REPORTS OF THE COUNCIL ON MEDICAL EDUCATION

The following reports, 1–9, were presented by Patricia Turner, MD, Chair.

1. COUNCIL ON MEDICAL EDUCATION SUNSET REVIEW OF 2007 HOUSE POLICIES

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS
REMAINDER OF REPORT FILED

AMA Policy G-600.110, "Sunset Mechanism for AMA Policy," is intended 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. The current policy 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to the HOD or resolution to sunset a policy earlier than its 10-year horizon if it is no longer relevant, has been superseded by a more current policy, or has been accomplished.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 2007 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 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 2007 and Other House of Delegates Policies

HOUSE OF DELEGATES POLICIES	
Policy Number, Title, Policy	*Recommended Action*
H-35.985, AMA Role in Allied Health Education and Accreditation The AMA reaffirms its commitment to promoting quality in allied health education. (CME Rep. E, I-86; Amended by Sunset Report, I-96; Reaffirmed: CME Rep. 2, A-06; Reaffirmed in lieu of Res. 705, I-07)	Sunset; the AMA is no longer involved in oversight of allied health education.
H-150.993, Medical Education in Nutrition The AMA recommends that instruction on nutrition be included in the curriculum of medical schools in the United States. (Sub. Res. 82, I-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: CME Rep. 3, I-97; Reaffirmed: CME Rep. 2, A-07)	Sunset; superseded by Basic Courses in Nutrition, H-150.995, which reads, "Our AMA encourages effective education in nutrition at the undergraduate, graduate, and postgraduate levels."
H-150.996, Nutrition Courses in Medicine Our AMA recommends the teaching of adequate nutrition courses in elementary and high schools and that the LCME work toward enhancement of the teaching of nutrition in medical schools. (Sub. Res. 66, I-77; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CME Rep. 2, A-10)	Revise as follows; the excised portion is superseded by H-150.995, Basic Courses in Nutrition. "Nutrition ~~Courses in Medicine~~ Education "Our AMA recommends the teaching of adequate nutrition courses in elementary and high schools~~ and that the LCME work toward enhancement of the teaching of nutrition in medical schools~~."
H-275.941, Out-of-State Residents in Training and State Licensing Board Requirements for Temporary Licenses The AMA will work with the Federation of State Medical Boards (FSMB) to facilitate a timely process so that residents in a training program can meet the licensure requirements to avail themselves of opportunities for educational experiences in states other than that of their primary program location. (Sub. Res. 301, A-97; Reaffirmed: CME Rep. 2, A-07)	Sunset; no longer relevant.
H-275.975, Qualifications of Health Professionals (1) Private certifying organizations should be encouraged to continue certification programs for all health professionals and to communicate to the public the qualifications and standards they require for certification. Decisions concerning recertification should be made by the certifying organizations. (2) Working with state licensing and certifying boards, health care professions should use the results of quality assurance activities to ensure that substandard practitioner behavior is dealt with in a professional and timely manner. Licensure and disciplinary boards, in cooperation with their respective professional and occupational associations, should be encouraged to work to identify "deficient Health care professionals. (BOT Rep. NN, A-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CME Rep. 2, A-07)	Retain; still relevant.
H-295.870, Medical School Language Electives in Medical School Curriculum Our AMA strongly encourages all Liaison Committee on Medical Education- and American Osteopathic Association-accredited US medical schools to offer medical second languages to their students as electives. (Res. 304, A-07)	Retain; still relevant.
H-295.871, Initiative to Transform Medical Education: Strategies for Medical Education Reform Our AMA continues to recognize the need for transformation of medical education across the continuum from premedical preparation through continuing physician professional development and the need to involve multiple stakeholders in the transformation process, while taking an appropriate leadership and coordinating role. (CME Rep. 13, A-07)	Retain, still relevant, but with title change as shown below, as this work has been incorporated into the AMA's Accelerating Change in Medical Education strategic focus area. ~~Initiative to Transform~~ Accelerating Change in Medical Education: Strategies for Medical Education Reform H-295.871

H-295.895, Progress in Medical Education: Structuring the Fourth Year of Medical School It is the policy of the AMA that: (1) Trends toward increasing structure in the fourth year of medical school should be balanced by the need to preserve opportunities for students to engage in elective clinical and other educationally appropriate experiences. (2) The third and fourth years as a continuum should provide students with a broad clinical education that prepares them for entry into residency training. (3) There should be a comprehensive assessment of clinical skills administered at a time when the results can be used to plan each student's fourth-year program, so as to remedy deficiencies and broaden clinical knowledge. (4) Medical schools should develop policies and procedures to ensure that medical students receive counseling to assist them in their choice of electives. (5) Adequate and timely career counseling should be available at all medical schools. (6) The ability of medical students to choose electives based on interest or perceived academic need should not be compromised by the residency selection process. The American Medical Association should work with the Association of American Medical Colleges, medical schools, and residency program directors groups to discourage the practice of excessive audition electives. (7) Our AMA should continue to work with relevant groups to study the transition from the third and fourth years of medical school to residency training, with the goal of ensuring that a continuum exists in the acquisition of clinical knowledge and skills. (CME Rep. 1, I-98; Reaffirmed: CME Rep. 9, A-07)	Retain; still relevant.
H-295.897, Enhancing the Cultural Competence of Physicians 1. Our AMA continues to inform medical schools and residency program directors about activities and resources related to assisting physicians in providing culturally competent care to patients throughout their life span and encourage them to include the topic of culturally effective health care in their curricula. 2. Our AMA continues research into the need for and effectiveness of training in cultural competence, using existing mechanisms such as the annual medical education surveys and focus groups at regularly scheduled meetings. 3. Our AMA will form an expert national advisory panel (including representation from the AMA Minority Affairs Consortium and International Medical Graduate Section) to consult on all areas related to enhancing the cultural competence of physicians, including developing a list of resources on cultural competencies for physicians and maintaining it and related resources in an electronic database. 4. Our AMA will assist physicians in obtaining information about and/or training in culturally effective health care through development of an annotated resource database on the AMA home page, with information also available through postal distribution on diskette and/or CD-ROM. 5. Our AMA will seek external funding to develop a five-year program for promoting cultural competence in and through the education of physicians, including a critical review and comprehensive plan for action, in collaboration with the AMA Consortium on Minority Affairs and the medical associations that participate in the consortium (National Medical Association, National Hispanic Medical Association, and Association of	Revise as shown below: 1. Our AMA continues to inform medical schools and residency program directors about activities and resources related to assisting physicians in providing culturally competent care to patients throughout their life span and encourage them to include the topic of culturally effective health care in their curricula. 2. Our AMA continues to support research into the need for and effectiveness of training in cultural competence, using existing mechanisms such as the annual medical education surveys ~~and focus groups at regularly scheduled meetings~~. ~~3. Our AMA will form an expert national advisory panel (including representation from the AMA Minority Affairs Consortium and International Medical Graduate Section) to consult on all areas related to enhancing the cultural competence of physicians, including developing a list of resources on cultural competencies for physicians and maintaining it and related resources in an electronic database.~~ ~~4~~3. Our AMA will assist physicians in obtaining information about and/or training in culturally effective health care through-dissemination of currently available resources from the AMA and other relevant organizations.~~development of an annotated resource database on the AMA home page, with information also available through postal distribution on diskette and/or CD-ROM.~~ ~~5. Our AMA will seek external funding to develop a five-~~

American Indian Physicians,) the American Medical Women's Association, the American Public Health Association, the American Academy of Pediatrics, and other appropriate groups. The goal of the program would be to restructure the continuum of medical education and staff and faculty development programs to deliberately emphasize cultural competence as part of professional practice. 6. Our AMA encourages training opportunities for students and residents, as members of the physician-led team, to learn cultural competency from community health workers, when this exposure can be integrated into existing rotation and service assignments. (CME Rep. 5, A-98; Reaffirmed: Res. 221, A-07; Reaffirmation A-11; Appended: Res. 304, I-16)	~~year program for promoting cultural competence in and through the education of physicians, including a critical review and comprehensive plan for action, in collaboration with the AMA Consortium on Minority Affairs and the medical associations that participate in the consortium (National Medical Association, National Hispanic Medical Association, and Association of American Indian Physicians,) the American Medical Women's Association, the American Public Health Association, the American Academy of Pediatrics, and other appropriate groups. The goal of the program would be to restructure the continuum of medical education and staff and faculty development programs to deliberately emphasize cultural competence as part of professional practice.~~ ~~6~~4. Our AMA encourages training opportunities for students and residents, as members of the physician-led team, to learn cultural competency from community health workers, when this exposure can be integrated into existing rotation and service assignments.
H-295.901, Restrictive Covenants in Residency and Fellowship Training Programs Our AMA adopts as policy and publicizes to all teaching institutions the Current Opinion that it is unethical for a teaching institution to seek a non-competition guarantee in return for fulfilling its educational obligations. Physicians-in-training should not be asked to sign covenants not-to-compete as a condition of their entry into any residency or fellowship program. (Sub. Res. 305, I-97; Reaffirmed: CME Rep. 2, A-07)	Sunset; this is reflected in the current institution requirements of the Accreditation Council for Graduate Medical Education.
H-295.903, Opposition to Legislation that Directs the Content of Medical School Curriculum The AMA opposes efforts from all levels of government to dictate the content of medical school curricula either directly or as a condition for receipt of funding. (Res. 322, A-97 Reaffirmed: CME Rep. 2, A-07)	Sunset; superseded by Federal Intervention in the Setting of Educational Standards, H-295.921.
H-295.904, Commitment to Honor Resident Contracts The AMA adopts the following language as policy: In the event of a residency program reduction or closure, institutions should make every effort possible to allow residents already in the program to complete their education and, should honor the provisions of their existing contracts. (Res. 314, A-97; Reaffirmed: CME Rep. 2, A-07)	Sunset; superseded by Closing of Residency Programs, H-310.943, which reads: "The AMA: (1) encourages the Accreditation Council for Graduate Medical Education (ACGME) to address the problem of non-educational closing or downsizing of residency training programs; (2) reminds all institutions involved in educating residents of their contractual responsibilities to the resident; (3) encourages the ACGME and the various Residency Review Committees to reexamine requirements for "years of continuous training" to determine the need for implementing waivers to accommodate residents affected by non-educational closure or downsizing; (4) will work with the American Board of Medical Specialties Member Boards to encourage all its member boards to develop a mechanism to accommodate the discontinuities in training that arise from residency closures, regardless of cause, including waiving continuity care requirements and granting residents credit for partial years of training; (5) urges residency programs and teaching hospitals be monitored by the applicable Residency Review Committees to ensure that decreases in resident numbers do not place undue stress on remaining residents by affecting work hours or working conditions, as specified in Residency Review Committee requirements; (6) opposes the closure of residency/fellowship programs or reductions in the number of current positions in programs as a result of changes in GME funding; and (7) will work

