

AMA guiding principles to protect learners responding to COVID-19

This article is part of a series of COVID-19 articles and resources on medical education.

In their efforts to meet workforce demands in response to COVID-19, medical schools and health systems must make responsible decisions about engaging medical students. There are many opportunities for students to contribute to the clinical care of patients without engaging in direct physical contact with patients. However, in some institutions the workforce demands may be great enough that it is appropriate to consider including medical students in direct patient care.

Some students may be permitted to graduate early from medical school and may subsequently contribute as employed members of medical staffs prior to entering their planned residency training. Some students may be enlisted while retaining the status of student, on a voluntary basis, with appropriate supervision and with attention to infection control.

It is the responsibility of the AMA to support and protect medical students as we rely on them during this time. We stand with key stakeholders across the continuum of medical education, including but not limited to the Association of American Medical Colleges, Liaison Committee on Medical Education (LCME), Accreditation Council for Graduate Medical Education, American Osteopathic Association, American Association of Colleges of Osteopathic Medicine and the Educational Commission for Foreign Medical Graduates in support of conscientious oversight of the deployment of medical students. The AMA Council on Medical Education recommends observance of the following principles:

For all institutions engaging medical students in physical contact with patients:

1. Thoughtful planning will allow the safe re-engagement of students in the direct care of patients and thus support the continuation of student training. For required coursework involving direct patient contact, schools should provide reasonable accommodations to learners who are unable to participate.

2. Medical students should be included in conversations as direct patient interaction activities are being explored, developed and implemented.
3. Medical students must be provided proper training and oversight in the use and reuse of personal protective equipment (PPE). This includes fit testing for N95 or other respirators, donning and doffing of enhanced PPE, and institutional policies related to the use of one's own PPE to augment hospital-supplied PPE.
4. Appropriate COVID-19 testing protocols for students and health care workers should be in place to reduce risk of transmission and to monitor trends in disease burden among students.
5. Each clinical environment in which students will come into direct contact with patients should be assessed for safety and educational readiness, including:
 - Burden of COVID-19 exposure
 - Stability of care protocols and clarity of roles
 - Appropriate patient mix to support learning goals
 - Faculty capacity to provide supervision, teaching and feedback
6. Health systems and medical schools should support the wellbeing of all providers and recognize that learners face an added stressor of uncertainty about their educational pathways.
7. Medical students should not be financially responsible for diagnosis and treatment of their own disease should they become ill due to care of COVID-19 patients through school-approved activities.
8. Medical schools should use a competency-based approach to redesign educational and assessment activities, considering alternatives to direct patient contact to meet desired learning outcomes.
9. Medical schools should work with the LCME to identify viable options to assess students' competency and meet curricular requirements in order to avoid, to the extent possible, any delay in medical students' graduation or progression in medical school.

Additionally, for institutions implementing early graduation to allow students to join the physician workforce:

10. Early graduation should be enacted on a voluntary basis and founded upon attainment of core competencies.
11. To the extent possible, early graduates should serve under the supervision of an approved graduate medical education program.
12. Medical school graduates should not be compelled to work for their matched residency institution prior to the intended date of employment.
13. Institutions deploying early graduates should grant these providers full status as health care employees with appropriate salary and benefits, while continuing efforts to mitigate their

personal risk.

14. Institutions and medical school graduates should remain mindful of graduates' contractual obligations to their matched residencies, including consideration of the potential for quarantine and/or illness due to care of COVID-19 patients.
15. Financial institutions overseeing all loans, public and private, for medical school graduates deployed into the workforce between graduation and beginning residency should exercise forbearance and/or forgiveness of debt service during this time.

For organizations tasked with assessment and evaluation of students, residents, fellows and/or physicians via standardized examinations:

1. Organizations utilizing commercial testing centers for administration of computer-based examinations should ensure that those testing centers follow appropriate local, state-mandated, and Centers for Disease Control and Prevention (CDC) public health guidelines to reduce transmission of and exposure to COVID-19.
2. Organizations responsible for conducting standardized examinations should explore opportunities for remote proctoring of computer-based examinations.
3. Testing that requires travel to a limited number of remote testing centers should be postponed until local, state-mandated, and CDC public health guidelines reflect that travel no longer presents an increased risk of transmission to the learner.
4. Learners should not be required nor encouraged to travel to testing sites that recommend or mandate quarantine periods due to local and/or state restrictions, as this will negatively affect participation in educational activities at their schools or clinical sites.
5. Testing that requires evaluation of standardized patients should follow all appropriate guidelines to reduce transmission of and exposure to COVID-19 between standardized patients and examinees, including postponing of in-person examinations when public health guidance reflects significant risks.
6. Organizations should evaluate opportunities for local administration of examinations that require clinical skills assessments, to reduce the need for learners to travel to complete those examinations.

Related guidance regarding roles for medical students

- Liaison Committee on Medical Education COVID-19 updates and resources
- Accreditation Council for Graduate Medical Education response to pandemic crisis

- Association of American Medical Colleges resource hub
- Council on Ethical & Judicial Affairs' opinion on graduating early to join the physician workforce

Additional COVID-19 medical education articles

- Medical education COVID-19 resource guide
- COVID-19 resources for medical educators
- Guiding principles to protect resident & fellow physicians responding to COVID-19