

REPORTS OF THE COUNCIL ON MEDICAL EDUCATION

The following reports, 1–8, were presented by Jeffrey P. Gold, MD, Chair:

1. ANNUAL REPORT OF AMA MEDICAL EDUCATION ACTIVITIES

Informational report; no reference committee hearing.

HOUSE ACTION: FILED

This informational report summarizes the activities of the Council on Medical Education, the Section on Medical Schools, and American Medical Association (AMA) Medical Education Group during 2013.

THE COUNCIL ON MEDICAL EDUCATION

The Council on Medical Education (ama-assn.org/go/councilmeded) assists in the development of policy on medical education by recommending educational policies to the AMA House of Delegates through the AMA Board of Trustees.

In 2013, the Council submitted nine reports for consideration by the House of Delegates at the Annual Meeting and one report at the Interim Meeting. As part of its work, the Council worked with leaders of the following organizations to address important issues in medical education:

- Association of American Medical Colleges (AAMC) (including its Physician Workforce Meeting)
- American Board of Medical Specialties (ABMS)
- Accreditation Council for Graduate Medical Education (ACGME)
- Accreditation Council for Continuing Medical Education (ACCME)
- Accreditation Review Commission on Education for the Physician Assistant (ARC-PA)
- Coalition for Physician Accountability
- Commission on Accreditation of Allied Health Education Programs (CAAHEP)
- Council of Deans Administrative Meeting
- Federation of State Medical Boards (FSMB)
- AMA/American Hospital Association Joint Leadership Conference
- National Commission on Certification of Physician Assistants (NCCPA)
- Canadian Association/AMA Meeting
- Liaison Committee on Medical Education (LCME)
- National Board of Medical Examiners (and its Advisory Committee for Medical School Programs) (NBME)
- National Resident Matching Program (NRMP)

As part of its role in monitoring professional standards in medical education and credentialing, the Council reviews and comments on proposed changes in medical education accreditation, licensure and certification standards. In 2013, the Council reviewed and commented on the following:

- Accreditation Council for Continuing Medical Education Proposal for Simplifying and Evolving the Accreditation Requirements and Process
- Accreditation Council for Graduate Medical Education - 57 sets of new or revised program requirements
- American Academy of Pediatrics (AAP) Committee on Pediatric Workforce Policy Statements on Pediatric Workforce and Enhancing Pediatric Workforce Diversity and Providing Culturally Effective Pediatric Care: Implications for Practice, Education and Policy Making
- American Board of Medical Specialties (ABMS) Disciplinary Action Notification Service (DANS) Working Group Report
- ABMS regarding the Committee on Certification, Subcertification, and Maintenance of Certification (COCERT) Work Group on Subspecialization
- ABMS Proposed Standards for the ABMS Program for Maintenance of Certification (MOC) 2015

- Council on Graduate Medical Education's (COGME) 21st Report, Improving Value in Graduate Medical Education
- Federation of State Medical Boards (FSMB) Draft Report of the Special Committee on Reentry for the Ill Physician

The Council assisted the AMA Board of Trustees by recommending qualified AMA members to serve on boards and committees of organizations involved in medical education, accreditation and certification. During 2013, the Council vetted 84 member candidates and made recommendations for over 24 different AMA appointments.

In addition, the Council hosted two medical education stakeholders' forums in conjunction with the Annual and Interim Meetings that convened leaders from state and national organizations to discuss critical issues affecting medical education. The A-13 session focused on the impact of the ACA on medical education and the I-13 session addressed the GME funding crisis in terms of how it may impact medical education and the physician workforce in the future.

In June 2013, the Council commenced an aggressive year-long plan to advance the role and credibility of the CME as respected content experts, thought leaders on medical education, contributors to AMA policy development, disseminators of information and best practices related to the AMA strategic initiatives, and advisors on strategy and program development along the continuum of medical education. The plan resulted in a reorganization of the Council's committees; initiation of two task forces to address the implementation of competency-based medical education frameworks and the alignment of accreditation and certification processes across the continuum of medical education; engagement of representatives from relevant sections to gather perspectives on the Council's work; and identification of specific charges, goals, tasks and timelines for each CME task force and committee.

SECTION ON MEDICAL SCHOOLS

The SMS (ama-assn.org/go/sms) provides the leaders and faculty of all medical schools accredited by the LCME or American Osteopathic Association (AOA) a voice in House of Delegates deliberations and offers a forum for discussing and developing policies on medical education and national research and health care issues.

During the Annual and Interim Meetings, the Section provides education programs on issues of importance to the academic community. In June 2013, the Section held an educational program on planned medical school innovations, featuring representatives of five of the 11 awardees of the AMA's Accelerating Change in Medical Education initiative. Also featured was a presentation on how to administer and ensure safety and ethics in international experiences for medical students.

In November 2013, the meeting's educational focus was stewardship of health care resources and how to teach students and residents about this key concern facing both academic medicine and health care. Presenters discussed how medical schools and residency programs can ensure that physicians-in-training understand the need to consider cost of care in clinical decisions and avoid overuse and misuse of resources. Presenters included Steven Weinberger, MD, Executive Vice President and CEO of the American College of Physicians, and Jacqueline Bello, MD, representing the CME. Reactors to the presentations were two leaders from the Accelerating Change in Medical Education consortium schools.

Increasing AMA membership among academic physicians continues to be a top priority for the AMA-SMS and its governing council. The governing council and staff are assisting in promoting an AMA academic leadership group membership program (which was in place at 21 medical schools by early 2014) that offers special group membership pricing to the medical school leadership.

In addition, in June 2013 the SMS approved a proposed resolution linking graduate medical education funding to quality outcomes; this was subsequently forwarded to the AMA House of Delegates and adopted (as amended) as new AMA policy.

Finally, the SMS Governing Council, at its November 2013 meeting, held a strategic planning session to help direct its future plans and to ensure that it continues to serve as a key link between academic physicians and the AMA and HOD.

MEDICAL EDUCATION GROUP ACTIVITIES

Accelerating Change in Medical Education

The AMA selected the following 11 US medical schools to receive funding as part of its Accelerating Change in Medical Education initiative aimed at transforming the way future physicians are trained.

- Indiana University School of Medicine
- Mayo Medical School
- NYU School of Medicine
- Oregon Health & Science University School of Medicine
- Penn State College of Medicine
- The Brody School of Medicine at East Carolina University
- The Warren Alpert Medical School of Brown University
- University of California, Davis School of Medicine
- University of California, San Francisco School of Medicine
- University of Michigan Medical School
- Vanderbilt University School of Medicine

The Accelerating Change in Medical Education Request for Proposals was launched in January of 2013, and over 80% of eligible medical schools submitted a Letter of Intent. After a comprehensive, rigorous selection process involving national medical education experts, the 11 schools above were chosen to carry out bold, innovative projects. The projects encompass many educational innovations, including models for competency-based student progression, total student immersion within the health care system from the first day of medical school, and the increased use of health IT and virtual patients.

The AMA will provide approximately \$1 million to each school over five years to fund the educational innovations envisioned by each institution. The grant cycle officially began September 1, 2013. A critical component of the AMA's initiative is the establishment of a Learning Consortium with the selected schools to rapidly disseminate best practices to other medical and health profession schools. This Consortium met for the first time face-to-face on October 3, 2013 in Chicago to share information and begin to establish common goals and outcomes. Numerous Interest Groups were developed to connect schools around shared interests and to increase the sample size for selected innovations. The Interest Groups include systems-based practice, competency-based assessment/milestones, evaluation, population health, faculty development, technology and organizational change.

Directly after the Consortium meeting, the AMA Accelerating Change in Medical Education Conference was held October 4-5, 2013, in Chicago. The conference brought together nearly 200 leaders in medical education from across the nation to discuss needed changes to bridge the gap between the training of medical students and the needs of our health care system. It also gave attendees a chance to learn about the grant projects supported by the Accelerating Change in Medical Education initiative. Podcasts and presentations from this event can be found at ama-assn.org/sub/accelerating-change/conference.shtml.

More information about the initiative is available at changemed.org.

The Learning Environment Study

In 2013, the AMA also continued its work on a study of the medical education learning environment through a broad consortium of 27 medical schools nationwide and in Canada, with data being collected from approximately 4,800 medical students. Work is ongoing to identify factors in the learning environment that either inhibit or promote the acquisition of professional values and the demonstration of professional behaviors by medical students and resident physicians. The longitudinal and multi-institutional design of the LES will yield data on the student experience throughout the four years of medical school and allow for comparison across varying medical education learning environments with regard to educational outcomes. Two meetings of the Learning Environment Study were held in 2013, and work groups communicated regularly to begin analysis on issues such as ways of coping, empathy and tolerance of ambiguity.

Reference Committee Support

As part of the AMA's work in addressing these and other critical issues in medical education, staff supports and coordinates the work of Reference Committee C at the Annual Meeting of the AMA House of Delegates and Reference Committee K at the Interim Meeting. This work helps ensure that AMA policy and activities reflect the needs of academic physicians as well as medical students, resident/fellow physicians, and patients.

Communications

The monthly email newsletter AMA MedEd Update, distributed free to 30,000 subscribers, provides news, information and updates on medical education activities at the AMA and other organizations. With the release of the AMA's Accelerating Change in Medical Education initiative and request for proposals in 2013, the newsletter has become a key communications venue for sharing information with the medical education community on the progress of this key AMA strategic focus area.

Undergraduate Medical Education

The LCME, jointly sponsored by the AMA and the AAMC, is responsible for accrediting medical education programs in the United States. In late 2012 the two organizations officially signed a memorandum of understanding (MOU), creating an LCME Council to provide formal joint guidance for administrative aspects of the organization. In 2013 the LCME Council began meeting and developing working policy and procedure. The LCME also jointly accredits medical schools in Canada working with the Committee on the Accreditation of Canadian Medical Schools (CACMS), in Canada. Although the LCME and CACMS have been collaborating closely for years for joint accreditation, in 2013 the LCME and CACMS negotiated and signed a formal MOU codifying procedures for the accreditation of Canadian medical schools.

During 2013, the LCME completed the final stages of a thorough evaluation and restructuring of its accreditation standards. Aiming to reduce the burden of accreditation and improve efficiency and a focus on measures of effectiveness, the new format moves from 132 individual standards to 12 standards with a total of 94 elements. With a guiding principle of "Not as onerous, but just as rigorous," the new standards contain the same requirements but have less redundancy and are written in a clearer, declarative format. The new accreditation standards were approved by the LCME in 2014; they are posted on the LCME website and are in effect for schools with reviews during the 2015-2016 academic year. Along with new standards, the LCME has streamlined the self-study materials and is working on aligning and streamlining other supporting documents, data collection, and data reporting.

At the end of 2013, a total of 141 medical schools held preliminary, provisional, or full accreditation status in the United States. The LCME accredits 17 medical schools in Canada jointly with the CACMS. In addition, five developing US medical schools have applied to be considered for LCME accreditation. Information on developing medical schools is available at lcme.org.

In 2013, the LCME completed an application for the World Federation of Medical Education recognition process. The LCME is regarded as a world-wide leader in medical education accreditation. Consequently, the LCME has been increasingly consulted by foreign and international organizations for its expertise in developing accreditation systems.

Under the auspices of the LCME, annual surveys are sent to the deans of all LCME-accredited US medical schools. The 2013 surveys had a 100% response rate. The surveys allow the LCME to track trends related to medical school finances, medical education costs, medical student debt burden, and the curriculum and evaluation methods used in medical schools. Data from the survey are published as Appendix tables in the annual medical education issue of Journal of the American Medical Association (JAMA) and shared with members of various stakeholder groups on request.

Graduate Medical Education

The AMA works to ensure the quality of graduate medical education and the appropriate number and mix of physicians. For example, FREIDA Online®, an Internet database with information on more than 9,600 ACGME-accredited and ABMS board-approved GME programs and over 4,000 GME teaching institutions, is a popular

source of information for medical students. During 2013, the AMA released a major enhancement to FREIDA Online, adding intuitive and keyword searches, maps of program locations, mobile-optimization and additional features available only to AMA members. In the three months since the release in mid-October 2013, the new version of FREIDA Online received over 186,000 visits from 55,000 unique visitors, generating 2.5 million page views. Furthermore, the AMA (in collaboration with the AAMC) administered the National GME Census, which collects key residency program and resident/fellow data; these data were published in the medical education issue of *JAMA* and via FREIDA Online. Finally, staff developed and published new editions of the Electronic State-level GME Data and State Medical Licensure Requirements and Statistics.

The AMA supported H.R. 297, the “Children’s Hospital GME Support Reauthorization Act of 2013,” and S.577 and H.R. 1180, the “Resident Physician Shortage Reduction Act” in 2013, and in August 2013, the AMA launched a national “Save GME Action Week” to raise awareness about the cap on funding for residency training programs. Students from over 50 medical schools across 20 states met with their Representatives and Senators advocating for GME funding and seeking ways to combat pending physician shortages. The AMA also expanded its Save GME website (SaveGME.org) and began issuing bands that can be worn on stethoscopes as a symbol of our GME campaign. These advocacy efforts have generated significant support, resulting in over 25,000 letters urging lawmakers to protect GME funding.

Continuing Physician Professional Development (CPPD)

The Division of CPPD (ama-assn.org/go/cppd) provides support to the Council on Medical Education in relation to continuing medical education (CME) policies and trends. It also staffs the Continuing Medical Education/Maintenance of Certification/Maintenance of Licensure (CME/MOC/MOL) Committee of the Council. To ensure effective liaison to key continuing medical education organizations, CPPD staff hold committee/leadership appointments in six such organizations, perform manuscript reviews for three peer reviewed journals and represent the AMA in various other organizations.

The Council has delegated responsibility for administering the AMA’s accredited CME program to Educational Services within the AMA. CPPD staff actively participates in the work of the AMA Program Committee which oversees the AMA CME Program and collaborates with Educational Services. The Council keeps informed on the AMA’s CME program through the regular updates provided to the CME/MOC/MOL Committee by the director of the division and the review and approval of the annual CME program report developed by Educational Services. In 2013, the updates included information on the ACCME reaccreditation process. The CME/MOC/MOL committee also reviewed and contributed to the AMA’s reaccreditation self-study prior to its submission to the ACCME.

Approximately 208,000 certificates were awarded to physicians for participating in CME activities offered by the AMA in 2013. The AMA currently awards *AMA PRA Category 1 Credit*[™] for live activities, enduring materials (both print-based and online), journal-based CME activities, manuscript review and Performance Improvement CME activities. In addition, members of the CPPD team participated in the further development of the AMA’s online learning management system. By the end of 2013, 61 CME activities were available via the online learning center.

CPPD staff served as faculty in webinars that were developed by the Association of American Medical Colleges, the Federation of State Medical Boards and the Illinois Alliance for Continuing Medical Education. In addition, members of the CPPD team represented the AMA by providing presentations at meetings convened by, among others, the European Union of Medical Specialists, Accreditation Council for Continuing Medical Education, Alliance for Continuing Education in the Health Professions, Illinois State Medical Society, Kansas Medical Society/Missouri State Medical Association, Ohio State Medical Association and South Carolina Medical Association.

CPPD also hosted the sixth annual roundtable meeting with representatives from state medical societies recognized by the ACCME as accreditors of intrastate CME providers. This meeting provided an opportunity to discuss several issues related to the AMA PRA credit system, including certifying the learning associated with teaching medical students and residents as a live activity, the AMA PRA credit system pilots, progress/updates on Maintenance of Licensure and Maintenance of Certification, and the Sunshine Act, as well as updates on CEJA reports and opinions relevant to CME, the AMA strategic initiatives and AMA House of Delegates resolutions and reports.

In 2013 it was announced that the National Task Force on CME Provider Industry Collaboration, which had been staffed by the AMA, ceased operations. The Fact Sheets that were developed by the Task Force remain available to interested parties.

The Council approved an amendment to the agreement with the Royal College of Physicians and Surgeons of Canada (RCPSC) effective January 1, 2014. The amendment adds the Canadian medical school University Offices of CME, recognized by the RCPSC, to the list of organizations covered by the agreement. The agreement allows for physicians to request the AMA for conversion of RCPSC CME Credits awarded by the covered institutions to *AMA PRA Category 1 Credit™*.

In addition, CPPD continued to work closely with the AMA's Washington, DC, office on issues related to the Risk Evaluation and Mitigation Strategy (REMS) associated with opioids and on "Open Payments," which is the term CMS is currently using when referencing the Physician Payment Sunshine Act.

2. COUNCIL ON MEDICAL EDUCATION SUNSET REVIEW OF 2004 HOUSE POLICIES

Reference committee hearing: see report of [Reference Committee C](#).

HOUSE ACTION: RECOMMENDATIONS ADOPTED AND REMAINDER OF REPORT FILED

At its 1984 Interim Meeting, the House of Delegates established a sunset mechanism for House policies (Policy G-600.110). Under this mechanism, a policy established by the House ceases to exist after 10 years unless action is taken by the House to retain it. The objective of the sunset mechanism is to help ensure that the AMA Policy Database is current, coherent, and relevant. By eliminating outmoded, duplicative, and inconsistent policies, the sunset mechanism contributes to the ability of the AMA to communicate and promote its policy positions. It also contributes to the efficiency and effectiveness of House of Delegates deliberations.

At its 2012 Annual Meeting, the House amended Policy G-600.110, which now reads as follows:

1. As the House of Delegates adopts policies, a maximum ten-year time horizon shall exist. A policy will typically sunset after ten years unless action is taken by the House of Delegates to retain it. Any action of our AMA House that reaffirms or amends an existing policy position shall reset the sunset "clock," making the reaffirmed or amended policy viable for another 10 years.
2. In the implementation and ongoing operation of our AMA policy sunset mechanism, the following procedures shall be followed: (a) Each year, the Speakers shall provide a list of policies that are subject to review under the policy sunset mechanism; (b) Such policies shall be assigned to the appropriate AMA Councils for review; (c) Each AMA council that has been asked to review policies shall develop and submit a report to the House of Delegates identifying policies that are scheduled to sunset; (d) For each policy under review, the reviewing council can recommend one of the following actions: (i) Retain the policy; (ii) Sunset the policy; (iii) Retain part of the policy; or (iv) Reconcile the policy with more recent and like policy; (e) For each recommendation that it makes to retain a policy in any fashion, the reviewing Council shall provide a succinct, but cogent justification (f) The Speakers shall determine the best way for the House of Delegates to handle the sunset reports.
3. Nothing in this policy shall prohibit a report to the HOD or resolution to sunset a policy earlier than its 10-year horizon if it is no longer relevant, has been superseded by a more current policy, or has been accomplished.
4. The AMA Councils and the House of Delegates should conform to the following guidelines for sunset: (a) when a policy is no longer relevant or necessary; (b) when a policy or directive has been accomplished; or (c) when the policy or directive is part of an established AMA practice that is transparent to the House and codified elsewhere such as the AMA Bylaws or the AMA House of Delegates Reference Manual: Procedures, Policies and Practices.
5. The most recent policy shall be deemed to supersede contradictory past AMA policies.

6. Sunset policies will be retained in the AMA historical archives.

The Council on Medical Education's recommendations on the disposition of the 2004 House policies that were assigned to it are included in the Appendix to this report.

RECOMMENDATION

The Council on Medical Education recommends that the House of Delegates policies that are listed in the Appendix to this report be acted upon in the manner indicated and the remainder of this report be filed.

APPENDIX - Recommended Actions on 2004 and Other Related House of Delegates Policies

<i>Policy Number</i>	<i>Title</i>	<i>Recommended Action</i>
H-40.979	Reserve Physicians In-Training	Still relevant; rescind and integrate into H-40.983.
H-40.983	Active and Reserve Physicians	Retain, still relevant; revise to integrate H-40.979, as follows: 1) Change title to Active and Reserve Physicians and <u>Physicians In-Training</u> ; 2) Add a new item, to read: <u>“(3) Our AMA supports the position that, at the time of national emergency, residents and fellows called to support their country in military service should be placed, when possible, in positions consistent with their specialty and level of training.”</u>
H-255.993	Evaluation of Foreign Medical Schools	Rescind; this is already reflected in H-255.988, “Report of the Ad Hoc Committee on Foreign Medical Graduates,” which reads, in part, “(4) The AMA continues to support cooperation in the collection and analysis of information on medical schools in nations other than the U.S. and Canada.”
H-255.995	International Medical Graduates	Retain; still relevant.
H-275.929	Additions to United States Medical Licensure Examination and Comprehensive Osteopathic Medical Licensure Examination	Retain; still relevant.
H-275.930	Opposition to Clinical Skills Examinations for Physician Medical Relicensure	Retain; still relevant.
H-275.945	Self-Incriminating Questions on Applications for Licensure and Specialty Boards	Retain; still relevant.
H-275.953	The Grading Policy for Medical Licensure Examinations	Retain; still relevant.
H-275.970	Licensure Confidentiality	Retain; still relevant.
H-275.988	Identifying Persons with Illegally Obtained Medical Degrees	Retain; still relevant.
H-295.880	Service Learning in Medical Education	Retain; still relevant.
H-295.911	Medical Student Education on Termination of Pregnancy Issues	Still relevant; rescind and integrate into related Policy H-295.923.
H-295.923	Medical Training and Termination of Pregnancy	Retain; still relevant; edit to include H-295.911, as follows: “The AMA supports the education of medical students, residents and young physicians about the need for physicians who provide termination of pregnancy services, and about the medical and public health importance of access to safe termination of pregnancy, <u>and the medical, ethical, legal and psychological principles associated with termination of pregnancy, although observation of, attendance at, or any direct or indirect participation in an abortion should not be required.</u> ”
H-295.925	Restriction of Medical Staff Appointments	Still relevant; rescind and append to H-295.929, “Faculty/Staff Appointments at More Than One Medical School,” to read as follows: “The AMA encourages medical schools that currently do not permit volunteer faculty members to hold

<i>Policy Number</i>	<i>Title</i>	<i>Recommended Action</i>
		appointments at more than one medical school to review this policy, to ensure that it is in the best interests of medical education and program integrity. <u>Nonsalaried faculty members of medical schools should be allowed to hold concurrent appointments at more than one medical school as long as the individual physician agrees to carry out all responsibilities assigned by each medical school.</u>
H-295.942	Providing Dental and Vision Insurance to Medical Students and Resident Physicians	Retain, still relevant; the title is more specific than the actual content of the policy, however, so revise to read as follows: "Providing Dental and Vision Insurance Coverage to <u>for</u> Medical Students and Resident Physicians"
H-295.983	Extramural Clerkships and Early Career Decisions	Retain; still relevant.
H-295.985	Humanism in Graduate Medical Education	Retain; still relevant.
H-295.989	Computer and Information Systems in Medical Education	Rescind; no longer relevant.
H-300.954	Reduced Fees for Retired Physicians to Attend Continuing Medical Education Courses	Still relevant; rescind and append to D-300.994, "Reduced Continuing Medical Education (CME) Fees for Retired Physicians," to read as follows: "Our AMA will support <u>reduced registration fees for retired physicians at all continuing medical education (CME) programs and encourages CME providers to consider a reduced fee policy for retired physicians.</u> "
H-300.956	Practice Management Training	Rescind; still relevant, but reflected in greater detail in H-295.864, "Systems-Based Practice Education for Medical Students and Resident/Fellow Physicians" and in H-295.924, "Future Directions for Socioeconomic Education."
H-300.957	Promoting Primary Care Services Through Continuing Medical Education	Retain; still relevant.
H-305.931	State Support of Public Medical School Education	Rescind. Section 1 of the policy is no longer relevant; there are no such legislative efforts pending or anticipated; section 2 of the policy is already reflected in other AMA policy in support of loan repayment programs.
H-305.950	Fairness in Publication of Names of Loan Defaulters	Still relevant; rescind and append to H-305.982, "Student Loan Repayment Defaults," to read as follows: "The AMA encourages the HHS Inspector General to pursue all legal avenues within his jurisdiction to withhold Medicare and Medicaid reimbursements, research grant awards, and salaries or stipends from physicians who have defaulted on repayments of student loans, unless a physician can prove hardship. <u>The AMA opposes the selective publication of names of defaulters on federally funded student loans.</u> " Note: From FY 1978 through FY 1998, the Federal Health Education Assistance Loan (HEAL) Program insured loans made by participating lenders to eligible graduate students in schools of medicine, osteopathy, and other health fields. Recipients could refinance their HEAL loans from FY 1994 through FY 2004. A list of defaulted borrowers is posted on the HRSA website.
H-305.986	Student Loan Consolidation	Rescind; already reflected in other AMA policy, such as D-305.978, "Mechanisms to Reduce Medical Student Debt," and D-305.970, "Proposed Revisions to AMA Policy on Medical Student Debt." In addition, the organization referred to in the policy

<i>Policy Number</i>	<i>Title</i>	<i>Recommended Action</i>
		(the Student Loan Marketing Association) is now Sallie Mae.
H-310.989	Information on Shared Residency Positions	Still relevant; rescind and append to H-310.990, as shown below.
H-310.990	Support of Shared Schedule Residency Positions	Retain with edits, as shown: “H-310.990 Support of Shared Schedule Residency Positions: The AMA supports the concept of shared schedule residency positions <u>and the continued collection and publication of data on these positions</u> , and encourages residency program directors to offer such positions where feasible.”
H-365.994	Funding of Educational Resource Centers Program	Rescind; policy no longer needed. This federal program, founded in 1977, is still in existence and offers a significant number of opportunities nationwide: cdc.gov/niosh/oep/centers.html
H-420.984	Paternity Leave	Rescind; still relevant, but covered in more detail in H-310.912, “Residents and Fellows’ Bill of Rights,” and H-310.999, “Guidelines for Housestaff Contracts or Agreements.”
HOUSE OF DELEGATES’ DIRECTIVES		
D-275.979	Non-Physician “Fellowship” Programs	Retain; still relevant.
D-275.981	Potential Impact of the USMLE Step 2 CS and COMLEX-PE on Undergraduate and Graduate Medical Education	Retain in part, as follows: “Our AMA will: (1) continue to closely monitor the implementation of the USMLE Step 2 CS and the COMLEX-USA Level 2-PE, collecting data on initial and final pass rates, delays in students starting residency training due to scheduling of examinations, economic impact on students, and the potential impact of ethnicity on passing rates; (2) inform residency program directors of the potential impact of the implementation of the USMLE Step 2 CS and the COMLEX-USA Level 2-PE by distributing copies of this report to all program directors; and (3) encourage residency program directors to proactively evaluate their access to resources needed to assist resident physicians who have not passed these examinations to remediate.”
D-295.958	Support of Business of Medicine Education for Medical Students	Rescind; still relevant, but reflected in greater detail in H-295.864, “Systems-Based Practice Education for Medical Students and Resident/Fellow Physicians,” H-295.924, “Future Directions for Socioeconomic Education,” and E-9.0652, “Physician Stewardship of Health Care Resources.”
D-295.998	Teaching Professionalism Across the Continuum of Medical Education	Rescind; this is still relevant, but reflected in D-295.983, “Fostering Professionalism During Medical School and Residency Training,” which reads, in part: “(1) Our AMA, in consultation with other relevant medical organizations and associations, will work to develop a framework for fostering professionalism during medical school and residency training ...” and “(2) Our AMA, along with other interested groups, will continue to study the clinical training environment to identify the best methods and practices used by medical schools and residency programs to fostering the development of professionalism.”
D-300.988	Implications of the “Stark II” Regulations for Continuing Medical Education	Retain; still relevant.
D-300.989	Developing a Standardized Letter of Agreement for Use by Accredited CME Programs When Requesting Commercial Support	Rescind; no longer needed. Also, the Accreditation Council for Continuing Medical Education website can be used by providers if desired: accme.org/news-publications/

<i>Policy Number</i>	<i>Title</i>	<i>Recommended Action</i>
		publications/tools/sample-written-agreement-commercial-support.
D-305.977	Deductibility of Medical Student Loan Interest	Retain; still relevant; the Medical Student Section points to this goal in its advocacy materials on the subject of student debt: ama-assn.org/resources/doc/mss/student-debt-mss-advocacy.pdf .
D-305.982	Long Term Solutions to Medical Student Debt	Rescind; already accomplished; also, reflected in D-305.975, "Long-Term Solutions to Medical Student Debt."
D-310.979	International Medical Graduate Application for National Resident Matching Program	Rescind; directive accomplished.
D-310.980	Increase in ACGME Fees	Retain; still relevant.
D-310.982	Protecting the Privacy of Physician Information Held by the ACGME	Retain; still relevant.
D-310.983	Measure Effectiveness of AMA Anti-Discrimination Policy	Rescind; reflected in D-255.982, "Oppose Discrimination in Residency Selection Based on International Medical Graduate Status" and H-255.988, "Report of the Ad Hoc Committee on Foreign Medical Graduates."

APPENDIX

H-40.979 Reserve Physicians In-Training

Our AMA supports the position that, at the time of national emergency, residents and fellows called to support their country in military service should be placed, when possible, in positions consistent with their specialty and level of training. (Res. 67, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CME Rep. 2, I-04)

H-40.983 Active and Reserve Physicians

(1) Our AMA requests the Residency Review Committees and Specialty Boards to develop flexible policies to ensure that (a) resident physicians and fellows who are members of the active or reserve components of the uniformed services of the United States retain their academic and training status within their respective training programs during periods of reserve activation or active duty with the uniformed services; and (b) active duty or deployment time with the uniformed services during a residency or fellowship should be credited toward the usual training period for eligibility for matriculation and Board examinations when the trainee's experiences have been educationally appropriate. (2) Our AMA strongly encourages state licensing boards to waive requirements for continuing medical education credits for physicians during periods of reserve or national guard activation or active duty with the uniformed services. (Res. 187, I-90; Modified: Sunset Report, I-00; Reaffirmed: CME Rep. 2, I-04)

H-255.993 Evaluation of Foreign Medical Schools

The AMA continues to support the efforts of appropriate organizations to gather information that will assist state licensing authorities in evaluating foreign medical schools. (Sub. Res. 56, A-84; Reaffirmed by CLRPD Rep. 3 - I-94; Reaffirmed: CME Rep. 2, A-04)

H-255.995 International Medical Graduates

The AMA believes that reduced requirements for licensure should not be applied under any circumstances to graduates of foreign medical schools. (Res. 23, A-82; Reaffirmed: CLRPD Rep. A, I-92; Modified: CME Rep. 5, A-04)

H-275.929 Additions to United States Medical Licensure Examination and Comprehensive Osteopathic Medical Licensure Examination

Our AMA opposes additions to the United States Medical Licensing Examination and Comprehensive Osteopathic Medical Licensure Examination that lack predictive validity for future performance as a physician. (Res. 308, A-04)

H-275.930 Opposition to Clinical Skills Examinations for Physician Medical Relicensure

Our AMA: (1) opposes clinical skills examinations for the purpose of physician medical relicensure; (2) reaffirms its support for continuous quality improvement of practicing physicians, and supports research into methods to improve clinical practice, including practice guidelines; and (3) continues to support the implementation of quality improvement through local professional, non-governmental oversight. (Res. 307, A-04)

H-275.945 Self-Incriminating Questions on Applications for Licensure and Specialty Boards

The AMA will: (1) encourage the Federation of State Medical Boards and its constituent members to develop uniform definitions and nomenclature for use in licensing and disciplinary proceedings to better facilitate the sharing of information; (2) seek clarification of the application of the Americans with Disabilities Act to the actions of medical licensing and medical specialty

boards; and (3) until the applicability and scope of the Americans with Disabilities Act are clarified, will encourage the American Board of Medical Specialties and the Federation of State Medical Boards and their constituent members to advise physicians of the rationale behind inquiries on mental illness, substance abuse or physical disabilities in materials used in the licensure, reregistration, and certification processes when such questions are asked. (BOT Rep. 1, I-933; CME Rep. 10 - I-94; Reaffirmed: CME Rep. 2, A-04)

H-275.953 The Grading Policy for Medical Licensure Examinations

(1) The AMA's representatives to the ACGME are instructed to promote the principle that selection of residents should be based on a broad variety of evaluative criteria, and to propose that the ACGME General Requirements state clearly that residency program directors must not use NBME or USMLE ranked passing scores as a screening criterion for residency selection. (2) The AMA adopts the following policy on NBME or USMLE examination scoring: (a) Students receive "pass/fail" scores as soon as they are available. (If students fail the examinations, they may request their numerical scores immediately.) (b) Numerical scores are reported to the state licensing authorities upon request by the applicant for licensure. At this time, the applicant may request a copy of his or her numerical scores. (c) Scores are reported in pass/fail format for each student to the medical school. The school also receives a frequency distribution of numerical scores for the aggregate of their students. (CME Rep. G, I-90; Reaffirmed by Res. 310, A-98; Reaffirmed: CME Rep. 3, A-04)

H-275.970 Licensure Confidentiality

The AMA (1) encourages specialty boards, hospitals, and other organizations involved in credentialing, as well as state licensing boards, to take all necessary steps to assure the confidentiality of information contained on application forms for credentials; (2) encourages boards to include in application forms only requests for information that can reasonably be related to medical practice; (3) encourages state licensing boards to exclude from license application forms information that refers to psychoanalysis, counseling, or psychotherapy required or undertaken as part of medical training; (4) encourages state medical societies and specialty societies to join with the AMA in efforts to change statutes and regulations to provide needed confidentiality for information collected by licensing boards; and (5) encourages state licensing boards to require that, if an applicant has had psychiatric treatment, the physician who has provided the treatment submit to the board an official statement that the applicant's current state of health does not interfere with his or her ability to practice medicine. (CME Rep. B, A-88; Reaffirmed: BOT Rep. 1, I-933; CME Rep. 10 - I-94; Reaffirmed: CME Rep. 2, A-04)

H-275.988 Identifying Persons with Illegally Obtained Medical Degrees

The AMA supports appropriate efforts of private and governmental agencies in identification of persons possessing illegally obtained medical degrees. (Res. 43, A-84; Reaffirmed by CLRPD Rep. 3 - I-94; Reaffirmed: CME Rep. 2, A-04)

H-295.880 Service Learning in Medical Education

Our AMA will support the concept of service learning as a key component in medical school and residency curricula, and that these experiences should include student and resident collaboration with a community partner to improve the health of the population. (Res. 321, A-04)

H-295.911 Medical Student Education on Termination of Pregnancy Issues

The AMA encourages education on termination of pregnancy issues so that medical students receive a satisfactory knowledge of the medical, ethical, legal and psychological principles associated with termination of pregnancy, although observation of, attendance at, or any direct or indirect participation in an abortion should not be required. (Res. 304, I-96; Reaffirmed: CME Rep. 2, A-06)

H-295.923 Medical Training and Termination of Pregnancy

The AMA supports the education of medical students, residents and young physicians about the need for physicians who provide termination of pregnancy services and about the medical and public health importance of access to safe termination of pregnancy. (Res. 315, I-94; Reaffirmed: CME Rep. 2, A-04)

H-295.925 Restriction of Medical Staff Appointments

AMA policy states that nonsalaried faculty members of medical schools be able to hold concurrent appointments at more than one medical school as long as the individual physician agrees to carry out all responsibilities assigned by each medical school. (Sub. Res. 812, A-94; Reaffirmed: CME Rep. 2, A-04)

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)

H-295.983 Extramural Clerkships and Early Career Decisions

The AMA (1) recognizes the essential role of the medical school faculty in the determination of the core clinical education of medical students; and (2) opposes resident recruitment practices which would interfere with scheduled core clinical clerkships at the student's medical school. (Res. 77, I-84; CLRPD Rep. 3 - I-94; Reaffirmed: CME Rep. 2, A-04)

H-295.985 Humanism in Graduate Medical Education

The AMA encourages medical schools and teaching hospitals to strengthen educational programs for undergraduates and resident physicians in recognizing and meeting the emotional needs of patients and their families. (Sub. Res. 154, A-84; Reaffirmed by CLRPD Rep. 3 - I-94; Reaffirmed: CME Rep. 2, A-04)

H-295.989 Computer and Information Systems in Medical Education

The AMA believes that, within the limits of its resources, including both finances and skilled personnel, each medical school should determine the methodology for, and the extent of the incorporation of, computer-based technology in its educational program. (CME Rep. B, A-84; Reaffirmed by CLRPD Rep. 3 - I-94; Reaffirmed: CME Rep. 2, A-04)

H-300.954 Reduced Fees for Retired Physicians to Attend Continuing Medical Education Courses

Our AMA encourages all providers of continuing medical education to consider a reduced fee policy for retired physicians. (Res. 319, A-96; Reaffirmation I-01; Reaffirmed: BOT Rep. 17, A-04)

H-300.956 Practice Management Training

The AMA continues to develop and encourage the use by medical schools and residency programs of curricula on medical practice management and the efficient and economical use of time and resources. (Res. 308, A-94; Reaffirmed: CME Rep. 2, A-04)

H-300.957 Promoting Primary Care Services Through Continuing Medical Education

The AMA urges accredited continuing medical education sponsors to promote and establish continuing medical education courses in performing, prescribing, interpreting and reinforcing primary care services. (Res. 311, A-94; Reaffirmed: CME Rep. 2, A-04)

H-305.931 State Support of Public Medical School Education

Our AMA (1) opposes any legislation that would require graduates of public medical schools to agree to practice in a particular locale as a condition of matriculation; and (2) strongly endorses and supports voluntary programs involving loan repayment, discounted tuition, or a tuition waiver for medical students who voluntarily agree to practice in particular locales or underserved areas. (Res. 708, I-04)

H-305.950 Fairness in Publication of Names of Loan Defaulters

The AMA opposes the selective publication of names of defaulters on federally funded student loans. (Res. 309, A-94; Reaffirmed: CME Rep. 2, A-04)

H-305.986 Student Loan Consolidation

The AMA supports the availability of opportunities for student loan consolidation, for example, through the Student Loan Marketing Association or a similar organization. (Res. 163, A-84; Reaffirmed by CLRPD Rep. 3 - I-94; Reaffirmed and Modified: CME Rep. 2, A-04)

H-310.989 Information on Shared Residency Positions

The AMA supports the continued collection and publication of data on shared schedule positions. (Sub. Res. 38, I-84; Reaffirmed by CLRPD Rep. 3 - I-94; Reaffirmed and Modified: CME Rep. 2, A-04)

H-310.990 Support of Shared Schedule Residency Positions

The AMA supports the concept of shared schedule residency positions and encourages residency program directors to offer such positions where feasible. (Res. 81, I-84; Reaffirmed by CLRPD Rep. 3 - I-94; Reaffirmed: CME Rep. 2, A-04)

H-365.994 Funding of Educational Resource Centers Program

The AMA supports adequate federal funding for the NIOSH's Education and Research Centers program, as an appropriate means to help ensure that a sufficient number of physicians trained in occupational medicine will be available to meet future needs. (BOT Rep. O, A-84; Reaffirmed by CLRPD Rep. 3 - I-94; Reaffirmed and Modified: CME Rep. 2, A-04)

H-420.984 Paternity Leave

The AMA supports the requirement by the Accreditation Council for Graduate Medical Education (ACGME) for maternity and paternity leave guidelines. (Sub. Res. 88, I-84; Reaffirmed by CLRPD Rep. 3 - I-94; Reaffirmed and Modified: CME Rep. 2, A-04)

D-275.979 Non-Physician "Fellowship" Programs

Our AMA will (1) 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; and (2) 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. (CME Rep. 4, I-04)

D-275.981 Potential Impact of the USMLE Step 2 CS and COMLEX-PE on Undergraduate and Graduate Medical Education

Our AMA will: (1) continue to closely monitor the implementation of the USMLE Step 2 CS and the COMLEX-USA Level 2-PE, collecting data on initial and final pass rates, delays in students starting residency training due to scheduling of examinations, economic impact on students, and the potential impact of ethnicity on passing rates; (2) inform residency program directors of the potential impact of the implementation of the USMLE Step 2 CS and the COMLEX-USA Level 2-PE by distributing copies of this report to all program directors; and (3) encourage residency program directors to proactively evaluate their access to resources needed to assist resident physicians who have not passed these examinations to remediate. (CME Rep. 4, A-04)

D-295.958 Support of Business of Medicine Education for Medical Students

Our AMA will encourage all US medical schools to provide students with a basic foundation in medical business, drawing upon curricular domains referenced in Undergraduate Medical Education for the 21st Century (UME-21), in order to assist students in fulfilling their professional obligation to patients and society in an efficient, ethical, and cost-effective manner. (Res. 305, A-04)

D-295.998 Teaching Professionalism Across the Continuum of Medical Education

Our AMA, through its relevant Councils and Sections, will develop plans and strategies for enhancing the teaching and learning of professionalism as part of medical education. (Res. 318, I-98; Reaffirmed: CME Report 2, A-08; Reaffirmation I-09)

D-300.988 Implications of the "Stark II" Regulations for Continuing Medical Education

Our AMA will (1) 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; and (2) 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. (CME Rep. 6, I-04)

D-300.989 Developing a Standardized Letter of Agreement for Use by Accredited CME Programs When Requesting Commercial Support

Our AMA will work with the Accreditation Council for Continuing Medical Education to develop a standardized letter of agreement to be used by all accredited providers when requesting commercial support and the use of the standardized letter of agreement will be incorporated into the accreditation Essentials. (Res. 318, A-04)

D-305.977 Deductibility of Medical Student Loan Interest

Our AMA will work toward 100% tax deductibility of medical student loan interest on federal and state income tax returns. (Res. 705, I-04)

D-305.982 Long Term Solutions to Medical Student Debt

Our AMA will: (1) explore membership in the American Council on Education and/or the Committee for Education Financing, in order to build our ties to the higher education community and report back by the 2004 Annual Meeting; (2) more aggressively publicize existing work done through the Coalition for Student Loan Fairness; (3) study and report back at the 2004 Interim Meeting on potential new sources of Graduate Medical Education funding and ways to increase resident salaries; (4) study and report back at the 2004 Interim Meeting on feasible strategies for creating new and/or expanded loan programs specifically for the health professions; (5) study and report back at the 2005 Annual Meeting on the feasibility of earmarking federal funds to undergraduate medical education for the purpose of reducing medical school tuition at public and private universities; (6) study and report back at the 2004 Interim Meeting on 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; and (7) study and report back at the 2005 Annual Meeting on appropriate methods for calculating the value of the clinical work performed by medical students and taking such calculations into account when determining the cost of educating a medical student. (Res. 848, I-03; Reaffirmation I-06)

D-310.979 International Medical Graduate Application for National Resident Matching Program

Our AMA will ask the Electronic Resident Application Service to review the pricing structure for applicants applying to numerous residency sites and specialties. (Res. 315, A-04)

D-310.980 Increase in ACGME Fees

Our AMA will work with the Accreditation Council for Graduate Medical Education to limit the increase of the ACGME fees. (Res. 311, A-04)

D-310.982 Protecting the Privacy of Physician Information Held by the ACGME

Our AMA will request the Accreditation Council for Graduate Medical Education and any other organization with a similar case and procedure log for resident physicians to (1) develop and implement a system to remove or sufficiently protect identifying data from individual physicians' data logs; and (2) adopt a policy not to disseminate any data specific to individual physicians without the written consent of the physician. (Res. 301, A-04)

D-310.983 Measure Effectiveness of AMA Anti-Discrimination Policy

Our AMA will continue to collect data on international medical graduate participation in graduate medical education, monitor trends, and disseminate the findings widely, for example, through publication in the annual Medical Education Issue of the Journal of the American Medical Association. (CME Rep. 7, A-04)

3. COMPETENCY-BASED MEDICAL EDUCATION ACROSS THE CONTINUUM OF EDUCATION AND PRACTICE

Reference committee hearing: see report of [Reference Committee C](#).

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

See Policy [D-295.317](#).

In 2013, the AMA Council on Medical Education formed a Competency Alignment Task Force to review and disseminate information about the current state of competency-based education across the medical education continuum and into practice. The overarching goal of the Task Force is to seek opportunities to accelerate change in medical education curriculum, pedagogy and competency-based learning. This preliminary report summarizes information from a review of the literature regarding the current state of competency-based medical education (CBME) in the health professions.

INTRODUCTION

After a comprehensive systematic review of the medical education definitions related to CBME, Frank et al. proposed the following definition of competency-based education based on recurring concepts in the literature over several decades:

Competency-based education is an approach to preparing physicians for practice that is fundamentally oriented to graduate outcome abilities and organized around competencies derived from an analysis of societal and patient needs. It deemphasizes time-based training and promises greater accountability, flexibility, and learner-centredness.¹

The term “competency” refers to the individual physician, while the term “accreditation” refers to the system to ensure that educational programs at each phase of the continuum teach the competencies at an appropriate level and in an appropriate sequence. CBME is growing across the health professions for a variety of reasons. The government and other payers are increasingly demanding that the profession demonstrate accountability for the competency of those they educate, license, certify and/or credential. To ensure that this need for accountability is met, demonstration and re-demonstration of professional competence have been demanded. This demand is a moving force behind Maintenance of Certification (MOC) and the principles of Maintenance of Licensure (MOL).

In 1999, the Accreditation Council for Graduate Medical Education (ACGME) and American Board of Medical Specialties (ABMS) adopted a set of competencies intended to assess resident and physician performance in six areas: patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice.² This project was originally developed for graduate medical

education (GME); each competency is made up of milestones for which residents are required to demonstrate proficiency as they progress through training. These same competency domains are now being used to evaluate medical students and attending physicians. (The ABMS and ACGME subsequently modified the patient care competency domain; it is now called patient care and procedural skills.)

Competencies in GME have been further broken down to subcompetencies or requisite knowledge, skills and attitudes representing the domains of the broader competencies. To further explicate learning objectives and expectations for learner performance along a developmental continuum, essential behavioral attributes, or milestones, within each competency domain are being further defined and are expected to be demonstrated at key points during the resident's education.^{3,4} For selected specialties, the concept of Entrustable Professional Activities (EPAs) has been developed in light of the difficulties in reliably measuring competencies. EPAs are work tasks that are independently executable, observable and measurable in their process and outcome.⁵ Faculty use EPAs to make decisions about the level of supervision required for individual trainees. As trainees attain various milestones, their attending supervisors can entrust them to function with more autonomy.

CBME focuses on the skills and progression of learning of an individual, promoting greater learner-centeredness and potentially allowing greater flexibility in the time required for training. Reducing the emphasis on time-based curricula design may allow physicians to acquire and demonstrate competency in new specialty areas.

This learner-centered approach could then replace or de-emphasize time-based curriculum frameworks. Time in a given level of education or training would no longer be the most important criterion for board eligibility or even medical school admission criteria or graduation. "Expertise is the ultimate goal of CBME and requires reflective practice."⁶

SUMMARY OF THE LITERATURE

Historically, the accreditation process for undergraduate medical education (UME) and GME favored a time-based system, with less focus on trainee competency and achievement of milestones during or at the completion of training. Implementation of competency-based education by the ACGME has subsequently led to a drive for competency-based learning in UME, but a lack of standardization in UME has slowed this transition. The 2011 release from the Liaison Committee on Medical Education (LCME) of the "Functions and Structure of a Medical School: Standards for Accreditation of Medical Education Programs Leading to the MD Degree" states that medical schools must provide the means for assessing student development of core competencies that are expected by the public and the profession.⁷

To provide a single, relevant infrastructure for curricular resources in the Association of American Medical Colleges' (AAMC) MedEdPORTAL and Curriculum Inventory and Reports (CIR) sites, the AAMC undertook a project to compile and compare a representative sample of competency frameworks from medicine (i.e., the continuum of physician of education, physician specialties, subspecialties, and other countries) to those of other health professions.⁸ This initiative represents a first step toward establishing a common taxonomy of competencies. The Physician Competency Reference Set (PCRS) will serve as an aggregation tool that allows the AAMC to collect and analyze data through the Curriculum Inventory about competency-based education and the use of expectations (competencies, objectives, milestones, EPAs, etc.) in medical education (aamc.org/initiatives/cir/about/348808/aboutpcrs.html). Possible reporting includes information on what competencies schools are incorporating into their curricula; where in their curricula schools are incorporating expectations and competencies; how schools are teaching and assessing competencies; and in what context and/or content competencies are being taught.

The University of California, San Francisco (UCSF) medical school has fully embraced competencies in its UME training programs, and curricula are being developed around them to ensure that trainees are prepared for residency.⁹ Other competency systems that have been formulated include those developed by the Canadian Medical Education Directions for Specialists (CanMEDS) 2005 and the Institute for International Medical Education. As competency-based training is an evolving field, some authors have provided criteria for specifically evaluating a given competency domain. These include focusing on end performance, creating goals that immediately reflect instruction, identifying measurable behaviors, setting goals that are achievable by all learners, and keeping learners informed of what is expected.¹⁰

There are several proposed models for competency-based assessment, and the 11 medical schools that were recently funded by the AMA's Accelerating Change in Medical Education initiative will integrate competency-based assessment into their respective curricula over the next five years. Several Canadian and US medical schools have begun offering three-year fast-track programs, some of which are focused specifically on primary care, while others assure a position in a specialty in the institution's GME training programs for fast-track students. Many of these programs, including New York University School of Medicine (NYUSOM), which is a recipient of the AMA funding initiative, are using competency-based assessment in UME and GME to prepare physicians in a shorter period of time. The NYUSOM will use an electronic portfolio and a virtual patient panel in order to teach and track skills within competency domains for students in the three-year program.¹¹ Another example of a portfolio-based tracking system has been implemented at the Cleveland Clinic Lerner College of Medicine of Case Western Reserve University (CWRU).¹² This program was first implemented in 2004 as a result of a joint venture between the Lerner College of Medicine and CWRU to train future physician-scientists in a five-year track. It is clear from these and other models that technology, electronic portfolios, virtual and simulated patient cases, and digital dashboards have become critical tools in assessing competency.

In addition, service-based learning and longitudinal clinical experiences are tools being used at medical schools to help students achieve competency in caring for unique populations and in the long-term management of chronic ailments. Many medical schools have implemented single or multi-year continuity clinics^{12,13,14,15} in order to give students the ability to participate in patient care over time. This reinforces didactic and clinical knowledge early and fills a needed niche as inpatient stays shorten, thereby limiting a learner's ability to experience the complete management of more complex diseases. It also instills a sense of personal responsibility to a patient population and allows trainees to improve multiple competencies while working with a familiar group of clinic patients. Continuity clinics have long been an aspect of many GME programs, but are a relatively new and evolving concept for UME.

SUMMARY OF CURRENTLY AVAILABLE VALID AND RELIABLE ASSESSMENTS OF COMPETENCIES

Early in the implementation of CBME, Carraccio and colleagues summarized the steps to achieving CBME.¹⁶ Two of the four steps identified involved assessment. First was the need to delineate the performance level expected for a particular competence. The next step is to identify how the attainment of that competence will be assessed. These assessment tools should be matched to the competency being evaluated to be most effective.

Developing assessment tools that are valid and reliable has been felt to be a significant challenge to the implementation of CBME.^{6, 17} The component of health professions education that has been most frequently and reliably assessed is that of knowledge acquisition as applied in various high stakes exams for licensure, certification and recertification. Assessments for the full spectrum of competence required for CBME must evaluate the integration of the various domains of the health profession, including knowledge to provide safe and effective care to patients. This generally requires multiple assessments of the learner, utilizing direct observations in the context of a range of simulated or real clinical activities. The latter requires that faculty consistently interpret their observations and evaluations of learners. Thus it requires significant faculty development to achieve reliable and valid ratings of learners.^{6,17,18}

The competencies required for providing patient care are necessarily complex. Reliability of assessments of these competencies can be improved by increased frequency of assessment. Assessments need to be built into the daily work done by the learners and teachers in the care of patients.⁶ Some specialties initially implementing the ACGME milestones have moved to define EPAs to provide a more all-inclusive and patient care-focused perspective on these complex competencies.

CBME requires assessment of learners along the training continuum toward the competence required to practice at the next level of training or to enter into unsupervised practice if at the end of formal training. Several tools for assessing areas of competence other than knowledge acquisition have been validated and found acceptable. Examples of these are Objective Structured Clinical Examinations (OSCE), Objective Structured Assessment of Technical Skills (OSATS), Mini-Clinical Evaluation Exercise (CEX), simulation-based scenarios, and multi-source evaluations.¹⁹ Performance on patient care processes and outcomes can be assessed for practicing physicians or advanced trainees practicing in certain venues somewhat independently.

Some perceive that assessment of competencies cannot be done unless the perfect evaluation instruments are available, which is not currently the case. Most would agree, however, that great progress can be made with current assessment tools, while always working to refine and improve them.

CONSIDERATIONS ACROSS THE CONTINUUM OF EDUCATION AND PRACTICE

In 2000, the ABMS and its 24 Member Boards adopted the MOC programs, which incorporated the six core competencies into a system of documentation of life-long learning and maintenance of clinical competence throughout physicians' careers by the diplomates of the ABMS Member Boards. The changes in each of these component areas have evolved over the years since 1999 so that the graduates of residency training and fellowship programs expect that evaluation in all of these domains will continue throughout their professional careers. For graduates of earlier eras, the establishment and maintenance of professional competence is a complex endeavor.²⁰

The ABMS organized MOC activities into the following four domains:

1. Licensure and Professional Standing
2. Lifelong Learning and Self-Assessment
3. Cognitive Expertise
4. Practice Performance Assessment

Early in the process, maintenance of a valid, unrestricted state license, often requiring providing documentation of continuing professional education activities, and taking a high-stakes exam at intervals, were the main requirements. Additional emphasis on identifying and addressing gaps in one's own medical knowledge or practice performance is now also required.

Board-certified physicians have had to pass high-stakes exams in addition to successfully completing GME training during the initial certification process. As a physician's career evolves, however, he/she may no longer practice within the full spectrum of the specialty in which he/she holds primary board certification. This is particularly true if the physician does fellowship training in a particular area. The subspecialty board generally also has requirements for maintaining certification. Some of these requirements may overlap sufficiently such that satisfying self-assessment and practice performance assessment activities may suffice for both. However, taking an exam on content that one does not use often or at all in one's practice, and for which the physician would use easily available electronic resources to update his/her knowledge base if such content were needed in patient care, is understandably daunting for many physicians. The ABMS Member Boards have begun to enhance their programs to be more authentic and relevant to practice.²¹ The AMA and the ABMS are also considering the need for mandatory, ongoing, and secure high-stakes examinations and exploring alternative ways to assess knowledge in a way that better integrates with other MOC elements and reflects the application of knowledge in patient care or other professional activities.

The requirements of MOC do not exist in a vacuum. Although specialty board certification remains a voluntary professional self-regulatory program independent of state medical licensure, the number of hospitals and other health care organizations that make board certification a key qualification, e.g., the Joint Commission and Centers for Medicare and Medicaid Services (CMS), continues to expand. Physicians are frequently asked to report quality data from their practices to payers, participate in group quality projects in their practices and/or hospitals, and undergo ongoing surveys of their professional competence and communication skills from their patients, peers and coworkers conducted by payers, hospitals and other aspects of the health care system.

Some of the data that these processes collect are reasonably valid and useful to physicians and might, with the physician's permission, be forwarded to his/her specialty board as demonstration of the physician's participation in ongoing assessment of his/her practice environment and commitment to improvement.¹⁹ Then only those diplomates who either do not have the opportunity or who chose not to participate in these group activities would need to perform individual projects. As most practice improvement activities involve many team members other than a particular physician, reporting ongoing activities in a practice or hospital would more accurately reflect systems-based practice improvement.

The AMA has adopted Principles for MOC that stress the importance of focusing on the competencies that physicians are utilizing to provide care to their patients. The AMA is engaged in ongoing discussions with the ABMS and its Member Boards to encourage continued efforts to improve the validity and reliability of procedures

for the evaluation of candidates for certification. Council on Medical Education Report 6-A-14, being considered by the House of Delegates at this meeting, provides more information about MOC and includes a summary of current AMA policies and recommendations regarding MOC.

AMA POLICY

Policy H-275.936, “Mechanisms to Measure Physician Competency,” asks our AMA to review and propose improvements for assuring continued physician competence, including but not limited to performance indicators, board certification and recertification, professional experience, continuing medical education, and teaching experience.

SUMMARY AND RECOMMENDATIONS

As the health professions continue to build curriculum and assessment around the development of competencies, it has become increasingly important to break down the silos across the continuum of medical education and create consistency whenever possible from the premedical interval through lifelong learning in the knowledge and skills necessary for a contemporary physician. Further study is needed to identify the relationship of curriculum, pedagogy and assessment, particularly high stakes or gateway assessments, in the setting of learning styles, as well as the timeline and metrics for development of a lifelong continuum of defined competencies.

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

1. That our American Medical Association Council on Medical Education continue to study and identify challenges and opportunities and critical stakeholders in achieving a competency-based curriculum across the medical education continuum and other health professions that provides significant value to those participating in these curricula and their patients.
2. That our AMA Council on Medical Education work to establish a framework of consistent vocabulary and definitions across the continuum of health sciences education that will facilitate competency-based curriculum, andragogy and assessment implementation.

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4. ALIGNMENT OF ACCREDITATION ACROSS THE MEDICAL EDUCATION CONTINUUM

Reference committee hearing: see report of [Reference Committee C](#).

HOUSE ACTION: RECOMMENDATIONS ADOPTED AND REMAINDER OF REPORT FILED

See Policy [H-295.862](#).

DEFINITION OF THE IDEAL MEDICAL EDUCATION CONTINUUM

In order to provide a framework, this report begins with a description of an ideal medical education continuum that would support a learner's acquisition of the professional attributes—knowledge, skills, attitudes and behaviors—that are characteristic of a physician. In the ideal continuum, these attributes are organized as outcome-based competencies. As the learner moves along the educational continuum from premedical education, through medical school and residency training, and into practice, he or she is able to demonstrate these competencies at increasingly high levels of accomplishment that are appropriate to his or her level of training. For each of the competencies, benchmarks exist that allow a determination that the learner is ready to move from one phase of training to the next and, ultimately, into practice.

This ideal continuum requires significant cooperation across the phases of training to create and implement the following:

- Agreed-upon outcome-based competencies,
- Benchmarks for progression, and
- A process and tools for education and assessment across phases of the continuum that support an orderly and timely progression of the learner.

In the ideal continuum, there is coordination of the processes for both the accreditation of educational programs and the assessment of learners that supports this orderly progression of learners. Accreditation ensures that educational programs at each phase of the continuum teach to the competencies at an appropriate level and in an appropriate sequence. Assessment determines if the learner has achieved the relevant outcomes at a level appropriate to his or her phase of training.

PURPOSE AND SCOPE OF THIS REPORT

This report on accreditation alignment is the first in a series. It specifically examines the extent to which the current processes for accreditation are designed to facilitate an ideal medical education continuum. This report will focus on accreditation of undergraduate medical education (education leading to the MD or DO degree) and graduate medical education (residency training). A subsequent report will review assessment across the continuum as reflected in continuing medical education and in the processes for licensure and certification/maintenance of certification.

THE DEFINITION OF ACCREDITATION

Accreditation is the evaluation of institutions or programs using a defined set of standards. The assumptions implicit in this definition, which are reflected in current practice in the United States, are that these standards are agreed-upon by stakeholders, measurable, and related to the quality of both the educational process and its outcomes.

Distinction between Accreditation and Assessment

Accreditation ensures that learners have the opportunity to acquire the desired knowledge and skills (i.e., achieve the defined competencies) by setting requirements related to teaching and learning. Accreditation does not, however, ensure that any given learner has mastered these knowledge and skill competencies. Assessment in education is defined as the act of making a judgment about an individual's competencies. Through the use of relevant methods, assessment determines if the specified competencies have been acquired by a given learner.

A program may be accredited even if one or more learners do not meet school or accreditor-specified competencies as judged by internal or external methods of assessment. For example, the accreditation standards of the Liaison Committee on Medical Education (LCME), the accrediting body for educational programs leading to the MD degree, include a standard that states:

A medical education program must collect and use a variety of outcome data, including national norms of accomplishment, to demonstrate the extent to which its educational program objectives are being met. (standard ED-46)¹

To determine compliance with this standard the LCME reviews whether a medical school uses outcome data, such as performance on internal examinations that test knowledge and skills and USMLE performance, and considers the results in aggregate across a given medical school class or the student body as a whole. Accreditation does not typically review results at the level of the individual learner. The medical school itself sets the requirements for performance on both internal and external assessments. For example, a medical school may require a student to pass internal examinations and Steps 1 and 2 of the United States Medical Licensing Examination to progress through the curriculum and/or graduate.

THE CURRENT ACCREDITATION PROCESSES FOR UNDERGRADUATE AND GRADUATE MEDICAL EDUCATION

This section provides an overview of how educational programs across the continuum are accredited and summarizes the similarities and differences in the ideal model of the continuum.

Historical Overview

Accreditation of educational programs across the levels of the continuum has evolved separately and is represented by distinct organizations and processes (see Figure 1).

Colleges and universities that sponsor baccalaureate programs are accredited by one of six regional accrediting bodies, each of which is responsible for institutions in a defined group of states. Each of the regional accrediting bodies has its own standards and processes. The accreditation of colleges and universities by regional accrediting bodies began with the formation of the New England Association of Colleges and Schools in 1885.²

The accreditation of medical education leading to the MD degree (allopathic medical education) began in the early twentieth century with separate accreditation by the American Medical Association Council on Medical Education (AMA CME) and the Association of American Medical Colleges (AAMC). The AMA and the AAMC formed the LCME in 1942, with representation from both organizations.¹ The accreditation of colleges of osteopathic medicine, based in the American Osteopathic Association (AOA), began in 1903 and currently is the responsibility of the Commission on Osteopathic College Accreditation (COCA).³ Both LCME and COCA standards have evolved independently over time.

Accreditation of allopathic graduate medical education began with a review of hospitals for internship training by the AMA in 1919, with a set of "Essentials for Approved Internships" (standards) approved in 1927. The standards

for and approval of residency programs began in 1928. In 1975, the Liaison Committee on Graduate Medical Education (LCGME) was formed which included the AMA, the AAMC, the American Board of Medical Specialties, the American Hospital Association, and the Council for Medical Specialty Societies. The LCGME was replaced by the Accreditation Council for Graduate Medical Education (ACGME) in 1981.⁴ Accreditation of osteopathic graduate medical education has been the responsibility of the AOA through its Bureau of Osteopathic Education. The March 2014 announcement of an agreement between the ACGME, the AOA, and the American Association of Colleges of Osteopathic Medicine to move osteopathic graduate medical education accreditation under the auspices of an expanded ACGME will bring this phase of the continuum into alignment, with the AOA ceasing accreditation of GME programs on or before June 2020.⁵

There is movement of learners between the allopathic (MD-granting) and osteopathic (DO-granting) educational pathways. Medical students may transfer between COCA and LCME-accredited medical education programs, under specified circumstances.^{1,3} Graduates of osteopathic medical colleges may enter ACGME-accredited residency programs. For example, of all residents enrolled in ACGME-accredited and in combined specialty graduate medical education programs in 2012, 8% were graduates of osteopathic medical colleges.⁶

Similarities and Differences in the Accreditation of Undergraduate and Graduate Medical Education Programs and Institutions

There are overarching similarities in the processes for accreditation of undergraduate and graduate medical education programs and institutions. All utilize defined standards, require programs to provide evidence of compliance with standards, conduct surveys to review the evidence for compliance, and utilize a peer decision-making process to determine accreditation status. However, each accrediting body functions according to its own processes and timelines.

Complexities Due to Timing of Accreditation Reviews

Allopathic and osteopathic medical education programs exist in colleges and universities accredited by one of the six regional (institutional) accrediting bodies. As a consequence, a given medical school may be preparing for an LCME or COCA review in a timeframe that differs from the accreditation review of its sponsoring university. More difficulty exists when the two reviews occur in close temporal proximity, as the medical school is expending considerable effort to prepare for both review processes. Similarly, the accreditation of an allopathic medical education program occurs in a distinct timeframe and using a distinct process versus the graduate medical education programs sponsored by the same institution. For example, LCME reviews occur on a fixed eight-year cycle while ACGME institutional reviews occur on a one- to six-year cycle.⁷

Complexities Due to the Content and Interpretation of Accreditation Standards

As noted, accreditation standards have been independently developed and revised by each accrediting body. There currently are differences in standards, including areas that are covered in the standards of one accrediting body but not others and/or that have a different emphasis.

Some similarities exist that touch on elements of the ideal continuum. For example:

- The COCA and LCME standards both address the need for undergraduate medical education programs to evaluate learner outcomes and track these into the next phase of training (COCA standard 6.6, LCME standard ED-46).^{1,3} The ACGME institutional requirements state the expectation that programs provide educational experiences for resident physicians that lead to measurable achievement of educational outcomes based in the ACGME competencies (ACGME Institutional Requirements II.E.1).⁸ The AOA Common Institutional and Program Requirements for residency training address a Core Competency Plan (V A 5.1g).⁹
- As medical students and residents share a common clinical learning environment, both the LCME and the ACGME have standards that require policies related to learner harassment and abuse (LCME standard MS-32, ACGME institutional requirement II.D.4.m).^{1,8} The COCA standards address this issue through requiring a comprehensive ethics statement with guidelines for student interaction with faculty, administrators, and staff (COCA standard 4.7).³

FACTORS THAT COULD ENHANCE ALIGNMENT

Alignment of accreditation across the continuum has been recognized as a potentially necessary step to bring about desired changes in the process and outcomes of medical education. For example, the Future of Medical Education in Canada reports on MD education and postgraduate education (residency training) both include the realignment of accreditation standards as major enabling recommendations.^{10,11} The potential to carry out such recommendations in the United States is supported by several emerging factors.

Stakeholder Expectations

There is a perception that graduating medical students are not adequately prepared to enter residency training and that residents are not prepared for the practice environment.¹² Such concerns need to be clarified and questions that will help address any gaps need to be answered:

- What are the specific gaps in preparation?
- What educational or other types of interventions at what phase of the continuum could address the problems?

For example, a common set of outcome competencies that learners are expected to achieve at each transition point in the educational continuum would be helpful.

The Definition of Core Competencies

The six competency domains articulated by the ACGME (patient care and procedural skills, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice) and the American Board of Medical Specialties were introduced in 1999¹³ and are included in the ACGME Common Program Requirements that all programs must address.¹⁴ They have been widely accepted as a way to ensure that residency training introduces learners to and assesses learners on key domains of clinical competence. The six competencies have been widely adopted and adapted by allopathic medical schools, based in part on the LCME accreditation standard that states:

The objectives of a medical education program must be stated in outcome-based terms that allow assessment of student progress in developing the competencies that the profession and the public expect of a physician. (standard ED-1-A)¹

The language of the competencies supports alignment by providing an organizing framework for educational program outcomes across the phases of the continuum.

The Creation of Milestones of Learner Achievement

The ACGME is in the process of implementing the Next Accreditation System (NAS) as a means to move from an episodic review of compliance to a more continuous quality enhancement model. As part of the NAS, specialty-specific milestones have been created for the six competencies which reflect “a logical trajectory of professional development” and provide a framework for the assessment of residents as they proceed through the program.¹³

The milestones provide a mechanism for graduate medical education to articulate with undergraduate medical education. That is, medical schools can use the milestones for the entering resident to create graduation competencies for medical students. For example, the AAMC has created a draft set of 13 “Core Entrustable Professional Activities for Entering Residency”¹⁵ (EPAs). These are sets of psychomotor and cognitive skills for medical students linked to the six ACGME domains of competence. Selected examples include: gather a history and perform a physical examination, develop a prioritized differential diagnosis and select a working diagnosis following a patient encounter, participate as a contributing and integrated member of an interprofessional team, and obtain informed consent for tests and/or procedures that a “day 1” intern is expected to perform or order without supervision. As with the milestones, the EPAs include defined levels of performance that can be used to assess if the learner can be “trusted” to appropriately perform the activity.¹⁵ The November 2013 draft of the EPA plan was open for comment as of the spring of 2014.

Tools to Facilitate Tracking of Learner Accomplishment Across the Continuum

Tools to record the performance, and often the self-perceptions, of learners are becoming more available. For example, portfolios are being used both in medical schools and in residency programs.¹⁶ Typically, such portfolios currently are limited to only one phase of training. The technology exists to create a portfolio that follows learners across the educational continuum. Such tools could be used by learners and mentors to track growth related to the core competencies.

THE ROLE OF ACCREDITATION

Each of the factors acting to support alignment could be facilitated by enhancements to accreditation standards and processes. These changes, however, cannot be made by one accrediting body alone. As described, the ideal medical education continuum requires feedback from one phase of the continuum to the previous one. For example, medical schools could use information about medical student performance to inform premedical students and their advisors about needed knowledge, skills, attitudes and behaviors that would support success. Similarly, using medical school graduation competencies and the ACGME milestones as a starting point, it should be possible to develop an agreed-upon set of expectations of what learners should know and be able to do as they move from medical school to residency training and from residency training into practice. These expectations could be codified in the standards of each accrediting body.

AMA POLICY ON ACCREDITATION

AMA policy focuses on the role of accreditation in ensuring educational quality (H-310.997[1]). Accreditation standards should address the knowledge, skills, attitudes and behaviors that the learner (in the case of this policy, the resident physician) should have on completing his or her education (H-310.929[2]). Accreditation standards at the undergraduate or graduate medical education levels should require that programs increase attention to specific topics in the curriculum, for example women's health (H-295.890[7]), professionalism (D-295.954[1]), and education in health care delivery environments, such as the patient-centered medical home, that promote interest in primary care as a specialty choice (D-200.979[7]).

SUMMARY AND RECOMMENDATIONS

While each accreditation system has worked to support quality education within its own phase of the medical education continuum, the ideal model requires enhanced coordination of accreditation across the phases. Many of the elements that could support such coordination already exist. Therefore, the Council on Medical Education recommends that the following be adopted and that the remainder of this report be filed:

1. Our American Medical Association supports the concept that accreditation standards for undergraduate and graduate medical education should adopt a common competency framework that is based in the Accreditation Council for Graduate Medical Education (ACGME) competency domains.
2. Our AMA recommends that the relevant associations, including the AMA, Association of American Medical Colleges (AAMC), American Osteopathic Association (AOA), and American Association of Colleges of Osteopathic Medicine (AACOM), along with the relevant accreditation bodies for undergraduate medical education (Liaison Committee on Medical Education, Commission on Osteopathic College Accreditation) and graduate medical education (ACGME, AOA) develop strategies to:
 - a. Identify guidelines for the expected general levels of learners' competencies as they leave medical school and enter residency training.
 - b. Create a standardized method for feedback from medical school to premedical institutions and from the residency training system to medical schools about their graduates' preparedness for entry.
 - c. Identify areas where accreditation standards overlap between undergraduate and graduate medical education (e.g., standards related to the clinical learning environment) so as to facilitate coordination of data gathering and decision-making related to compliance.

All of these activities should be codified in the standards or processes of accrediting bodies.

3. Our AMA encourages development and implementation of accreditation standards or processes that support utilization of tools (e.g., longitudinal learner portfolios) to track learners' progress in achieving the defined competencies across the continuum.

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Figure 1: Accreditation of Institutions/Programs as of February 2014

	Phase of the Continuum		
	Premedical Education (College/University)	Undergraduate Medical Education (Medical school)	Graduate Medical Education (Residency Training)
Accrediting Body	Regional (institutional) accrediting body	LCME (allopathic) COCA (osteopathic)	ACGME AOA
Entity Accredited	College/university	Medical college/ Educational program leading to the MD/DO degree	Medical school/hospital-sponsored residency program

5. AMA DUTY HOURS POLICY

Reference committee hearing: see report of [Reference Committee C](#).

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

See Policy [H-310.907](#).

This report is in response to AMA Policy D-310.955, "Resident/Fellow Duty Hours, Quality of Physician Training, and Patient Safety," which asks that our American Medical Association (AMA) "continue to monitor the enforcement and impact of the Accreditation Council for Graduate Medical Education duty hour standards ... with a report back no later than the 2014 Annual Meeting of the AMA House of Delegates (HOD)." This report builds on

information provided in three previous Council reports to the House of Delegates on this topic, 2011¹, 2009², and 2008.³

BACKGROUND

Public and professional attention to the issue of resident/fellow duty hours has increased significantly since the implementation of duty hour limits in 2003 by the Accreditation Council for Graduate Medical Education (ACGME) and the revised set of regulations that became effective in 2011. Debate continues as to the impacts on a host of key issues, including patient safety, physician preparedness for practice, professionalism, well-being and costs. This report reviews recent research on duty hours and related concerns and outlines potential areas for further research.

Over the last several years, our AMA has written numerous reports and adopted policy on this issue. A significant portion of this policy, however, is redundant, inconsistent or no longer relevant. To ensure that AMA policy serves as a tool for effective advocacy on duty hours, this report recommends rescission of all existing AMA policy thereof and implementation of new, streamlined policy that incorporates all relevant concerns and reflects current ACGME standards.

RECENT RESEARCH AND MEDIA COVERAGE ON DUTY HOURS

A number of recent studies/reports raise questions about both the intended and unintended consequences of the 2003 and 2011 ACGME standards. Some key conclusions and findings from these publications are highlighted below.

The 2011 ACGME regulations “produced increased sleep duration during the on-call period, [but] they also decreased continuity of patient care, intern and nurse perceptions of quality of care, and educational opportunities from teaching and patient care.”⁴

Program directors share these concerns. Nearly three out of four responding to a survey felt that residents were less prepared to take on more senior roles under the 2011 ACGME standards. About two out of three believed that resident education had gotten worse, and only six percent reported that patient safety and quality of care had improved. Further, less than half thought resident quality of life had improved. The authors note, “Perhaps our most important finding is the strongly negative response to the 16-hour shift limitation for first-year residents, which mirrors that of earlier surveys.”⁵ Meanwhile, pediatric program directors reported negative effects from the duty hour standards on patient care as well as resident education and quality of life. Nearly three of four respondents expressed disapproval of the 16-hour limit for interns. Further, fewer than half reported that their residents always complied with the 2011 regulations.⁶

Like program directors, resident physicians also have expressed dissatisfaction with the 2011 rules. A 2012 survey of residents found that only 23 percent approved of the regulations.⁷ Surgery residents, in particular, disapprove of the 2011 duty hour standards, citing “decreased continuity with patients, coordination of patient care, and time spent in the operating room. Furthermore, suboptimal quality of life, burnout, and thoughts of giving up surgery were common, even under the new paradigm of reduced work hours.”⁸

Some positive news was reported in a study finding that clinical exposure did not decrease for internal medicine interns after the 16-hour limit was enacted in 2011; in fact, interns “saw more patients, produced more detailed notes, and attended more conferences.”⁹ A separate study, however, found that operative case volume for surgery interns saw a “significant decrease” with the 16-hour limit; this early gap in experience may have “a domino effect on subsequent competence.”¹⁰

For trainees at the other end of the spectrum—that is, chief resident physicians—a study found that total cases declined, “especially acutely following implementation of the 80-hour work week [in 2003,] but have since rebounded.” It was also noted that “case mix has narrowed ... [and] broad-based general surgery training may be jeopardized by reduced case diversity.” Innovation is needed to ensure that the surgical chief residency year continues to offer a “robust educational experience.”¹¹ The authors of a related commentary noted that the “erosion of the chief resident’s evolution toward independent practice may be the most threatening finding.”¹² Indeed, the number of residents failing board exams in thoracic surgery has risen significantly since 2000. Failure rates nearly doubled between 2000 and 2005, from 14.4 percent to 28.1 percent, and reached 30 percent in 2012.¹³

Medical errors were also cited in one study as an unfortunate consequence of duty hour limits. About one in five interns reported committing an error that harmed a patient in 2010; this number increased to 23.3 percent after the 2011 standards were implemented. Meanwhile, hours of sleep and risk for symptoms of depression remained steady. It was suggested that work compression may be to blame; reductions in intern duty hour limits (to 16 hours) were not accompanied by an increase in funding, leaving current interns with less time to complete the same amount of work.¹⁴ Work compression was also cited in a study finding that today's internal medicine interns spent "less time in direct patient care and sleeping, and more time talking with other providers and documenting" compared to interns prior to 2003.¹⁵

Limited duty hours also lead to an increase in patient care handoffs—which in turn become a pivot point for the possibility of medical error. This highlights the need for more robust and efficient handoff protocols.¹⁶ Nonetheless, note the authors of one study, the 2003 iteration of duty hour limits "was associated with no significant change in mortality [rates] in the early years after implementation, and with a trend toward improved mortality [rates] among medical patients in the fourth and fifth years... [C]oncerns about worsening outcomes seem unfounded."¹⁷ Despite a plethora of studies, researchers have yet to definitively connect resident fatigue with adverse patient outcomes.

While ACGME data on duty hours reflect a high rate of compliance among programs, published reports tracking resident work hours and anonymous resident surveys have identified frequent noncompliance and underreporting of duty hours. More than half of residents surveyed in one study reported noncompliance with the 2011 duty hour standards; those at earlier stages of training reported higher rates, perhaps reflecting the difficulty of complying with the new 2011 requirement that caps intern shifts at 16 hours. In short, many residents may be caught between complying with ACGME standards and adhering to their ethical and professional standards of medical practice.¹⁸

A related commentary considers the unintended ethical consequences of duty hour limits: "[P]unitive measures created to keep residents compliant, while well intentioned, have inadvertently generated a learning environment muddied with dishonest behavior."¹⁹ A second commentary on this topic noted, "Old values do not simply die in a new system . . . [but] consistently placing a patient's or the profession's needs above one's own personal needs" may, at times, "directly conflict with the current system of medical training."²⁰

In addition to the many studies on duty hours, the general media continues to cover this issue and to raise questions about duty hour limits and their potential consequences on physician quality and patient safety. One article asks, "Medical interns may be more awake, but are they getting enough training?"²¹ Similarly, asks another, "Why doesn't medical care get better when doctors rest more?"²² The author, a cardiologist, laments the toll duty hour restrictions have taken on continuity of care and wonders whether the new system might actually yield more errors than in the pre-reform era of 30-hour shifts.

Many of these issues are highlighted in a point/counterpoint that asks, "Should Medical Residents Be Required to Work Shorter Shifts?" The authors square off over patient safety and physician well-being, on the pro side, versus the need for more opportunities to learn and develop competence in a supervised environment, on the con side.²³ Another article considers the issue of work compression. The piece quotes a researcher, who notes, "Fatigue is bad, but overwork is worse," and describes the issues for residency program directors as "a Rubik's-cube conundrum of covering all the work with the same number of interns working fewer hours."²⁴

Finally, one physician blogger and medical educator calls for systemic change in residency education: "We have to adjust call schedules for the benefit of continuity. We need call schedules that value 'ownership' and patient responsibility. We have to help our residents function as a team, with different members of the team working different shifts."²⁵

ACGME WORK IN ADDRESSING ISSUES SURROUNDING DUTY HOURS

Work is under way by the ACGME to improve the quality and safety of residency training and move from a focus on process toward outcomes.^{26,27} The ACGME's Clinical Learning Environment Review (CLER) program is intended to measure the work of US teaching hospitals to engage residents in six focus areas, including duty hours and fatigue management and mitigation as well as professionalism. CLER is the first component of the ACGME's Next Accreditation System (NAS) to be operationalized nationally.

CLER site visits have been initiated at all ACGME-accredited sponsoring institutions with two or more training programs. After CLER site visits, the institution is provided with feedback and a written report. The current plan is for the ACGME to repeat the CLER visits every 18 months “to assess institutional progress in improving resident involvement in the six focus areas.” In addition, the aggregated experience/data that are collected from institutions will be used to inform and shape future ACGME accreditation requirement. A second component of NAS is the ACGME’s Milestones project, in collaboration with relevant member boards of the American Board of Medical Specialties (ABMS). Milestones “are observable developmental steps that describe progression from a beginning learner to the expected level of proficiency at the completion of training. Accordingly, predefined milestones can be used to assess and document a trainee’s developmental progression toward competence.”²⁸

In addition, the ACGME has recently awarded seed funding for duty hours research as part of its five-year diligence in review of the requirements it established. One research project examines the effect of reduction of duty hour restrictions for first-year residents in internal medicine programs at multiple sites nationally. To start the work, the ACGME provided partial funding of \$1 million over four years. The project’s leadership team also plans to submit the study to the National Institutes of Health for additional peer-reviewed funding to complete the study. As part of this work, the ACGME granted a duty hours’ exemption to participating programs, waiving the 16-hour work limit for first-year residents (interns). In another such project, the American Board of Surgery was funded to study the impact of reducing duty hour requirements for some surgical trainees. Patient outcomes will be examined using National Surgical Quality Improvement Program data. The ACGME board approved a waiver of some of the duty hour rules to permit the conduct of this research project in the participating programs.

KEY ISSUES, AND QUESTIONS FOR FURTHER STUDY

A number of key issues continue to rise to the forefront during discussion of duty hour limits, including patient safety, trainees’ preparedness for practice, flexible solutions for different disciplines, biologic variation among individuals in their tolerances for sleep deprivation and fatigue, workload and patient volume, handoffs and continuity, professionalism and personal responsibility, resident physician well-being, faculty supervision, impact on the overall physician workforce and interprofessional training, and costs.

