

HOD ACTION: Council on Medical Education Report 14 adopted as amended and the remainder of the report filed.

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 14-A-09

Subject: Resident and Fellow Benefit Equity During Research Assignments
(Resolution 314, A-08)

Presented by: Claudette E. Dalton, MD, Chair

Referred to: Reference Committee C
(Rodney G. Hood, MD, Chair)

1 Resolution 314 (A-08), “Physician-Scientist Benefit Equity,” introduced by the Resident and
2 Fellow Section and referred to the Board of Trustees, asked that our American Medical Association
3 (AMA):

4
5 “support the concept that all resident and fellow physicians who function in a role as
6 physician-scientists are provided with benefits packages comparable to those provided to
7 their peers in clinical residencies or fellowships, to include disability insurance, life
8 insurance, HIV indemnity, malpractice insurance including tail coverage, retirement
9 benefits, health, sick leave and wages commensurate with their education and experience,
10 and if a given benefit or salary is provided to some residents within a given program at the
11 same postgraduate level, then that benefit must be provided to all residents.”

12
13 Reference Committee testimony stated that the issues referenced in this resolution are complex and
14 include, but are not limited to, the sources of funding, which can be different for residents and
15 fellows when they are doing research assignments instead of clinical duties. For example,
16 depending on the employer, payroll issues and benefit packages available may be different. The
17 following report summarizes the sources of funding for graduate medical education (GME)
18 research activities and discusses how funding from different sources impacts resident and fellow
19 benefits.

20
21 **BACKGROUND**

22
23 Residents and fellows training as scientists play a unique and important role in research at medical
24 schools and teaching hospitals. Their training is critical for future scientific advances into better
25 diagnostics, treatments, and prevention of diseases. However, the number of physicians pursuing
26 research careers is static, and their average age is rising. Trends in major professional activity
27 classifications show that the number of physicians in research decreased (6.1%) from 15,377 in
28 1980 to 14,490 in 2007, even though the total number of physicians grew (101.3%) from 467,679
29 in 1980 to 941,304 in 2007.¹

30
31 Recent data and studies indicate that the benefits of this career path are being outweighed by many
32 negative factors, such as, the increasing indebtedness of medical school graduates caused by
33 rapidly rising medical school tuition. Physicians who choose research careers take on many extra
34 years of training and are therefore more strongly affected by the relatively low wages of residency
35 and fellowship training.² Furthermore, due to increasing financial constraints placed on academic
36 medical centers, physician-scientists are being asked to assume more clinical responsibilities, thus

1 causing many to choose between research or clinical practice, a choice that prevents them from
2 maximizing contributions to research and medicine.³

3
4 The Association of American Medical Colleges (AAMC) recently convened a Task Force on
5 Clinical Research (CRTF II) to advise the academic medical community how best to (a) attract,
6 develop, and nurture increased numbers of independent translational and clinical investigators; (b)
7 create the infrastructure needed by these investigators to be successful; and (c) finance translational
8 and clinical science. The CRTF II surveyed 125 research deans and published a report in 2006
9 showing that 72% of the responding institutions had introduced one or more new clinical research
10 training programs for fellows and/or junior faculty, or enhanced the rigor of an existing program.⁴
11 New NIH funding helped stimulate this positive change. The study also showed:

12
13 The current healthcare financing systems do not provide a dependable funding source for
14 sustaining salary for translational and clinical investigators. Unremitting pressures to
15 contain healthcare costs have drained excess patient care revenues from the system,
16 markedly increased the clinical service demands on physicians, and reduced the ability to
17 cost shift from patient care to research.⁴

18
19 Although many mechanisms have been proposed to reverse the decline in the number of physician-
20 scientists in the United States, most of these have concentrated on MD/PhD programs, research in
21 subspecialty fellowships, and other approaches that occur later in physician training.⁵

22 23 SOURCES OF GRADUATE MEDICAL EDUCATION FUNDING FOR RESEARCH

24
25 The sponsors of GME programs (e.g., teaching hospitals, medical schools, regional consortia) have
26 ultimate responsibility for the management and quality of the GME-related activities conducted
27 under their purview, and must balance multiple social missions, including specialized patient care,
28 indigent care, teaching, and particularly for academic health centers, research. Total health
29 research and development in the United States from all sources is only 6% of the annual total
30 expenditures on health care.⁶ GME funding for research comes from many different sources
31 including federal and non-federal agencies, philanthropic foundations, industry (biomedical
32 research), and GME sponsoring institutions (discretionary spending).

33
34 *Centers for Medicare and Medicaid Services (CMS)*

35 http://www.cms.hhs.gov/AcuteInpatientPPS/06_dgme.asp

36
37 Medicare, the single largest funding source for GME, helps offset some of the costs associated with
38 educating residents, caring for patients who require more intense and complex care, and the other
39 special missions of teaching hospitals. Medicare's direct graduate medical education (DGME)
40 reimbursement covers salary, fringe benefits, and attending physician compensation for residents in
41 an approved program working in all areas of the hospital complex,⁷ based on the institution's
42 number of residents in an approved program in a current year and a historical average GME cost
43 per resident in a base year.⁸ Additional years spent in research, employment, or training outside of
44 prerequisites for the specialty or subspecialty program are not used to determine the graduate-year
45 level. Any and all GME activity performed during dedicated research time may not be included on
46 the Medicare cost report, and therefore has no CMS reimbursement for DGME or indirect graduate
47 medical education reimbursement.

48
49 Teaching institutions often employ a resident physician or fellow to stay in their program longer in
50 order to continue a course of research together with or under the general oversight of faculty
51 physicians who are on teaching staff at the hospital. The resident physician's or fellow's time

1 would not be included in the hospital's resident counts for the DGME and indirect medical
2 education (IME) payments if the individual is no longer in an approved training program.⁸

3
4 *Other Federal Funding Agencies*

5
6 Federal funding for health services research is also a small fraction of the Public Health Service
7 budget, administered largely through the Agency for Healthcare Research and Quality, the
8 Veterans Health Administration, and the National Institutes of Health (NIH) itself.

9
10 *National Institutes of Health*

11
12 • National Institute of General Medical Sciences

13 <http://www.nigms.nih.gov/Training/InstPredoc/PredocOverview-MSTP.htm>

14 In 1964, the National Institute of General Medical Sciences (NIGMS) established the Medical
15 Scientist Training Program (MSTP). This program encourages and supports the training of
16 students with outstanding credentials and potential who are motivated to undertake careers in
17 biomedical research and academic medicine. MSTP students participate in an integrated
18 program of undergraduate and medical residency and fellowship training in the biomedical
19 sciences and clinical training offered through medical schools. Graduates receive the
20 combined MD-PhD degree, and the majority of them pursue careers in basic biomedical or
21 clinical research.⁹

22
23 MSTP grants are made to universities and their medical schools, which are responsible for
24 program operation and trainee selection. About 170 positions for new students are available in
25 the United States each year. Awardee institutions also support additional students using funds
26 from other sources. For those selected, the program provides a maximum of six years of
27 support, although an individual's course of study for the combined degree may take somewhat
28 longer. All institutions identify other sources of support for a trainee's additional years of
29 study. Trainee support provided by an MSTP grant includes stipend; tuition allowance; and
30 modest sums for travel, equipment, and supplies. Many institutions supplement the basic
31 stipend provided by the MSTP grant.¹⁰

32
33 • Clinical and Translational Science Awards (CTSA)

34 [http://www.ncrr.nih.gov/clinical_research_resources/clinical_and_translational_science_awa](http://www.ncrr.nih.gov/clinical_research_resources/clinical_and_translational_science_awards/index.asp)
35 [rds/index.asp](http://www.ncrr.nih.gov/clinical_research_resources/clinical_and_translational_science_awards/index.asp)

36 The NIH's Clinical and Translational Science Awards (CTSA) offers funding and other
37 services to research training centers to establish multi-disciplinary "academic homes" for
38 clinical research. Thirty-eight institutions are now participating; this number is expected to
39 reach 60 by 2012.¹¹

40
41 *Physician-Scientist Training Programs*

42
43 There are more than one hundred physician-scientist residency training programs that range from
44 MD-PhD Programs, to DO-PhD Programs, to Research Residency programs. These programs have
45 various levels and sources of funding. Many offer their students tuition remission and/or stipends.
46 These programs are designed for students with an interest in a career as a physician-scientist, and
47 are not designed to provide a "free-ride" through medical school. Fully funded programs pay
48 tuition for both medical and graduate school, health insurance, fees, and a yearly stipend. There
49 are programs that will pay for some, but not all medical school expenses and some programs offer
50 some of their students fully funded positions, while other students get only partial funding or no
51 funding at all.¹²

1 *Philanthropic Foundations*

2

3 Philanthropic foundations also support research. Two examples include the Josiah Macy, Jr.
4 Foundation, which created a program to increase exposure of post-doctoral students and medical
5 faculty to conduct research away from their home institutions, and the Howard Hughes Medical
6 Institute, which launched its own program known as the “Med into Grad Initiative,” of institutional
7 grants to integrate medical knowledge into graduate education and train PhD students in medical
8 and clinical sciences.^{13, 14}

9

10 *Biomedical research supported by industry*

11

12 Biomedical research supported by industry has increased from approximately 32% to 62% during
13 the last 2 decades, and financial relationships among industry, scientific investigators, and
14 academic institutions are widespread. Studies show that researchers with industry support “publish
15 at higher rates, patent more frequently, participate in more administrative and professional
16 activities and earn more than colleagues without such support.”¹⁵ However, significant conflicts of
17 interest may arise from these ties, which can influence biomedical research and pose risks for
18 academic institutions.

19

20 *Institutional funding*

21

22 Some institutions also make research a high priority and invest a portion of their discretionary
23 funds in the clinical research enterprise. These medical schools and teaching hospitals determine
24 their level of investment relative to their size, circumstances, and competing priorities. The sources
25 of revenue are similar in public and private institutions, and significant research funding is
26 leveraged on a relatively small share of available “other institutional support” that includes fund-
27 raising.⁴

28

29 **AMA POLICY**

30

31 AMA Policies H-460.971, “Support for Training of Biomedical Scientists and Health Care
32 Researchers;” H-310.999, “Guidelines for Housestaff Contracts or Agreements;” H-310.929,
33 “Principles for Graduate Medical Education;” and H-295.942, “Providing Dental and Vision
34 Insurance to Medical Students and Resident Physicians.” (Appendix A)

35

36 To summarize AMA policy:

37

- 38 • Continuation and adequate funding should be available for stipends in federal research
39 training programs.
- 40 • A comprehensive strategy to increase the number of physician-scientists should be
41 supported.
- 42 • Strategies for federal government-sponsored programs should include reduction of
43 education-acquired debt to encourage training of physician-scientists for biomedical
44 research.

45

46 **ACCREDITATION COUNCIL FOR GRADUATE MEDICAL EDUCATION INSTITUTIONAL**
47 **REQUIREMENTS**

48

49 ACGME Institutional Requirements state that: “sponsoring and participating sites must
50 provide all residents with appropriate financial support and benefits to ensure that they are
51 able to fulfill the responsibilities of their educational programs. Candidates for programs

1 (applicants who are invited for an interview) must be informed, in writing or by electronic
2 means, of the terms, conditions, and benefits of their appointment, including financial
3 support; vacations; parental, sick, and other leaves of absence; professional liability,
4 hospitalization, health, disability and other insurance provided for the residents and their
5 families; and the conditions under which the sponsoring institution provides call rooms,
6 meals, laundry services, or their equivalents.”

7
8 “The Sponsoring Institution must provide hospital and health insurance benefits for the
9 residents and their families. Coverage for such benefits should begin upon the first
10 recognized day of their respective programs, unless statute or regulation requires a later
11 date to begin coverage. The Sponsoring Institution must also provide access to insurance
12 to all residents for disabilities resulting from activities that are part of the educational
13 program.”¹⁶

14 15 DISCUSSION

16
17 Research funding and the development of a national educational research infrastructure will
18 ultimately determine the success of clinical research. In 2007, Medicare payments for GME
19 totaled \$8.8 billion and supported the training of nearly 106,012 residents and fellows in the United
20 States.¹⁷ Of this total, less than 0.001% was invested in health professions education research.¹⁸

21
22 Limited funding by the CMS due to caps on the number of resident trainees imposed by the
23 Balanced Budget Amendment of 1997 restricts the flexibility of teaching hospitals to expand the
24 number of resident physicians in their programs. In addition, CMS rules and regulations impose
25 limits on the settings in which GME can occur. Such limitations of funding regarding ambulatory
26 and other non-hospital sites of training have resulted in concentrating GME training in limited
27 modalities and settings, predominantly inpatient services. On August 22, 2008, the AAMC
28 submitted an *amicus curiae* brief arguing that time spent in research and other scholarly activities
29 by resident physicians should be included in the Medicare IME payment count of FTE residents.¹⁹

30
31 Investigator training generally includes 4-to-5 years of medical school plus 5-to-7 years of
32 residency. The training component for a combined MD-PhD degree could take 8 years to
33 complete. Physician compensation is relatively low during residency and fellowship, and most
34 have already accumulated significant educational debt (the average debt burden for the 87.6% of
35 medical school graduates with debt has risen to \$155,000). Rates of indebtedness have been
36 growing at an average of 6.9% for public medical school graduates and 5.9% for their private
37 school counterparts. High medical student indebtedness is likely to continue to influence choice of
38 specialty and type of practice. The AMA supports legislation that would provide incentives to ease
39 medical school debt burdens, such as loan forgiveness and loan deferment programs (i.e., restoring
40 the 20/220 pathway) and income tax exemptions for medical student scholarships.

41
42 Ley and Rosenbert conducted a study using data obtained from the NIH, the AMA, the AAMC,
43 and other sources to review the total numbers of physicians performing research, grant application
44 numbers and success rates for MDs, MD-PhDs, and PhDs at various stages in their careers. They
45 looked at interest in research among medical students, medical school tuitions, and postgraduate
46 salaries, numbers and composition of applicants for NIH loan repayment programs, and gender
47 distribution of young physician-scientists. Their study showed that “the number of physician-
48 scientists in the United States has been in a steady state for the past decade, but funded physician-
49 scientists are significantly older than they were 2 decades ago. The study also showed that early
50 career markers over the past 7-to-10 years demonstrated increasing interest in research careers by
51 medical students, steady growth of the MD-PhD pool, and a new burst of activity in the ‘late

1 bloomer' pool of MDs (individuals who choose research careers in medical school or in residency
2 training), fueled by loan repayment programs that were created by the NIH in 2002.”²⁰

3
4 SUMMARY AND RECOMMENDATIONS

5
6 Resident and fellow-scientist compensation and benefits vary depending on the research activity and the
7 individual graduate medical education (GME) sponsoring institution's policies for funding research.
8 AMA policy supports benefit packages for resident physicians, and the AMA Resident and Fellow
9 Section monitors the *Essentials of Accredited Residencies in Graduate Medical Education* for
10 significant changes in benefits language. Programs accredited by the ACGME provide all residents
11 with appropriate financial support and benefits to ensure that they are able to fulfill the
12 responsibilities of their educational programs. However, institutional funding for residency training
13 is complex, and many independent research programs are not accredited by the ACGME. Thus it
14 is the GME sponsoring institution's responsibility to determine compensation and benefits for
15 residents based on their accreditation status, policies, budgets, and grant awards.

16
17 The Council on Medical Education, therefore, recommends that the following be adopted in lieu of
18 Resolution 314 (A-08), and that the remainder of this report be filed.

- 19
20 1. That our American Medical Association (AMA) urge the Accreditation Council for
21 Graduate Medical Education to require accredited sponsoring residency and fellowship
22 training programs to continue to provide comparable benefits to resident and fellow
23 physicians engaged in research activities that are required by either their sponsoring
24 residency and fellowship training programs or residency review committees as if it were
25 full-time clinical service. (Directive to Take Action)
26
27 2. That our AMA collect data on resident and fellow physician benefits including resident and
28 fellow physicians engaged in research activities. (Directive to Take Action)
29
30 3. That our AMA reaffirm AMA Policies H-460.971 and H-310.929, which support training
31 of biomedical scientists and health care researchers. (Reaffirm HOD Policy)
32
33 4. That our AMA, through the AMA Resident and Fellow Section, continue to work with
34 residents and fellows and support training of biomedical scientists and health care
35 researchers. (Directive to Take Action)
36
37 5. That our AMA advocate that the Centers for Medicare and Medicaid Services (CMS)
38 include in the FTE count for GME payment formulas the time that resident and fellow
39 physicians spend in research and other scholarly activities that is required by the ACGME.
40 (Directive to Take Action)

Fiscal Note: \$10000 to collect data on resident physician benefits.

Appendix A

AMA Policies

H-460.971 Support for Training of Biomedical Scientists and Health Care Researchers

Our AMA: (1) continues its strong support for the Medical Scientists Training Program's stated mission goals; (2) supports taking immediate steps to enhance the continuation and adequate funding for stipends in federal research training programs in the biomedical sciences and health care research, including training of combined MD and PhD, biomedical PhD, and post-doctoral (post MD and post PhD) research trainees; (3) supports monitoring federal funding levels in this area and being prepared to provide testimony in support of these and other programs to enhance the training of biomedical scientists and health care research; (4) supports a comprehensive strategy to increase the number of physician-scientists by: (a) emphasizing the importance of biomedical research for the health of our population; (b) supporting the need for career opportunities in biomedical research early during medical school and in residency training; (c) advocating National Institutes of Health support for the career development of physician-scientists; and (d) encouraging academic medical institutions to develop faculty paths supportive of successful careers in medical research; and (5) supports strategies for federal government-sponsored programs, including reduction of education-acquired debt, to encourage training of physician-scientists for biomedical research. (Res. 93, I-88; Reaffirmed: Sunset Report, I-98; Amended: Sub. Res. 302, I-99; Appended: Res. 515 and Reaffirmation A-00)

H-310.999 Guidelines for Housestaff Contracts or Agreements

The "Essentials of Approved Residencies, " approved by the House of Delegates in 1970, includes a section on relationships of housestaff and institutions. The following outline is intended to promote additional guidance to all parties in establishing the conditions under which house officers learn and provide services to patients. Training programs have been central to the process of graduate medical education which has produced a high level of medical competence in the United States. The American Medical Association recognizes that the integrity of these programs is a primary objective in achieving the best possible care of the patient. It is, therefore, incumbent upon members of the housestaff and the institutions in which they are being trained to be aware of the parameters and responsibilities applicable to their training programs. In the absence of such awareness, unreasonable expectations may arise to threaten the harmony between hospital and housestaff in the performance of their joint mission. It should be emphasized that these guidelines are not intended as a fixed formula. Guidelines that seek to cover public, voluntary and proprietary hospitals necessarily entail so many variables from training institution to training institution that no single form of contract or agreement would be universally applicable. This set of guidelines has, therefore, been developed to cover the more significant substantive provisions of a housestaff contract or agreement. The subjects included in the Guidelines are not intended to be the only subjects important or appropriate for a contract or agreement. Moreover, the definition of the respective responsibilities, rights and obligations of the parties involved can assume various forms: individual contracts or agreements, group contracts or agreements, or as a part of the rules of government of the institution. II. Proposed Terms and Conditions A. Parties to the Contract or Agreement (1) Contracts or agreements may be formed between individuals or groups, and institutions. Such a group might be a housestaff organization. (2) The two parties to an agreement or contract may be a single institution or a group of institutions, and an individual member of the housestaff, an informal group of the housestaff, or a formally constituted group or association of the housestaff, as determined by the housestaff organization. B. General Principles (1) Contracts or

agreements are legal documents and must conform to the laws, rules, and regulation to which the institutions are subject. Position, salary and all other benefits should remain in effect insofar as possible without regard to rotational assignments even when the member of the housestaff is away from the parent institution. Exceptions required by law or regulations should be clearly delineated to the house officer at the time of the appointment. Changes in the number of positions in each year of a training program should be made so as not to affect adversely persons already in, or accepted in, that program. The agreement should provide fair and equitable conditions of employment for all those performing the duties of interns, residents and fellows. When a general contract or agreement is in effect between an association and an institution, individual contracts or agreements should be consistent. (2) Adequate prior notification of either party's intent not to review the contract or agreement should be required, and the date of such notification should be included in the contract or agreement. (3) The institution and the individual members of the housestaff must accept and recognize the right of the housestaff to determine the means by which the housestaff may organize its affairs, and both parties should abide by that determination; provided that the inherent right of a member of the housestaff to contract and negotiate freely with the institution, individually or collectively, for terms and conditions of employment and training should not be denied or infringed. No contract should require or prescribe that members of the housestaff shall or shall not be members of an association or union. C. Obligation of the Housestaff (1) Members of the housestaff agree to fulfill the educational requirements of the graduate training programs, and accept the obligation to use their efforts to provide safe, effective and compassionate patient care as assigned or required under the circumstances as delineated in the ACGME "Essentials of Approved Residencies" and previously approved standards of the AMA Council on Medical Education. (2) Members of the housestaff should comply with the laws, regulations, and policies to which the institution is subject. D. Obligation of the Institution (1) The institution agrees to provide an educational program that meets the standards of the ACGME "Essentials of Approved Residencies." (2) The institution agrees to maintain continuously its staff and its facilities in compliance with all of the standards in the ACGME "Essentials of Approved Residencies." E. Salary for Housestaff (1) The salary to be paid and the frequency of payment should be specified. The salary schedule should be published. The basis for increments and the time of the increments should be specified. (2) In determining the salary level of a member of the housestaff, prior educational experience should be considered, and a determination made as to whether credit should be given. (3) The responsibilities of senior residents should be recognized in salary differentials. F. Hours of Work. There should be recognition of the fact that long duty hours extending over an unreasonably long period of time or onerous on-call schedules are not consistent with the primary objective of education or the efficient delivery of optimal patient care. The institution should commit itself to fair scheduling of duty time for all members of the housestaff, including the provision of adequate off-duty hours. G. Off-Duty Activities The contract or agreement should provide that a member of the housestaff is free to use his off-duty hours as he sees fit, including engaging in outside employment if permitted by the terms of the original contract or agreement, so long as such activity does not interfere with his obligations to the institution or to the effectiveness of the educational program to which he has been appointed. H. Vacation and Leave The AMA encourages residency programs across the country to permit and schedule off-duty time separate from personal vacation time to enable residents to attend educational and/or organized medicine conferences. The amount of vacation, sick leave, and educational leave to which each member of the housestaff is entitled should be specified. Vacations should be expressed in terms of customary working days as defined by the institution. If vacations may be taken only at certain times of the year, this restriction should be stated. Any requirements for scheduling vacation time should also be stated. Provisions may also cover leaves for maternity, paternity, bereavement, military duty, examinations and preparations therefore, and educational conferences. Reimbursement for tuition

and expenses incurred at educational conferences should be considered. The agreement should set forth any progressive increases in the amount of time allowed for vacation, sick leave, and educational leave. Educational leave should not be deducted from vacation time.

I. Insurance Benefits Insurance benefits should be set forth with particularity and should be tailored to the specific needs of the housestaff. Some of the more common insurance benefit provisions are (1) hospitalization and basic medical coverage for the member of the housestaff, spouse, and minor children; (2) major medical coverage for the member of the housestaff, spouse, and minor children; and (3) group life insurance, and dismemberment and disability insurance for the member of the housestaff only. It should also be specified whether the institution will pay the full amount of premiums or only a portion of the premiums, the balance to be paid by the member of the housestaff. Co-paid benefits should be established, separately from other hospital employee benefits, as a means of maximizing benefits. In some instances, free care for the housestaff and their families at the training institutions may be provided. In lieu of insurance benefits, the contract or agreement may provide for fixed annual payments to a housestaff association for each member of the housestaff so that the housestaff association may determine and provide for insurance or other benefits for the housestaff.

J. Professional Liability Insurance The contract or agreement should specify the amount of professional liability insurance that the institution will provide for each member of the housestaff together with the limits of liability applicable to such coverage. It might also be appropriate to provide in the contract or agreement that the housestaff and the institution will cooperate fully with the insurance company in the handling of any professional liability claim.

K. Committee Participation Insofar as possible, the institution should agree to provide for appropriate participation by the housestaff on the various committees within the institution. This participation should be on committees concerning institutional, professional and administrative matters including grievance and disciplinary proceedings. Members should have full voting rights. Representatives of the housestaff should be selected by the members of the housestaff.

L. Grievance Procedures The contract or agreement should require and publish a grievance procedure. A grievance procedure typically involves the following: (1) A definition of the term "grievance" (e.g., any dispute or controversy about the interpretation or application of the contract, any rule or regulation, or any policy or practice). (2) The timing, sequence, and end point of the grievance procedure. (3) The right to legal or other representation. (4) The right of an individual member of the housestaff or a housestaff association to initiate a grievance procedure and the obligation of the housestaff to maintain patient care during the grievance procedure. (5) A statement of the bases and procedures for the final decision on grievances (end point), and agreement of both parties to abide by the decision. (6) Should costs arise in the grievance procedure, a prior agreement as to how these costs will be apportioned between the parties.

M. Disciplinary Hearings and Procedure With respect to disciplinary procedures, the provisions of Article VIII - Hearing and Appellate Review Procedure of the JCAHO Guidelines for the Formulation of Medical Staff Bylaws, Rules, and Regulations shall be applicable to the housestaff in the same manner as they are to all other members of the medical staff with the proviso that the Hearing and Appeals Committees shall contain appropriate representation of the housestaff.

N. Description of the Educational Program The specific details of the operation of the educational experience should be made available to each prospective candidate. These data should include specific descriptions of training programs, including numbers of resident positions at each level of training, copies of existing housestaff contracts or agreements, approval status of programs to which candidate is applying, methods of evaluation, procedures for grievances and disciplinary action, and commitments for further training.

O. Patient-Care Issues The quality of patient-care services and facilities may be specified in the contract, and could include such matters as adequate equipment, bedspace, clinical staffing, and clinical staff structuring.

P. Other Provisions The agreement should provide for adequate, comfortable, safe, and sanitary facilities. The foregoing

provisions are not all-inclusive. Depending upon the institution's size, resources, location, and affiliations, if any, and also depending upon the relationship between the institution and the housestaff association, other provisions may be included, such as: (1) Maintenance of existing benefits and practices not otherwise expressly covered; (2) Housing, meals, laundry, uniforms, living-out and telephone allowances; (3) Adequate office space, facilities, and supporting services for housestaff affairs; (4) Housestaff association seminars and meetings. (BOT Rep. H, I-74; Reaffirmed: CLRPD Rep. C, A-89; Appended: Res.323, I-97; Reaffirmation A-00; Reaffirmation A-08)

H-310.929 Principles for Graduate Medical Education

Our AMA urges the Accreditation Council for Graduate Medical Education to incorporate these principles in the revised "Institutional Requirements" of the Essentials of Accredited Residencies of Graduate Medical Education, if they are not already present. (1) PURPOSE OF GRADUATE MEDICAL EDUCATION. There must be objectives for residency education in each specialty that promote the development of the knowledge, skills, attitudes, and behavior necessary to become a competent practitioner in a recognized medical specialty. (2) RELATION OF ACCREDITATION TO THE PURPOSE OF RESIDENCY TRAINING. Accreditation requirements should relate to the stated purpose of a residency program and to the knowledge, skills, attitudes, and behaviors that a resident physician should have on completing residency education. (3) EDUCATION IN THE BROAD FIELD OF MEDICINE. GME should provide a resident physician with broad clinical experiences that address the general competencies and professionalism expected of all physicians, adding depth as well as breadth to the competencies introduced in medical school. (4) SCHOLARLY ACTIVITIES FOR RESIDENTS. Graduate medical education should always occur in a milieu that includes scholarship. Resident physicians should learn to appreciate the importance of scholarly activities and should be knowledgeable about scientific method. However, the accreditation requirements, the structure, and the content of graduate medical education should be directed toward preparing physicians to practice in a medical specialty. Individual educational opportunities beyond the residency program should be provided for resident physicians who have an interest in, and show an aptitude for, academic and research pursuits. The continued development of evidence-based medicine in the graduate medical education curriculum reinforces the integrity of the scientific method in the everyday practice of clinical medicine. (5) FACULTY SCHOLARSHIP. All residency faculty members must engage in scholarly activities and/or scientific inquiry. Suitable examples of this work must not be limited to basic biomedical research. Faculty can comply with this principle through participation in scholarly meetings, journal club, lectures, and similar academic pursuits. (6) INSTITUTIONAL RESPONSIBILITY FOR PROGRAMS. Specialty-specific GME must operate under a system of institutional governance responsible for the development and implementation of policies regarding the following; the initial authorization of programs, the appointment of program directors, compliance with the Essentials for Accredited Residencies in Graduate Medical Education, the advancement of resident physicians, the disciplining of resident physicians when this is appropriate, the maintenance of permanent records, and the credentialing of resident physicians who successfully complete the program. If an institution closes or has to reduce the size of a residency program, the institution must inform the residents as soon as possible. Institutions must make every effort to allow residents already in the program to complete their education in the affected program. When this is not possible, institutions must assist residents to enroll in another program in which they can continue their education. Programs must also make arrangements, when necessary, for the disposition of program files so that future confirmation of the completion of residency education is possible. Institutions should allow residents to form housestaff organizations, or similar organizations, to address patient care and resident work environment concerns. Institutional committees should

include resident members. (7) **COMPENSATION OF RESIDENT PHYSICIANS.** All residents should be compensated. Residents should receive fringe benefits, including, but not limited to, health, disability, and professional liability insurance and parental leave and should have access to other benefits offered by the institution. Residents must be informed of employment policies and fringe benefits, and their access to them. Restrictive covenants must not be required of residents or applicants for residency education. (8) **LENGTH OF TRAINING.** The usual duration of an accredited residency in a specialty should be defined in the "Program Requirements." The required minimum duration should be the same for all programs in a specialty and should be sufficient to meet the stated objectives of residency education for the specialty and to cover the course content specified in the Program Requirements. The time required for an individual resident physician's education might be modified depending on the aptitude of the resident physician and the availability of required clinical experiences. (9) **PROVISION OF FORMAL EDUCATIONAL EXPERIENCES.** Graduate medical education must include a formal educational component in addition to supervised clinical experience. This component should assist resident physicians in acquiring the knowledge and skill base required for practice in the specialty. The assignment of clinical responsibility to resident physicians must permit time for study of the basic sciences and clinical pathophysiology related to the specialty. (10) **INNOVATION OF GRADUATE MEDICAL EDUCATION.** The requirements for accreditation of residency training should encourage educational innovation and continual improvement. New topic areas such as continuous quality improvement (CQI), outcome management, informatics and information systems, and population-based medicine should be included as appropriate to the specialty. (11) **THE ENVIRONMENT OF GRADUATE MEDICAL EDUCATION.** Sponsoring organizations and other GME programs must create an environment that is conducive to learning. There must be an appropriate balance between education and service. Resident physicians must be treated as colleagues. (12) **SUPERVISION OF RESIDENT PHYSICIANS.** Program directors must supervise the clinical performance of resident physicians. The policies of the sponsoring institution, as enforced by the program director, must ensure that the clinical activities of each resident physician are supervised to a degree that reflects the ability of the resident physician. Integral to resident supervision is the necessity for frequent evaluation of residents by faculty, with discussion between faculty and resident. It is a cardinal principle that responsibility for the treatment of each patient and the education of resident and fellow physicians lies with the physician/faculty to whom the patient is assigned and who supervises all care rendered to the patient by residents and fellows. (13) **EVALUATION OF RESIDENTS AND SPECIALTY BOARD CERTIFICATION.** Residency program directors and faculty are responsible for evaluating and documenting the continuing development and competency of residents, as well as the readiness of residents to enter independent clinical practice upon completion of training. Program directors should also document any deficiency or concern that could interfere with the practice of medicine and which requires remediation, treatment, or removal from training. Inherent within the concept of specialty board certification is the necessity for the residency program to attest and affirm to the competence of the residents completing their training program and being recommended to the specialty board as candidates for examination. This attestation of competency should be accepted by specialty boards as fulfilling the educational and training requirements allowing candidates to sit for the certifying examination of each member board of the ABMS. (14) **GRADUATE MEDICAL EDUCATION IN THE AMBULATORY SETTING.** Graduate medical education programs must provide educational experiences to residents in the broadest possible range of educational sites, so that residents are trained in the same types of sites in which they may practice after completing GME. It should include experiences in a variety of ambulatory settings, in addition to the traditional inpatient experience. The amount and types of ambulatory training is a function of the given specialty. (15) **VERIFICATION OF RESIDENT PHYSICIAN**

EXPERIENCE. The program director must document a resident physician's specific experiences and demonstrated knowledge, skills, attitudes, and behavior, and a record must be maintained within the institution. (CME Rep. 9, A-99)

H-295.942 Providing Dental and Vision Insurance to Medical Students and Resident Physicians

The AMA urges (1) all medical schools to pay for or offer affordable policy options and, assuming the rates are appropriate, require enrollment in disability insurance plans by all medical students; (2) all residency programs to pay for or offer affordable policy options for disability insurance, and strongly encourage the enrollment of all residents in such plans; (3) medical schools and residency training programs to pay for or offer comprehensive and affordable health insurance coverage, including but not limited to medical, dental, and vision care, to medical students and residents which provides no less than the minimum benefits currently recommended by the AMA for employer-provided health insurance and to require enrollment in such insurance; (4) carriers offering disability insurance to: (a) offer a range of disability policies for medical students and residents that provide sufficient monthly disability benefits to defray any educational loan repayments, other living expenses, and an amount sufficient to continue payment for health insurance providing the minimum benefits recommended by the AMA for employer-provided health insurance; and (b) include in all such policies a rollover provision allowing continuation of student disability coverage into the residency period without medical underwriting. (5) Our AMA: (a) actively encourages medical schools, residency programs, and fellowship programs to provide access to portable group health and disability insurance, including human immunodeficiency virus positive indemnity insurance, for all medical students and resident and fellow physicians; (b) will work with the ACGME and the LCME, and other interested state medical societies or specialty organizations, to develop strategies and policies to ensure access to the provision of portable health and disability insurance coverage, including human immunodeficiency virus positive indemnity insurance, for all medical students, resident and fellow physicians; and (c) will prepare informational material designed to inform medical students and residents concerning the need for both disability and health insurance and describing the available coverage and characteristics of such insurance. (BOT Rep. W, I-91; Reaffirmed: BOT Rep. 14, I-93; Appended: Res. 311, I-98; Modified: Res. 306, A-04)

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