	with the Centers for Medicare and Medicaid Services (CMS), ACGME, and other appropriate organizations to advocate for the development and implementation of effective policies to permit graduate medical education funding to follow the resident physician from a closing to the receiving residency program (including waivers of CMS caps), in the event of temporary or permanent residency program closure."
H-295.905, Promoting Culturally Competent Health Care The AMA encourages medical schools to offer electives in culturally competent health care with the goal of increasing awareness and acceptance of cultural differences between patient and provider. (Res. 306, A-97; Reaffirmed: CME Rep. 2, A-07)	Sunset; superseded by Enhancing the Cultural Competence of Physicians, H-295.897.
H-295.908, Protection of Medical Students in the Event of Medical School Closure or Reduction in Enrollment The AMA will continue to monitor medical school closures, mergers, and changes in ownership. In the case of medical school closure or decreases in class size that affect enrolled students, the AMA will provide appropriate assistance, where feasible, so that medical students will experience an orderly transition. (CME Rep. 4, A-97; Reaffirmed: CME Rep. 2, A-07)	Retain.
H-295.914, Instruction in Managed Care The AMA will communicate with medical school deans and residency program directors urging the inclusion in their curricula of appropriate instruction regarding the concept, implementation and impact of managed care on the practice of medicine. (Res. 309, A-96; Reaffirmed by CME Rep. 5, A-97; Reaffirmed: CME Rep. 2, A-07)	Sunset; superseded by Future Directions for Socioeconomic Education, H-295.924, which reads: "The AMA: (1) asks medical schools and residencies to encourage that basic content related to the structure and financing of the current health care system, including the organization of health care delivery, modes of practice, practice settings, cost effective use of diagnostic and treatment services, practice management, risk management, and utilization review/quality assurance, is included in the curriculum; (2) asks medical schools to ensure that content related to the environment and economics of medical practice in fee-for-service, managed care and other financing systems is presented in didactic sessions and reinforced during clinical experiences, in both inpatient and ambulatory care settings, at educationally appropriate times during undergraduate and graduate medical education; and (3) will encourage representatives to the Liaison Committee on Medical Education (LCME) to ensure that survey teams pay close attention during the accreditation process to the degree to which 'socioeconomic' subjects are covered in the medical curriculum."
H-295.921, Federal Intervention in the Setting of Educational Standards The AMA strongly opposes federal intervention, through legislative restrictions, that would limit the authority of professional accrediting bodies to design and implement appropriate educational standards for the training of physicians. The AMA strongly opposes infringements and mandates on medical school curricular requirements through state and federal legislative efforts, and also recommends that state medical societies should carefully monitor such activities and notify the AMA when such intrusions take place. (Res. 323, A-95; Appended: CME Rep. 4, I-97; Reaffirmed: CME Rep. 2, A-07)	Retain; still relevant.
H-295.922, Establishing Essential Requirements for Medical Education in Substance Abuse AMA policy states that alcohol and other drug abuse education needs to be an integral part of medical education; and that the AMA supports the development of programs to train medical students in the identification, treatment, and prevention of alcoholism and other chemical dependencies. Our AMA: (1) asks all residency review	Sunset; superseded by Prescription Drug Diversion, Misuse and Addiction H-95.945, which reads, in part, that our AMA "(5) will promote medical school and postgraduate training that incorporates curriculum topics focusing on pain medicine, addiction medicine, safe prescribing practices, safe medication storage and disposal practices, functional assessment of patients with

committees to review their training requirements in the treatment and management of substance abuse and addiction and to make recommendations for strengthening this provision as needed; and (2) encourages the development of specialty-specific needs assessment to determine whether targeted educational activities in substance abuse would be useful in their overall program of continuing medical education. (Res. 303, I-94; Reaffirmed and Appended: CME Rep. 10, I-98; Reaffirmed: CME Rep. 11, A-07)	chronic conditions, and the role of the prescriber in patient education regarding safe medication storage and disposal practices, in order to have future generations of physicians better prepared to contribute to positive solutions to the problems of prescription drug diversion, misuse, addiction and overdose deaths." In addition, Substance Use and Substance Use Disorders D-95.984 states that our AMA "(2) will renew efforts to: (a) have substance use disorders addressed across the continuum of medical education; (b) provide tools to assist physicians in screening, diagnosing, intervening, and/or referring patients with substance use disorders so that they have access to treatment…."
H-295.974, Regulation of Medical Student Educational Opportunities The AMA (1) reaffirms its support for the LCME standard for accreditation of undergraduate medical education programs that the curriculum be designed to instill in its graduates the knowledge and skills fundamental to the practice of medicine; and (2) opposes legislation or other efforts by state or federal regulatory agencies to define standards which limit educational opportunities in the training process of future physicians. (Res. 142, I-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CME Rep. 2, A-07)	Sunset; no longer relevant; item (2) is superseded by Federal Intervention in the Setting of Educational Standards, H-295.921.
H-295.975, Educating Competent and Caring Health Professionals (1) Programs of health professions education should foster educational strategies that encourage students to be independent learners and problem-solvers. Faculty of programs of education for the health professions should ensure that the mission statements of the institutions in which they teach include as an objective the education of practitioners who are both competent and compassionate. (2) Admission to a program of health professions education should be based on more than grade point average and performance on admissions tests. Interviews, applicant essays, and references should continue to be part of the application process in spite of difficulties inherent in evaluating them. Admissions committees should review applicants' extra-curricular activities and employment records for indications of suitability for health professions education. Admissions committees should be carefully prepared for their responsibilities, and efforts should be made to standardize interview procedures and to evaluate the information gathered during interviews. Research should continue to focus on improving admissions procedures. Particular attention should be paid to improving evaluations of subjective personal qualities. (3) Faculty of programs of education for the health professions must continue to emphasis than they have in the past on educating practitioners who are skilled in communications, interviewing and listening techniques, and who are compassionate and technically competent. Faculty of health professions education should be attentive to the environment in which education is provided; students should learn in a setting where respect and concern are demonstrated. The faculty and administration of programs of health professions education must ensure that students are provided with appropriate role models; whether a faculty member serves as an appropriate role model should be considered when review for promotion or tenure occurs. Efforts should be made by the faculty to evaluate the attitudes of students toward patients. Where these attitudes are found lacking, students should be counseled. Provisions for dismissing students who clearly indicate personality characteristics inappropriate to practice should be enforced. (4) In spite of the high degree of specialization in health care, faculty of programs of education for the health professions must prepare students to provide integrated patient care; programs of education	Retain; still relevant.

should promote an interdisciplinary experience for their students. (BOT Rep. NN, A-87; Modified: Sunset Report, I-97; Reaffirmed: CME Rep. 2, A-07)	
H-295.988, Alcohol and Substance Abuse Education of Medical Students and Residents In cooperation with other organizations, the AMA supports the education of medical students and residents in the prevention and treatment of alcoholism and substance abuse in our nation's youth. (Sub. Res. 100, A-84; Reaffirmed by CLRPD Rep. 3 - I-94; Reaffirmed: CME Rep. 2, A-04; Reaffirmed: CME Rep. 11, A-07)	Sunset; superseded by Prescription Drug Diversion, Misuse and Addiction H-95.945, which reads, in part, that our AMA "(5) will promote medical school and postgraduate training that incorporates curriculum topics focusing on pain medicine, addiction medicine, safe prescribing practices, safe medication storage and disposal practices, functional assessment of patients with chronic conditions, and the role of the prescriber in patient education regarding safe medication storage and disposal practices, in order to have future generations of physicians better prepared to contribute to positive solutions to the problems of prescription drug diversion, misuse, addiction and overdose deaths." In addition, Substance Use and Substance Use Disorders D-95.984 states that our AMA "(2) will renew efforts to: (a) have substance use disorders addressed across the continuum of medical education; (b) provide tools to assist physicians in screening, diagnosing, intervening, and/or referring patients with substance use disorders so that they have access to treatment…."
H-300.948, Continuing Medical Education Activities for Procedural Skills The AMA encourages the ACCME to require sponsors of courses in new procedures to provide documentation for physician attendees, using the following four levels of achievement: Level 1: Verification of attendance, Level 2: Verification of satisfactory completion of course objectives, Level 3: Verification of "proctor readiness", and Level 4: Verification of physician competence to perform the procedure. (CME Rep. 12, A-97; Reaffirmed: CME Rep. 2, A-07)	Retain; still relevant.
H-300.949, The Ecology of Medical Education: Physician Self-Directed Learning and Continuing Medical Education The AMA: (1) encourages medical schools and residency programs to define and educate the trainee on principles of self-directed learning, including self-assessment and how to use these principles to achieve continuing professional development; (2) supports efforts of the ACCME to develop ethical guidelines for the providers of CME, recognizing the unique needs of those funding CME and their potential to influence the direction of CME; and (3) will seek support for a national study of the future directions of continuing medical education so that effective strategies and policies are developed for maintaining and improving the competence of physicians in caring for patients. (CME Rep. 10, A-97; Reaffirmed: CME Rep. 2, A-07)	Retain; still relevant, with the edits shown below. The Standards for Commercial Support have been developed by the ACCME and are in place, so #2 has been accomplished. The AMA: (1) encourages medical schools and residency programs to define and educate the trainee on principles of self-directed learning, including self-assessment and how to use these principles to achieve continuing professional development; and (2) ~~supports efforts of the ACCME to develop ethical guidelines for the providers of CME, recognizing the unique needs of those funding CME and their potential to influence the direction of CME; and (3)~~ will seek support for a national study of the future directions of continuing medical education so that effective strategies and policies are developed for maintaining and improving the competence of physicians in caring for patients.
H-305.927, Payment Cuts to Teaching Programs Our AMA opposes payment cuts to any teaching program on the basis that the attending physician is concurrently or sequentially supervising more than one resident, fellow or student. (Sub. Res. 719, I-07)	Retain; still relevant.
H-305.935, Policy Options for Support of Graduate Medical Education Our AMA adopts the following principles: GRADUATE MEDICAL EDUCATION POSITIONS (1) Planning for the number of residency positions should take into	Sunset; superseded by other AMA policy, including H-200.955, Revisions to AMA Policy on the Physician Workforce, and H-305.929, Proposed Revisions to AMA Policy on the Financing of Medical Education Programs.

account the contributions to patient care made by other health professions and occupations, considering that other health professions and occupations do not substitute for physicians. (2) Explicit immunity from antitrust constraints should be provided to private professional groups, to allow participation in the national debate on the physician workforce. (3) Program quality, based on an assessment of educational program outcomes under the leadership of the Accreditation Council for Graduate Medical Education and its Residency Review Committees, should be a factor in the allocation of funded residency positions. (4) Transitional funds should be provided to teaching institutions that lose residents as a result of cuts in the number of funded positions. (CME Rep. 10, A-99; Reaffirmed: CME Rep. 2, A-00; Modified: CME Rep. 2, I-03; Modified: CME Rep. 7, A-05; Reaffirmation I-07)	
H-310.921, Credentialing Materials: Timely Submission by Residency and Fellowship Programs 1. Our AMA encourages residency programs and fellowship programs to submit credentialing and verification data requested on behalf of their graduating residents and fellows to the requesting agency within thirty days of the request. 2. Our AMA encourages the Accreditation Council for Graduate Medical Education to establish an accreditation standard for residency and fellowship programs calling for submission of credentialing and recredentialing verification data requested on behalf of their graduating residents and fellows to the requesting agency within thirty days of the request. (Res. 312, A-07)	Sunset; superseded by D-310.965, Credentialing Materials: Timely Submission by Residency and Fellowship Programs.
H-360.995, Nursing Education and the Supply of Nursing Personnel in the United States The AMA supports: (1) all levels of nursing education, at least until the crisis in the supply of bedside care personnel is resolved; (2) government and private initiatives that would facilitate the recruitment and education of nurses to provide care at the bedside; (3) economic and professional incentives to attract and retain high quality individuals to provide bedside nursing care; (4) hospital-based continuing education programs to promote the education of caregivers who assist in the implementation of medical procedures in critical care units, operating and emergency rooms, and medical-surgical care; and (5) cooperation with other organizations concerned with acute and chronic hospital care to develop quality educational programs and methods of accreditation of programs to increase the availability of caregivers at the bedside and to meet the medical needs of the public. (BOT Rep. CC, I-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CLRPD Rep. 2, A-07)	Sunset; superseded by D-360.998, The Growing Nursing Shortage in the United States.
H-425.988, The US Preventive Services Task Force Guide to Clinical Preventive Services It is the policy of the AMA: (1) to continue to work with the federal government, specialty societies, and others, to develop guidelines for, and effective means of delivery of, clinical preventive services; and (2) to continue our efforts to develop and encourage continuing medical education programs in preventive medicine. (CME Rep. I, A-90; Reaffirmed by CME Rep. 5, I-95; Reaffirmed and Modified with change in title: CME Rep. 2, A-05; Reaffirmation A-07)	Retain; still relevant.
H-425.991, Support for Preventive Medicine The AMA reaffirms its commitment to preventive medicine. (Res. 135, I-87; Modified: Sunset Report, I-97; Modified and Reaffirmed: CME Rep. 2, A-07)	Sunset; no longer needed, as preventive medicine is a mature specialty field.

HOUSE OF DELEGATES DIRECTIVES	
Policy Number, Title, Policy	*Recommended Action*
D-200.991, The Physician Workforce: Recommendations for Policy Implementation To address current and predicted physician shortages, our AMA will work with members of the Federation and national and regional policymakers to develop mechanisms, including identification of funding sources, to create medical school and residency positions in or adjacent to physician shortage/underserved areas and in undersupplied specialties. (CME Rep. 8, A-05; Reaffirmation I-06; Reaffirmation I-07)	Sunset; superseded by D-305.967(17), The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education, which reads as follows: "Our AMA will 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: (a) train more physicians to meet state and regional workforce needs; (b) train physicians who will practice in physician shortage/underserved areas; or (c) train physicians in undersupplied specialties and subspecialties in the state/region."
D-220.973, Effective AMA Leadership for Patient Safety: Reducing the Hospital Registered Nurse Shortage Our AMA: (1) will work with The Joint Commission to consider nurse staffing as a national patient safety goal and to examine the Hospital Accreditation Standards at NR.3.10 (regarding nursing policies and procedures, nursing standards, and nurse staffing plans), LD.3.15 (regarding management of the flow of patients to mitigate patient crowding and ensure appropriate care of patients in temporary locations), and HR.1.10-1.1.20 (regarding the hospital staffing plan and the qualifications of staff), to ensure that nursing staffs are adequate relative to patient number and acuity, are competent, and are appropriately oriented and trained in specialized departments; (2) supports professional nursing associations in their efforts to educate the public and advocate for programs aimed at protecting patient safety by ameliorating the RN shortage in hospitals; (3) encourages hospital organized medical staffs to take steps to improve the working environment and professional standing of nurses in hospitals in order to improve the quality and safety of patient care; (4) will provide reports to the House of Delegates at the 2008, 2009 and 2010 Annual Meetings detailing progress made in its efforts to address the nursing shortage. (Res. 534, A-07)	Sunset, due to directives that are outdated or have been accomplished, or are reflected in other AMA policy. The standards noted in item 1 have been updated multiple times since 2007 and require hospitals to confront staffing shortages. Item 2 is superseded by D-360.998(1), "The Growing Nursing Shortage in the United States," which reads, in part: "Our AMA: (1) recognizes the important role nurses and other allied health professionals play in providing quality care to patients, and participate in activities with state medical associations, county medical societies, and other local health care agencies to enhance the recruitment and retention of qualified individuals to the nursing profession and the allied health fields." Item 3 is superseded by D-360.998(2)(5), "The Growing Nursing Shortage in the United States," which reads, in part: "Our AMA… (2) encourages physicians to be aware of and work to improve workplace conditions that impair the professional relationship between physicians and nurses in the collaborative care of patients; … (5) will work with nursing, hospital, and other appropriate organizations to seek to remove administrative burdens, e.g., excessive paperwork, to improve efficiencies in nursing and promote better patient care." Item 4 was accomplished by Board of Trustees Report 27-A-08, which resulted in AMA policy H-360.982, "Leadership for Patient Safety: Reducing the Hospital Registered Nurse Shortage at the Bedside."
D-255.996, ECFMG Representation Our AMA will strongly encourage the ECFMG to regularly appoint an international medical graduate as one of the at-large members on its Board of Trustees. (Res. 304, A-00 Reaffirmed: CME Rep. 2, A-10)	Sunset; directive fulfilled. Also, reflected in AMA Principles on International Medical Graduates H-255.988 (5), which states, in part, "An AMA member, who is an IMG, should be appointed regularly as one of the AMA's representatives to the ECFMG Board of Trustees."
D-295.941, Facilitating Access to Health Care Facilities for Training Our AMA will continue 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. (Res. 811, I-07)	Retain; still relevant.

D-295.946, The Status of Education in Substance Use Disorders in America's Medical Schools and Residency Programs Our AMA will: (1) advocate for in-depth qualitative studies to facilitate the preparation of physicians to care for patients with substance use disorders; (2) facilitate the identification, dissemination, and implementation of successful substance use disorder educational programs across the educational continuum; (3) encourage the Accreditation Council for Graduate Medical Education (ACGME) to include education about substance use disorders in their program accreditation requirements; (4) encourage the American Board of Medical Specialties (ABMS) to encourage its member boards to include substance use disorder questions in their certification process; and (5) through its Council on Medical Education, monitor and track implementation of the recommendations of the December 2006 House Office of National Drug Control Policy White House Leadership Conference on Medical Education in Substance Abuse report. (CME Rep. 11, A-07)	Sunset; items 1 and 2 superseded by D-95.984, Substance Use and Substance Use Disorders; items 3, 4, and 5 accomplished.
D-295.990, Nutritional and Dietetic Education for Medical Students Our AMA will: (1) offer to assist the American Society for Clinical Nutrition in meeting its commitment to ensure that medical schools have appropriate faculty role models to teach clinical nutrition; and (2) identify and disseminate to medical schools new instructional initiatives that heighten the relevance of clinical nutrition content to medical practice. (CME Rep. 1, I-99; Reaffirmed: CME Rep. 2, A-09)	Sunset; superseded by H-150.995, Basic Courses in Nutrition.
D-305.968, CMS to Pay for Residents' Vacation and Sick Leave Our AMA will lobby the Centers for Medicare and Medicaid Services to continue to reimburse the direct and indirect costs of graduate medical education for the time resident physicians are on vacation or sick leave. (Res. 321, A-07)	Retain; still relevant.
D-310.971, The Residency Physician Shortage Reduction Act of 2007 Our AMA will vigorously support in its national legislative activities the passage of pending and future legislation which will increase physician residency positions throughout many states while not undermining existing physician residency positions in any of the states. (Res. 204, A-07); Reaffirmation I-07)	Sunset; refers to a specific piece of legislation, and year. Also, superseded by other AMA policy, such as D-305.958, Increasing Graduate Medical Education Positions as a Component to any Federal Health Care Reform Policy, which reads, in part: "1. Our AMA will ensure that actions to bolster the physician workforce must be part of any comprehensive federal health care reform. "2. Our AMA will work with the Centers for Medicare and Medicaid Services to explore ways to increase graduate medical education slots to accommodate the need for more physicians in the US. "3. Our AMA will work actively and in collaboration with the Association of American Medical Colleges and other interested stakeholders to rescind funding caps for GME imposed by the Balanced Budget Act of 1997. "4. Our AMA will actively advocate for expanded funding for entry and continued training positions in specialties and geographic regions with documented medical workforce shortages. "5. Our AMA will lobby Congress to find ways to increase graduate medical education funding to accommodate the projected need for more physicians." Also superseded by D-305.967, The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education, which reads, in part: "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)…. "4. Our AMA will strenuously advocate for increasing the number of GME positions to address the future physician workforce needs of the nation…. "8. Our AMA will vigorously advocate for the continued and expanded contribution by all payers for health care (including the federal government, the states, and local and private sources) to fund both the direct and indirect costs of GME…. "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…. "13. Our AMA will 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…. "17. Our AMA will 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: (a) train more physicians to meet state and regional workforce needs; (b) train physicians who will practice in physician shortage/underserved areas; or (c) train physicians in undersupplied specialties and subspecialties in the state/region. "18. Our AMA supports 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. "19. Our AMA will continue to work with

	stakeholders such as Association of American Medical Colleges (AAMC), 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….

2. UPDATE ON MAINTENANCE OF CERTIFICATION AND OSTEOPATHIC CONTINUOUS CERTIFICATION (RESOLUTION 315-A-16)

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS
REMAINDER OF REPORT FILED
See Policy D-275.954

Resolution 315-A-16, "Maintenance of Certification (MOC) and Licensure (MOL) vs. Board Certification, CME and Life-Long Commitment to Learning," introduced by the Tennessee Delegation and referred by the American Medical Association (AMA) House of Delegates (HOD), asks the AMA to: 1) oppose discrimination by any hospital or employer, state board of medical licensure, insurers, Medicare, Medicaid, and other entities, which results in the restriction of a physician's right to practice medicine without interference (including discrimination by varying fee schedules) due to lack of recertification or participation in a Maintenance of Licensure, Maintenance of Certification program, or due to a lapse of a time-limited board certification; and 2) develop an action plan to protect physicians when the Maintenance of Certification is punitively used as a requirement for licensure, credentialing, reimbursement, network participation, or employment with a report back at the 2016 Interim Meeting.

Policy D-275.954 (28), "Maintenance of Certification (MOC) and Osteopathic Continuous Certification (OCC)," directs the AMA to: 1) examine the activities that medical specialty organizations have underway to review alternative pathways for board recertification; and 2) determine if there is a need to establish criteria and construct a tool to evaluate if alternative methods for board recertification are equivalent to established pathways.

This annual report, mandated by Policy D-275.954 (1), addresses Resolution 315-A-16 and Policy D-275.954 (28) and provides an update on some of the changes that have occurred during the last year as a result of AMA efforts with the American Board of Medical Specialties (ABMS) and ABMS member boards to improve the MOC process.

INTRODUCTION

The Council has prepared reports covering MOC and OCC for the past eight years.[1,2,3,4,5,6,7,8] As shown in the Appendix, the AMA has extensive policy on MOC and OCC. During the last year, Council members, along with Trustees and AMA staff, have participated in numerous meetings with the ABMS and its member boards, including:

- ABMS Committee on Continuing Certification (a Council member is appointed to this committee, which develops and reviews principles and standards for MOC and oversees the review program for MOC and continuing certification programs; the Council member appointee facilitates bidirectional communication between the AMA and ABMS regarding MOC standards and policies)
- August 2016 Council on Medical Education-ABMS Leadership Meeting
- ABMS Forum on Organizational Quality Improvement
- ABMS 2016 Conference
- Maintenance of Certification Summit
- ABMS Board of Directors Meeting
- ABMS Committee on Certification (COCERT)

MAINTENANCE OF CERTIFICATION (MOC): AN UPDATE

Update on the emerging data and literature regarding the value of MOC

The Council has continued to review published literature and emerging data as part of its ongoing efforts to critically review MOC and OCC issues. Some of the more important studies published during the last year are summarized below.

Two studies were related to the effectiveness of new MOC assessment models:

- An observational study showed that voluntary enrollment and participation in the Maintenance of Certification in Anesthesiology (MOCA®) Minute program, featuring frequent knowledge assessments accompanied by targeted learning resources, is associated with improved performance in the subsequent MOCA Cognitive (high-stakes) Examination when compared to the performance of individuals who do not participate.[9]
- The American Board of Family Medicine (ABFM) examined the impact of module selection on examination performance. The study showed that permitting candidates to select the content category for portions of their examination has a tendency to bias their scores in a systematic way, which is psychometrically undesirable and makes the meaning of the scores dependent on the particular modules selected.[10] However, selecting one module rather than two would likely increase both the psychometric stability of the examination and more closely align with the content of the physician's practice.[10]

A longitudinal study contributed to research on the predictive validity of examinations. The study showed how performance on the National Board of Osteopathic Medical Examiners' Comprehensive Osteopathic Medical Licensing Examination of the United States of America (COMLEX-USA), predicted performance on the ABFM Maintenance of Certification-Family Practice (MC-FP) examination. This study demonstrated how examination scores can provide an early glimpse into a prospective physician's probability of success on future examinations.[11]

To better understand the time and effort put forth by diplomates to prepare for the MOC Part III high-stakes examinations, the American Board of Emergency Medicine (ABEM) conducted a survey of emergency physicians taking the 2014 ABEM ConCert examination. The survey results showed that a study method used by a substantial majority (97.8 percent) of emergency physicians who prepared for the examination by using written materials specifically designed for test taking was associated with the highest performance.[12] This association with preparation and the examination demonstrated the significance of the MOC Part III component as an important incentive to maintain current medical knowledge and skills over time.[12]

Three studies show that meaningful practice improvement activities undertaken as part of MOC result in improved quality care measures:

- An evaluation of the effectiveness of the American Board of Ophthalmology's (ABO) practice improvement modules (PIMs) on processes such as primary open-angle glaucoma, surgical management of cataracts, age-related macular degeneration, etc., showed that after completing the PIMs, performance improved on 80 percent of individual process measures and 38.9 percent of individual outcome measures.[13] This retrospective analysis demonstrated that improvements in technology and data collection methods—for example, standardized documentation and the use of electronic health records—may contribute significantly to meaningful QI efforts.
- A study showed how participation in MOC Part IV by primary care pediatricians was associated with a significant increase in captured opportunities for improved vaccination coverage. In addition, results were achieved at a relatively modest cost and with high pediatrician satisfaction. This study demonstrated that MOC-required QI projects may have the benefits of engaging physicians in projects that they may not otherwise participate in, and allowing physicians to be involved in the project from inception to completion.[14]
- A practice quality improvement project in thoracic imaging was undertaken to reduce the effective radiation dose of routine chest CT imaging in a busy clinical practice. In addition to demonstrating a significant reduction in the effective radiation dose of thoracic CT scans, this project had a direct benefit for patients.[15]

Two studies examined MOC and quality reporting requirements:

- One study comparing changes in quality measures from the ABFM Performance in Practice Modules (PPMs), Physician Quality Reporting System (PQRS), and a combined PQRS/PPM for diabetes showed that combining

PQRS and PPM resulted in improvement in the outcomes quality of care measures. This study showed that practice assessment combined with feedback improves care and that further aligning MOC with quality reporting may be beneficial.[16]

- A second retrospective study involving 30,614 radiologists enrolled in Medicare's Physician Compare Initiative showed that participation in the MOC program is an additional incentive because of PQRS requirements.[17] Radiologists performed highly in the MOC program specialty-specific metrics.[17]

To address physicians' concerns about MOC and other required data reporting requirements, the ABFM launched the development of its primary care registry (PRIME) to support physician capacity for quality assessment, improvement, data-reporting requirements, and population management. The ABFM has also pledged to move away from the recertification examination for most diplomates once the registry is reliably providing benchmark quality data and the breadth and scope of physician practice can be assessed.[18]

The literature also shows that, despite recent criticism about the value of MOC as well as negative perceptions with the current MOC Program,[19,20] recent changes to MOC performance in practice modules (PPM) are resulting in increased physician satisfaction and practice changes:

- A study was conducted to understand how ABFM diplomates viewed their PPM participation, and their resulting experience with QI. In the study, which involved 29,755 diplomates who completed PPMs in topics such as diabetes, hypertension, and asthma, 78.7 percent of the respondents indicated that they would change patient care, and 90.2 percent indicated that they would continue QI activities after completing the PPM.[21]
- A separate survey study showed that recent efforts by the American Academy of Pediatrics and the American Board of Pediatrics (ABP) to develop learning modules that integrate QI methods and projects have resulted in high participation rates in QI activities.[22]

Two retrospective studies, including one of rural general surgeons who participated in the American Board of Surgery (ABS) MOC program, and a second involving recertifying pediatric surgeons who perform complex cases, reinforced the need for continuous learning to maintain surgical skills and promote optimal patient outcomes.[23,24] Two studies regarding the practice considerations and needs of aging physicians showed how the ongoing MOC process contributes to maintaining clinical knowledge and skills, which research suggests declines with increasing years in medical practice.[25,26,27]

To determine if patient experience is associated with MOC status, a project to review Marshfield (Wisconsin) Clinic physicians was undertaken. During the study, randomly selected patients seen by Marshfield Clinic physicians completed a patient experience survey that did not indicate whether the physician was participating in MOC. The analysis was based on information that was combined from the Clinic's patient experience database and MOC database. Although the analysis did not demonstrate significant differences, the findings did show that physicians participating in MOC had patients reporting they were more likely to recommend them to others; they were more confident in their skills as physicians; and they felt they received more information about medications compared to patients of physicians who were not participating in MOC.[28]

Twenty-eight improvement efforts from organizations including the Mayo Clinic, Boston Medical Center, Carolinas Healthcare System, Johns Hopkins All Children's Hospital, and many others were presented during the 2016 Forum on Organizational Quality Improvement (QI Forum), hosted by the ABMS in conjunction with the ABMS Multi-Specialty Portfolio Program™. Posters presented by Portfolio Program sponsors and other health care researchers that highlight best practices and research in organizational QI and MOC activities are available at: abms.org/initiatives/delivering-organizational-quality-improvement/forum-on-organizational-quality-improvement/2016-qi-forum-posters/. The QI Forum also featured speakers from organizations such as the Agency for Healthcare Research and Quality, Institute for Healthcare Improvement, AMA, and University of Leicester in the United Kingdom who discussed the emerging role of public policy on QI and research and the ABMS Program for MOC.

To accommodate and organize the growing body of literature regarding improvements in practice related to MOC, the ABMS Continuing Certification Reference Center™ replaced its Evidence Library™ in 2016 (http://ccrc.abms.org/). The latter was revised to accommodate the broad and continually growing variety of literature and internet resources relevant to the board certification community. While the format of the publicly accessible, web-based resource remains the same, new indexing and filtering options have been added that further

divide the literature by study types and certification topics. Several hundred articles have been reviewed by ABMS staff and physician volunteers/consultants for inclusion in the Center.[29]

The Council on Medical Education is committed to monitoring emerging data and the literature to identify improvements to the MOC program, especially those that improve physician satisfaction with MOC as well as those that enable physicians to keep pace with advances in clinical practice, technology, and assessment.

ABMS MOC Directory

In 2015, the ABMS, in collaboration with the Association of American Medical Colleges, developed the MOC Directory (http://mededportal.org/abmsmoc/continuingeducation/) to assist physicians by reducing the time required to find practice-relevant MOC activities acceptable to the ABMS member boards. The MOC Directory offers diplomates easy access to a comprehensive, centralized repository of approved MOC activities across medical specialties and subspecialties. A number of AMA continuing medical education (CME) activities are listed on the Directory as being eligible for Lifelong Learning and Self-Assessment (MOC Part II).

In addition, the Accreditation Council for Continuing Medical Education (ACCME) also announced collaborations with the American Board of Anesthesiology (ABA) and ABP, similar to its collaboration with the American Board of Internal Medicine (ABIM) in 2015 that allows accredited CME providers to identify CME activities that also meet the MOC requirements for each of the member boards (ABIM, ABP, and ABA) and facilitates reporting of learner data from the accredited provider to the relevant member board (http://accme.org/news-publications/news/accreditation-council-cme-american-board-anesthesiology-and-american-board).

The collaborations are designed to expand the number and diversity of accredited CME activities that meet the member boards' MOC requirements for MOC Part II. They also will simplify the search for approved activities by physicians. CME providers that choose to participate will use the ACCME Program and Activity Reporting System (PARS) to attest that their activities comply with board requirements. The ACCME maintains a list of accredited and certified CME activities registered for ABIM MOC, ABA MOC, and ABP MOC. The ABIM currently has more than 6,200 activities that have been certified for CME credit and registered for MOC points. Many of these activities are available across specialties, while some are specialty specific. The AMA currently transmits JAMA Network data to the ACCME for ABIM, and is considering expansion to additional boards in the future.

Alternatives to the secure, high-stakes examination for assessing knowledge and cognitive skills in MOC

The Council continues to work with the ABMS and its member boards to address AMA member concerns about the MOC Part III examination. About half of the ABMS member boards have taken steps to make the examination more constructive and less onerous for physicians.[30] The boards are addressing issues of convenience, relevance, and cost, and many are moving toward longitudinal low-stakes assessment to reduce the anxiety and burden of the 10-year examination. Concurrent with these efforts, some member boards are also looking at ways to innovate assessment of medical knowledge, and some are testing or have already implemented alternatives to the traditional secure, high-stakes examination (Table 1). New initiatives include incorporating more physician input into examination blueprints as well as experimenting with the use of modular examinations that allow physicians to focus on specific areas of assessment based on their actual areas of practice. Several boards are also allowing access to resources for the examination similar to those used at the point of care. Some boards have adopted or are considering the adoption of remote proctoring of examinations, which alleviates the need for examinees to travel to testing centers and minimizes time spent away from work. Other boards, i.e., ABIM, American Board of Neurological Surgery (ABNS), ABP, and American Board of Radiology (ABR), are testing mechanisms that provide immediate feedback and references. (Table 1).[30]

Seven of the member boards will be utilizing CertLink™, a web-based platform that leverages smart mobile technology to support the design, delivery, and evaluation of assessment pilots. Other pilot projects will resemble the ABA's MOCA Minute™, which encourages anesthesiologists to frequently assess and improve their specialty knowledge by answering 30 questions per quarter related to clinical practice. Pilot projects underway at several boards will integrate assessments based on curated articles focusing on important new evidence in the discipline, in addition to, or in lieu of, more traditional test questions. In addition, some boards are participating in an ABMS-led MOC Assessment Initiative to understand how emerging adult learning theories and technologies can be integrated

into the MOC framework and to explore how more frequent, smaller-bite, longitudinal formative assessments can be used to make summative decisions regarding specialty certification.

Some of these assessment formats highlight the use of spaced repetition, a technique that promotes learning and retention by exposing examinees to the same or similar content over time to test and stimulate recall. This testing technique has been shown to improve knowledge retention over traditional approaches. In addition, physicians are provided with immediate feedback about their performance and offered a dashboard that displays areas of strength and weakness, which can encourage learning targeted to identified knowledge and practice gaps. In some cases, physicians will have the option of tailoring the assessment content based on the nature of their actual practices. The ABMS and its member boards are also reviewing how information regarding aggregate longitudinal assessment performance can be used by CME providers to develop activities for physicians that address their knowledge gaps.

Some of the boards, i.e., the ABIM, are allowing for greater flexibility in the scheduling of the assessment during the year. It should also be noted that some of the boards have reduced the price of the examination. For example, the American Board of Allergy and Immunology (ABAI) reduced the MOC examination fee by 50 percent, the American Board of Plastic Surgery (ABPS) reduced the MOC examination fee by 10 percent, and the American Board of Otolaryngology (ABOto) has eliminated the examination fee and includes a portion of the fee in its new MOC annual fee.

Update on Improvement in Medical Practice

Recognizing the many changes being adopted by the member boards to their Improvement in Medical Practice (IMP) requirements, in late 2015 the Executive Committee of the ABMS Board of Directors (BOD) convened the Task Force on Improvement in Medical Practice to review the purpose and increase the value of the Improvement in Medical Practice (IMP) component of MOC. The Task Force consulted extensively with multiple stakeholders, including hospitals, health plans, consumers, specialty societies, and quality measurement and improvement experts. The Task Force also met separately with the AMA Council on Medical Education to obtain its input. The Task Force explored core issues identified by key stakeholders, including the relationship between individual and system improvement and the need for alignment with other professional assessment and improvement activities. In developing its recommendations, the Task Force sought to strike a balance of two goals: consistency in what the Boards are expected to achieve and flexibility in how they achieve it. The Task Force presented its final report and recommendations to the ABMS BOD at its October 2016 meeting.

The ABMS Committee on Continuing Certification also conducted a comprehensive review of the IMP MOC Program component (MOC Part IV) in 2016. In its report, the Committee noted that the ABMS member boards have broadened the range of acceptable activities that meet the IMP requirements in order to address physician concerns about the relevance, cost, and burden associated with fulfilling the IMP requirements. The report also highlighted a number of activities being implemented by the boards related to registries, systems-based practice, and practice audits.

Registries

Many of the member boards recognize participation in registries developed by their professional societies as satisfying their IMP requirements; the American Board of Family Medicine (ABFM) has its own registry. The ABFM, with funding from the Agency for Healthcare Research and Quality, obtains data from electronic health records (EHRs) without cumbersome data entry and provides feedback to participating clinicians on a variety of measures. The American Board of Orthopaedic Surgery (ABOS) pilot tested collecting patient-reported outcome data to track patient functional outcomes, and is planning to release it to younger physicians this year.

Systems-based practice

The member boards are aligning MOC activities with other organizations' quality improvement (QI) efforts to reduce redundancy and physician burden while promoting meaningful participation. Twenty-one of the boards encourage participation in organizational QI initiatives through the ABMS Multi-Specialty Portfolio Program™ (described below). Many boards encourage involvement in the development and implementation of safety systems or the investigation and resolution of organizational quality and safety problems. Some boards encourage assessment and training in teamwork, for example, through Team Strategies and Tools to Enhance Performance and Patient

Safety (TeamSTEPPS) training programs.[31] Six boards accept physician activities related to hospital-based Ongoing and Focused Professional Practice Evaluation conducted under The Joint Commission standards. For physicians serving in research or executive roles, some boards have begun to give IMP credit for having manuscripts published, writing peer-reviewed reports, giving presentations, and serving in institutional roles that focus on QI (provided that an explicit Plan-Do-Study-Act process is used). Physicians who participate in QI projects resulting from morbidity and mortality conferences and laboratory accreditation processes resulting in the identification and resolution of quality and safety issues can also receive IMP credit from some boards.

Practice Audits

Several member boards have developed online practice assessment protocols that allow physicians to assess patient care using evidence-based quality indicators. The American Board of Ophthalmology (ABO) is working with the American Academy of Ophthalmology (AAO) to integrate data from the AAO's Intelligent Research in Sight (IRIS) registry, which is populated with data extracted directly from electronic health records (EHRs). Other initiatives include:

- Successful integration of patient experience and peer review into several of the boards' IMP requirements; one board has aggressively addressed the issue of cost and unnecessary procedures with an audit and feedback program.
- Integration of simulation options.
- Substantial efforts to educate physicians about QI theory and practice; one board has set up standard templates to guide the QI process, while another has built step-by-step instructions into some of its modules. Both of these interventions have received positive feedback from physicians.
- A process for individual physicians to develop their own improvement exercises that address an issue important to them, using data from their own practices, built around the basic PDSA (Plan-Do-Study-Act) process.

To continue the discussion about practice-relevant and innovative IMP activities, the ABMS and the AMA will cosponsor a meeting in June 2017 that will bring together representatives from the Council on Medical Education, AMA sections, and ABMS member boards.

ABMS Multi-Specialty Portfolio Program

The Portfolio Program (www.mocportfolioprogram.org) continues to offer health care organizations opportunities to support and encourage physician involvement in internal QI projects and team-based initiatives while providing MOC Part IV credit to physicians actively participating in the program. Many of these MOC activities also satisfy other national, state, and private-sector QI and reporting activities. The Portfolio Program eases the burden on physicians by reducing duplication of QI projects, with no additional costs to physicians who participate in the program.

More than 1,800 types of QI projects have been approved by the Portfolio Program in areas such as prevention and screening, improvements in disease-specific care processes, patient-physician communication, patient safety, harm reduction, and interdisciplinary team-based care. The number of organizations participating in the program continues to grow. Currently, there are more than 80 portfolio sponsors, and additional organizations are exploring the opportunity to join. In 2016, the American Heart Association-The Guideline Advantage™ program, Boston Medical Center, Dartmouth-Hitchcock, Johns Hopkins Medicine, Oregon Health & Science University, Sharp Healthcare, Texas Children's Hospital, University of Arkansas for Medical Sciences, University of Kansas School of Medicine, and Vanderbilt University Medical Center became portfolio sponsors. The AMA is approved as a portfolio sponsor and is developing some CME activities to be eligible for MOC Part IV. The program has engaged more than 9,300 physicians in practice improvement initiatives at hospitals and health systems across the country (many showing improvement in care outcomes). Twenty-one ABMS member boards participate in the program. Sponsoring relationships with medical societies and two specialty societies have also been developed to provide more support for physicians with practices that are not primarily hospital-based.

ALTERNATIVE PATHWAYS TO BOARD RECERTIFICATION

Policy D-275.954 (28), "Maintenance of Certification and Osteopathic Continuous Certification," asked that the AMA: 1) examine the activities that medical specialty organizations have underway to review alternative pathways for board recertification; and 2) determine if there is a need to establish criteria and construct a tool to evaluate if

alternative methods for board recertification are equivalent to established pathways. As a first step, the Council provided background information about recertification programs in CME Report 2-A-16, "Update on Maintenance of Certification and Osteopathic Continuous Certification."[1]

In its report, the Council noted that wide-scale use of long-standing traditional recertification programs, such as the ABMS MOC, are reflected in training and delivery systems, and based on core competencies developed and adopted by the ABMS and the Accreditation Council for Graduate Medical Education (ACGME). The MOC program was designed to provide a comprehensive approach to physician life-long learning, self-assessment, and practice improvement, and strives to identify those physicians capable of delivering high-quality specialized medical care.[32]

Newer alternative pathways to specialty board recertification, such as the National Board of Physicians and Surgeons (NBPAS), have been formed to address physician concerns about the rigorous MOC process.[20] There are ongoing concerns about the administrative burdens, the value of the program, the relevance and cost of the examination, and the time it takes physicians away from patient care. Although there is variability among specialties, participation in the MOC program may require passing a secured, high-stakes examination every 10 years. The NBPAS does not require an external assessment or practice improvement.

Many hospitals have independently made the decision to require board recertification for staff privileges. Their leadership recognizes that diagnostic and treatment knowledge changes rapidly, and that learned skills in medicine can decline over time. They value the competencies for medical practice set by the profession and create procedures for their own institutions with respect to those competencies. Although newer recertification programs, such as the NBPAS, are gaining acceptance by some hospitals, many hospitals still rely on the traditional MOC and OCC programs.[20, 33]

The American Gastroenterological Association (AGA) addressed physician dissatisfaction with the current MOC process by convening a Task Force to identify their vision of the ideal pathway for recertification of gastroenterologists. After the Task Force conducted a scholarly review of educational theory and literature and considered current health care environmental and technology factors, they recommended that MOC be replaced with individual pathways that would integrate self-assessment activities, allowing physicians to achieve a high level of competency in one or more areas while maintaining a more modest level of competency in other areas. The individualized self-assessment activities would provide constant feedback and opportunities for learning and remove the secure high-stakes examination required every 10 years. The proposal is based on a broad agreement on competencies established by educational leaders from five gastroenterology societies. This alternative pathway, called "The Gastroenterologist: Accountable Professionalism in Practice (G-APP)" would allow physicians to receive credit for activities they already do in practice, research, or teaching. The AGA has communicated this proposal to the ABIM and acts as an intermediary between AGA members and the ABIM, since gastroenterology is a subspecialty of internal medicine.[34]

The American College of Cardiology (ACC) has also continued to work with ABIM to produce meaningful changes to the MOC process. Alternative options, including initiating a new recertification process, have been investigated and remain an option, depending on the outcomes of current MOC modification efforts, but they are not currently felt to be the ideal pathway. The ACC believes that over the past year, the ABIM has made substantial changes to its MOC process in response to concerns raised by physicians and specialty organizations including ACC. The ACC is also seeking further improvements to the ABIM's shorter, more focused assessment planned for 2018, adoption of an open-book format for those diplomates choosing the 10-year exam option, elimination of practice improvement (Part IV) activities as a requirement for MOC (which are important but will soon be required of all providers by federal law), and ongoing research to test the outcome of MOC activities on the actual improvement in patient care (to provide an evidence-base for the value of MOC). Additional improvements, such as allowing the ACC and qualified entities to put forth standards-based processes that would be certified by the ABIM as well as enabling diplomates to receive credit for activities in which they lead and participate on behalf of hospitals, health care systems, payers, and state medical boards, are also being sought by the ACC. The ACC was approved as a Portfolio Program Sponsor through the ABMS Multi-Specialty Portfolio Approval Program™. Additionally, the ACC continues to work with ABIM and other internal medicine stakeholder groups to find solutions that best allow clinicians to maintain and demonstrate competence as it relates to patient outcomes, quality care, and cost-effectiveness.[35]

The American College of Physicians, ACC, and American Society of Clinical Oncology are also working with the ABIM to explore piloting a "Society Maintenance Pathway" option. If the pilots go forward and are successful, they may be expanded to more internal medicine subspecialty groups. These pathways would be in addition to any pathways offered by the ABIM, such as the 10-year secure examination, or the two or five-year approaches that ABIM may develop.[36]

As noted above, the AMA actively participates in the ongoing development of MOC, and meets regularly with the ABMS and its member boards. Due to Council efforts with the ABMS and its member boards, many changes are occurring to improve the MOC process. Many of the member boards have taken steps to improve the MOC Part III high-stakes examination. The ABMS Portfolio Program is also providing a streamlined approach for hospitals, health care organizations, and professional societies to support physician involvement in QI initiatives by allowing physicians the opportunity to receive MOC Part IV credit. The AMA supports the development of Performance Improvement CME (PICME) activities that are consistent with the requirements of the AMA Physician's Recognition Award (AMA PRA) Credit system, one of the three major credit systems that comprise the foundation for CME in the United States, and continues to develop relationships and agreements that may lead to standards accepted by all U.S. licensing boards, specialty boards, hospital credentialing bodies, and other entities requiring evidence of physician participation in CME. In addition, the AMA has adopted extensive policy on MOC, including the AMA Principles of MOC (Policy H-275.924), to continue to improve the process for physicians who choose to participate in the MOC program.

The AMA does not have the same relationship with other recertification programs, and is not directly involved in the processes being developed by other organizations such as the NBPAS. Although alternative pathways to board recertification appear to be less rigorous than the traditional MOC and OCC processes, as outlined in CME Report 2-A-16,[1] establishing criteria and constructing a tool to evaluate if alternative methods for board recertification are equivalent to established pathways would require substantial resources and may not be necessary at this time if the ABMS member boards continue to improve their processes for physicians.

AMA POLICY RELATED TO DISCRIMINATION DUE TO NONPARTICIPATION IN MOC

AMA policy related to MOC supports the intent of this program (see Appendix). MOC is a career-long process of learning, assessment, and performance improvement that is meant to demonstrate proficiency within a chosen discipline, but is separate and not required for licensure, employment, or reimbursement.

The following policies support the first resolve in Resolution 315-A-16, "Maintenance of Certification (MOC) and Licensure (MOL) vs. Board Certification, CME and Life-Long Commitment to Learning," introduced by the Tennessee Delegation.

- AMA Policy H-275.924 (15), amended at the 2016 Interim Meeting, currently states, "The MOC program should not be a mandated requirement for licensure, credentialing, recredentialing, privileging, reimbursement, network participation, employment, or insurance panel participation."

- In addition, Policy D-275.954 (34) states that the AMA, "through legislative, regulatory, or collaborative efforts, will work with interested state medical societies and other interested parties by creating model state legislation and model medical staff bylaws while advocating that Maintenance of Certification not be a requirement for: (a) medical staff membership, privileging, credentialing, or recredentialing; (b) insurance panel participation; or (c) state medical licensure."

- Policy H-275.926 (3) also states that the AMA "opposes discrimination against physicians based solely on lack of ABMS or equivalent AOA-BOS board certification, or 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. Our AMA also opposes 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."

The AMA Council on Legislation has developed, and the AMA Board of Trustees approved, model state legislation intended to prohibit state boards of medicine and osteopathic medicine from requiring physicians to maintain

certification for licensure or license renewal; prohibit hospitals from denying staff privileges or admitting privileges to a physician solely based on the physician's lack of participation in MOC or OCC; and prohibit insurers from denying reimbursement to a physician, or preventing a physician from participating in the insurer's network, based solely on the physician's lack of participation in MOC or OCC. The model bill is on file with the AMA Advocacy Resource Center, which will assist any interested state medical association in pursuing such legislation or any other legislation consistent with AMA policy.

In April 2017, the American College of Obstetricians and Gynecologists (ACOG) and the American Board of Obstetrics and Gynecology (ABOG) issued a joint statement, "Political Interference in Physician Maintenance of Skills Threatens Women's Health Care" (http://www.acog.org/-/media/Departments/State-Legislative-Activities/2017ACOG-ABOGJntStmntCertification.pdf?dmc=1&ts=20170413T1546120618). The statement urges state lawmakers not to interfere with successful self-regulation and to realize that each medical specialty has its own experience with its MOC program.

The AMA is in the process of fully analyzing the regulations of a final rule released by the Centers for Medicare & Medicaid Services (CMS), on October 14, 2016, that details the final regulations for implementation of the Medicare Access and CHIP Reauthorization Act (MACRA), the historic Medicare reform law that replaced the Sustainable Growth Rate (SGR) formula last year (ama-assn.org/sites/default/files/media-browser/public/physicians/macra/macra-qpp-summary.pdf). It will be important for the Council on Medical Education to collaborate with the Council on Legislation and/or the Council on Medical Service to determine the MOC alignment with legislative activities and quality, patient safety and value qualifiers—such as the Quality Payment Program (QPP) created by MACRA—that will reward physicians for delivering coordinated care with better outcomes.

Currently, MOC is meant to demonstrate proficiency within a chosen discipline, but is not required for state medical licensure. In addition, many hospitals have independently made the decision to require recertification for the granting of privileges, and various quality organizations and insurers use MOC to help identify commitment to professionalism and continuous performance improvement. These requirements are within their legal rights. However, some states are considering or have enacted legislation that prohibits the use of MOC as a criterion for privileging, employment, and reimbursement. Additional data will be needed to determine if an action plan should be developed to protect physicians when MOC is used as a requirement for licensure, credentialing, reimbursement, network participation or employment (Resolution 315-A-16, resolve 2). To date, the Council has not accumulated data on instances where this has occurred. However, when data become available, the Council will determine if these cases fit into a pattern and will advise the HOD on how to proceed.

OSTEOPATHIC CONTINUOUS CERTIFICATION (OCC): AN UPDATE

The American Osteopathic Association Bureau of Osteopathic Specialists (AOA-BOS) (http://osteopathic.org/inside-aoa/development/aoa-board-certification/Pages/bos-history.aspx) was organized in 1939 as the Advisory Board for Osteopathic Specialists to meet the needs resulting from the growth of specialization in the osteopathic profession. Today, 18 AOA-BOS specialty certifying boards offer osteopathic physicians the option to earn board certification in a number of specialties. As of November 2016, over 28,000 osteopathic physicians held active board certification through the AOA (with some of these physicians holding multiple certifications).

OCC was implemented on January 1, 2013 by all of the 18 specialty certifying member boards of the AOA-BOS. 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 - Active Licensure: physicians who are board certified by the AOA must hold a valid, active 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 number of hours of CME credit during each three-year CME cycle (15 certifying boards require 120 hours; three certifying boards require 150 hours). A minimum of 50 credit hours of this requirement must be in the specialty area of certification. Self-assessment activities are also designated by each of the 18 specialty certification boards. For osteopathic physicians who hold subspecialty certification(s), a percentage of their specialty credit hours must be in their subspecialty certification 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 their respective medical specialty.
- Component 5 - Continuous AOA Membership.

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

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

In April 2016, the AOA empaneled a Certifying Board Services Task Force charged with the following tasks:

1. Improve customer experience through user-friendly processes.
2. Continuously increase quality and enhance standards of high-stakes examinations.
3. Simplify and align the OCC process across all specialties.
4. Serve as a focus group on technological enhancements.

The Task Force reported its findings and recommendations regarding the five OCC components to the BOS at its annual meeting on November 6, 2016. The Task Force's recommendations focus on making the OCC process less onerous, and apply current and new evaluation processes that take advantage of the latest concepts in certification and supporting technology. The BOS has drafted resolutions based on the Task Force's recommendations, which were submitted to the AOA Board of Trustees for approval at its February 2017 meeting.

RECERTIFICATION AND ASSESSMENT PROCESSES FOR OTHER HEALTH CARE PROFESSIONS

The Council also monitors the assessment models used for recertification of other health care professionals. Recent changes to the recertification requirements for nurses and physician assistants (PAs) are highlighted below.

Nurses

The American Nurses Credentialing Center (ANCC), a subsidiary of the American Nurses Association, recertifies and recognizes individual nurses in specialty practice areas. There are over 200 nursing specialties and subspecialties. Although nurses are not required to participate in a formal maintenance of certification program, their certification generally must be renewed every five years through completion of 75 continuing education hours in the clinical nurse specialist (CNS) or nurse practitioner (NP) certification held. An assessment is required only if the nurse's certification has expired (www.nursecredentialing.org/Certification/CertificationRenewal).

Physician assistants

The National Commission on Certification of Physician Assistants (NCCPA) recertifies PAs. State requirements to maintain PA certification differ. Some states require CME and/or the Physician Assistant National Recertification Examination (PANRE), which is administered by NCCPA (www.nccpa.net/CertificationProcess). Twenty-seven states currently require PAs to pass PANRE in order to maintain certification.

In 2014, PANRE was transitioned from a six-year to a 10-year cycle. More recently, there has been concern that the PANRE examination is considered by many to be outdated and too broad in scope (70% of PAs specialize in practice). The American Academy of Physician Assistants (AAPA) is opposed to the PANRE, and has been advocating for the creation of a new PA certifying body, which may not be accepted by the state medical boards. Many PAs are calling to eliminate the PANRE entirely. In response, NCCPA has proposed a new assessment model, composed of a core medical knowledge examination administered during a 10-year cycle through periodic take-home examinations. Specialty-related knowledge would be assessed through a secure, proctored, timed exam during the final years of the 10-year cycle. Ten to twelve specialty examinations may initially be offered.

As other health care professions such as nurses or PAs contemplate or implement MOC programs, it would be important for physicians to clarify the purpose and standards of ABMS MOC or AOA OCC as they may be relevant considerations about scope of practice.

SUMMARY AND RECOMMENDATIONS

The public relies on members of the medical profession to establish standards for entering the profession to practice medicine and to ensure that they are maintaining certification.[36] Patients expect that their physician's certification reflects ongoing education and practice improvement and that they are competent and provide high-quality care.[23] Patients also expect that physicians are periodically examined to assure that they are up to date in knowledge and practice. Contemporary methods of self-regulation, such as MOC, clinical performance measurement, and CME requirements, were created by the profession in part due to increasing recognition that sole reliance on individual physicians reporting colleagues' performance, even if it were 100 percent reliable, still would not be enough to meet shared obligations for quality assurance and patient safety.[37] The limitations of a more formal peer review process, which is often used in the context of hospital staff privileging procedures, relate to significant variability across institutions in their oversight mechanisms, methods used, performance criteria and standards, resource requirements, and perceptions of quality.[38,39]

The Council on Medical Education is committed to ensuring that MOC and OCC support physicians' ongoing learning and practice improvement as well as to assuring the public that physicians are providing high-quality patient care in their practice settings. The AMA will continue to advocate for a certification process that is evidence-based and relevant to clinical practice as well as cost-effective and inclusive to reduce duplication of work. During the last year, the Council on Medical Education has continued to monitor the development of MOC and OCC and work with the ABMS, AOA, and ABMS member boards to identify and suggest improvements to the MOC and OCC programs. During the next year, the Council will also engage in cross council collaborations with the Council on Legislation and/or Council on Medical Service to review MOC alignment with legislative activities and quality, patient safety, and value qualifiers, such as the Quality Payment Program (QPP) created by the Medicare Access and CHIP Reauthorization Act (MACRA).

The Council on Medical Education therefore recommends that the following recommendations be adopted in lieu of Resolution 315-A-16, and the remainder of the report be filed.

1. That our American Medical Association (AMA) advocate that physicians who participate in programs related to quality improvement and / or patient safety receive credit for MOC Part IV.

2. That our AMA rescind Policy D-275.954 (28), "Maintenance of Certification (MOC) and Osteopathic Continuous Certification (OCC)," since that has been accomplished through this report.

TABLE 1. Improvements to the American Board of Medical Specialties (Abms) Part III, Secure, High-Stakes Examination*

The American Board of:	Current Examination Format	New Models/Innovations
Allergy and Immunology (ABAI) www.abai.org	Computer-based, secure exam administered at a proctored test center once a year. Diplomates must pass the exam once every 10 years.	In 2018, ABAI-Continuous Assessment Pilot Program will be implemented in place of current exam: • A 10-year program with two 5-year cycles. • Diplomates take exam where and when it is convenient. • Diplomates required to answer three questions for each of ten journal articles in each cycle. The articles will be posted in January and July and remain open for 6 months. Articles can be printed or downloaded for review. • Questions can be answered for each article independently. Diplomate feedback on each question will be required. • "Open-book" with a total of approximately 80 questions per year. • Mostly article-based with some core questions during each 6-month cycle.

		• Opportunity to drop the two lowest 6-month cycle scores during each 5-year period to allow for unexpected life events. • Ability to complete questions on PC, laptop, MAC, tablet, and smart phone formats by using the new diplomate dashboard via the existing ABAI Web Portal page. • The exam fee reduced by 50% to $1300.
Anesthesiology www.theaba.org	• Traditional Maintenance of Certification in Anesthesiology Program (MOCA): Computer-based, secure exam administered at a proctored test center. Diplomates must pass the exam once every 10 years. • MOCA 2.0 introduced in 2014 to provide a tool for ongoing low-stakes assessment and provide more extensive, question-specific feedback. Also provides focused content that could be reviewed periodically to refresh knowledge and document cognitive expertise. *All diplomates with time-limited certification that expired on or before Dec. 31, 2015 must complete the traditional MOCA® requirements before they can register for MOCA 2.0®.*	• Currently piloting a free web application known as MOCA Minute™—a longitudinal assessment tool that requires diplomates to answer 30 questions per calendar quarter, or 120 per year, in lieu of taking a 10-year exam. • Analysis of the pilot data is underway to determine whether participants accessed the links to additional resources, learned the material, and improved performance in the content knowledge areas represented in the MOCA Minute Pilot.
Colon and Rectal Surgery[1] www.abcrs.org	Computer-based secure exam administered at a proctored test center once a year (in May). Diplomates must pass the exam once every 10 years.	• ABCRS is exploring ways to modify the exam experience to provide a more consistent evaluation process and to replace the exam as it presently is administered. • Participating in the ABMS Longitudinal Assessment pilot utilizing the CertLink™ platform.[1]
Dermatology (ABD)[1] www.abderm.org	• Computer-based secure modular exam administered at a proctored test center twice a year or by remote proctoring technology. Diplomates must pass the exam once every 10 years. • ABD makes test preparation material available 6 months before the exam. The material includes diagnoses from which the general dermatology clinical images will be drawn and questions that will be used to generate the subspecialty modular exams. • Examinees are required to take the general dermatology module, consisting of 100 clinical images designed to assess diagnostic skills, and can then choose among 50-item subspecialty modules.	• ABD successfully completed trials employing remote proctoring technology to monitor exam administration in the diplomates' homes or offices. • Participating in the ABMS Longitudinal Assessment pilot utilizing the CertLink™ platform.[1]
Emergency Medicine (ABEM) www.abem.org	ABEM's ConCert™, computer-based, secure exam administered at a proctored test center once a year. Diplomates must pass the exam once every 10 years.	ABEM is monitoring recent efforts within the ABMS board community that have focused on pilots that assess knowledge, judgment, and skills using longitudinal assessments rather than an every-10-year exam. The alternative assessment method would have to show that its learning and assessment advantage is better than the current ABEM exam.
Family Medicine www.theabfm.org	Computer-based secure exam administered at a proctored test center twice a year or by remote proctoring technology. Diplomates must pass the exam once every 10 years.	Changes to the ABFM exam are not being considered at this time.

Internal Medicine (ABIM) www.abim.org	Computer-based secure exam administered at a proctored test center. Diplomates must pass the exam once every 10 years.	In 2018, ABIM plans to offer two assessment options: 1) Certified physicians will be eligible to take shorter more frequent assessments with continuous learning, feedback, and improvement. Assessments can be taken on their home or office computer instead of taking the long-form exam every 10 years at a testing facility. Diplomates who perform well on the shorter exam can test out of the current assessment taken every 10 years. Those who meet a performance standard on shorter assessments will not need to take the 10-year exam again to remain certified. 2) Diplomates can also choose to take a long-form assessment given every 10 years. This option is the same as the current 10-year exam, but it will include some new features that physicians requested. • New fidelity features may include a zoom feature for images, presentation of realistic laboratory reports with normal ranges, embedded audio clips of heart sounds, and video clips of patient presentations. • New web-based, geographic score report presents more clearly performance results for a given examinee, to highlight areas of strength and weakness for specific exam questions that were missed. • Some exams allow the examinee to select the best of two or best of three options instead of being limited to a single option response. • ABIM is researching and developing the use of external or web resources during the exam, computer-based simulation with patient avatars, and the introduction of adaptive testing techniques, where the exam advances differently depending on an examinee's response to each situation and where the examinees might be able to leave early based on their performance.
Medical Genetics and Genomics[1] www.abmgg.org	Computer-based secure exam administered at a proctored test center once a year (August). Diplomates must pass the exam once every 10 years.	• Participating in the ABMS Longitudinal Assessment pilot utilizing the CertLink™ platform.[1]
Neurological Surgery (ABNS) www.abns.org	The 10-year secure exam can be taken from any computer, i.e., in diplomate's office or home. Access to reference materials is not restricted; it is an open book test. On applying to take the examination, a diplomate must assign a person to be his or her proctor. Prior to the exam, that individual will participate in an on-line training session and "certify" the exam computers.	In 2017, an adaptive MOC cognitive learning tool will be piloted: • The tool will consist of updated knowledge that has evolved since the diplomate's last certification and the tool will be far shorter, relevant, and more focused than the prior MOC exam. • The ABNS will use the platform designed by the same company which delivers millions of American Heart Association exams, such as Basic Life Support, so the format will be familiar and easy to use. • The exam will provide updated "evidence based" core neurological surgery knowledge in a web-based format. • The web-based learning tool can be mastered in the diplomates' home, or office, anytime 24/7. • Immediate feedback to each question will be provided to the diplomate. References with links and/or articles will be provided.

Nuclear Medicine[1] www.abnm.org	Computer-based secure exam administered at a proctored test center once a year (October). Diplomates must pass the exam once every 10 years.	• Participating in the ABMS Longitudinal Assessment pilot utilizing the CertLink™ platform.[1]
Obstetrics and Gynecology (ABOG) www.abog.org	The secure, external assessment is offered in the last year of each ABOG diplomate's six-year cycle in a modular test format, and physicians are allowed to choose two selections that are the most relevant to their current practice.	In 2016, ABOG launched a pilot program to integrate the self-assessment and external assessment MOC requirements to allow diplomates to continuously demonstrate their knowledge of the specialty. The pilot allows diplomates to earn an exemption from the current computer-based exam in the sixth year of the program if they reach a threshold of performance during the first 5 years of the self-assessment program.
Ophthalmology (ABO) www.abop.org	Diplomates must successfully pass the Demonstration of Ophthalmic Cognitive Knowledge (DOCK) exam, a computer-based secure modular exam administered at a proctored test center once a year (September). Diplomates must pass the exam once every 10 years.	In 2017, a Quarterly Question Pilot Program will evaluate shorter, more frequent assessments. 1) Will deliver 40 multiple-choice questions (MCQs) on fundamental knowledge needed in the everyday practice of ophthalmology through computer, tablet or mobile apps. The MCQs should not require preparation in advance, but a content outline for the MCQs will be available. Users will see instant feedback and receive recommendations for resources related to gaps in knowledge. 2) Key ophthalmic journal articles with questions focused on the application of this information to patient care will be provided. The journal portion will require reading five articles from a list of 15 options. The articles will be available at the beginning of 2017 and the 10 article-based questions will be delivered in Q4 (October). *Based on the performance of the pilots, these programs may replace the DOCK Exam.*
Orthopaedic Surgery (ABOS) www.abos.org	Computer-based secure modular exam administered at a proctored test center. Diplomates must pass the exam once every 10 years. The optional oral exam is given in Chicago in July.	Changes to the ABOS exam are not being considered at this time.
Otolaryngology[1] www.aboto.org	Computer-based secure modular exam administered at a proctored test center. Diplomates must pass the exam once every 10 years.	• Participating in the ABMS Longitudinal Assessment pilot utilizing the CertLink™ platform.[1]
Pathology[1] www.abpath.org	• Computer-based secure modular exam administered at the ABP Exam Center in Tampa, Florida twice a year (March and August). • Remote computer exams can be taken any time 24/7 that the registrant chooses during the assigned 2-week period (spring and fall) from their home or office. *Diplomates must pass the exam once every 10 years.*	• New modules were added to make the exam more relevant to a diplomate's practice. • Participating in the ABMS Longitudinal Assessment pilot utilizing the CertLink™ platform.[1]
Pediatrics www.abp.org	Computer-based secure exam administered at a proctored test center. Diplomates must pass the exam once every 10 years.	In 2017, launching (pilot) Maintenance of Certification Assessment for Pediatrics (MOCA-Peds), a new testing platform with shorter and more frequent assessments. • A series of questions will be released through mobile devices or a web browser at regular intervals. • Twenty MCQs will be available every 2 months and may be answered anytime during the quarter.

		• Provides immediate feedback and references. • Allows for questions to be tailored to the pediatrician's practice profile. • Participants will provide feedback on individual questions so that the exam can be continuously improved.
Physical Medicine and Rehabilitation[1] www.abpmr.org	Computer-based secure exam administered at a proctored test center. Diplomates must pass the exam once every 10 years.	Participating in the ABMS Longitudinal Assessment pilot utilizing the CertLink™ platform.[1]
Plastic Surgery www.abplasticsurgery.org	Computer-based secure exam administered at a proctored test center once a year (October). Diplomates must pass the exam once every 10 years.	• Eliminated the 6-month case log requirement for the exam application. • Reduced the exam fee by 10%. • Offers an MOC Study Guide with more than 2,300 MCQ items derived from the same sources used for the exam.
Preventive Medicine (ABPM) www.theabpm.org	In-person, pencil-and-paper, secure exam administered at secure test facility. MOC exams follow the same content outline as the initial certification exam (without the core portion). *In 2016, new multispecialty subspecialty of Addiction Medicine was established.*	Changes to the ABPM exam are not being considered at this time. *In 2017, Addiction Medicine subspecialty certification exam to be administered to diplomates of any of the 24 ABMS member boards who meet the eligibility requirements.*
Psychiatry and Neurology (ABPN) www.abpn.com	Computer-based secure exam administered at a proctored test center. Diplomates must pass the exam once every 10 years.	Changes to the ABPN exam are not being considered at this time.
Radiology (ABR) www.theabr.org	Computer-based secure modular exam administered at a proctored test center. Diplomates must pass the exam once every 10 years.	ABR is developing a pilot that may replace the current 10-year traditional exam, with an online continuous assessment process. The online longitudinal assessment model that will be piloted incorporates modern and more relevant adult learning concepts to provide psychometrically valid sampling of diplomate knowledge. • Diplomates will create a practice profile of the subspecialty areas that most closely fit what they do in practice, as they do now for the modular exams. • Diplomates will receive weekly emails with links to questions relevant to their registered practice profile. • Questions may be answered singly or, for a reasonable time, in small batches, in a limited amount of time. • Diplomates will learn immediately whether they answered correctly or not and will be presented with the question's rationale, a critique of the answers, and brief educational material. • Feedback will assist diplomates by guiding their CME (MOC Part II). • Those who answer questions incorrectly will receive future questions on the same topic to gauge whether they have learned the material.
Surgery (ABS) www.absurgery.org	Computer-based secure exam administered at a proctored test center. Diplomates must pass the exam once every 10 years.	ABS soliciting feedback from diplomates.
Thoracic Surgery (ABTS) www.abts.org	Remote, secure, computer exams can be taken any time 24/7 that the registrant chooses during the assigned 2-month period (September-October) from their home or office. Diplomates will be allowed to enter the online program 10 times for a total of 15 hours. Modular exam, based on specialty, and presented in a self-	ABTS developed a web-based assessment available for immediate access upon purchase. The latest version (SESATS XI) includes all exam materials, instant access to questions, critiques, abstracts and references, plus hundreds of digital images and movies.

	assessment format with critiques and resources made available to diplomates.	
Urology www.abu.org	Computer-based secure exam administered at a proctored test center once a year (October). Diplomates must pass the exam once every 10 years.	In 2017, a modular MOC exam will be reinstituted. • Diplomates will be required to take the 40 question core module on general urology, and choose one of four 35 question content modules.

*The information in this table is sourced from ABMS Member Board websites and is current as of February 15, 2017.

1. Seven ABMS member boards are utilizing CertLink™, an ABMS web-based platform that leverages smart mobile technology to support the design, delivery, and evaluation of longitudinal assessment pilots, some of which will launch in 2017. More information is available at: http://www.abms.org/news-events/american-board-of-medical-specialties-announces-development-of-new-web-based-platform/

REFERENCES

1. Report 2-A-16, Update on Maintenance of Certification and Osteopathic Continuous Certification. AMA Council on Medical Education. Available at: https://www.ama-assn.org/sites/default/files/media-browser/public/about-ama/councils/Council%20Reports/council-on-medical-education/a16-cme-02.pdf (accessed 1-22-17)
2. Report 2-A-15, Update on Maintenance of Certification and Osteopathic Continuous Certification. AMA Council on Medical Education. Available at: https://download.ama-assn.org/resources/doc/council-on-med-ed/x-pub/cme-report-02-a-15-moc-final.pdf (accessed 1-10-17)
3. Report 6-A-14, Update on Maintenance of Certification, Osteopathic Continuous Certification, and Maintenance of Licensure. AMA Council on Medical Education. Available at: https://download.ama-assn.org/resources/doc/council-on-med-ed/x-pub/cme-rpt6-a-14.pdf (accessed 1-10-17)
4. Report 4-A-13, An Update on Maintenance of Certification, Osteopathic Continuous Certification, and Maintenance of Licensure. AMA Council on Medical Education. Available at: http://ama.nmtvault.com/jsp/browse.jsp (accessed 1-22-17).
5. Report 10-A-12, An Update on Maintenance of Certification, Osteopathic Continuous Certification, and Maintenance of Licensure. AMA Council on Medical Education. Available at: http://ama.nmtvault.com/jsp/browse.jsp (accessed 1-22-17).
6. Report 11-A-12, Impact of Maintenance of Certification, Osteopathic Continuous Certification, Maintenance of Licensure on the Physician Workforce. AMA Council on Medical Education. Available at: http://ama.nmtvault.com/jsp/browse.jsp (accessed 1-22-17).
7. Report 3-A-10, Specialty Board Certification and Maintenance of Licensure AMA Council on Medical Education. Available at: http://ama.nmtvault.com/jsp/browse.jsp (accessed 1-22-17).
8. Report 16-A-09, Maintenance of Certification/Maintenance of Licensure. AMA Council on Medical Education. Available at: http://ama.nmtvault.com/jsp/browse.jsp (accessed 1-22-17).
9. Sun H, Zhou Y, Culley DJ, et al. Association between Participation in an Intensive Longitudinal Assessment Program and Performance on a Cognitive Examination in the Maintenance of Certification in Anesthesiology Program®. *Anesthesiology*. 2016.
10. O'Neill TR, Peabody MR. Impact of One Versus Two Content-Specific Modules on American Board of Family Medicine Certification Examination Scores. *J Am Board Fam Med*. 2017;30(1):85-90.
11. O'Neill TR, Peabody MR, Song H. The Predictive Validity of the National Board of Osteopathic Medical Examiners' COMLEX-USA Examinations With Regard to Outcomes on American Board of Family Medicine Examinations. *Acad Med*. 2016;91(11):1568-1575.
12. Marco CA, Wahl RP, Counselman FL, et al. Physician Preparation for the American Board of Emergency Medicine ConCert Examination. *Academic Emergency Medicine*. 2016;23:191-196.
13. Wiggins RE, Etz, R. Assessment of the American Board of Ophthalmology's Maintenance of Certification Part 4 (Improvement in Medical Practice). *JAMA Ophthalmology*. 2016;134(9):967-974.
14. Fiks AG, Luan X, Mayne SL. Improving HPV Vaccination Rates Using Maintenance-of-Certification Requirements. *Pediatrics*. 2016;137(3):1-11.
15. Takahashi EA, Kohli MD, Teague SD. A Practice Quality Improvement Project: Reducing Dose of Routine Chest CT Imaging in a Busy Clinical Practice. *J Digit Imaging*. 2016;29(5):622-6.
16. Phillips RL, Blackburn B, Peterson LE, Puffer JC. Maintenance of Certification, Medicare Quality Reporting, and Quality of Diabetes Care. *Am J Med Qual*. 2016;31(3):217-223.
17. Rosenkrantz AB, Hughes DR, Duszak R. How Do Publicly Reported Medicare Quality Metrics for Radiologists Compare with Those of Other Specialty Groups? *J Am Coll Radiol*. 2016;13(3):243-248.
18. Phillips R, Kennedy J, Jaén C, Stelter K, Puffer J. Transforming physician certification to support physician self-motivation and capacity to improve quality and safety. *J Enterp Transform*. 2016;6(3-4):162-169.
19. Cook DA, Blachman MJ, West CP, Wittich CM. Physician Attitudes About Maintenance of Certification: A Cross-Specialty National Survey. *Mayo Clin Proc*. 2016;91(10):1336-1345.
20. Teirstein PS. Boarded to death—why maintenance of certification is bad for doctors and patients. *N Engl J Med*. 2015;372(2):106-108.
21. Peterson LE, Eden A, Cochrane A, Hagen M. Physician Satisfaction With and Practice Changes Resulting From American Board of Family Medicine Maintenance of Certification Performance in Practice Modules. *J Contin Educ Health Prof*. 2016 Winter;36(1):55-60.

22. Freed GL, Moran LM, Van KD, Leslie LK. Current Workforce of General Pediatricians in the United States. *Pediatrics*. 2016;137(4):50.
23. Moore J, Pellet A, Hyman N. Laparoscopic Colectomy and the General Surgeon. J Gastrointest Surg. 2016;20(3):640-643.
24. Abdullah F, Salazar JH, Gause CD, et al. Understanding the Operative Experience of the Practicing Pediatric Surgeon. *JAMA Surg*. 2016;60611(8):1-7.
25. Babu MA, Liau LM, Spinner RJ, Meyer FB. Maintenance of Certification and the Aging Neurosurgeon. *Neurosurgery*. 2016 Aug;63 Suppl 1:194-5.
26. Shen L, Juul D, Faulkner LR. Performance of Certification and Recertification Examinees on Multiple Choice Test Items: Does Physician Age Have an Impact? *J Contin Educ Health Prof.* 2016;36(2):119-122.
27. Hawkins RE, Welcher CM, Stagg Elliott V, et al. Ensuring Competent Care by Senior Physicians. *J Contin Educ Health Prof.* 2016 Summer;36(3):226-31.
28. Morrell J, Stratman EJ. Relationship Between Physicians Active Participation in Maintenance of Certification and Patients Perspective of Care Surveys. *J Patient Exp*. 2016;3(2):43-47.
29. Wolfe S, Carol R, Mejicano G. Using the Evidence to Make the Case for ABMS Board Certification and Maintenance of Certification. *J Contin Educ Health Prof.* 2014;34(S1):S47-S48.
30. Hawkins RE, Irons MB, Welcher CM, et al. The ABMS MOC Part III Examination: Value, Concerns and Alternative Formats. *Acad Med*. 2016 Nov;91(11):1509-1515.
31. TeamSTEPPs®. Agency for Healthcare Research and Quality. U.S. Department of Health & Human Services. Available at: www.ahrq.gov/teamstepps/index.html (Accessed 3-20-17)
32. Hawkins RE, Lipner RS, Ham HP, Wagner R, et al. American Board of Medical Specialties Maintenance of Certification: Theory and Evidence Regarding the Current Framework. *J Contin Educ Health Prof.* 2013;33(S1):S7-S19.
33. A Trusted Credential. American Board of Medical Specialties. Available at: http://www.abms.org/board-certification/a-trusted-credential/ (accessed 1-17-17).
34. Rose S, Shah BJ, Onken J, et al. Introducing the Gastroenterologist-accountable Professionalism in Practice (G-APP) Pathway: Bridging the G-APP0-Replacing MOC With a Model for Lifelong Learning and Accountability. *Gastroenterology*. 2015;149:1609-1626.
35. Understanding MOC. American College of Cardiology. Available at: https://www.acc.org/education-and-meetings/maintenance-of-certification-information-hub (accessed 1-18-17).
36. ACP's Role & Professional Accountability. American College of Physicians. Available at: https://www.acponline.org/cme-moc/moc/learn-more/acps-role-professional-accountability. (accessed 3-22-17).
37. Wynia MK. The Role of Professionalism and Self-regulation in Detecting Impaired or Incompetent Physicians. *JAMA*. 2010;304(2):210-211.
38. Edwards MT, Benjamin EV. The process of peer review in U.S. Hospitals. *J Clin Outcomes Manag*. 2009;16:461–467.
39. Belmont E, Haltom CC, Hastings DA, et al. A new quality compass: hospital boards' increased role under the Affordable Care Act. *Health Aff.* 2011;30:1282–1289.

APPENDIX

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 that specialty 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 permits 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 are neither 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. Our AMA affirms the current language regarding continuing medical education (CME): "Each Member Board will document that diplomates are meeting the CME and Self-Assessment requirements for MOC Part II. 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 PRA Category 1 CreditTM, American Academy of Family Physicians Prescribed, American College of Obstetricians and Gynecologists, and/or American Osteopathic Association Category 1A)." 10. In relation to MOC Part II, our AMA continues to support and promote the AMA Physician's Recognition Award (PRA) Credit system as one of the three major credit systems that comprise the foundation for continuing medical education in the U.S., including the Performance Improvement CME (PICME) format; and continues to develop relationships and agreements that may lead to standards accepted by all U.S. licensing boards, specialty boards, hospital credentialing bodies and other entities requiring

evidence of physician CME. 11. MOC is but one component to promote patient safety and quality. Health care is a team effort, and changes to MOC should not create an unrealistic expectation that lapses in patient safety are primarily failures of individual physicians. 12. MOC should be based on evidence and designed to identify performance gaps and unmet needs, providing direction and guidance for improvement in physician performance and delivery of care. 13. The MOC process should be evaluated periodically to measure physician satisfaction, knowledge uptake and intent to maintain or change practice. 14. MOC should be used as a tool for continuous improvement. 15. The MOC program should not be a mandated requirement for licensure, credentialing, recredentialing, privileging, reimbursement, network participation, employment, or insurance panel participation. 16. Actively practicing physicians should be well-represented on specialty boards developing MOC. 17. Our AMA will include early career physicians when nominating individuals to the Boards of Directors for ABMS member boards. 18. MOC activities and measurement should be relevant to clinical practice. 19. The MOC process should not be cost prohibitive or present barriers to patient care. 20. Any assessment should be used to guide physicians' self-directed study. 21. Specific content-based feedback after any assessment tests should be provided to physicians in a timely manner. 22. There should be multiple options for how an assessment could be structured to accommodate different learning styles. 23. Physicians with lifetime board certification should not be required to seek recertification. 24. No qualifiers or restrictions should be placed on diplomates with lifetime board certification recognized by the ABMS related to their participation in MOC. 25. Members of our House of Delegates are encouraged to increase their awareness of and participation in the proposed changes to physician self-regulation through their specialty organizations and other professional membership groups.

D-275.954, Maintenance of Certification and Osteopathic Continuous Certification
Our AMA will:
1. Continue to monitor the evolution of Maintenance of Certification (MOC) and Osteopathic Continuous Certification (OCC), continue its active engagement in discussions regarding their implementation, encourage specialty boards to investigate and/or establish alternative approaches for MOC, and prepare a yearly report to the House of Delegates regarding the MOC and OCC process. 2. Continue to review, through its Council on Medical Education, published literature and emerging data as part of the Council's ongoing efforts to critically review MOC and OCC issues. 3. Continue to monitor the progress by the American Board of Medical Specialties (ABMS) and its member boards on implementation of MOC, and encourage the ABMS to report its research findings on the issues surrounding certification and MOC on a periodic basis. 4. Encourage the ABMS and its member boards to continue to explore other ways to measure the ability of physicians to access and apply knowledge to care for patients, and to continue to examine the evidence supporting the value of specialty board certification and MOC. 5. Work with the ABMS to streamline and improve the Cognitive Expertise (Part III) component of MOC, including the exploration of alternative formats, in ways that effectively evaluate acquisition of new knowledge while reducing or eliminating the burden of a high-stakes examination. 6. Work with interested parties to ensure that MOC uses more than one pathway to assess accurately the competence of practicing physicians, to monitor for exam relevance and to ensure that MOC does not lead to unintended economic hardship such as hospital de-credentialing of practicing physicians. 7. Recommend that the ABMS not introduce additional assessment modalities that have not been validated to show improvement in physician performance and/or patient safety. 8. Work with the ABMS to eliminate practice performance assessment modules, as currently written, from MOC requirements. 9. Encourage the ABMS to ensure that all ABMS member boards provide full transparency related to the costs of preparing, administering, scoring and reporting MOC and certifying examinations. 10. Encourage the ABMS to ensure that MOC and certifying examinations do not result in substantial financial gain to ABMS member boards, and advocate that the ABMS develop fiduciary standards for its member boards that are consistent with this principle. 11. Work with the ABMS to lessen the burden of MOC on physicians with multiple board certifications, particularly to ensure that MOC is specifically relevant to the physician's current practice. 12. