an annual tuition cap (adjusted for inflation) at public and private medical schools within their states.

The AMA has made the issue of educational debt a high legislative priority (Policy H-310.934, AMA Policy Database). In discussing the mandated areas, this report makes reference to previous directives for action that addressed, in part, some of these issues and also draws from the “2003 Report of the AMA Medical Student Section Task Force on Medical Student Debt.”

#### BACKGROUND ON MEDICAL STUDENT DEBT

Medical student debt has been increasing steadily, reaching an average of \$109,457 for the 83% of 2003 graduates with debt. The average figure, however, masks wide variations among students. For example, 11.7% of 2003 graduates had total educational debt (premedical and medical school) of \$175,000 or greater.

Various strategies have been proposed to limit the debt that students acquire and must repay. These can be categorized into the following general areas:

- Limiting medical school tuition and fees;
- Increasing the availability of scholarship support and other financial aid opportunities that limit debt, such as loan repayment programs;
- Providing comprehensive debt counseling;
- Implementing favorable conditions for debt financing, such as loan consolidation, tax deductibility for loan interest and for funding from scholarship/loan repayment programs; and
- Redesigning the financing of medical education, in order to reduce dependence upon tuition as a source of medical school revenue and to ensure stable and explicit funding for graduate medical education.

Reducing medical student debt in the long term will require action in all of these areas. This report concentrates on the general issues of graduate medical education funding, creation of new financial/expanded financial aid opportunities, and limitations of tuition.

#### GRADUATE MEDICAL EDUCATION FUNDING AND RESIDENT SALARIES

Graduate medical education (GME) is funded from a variety of sources, some of which make explicit contributions and others of which do not.

##### *Government Funding*

Medicare is the single largest explicit payer for graduate medical education (GME), covering 30-40% of the total. Medicare paid almost \$8 billion dollars to teaching hospitals in 2000. Currently, Medicare supports GME in all specialties, including most pediatric residency training programs. Medicare funding to teaching hospitals comes in two segments.

- The “direct” funding reimbursement (about \$2.7 billion in 2000) is meant to support resident salaries, the costs of resident supervision, and other direct costs of the teaching program. It is calculated based on the number of residents in training, a “per resident” cost figure, and the percentage of Medicare patients at the given hospital. Medicare direct funding is reduced for residents (fellows) who are past their first board certification or in GME beyond the time required for first-board certification (e.g., fellows are counted as 0.5 FTE in most cases).
- The “indirect” adjustment (about \$5.1 billion in 2000) is paid to teaching hospitals and is calculated based on a formula that takes the number of residents into account. It is an adjustment to the amount paid for each diagnosis related group (DRG) and is meant to address the higher costs that teaching hospitals incur. The indirect adjustment is not directly linked to teaching activity.

Medicaid is the second-largest payer for GME, contributing about \$2.5-2.7 billion to teaching hospitals in 2002. In some cases (for example, for family practice programs), there also are line items in the state budget to support residency training. The federal government also offers training grants and research grants that support residents and fellows.

#### *Private Sector Funding*

This is much harder to define and is “implicit” since it is not possible to identify the amount of funding specifically allocated for GME. This funding stream results from cross subsidies made possible by the higher charges of teaching hospitals (payment over 100% of costs). Private-sector funding for GME also comes from other sources, such as grants/contracts, faculty practice plans (based in patient care revenue), philanthropy, and subsidies from sponsoring or affiliated managed care plans.

#### *Direct Patient Care Revenue*

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

#### *Resident Physician Salaries*

The salary for residents in the first year of GME averages about \$39,000. As a comparison, the Bureau of Labor Statistics reports that the average annual wage in the US was \$36,764 in 2002. However, the monthly costs for a resident physician with the national average debt (\$109,000) who cannot or does not defer repayment of his/her debt could be over \$1,000 per month.

#### *Options for Action*

The Council on Medical Education, in conjunction with other relevant AMA Councils and Sections, is in the process of conducting a comprehensive study of medical education financing. A report is planned for the 2005 Annual Meeting of the House of Delegates. The outcomes of the study will be suggestions for revision to current AMA policy and the identification of implementation strategies to bring about needed changes in financing mechanisms. The study addresses three related areas: (1) financing medical schools and residency programs, (2) financing the education of the individual medical students, and (3) financing possible increases in the physician workforce.

### NEW OR EXPANDED LOAN PROGRAMS

#### *Current Reliance on Loans*

Students rely heavily on loans to finance their education. In 2003, students entering medical school expected to pay an average of 63% of their costs from loans, about 15% from scholarships, and the rest from family, personal, and other sources. Dependence on loans has increased substantially in the past 15 years.

Currently, a number of loan programs are available for medical students. Under the federally subsidized Stafford loan program, students can borrow up to \$8,500 per year. An additional \$30,000 per year can be borrowed on an unsubsidized basis. The total borrowing limit in the Stafford program, including loans for college, is \$189,125. Students have 10 years to repay and the current interest rate on unsubsidized loans is below 3% (though interest rates have been considerably higher in the recent past). Additional loan programs are available through private sources, such as the AAMC MEDLOANS.

#### *Options for Action*

One source of loan funding that has not been fully explored is the school-managed lending pool. Medical schools typically provide emergency loans to students. Such a concept could be expanded into a school-based loan program. Most medical schools engage in active fund-raising for scholarship support. Some of this revenue could be used to create a pool to be used for low-interest loans. The pool would be self-renewing and could grow if a certain portion of philanthropic support received by the school were added on a regular basis. In addition to medical schools, such lending pools could be created and managed by state medical societies to support local residents attending medical school.

#### EXPANSION OF SERVICE PROGRAMS

A variety of programs exist that offer funding to repay medical school loans in return for a specified period of service.

#### *National Health Service Corps (NHSC) and Related State Programs*

The NHSC loan repayment program is available to allopathic or osteopathic primary care physicians and a number of other types of health professionals. For two years of practice in a rural or urban federally designated health professions shortage area, the physician receives up to \$50,000 along with a 39% tax assistance payment. In addition, the NHSC provides matching funds to states to operate their own loan repayment programs.

While the NHSC loan repayment program has been successful in retaining physicians in underserved areas, it is quite small. In 2003, 320 physicians participated in the program.

Some loan repayment programs are available in the private sector. Council on Medical Education Report 10-A-04, "Mechanisms to Reduce Medical Student Debt," reported on a survey of state and county medical societies. Of respondents to the survey, 15% of state societies and 7% of county societies offered loan repayment programs.

#### *Options for Action*

AMA Directive D-305.988 encourages federal and state agencies to review and expand options for financial aid programs for medical students, resident physicians, and young physicians by developing programs that address existing and emerging national and local need. The federal Council on Graduate Medical Education (COGME), in its draft report "Physician Workforce Policy Guidelines for the U.S., 2000-2020" recommended that the National Health Service Corps and similar programs be expanded to include non-generalist specialties. The report described the need for physicians in all specialties in underserved areas. The final report should be available by the end of 2004, and the AMA should support the concept of expanding the specialties eligible to participate in the NHSC as COGME presents its recommendations to Congress.

The amount of funding available through the NHSC is limited (\$31.4 million in 2003, with most expended for loan repayment), and also is spread widely among various health professions. Often, there are more applicants than can be accommodated. There is a need to expand funding for and the scope of the NHSC. The expanded scope of the NHSC could include the ability to practice in clinical settings that, while not in health professions shortage areas, have a large patient population who could otherwise be underserved. This could, for example, permit funding of faculty in academic health centers and physicians in public hospitals.

The AMA also supports the expansion of loan repayment options based in the private sector. A directive from Council on Medical Education Report 10-A-04 asked that our AMA encourage members of the federation to develop or enhance financial aid opportunities for medical students.

## TUITION CAPS

It is relatively rare for tuition to be capped for medical students at entry. In 2002, there were seven medical schools (out of 125) where tuition for the four years was set at entry.

The locus of responsibility to set medical school tuition varies. In about one-third of schools, tuition is set by the medical school or health science center administration. In almost half of schools, tuition is set by the parent university, including the board of trustees. In the remainder of schools, tuition is set by the state legislature or other state body. The differences among schools in where tuition is set result from multiple factors, including public/private status.

### *Options for Action*

The AMA supports the concept of providing entering medical students with an estimate of their future tuition costs and fees (D-295.978, D-305.988). The ability to impose tuition caps at the level of the state legislature would, however, only be feasible for public medical schools. Tuition caps for private medical schools would have to be addressed on a school-by-school basis. If tuition caps are not feasible, medical students should be given explicit notice about the level of tuition increase they can expect during their four-year enrollment. While not optimal, this would help medical students plan their borrowing.

One goal of capping tuition is to limit student debt. Some medical schools have capped the level of educational debt medical students can accumulate, independent of the tuition level. That is, scholarship funding is provided to students who have reached the maximum debt level. This changes how the pool of scholarship funding is allocated, but does both limit and make explicit the amount of student debt that students could carry. With this approach, there also is a need to ensure that students borrow responsibly. Our AMA supports the annual provision of sessions on debt counseling and management by medical schools (D-305.993).

## RECOMMENDATIONS

Review of the proposed areas revealed several options for action that could, if implemented, contribute to reducing medical student debt. Therefore, the Council on Medical Education recommends that the following be implemented and that the remainder of this report be filed:

1. That our American Medical Association, through its Council on Medical Education, continue a comprehensive study of medical education financing, with a report back to the House of Delegates at its 2005 Annual Meeting.
2. That our AMA encourage medical schools and state medical societies to consider the creation of self-managed, low-interest loan programs for medical students and that our AMA collect and disseminate information on such programs.
3. That our AMA advocate for increased funding for the National Health Service Corps Loan Repayment Program to assure adequate funding of primary care within the National Health Service Corps, as well as to permit: (a) inclusion of all medical specialties in need; and (b) service in clinical settings that care for the underserved but are not necessarily located in health professions shortage areas.
4. That our AMA work with state medical societies to advocate for the creation of either tuition caps or, if caps are not feasible, predefined tuition increases, so that medical students will be aware of their tuition and fee costs for the total period of their enrollment.
5. That our AMA collect and disseminate information on medical school programs that cap medical education debt, including the types of debt management education that is provided.

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

**4. NON-PHYSICIAN “FELLOWSHIP” PROGRAMS  
(RESOLUTION 304, A-04)**

**HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS  
IN LIEU OF RESOLUTION 304 (A-04) AND  
REMAINDER OF REPORT FILED**

Resolution 304 (A-04), which was submitted by the American Society of Anesthesiologists, the California Delegation, and the Michigan Delegation, asked that our American Medical Association:

publicly condemn use of the terms “fellowship” or “fellow” in connection with specialized non-physician training because of the risk of suggesting equivalency with specialty medical training undertaken by physicians following completion of a core residency program; and

communicate this view to any and all non-physician organizations engaged or proposing to engage in the creation or sponsorship of these non-physician training programs.

Testimony before the Reference Committee pointed out that the term “fellow” is widely used by multiple groups within the health professions, to include both research and clinical training. Some who testified did not believe that it would be feasible to limit the use of the term “fellow” or “fellowship training” to the medical profession. Instead, the Reference Committee proposed the following substitute resolution in the belief that the public should be informed about the special skills and competencies resulting from physician fellowship training:

That our American Medical Association, in cooperation with state and specialty societies, educate the public on the definition of the terms “fellow” and “fellowship” in the health care setting.

Resolution 304 was referred to the Board of Trustees for a report back at the 2004 Interim Meeting.

This report first addresses the specific issue of fellowship training in the medical profession and in other health professions, and then summarizes recent AMA activities related to scope of practice.

**FELLOWSHIP TRAINING**

“Fellowship” (subspecialty) training for physicians emerged after World War II, associated with the growth of subspecialization in many areas of medical practice. There was a perceived need for advanced training in a focused area of medicine to allow the clinician to master an expanding body of knowledge. Also, those physicians interested in an academic career desired an opportunity for training in research that was not available during the typical residency.

Even early in their history, many medical fellowship programs met defined standards of quality. Fellowship training programs came to be reviewed against accreditation standards (“Essentials”) in the same manner as the review of residency programs. For example, in 1949, the Council on Medical Education and the relevant medical specialty board approved fellowship training programs in cardiovascular diseases, gastroenterology, malignant diseases, and pulmonary diseases.

Over the next several decades, the number of physicians who participated in fellowship programs increased substantially. By the 1970s, about one-third of physicians extended their education beyond initial specialty training.

Fellowship training for physicians now is diverse, consisting of programs accredited by the Accreditation Council for Graduate Medical Education (ACGME), programs accredited by other bodies (such as the American Board of Obstetrics and Gynecology), and unaccredited clinical and research programs that may be formally structured (with defined objectives and an explicit curriculum) or more experiential. Based on a 2003-2004 survey, about 14% of all trainees in ACGME-accredited programs (13,607 out of 99,964) were in subspecialty (fellowship) programs. There are no data on the total number of physicians in all types of fellowship training.

Training experiences termed “residencies” and “fellowships” are widespread outside of medicine. An internet search revealed the presence of training programs with those designations in many health professions. For example, there are eight types of residency programs in optometry, including geriatric optometry, family practice optometry, pediatric optometry, and refractive and ocular surgery. Of the individuals in fellowship programs in clinical pharmacology in the mid-1990s, about 25% were non-physicians. Postdoctoral fellowships listed in nursing included cardiopulmonary, perinatal, pain/palliative care, and pediatric hematology/oncology. Fellowships in pain management are developing for nurse anesthetists.

#### ALTERNATIVE TO LIMITATIONS ON THE USE OF THE TERM “FELLOW”

The term “fellow” to designate a trainee beyond his/her basic training in a medical specialty is colloquial usage. According to the AMA Office of the General Counsel, there does not appear to be any legal basis to limit the use of the term to the medical profession. With the widespread use of the term within and outside the health professions, it is unlikely that a call for limiting the use of the term to physicians in subspecialty training would be heeded.

There is, however, a need to take action since the widespread use of the terms fellow and fellowship may be confusing to the public and to relevant bodies outside the medical profession, such as state licensing boards and payers. It is critical that the scope of practice of each profession be determined by the totality of the practitioner’s educational experience, not solely by participation in advanced training designated as a fellowship. In the interests of patient safety, the medical profession should take steps to ensure that information about the full spectrum of physician training is made widely available, so that the education of other health professionals can be placed in context.

A policy statement by the American Academy of Pediatrics provides an example of the type of informational materials that can be developed. The document compares physician (i.e., general pediatricians and pediatric subspecialists) with other health professionals using such variables as length of training, educational attainment, and certification.

#### ACTIVITIES OF THE AMA RELATED TO SCOPE OF PRACTICE

The AMA has been integrally involved in monitoring issues related to scope of practice and in providing assistance to members of the federation, upon request. The Advocacy Resource Center (ARC) monitors scope of practice legislation on a state-by-state basis and works with state medical societies, at their invitation. The ARC also collaborates with specialty societies at the national level. A scope of practice listserv has been created that allows subscribers to discuss issues that arise in a timely manner. The listserv includes government affairs staff from state and specialty societies, as well as interested physicians.

A Scope of Practice Working Group, led by AMA Executive Vice President Michael D. Maves, MD, consists of ten specialty society and ten state medical society executive vice presidents. The Working Group meets three to four times per year either in person or by conference call. This group serves to facilitate communication among members of the Federation and with AMA ARC staff on scope of practice issues.

At the request of the Working Group, the ARC staff developed a brief survey that was sent to all state and national medical specialty societies to determine how the organizations approach advocacy on scope of practice issues. This information has been very useful in assisting the federation to work in a unified fashion.

The ARC also has two meetings a year that are focused on individuals with responsibility for advocacy. The State Advocacy Roundtable meeting brings together government relations staff from state and specialty societies. The State Legislative Strategy Conference also includes AMA and federation leadership. Both these meetings devote several hours to scope of practice issues.

#### CONCLUSION AND RECOMMENDATIONS

In order for the public, state licensing boards, policymakers, and payers to make informed decisions about scope of practice issues, they must have accurate and comprehensive information about the qualifications of physicians and of other health professions groups. This information must then be incorporated into an advocacy agenda that ensures that decision-makers are well informed.

Therefore, the Council on Medical Education recommends that the following be adopted in lieu of Resolution 304 (A-04) and that the remainder of the report be filed:

1. That our American Medical Association, in collaboration with state and specialty societies, develop and disseminate informational materials directed at the public, state licensing boards, policymakers at the state and national levels, and payers about the educational preparation of physicians, including the meaning of fellowship training, as compared with the preparation of other health professionals.
2. That our AMA continue to work collaboratively with the Federation to ensure that decisions made at the state and national levels on scope of practice issues are informed by accurate information and reflect the best interests of patients.

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

### **5. MEDICAL STUDENT CLINICAL TRAINING AND EDUCATION CONDITIONS (RESOLUTION 310, A-04)**

#### **HOUSE ACTION: RECOMMENDATIONS ADOPTED IN LIEU OF RESOLUTION 310 (A-04) AND REMAINDER OF REPORT FILED**

Resolution 310 (A-04), which was submitted by the Medical Student Section and referred to the Board of Trustees, it asked that our American Medical Association:

1. Commend the Liaison Committee on Medical Education for addressing the issue of the medical student learning environment including student clerkship hours;
2. Urge the LCME to adopt specific medical student clinical training and education guidelines for the clerkship years including:
  - No more than one night on call every three nights;
  - No more than 80 hours total of clinical training and education time per week averaged over four weeks;
  - No more than 24 consecutive hours on call; and
3. Recommend that the LCME revisit the issue of medical student clinical training and education conditions every five years for revision.

This Council on Medical Education report responds to that referral.

#### **BACKGROUND**

Over the past 25 years there has been interest in the impact of fatigue and sleep deprivation on performance of resident physicians. As early as the 1980s, several specialties had begun to develop duty hour-standards for trainees. In 1989, the New York State Department of Health issued regulations governing resident physician work hours and supervision (Code 42-405 or Bell Commission Regulations). More than 10 years ago, nearly 40% of all resident physicians in ACGME-accredited programs were subject to an 80-hour weekly limit and even more were restricted to no more frequent call than every third night. During 2001, there was increasing pressure to develop more comprehensive limits on the hours worked by resident physicians.

Coincident with the public focus on work hours, the AMA Council on Medical Education cosponsored a conference with the Agency for Healthcare Research and Quality (AHRQ), the American Academy of Sleep Medicine, the National Center on Sleep Disorders Research at the National Institutes of Health, and the Sleep Research Society. The report of that conference, published in 2003, identified issues related to research, education, medical trainees, and patient safety and established an agenda for change. Several core principles of fatigue and sleep deprivation were presented during the conference. Most adults need about eight hours of sleep a night. If they have less than five hours of sleep, performance degrades in most individuals. Fatigue leads to increasing lapses of attention,

instability in alertness and vigilance, and cognitive slowing. Sleep debt accumulates over time and cannot be made up for with a single night of extra or adequate sleep. The only way to recover from sleep debt is to make up for lost sleep. Sleep deprivation undermines an individual's mood and can lead to irritability, hostility, and indifference to interpersonal relations.

In February 2003, the Accreditation Council for Graduate Medical Education (ACGME) approved new maximum duty hour standards for all ACGME-accredited residency programs. The common minimum standards became effective on July 1, 2003. The major provisions of the standards are:

- An 80-hour weekly limit, averaged over four weeks. Starting July 1, 2004, programs may request up to a 10% increase in the weekly maximum hours based on a sound educational rationale and with the approval of the sponsoring institution and appropriate residency review committee.
- Moonlighting done in the sponsoring institution counts toward the weekly limit.
- An adequate rest period, which should consist of 10 hours rest between duty periods.
- A 24-hour limit on continuous duty time, with an additional period of up to six hours permitted for continuity of care and educational activities.
- One day in seven free from all patient care and educational obligations, averaged over four weeks.
- In-house call no more than once every three nights, averaged over four weeks.

While the impact of the implementation of these minimum standards was unknown, there was concern that medical students might be required to assume some of the responsibilities of resident physicians and be subject to increased hours in the clinical setting. After the implementation of the resident physician work-hour limits in July 2003, 33 medical schools responding to the 2003-2004 annual LCME questionnaire indicated that they had specific work-hour policies for medical students. The Liaison Committee on Medical Education (LCME) subcommittee on standards developed an annotation to an existing standard on student work that was approved by the LCME for immediate implementation in February 2004. The standard and annotation are:

ED-38. The committee [responsible for the curriculum] should give careful attention to the impact of the amount of work required, including the frequency of examinations and their scheduling.

ANNOTATION: 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. Students' duty hours should be set taking 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.

Since implementation, this standard has been cited on several surveys as an area of partial or substantial noncompliance by the LCME. In response to such a citation, medical schools are being required to submit progress reports that detail systems for the monitoring of the workload imposed on medical students in the clinical setting.

Standards of the LCME are under continuous review for clarity and relevance. Secretaries of survey teams report back to the Secretariat of the LCME regarding standards that were difficult to interpret or caused concern among the members of the survey team. Members of the LCME who serve on at least one survey team each year raise issues related to the application of standards. Medical schools undergoing accreditation review also identify standards and annotations that are difficult to interpret. The LCME subcommittee on standards engages in the regular review of standards.

Modifications made to annotations of standards are approved by the LCME and can become effective immediately on approval or at a designated time in the future. Substantive modifications in standards or the introduction of new standards involves a more structured and time-consuming process.

Once approved by the LCME, recommendations for changes must be endorsed by the Executive Committee of the Association of American Medical Colleges, the Council on Medical Education of the AMA, and the Association of Canadian Medical Colleges and the Canadian Medical Association. Standards are then presented at a public hearing. If there is substantial agreement, the changes are considered for final adoption by the LCME. At the time of adoption, the LCME determines the date the change will become effective. This date is usually more than one year after the adoption. Substantial disagreement with the changes at any level of review may require restarting the process.

## CURRENT AMA POLICY

Policy H-310.927 (AMA Policy Database) details resident physician working conditions with specific restrictions that are similar to the standards approved by the ACGME. In response to the potential impact of the restrictions on medical students, the AMA was directed to work with the LCME to develop standards addressing appropriate medical student training hours and training conditions during clinical clerkships (H-295.973).

## DISCUSSION

While medical students as well as resident physicians are subject to the same effects of fatigue and sleep deprivation, their educational environment and responsibilities for patient care differ. Thus, it may not be appropriate to apply the same standards to both groups.

During the third year of medical school, students typically rotate through six clinical clerkships in different specialties. Each clerkship is required to have specific learning objectives for the students that include the numbers and kinds of patients that students must see in order to achieve those objectives. It is expected that there be formal learning experiences, such as lectures and conferences. The extent of student interaction with patients and the venues in which the interactions occur are to be specified as well as the level of supervision. Students must be provided with both formative and summative evaluations of their achievements during the clerkship.

In addition to the core clerkships described above, students are often required to take more advanced clerkships, usually during the fourth year of medical school designated as “acting internships.” In these courses, students have a greater level of independence and function more like resident physicians than third-year students. Although not specifically covered by the ACGME standards, students on these rotations follow a work schedule equivalent to the resident physicians.

In most residency training programs, resident physicians remain in one specialty and rotate through various services within that specialty. The structure of the training program is centered on patient care responsibilities that serve as the primary learning environment for the resident physician. A work schedule is developed for each service with the intent of providing appropriate educational experiences for the resident physicians. This environment is better structured for monitoring specific work hours than is the medical student setting.

To monitor compliance with the duty hour standards, the ACGME has adopted a system of monitoring that goes beyond the collection of data at the time of survey visits. Data are collected annually from all program directors of accredited programs online and there is a confidential survey of all resident physicians. It will be critical to also evaluate the impact of the duty hour standards on fatigue and sleep deprivation of resident physicians. While the standards were developed on existing scientific information, evidence needs to be collected on the outcome of their implementation and appropriate adjustments made based on that evidence. Recommendation 1 of CME Report 8-A-04 directs the AMA to 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 ACGME duty-hours standards on the clinical learning environment.

LCME accreditation is designed to evaluate the entire educational program leading to the MD degree. It relies heavily on self-assessment, quality improvement and peer review. Accreditation decisions and the need for follow-up evaluations are based on compliance with all standards and the ability of the school to make the necessary changes to correct deficiencies. While the existing LCME standard on student hours and the accompanying annotation currently provide some leverage for the LCME to monitor the medical student educational environment in the clinical setting and to cite medical education programs that do not adequately take into account the effects of fatigue and sleep deprivation on learning and patient care the relationship with the specific resident duty hours requirements of the ACGME is not explicit. This linkage to the duty hour standards for resident physicians will not require modification if adjustments are needed in the standards for resident physicians. Medical education programs that are cited for noncompliance with standards are required to respond to the LCME with evidence of compliance within two years of the initial citation.

In addition to the standard noted above that addresses the monitoring of the hours that medical students are scheduled during the clinical years, it is important for each institution to critically review this issue and to establish institutional policy on medical student hours and the educational environment in the clinical setting. Once established at a local level, it will be the responsibility of each school to be certain that their policy is followed.

## SUMMARY AND RECOMMENDATIONS

The AMA remains concerned about the effect of fatigue and sleep deprivation on education, health, and patient safety as it relates to medical students, resident physicians, and practicing physicians. Policy H-310.927 on resident physician working conditions includes specific restrictions on duty hours and stresses the importance of organized educational activities and minimizing time providing patient care services of limited or no educational value. The efforts of the LCME to address the issue for medical students are consistent with their accreditation process and the educational environment for medical students.

Therefore, the Council on Medical Education recommends that the following recommendations be adopted in lieu of Resolution 310 (A-04) and that the remainder of this report be filed:

1. That our American Medical Association commend the Liaison Committee on Medical Education (LCME) for addressing the issue of the medical student learning environment including student hours assigned during the clinical years.
2. That our AMA strongly encourage the LCME to continue to monitor work hour policies for medical students, to evaluate student work hours and educational environment in the clinical setting during regular accreditation reviews and to determine any impact on medical students resulting from the enforcement of duty-hour standards by the ACGME.
3. That our AMA request that the LCME modify its standard on medical student hours and its accompanying annotation to state as follows:

ED-38. The committee [responsible for the curriculum] should give careful attention to the impact of the amount of work required, including the frequency of examinations and their scheduling during the preclinical years; and on-call hours during the clinical years.

ANNOTATION: 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. Students' duty hours should be set taking into account the effects of fatigue and sleep deprivation on learning and patient care. Medical student hours should not exceed resident duty hours as delineated by the Accreditation for Graduate Medical Education (ACGME).

4. That our AMA monitor the action of the LCME and report back to the House of Delegates when final action has been taken.

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

## **6. IMPLICATIONS OF THE "STARK II" REGULATIONS FOR CONTINUING MEDICAL EDUCATION**

### **HOUSE ACTION: RECOMMENDATIONS ADOPTED IN LIEU OF RESOLUTION 310 (A-04) AND REMAINDER OF REPORT FILED**

There has been recent concern in the continuing medical education community about the implications of an interim final rule implementing Section 1877 of the Social Security Act ("Stark Law") published on March 26, 2004, by the Centers for Medicare & Medicaid Services (CMS). This report summarizes the provisions in the Phase I/II Stark regulations that have the potential to affect the ability of hospitals to offer continuing medical education without charge to unsalaried members of their medical staffs. As background for this report, the Council on Medical Education consulted with the AMA Office of the General Counsel and with a representative of the firm of Gardner Carton Douglas who is an expert in the Stark regulations.

## HISTORY OF SECTION 1877 OF THE SOCIAL SECURITY ACT

Section 1877 of the Social Security Act, also known as the “Stark” law, addresses the general issue of physician self-referral. It prohibits a physician from making referrals for certain designated health services payable by Medicare or Medicaid to an entity with which the physician or an immediate family member has a financial relationship, unless an exception applies.

The Omnibus Budget Reconciliation Act of 1989 (OBRA 1989) added section 1877 to the Social Security Act. Various modifications and refinements were made over the next several years, for example, expanding the prohibition against self-referral for laboratory services to add additional “designated health services.” Some provisions of what has come to be called “Stark I” went into effect on January 1, 1992, and other regulations known as “Stark II” became effective January 1, 1995.

Additional legislative changes to Section 1877, for example, including Medicaid as well as Medicare, led to the further development of Stark II regulations. These were issued in phases. Phase I of Stark II was published in the *Federal Register* on January 4, 2001, as a final rule (with comment period). The effective date of the Phase I regulations was delayed on several occasions, and they went into effect on July 7, 2004. The Phase II regulations were published March 26, 2004, with an effective date 120 days later.

In summary, the provisions that could affect the ability to offer continuing medical education were introduced in the Phase II regulations.

## PROVISIONS POTENTIALLY AFFECTING CONTINUING MEDICAL EDUCATION

The Stark Law and accompanying regulations are directed, in part, at ensuring that compensation arrangements between health care institutions and referring physicians do not stimulate overutilization of services and are not inducements to refer.

The existence of a financial relationship is a prerequisite for the Stark regulations to apply. If continuing medical education is deemed to have no financial value, it would not be covered under the act, since it would not constitute a financial relationship between the hospital and the referring physician. However, it would be hard to argue that continuing medical education has no tangible value. Continuing medical education programs typically carry credit (for example, AMA PRA category 1 credit), which is needed for such things as renewal of licensure and recertification. Therefore, beyond the utility of the program’s content, continuing medical education could likely be considered to be of value to the physician. Opinions expressed by CMS staff indicate that free continuing medical education “could constitute remuneration to the physician, depending on the content and the physician’s obligation to acquire CME credits.”

Within the regulations, there are two exceptions that could apply to continuing medical education to exempt it from Stark.

### *Medical Staff Incidental Benefits*

“Medical Staff Incidental Benefits”/42 USC Section 1395 (n)(b)(4) allows health care institutions to offer physicians compensation in the form of items or services (not cash) of up to \$25 per occurrence, if the following conditions are met:

- The benefit is offered to all members of the medical staff practicing in the same specialty without regard to the volume or value of referrals or other business generated.
- The compensation is provided only during periods when the medical staff members are making rounds or are participating in other activities that benefit the hospital or its patients.
- The compensation is provided by the hospital and used by staff members only at the hospital.
- The compensation is reasonably related to the provision of services or directly/indirectly facilitates the provision of services at the hospital.
- The compensation does not violate the anti-kickback statute or any federal or state law or regulation.

The incidental benefit exception was meant to cover such things as parking and cafeteria meals that are incidental to the physician's activities at the hospital (for example, when the physician was making rounds). One could argue that continuing medical education, offered at the hospital (and, perhaps, within the academic medical center) could come under this exception. Continuing medical education can facilitate the provision of medical services, and be of benefit to the hospital and its patients. One major problem, however, is the need to value the education at \$25 or less for each session.

#### *Non-Monetary Compensation*

"Non-monetary Compensation up to \$300"/42 USC Section 1395 (b)(4) allows physician compensation in the form of items or services (not cash) that do not exceed an aggregate of \$300 per year (Medical Staff Incidental Benefits/411.357m are independent of this section). The following conditions must be met.

- The compensation does not take into account the volume or value of referrals or other business generated.
- The compensation may not be solicited by the physician or the physician's practice.
- The compensation does not violate the anti-kickback section or federal or state law or regulation.

If it were fit within the section, the cumulative value of continuing medical education offered to a physician in a given year would have to be added to any other non-monetary benefits provided. There is a requirement for detailed monitoring and record-keeping, which places a significant burden on the hospital.

#### DISCUSSION

In summary, there are three general options that could be used to address the issue of continuing medical education in the context of the Stark II regulations.

1. Make the argument that continuing medical education has no intrinsic value and is not within the purview of Stark.
2. Advocate for the inclusion of continuing medical education in an existing Stark exception, such as Medical Staff Incidental Benefits or Non-Monetary Compensation. This could be problematic if the monetary value attributed to continuing education activities causes the exceptions' defined limits to be exceeded. In such cases, significant financial penalties in the form of fines could be imposed.
3. Ask CMS to promulgate an additional exception specifically directed to continuing medical education. While physicians derive some tangible benefit from participation in continuing medical education (for example, obtaining credit that is required for renewal of a medical license or re-certification), the main beneficiary is the patient (through enhanced patient care). Providing the medical staff with continuing medical education is not an inducement to refer. Instead, hospitals expect their medical staffs to maintain an up-to-date knowledge base, directed at the needs of the patient population served. Continuing education is offered to support this end, and may be an implicit or explicit expectation of medical staff participation.

#### RECOMMENDATIONS

After consideration of the options, the Council on Medical Education recommends that the following be adopted and the remainder of this report be filed:

1. That our American Medical Association request that the Centers for Medicare & Medicaid Services develop an explicit exception within the regulations for Section 1877 of the Social Security Act (Stark Law) that permits physician compensation without financial limit in the form of continuing medical education that is offered for the purpose of ensuring quality patient care.
2. That our AMA monitor the impact of the Section 1877 (Stark II) regulations on the ability of health care institutions to provide continuing medical education to their medical staffs.

(References pertaining to Report 6 of the Council on Medical Education are available from the Medical Education Group.)