Other questions that may merit further study and research:

- What has been the impact on the workload and learning of students?
- What has been the impact on attending physicians? Will duty hour limits eventually extend to practicing physicians as well (as in Europe)?
- Will some specialties extend the length of training programs because of the need for more clinical exposure? If so, what effect does this have on workforce? Will students be less likely to choose a field with such extended residency periods?
- What will be the effect of competency-based frameworks on resident progression and graduation from training programs?
- Will the transition into real-world practice (in which duty hour limits do not apply) become more difficult for young physicians who trained with duty hour limits?
- Do residents learn to function in a sleep-deprived environment and to recognize and compensate for their limits?

CURRENT AMA POLICY ON DUTY HOURS

A recent search of current AMA policy using the term “duty hours” returned the following six HOD policies and 10 directives (see Appendix for full policies):

1. H-310.918, “Resident and Duty Hours: A Review of the Institute of Medicine Recommendations”
2. H-310.926, “Resident/Fellow Work and Learning Environment”
3. H-310.927, “Resident Physician Working Conditions”
4. H-310.928, “Resident/Fellow Work and Learning Environment”
5. H-310.957, “Resident Working Conditions Reform Update”
6. H-310.963, “Residency/Fellowship Working Hours and Supervision”
7. D-310.955, “Resident/Fellow Duty Hours, Quality of Physician Training, and Patient Safety”
8. D-310.961, “Use of At-Home Call by Residency Programs”

9. D-310.964, "Enforcement of Duty Hours Standards and Improving Resident, Fellow and Patient Safety"
10. D-310.973, "Enforcement of ACGME Duty Hour Standards"
11. D-310.978, "Enforcement of ACGME Duty Hours Standards"
12. D-310.981, "Resident/Fellow Work and Learning Environment"
13. D-310.984, "Resident/Fellow Work and Learning Environment"
14. D-310.986, "Accreditation Council for Graduate Medical Education Enforcement of Duty Hour Standards"
15. D-310.989, "Resident Physician Working Conditions"
16. D-310.991, "Intern and Resident Working Hours"

Many of these policies are no longer relevant or already accomplished; those that are still relevant serve as the basis for this report's recommendation for a new, centralized policy on duty hours.

SUMMARY AND RECOMMENDATIONS

This report provides an update on resident/fellow duty hour regulation and its impact on patient safety and physician preparedness to practice, among other variables. It also encompasses a review of current AMA policies on duty hours, to ensure such policy is consistent, accurate and up-to-date. These policies are recommended for rescission, with relevant portions included in the new proposed policy below and minor editorial changes added where appropriate.

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 adopt the following Principles of Resident/Fellow Duty Hours, Patient Safety, and Quality of Physician Training:
 - 1) Our AMA reaffirms support of the 2003 Accreditation Council for Graduate Medical Education (ACGME) duty hour standards.
 - 2) Our AMA will continue to monitor the enforcement and impact of duty hour standards, in the context of the larger issues of patient safety and the optimal learning environment for residents.
 - 3) Our AMA encourages publication and supports dissemination of studies in peer-reviewed publications and educational sessions about all aspects of duty hours, to include such topics as extended work shifts, handoffs, in-house call and at-home call, level of supervision by attending physicians, workload and growing service demands, moonlighting, protected sleep periods, sleep deprivation and fatigue, patient safety, medical error, continuity of care, resident well-being and burnout, development of professionalism, resident learning outcomes, and preparation for independent practice.
 - 4) Our AMA endorses the study of innovative models of duty hour requirements and, pending the outcomes of ongoing and future research, should consider the evolution of specialty- and rotation-specific duty hours requirements that are evidence-based and will optimize patient safety and competency-based learning opportunities.
 - 5) Our AMA encourages the ACGME to:
 - a) Decrease the barriers to reporting of both duty hour violations and resident intimidation.
 - b) Ensure that readily accessible, timely and accurate information about duty hours is not constrained by the cycle of ACGME survey visits.
 - c) Use, where possible, recommendations from respective specialty societies and evidence-based approaches to any future revision or introduction of resident duty hour rules.
 - d) Broadly disseminate aggregate data from the annual ACGME survey on the educational environment of resident physicians, encompassing all aspects of duty hours.
 - 6) Our AMA recognizes the ACGME for its work in ensuring an appropriate balance between resident education and patient safety, and encourages the ACGME to continue to:
 - a) Offer incentives to programs/institutions to ensure compliance with duty hour standards.
 - b) 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.
 - c) Collect data on at-home call from both program directors and resident/fellow physicians; release these aggregate data annually; and develop standards to ensure that appropriate education and supervision are maintained, whether the setting is in-house or at-home.

- d) Ensure that resident/fellow physicians receive education on sleep deprivation and fatigue.
- 7) Our AMA supports the following statements related to duty hours:
 - a) Resident physician total duty hours must not exceed 80 hours per week, averaged over a four-week period (Note: "Total duty hours" includes providing direct patient care or supervised patient care that contributes to meeting educational goals; participating in formal educational activities; providing administrative and patient care services of limited or no educational value; and time needed to transfer the care of patients).
 - b) Scheduled on-call assignments should not exceed 24 hours. Residents may remain on-duty for an additional 4 hours to complete the transfer of care, patient follow-up, and education; however, residents may not be assigned new patients, cross-coverage of other providers' patients, or continuity clinic during that time.
 - c) Time spent in the hospital by residents on at-home call must count towards the 80-hour maximum weekly hour limit, and on-call frequency must not exceed every third night averaged over four weeks. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one-day-in-seven free of duty, when averaged over four weeks.
 - d) At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident.
 - e) Residents are permitted to return to the hospital while on at-home call to care for new or established patients. Each episode of this type of care, while it must be included in the 80-hour weekly maximum, will not initiate a new "off-duty period."
 - f) Given the different education and patient care needs of the various specialties and changes in resident responsibility as training progresses, duty hour requirements should allow for flexibility for different disciplines and different training levels to ensure appropriate resident education and patient safety; for example, allowing exceptions for certain disciplines, as appropriate, to the 16-hour shift limit for first-year residents, or allowing a limited increase to the total number of duty hours when need is demonstrated.
 - g) Resident physicians should be ensured a sufficient duty-free interval prior to returning to duty.
 - h) Duty hour limits must not adversely impact resident physician participation in organized educational activities. Formal educational activities must be scheduled and available within total duty hour limits for all resident physicians.
 - i) Scheduled time providing patient care services of limited or no educational value should be minimized.
 - j) Accurate, honest, and complete reporting of resident duty hours is an essential element of medical professionalism and ethics.
 - k) The medical profession maintains the right and responsibility for self-regulation (one of the key tenets of professionalism) through the ACGME and its purview over graduate medical education, and categorically rejects involvement by the Centers for Medicare & Medicaid Services, The Joint Commission, Occupational Safety and Health Administration, and any other federal or state government bodies in the monitoring and enforcement of duty hour regulations, and opposes any regulatory or legislative proposals to limit the duty hours of practicing physicians.
 - l) Increased financial assistance for residents/fellows, such as subsidized child care, loan deferment, debt forgiveness, and tax credits, may help mitigate the need for moonlighting. At the same time, resident/fellow physicians in good standing with their programs should be afforded the opportunity for internal and external moonlighting that complies with ACGME policy.
 - m) Program directors should establish guidelines for scheduled work outside of the residency program, such as moonlighting, and must approve and monitor that work such that it does not interfere with the ability of the resident to achieve the goals and objectives of the educational program.
 - n) The costs of duty hour limits should be borne by all health care payers.
 - o) The general public should be made aware of the many contributions of resident/fellow physicians to high-quality patient care and the importance of trainees' realizing their limits (under proper supervision) so that they will be able to competently and independently practice under real-world medical situations.
- 8) Our AMA is in full support of the collaborative partnership between allopathic and osteopathic professional and accrediting bodies in developing a unified system of residency/fellowship accreditation for all residents and fellows, with the overall goal of ensuring patient safety.

2. That our AMA rescind the following policies:

H-310.918, Resident and Duty Hours: A Review of the Institute of Medicine Recommendations
 H-310.926, Resident/Fellow Work and Learning Environment
 H-310.927, Resident Physician Working Conditions
 H-310.928, Resident/Fellow Work and Learning Environment
 H-310.957, Resident Working Conditions Reform Update
 H-310.963, Residency/Fellowship Working Hours and Supervision
 D-310.955, Resident/Fellow Duty Hours, Quality of Physician Training, and Patient Safety
 D-310.961, Use of At-Home Call by Residency Programs
 D-310.964, Enforcement of Duty Hours Standards and Improving Resident, Fellow and Patient Safety
 D-310.973, Enforcement of ACGME Duty Hour Standards
 D-310.978, Enforcement of ACGME Duty Hours Standards
 D-310.981, Resident/Fellow Work and Learning Environment
 D-310.984, Resident/Fellow Work and Learning Environment
 D-310.986, Accreditation Council for Graduate Medical Education Enforcement of Duty Hour Standards
 D-310.989, Resident Physician Working Conditions
 D-310.991, Intern and Resident Working Hours

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APPENDIX

H-310.918, Resident and Duty Hours: A Review of the Institute of Medicine Recommendations

Our AMA supports: (1) current duty hour requirements as set forth in the Common Program Requirements, Accreditation Council for Graduate Medical Education, Section VI; and (2) additional study of the issues raised with respect to duty hours in the IOM report and consider further modifications of the current duty hours requirements based on the results of this inquiry. (Res. 327, A-09)

H-310.926, Resident/Fellow Work and Learning Environment

Our AMA supports education during residency training programs on sleep deprivation and fatigue. (Res. 322, A-03).

H-310.927, Resident Physician Working Conditions

(1) Our AMA adopts the following definitions for resident physician education: (a) "Total duty hours" represents those scheduled hours of activity associated with a residency program and include: (i) scheduled time providing direct patient care or supervised patient care that contributes to the ability of the resident physician to meet educational goals and objectives; (ii) scheduled time to participate in formal educational activities, (iii) scheduled time providing administrative and patient care services of limited or no educational value, and (iv) time needed to transfer the care of patients; and (b) "Organized educational activities" are of two types: (i) "Formal educational activities" include scheduled educational programs such as conferences, seminars, and grand rounds and (ii) "Patient care educational activities" include individualized instruction with a more senior resident or attending physician and teaching rounds with an attending physician. (2) Resident physician total duty hours must not exceed 80 hours per week, averaged over a two-week period and that our AMA work with GME accrediting bodies to determine if an increase of 5% may be appropriate for some training programs. (3) Workdays that exceed 12 hours are defined as on-call. (4) Scheduled on-call assignments should not exceed 24 hours. Residents may remain on-duty for up to 30 hours to complete the transfer of care, patient follow-up, and education; however, residents may not be assigned new patients, cross-coverage of other providers' patients, or continuity clinic during that time. (5) On-call shall be no more frequent than every third night and there be at least one consecutive 24-hour duty-free period every seven days both averaged over a two-week period. (6) On-call from home shall be counted in the calculation of total duty hours and on-call frequency if the resident physician can routinely expect to get less than eight hours of sleep. (7) There should be a duty-free interval of at least 10 hours prior to returning to duty. (8) Limits on total duty hours must not adversely impact resident physician participation in the organized educational activities of the residency program. Formal educational activities must be scheduled and available within total duty hour limits for all resident physicians for at least eight hours per week averaged over a two-week period. (9) Scheduled time providing patient care services of limited or no educational value be minimized (10) Program directors should establish guidelines for scheduled work outside of the residency program, such as moonlighting, and must approve and monitor that work. (CME Rep. 9, A-02)

H-310.928, Resident/Fellow Work and Learning Environment

1. Our AMA may draft original, modify existing, or oppose legislation and pursue any regulatory or administrative strategies when dealing with resident work hours and conditions. 2. Our AMA will oppose any efforts by the federal government, including the Department of Labor's Occupational Safety and Health Administration, to regulate resident education and training, including resident and fellow duty hours. (Res. 310, I-01; Reaffirmed: Res. 322, A-03; Appended: Res. 219, I-10)

H-310.957, Resident Working Conditions Reform Update

(1) Our AMA supports the following new language pertaining to resident work hours and environment for the "General Requirements" of the "Essentials of Accredited Residencies in Graduate Medical Education": Each residency program must establish formal policies governing resident duty hours and working environment that are optimal for both resident education and the care of patients. (a) Special requirements relating to duty hours and on-call schedules shall be based on an educational rationale and patient need, including continuity of care. (b) The educational goals of the program and learning objectives of residents must not be compromised by excessive reliance on residents to fulfill institutional service obligations. Duty hours, however, must reflect the fact that responsibilities for continuing patient care are not automatically discharged at specific times. Programs must ensure that residents are provided backup support when patient care responsibilities are especially difficult or prolonged. (c) Resident duty hours and on-call schedules must not be excessive. The structuring of duty hours and on-call schedules must focus on the needs of the patient, continuity of care, and the educational needs of the resident. Duty hours must be consistent with the General and Special Requirements that apply to each program. Detailed structuring of resident service is an integral part of the approval process and therefore close adherence to the General and Special Requirements is essential to program accreditation. (2) Our AMA supports the following proposed revision of the "Special Requirements" for surgery: It is desirable that residents' work schedule be designed so that on the average, excluding exceptional patient care needs, residents have at least one day out of seven free of routine responsibilities and be on-call in the hospital no more often than every third night. The ratio of hours worked and on-call time will vary, particularly at the senior levels, and therefore necessitates flexibility. (BOT Rep. YY, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CME Rep. 2, A-11)

H-310.963, Residency/Fellowship Working Hours and Supervision

It is the policy of the AMA (1) to continue to work with the Accreditation Council for Graduate Medical Education to implement AMA policy for residency work hours reform; and (2) to use existing policy as a guideline in working with state medical societies and medical specialties to obtain modification, if needed, of pending and future legislation on or changes to total residency work hours, conditions and supervision. (Sub. Res. 191, I-90; Reaffirmed: Sunset Report, I-00; Modified: CME Rep. 2, A-10)

D-310.955, Resident/Fellow Duty Hours, Quality of Physician Training, and Patient Safety

1. Our American Medical Association will continue to monitor the enforcement and impact of the Accreditation Council for Graduate Medical Education duty hour standards, as they relate to the larger issue of the optimal learning environment for residents, and monitor relevant research on duty hours, sleep, and resident and patient safety, with a report back no later than the 2011 Annual Meeting of the AMA House of Delegates. 2. Our AMA will, as part of its Initiative to Transform Medical Education strategic focus, utilize relevant evidence on patient safety and sleep to develop a learning environment model that optimizes supervision, professionalism, communication, and teamwork as well as finding a balance between resident education, patient care, quality and safety, and a wholesome personal life for physician learners and teachers, with a report back no later than the 2012 Annual Meeting. 3. Our AMA (through the AMA GME e-Letter and other communications) encourages publication of studies (in peer-reviewed publications, including the ACGME's newly developed Journal of Graduate Medical Education) and will promote educational sessions about a) the potential effects of the Institute of Medicine recommendations and b) the effects of duty hour standards, extended work shifts, handoffs and continuity of care procedures, and sleep deprivation and fatigue on patient safety, medical error, resident well-being, and resident learning outcomes, and will disseminate study results to GME designated institutional officials (DIOs), program directors, resident/fellow physicians, attending faculty, and others. 4. Our AMA will call for pilot programs and further research into protected sleep periods during prolonged in-house call and, until such research shows improved patient care and safety, will encourage the ACGME to not adopt the IOM report's call for a protected sleep period, which could have significant unintended consequences for continuity of patient care and safety, as well as being difficult and expensive to implement and monitor. 5. Our AMA encourages the ACGME to allow appropriate flexibility for different disciplines and different training levels within the current ACGME maximum duty hour standards to best train residents for professional practice within their specialties while optimizing patient safety during their training. 6. Our AMA will communicate to all Graduate Medical Education Designated Institution Officials, program directors, resident/fellow physicians, and attending faculty the importance of accurate, honest, and complete reporting of resident duty hours as an essential element of medical professionalism and ethics. 7. Our AMA will ensure that medicine maintain the right and responsibility for self-regulation, one of the key tenets of professionalism, and categorically reject outside involvement by the Centers for Medicare & Medicaid Services or The Joint Commission and other state and federal government bodies in the monitoring and enforcement of duty hour regulations. 8. Our AMA will urge the ACGME to include external moonlighting hours in the calculation of duty hours, as defined in the IOM report, and also will work to ensure increased financial assistance for residents/fellows, such as subsidized child care, loan deferment, debt forgiveness, and tax credits, which may help mitigate the need for moonlighting. 9. Our AMA will collaborate with other key stakeholders to educate the general public about the many contributions of resident/fellow physicians to high-quality patient care; further the public should be made aware that residency/fellowship education offers trainees the opportunity to realize their limits (under proper supervision) so that they can competently and independently practice under real-world medical situations. 10. Our AMA will urge that any costs of further duty hour limits be

borne by all health care payers, and that any proposed changes to the ACGME standards have adequate funding allocated prior to implementation. 11. Our AMA encourages the American Osteopathic Association to monitor duty hours and related issues in collaboration with the ACGME. 12. Our AMA Council on Medical Education, Resident and Fellow Section, and Young Physicians Section will collaborate in developing a formal response, based on the best evidence for improving resident education as well as patient safety and quality, to the upcoming revisions of the duty hour requirements by the Accreditation Council for Graduate Medical Education. 13. Our AMA encourages the ACGME to allow appropriate flexibility for different disciplines and different training levels within the current ACGME maximum duty hours standards and will work with other key stakeholders to continue to develop strategies for implementing optimal work schedules to improve resident education and patient safety in healthcare. 14. Our AMA will continue to monitor the enforcement and impact of the Accreditation Council for Graduate Medical Education duty hour standards, as they relate to the larger issues of patient safety and the optimal learning environment for residents, and to track relevant research on duty hours, sleep, and resident and patient safety; and report back to the House of Delegates as needed, with a report back no later than the 2014 Annual Meeting of the AMA House of Delegates. 15. Our AMA, through the AMA GME e-Letter and other communications, will encourage publication of studies (in peer-reviewed publications, including the ACGME's newly developed Journal of Graduate Medical Education) and promote educational sessions about the impact of duty hour limits, extended work shifts, handoffs, protected sleep periods during in-house call, sleep deprivation, and fatigue on patient safety, medical error, continuity of care, resident well-being, and resident learning outcomes. Further, our AMA should facilitate wide dissemination of this information to the GME community. 16. Our AMA will strongly advocate to all Designated Institutional Officials (DIOs), program directors, resident/fellow physicians, and attending faculty the importance of accurate, honest, and complete reporting of resident duty hours as an essential element of medical professionalism and ethics. 17. Our AMA will ensure that the medical profession maintains the right and responsibility for self-regulation, one of the key tenets of professionalism, and categorically reject involvement by the Occupational Safety and Health Administration in the monitoring and enforcement of duty hour regulations. 18. Our AMA will lobby against any regulatory or legislative proposals to limit the duty hours of practicing physicians. 19. Our AMA will collaborate with other key stakeholders to educate the general public about the many contributions of resident/fellow physicians to high-quality patient care and the importance of trainees' realizing their limits (under proper supervision) so that they can competently and independently practice under real-world medical situations. 20. Our AMA will urge that the costs of duty hour limits be borne by all health care payers, and that any proposed changes to the ACGME standards have adequate funding allocated prior to implementation. 21. Our AMA will encourage the American Osteopathic Association to monitor duty hours and related issues in collaboration with the ACGME. (CME Rep. 2, I-09; Appended: Res. 322, A-10; Appended: CME Rep. 7, A-11)

D-310.961, Use of At-Home Call by Residency Programs

1. Our AMA encourages the Accreditation Council for Graduate Medical Education to collect data on at-home call by specialty from both program directors and from residents and fellows and to release these aggregate data annually to the Graduate Medical Education community. 2. Our AMA and the ACGME will collaborate on a survey (similar to those conducted by the AMA in 1989 and 1999) on the educational environment of resident physicians, encompassing all aspects of duty hours, including at-home call. 3. Our AMA will ask that the Council on Medical Education incorporate a review of at-home call issues in the duty hours follow-up report due at the 2010 Annual Meeting. 4. Our AMA will define "at-home" call and its appropriate or inappropriate uses, allowing for flexible solutions from one specialty to the next, with a report back to the House of Delegates. 5. Our AMA encourages the ACGME and the GME community to examine the effects of the increased use of at-home call on resident education and supervision and develop appropriate standards to ensure that appropriate education and supervision is maintained, regardless of the setting. (CME Rep. 5, I-08)

D-310.964, Enforcement of Duty Hours Standards and Improving Resident, Fellow and Patient Safety

Our AMA: 1. Reaffirms support of the current Accreditation Council for Graduate Medical Education duty hour standards. 2. Continues to monitor the enforcement and impact of the ACGME duty hour standards, as they relate to the larger issue of the optimal learning environment for residents, and will monitor relevant research on duty hours, sleep, and resident and patient safety, with a report back at the 2010 Annual Meeting of the AMA House of Delegates. 3. Will, as part of its Initiative to Transform Medical Education strategic focus, utilize relevant evidence on patient safety and sleep to develop a learning environment model that optimizes balance between resident education, patient care, quality and safety, and report back at the 2010 Annual Meeting. 4. Will review, evaluate, and publicize the work of the ACGME Committee on Innovation, in particular its pilot projects related to duty hours, and will encourage participation by ACGME Residency Review Committees and residency programs in these and other efforts towards innovation and improvement in graduate medical education and patient safety. 5. Will ask the ACGME to consider offering programs/institutions additional incentives, such as longer accreditation cycles or reduced accreditation fees, to ensure programmatic and institutional compliance with duty hour limits. 6. Encourages publication of studies about the effects of duty hour standards, extended work shifts, hand offs and continuity of care procedures, and sleep deprivation and fatigue on patient safety, medical error, resident well-being, and resident learning outcomes, and will disseminate study results to GME designated institutional officials (DIOs), program directors, resident/fellow physicians, attending faculty, and others. 7. Will communicate to all GME DIOs, program directors, resident/fellow physicians, and attending faculty about the importance of accurate, honest, and complete reporting of resident duty hours as an essential element of medical professionalism and ethics. 8. Will use the GME e-Letter, AMA Resident and Fellow Section publications, and other communications vehicles to raise awareness among residents (particularly first-year residents) of the ACGME and its role in monitoring and enforcing duty hours. 9. Council on Medical Education will closely monitor the progress of the Institute of Medicine (IOM) committee studying resident duty hours and patient safety and to respond, and/or assist the AMA Washington Office in responding, to any legislative

or regulatory initiatives that arise from the IOM or other bodies. 10. Urges the ACGME and AOA to decrease the barriers to reporting duty violations and resident intimidation. (CME Rep. 5, A-08)

D-310.973, Enforcement of ACGME Duty Hour Standards

Our AMA will: (1) Continue to monitor the enforcement and impact of the Accreditation Council for Graduate Medical Education duty hour standards, as they relate to the larger issues of optimal patient care and learning environment for residents, with a report back at the 2008 Annual Meeting of the AMA House of Delegates. (2) Encourage and disseminate the results of studies that link compliance with duty hours standards to patient care quality and medical errors, as well as to resident learning and professionalism. (3) Work with other interested groups to regularly inform GME designated institutional officials (DIOs), program directors, resident physicians, and attending faculty about the adverse effects of sleep deprivation and fatigue on patient safety and resident well-being. (4) Work with the ACGME to improve the reporting mechanisms for duty hour violations in order to better protect resident confidentiality and improve the learning environment. (CME Rep. 4, A-06)

D-310.978, Enforcement of ACGME Duty Hours Standards

Our AMA will: (1) continue to monitor the enforcement of the Accreditation Council for Graduate Medical Education duty hour standards, including the consistency, accuracy, and validity of reporting, and report back at the 2006 Annual Meeting; (2) 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) 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) 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) investigate ways to protect resident physicians who file a complaint to the ACGME, and report back at the 2006 Annual Meeting; and (6) encourage and disseminate the results of studies that link compliance with duty hour standards to patient care quality outcomes and patient safety. (CME Rep. 1, I-04)

D-310.981, Resident/Fellow Work and Learning Environment

(1) Our AMA will, with the input of other groups involved in medical education, pursue the creation and dissemination of a survey in 2005 to medical students, resident physicians, and attending faculty to determine the effects of the 2003 Accreditation Council for Graduate Medical Education (ACGME) duty hours standards on the clinical learning environment, with the scope of future surveys on the learning environment to be determined based on the results of the 2005 survey; and (2) our AMA and other relevant groups will offer to work with the ACGME in the design and analysis of the ACGME resident survey. (CME Rep. 8, A-04)

D-310.984, Resident/Fellow Work and Learning Environment

Our AMA will: (1) ask the Board of Directors of the Accreditation Council for Graduate Medical Education to reconsider the changes made in the Common Program Requirements for duty hours and the procedures for the approval exemptions at their meeting of February 11, 2003, and approve the original language and intent from June 2002 prior to the implementation of requirements on July 1, 2003; (2) 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 at the 2004 Annual Meeting; (3) study, develop, and promote a method of creating an environment for residents to safely report violations on resident duty hours without any repercussions; (4) request an annual report to ACGME's Member Organizations from the ACGME, which includes the number of complaints received, the number not in compliance due to duty hours and working conditions and the action taken by ACGME, and that this report be indexed by specialty; and (5) continue to work with the ACGME to refine the duty hours standards, and work with ACGME and other appropriate entities to collect evidence on the impact of current standards in regards to patient and resident safety, resident education, and eliminating fatigue and sleep deprivation. (Res. 322, A-03)

D-310.986, Accreditation Council for Graduate Medical Education Enforcement of Duty Hour Standards

Our AMA will: (a) continue to work with the Accreditation Council for Graduate Medical Education (ACGME) to further refine the standards for resident physician duty hours and to collect additional evidence on the impact of the current standards with respect to preserving the quality of resident physician education and eliminating fatigue and sleep deprivation; (b) continue to strongly encourage the ACGME to vigorously enforce its accreditation standards regarding resident physician duty hours; (c) request that an annual report be provided to the Member Organizations of the ACGME (AMA, American Association of Medical Colleges, American Board of Medical Specialties, American Hospital Association, Council of Medical Specialty Societies) on the number of programs by specialty that were not in compliance with resident physician duty hour standards and the action taken by the ACGME; (d) continue to 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; and (e) work with the ACGME to objectively evaluate the impact of the new standards for resident work hours upon patient care and safety. (2) The Council on Medical Education will continue to explore all possible approaches to the enforcement of duty hours and the protection of residents who report duty hour violations and report its findings to the ACGME Task Force on Duty Hours for its consideration. (CME Rep. 6, A-03)

D-310.989, Resident Physician Working Conditions

(1) As continued evidence is developed and collected regarding resident work hours, patient safety, resident well-being, and resident education, resident physician total duty hours shall be reassessed. (2) Our AMA shall: (a) strongly encourage the Accreditation Council for Graduate Medical Education (ACGME) to vigorously enforce the common accreditation standards adopted by their Board of Directors on June 11, 2002 regarding resident duty hours; and (b) requests that ACGME provide the AMA with a report on the number of programs by specialty that were required to provide immediate progress reports to Residency Review Committees and the Institutional Review Committee as well as the number of programs for which resident surveys and focused follow-up visits were conducted, beginning with the period of July 1, 2001-June 30, 2002 and then on an annual basis. (CME Rep. 9, A-02)

D-310.991, Intern and Resident Working Hours

The ACGME: (1) through its Residency Review Committees (RRC) and the Institutional Review Committee, enforce work hour guidelines rigorously and ensure compliance with work hour standards; and (2) be requested to investigate mechanisms to provide readily accessible, timely and accurate information about work hours for individual programs that is not constrained by the cycle of survey visits. (CME Rep. 1, I-01; Reaffirmed: CME Rep. 2, A-11)

6. UPDATE ON MAINTENANCE OF CERTIFICATION, OSTEOPATHIC CONTINUOUS CERTIFICATION, AND MAINTENANCE OF LICENSURE

Reference committee hearing: see report of [Reference Committee C](#).

HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS IN LIEU OF RESOLUTION 316 AND REMAINDER OF REPORT FILED

See Policies [H-275.950](#) and [D-275.960](#).

Policy D-275.960 (2) (6), An Update on Maintenance of Certification, Osteopathic Continuous Certification, and Maintenance of Licensure, calls on our American Medical Association (AMA) to:

- Continue to monitor the evolution of maintenance of certification (MOC), osteopathic continuous certification (OCC), and maintenance of licensure (MOL), continue its active engagement in the discussions regarding their implementation, and report back to the House of Delegates (HOD) on these issues.
- Solicit an independent entity to commission and pay for a study to evaluate the impact that MOL and MOC requirements have on physicians' practices, including but not limited to: physician workforce, physicians' practice costs, patient outcomes, patient safety, and patient access. Such a study will look at the examination processes of the American Board of Medical Specialties (ABMS), the American Osteopathic Association (AOA), and the Federation of State Medical Boards (FSMB). Such a study is to be presented to the AMA HOD, for deliberation and consideration before any entity, agency, board or governmental body requires physicians to sit for MOL licensure examinations. Progress report is to be presented at Annual 2014; complete report by Annual 2015.

BACKGROUND

The AMA has extensive policy on MOC and OCC as well as policy to support the principles of MOL (Appendix A). This update builds on information provided in five previous Council reports to the HOD on this topic (Council on Medical Education Reports: 4-A-13,¹ 10-A-12,² 11-A-12,³ 3-A-10,⁴ and 16-A-09⁵) and addresses the policy above by providing updates on:

1. Progress on the implementation of MOC, OCC, and the policies and framework for MOL.
2. The reported value of MOC.
3. AMA efforts to explore with the ABMS alternatives to the mandatory secure, high-stakes examination for MOC.
4. Efforts to ensure that the ABMS specialty boards provide full transparency.
5. AMA efforts to work with ABMS and specialty boards to lessen the burden for physicians who have multiple board certifications.
6. Streamlining educational and quality improvement efforts as related to MOC, OCC and MOL.
7. Tools and services that facilitate the physician's ability to meet MOC requirements.

8. The independent study to evaluate the impact that MOL and MOC requirements have on the physician workforce, physicians' practice costs, patient outcomes, patient safety and patient access.

As part of the effort of the Council on Medical Education to monitor the implementation of MOC, OCC, and MOL, Council members—along with the Board of Trustees and AMA staff—have participated in meetings that include the Special Committee on Maintenance of Licensure, Maintenance of Licensure Implementation Group, ABMS Continuing Certification Committee, MOL Workgroup on Non-clinical Physicians, Joint Working Group on MOC-CME, Workshops on ABMS MOC, and CEO Advisory Council conference calls. This report reflects an update based, in part, on these interactions.

MAINTENANCE OF CERTIFICATION (MOC): AN UPDATE

ABMS Updated Standards for Programs for MOC: An Overview

The ABMS Board of Directors approved the Updated Standards for the ABMS Program for MOC on January 15, 2014 (see Appendix B).⁶ The Standards were developed over two years, with input from physician leaders, practicing physicians and the public. AMA representatives, including the Council on Medical Education, provided comments to the ABMS during a two-month public comment period. The ABMS reported receiving over 625 comments. These Standards, which are being implemented during 2014, will take effect in 2015.

The focus of the Updated Standards is to provide a more flexible framework for ABMS Member Boards to develop their own programs for MOC. The Standards include elements common to MOC for all boards and define a patient-centric perspective, addressing professionalism, patient safety, and performance improvement. Member Boards were encouraged by ABMS to accept distinctions in learning and assessment appropriate for the specialty and to provide feedback to physicians on their examination performance. Physician feedback will be solicited related to the MOC evaluation process and how team-based learning and improvement relate to MOC. Patricia Turner, MD, FACS, of the Council on Medical Education, has been appointed to the new ABMS Committee on Continuing Certification. Dr. Turner will be able to communicate between the AMA and ABMS as these Standards are implemented as well as relate updates on ABMS Member Boards' MOC Programs.

In February 2014, the ABMS conducted an MOC Implementation Workshop for its member boards about the Standards. This and future workshops will focus on external and innovative methods of assessment, learning and practice improvement—incorporating existing feedback from secure, high-stakes examinations—to modify performance improvement and CME activities and to enhance the practice relevancy of MOC Part III activities.

MOC: Evidence of a Public Mandate

Rapid expansion in scientific knowledge, changes in disease management, and the ongoing development of procedures and technologies make continuous learning and improvement a professional necessity and a patient safety issue. Consumer groups such as AARP have adopted policies, based on their consumer survey results and research, and they encourage their members to seek out board-certified physicians.⁷ The ABMS reports that patients and family members routinely check their physicians' certification status by using the free ABMS search mechanism at CertificationMatters.org. In 2012, more than 1.5 million ABMS searches were conducted, though the breakdown as to who searched the site is not available.

The number of hospitals and other health care organizations, e.g., The Joint Commission, and Centers for Medicare and Medicaid Services (CMS), that include board certification and participation in MOC as a key qualification for medical staff privileges continues to expand.⁸ Freed et al. reported that a larger proportion of hospitals (80% vs. 67%) require pediatricians and pediatric subspecialists to be board certified, comparing 2010 and 2005 data.⁹ Hospitals may also be influenced by regulatory agencies, such as the CMS MOC Program Incentive, which provides physicians with an additional incentive payment beyond the Physician Quality Reporting System (PQRS) incentive when MOC program incentive requirements have been met.¹⁰

To better align the activities of practicing physicians with the requirements of MOC, the ABMS has delineated opportunities for ABMS Member Board-certified physicians to have MOC activities satisfy other national, state, and private-sector quality improvement and reporting activities. For example, to reduce the data collection burden on physicians, the MOC Part IV programs of nine ABMS member boards, including the American Boards of Allergy

and Immunology, Dermatology, Emergency Medicine, Internal Medicine, Nuclear Medicine, Neurological Surgery, Radiology, Obstetrics and Gynecology, and Ophthalmology, align with the PQRS quality initiative.

Value of MOC: ABMS Data

While no certification process guarantees performance or positive outcomes, evidence shows that physicians who keep current provide better quality care and show improved outcomes.¹¹ Initial certification only documents that the physician has completed the required educational program(s), been evaluated by knowledgeable educators, and passed a secure, high-stakes examination that assesses medical knowledge. In a recent study to examine the relationship between participation in MOC and the clinical knowledge of family physicians as they moved further away from residency training, O'Neill et al. concluded that "conscientious participation in the rigorous and structured processes required to maintain certification results in continued improvement in clinical knowledge over time."¹²

In July 2013, the ABMS created their *MOC Myths and Facts* card deck and an interactive online library of peer-reviewed references and annotations related to initial board certification and MOC (evidencelibrary.abms.org). The site lists more than 200 study annotations focusing on best practices in CME and the ABMS Program for MOC Part II, Lifelong Learning and Self-Assessment. The ABMS and the Member Boards cite these studies as the basis for their decisions about the initial certification process and MOC.

Self-assessment and Lifelong Learning: MOC Part II

Lifelong learning and self-assessment, integral parts of MOC, OCC and MOL, were reviewed in the December 2013 supplement of the *Journal of Continuing Education in the Health Professions (JCEHP)* available at abms.org/JCEHP_Supplement/JCEHP_v33_iS1_final.pdf. The supplement includes articles and editorials examining the ABMS MOC process. Hawkins et al. reviewed the theoretical rationale and empiric data regarding the MOC program and concluded that there was evidence to support the current structure and elements of the MOC program.¹³ Other articles noted opportunities for program improvement and further study as well as the efforts in countries other than the United States to incorporate MOC-like, career-long learning and assessment programs into their systems of professional regulation.

At the February 2014 ABMS Member Boards' Meeting, a half-day session focused on the need to better link cross-specialty education and assessment to create MOC activities that more truly reflect patient-centered care. The meeting sought to foster greater collaboration between CME providers, such as specialty societies and academic health centers, and the ABMS Member Boards. The ABMS plans to convene CME providers and representatives of the ABMS Member Boards to discuss gaps in educational programming and opportunities for sharing.

Mandatory Secure, High-stakes Examination: MOC Part III

In the *JCEHP* article referenced above, Hawkins et al. also recommend that a periodic assessment of physician knowledge is needed to assure the public about the knowledge and cognitive skills of physicians, although the manner and format of knowledge assessment may evolve as MOC develops into a more mature improvement framework.¹³ All ABMS Member Boards set the standards for passing secure, high-stakes examinations, based on accepted, standard-setting methodologies geared to achieve relevant, valid and reliable assessment based on psychometrics.^{14,15} There is disagreement, however, among physicians about the relevance of a closed book secure exam to current clinical practice. A recent American Board of Anesthesiology (ABA) survey reported that one in three anesthesiologists preferred not to take a secure, high stakes examination as part of MOC, citing concern that the ABA Cognitive Examination covered topics that were not relevant to their current practice.¹⁶ A December 2013 survey conducted by the Young Physicians Section (AMA-YPS), in conjunction with the ABMS, reported that more than half of the respondents (63%) agreed that the secure exam as part of MOC should be modified to make it more practice relevant. Integrating decision support or other point of care support to reflect what physicians use in daily practice (i.e., Internet access, online access to journal articles, PubMed, etc.) would make MOC Part III (the secure, high-stakes exam) more practice relevant.

Modifications to MOC Part III: Current ABMS Efforts

While the ABMS continues to engage in discussions about alternatives to a secure examination that would allow ABMS Member Boards to assess medical knowledge in a manner more relevant to practice, the Updated Standards emphasize the need to assess physician judgment and skills. Part III of the Updated Standards (Assessment of Knowledge, Judgment, and Skills - Purposes and Anticipated Outcomes) states that Part III (an objective external assessment) should be linked to Part II, continuous learning and self-assessment.⁶

To continue the discussion about practice-relevant and innovative MOC Part III activities, the ABMS and the AMA will sponsor a meeting in June 2014 that will bring subject matter experts in physician assessment together with representatives from the Council on Medical Education, AMA sections, and ABMS Member Boards.

MOC Part IV: Streamlining Efforts

The latest principles in adult learning are incorporated into MOC activities such as self-directed practice improvement modules (PIMs), simulations and interactive workshops. Most of the ABMS Member Boards permit these approaches in their performance improvement activities.

The December 2013 AMA-YPS survey, conducted in conjunction with the ABMS, showed that a variety of activities are used to satisfy Part IV of the MOC process, with the most common being PIMs (63%). Other popular activities that physicians engage in to satisfy Part IV of MOC include chart audit (41%), patient surveys (30%), and quality-improvement activities (group-based, 25%; board defined, 22%; and self-defined, 20%). More than half of the respondents (55%) indicated that allowing CME activities required for licensure or privileging to count for MOC could have the most impact on streamlining the MOC process.

Financial considerations related to MOC: ABMS and Member Board Transparency

The ABMS reports that the average annual amount a diplomate pays to one's ABMS Member Board is approximately \$270 for the past year. The ABMS cites the Updated Standards that focus on sharing of resources and of opportunities for innovation, and on developing added efficiencies to control costs for physicians and the ABMS Member Boards. In addition to direct costs, the ABMS is assessing time and administrative burden associated with participation.⁶

Multiple Board Certificates: Issues for Physicians

Diplomates certified by multiple ABMS Member Boards may have inconsistent and confusing experiences when interacting with two or more boards. As of February 2014, less than four percent of all diplomates were certified by more than one ABMS Member Board. The Council on Medical Education supports efforts by the ABMS to streamline MOC for diplomates with certification by multiple boards. In 2015, the ABMS Member Board Program for MOC review process will be launched. This review process will allow the ABMS to collect additional information on boards' policies pertaining to multiple certifications. Notable policies will be shared among the boards to facilitate the adoption of appropriate practices.

ABMS: Additional Proposed Programs

The ABMS Academic Programs and Services staff has begun to conceptualize several online toolkits highlighting existing educational and assessment resources categorized by the six ABMS/Accreditation Council for Graduate Medical Education (ACGME) core competencies. For example, the ABMS plans to work with the AMA Physician Practice Sustainability Program to identify existing AMA resources to be included in the systems-based practice toolkit. Utilization of the toolkits may further facilitate the fulfillment of MOC requirements by physicians certified by multiple Member Boards.

In April 2014, the ABMS National Policy Forum focused on medical specialty workforce development, specifically looking at opportunities to better link graduate medical training, practice, and certification to respond to a changing delivery system. The program included presentations by the Macy Foundation, the Program on Health Workforce Research and Policy (University of North Carolina), and other subject matter experts in health workforce analysis.

OSTEOPATHIC CONTINUOUS CERTIFICATE (OCC): AN UPDATE

Each of the 18 specialty certifying member boards of the American Osteopathic Association's Bureau of Osteopathic Specialists (AOA-BOS) has implemented OCC, effective January 1, 2013. All osteopathic physicians who hold a time-limited certificate are required to participate in the following five components of the OCC process in order to maintain osteopathic board certification:

- **Component 1 - Unrestricted Licensure:** requires that physicians who are board certified by the AOA hold a valid, unrestricted license to practice medicine in one of the 50 states, and adhere to the AOA's Code of Ethics.
- **Component 2 - Life Long Learning/Continuing Medical Education (CME):** requires that all recertifying diplomates fulfill a minimum of 120 hours of CME credit during each three-year CME cycle (some certifying boards have higher requirements). Of these 120 plus CME credit hours, a minimum of 50 credit hours must be in the specialty area of certification. Self-assessment activities will be designated by each of the 18 specialty certification boards. If an osteopathic physician holds a Certificate of Added Qualifications (CAQ), a percentage of their specialty credit hours must be in their CAQ area.
- **Component 3 - Cognitive Assessment:** requires provision of one (or more) psychometrically valid and proctored examinations that assess a physician's specialty medical knowledge as well as core competencies in the provision of health care.
- **Component 4 - Practice Performance Assessment and Improvement:** requires that physicians engage in continuous quality improvement through comparison of personal practice performance measured against national standards for his or her medical specialty. The Standards Review Committee of the AOA-BOS has specific criteria for each Component 4 activity.
- **Component 5 - Continuous AOA Membership.**

Specific requirements for each specialty are available at osteopathic.org/inside-aoa/development/aoa-board-certification/occ-requirements/Pages/default.aspx

Osteopathic physicians who hold non-time-limited certificates (non-expiring) are not required to participate in OCC. However, to maintain their certification, they must continue to meet licensure, CME (120-150 credits every three-year CME cycle, 30 of which are in AOA CME Category 1A), and membership requirements.

The AOA has developed policies for clinically inactive diplomates as well as for diplomates whose scope of practice is limited within their area of certification (limited scope physicians). For dually boarded (AOA/ABMS) diplomates, each board is developing mechanisms to partially accept ABMS MOC Part IV activities for the AOA Component 4 requirements; an osteopathic activity will still be required.

The AOA is encouraging all physicians to participate in OCC, because the FSMB recommends to state medical boards the acceptance of OCC for MOL requirements. After four AOA boards were awarded conditional approval of their OCC processes for the MOC Program incentive offered by CMS for the 2012 reporting year, the AOA applied to CMS on behalf of all AOA specialty boards for the 2013 reporting year, and all AOA board certification specialties and subspecialties were approved for the CMS MOC program incentive.¹⁰ CMS does not require physicians to report on quality measures.

MAINTENANCE OF LICENSURE (MOL): AN UPDATE

Pilot Projects

The FSMB is engaging in a series of pilot projects to advance understanding of the process, structure and resources necessary to develop an effective and comprehensive MOL system. Nine state medical boards are participating in pilot projects: Osteopathic Medical Board of California, Colorado Medical Board, Delaware Board of Medical Practice, Iowa Board of Medicine, Massachusetts Board of Registration in Medicine, Mississippi State Board of Medical Licensure, Oregon Medical Board, Virginia Board of Medicine and Wisconsin Medical Examining Board.

The first pilot project, a State Readiness Inventory survey, was distributed to participating pilot state medical boards in October 2012. The pilot consisted of an electronic survey designed to facilitate discussion of implementation of MOL and to identify issues state boards need to consider and possibly resolve to ensure successful implementation of MOL.

The second pilot, a survey to collect opinions from licensed physicians about the details and benefits of the CME activities in which they are currently participating, was conducted with practicing physicians in Colorado in fall 2013. Staff from the FSMB, National Board of Medical Examiners (NBME), and ABMS worked together with the Colorado Medical and Osteopathic Societies and the Colorado Medical Board to develop and disseminate the survey. The survey was administered from March 20 to July 10, 2013 via an online questionnaire and was made available to Colorado physicians by announcements on licensure renewal materials and several direct emails. Of the approximately 19,000 licensed physicians in Colorado, 3,084 completed the questionnaire.

Among respondents, the vast majority of whom were board certified, the most commonly reported methods for improving the quality of medical practice were conference attendance, reading the medical literature, and in-person and online CME programs. The primary reasons that most respondents participated in CME/continuing professional development (CPD) in the last two years were to improve overall knowledge and patient care. Respondents found all CME/CPD delivery methods to be useful for improving quality of medical practice and indicated that all methods provided insight into strengths and opportunities for improvement.

The survey was also distributed in Virginia through the Medical Society of Virginia and will be launched in other MOL pilot states in 2014. The FSMB will seek opportunities to formally publish the results of the survey after additional data is gathered. Additional pilot projects will be undertaken over the course of the year.

MOL Task Force on CPD Activities

FSMB Chair Jon Thomas, MD, convened the MOL Task Force on CPD Activities in 2013 to develop recommendations regarding tools and activities that could meet a state's requirements for MOL. Members of the Task Force include state medical board representatives, CME experts in the community and other stakeholders. The Task Force presented an informational report to the FSMB House of Delegates at its April 2014 meeting. The report addressed issues such as models for compliance, standards, and criteria for CPD activities, and recommendations for state medical boards, the FSMB and other stakeholders.

Currently, the guiding principles for MOL, adopted by the FSMB, also recognize the value of active engagement in meeting MOC and OCC requirements. MOC and OCC are not intended to become mandatory requirements for medical licensure but should be recognized as meeting some or all of a state's requirements for MOL to avoid unnecessary duplication of work.¹⁷ AMA Policy H-275.923, "Maintenance of Certification/Maintenance of Licensure," opposes mandatory board certification.

Additional information about MOL is available at fsmb.org/mol.html.

STUDY BY AN INDEPENDENT ENTITY ON MOC, OCC, AND MOL: CURRENT STATUS

Most of the data about the value, validity and benefits of MOC has been assembled by the ABMS and its Member Boards. These entities cannot be considered independent of the MOC process or unbiased in their assessment. The HOD therefore requested that the AMA "solicit an independent entity to commission and pay for a study to evaluate the impact..." of MOC, MOL and OCC on a number of issues (Policy D-275.960[6]).

As an initial step in exploring the feasibility of such a study, the AMA contacted the Cecil G. Sheps Center for Health Services Research (The University of North Carolina at Chapel Hill). The Sheps Center's Program on Health Workforce Research and Policy is one of four new national Health Workforce Centers focused on addressing the question of what health care workforce is needed to ensure access to high quality, efficient health care for the US population. The impact of MOC/OCC/MOL on physician workforce was one of the areas the study was to address. The Center is supported through a cooperative agreement with the Health Resources and Services Administration and managed by the Bureau of Health Professions' National Center for Health Workforce Analysis. As such, the Center would be considered an independent entity.

The AMA was advised that data are currently not available to study the effect of MOC and MOL on the retention of physicians in the workforce. Developing a study to answer the question of whether some physicians choose retirement over maintaining certification would require a fairly complex study design. Given the rapid pace of health system change currently underway, a multivariate analysis would be required to isolate the effect that MOC and MOL have relative to other factors that also affect physician retention in the workforce, including meaningful use requirements, electronic health records, accountable care organizations (ACOs), economic conditions, etc. A longitudinal study would be needed that also adjusted for physician age, specialty, certification cohort, gender, and years since graduation. Further, the study would need to adjust for geographic factors including rural versus urban/suburban practices.

In an effort to look at physician workforce from a different perspective, the American Academy of Family Physicians' Robert Graham Center conducted a study to investigate the characteristics of differential participation in MOC by family physicians. The study reported that after completing the transition of all family physicians into MOC in 2010, participation appears to be higher than previously, and large numbers of family physicians are participating in MOC and meeting the requirements in a timely fashion. The study also showed that physicians who have not participated in MOC for family physicians tend to be practicing in underserved areas or caring for underserved populations where health care providers and technological resources are generally limited.^{18,19,20} This raises questions about the impact of MOC participation related to workforce, physician maldistribution, and the potentiation of health care disparities.

Another issue that impacts physician workforce is physician re-entry. Representatives from the Federation of State Physician Health Programs met with the ABMS Member Boards community in February 2014 during an ABMS-sponsored workshop. The discussion focused on improving awareness of and communication between the Member Boards and the state-based physician health programs in order to facilitate the exchange of appropriate information to assist in certification and re-entry decisions of physicians participating in physician health programs.

SUMMARY AND RECOMMENDATIONS

Literature citing the decline of physician knowledge, skills and performance over time, and the perceived need to reassure the public about a physician's ongoing competence, form the basis for programs such as MOC, OCC, and MOL, which will measure and monitor physician competencies over time. These programs continue to be developed and refined, and the Council on Medical Education has ongoing and active dialogue with the organizations responsible for these programs.

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

1. That our American Medical Association Council on Medical Education continue to review published literature and emerging data as part of the Council's ongoing efforts to critically review maintenance of certification (MOC), osteopathic continuous certification (OCC), and maintenance of licensure (MOL) issues.
2. That our AMA continue to explore with independent entities the feasibility of conducting a study to evaluate the impact that MOC requirements and the principles of MOL have on physicians' practices, including, but not limited to physician workforce, physicians' practice costs, patient outcomes, patient safety, and patient access.
3. That our AMA work with the American Board of Medical Specialties (ABMS) and the ABMS Member Boards to collect data on why physicians choose to maintain or discontinue their board certification.
4. That our AMA work with the ABMS and the Federation of State Medical Boards to study whether MOC and the principles of MOL are important factors in a physician's decision to retire and have a direct impact on the US physician workforce.
5. That our AMA oppose mandatory MOC as a condition of medical licensure and encourage physicians to strive constantly to improve their care of patients by the means they find most effective.

APPENDIX A - AMA Policies on MOC, OCC, and MOL (as of February 14, 2014)

D-275.960, An Update on Maintenance of Certification, Osteopathic Continuous Certification, and Maintenance of Licensure

1. Our AMA will encourage the American Board of Medical Specialties (ABMS) and the specialty certification boards to continue to explore other ways to measure the ability of physicians to access and apply knowledge to care for patients as an alternative to high stakes closed book examinations. 2. Our AMA will continue to monitor the evolution of Maintenance of Certification (MOC), Osteopathic Continuous Certification (OCC), and Maintenance of Licensure (MOL), continue its active engagement in discussions regarding their implementation, and report back to the House of Delegates on these issues. 3. Our AMA will (a) work with the ABMS and ABMS specialty boards to continue to examine the evidence supporting the value of specialty board certification and MOC and to determine the continued need for the mandatory high-stakes examination; and (b) work with the ABMS to explore alternatives to the mandatory high-stakes examination. 4. Our AMA encourages the ABMS to ensure that all ABMS specialty boards provide full transparency related to the costs of preparing, administering, scoring, and reporting MOC and certifying/recertifying examinations and ensure that MOC and certifying/recertifying examinations do not result in significant financial gain to the ABMS specialty boards. 5. Our AMA will work with the ABMS to lessen the burden of MOC on physicians with multiple board certifications, in particular to ensure that MOC is specifically relevant to the physician's current practice. 6. Our AMA will solicit an independent entity to commission and pay for a study to evaluate the impact that MOL and MOC requirements have on physicians' practices, including but not limited to: physician workforce, physicians' practice costs, patient outcomes, patient safety and patient access. Such study will look at the examination processes of the ABMS, the American Osteopathic Association, and the Federation of State Medical Boards. Such study is to be presented to the AMA HOD, for deliberation and consideration before any entity, agency, board or governmental body requires physicians to sit for MOL licensure examinations. Progress report is to be presented at Annual 2014; complete report by Annual 2015. 7. Our AMA: (a) supports ongoing ABMS specialty board efforts to allow other physician educational and quality improvement activities to count for MOC; (b) supports specialty board activities in facilitating the use of MOC quality improvement activities to count for other accountability requirements or programs such as pay for quality/performance or PQRS reimbursement; (c) encourages the ABMS specialty boards to enhance the consistency of such programs across all boards; and (d) will work with specialty societies and specialty boards to develop tools and services that facilitate the physician's ability to meet MOC requirements. (CME Rep. 10, A-12; Modified: CME Rep. 4, A-13)

H-275.920, Impact of Maintenance of Certification, Osteopathic Continuous Certification, Maintenance of Licensure on the Physician Workforce

1. Our AMA encourages the Federation of State Medical Boards to continue to work with state licensing boards to accept physician participation in maintenance of certification (MOC) and osteopathic continuous certification (OCC) as meeting the requirements for MOL and to develop alternatives for physicians who are not certified/recertified, and that MOC or OCC not be the only pathway to MOL for physicians. 2. Our AMA encourages the American Board of Medical Specialties to use data from maintenance of certification to track whether physicians are maintaining certification and share this data with the AMA. (CME Rep. 11, A-12)

H-275.923, Maintenance of Certification / Maintenance of Licensure

Our AMA will: 1. Continue to work with the Federation of State Medical Boards (FSMB) to establish and assess maintenance of licensure (MOL) principles with the AMA to assess the impact of MOC and MOL on the practicing physician and the FSMB to study the impact on licensing boards. 2. Recommend that the American Board of Medical Specialties (ABMS) not introduce additional assessment modalities that have not been validated to show improvement in physician performance and/or patient safety. 3. Encourage rigorous evaluation of the impact on physicians of future proposed changes to the MOC and MOL processes including cost, staffing, and time. 4. Review all AMA policies regarding medical licensure; determine if each policy should be reaffirmed, expanded, consolidated or is no longer relevant; and in collaboration with other stakeholders, update the policies with the view of developing AMA Principles of Maintenance of Licensure in a report to the HOD at the 2010 Annual Meeting. 5. Urge the National Alliance for Physician Competence (NAPC) to include a broader range of practicing physicians and additional stakeholders to participate in discussions of definitions and assessments of physician competence. 6. Continue to participate in the NAPC forums. 7. Encourage members of our House of Delegates to increase their awareness of and participation in the proposed changes to physician self-regulation through their specialty organizations and other professional membership groups. 8. Continue to support and promote the AMA Physician's Recognition Award (PRA) Credit system as one of the three major CME credit systems that comprise the foundation for post graduate medical education in the US, including the Performance Improvement CME (PICME) format; and

continue to develop relationships and agreements that may lead to standards, accepted by all US licensing boards, specialty boards, hospital credentialing bodies, and other entities requiring evidence of physician CME. 9. Collaborate with the American Osteopathic Association and its eighteen specialty boards in implementation of the recommendations in CME Report 16-A-09, Maintenance of Certification / Maintenance of Licensure. 10. Continue to support the AMA Principles of Maintenance of Certification (MOC). 11. Monitor MOL as being led by the Federation of State Medical Boards (FSMB), and work with FSMB and other stakeholders to develop a coherent set of principles for MOL. 12. Our AMA will 1) advocate that if state medical boards move forward with the more intense MOL program, each state medical board be required to accept evidence of successful ongoing participation in the American Board of Medical Specialties Maintenance of Certification and American Osteopathic Association-Bureau of Osteopathic Specialists Osteopathic Continuous Certification to have fulfilled all three components of the MOL if performed, and 2) also advocate to require state medical boards accept programs created by specialty societies as evidence that the physician is participating in continuous lifelong learning and allow physicians choices in what programs they participate to fulfill their MOL criteria. (CME Rep. 16, A-09; Appended: CME Rep. 3, A-10; Reaffirmed: CME Rep. 3, A-10; Appended: Res. 322, A-11; Reaffirmed: CME Rep. 10, A-12; Reaffirmed in lieu of Res. 313, A-12; Reaffirmed: CME Rep. 4, A-13; Reaffirmed in lieu of Res. 919, I-13)

H-275.924, Maintenance of Certification

AMA Principles on Maintenance of Certification (MOC): 1.Changes in specialty-board certification requirements for MOC programs should be longitudinally stable in structure, although flexible in content. 2. Implementation of changes in MOC must be reasonable and take into consideration the time needed to develop the proper MOC structures as well as to educate physician diplomates about the requirements for participation. 3. Any changes to the MOC process for a given medical specialty board should occur no more frequently than the intervals used by each board for MOC. 4. Any changes in the MOC process should not result in significantly increased cost or burden to physician participants (such as systems that mandate continuous documentation or require annual milestones). 5. MOC requirements should not reduce the capacity of the overall physician workforce. It is important to retain a structure of MOC programs that permit physicians to complete modules with temporal flexibility, compatible with their practice responsibilities. 6. Patient satisfaction programs such as The Consumer Assessment of Healthcare Providers and Systems (CAHPS) patient survey would not be appropriate nor effective survey tools to assess physician competence in many specialties. 7. Careful consideration should be given to the importance of retaining flexibility in pathways for MOC for physicians with careers that combine clinical patient care with significant leadership, administrative, research, and teaching responsibilities. 8. Legal ramifications must be examined, and conflicts resolved, prior to data collection and/or displaying any information collected in the process of MOC. Specifically, careful consideration must be given to the types and format of physician-specific data to be publicly released in conjunction with MOC participation. 9. The AMA affirms the current language regarding continuing medical education (CME): “By 2011, each Member Board will document that diplomates are meeting the CME and Self-Assessment requirements for MOC Part 2. The content of CME and self-assessment programs receiving credit for MOC will be relevant to advances within the diplomate’s scope of practice, and free of commercial bias and direct support from pharmaceutical and device industries. Each diplomate will be required to complete CME credits (AMA Physician’s Recognition Award (PRA) Category 1, American Academy of Family Physicians Prescribed, American College of Obstetricians and Gynecologists, and or American Osteopathic Association Category 1A).” 10. MOC is an essential but not sufficient component to promote patient-care safety and quality. Health care is a team effort and changes to MOC should not create an unrealistic expectation that failures in patient safety are primarily failures of individual physicians. (CME Rep. 16, A-09; Reaffirmed: CME Rep. 11, A-12; Reaffirmed: CME Rep. 10, A-12; Reaffirmed in lieu of Res. 313, A-12; Reaffirmed: CME Rep. 4, A-13; Reaffirmed in lieu of Res. 919, I-13)

D-275.971, American Board of Medical Specialties - Standardization of Maintenance of Certification Requirements

1. Our AMA will work with the American Board of Medical Specialties to streamline Maintenance of Certification (MOC) to reduce the cost, inconvenience, and the disruption of practice due to MOC requirements for all of their member boards, including subspecialty requirements. 2. Our AMA will actively work to enforce existing policies to reduce current costs and effort required for the maintenance of certification and to work to control future charges and expenses. (Sub. Res. 313, A-06; Reaffirmed: CME Rep. 7, A-07; Reaffirmed: CME Rep. 16, A-09; Appended: Res. 319, A-12; Reaffirmed in lieu of Res. 313, A-12; Reaffirmed in lieu of Res. 919, I-13)

D-275.969, Specialty Board Certification and Recertification

1. Our AMA will continue to monitor the progress by the ABMS and its member boards on implementation of Maintenance of Certification (MOC) and encourage ABMS to report its research findings on the issues surrounding

certification, recertification and MOC on a periodic basis. 2. An update report will be prepared for the AMA House of Delegates no later than 2010. 3. Our AMA will encourage dialogue between the ABMS and its respective specialty societies to work on development, implementation, and monitoring of MOC that meets the needs of practicing physicians and improves patient care. 4. Our AMA will exercise its full influence to protect physicians from undue burden and expense in the Maintenance of Certification process. (CME Rep. 7, A-07; Reaffirmed: CME Rep. 16, A-09; Reaffirmed in lieu of Res. 919, I-13)

H-275.978, Medical Licensure

The AMA: (1) urges directors of accredited residency training programs to certify the clinical competence of graduates of foreign medical schools after completion of the first year of residency training; however, program directors must not provide certification until they are satisfied that the resident is clinically competent; (2) encourages licensing boards to require a certificate of competence for full and unrestricted licensure; (3) urges licensing boards to review the details of application for initial licensure to assure that procedures are not unnecessarily cumbersome and that inappropriate information is not required. Accurate identification of documents and applicants is critical. It is recommended that boards continue to work cooperatively with the Federation of State Medical Boards to these ends; (4) will continue to provide information to licensing boards and other health organizations in an effort to prevent the use of fraudulent credentials for entry to medical practice; (5) urges those licensing boards that have not done so to develop regulations permitting the issuance of special purpose licenses. It is recommended that these regulations permit special purpose licensure with the minimum of educational requirements consistent with protecting the health, safety and welfare of the public; (6) urges licensing boards, specialty boards, hospitals and their medical staffs, and other organizations that evaluate physician competence to inquire only into conditions which impair a physician's current ability to practice medicine. (BOT Rep. I-93-13; CME Rep. 10 - I-94); (7) urges licensing boards to maintain strict confidentiality of reported information; (8) urges that the evaluation of information collected by licensing boards be undertaken only by persons experienced in medical licensure and competent to make judgments about physician competence. It is recommended that decisions concerning medical competence and discipline be made with the participation of physician members of the board; (9) recommends that if confidential information is improperly released by a licensing board about a physician, the board take appropriate and immediate steps to correct any adverse consequences to the physician; (10) urges all physicians to participate in continuing medical education as a professional obligation; (11) urges licensing boards not to require mandatory reporting of continuing medical education as part of the process of reregistering the license to practice medicine; (12) opposes the use of written cognitive examinations of medical knowledge at the time of reregistration except when there is reason to believe that a physician's knowledge of medicine is deficient; (13) supports working with the Federation of State Medical Boards to develop mechanisms to evaluate the competence of physicians who do not have hospital privileges and who are not subject to peer review; (14) believes that licensing laws should relate only to requirements for admission to the practice of medicine and to assuring the continuing competence of physicians, and opposes efforts to achieve a variety of socioeconomic objectives through medical licensure regulation; (15) urges licensing jurisdictions to pass laws and adopt regulations facilitating the movement of licensed physicians between licensing jurisdictions; licensing jurisdictions should limit physician movement only for reasons related to protecting the health, safety and welfare of the public; (16) encourages the Federation of State Medical Boards and the individual medical licensing boards to continue to pursue the development of uniformity in the acceptance of examination scores on the Federation Licensing Examination and in other requirements for endorsement of medical licenses; (17) urges licensing boards not to place time limits on the acceptability of National Board certification or on scores on the United State Medical Licensing Examination for endorsement of licenses; (18) urges licensing boards to base endorsement on an assessment of physician competence and not on passing a written examination of cognitive ability, except in those instances when information collected by a licensing board indicates need for such an examination; (19) urges licensing boards to accept an initial license provided by another board to a graduate of a US medical school as proof of completion of acceptable medical education; (20) urges that documentation of graduation from a foreign medical school be maintained by boards providing an initial license, and that the documentation be provided on request to other licensing boards for review in connection with an application for licensure by endorsement; (21) urges licensing boards to consider the completion of specialty training and evidence of competent and honorable practice of medicine in reviewing applications for licensure by endorsement; and (22) encourages national specialty boards to reconsider their practice of decertifying physicians who are capable of competently practicing medicine with a limited license. (CME Rep. A, A-87; Modified: Sunset Report, I-97; Reaffirmation A-04; Reaffirmed: CME Rep. 3, A-10; Reaffirmation I-10; Reaffirmed: CME Rep. 6, A-12; Appended: Res. 305, A-13)

D-300.978, Continuing Medical Education Credit for Maintenance of Certification / Osteopathic Continuous Certification Activities

1. Our AMA will petition both the American Board of Medical Specialties (ABMS) and the American Osteopathic Association (AOA) to strongly encourage each of its specialty boards to offer certified Continuing Medical Education (CME) credit for required Maintenance of Certification (MOC) and Osteopathic Continuous Certification (OCC) activities dealing with practice performance assessment and life long learning. 2. Our AMA encourages all specialty societies to grant certified CME credit for activities that they offer to fulfill requirements of their respective specialty boards' MOC and associated processes. (Res. 329, A-11)

H-275.926, Maintaining Medical Specialty Board Certification Standard

1. Our AMA opposes any action, regardless of intent, that appears likely to confuse the public about the unique credentials of board certified physicians in any medical specialty, or take advantage of the prestige of any medical specialty for purposes contrary to the public good and safety. 2. Our AMA will communicate its concerns about the misleading use of the term "board certification" by the National Board of Public Health Examiners and others to the specialty and service societies in the federation, the Association of Schools of Public Health, the American Board of Medical Specialties, the Accreditation Council for Graduate Medical Education, the National Board of Medical Examiners, and the Institute of Medicine. 3. Our AMA will continue to work with other medical organizations to educate the profession and the public about the board certification process. It is AMA policy that when the equivalency of board certification must be determined, accepted standards, such as those adopted by state medical boards or the Essentials for Approval of Examining Boards in Medical Specialties, be utilized for that determination. (Res. 318, A-07; Reaffirmation A-11)

D-275.987, Internal Medicine Board Certification Report - Interim Report

Our AMA shall: (1) support the ACP/ASIM in its efforts to work with the American Board of Internal Medicine (ABIM) to improve the Maintenance of Certification (MOC) program; (2) encourage specialty societies to work with their respective ABMS member board to develop, implement and evaluate the Maintenance of Certification (MOC) program; (3) continue to assist physicians in practice performance improvement; (4) continue to monitor the progress by the American Board of Internal Medicine and the other member boards of the American Board of Medical Specialties (ABMS) on implementing the Maintenance of Certification (MOC) program; (5) encourage the ABMS to include practicing physicians and physicians with time limited board certificates to assist in designing and evaluating the Maintenance of Certification (MOC) process for each of the ABMS member boards; and (6) shall study the ethical implications of the Maintenance of Certification (MOC) program including the patient assessment component vis-à-vis the doctor-patient relationship and the ethical implications of the peer review component vis-à-vis the practice environment. (CMS Rep. 7, A-02; Reaffirmed: CME Rep. 9, A-05; Reaffirmed: CME Rep. 7, A-07; Reaffirmed: CME Rep. 16, A-09)

H-275.944, Board Certification and Discrimination

(1) Where board certification is one of the criteria considered for purposes of measuring quality of care, determining eligibility to contract with managed care entities, eligibility to receive hospital staff or other clinical privileges, ascertaining competence to practice medicine, or for other purposes, the AMA oppose discrimination that may occur against physicians involved in the board certification process including those who are in a clinical practice period for the specified minimum period of time that must be completed prior to taking the board certifying examination. (2) Our AMA reaffirms and communicates its policy of opposition to discrimination against member physicians based solely on lack of American Board of Medical Specialties or equivalent American Osteopathic Board certification. (3) Our AMA continues to advocate for nomenclature to better distinguish those physicians who are in the board certification pathway from those who are not. (Sub. Res. 701, I-95; Appended: Res. 314, I-98; Appended: Sub. Res. 301, I-99; Reaffirmed: Sub. Res. 722, A-00; Reaffirmed: CME Rep. 7, A-07)

H-405.975, Recertification Exam for the American Board of Medical Specialties

Our AMA actively encourages those specialty boards that issue time limited certificates to include young physicians with such certificates in the decision-making process for any design of plans for recertification. (Res. 303, A-92; Reaffirmed: CME Rep. 7, A-02; Reaffirmed: CME Rep. 2, A-03; Reaffirmed: CME Rep. 7, A-07; Reaffirmed: CME Rep. 16, A-09)

H-275.950, Board Certification

Our AMA (1) reaffirms its opposition to the use of board certification as a requirement for licensure or reimbursement; and (2) seeks an amendment to the new Medicaid rules that would delete the use of board

certification as a requirement for reimbursement and would address the exclusion of internal medicine, emergency medicine, and other specialties. (Res. 143, A-92; ; Reaffirmed by Res. 108, A-98; Reaffirmation A-00; Reaffirmed: CME Rep. 16, A-09)

H-295.995, Recommendations for Future Directions for Medical Education

Our AMA supports the following recommendations relating to the future directions for medical education: (1) The medical profession and those responsible for medical education should strengthen the general or broad components of both undergraduate and graduate medical education. All medical students and resident physicians should have general knowledge of the whole field of medicine regardless of their projected choice of specialty. (2) Schools of medicine should accept the principle and should state in their requirements for admission that a broad cultural education in the arts, humanities, and social sciences, as well as in the biological and physical sciences, is desirable. (3) Medical schools should make their goals and objectives known to prospective students and premedical counselors in order that applicants may apply to medical schools whose programs are most in accord with their career goals. (4) Medical schools should state explicitly in publications their admission requirements and the methods they employ in the selection of students. (5) Medical schools should require their admissions committees to make every effort to determine that the students admitted possess integrity as well as the ability to acquire the knowledge and skills required of a physician. (6) Although the results of standardized admission testing may be an important predictor of the ability of students to complete courses in the preclinical sciences successfully, medical schools should utilize such tests as only one of several criteria for the selection of students. Continuing review of admission tests is encouraged because the subject content of such examinations has an influence on premedical education and counseling. (7) Medical schools should improve their liaison with college counselors so that potential medical students can be given early and effective advice. The resources of regional and national organizations can be useful in developing this communication. (8) Medical schools are chartered for the unique purpose of educating students to become physicians and should not assume obligations that would significantly compromise this purpose. (9) Medical schools should inform the public that, although they have a unique capability to identify the changing medical needs of society and to propose responses to them, they are only one of the elements of society that may be involved in responding. Medical schools should continue to identify social problems related to health and should continue to recommend solutions. (10) Medical school faculties should continue to exercise prudent judgment in adjusting educational programs in response to social change and societal needs. (11) Faculties should continue to evaluate curricula periodically as a means of insuring that graduates will have the capability to recognize the diverse nature of disease, and the potential to provide preventive and comprehensive medical care. Medical schools, within the framework of their respective institutional goals and regardless of the organizational structure of the faculty, should provide a broad general education in both basic sciences and the art and science of clinical medicine. (12) The curriculum of a medical school should be designed to provide students with experience in clinical medicine ranging from primary to tertiary care in a variety of inpatient and outpatient settings, such as university hospitals, community hospitals, and other health care facilities. Medical schools should establish standards and apply them to all components of the clinical educational program regardless of where they are conducted. Regular evaluation of the quality of each experience and its contribution to the total program should be conducted. (13) Faculties of medical schools have the responsibility to evaluate the cognitive abilities of their students. Extramural examinations may be used for this purpose, but never as the sole criterion for promotion or graduation of a student. (14) As part of the responsibility for granting the MD degree, faculties of medical schools have the obligation to evaluate as thoroughly as possible the non-cognitive abilities of their medical students. (15) Medical schools and residency programs should continue to recognize that the instruction provided by volunteer and part-time members of the faculty and the use of facilities in which they practice make important contributions to the education of medical students and resident physicians. Development of means by which the volunteer and part-time faculty can express their professional viewpoints regarding the educational environment and curriculum should be encouraged. (16) Each medical school should establish, or review already established, criteria for the initial appointment, continuation of appointment, and promotion of all categories of faculty. Regular evaluation of the contribution of all faculty members should be conducted in accordance with institutional policy and practice. (17a) Faculties of medical schools should reevaluate the current elements of their fourth or final year with the intent of increasing the breadth of clinical experience through a more formal structure and improved faculty counseling. An appropriate number of electives or selected options should be included. (17b) Counseling of medical students by faculty and others should be directed toward increasing the breadth of clinical experience. Students should be encouraged to choose experience in disciplines that will not be an integral part of their projected graduate medical education. (18) Directors of residency programs should not permit medical students to make commitments to a residency program prior to the final year of medical school. (19) The first year of postdoctoral medical education for all graduates should consist of a broad year of general training. (a) For physicians entering residencies in internal

medicine, pediatrics, and general surgery, postdoctoral medical education should include at least four months of training in a specialty or specialties other than the one in which the resident has been appointed. (A residency in family practice provides a broad education in medicine because it includes training in several fields.) (b) For physicians entering residencies in specialties other than internal medicine, pediatrics, general surgery, and family practice, the first postdoctoral year of medical education should be devoted to one of the four above-named specialties or to a program following the general requirements of a transitional year stipulated in the "General Requirements" section of the "Essentials of Accredited Residencies." (c) A program for the transitional year should be planned, designed, administered, conducted, and evaluated as an entity by the sponsoring institution rather than one or more departments. Responsibility for the executive direction of the program should be assigned to one physician whose responsibility is the administration of the program. Educational programs for a transitional year should be subjected to thorough surveillance by the appropriate accrediting body as a means of assuring that the content, conduct, and internal evaluation of the educational program conform to national standards. The impact of the transitional year should not be deleterious to the educational programs of the specialty disciplines. (20) The ACGME, individual specialty boards, and respective residency review committees should improve communication with directors of residency programs because of their shared responsibility for programs in graduate medical education. (21) Specialty boards should be aware of and concerned with the impact that the requirements for certification and the content of the examination have upon the content and structure of graduate medical education. Requirements for certification should not be so specific that they inhibit program directors from exercising judgment and flexibility in the design and operation of their programs. (22) An essential goal of a specialty board should be to determine that the standards that it has set for certification continue to assure that successful candidates possess the knowledge, skills, and the commitment to upgrade continually the quality of medical care. (23) Specialty boards should endeavor to develop a consensus concerning the significance of certification by specialty and publicize it so that the purposes and limitations of certification can be clearly understood by the profession and the public. (24) The importance of certification by specialty boards requires that communication be improved between the specialty boards and the medical profession as a whole, particularly between the boards and their sponsoring, nominating, or constituent organizations and also between the boards and their diplomates. (25) Specialty boards should consider having members of the public participate in appropriate board activities. (26) Specialty boards should consider having physicians and other professionals from related disciplines participate in board activities. (27) The AMA recommends to state licensing authorities that they require individual applicants, to be eligible to be licensed to practice medicine, to possess the degree of Doctor of Medicine or its equivalent from a school or program that meets the standards of the LCME or accredited by the American Osteopathic Association, or to demonstrate as individuals, comparable academic and personal achievements. All applicants for full and unrestricted licensure should provide evidence of the satisfactory completion of at least one year of an accredited program of graduate medical education in the US. Satisfactory completion should be based upon an assessment of the applicant's knowledge, problem-solving ability, and clinical skills in the general field of medicine. The AMA recommends to legislatures and governmental regulatory authorities that they not impose requirements for licensure that are so specific that they restrict the responsibility of medical educators to determine the content of undergraduate and graduate medical education. (28) The medical profession should continue to encourage participation in continuing medical education related to the physician's professional needs and activities. Efforts to evaluate the effectiveness of such education should be continued. (29) The medical profession and the public should recognize the difficulties related to an objective and valid assessment of clinical performance. Research efforts to improve existing methods of evaluation and to develop new methods having an acceptable degree of reliability and validity should be supported. (30) U.S. citizens should have access to factual information on the requirements for licensure and for reciprocity in the various jurisdictions, prerequisites for entry into graduate medical education programs, and other factors that should be considered before deciding to undertake the study of medicine in schools not accredited by the LCME. (31) Policies governing the accreditation of U.S. medical education programs specify that core clinical training be provided by the parent medical school; consequently, the AMA strongly objects to the practice of substituting clinical experiences provided by U.S. institutions for core clinical curriculum of foreign medical schools. Moreover, it strongly disapproves of the placement of any medical school undergraduate students in hospitals and other medical care delivery facilities which lack educational resources and experience for supervised teaching of clinical medicine. (32) Methods currently being used to evaluate the readiness of graduates of foreign medical schools to enter accredited programs in graduate medical education in this country should be critically reviewed and modified as necessary. No graduate of any medical school should be admitted to or continued in a residency program if his or her participation can reasonably be expected to affect adversely the quality of patient care or to jeopardize the quality of the educational experiences of other residents or of students in educational programs within the hospital. (33) The Educational Commission for Foreign Medical Graduates should be encouraged to study the feasibility of including in its procedures for certification of graduates of foreign medical schools a period of observation adequate

for the evaluation of clinical skills and the application of knowledge to clinical problems. (34) The AMA, in cooperation with others, supports continued efforts to review and define standards for medical education at all levels. The AMA supports continued participation in the evaluation and accreditation of medical education at all levels. (35) The AMA, when appropriate, supports the use of selected consultants from the public and from the professions for consideration of special issues related to medical education. (36) The AMA encourages entities that profile physicians to provide them with feedback on their performance and with access to education to assist them in meeting norms of practice; and supports the creation of experiences across the continuum of medical education designed to teach about the process of physician profiling and about the principles of utilization review/quality assurance. (37) Our AMA encourages the accrediting bodies for MD- and DO-granting medical schools to review, on an ongoing basis, their accreditation standards to assure that they protect the quality and integrity of medical education in the context of the emergence of new models of medical school organization and governance. (CME Rep. B, A-82; Amended: CLRPD Rep. A, I-92; Res. 331, I-95; Reaffirmed by Res. 322, A-97; Reaffirmation I-03; Modified: CME Rep. 7, A-05; Modified: CME Rep. 2, I-05; Appended: CME Rep. 5, A-11; Reaffirmed: CME Rep. 3, A-11)

H-405.973, Board Certification

It is the policy of the AMA (1) to continue to work with other medical organizations to educate the profession and the public about the board certification process; and (2) that, when the occasion arises that equivalency of board certification must be determined, the Essentials for Approval of Examining Boards in Medical Specialties be utilized for that determination. (CME Rep. D, A-92; Reaffirmed: CME Rep. 2, A-03; Reaffirmed: CME Rep. 7, A-07; Reaffirmed: CME Rep. 16, A-09)

D-275.977, Update on the American Board of Medical Specialties Program on Maintenance of Certification (MOC)
Our AMA will: (1) continue to monitor the progress of Maintenance of Certification (MOC) and its ultimate impact on the practice community; (2) encourage the Physician Consortium for Performance Improvement, the American Board of Medical Specialties (ABMS), and the Council of Medical Specialty Societies to work together toward utilizing Consortium performance measures in Part IV of MOC; (3) encourage the ABMS Maintenance of Certification Task Force to develop and adopt recommendations for re-entry into clinical practice and entry into Step IV of MOC for diplomates not involved in direct patient care; and (4) request that the ABMS refrain from dividing every aspect of their specialist physician practice into numerous added qualification exams and that, whenever possible, alternate methods be sought to ensure adequate qualifications and make the process less onerous for physicians. (CME Rep. 9, A-05; Reaffirmed: CME Rep. 7, A-07; Reaffirmed: CME Rep. 16, A-09; Appended: Res. 314, A-11)

H-275.932, Internal Medicine Board Certification Report--Interim Report

Our AMA opposes the use of recertification or Maintenance of Certification (MOC) as a condition of employment, licensure or reimbursement. (CME Rep. 7, A-02; Reaffirmed: CME Rep. 2, A-12)

H-275.919, American Board of Medical Specialties Board Member Enrollment in Maintenance of Certification

Our AMA will recommend to the American Board of Medical Specialties that all physician members of those boards governing the Maintenance of Certification (MOC) process be required to participate in the MOC process. (Res. 310, A-12)

H-405.970, Specialty Board Certification Fee Requirements

The AMA strongly encourages member boards of the American Board of Medical Specialties to adopt measures aimed at mitigating the financial burden on residents related to specialty board fees and fee procedures, including shorter preregistration periods, lower fees and easier payment terms. (Res. 303, A-93; Reaffirmed: CME Rep. 2, A-03; Reaffirmed: CME Rep. 16, A-09)

H-405.974, Specialty Recertification Examinations

Our AMA (1) encourages the American Board of Medical Specialties and its member boards to continue efforts to improve the validity and reliability of procedures for the evaluation of candidates for certification; and (2) believes that the holder of a certificate without time limits should not be required to seek recertification. (CME Rep. E, A-92; Reaffirmed: CME Rep. 7, A-02; Reaffirmed: CME Rep. 7, A-07; Reaffirmed: CME Rep. 16, A-09; Reaffirmed: CME Rep. 10, A-12; Reaffirmed in lieu of Res. 313, A-12)

H-275.996, Physician Competence

Our AMA: (1) urges the American Board of Medical Specialties and its constituent boards to reconsider their positions regarding recertification as a mandatory requirement rather than as a voluntarily sought and achieved validation of excellence; (2) urges the Federation of State Medical Boards and its constituent state boards to reconsider and reverse their position urging and accepting specialty board certification as evidence of continuing competence for the purpose of re-registration of licensure; and (3) favors continued efforts to improve voluntary continuing medical education programs, to maintain the peer review process within the profession, and to develop better techniques for establishing the necessary patient care data base. (CME Rep. J, A-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CME Rep. 7, A-02; Reaffirmed: CME Rep. 7, A-07; Reaffirmed: CME Rep. 16, A-09; Reaffirmed in lieu of Res. 302, A-10)

D-275.999, Board Certification and Discrimination

Our AMA will collect information from members discriminated against solely because of lack of American Board of Medical Specialties or equivalent American Osteopathic Board certification (Res. 314, I-98; Reaffirmed: CME Report 2, 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 in 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; Reaffirmed: CME Rep. 2, A-09; Reaffirmed: CME Rep. 14, A-09)

D-275.995, Licensure and Credentialing Issues

Our AMA will: (1) support recognition of the Federation of State Medical Boards' (FSMB) Credentials Verification Service by all licensing jurisdictions; (2) work jointly with the FSMB to take measures to encourage increased standardization of credentials requirements, and improved portability by increased use of reciprocal relationships among all licensing jurisdictions; (3) communicate, either directly by letter or through its publications, to all hospitals and licensure boards that the Joint Commission on Accreditation of Healthcare Organizations encourages recognition of both the Educational Commission for Foreign Medical Graduates' Certification Verification Service and the AMA's Masterfile as primary source verification of medical school credential; and (4) encourage the National Commission on Quality Assurance (NCQA) and all other organizations to accept the Federation of State Medical Boards' Credentials Verification Service, the Educational Commission for Foreign Medical Graduates' Certification Verification Service, and the AMA Masterfile as primary source verification of credentials. (Res. 303, I-00; Reaffirmation A-04)

APPENDIX B - Standards for the ABMS Program for Maintenance of Certification (MOC)

The American Board of Medical Specialties (ABMS) standards are available on their website at abms.org/pdf/Standards%20for%20the%20ABMS%20Program%20for%20MOC%20FINAL.pdf.

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7. PHYSICIAN WORKFORCE SHORTAGE: APPROACHES TO GME FINANCING (RESOLUTION 914-I-13)

Reference committee hearing: see report of [Reference Committee C](#).

**HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS
IN LIEU OF RESOLUTION 309 AND RESOLUTION 914-I-13 AND
REMAINDER OF REPORT FILED**
See Policies [H-200.954](#) and [D-305.967](#).

Referred Resolution 914-I-13, “Change Rural and Off Site Rural Training Track Requirements in Order to Preserve and Encourage Interest in Rural Residency Programs,” introduced by the Mississippi Delegation, asked our AMA to:

1. Work with the Centers for Medicare & Medicaid Services to allow for up to one month in the second post graduate year and one month in the third post graduate year of an ABMS/AOA approved Family Medicine, General Internal Medicine or General Pediatric residency to occur in the office of a primary care physician who is listed and meets the qualifications for adjunct faculty of the sponsoring institution; and
2. Work with the Accreditation Council of Graduate Medical Education Residency Review Committee for Family Medicine and other specialties to adjust GME program requirements so that the patient encounters during this experience may count toward the continuity requirements for the completion of a residency.

Policy H-200.954 (12), “U.S. Physician Shortage,” asks our AMA to continue to study the effect of ever increasing match participants and the stagnant growth of US residency positions with a report back at the 2014 Annual Meeting.

Policy D-305.967 (13), “The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education,” asks our AMA to work with the Association of American Medical Colleges and other key stakeholders to continue to examine alternative models of funding for graduate medical education, with a report back at the 2014 Annual Meeting.

INTRODUCTION

This report builds on information provided in a previous Council Report to the House of Delegates on this topic (Council on Medical Education Report 5-A-13) and addresses the resolutions and policies above by providing information on:

1. The current state of the physician workforce;
2. Congressional actions and what the Patient Protection and Affordable Care Act (ACA) (P.L. 111-148) has accomplished;
3. Funding models for graduate medical education (GME) at the state level;
4. Current AMA policy; and
5. Recent AMA GME advocacy.

CURRENT STATE OF THE PHYSICIAN WORKFORCE

Although there is not universal agreement, the understanding that the United States is confronting a physician workforce shortage has broad support. The expanded insurance coverage resulting from the ACA is estimated to provide health insurance for 34 million more people by 2016 (relative to 2013), with an additional 3 million by 2023.¹ Assuming similar use and delivery of care patterns for these newly insured individuals, demand by the adult population for primary care physicians, including geriatricians, is estimated to grow 14% by 2025. Specialty care demand may increase from 16% for some services, up to 31% for others.² Even before the ACA was in place, various workforce research reports projected physician workforce shortages ranging from 35,000 to 49,000.^{3,4} As a result, the Association of American Medical Colleges (AAMC) in 2006 recommended increasing medical school class sizes by 30% over 2002 levels.⁵ Given the increased demands expected by the newly insured, the AAMC now projects a shortage of 45,000 primary care physicians and 46,000 specialty physicians by 2020.⁵ The latest modeling

by the National Center for Health Workforce Analysis projects a shortage of approximately 20,400 full-time equivalent primary care physicians by 2020.⁶

Current enrollment projections made by medical schools will match in 2017-2018 the targeted goal of a 30% increase. First year enrollment in Liaison Committee on Medical Education (LCME)-accredited medical schools is now projected to be 21,434 in 2017-2018. First year enrollment in osteopathic medical schools is expected to reach 6,675 the same year.⁷ The expansion in medical schools is not only in class size, but also includes some new schools in locations that did not previously have a medical school, such as in areas in several Southern states.⁷ Existing schools that have expanded enrollments to a greater degree tend to have higher percentages of graduates who go on to practice in primary care specialties, and in rural or underserved areas.⁸

Also continuing to contribute to the primary care workforce, and practice in underserved areas and treat low-income patients, are international medical graduates (IMGs)—in particular, non-US citizen IMGs. Altogether, IMGs make up approximately 25% of the US physician workforce.^{9,10}

Stagnant Growth of US Residency Positions

Although the United States is now educating more physicians in order to alleviate forecasted shortages, the lack of a concomitant increase in GME positions jeopardizes the nation's ability to increase the active physician workforce. The principal cause of this lack of growth is the Balanced Budget Act of 1997, which capped the number of GME positions funded by Medicare (the primary funding source for GME) at 1996 levels.

Training institutions, in general, decide for themselves the number of physicians they can train, and the number of trainees overall has increased despite the cap, but principally in subspecialty areas.¹¹ Hospitals are able to create funding for these advanced positions, but are more limited in their ability to increase support for entry-level positions available to medical school graduates without prior GME. In fact, from 1998 to 2012, the number of first-year residents in GME programs accredited by the Accreditation Council for Graduate Medical Education (ACGME) has grown 5.8%, an annual rate of only .4%. In comparison, growth in the number of fellows in subspecialty programs has been 71.2%, an annual growth rate of 4.7%.^{12,13} The result has been a growing inability for medical school graduates to enter the specialty training programs of their choice. At the conclusion of the 2013 Match, run by the National Resident Matching Program (NRMP), which matches eligible applicants into ACGME-accredited training programs, 528 US allopathic graduating seniors did not have a residency position,¹⁴ approximately double the number of those who did not obtain a residency position in the 2012 Match. Data for the 2014 Match were not available when this report was drafted, so it is unknown how many students ultimately were left without positions. Nonetheless, all indications point to a further tightening of residency positions in the coming years and an increase in the number of otherwise qualified medical school graduates who are not able to enter and complete a residency, which is a required component for medical practice in the United States.

Total federal funding in 2012 for GME was \$11.1 billion,¹⁵ including contributions from Medicare, Medicaid, Department of Defense, and Department of Veterans Affairs. Despite continuing advocacy by the AMA, AAMC, and other key stakeholders to increase GME funding, the current economic and political climate reflects a reluctance to increase GME funding as well as the possibility of reduced funding. The Medicare Payment Advisory Commission has recommended reducing indirect medical education payments to fund a new performance-based GME program.¹⁶ The President's FY 2015 budget suggests ways to redistribute payments for medical education that may affect GME in academic medical centers, by reducing indirect payments by \$14.6 billion over ten years and then reinvesting these savings to train new health care providers in areas such as primary care and other high-need specialties. To encourage and enhance training of primary care practitioners and other physicians in high-need specialties, the budget proposes \$5.23 billion over 10 years to support 13,000 new resident slots through a new competitive GME program that incentivizes high-quality physician training. This would replace current Teaching Health Center funding and Children's Hospital GME funding. In 2015, this new program would include \$100 million in mandatory funding to support pediatric training in children's hospitals. In addition, the budget also calls for investments of more than \$3.9 billion over the next six years in the National Health Service Corps to place 15,000 health care providers in underserved areas.¹⁷ Other organizations of note, including the Josiah Macy Jr. Foundation, and the Council of Graduate Medical Education, have called for more efficient methods of training physicians, as well as an examination of how resources are distributed to best produce the physicians the public needs.¹⁸

CONGRESSIONAL ACTIONS AND WHAT THE ACA HAS ACCOMPLISHED

To counteract the impact of the Balanced Budget Act's cap on residency positions, bills have been introduced that would increase the number of GME slots funded by Medicare by 15%, or roughly 15,000 (S. 577, H.R. 1180, H.R. 1201). In addition, H.R.297, the "Children's Hospital GME Support Reauthorization Act of 2013," would reauthorize federal funding to support GME for free-standing children's hospitals. The likelihood of these bills being seriously considered, however, is remote, given the current fiscal and political environment.

Nonetheless, federal support for some expansion in GME has come through various programs that are part of the ACA. In 2010, for example, the Health Resources and Services Administration (HRSA) awarded \$167.3 million to fund 82 primary care residency training programs for five years, as part of the Primary Care Residency Expansion Program (PCRE) for 2010-2014. The program provides \$80,000 per resident, per year, for three years. Most of the awardees have as missions a goal to increase diversity and/or address cultural competency, and work in partnership with Federally Qualified Health Centers, community hospitals, and other community health settings. It is estimated that 889 new physicians will be trained through this program, with an average expansion size of two residency positions per year.¹⁹

Through Section 5508 of the ACA, the Teaching Health Center Graduate Medical Education program (THC GME), \$230 million is available to fund increases in primary care residency training and general or pediatric dentistry training in community-based settings. This program provides payments to support both direct and indirect expenses for newly established THCs or for expansion in existing THCs. As of July 2013, 21 THCs were awarded grants, training more than 300 residents in 2013-2014, twice as many as in the previous academic year.²⁰

Through Section 5503 of the ACA, unfilled GME positions were converted to primary care positions in 2011. Certain geographic areas and types of hospitals were given preference for redistributed positions, e.g., states with low resident physician-to-population ratio and hospitals with rural training programs. Altogether, 726 direct graduate medical education (DGME)-funded and 628 indirect medical education (IME)-funded resident slots were redistributed. It is estimated that this program will increase the number of residents trained per year by 200.¹⁹

Section 5506 of the ACA calls for the preservation of GME positions when a hospital closes; prior to the ACA, these positions would be lost. Now these positions can be allocated to existing hospitals, generally in the same geographic area.

Section 5207 of the ACA reauthorizes the National Health Service Corps (NHSC) and provides increased support with new dedicated funding for 2011 through 2015. The NHSC does not necessarily increase the physician workforce per se, but may affect the physician supply in that it provides loan repayment for students and physicians who commit to primary care practice in underserved areas.¹⁹

Although the opportunities provided through the ACA are welcome, many of the awards are time-limited through fiscal year 2015 (with resources scarce within some states to continue the funding), and these efforts do not ultimately increase the number of physicians trained to adequately meet anticipated workforce needs.

FUNDING MODELS FOR GME AT THE STATE LEVEL

Because of the uncertain or diminished likelihood of significantly increased federal support for GME funding, and frustration with the lack of influence over the specialty choices and locale of physicians practicing in their states, several states have proposed and/or enacted programs that aim to expand residency positions via alternative GME funding, and/or encourage physicians to practice in the state after the required GME is completed. Below are key examples of such efforts.

Expansion of Residency Positions through Alternative Financing

California: The state legislature introduced AB 1176, "Primary Care Access: Residency Programs," that proposed a \$5 per covered life fee for health insurers to fund GME. Besides creating a body to distribute GME funding to new and existing programs, eligibility for funds is based on a program's location in an underserved area; record of placing graduates in underserved areas; training in primary care; or undersupplied specialties in the local community. The bill is eligible to be taken up in 2014.

Florida: State and private funding options have been pursued, and various models have been used for GME funding. In 2013, the state legislature used \$20.6 million in state funds, coupled with \$52 million in existing funds, to provide \$80 million in supplemental funding for a Statewide Medicaid Residency Program (Senate Bill [S.B.] 1520). For this program, GME funds related to Medicaid are removed from regular hospital reimbursement payments and will instead be subject to a formula-based distribution. Each hospital participating in the program will receive an annual allocation determined by a calculation of the hospital's percentage of total residents statewide and the hospital's percentage of total Medicaid inpatient reimbursement among participating hospitals. By definition, this program can only increase residency positions/programs in hospitals with existing programs. In 2010, S.B. 1256, "Physician Workforce," which passed committees in the State Senate, was to have funded the direct costs of innovative GME programs, among other physician workforce goals; the bill did not become law.

Georgia: Beginning in FY 2013, dollar-for-dollar funds are available from the state for hospitals to start residency programs. The goals of this funding stream include creating 400 new positions in hospitals that previously had no programs, ensuring some concentration in primary care specialties and general surgery, and developing residencies in geographically underserved parts of the state. Currently four hospitals are developing programs, with the potential of creating upwards of 267 positions. Funding is only for the process of creating a program, thus covering accreditation costs, hiring staff, purchasing new equipment and so forth. Once a hospital has residents enrolled and is receiving Medicare funds, the state program ceases to support the hospital.

Hawaii: The state legislature and governor approved a \$1.8 million appropriation for the Primary Care Training Program at Hilo Medical Center, which will support several disciplines, including four new family medicine residents a year for three years.

Idaho: The state legislature recently funded a new family medicine program. In addition, the Family Medicine Residency of Idaho received from the Blue Cross Foundation of Idaho \$100,000 per year to support rural rotations for residents.

Maryland: The state boasts an all-payer system to fund GME, the only one in the nation, which is managed through the Health Service Cost Review Commission (HSCRC). However, in recent years no additional funding has been requested explicitly for new programs or positions. The HSCRC has no role in influencing the number or specialty of residents in training.

Minnesota: Clinical training sites consisting of a variety of health professions are supported through the Medical Education and Research Costs program; these grants are provided through state and federal Medical Assistance funds and cigarette tax proceeds. The FY 2014-15 base budget is \$44.3 million. New in FY 2013 was a \$1 million per year grant program for family medicine residency programs outside the seven-county metropolitan area. To be eligible, programs must demonstrate that at least 25% of graduates practice in Minnesota communities outside the metropolitan area for the most recent three years.

Montana: In 2013, the legislature added \$200,000 to the state's appropriation for GME, and also approved an additional \$240,000 to support rural rotations for residents.

North Carolina: The Blue Cross Blue Shield of North Carolina Foundation is providing partial funding to establish the University of North Carolina Family Medicine's Underserved Residency Track, which will train two residents per year for three years in underserved communities.

North Dakota: The Health Care Workforce Initiative, funded by state government, will allow the University of North Dakota School of Medicine and Health Sciences to expand with the expectation that by the 2017-2018 academic year, there will be 64 additional medical students (16 per year), 90 health sciences students (30 per year), and 51 residents (post-MD degree trainees, with 17 per year added). This initiative is expected to retain more of the graduates for practice in North Dakota.

Oklahoma: In 2012, the state legislature allocated \$3 million to establish new primary care residency programs in underserved areas, administered by the Oklahoma State University College of Osteopathic Medicine or the University of Oklahoma College of Medicine, with the expectation that the programs become funded by Medicare.

Tennessee: There is discussion of redirecting the professional privilege tax that licensed physicians pay towards expansion of GME funding. Replacement dollars need to be identified or a reduction in expenses would be required, as this tax adds approximately \$8 million to the general fund.

Texas: House Bill (H.B.) 2908, which was adopted in 2011, directed the Texas Higher Education Coordinating Board to conduct assessments of the state's GME system to accommodate the training needs of the state's medical school graduates. During 2013, the legislature appropriated \$16.3 million for grants to develop new GME programs, expand existing programs, and help fill existing unfilled GME positions. Funding of \$7.4 million goes to up to 25 first-year unfilled/unfunded GME slots and up to 63 new first-year positions at existing or new programs, at \$65,000 per year per resident, for one year. In addition, \$5 million goes to encourage development of new GME positions through community collaboration and innovative funding, for new positions created on or after January 1, 2014, or positions unfilled on January 1, 2013. Additional funding depends upon appropriation. The balance goes to planning grants and primary care innovation programs to encourage more students to enter primary care. Concerns revolve around funding beyond the first year.

Wisconsin: New funding for several new GME initiatives has recently been approved, including \$1.7 million to increase the Medical College of Wisconsin's (MCW) family medicine programs by 12 new positions, primarily in underserved areas of Milwaukee. The state has also made a start-up investment for MCW's planned new programs in northeastern and central Wisconsin. In addition, the Wisconsin Department of Health Services will be supporting 10 new residency slots in existing programs, targeting specialties in need (family medicine, general internal medicine, general surgery, pediatrics, and psychiatry) and in rural locations. Programs can apply for expansion of up to three positions (three in one year, or one in each of three years). Programs in bordering states are eligible if they have a substantial presence in Wisconsin (e.g., rotations in the state, graduates who practice in Wisconsin). The state is seeking matching Medicaid funds, which would allow for doubling the number of new positions. Finally, the state will assist rural hospitals or consortia of rural hospitals to develop new residency programs, with up to \$1.75 million available for three years, limited to the same specialties as above.

Retention of Physicians

At least 30 states use, or plan to use, some kind of loan forgiveness/repayment program to encourage physicians to practice in primary care and or/underserved area. There generally are stipulations as to how long the service must be, and maximum dollar amounts allowed.

California: S.B. 21, signed into law in 2013, requests that the newly accredited University of California Riverside School of Medicine identify eligible residents and assist them with applying to physician retention programs, such as loan repayment programs, that require service to an underserved or rural area of the state in exchange for debt assistance.

Iowa: The state's Rural Physician Loan Repayment program is funded as a public/private partnership. Specialties are either primary care or otherwise approved; physicians are Iowa-trained and must commit to serve for five years in a community with fewer than 26,000 residents that is more than 20 miles from a large city in exchange for up to \$50,000 per year for four years of loan repayment. Private donations are added to the nearly \$2 million state appropriation for the fund. The expectation is that eventually the fund will be able to forgive student debt for 20 physicians each year—10 from the University of Iowa and 10 from Des Moines University.

New York: Loan repayment program of \$30,000 per year for a two-year commitment to serve in a NY health professions shortage area (HPSA).

North Dakota: Tuition forgiveness for medical students at the University of North Dakota School of Medicine and Health Sciences who commit to practicing primary care in a rural area in the state.

Ohio: The state's Council of Medical School Deans has proposed a GME funding program that would accept and fund residents based on individual characteristics and planned intentions to practice in primary care, rural areas and/or underserved areas. The intent is to use Medicaid funds to create a workforce that best meets the state's needs and reduce exporting physicians to other states.

Tennessee: Loan repayment program of \$60,000 per year for a two-year commitment, and up to \$40,000 per year after that, in exchange for service in a HPSA, federally qualified health center, or rural health center.

Texas: Loan repayment funding is currently part of an appropriations bill. Also, the state monitors NRMP Match results to identify the number of students who leave Texas for training in specialties that do not have enough positions in-state.

Lessons Learned from State GME Stakeholders

The Cecil G. Sheps Center of the University of North Carolina recently published an analysis of in-depth GME stakeholder interviews from a nationally representative sample of states.²¹ Key informants included medical educators and government employees with knowledge of state-level GME policy, as well as medical association health policy specialists. Several relevant lessons learned include: 1) states can learn from one another about data collection and GME data analysis to inform policy; 2) although Medicaid is a policy lever states can use to modify health care delivery, with few exceptions states have not been able to effectively use Medicaid GME funding to target GME expansion; 3) although expansion through the ACA has been important and innovative in expanding GME training in needed specialties and geographic areas, with a measure of accountability not found elsewhere in federal GME funding, the lack of sustainability in the funds has made programs vulnerable to closure and recruitment of residents difficult; 4) if there are new state funding streams for GME (either through instituting an all-payer system, state appropriations, or third party payers mandated by legislation), funding must be sustainable to ensure long-term impact; 5) metrics for in-state retention or other accountability measures are infrequent, and expansion efforts have often been in response to teaching hospitals' own service needs rather than population health needs; and 6) two more effective strategies for states may be to invest in core specialties in programs in underserved areas, and to use non-GME funding such as loan repayment programs.

The report concluded with five recommendations that can inform states that are considering broadening their role in influencing GME locally:

Recommendation 1: States should develop ongoing physician workforce data collection systems that allow policy makers to continuously identify the changing workforce needs of the state.

Recommendation 2: States should create a GME advisory entity that promotes discussion, coordination and education about GME.

Recommendation 3: All payer, third-party payer, Medicaid and state appropriations for GME need to be carefully considered and designed to be responsive to the state's population health needs.

Recommendation 4: New GME funding should be tied to performance metrics and require monitoring about how funds are spent.

Recommendation 5: State policy makers should coordinate efforts that touch on the physician's entire career from medical school admissions through GME and into practice.²¹

AMA POLICY

AMA policy supports maintaining adequate and stable Medicare and Medicaid GME funding levels and advocates for contributions by all payers of health care to fund GME (e.g., federal government, states, and private payers). In addition, the AMA supports exploring additional sources of funding, and in particular new funding to support increases in training positions, preferably in or adjacent to physician shortage/underserved areas and in undersupplied specialties. For example, Policy H-305.929 (4), "Proposed Revisions to AMA Policy on the Financing of Medical Education Programs," states that diversified sources of funding should be available to support medical schools' multiple missions, including education, research, and clinical service. Reliance on any particular revenue source should not jeopardize the balance among a medical school's missions. Policy D-305-967 (11), "The Preservation, Stability, and Expansion of Full Funding for Graduate Medical Education," states that the AMA recognizes that funding for and distribution of positions for GME are in crisis in the United States and that meaningful and comprehensive reform is urgently needed, and directs the AMA to immediately work with Congress to expand medical residencies in a balanced fashion based on expected specialty needs throughout our nation to

produce a geographically distributed and appropriately sized physician workforce, and to make increasing support and funding for GME programs and residencies a top priority of the AMA in its national political agenda. Policy D-310.953, “Exploring the Feasibility of Clinic-based Residency Programs,” advocates that key stakeholders, such as the Accreditation Council for Graduate Medical Education, explore the feasibility of extending residency programs through a pilot study placing medical graduates in integrated physician-led practices in order to expand training positions and increase the number of physicians providing healthcare access; and encourages that pilot studies of clinic-based residency program expansion be funded by private sources. (Other relevant AMA policy is in the Appendix.)

RECENT AMA ADVOCACY REGARDING GME

In addition to supporting H.R. 297, the “Children’s Hospital GME Support Reauthorization Act of 2013,” and S.577 and H.R. 1180, the “Resident Physician Shortage Reduction Act” in 2013, the AMA launched in August 2013 a national “Save GME Action Week” to raise awareness about the cap on funding for residency training programs. Students from over 50 medical schools across 20 states met with their representatives and senators to advocate for GME funding and solutions to pending physician shortages.

The AMA also recently expanded its Save GME website (SaveGME.org) and began issuing bands that can be worn on stethoscopes as a symbol of our GME campaign. These advocacy efforts have generated significant support, resulting in over 26,000 letters urging lawmakers to protect GME funding.

In November 2013, during the AMA Interim Meeting, the Council on Medical Education convened a meeting of leaders from GME programs, state medical societies, and national medical organizations to discuss concerns, initiatives and potential collaborations that may be needed to respond to the GME crisis in terms of how it may impact medical education and the physician workforce in the future.

DISCUSSION

Barriers to Expansion

Limited GME funding may not be the only barrier to an expansion in the number of GME positions. Although well-established GME institutions have the infrastructure in place for expansion, most are likely at capacity or, if considering expansion, would choose hospital-intensive specialties. There appears to be limited consideration for physician workforce needs, either nationally or locally, among many academic health centers.^{22,23} Obvious candidates for substantial expansion, so-called GME “naïve” or “virgin” hospitals, such as community hospitals, and in particular rural hospitals, may not be able to increase capacity at the desired rate, or lack the patient base needed to meet accreditation standards. Though these GME-naïve hospitals may not be ideal candidates for stand-alone residency programs, many of them may serve a role as additional sites to increase the capacity of existing GME programs with established infrastructure and oversight. Funding rural training networks, flexibility and innovation within ACGME standards, altering Medicare GME reimbursement to increase the viability of rural training, and possibly reducing the time needed to complete training in core specialties are ideas that have been proposed to ease entry into GME by new institutions.^{24,25}

Barriers within states to an expansion of GME have been identified as including:

- A lack of reliable data on GME and its state-wide implications on physician workforce,
- Lack of understanding by state policy makers of how Medicaid can be used to supplement Medicare GME funding,
- The effect on state appropriations of temporal swings in state politics,
- Lack of state-level GME decision-making authorities/entities, and
- The attractiveness to politicians and their constituents of developing a new medical school versus adding residency training programs.²¹

Changes Within the Health Care Delivery System

Reforms within the health care delivery system, if enacted comprehensively, could reduce the physician shortage, and therefore mitigate the need for GME expansion. Demonstrations of accountable care organizations (ACOs) are

still ongoing, but theoretically the emphasis on preventive care and team management of chronic conditions provide a more efficient model of work for physicians.² ACOs and patient-centered medical homes could allow for more patients served per physician resulting from team productivity and coordination; alternatively, the greater levels of physician coordination and higher levels of patient education desired may not produce this efficiency.²⁶ There may be limitations to the acceptance of ACOs. Development of ACOs in rural areas may be challenging,²⁷ and so far nine of 32 ACOs have left the pioneer program.²⁸

Some have suggested that payment reform, training non-clinicians in new responsibilities, personnel efficiency resulting from the inevitability of smaller practices joining networks or systems, innovations in technology, and promoting an innovation culture might help to address the primary care demand-physician capacity mismatch without relying solely on expansion of GME.²⁹ As noted in the Council on Medical Education and Council on Medical Service Joint Report 1-I-12 (Joint Report), “The Structure and Function of Interprofessional Health Care Teams,” improved teamwork holds the promise of alleviating patient access to health care challenges caused by the shortage of primary care physicians. The Joint Report defined “team-based health care” as the provision of health care services by a physician-led team of at least two health care professionals who work collaboratively with each other, the patient, and the family to accomplish shared goals within and across settings to achieve coordinated, high-quality, patient-centered care (Policy H-160.912, “The Structure and Function of Interprofessional Health Care Teams”). HRSA suggests that a full integration of nurse practitioners (NPs) and physician assistants (PAs) into the health care system could mitigate the projected primary care physician shortage;⁶ adding NPs and PAs to physician-led medical teams may improve efficiency. Council on Medical Service Report 6-A-14, also being considered at this meeting, calls on the AMA to study and report back on the definition of leadership in physician-led medical teams, and to propose acceptable models that value the expertise of the physician and models that can be used by medical teams that address specific issues such as patient safety, the nature of physician authority within the teams, and the ethical and legal issues of the team model.

Flexibility and Innovation

The increased scrutiny in previously unquestioned public funding of GME and the current fiscal and political climate makes a surge in new Medicare funding dedicated to GME expansion doubtful and the possibility of significant cuts an ongoing concern.¹⁶ Pairing a growing interest in social accountability within the GME community³⁰ with innovations in medical education (undergraduate and graduate), and increased physician workforce concerns among state health policymakers, could produce models of GME that would create physicians in needed specialties and with affinities towards rural and team-based care. The ACGME’s Milestones Project and the Next Accreditation System³¹ are considered a first step in accountability and competency-based education in GME. If Medicare or state policymakers were to incentivize the collection and utilization of outcomes data, then a future funding system that rewarded programs based on desired outcomes could develop.³² An educational system that is performance- rather than time-based could shorten the length of training, and thus decrease the lengthy educational pipeline.^{30,33} A recent proposal that rewards innovation, quality, and accountability through competitive funding merits attention. This model of funding could be incremental, and could also be administered locally rather than federally (and indeed resembles some proposed models of state-level GME funding). Training programs meeting social needs (e.g., primary and/or rural care, community-based training, team-based care) while maintaining high quality standards would be rewarded with greater funding, and thus could expand; programs that were uncompetitive would lose funded positions.¹⁸

SUMMARY AND RECOMMENDATIONS

The Council on Medical Education realizes that the US health care system is at a turning point; models of health care delivery and funding are changing much more rapidly than our current system of educating and training physicians. The projected result is a patient population without adequate access to physicians. Beyond advocating with the AAMC and other stakeholders that expansion of the GME is necessary, the AMA should also be a proponent of innovations in training that will enable future physicians to best serve the health care needs of the public.

The Council on Medical Education recommends that the following recommendations be adopted in lieu of Resolution 914-I-13 and that the remainder of the report be filed.

1. That our American Medical Association continue to strongly advocate that Congress fund additional graduate medical education (GME) positions for the most critical workforce needs, especially considering the current and worsening maldistribution of physicians.
2. That our AMA advocate that the Centers for Medicare & Medicaid Services allow for rural and other underserved rotations in Accreditation Council for Graduate Medical Education (ACGME)-accredited residency programs, in disciplines of particular local/regional need, to occur in the offices of physicians who meet the qualifications for adjunct faculty of the residency program's sponsoring institution.
3. That our AMA encourage the ACGME to reduce barriers to rural and other underserved community experiences for graduate medical education programs that choose to provide such training, by adjusting as needed its program requirements, such as continuity requirements or limitations on time spent away from the primary residency site.
4. That our AMA encourage the ACGME and the American Osteopathic Association (AOA) to continue to develop and disseminate innovative methods of training physicians efficiently that foster the skills and inclinations to practice in a health care system that rewards team-based care and social accountability.
5. That our AMA work with interested state and national medical specialty societies and other appropriate stakeholders to share and support legislation to increase GME funding, enabling a state to accomplish one or more of the following: (1) train more physicians to meet state and regional workforce needs; (2) train physicians who will practice in physician shortage/underserved areas; or (3) train physicians in undersupplied specialties and subspecialties in the state/region.
6. That our AMA support the ongoing efforts by states to identify and address changing physician workforce needs within the GME landscape and continue to broadly advocate for innovative pilot programs that will increase the number of positions and create enhanced accountability of GME programs for quality outcomes.
7. That our AMA continue to work with stakeholders such as Association of American Medical Colleges, ACGME, AOA, American Academy of Family Physicians, American College of Physicians and other specialty organizations to analyze the changing landscape of future physician workforce needs as well as the number and variety of GME positions necessary to provide that workforce.
8. That our AMA rescind Policies H-200.954 (12), "US Physician Shortage," and D-305.967 (13), "The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education," since these have been accomplished through this report.

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APPENDIX - AMA Policies on GME Financing and Medical Workforce

H-305.929 "Proposed Revisions to AMA Policy on the Financing of Medical Education Programs"

It is AMA policy that: (1) Since quality medical education directly benefits the American people, there should be public support for medical schools and graduate medical education programs and for the teaching institutions in which medical education occurs. Such support is required to ensure that there is a continuing supply of well-educated, competent physicians to care for the

American public. (2) Planning to modify health system organization or financing should include consideration of the effects on medical education, with the goal of preserving and enhancing the quality of medical education and the quality of and access to care in teaching institutions are preserved. (3) Adequate and stable funding should be available to support quality undergraduate and graduate medical education programs. Our AMA and the federation should advocate for medical education funding. (4) Diversified sources of funding should be available to support medical schools' multiple missions, including education, research, and clinical service. Reliance on any particular revenue source should not jeopardize the balance among a medical school's missions. (5) All payers for health care, including the federal government, the states, and private payers, benefit from graduate medical education and should directly contribute to its funding. (6) Full Medicare direct medical education funding should be available for the number of years required for initial board certification. For combined residency programs, funding should be available for the longest of the individual programs plus one additional year. There should be opportunities to extend the period of full funding for specialties or subspecialties where there is a documented need, including a physician shortage. (7) Medical schools should develop systems to explicitly document and reimburse faculty teaching activity, so as to facilitate faculty participation in medical student and resident physician education and training. (8) Funding for graduate medical education should support the training of resident physicians in both hospital and non-hospital (ambulatory) settings. Federal and state funding formulas must take into account the resources, including volunteer faculty time and practice expenses, needed for training residents in all specialties in non-hospital, ambulatory settings. Funding for GME should be allocated to the sites where teaching occurs. (9) New funding should be available to support increases in the number of medical school and residency training positions, preferably in or adjacent to physician shortage/underserved areas and in undersupplied specialties. (CME Rep. 7, A-05; Reaffirmation I-06; Reaffirmed: Sub. Res. 314, A-07; Reaffirmation I-07; Reaffirmed: CME Rep. 4, I-08; Reaffirmed: Sub. Res. 314, A-09; Reaffirmed: CME Rep. 3, I-09; Reaffirmed: CME Rep. 15, A-10; Reaffirmation A-11; Reaffirmation A-13; Reaffirmed: CME Rep. 5, A-13)

D-305.967 "The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education"

1. Our AMA will actively collaborate with appropriate stakeholder organizations, (including Association of American Medical Colleges, American Hospital Association, state medical societies, medical specialty societies/associations) to advocate for the preservation, stability and expansion of full funding for the direct and indirect costs of graduate medical education (GME) positions from all existing sources (e.g. Medicare, Medicaid, Veterans Administration, CDC and others). 2. Our AMA will actively advocate for the stable provision of matching federal funds for state Medicaid programs that fund GME positions. 3. Our AMA will actively seek congressional action to remove the caps on Medicare funding of GME positions for resident physicians that were imposed by the Balanced Budget Amendment of 1997 (BBA-1997). 4. Our AMA will strenuously advocate for increasing the number of GME positions to address the future physician workforce needs of the nation. 5. Our AMA will oppose efforts to move federal funding of GME positions to the annual appropriations process that is subject to instability and uncertainty. 6. Our AMA will oppose regulatory and legislative efforts that reduce funding for GME from the full scope of resident educational activities that are designated by residency programs for accreditation and the board certification of their graduates (e.g. didactic teaching, community service, off-site ambulatory rotations, etc.). 7. Our AMA will actively explore additional sources of GME funding and their potential impact on the quality of residency training and on patient care. 8. Our AMA will vigorously advocate for the contribution by all payers for health care, (including the federal government, the states and private payers), to funding both the direct and indirect costs of GME. 9. Our AMA will work, in collaboration with other stakeholders, to improve the awareness of the general public that GME is a public good that provides essential services as part of the training process and serves as a necessary component of physician preparation to provide patient care that is safe, effective and of high quality. 10. Our AMA staff and governance will continuously monitor federal, state and private proposals for health care reform for their potential impact on the preservation, stability and expansion of full funding for the direct and indirect costs of GME. 11. Our AMA: (A) recognizes that funding for and distribution of positions for GME are in crisis in the United States and that meaningful and comprehensive reform is urgently needed; (B) will immediately work with Congress to expand medical residencies in a balanced fashion based on expected specialty needs throughout our nation to produce a geographically distributed and appropriately sized physician workforce; and to make increasing support and funding for GME programs and residencies a top priority of the AMA in its national political agenda; and (C) will continue to work closely with the Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, American Osteopathic Association, and other key stakeholders to raise awareness among policymakers and the public about the importance of expanded GME funding to meet the nation's current and anticipated medical workforce needs. 12. Our AMA will collaborate with other organizations to explore evidence-based approaches to quality and accountability in residency education to support enhanced funding of GME. 13. Our AMA will work with the Association of American Medical Colleges and other key stakeholders to continue to examine alternative models of funding for graduate medical education, with a report back at the 2014 Annual Meeting. (Sub. Res. 314, A-07; Reaffirmation I-07; Reaffirmed: CME Rep. 4, I-08; Reaffirmed: Sub. Res. 314, A-09; Reaffirmed: CME Rep. 3, I-09; Reaffirmation A-11; Appended: Res. 910, I-11; Reaffirmed in lieu of Res. 303, A-12; Reaffirmed in lieu of Res. 324, A-12; Reaffirmation: I-12; Reaffirmation A-13; Appended: Res. 320, A-13; Appended: CME Rep. 5, A-13)

Workforce shortages and access to care

H-200.954 "US Physician Shortage"

Our AMA: (1) explicitly recognizes the existing shortage of physicians in many specialties and areas of the US; (2) supports efforts to quantify the geographic maldistribution and physician shortage in many specialties; (3) supports current programs to alleviate the shortages in many specialties and the maldistribution of physicians in the US; (4) encourages medical schools and residency programs to consider developing admissions policies and practices and targeted educational efforts aimed at attracting

physicians to practice in underserved areas and to provide care to underserved populations; (5) encourages medical schools and residency programs to continue to provide courses, clerkships, and longitudinal experiences in rural and other underserved areas as a means to support educational program objectives and to influence choice of graduates' practice locations; (6) encourages medical schools to include criteria and processes in admission of medical students that are predictive of graduates' eventual practice in underserved areas and with underserved populations; (7) will continue to advocate for funding from public and private payers for educational programs that provide experiences for medical students in rural and other underserved areas; (8) will continue to advocate for funding from all payers (public and private sector) to increase the number of graduate medical education positions in specialties leading to first certification; (9) will work with other groups to explore additional innovative strategies for funding graduate medical education positions, including positions tied to geographic or specialty need; (10) continues to work with the Association of American Medical Colleges (AAMC) and other relevant groups to monitor the outcomes of the National Resident Matching Program; and (11) continues to work with the AAMC and other relevant groups to develop strategies to address the current and potential shortages in clinical training sites for medical students. (Res. 807, I-03; Reaffirmation I-06; Reaffirmed: CME Rep. 7, A-08; Appended: CME Rep. 4, A-10; Appended: CME Rep. 16, A-10; Reaffirmation: I-12; Reaffirmation A-13)

H-200.982 "Significant Problem of Access to Health Care in Rural and Urban Underserved Areas"

1. Our AMA encourages state legislatures and the Congress of the United States to recognize this significant problem and to develop rapidly incentives to make practice in rural and urban underserved areas more attractive to primary care physicians in order to provide access to necessary medical services in these areas. 2. Our AMA will encourage the Centers for Medicare & Medicaid Services, American Osteopathic Association, Accreditation Council for Graduate Medical Education, American Board of Medical Specialties and the Association of American Medical Colleges to foster the development of innovative training programs for medical students, residents and fellows in rural and underserved areas so that the number of physicians increases in these underserved areas, which would facilitate the elimination of geographic, racial, and other health care disparities. (Sub. Res. 35, I-90; Reaffirmed: BOT Rep. GG, I-92; Reaffirmation A-01; Modified: CME Rep. 2, I-03; Appended: Res. 320, A-10)

H-465.988 "Educational Strategies for Meeting Rural Health Physician Shortage"

In light of the data available from the current literature as well as ongoing studies being conducted by staff, the AMA recommends that: (1) Our AMA encourage medical schools and residency programs to develop educationally sound rural clinical preceptorships and rotations consistent with educational and training requirements, and to provide early and continuing exposure to those programs for medical students and residents. (2) Our AMA encourage medical schools to develop educationally sound primary care residencies in smaller communities with the goal of educating and recruiting more rural physicians. (3) Our AMA encourage state and county medical societies to support state legislative efforts toward developing scholarship and loan programs for future rural physicians. (4) Our AMA encourage state and county medical societies and local medical schools to develop outreach and recruitment programs in rural counties to attract promising high school and college students to medicine and the other health professions. (5) Our AMA urge continued federal and state legislative support for funding of Area Health Education Centers (AHECs) for rural and other underserved areas. (6) Our AMA continue to support full appropriation for the National Health Service Corps Scholarship Program, with the proviso that medical schools serving states with large rural underserved populations have a priority and significant voice in the selection of recipients for those scholarships. (7) Our AMA support full funding of the new federal National Health Service Corps loan repayment program. (8) Our AMA encourage continued legislative support of the research studies being conducted by the Rural Health Research Centers funded by the National Office of Rural Health in the Department of Health and Human Services. (9) Our AMA continue its research investigation into the impact of educational programs on the supply of rural physicians. (10) Our AMA continue to conduct research and monitor other progress in development of educational strategies for alleviating rural physician shortages. (11) Our AMA reaffirm its support for legislation making interest payments on student debt tax deductible. (12) Our AMA encourage state and county medical societies to develop programs to enhance work opportunities and social support systems for spouses of rural practitioners. (CME Rep. C, I-90; Reaffirmation A-00; Reaffirmation A-01; Reaffirmation I-01; Reaffirmed: CME Rep. 1, I-08)

Rural and off-site training requirements

H-200.982 "Significant Problem of Access to Health Care in Rural and Urban Underserved Areas"

1. Our AMA encourages state legislatures and the Congress of the United States to recognize this significant problem and to develop rapidly incentives to make practice in rural and urban underserved areas more attractive to primary care physicians in order to provide access to necessary medical services in these areas. 2. Our AMA will encourage the Centers for Medicare & Medicaid Services, American Osteopathic Association, Accreditation Council for Graduate Medical Education, American Board of Medical Specialties and the Association of American Medical Colleges to foster the development of innovative training programs for medical students, residents and fellows in rural and underserved areas so that the number of physicians increases in these underserved areas, which would facilitate the elimination of geographic, racial, and other health care disparities. (Sub. Res. 35, I-90; Reaffirmed: BOT Rep. GG, I-92; Reaffirmation A-01; Modified: CME Rep. 2, I-03; Appended: Res. 320, A-10)

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primary care residencies in smaller communities with the goal of educating and recruiting more rural physicians. (3) Our AMA encourage state and county medical societies to support state legislative efforts toward developing scholarship and loan programs for future rural physicians. (4) Our AMA encourage state and county medical societies and local medical schools to develop outreach and recruitment programs in rural counties to attract promising high school and college students to medicine and the other health professions. (5) Our AMA urge continued federal and state legislative support for funding of Area Health Education Centers (AHECs) for rural and other underserved areas. (6) Our AMA continue to support full appropriation for the National Health Service Corps Scholarship Program, with the proviso that medical schools serving states with large rural underserved populations have a priority and significant voice in the selection of recipients for those scholarships. (7) Our AMA support full funding of the new federal National Health Service Corps loan repayment program. (8) Our AMA encourage continued legislative support of the research studies being conducted by the Rural Health Research Centers funded by the National Office of Rural Health in the Department of Health and Human Services. (9) Our AMA continue its research investigation into the impact of educational programs on the supply of rural physicians. (10) Our AMA continue to conduct research and monitor other progress in development of educational strategies for alleviating rural physician shortages. (11) Our AMA reaffirm its support for legislation making interest payments on student debt tax deductible. (12) Our AMA encourage state and county medical societies to develop programs to enhance work opportunities and social support systems for spouses of rural practitioners. (CME Rep. C, I-90; Reaffirmation A-00; Reaffirmation A-01; Reaffirmation I-01; Reaffirmed: CME Rep. 1, I-08)

Innovations in training

D-295.934 "Encouragement of Interprofessional Education Among Health Care Professions Students"

1. Our AMA: (A) recognizes that interprofessional education and partnerships are a priority of the American medical education system; and (B) will explore the feasibility of the implementation of Liaison Committee on Medical Education and American Osteopathic Association accreditation standards requiring interprofessional training in medical schools. 2. Our AMA supports the concept that medical education should prepare students for practice in physician-led interprofessional teams. 3. Our AMA will encourage health care organizations that engage in a collaborative care model to provide access to an appropriate mix of role models and learners. 4. Our AMA will encourage the Liaison Committee on Medical Education, Commission on Osteopathic College Accreditation, American Osteopathic Association, and Accreditation Council for Graduate Medical Education to facilitate the incorporation of physician-led interprofessional education into the educational programs for medical students and residents in ways that support high quality medical education and patient care. 5. Our AMA will encourage the development of skills for interprofessional education that are applicable to and appropriate for each group of learners. (Res. 308, A-08; Appended: CME Rep. 1, I-12)

D-200.979 "Barriers to Primary Care as a Medical School Choice"

1. In collaboration with relevant specialty societies, our AMA will take the following actions related to reimbursement for primary care physician services: a. Continue to advocate for the recommendations from the AMA/Specialty Society RVS Update Committee (RUC) related to reimbursement for E&M services and coverage of services related to care coordination, including patient education, counseling, team meetings and other functions. b. Work to assure that private payers fully recognize the value of E&M services, incorporating the RUC recommended increases adopted for the most current Medicare RBRVS. 2. In collaboration with relevant specialty societies, our AMA will study the following related to new models of provision of primary care services (such as the medical home concept): a. the impact on primary care physician work-life balance and satisfaction, b. the growth/expansion of such models in the public and private sectors, c. the availability of expanded public- and private-sector funding at the national and local levels to support implementation of such models. d. the impact on primary care physician compensation. e. options that explore additional funding. The results of the study shall be reported no later than the 2010 Annual Meeting of the AMA House of Delegates. 3. Our AMA supports existing programs and advocate for the introduction of new programs in the public and private sectors that decrease the debt load of physicians who choose to practice in a primary care specialty. 4. Our AMA will continue to monitor trends in the choice of a primary care specialty and the availability of primary care graduate medical education positions. 5. Our AMA will collaborate with appropriate organizations to support the development of innovative models to recruit medical students interested in primary care, to train primary care physicians, and to enhance the image of primary care practice. 6. Our AMA will collaborate with appropriate organizations in urging medical schools to develop policies and to allocate appropriate resources to activities and programs that encourage students to select primary care specialties, including: a. admissions policies b. utilization of primary care physicians in the roles of teachers, mentors, and role models, and c. educational experiences in community-based primary care settings. 7. Our AMA will work with the Accreditation Council for Graduate Medical Education (ACGME) to develop an accreditation environment and novel pathways that promote innovations in training that use progressive, community-based models of integrated care focused on quality and outcomes such as the patient-centered medical home and the chronic care model. 8. Our AMA will advocate for public (federal and state) and private payers to develop enhanced funding and related incentives from all sources to provide graduate medical education for resident physicians and fellows in progressive, community-based models of integrated care focused on quality and outcomes such as the patient-centered medical home and the chronic care model in order to enhance primary care as a career choice. 9. Our AMA will advocate for public (federal and state) and private payers to develop enhanced funding and related incentives from all sources to provide undergraduate medical education for students in progressive, community-based models of integrated care focused on quality and outcomes such as the patient-centered medical home and the chronic care model in order to enhance primary care as a career choice. 10. Our AMA will advocate for public (federal and state) and private payers to develop physician reimbursement systems to promote primary care and specialty practices in progressive, community-based models of integrated care focused on quality and outcomes such as the patient-centered medical home and the

chronic care model consistent with current AMA Policies H-160.918 and H-160.919. (CME Rep. 3, I-08; Appended: CME Rep. 8, A-10)

8. GUIDELINES FOR STUDENTS SHADOWING PHYSICIANS (RESOLUTIONS 310-A-13 AND 913-I-13)

Reference committee hearing: see report of [Reference Committee C](#).

HOUSE ACTION: REFERRED

Resolution 310-A-13, “Medical Facility Regulations for Students Shadowing Physicians,” introduced by the Georgia delegation and referred by the House of Delegates (HOD), asked that our American Medical Association (AMA) develop standard criteria for students to shadow physicians in medical facilities.

Resolution 913-I-13, “Pre-Medical School Shadowing,” submitted by the Washington delegation and referred by the HOD, asked that our AMA (1) promote the development of programs that assist physicians in providing pre-medical shadowing opportunities; and (2) communicate to the Association of American Medical Colleges that for medical schools which have the pre-medical shadowing requirement, aiding these underprivileged students in getting their shadowing is an obligation of the medical school.

This report focuses on areas common to Resolutions 310-A-13 and 913-I-13, namely concerns and strategies around pre-medical students shadowing physicians.

Resolution 310-A-13 noted that high school and pre-medical students are “strongly encouraged” by medical school admissions committees to have clinical shadowing experience. However, the Health Insurance Portability and Accountability Act (HIPAA) and other regulations (e.g., those dealing with patient rights, privacy, and confidentiality) often serve as impediments to many physicians who might otherwise provide student shadowing experiences. In addition, individual hospitals may have standards for shadowing of physicians by students, but these vary widely from one institution to the next, with no recognized national standard in place.

Testimony on Resolution 913-I-13 supported the need for appropriate guidelines for providing pre-medical school shadowing opportunities. It was also noted that increased opportunities for shadowing can help increase diversity in medicine by raising awareness among individuals from diverse backgrounds in the possibility of medicine as a career (through the AMA Doctors Back to School program, for example) and can help bring this goal to fruition. It was suggested that such programs may contribute to improved motivation and experience, leading to increased matriculation and lower attrition rates. Questions were raised, however, as to the responsibility of medical schools to offer shadowing opportunities.

BACKGROUND

It is important to differentiate shadowing from volunteering. Volunteering offers an opportunity to help (without compensation) in a health care setting; duties might include filing paperwork, answering phones, and similar functions. Shadowing, in contrast, is strictly observational but directly related to the provision of clinical care, with the student observing as the health professional provides care to patients. This may occur in varied clinical settings, including hospitals, outpatient clinics, long-term care facilities and/or office practices. Observation always occurs under the appropriate supervision of a licensed physician or other licensed health care professional.

The benefits of a shadowing experience for the student include exposure to the day-to-day realities of medical practice and tangible evidence (for admissions committees) of their commitment to becoming a physician. For example, one summertime medical program for high school students, which included a shadowing component, resulted in “increased understanding of the medical school application process, the medical curriculum and the medical field, and an increase in students’ likeliness to choose a medical career.”¹

Such experiences, however, may raise ethical issues for patients in the clinical setting. The author of a June 2011 commentary in *JAMA*, for example, stated that any potential benefits of shadowing from the student perspective “are eclipsed by potential damage to the patient-physician relationship.”² Further, a review published in *Academic Medicine* in January 2013 found scant medical literature on shadowing and its impacts on students, physicians and

patients, and called for further research and the creation of objective outcomes measures. The authors proposed “developing guidelines and introducing a code of conduct for pre-medical students, to enhance the consistency of shadowing experiences and address ethical and practical considerations.”³

Shadowing and its attendant concerns were the subject of a July 2013 email thread on the listserv of the National Association of Advisors for the Health Professions (NAAHP). Advisors noted that, as regulations tighten in health care settings, developing and overseeing clinical educational and shadowing experiences has become more challenging than in the past. Some of the issues that may dissuade physician offices and hospitals from serving as sites for clinical shadowing include concerns over potential liability, HIPAA regulations, lack of time or staff for oversight, and ethical concerns, including informed consent and patient confidentiality.

In some areas, students are required to complete a training program prior to entering into a shadowing experience, to include HIPAA certification, criminal and child abuse background checks and drug testing. The authors of a 2011 letter to *JAMA* proposed three broad guidelines to ensure that medical ethics and legal requirements are not compromised during shadowing experiences: “First, the student must complete HIPAA regulations, the physician must judge if the appointment is appropriate for observing, and the physician should specify boundaries for educational dialogue and note taking. Second, on being introduced to the patient, the premedical student should clearly identify himself or herself as a college student observing to learn more about a medical career. It is deceptive to say he or she is a member of the team or working with the physician. Third, the patient should be told that there is no obligation to allow the observation and refusal is understandable. These criteria would prevent misrepresentation and create transparency—ethical principles that can never be introduced too early in an education.”⁴

SHADOWING: WHO SHOULD BE RESPONSIBLE?

In theory, physicians are willing to engage and train the next generation of practitioners and provide career guidance for college and university students aspiring to become physicians. In practice, however, this inclination often collides with the reality of modern medicine, in which physicians are under significant time and performance pressures. In addition, the regulatory, legal and ethical issues cited in the previous section may cause even the most altruistic physician to reconsider taking on this additional “unfunded mandate.” Often there are also first and second-year medical students who want to shadow, and these students may have priority, given a physician’s busy schedule.

Most medical schools have admissions criteria that medical school applicants should have a certain number of hours (some recommend at least 40 hours) experience in shadowing/observership. Accordingly, as proposed in Resolution 913-I-13, it may be appropriate to encourage medical schools to help pre-medical students meet this requirement by ensuring availability of shadowing programs. This is particularly needed with regard to students from underrepresented minority populations, who may lack the resources and connections to obtain the needed experience.⁵ Not providing ready access to such experiences could mean that shadowing requirements have the unintended effect of further disenfranchising minority and economically disadvantaged students and reducing the number of medical school matriculants from these sectors of society.

DEVELOPMENT OF SHADOWING GUIDELINES

After concerns with shadowing were brought to the attention of the Association of American Medical Colleges, the AAMC developed shadowing guidelines for pre-medical students, in close collaboration with the AMA and the NAAHP. The recommended guidelines (aamc.org/download/356316/data/shadowingguidelines2013.pdf) for clinical shadowing include student learning objectives and responsibilities, a model physician-student agreement, a student code of conduct, and a student agreement on confidentiality and privacy of patient information.

Another organization that provides information on shadowing is the American Association of Colleges of Osteopathic Medicine (aacom.org/InfoFor/applicants/becoming/Pages/ShadowaDO.aspx). Similar to allopathic medical schools, colleges of osteopathic medicine encourage applicants to learn more about the profession by identifying an osteopathic physician to shadow. Many DOs’ offices will host a pre-medical student for one or two days.

EXISTING AMA POLICY

AMA Policy D-295.941, "Facilitating Access to Health Care Facilities for Training," calls on the AMA to "work with the Association of American Medical Colleges and other national organizations to expedite, wherever possible, the standardization of requirements in regards to training on HIPAA, drug screening, and health requirements for medical students, and resident and fellow physicians who are being educated in hospitals and other health care settings." This particular policy, however, specifies medical students and resident/fellow physicians, not pre-med students. (At the A-13 AMA meeting, Reference Committee C recommended addition of the phrase "pre-medical students" to this policy, in response to Resolution 310-A-13, but the AMA House of Delegates instead referred this resolution.)

SUMMARY AND RECOMMENDATIONS

The development of guidelines for clinical shadowing by the AAMC is timely and should help increase nationwide standardization of shadowing experiences for pre-medical students. Development of a separate set of guidelines by the AMA could create confusion regarding optimal approaches to shadowing in health care settings. A better role for the AMA would be to encourage awareness and use of these guidelines and to call upon medical schools, physicians and others to help ensure availability of shadowing opportunities, particularly for students from underrepresented populations. Therefore, the Council on Medical Education recommends that the following recommendations be adopted in lieu of Resolutions 310-A-13 and 913-I-13 and that the remainder of this report be filed:

1. That our American Medical Association encourage wide dissemination of the Association of American Medical Colleges' clinical shadowing guidelines to interested parties, including K-12 students, pre-medical students, health professions advisors, hospitals, medical schools and physicians.
2. That our AMA encourage all physicians to provide shadowing opportunities to pre-medical students.
3. That AMA Policy D-295.941, "Facilitating Access to Health Care Facilities for Training," be amended by addition to state that the AMA "work with the Association of American Medical Colleges and other national organizations to expedite, wherever possible, the standardization of requirements in regards to training on HIPAA, drug screening, and health requirements for pre-medical and medical students, and resident and fellow physicians who are being educated in hospitals and other health care settings."

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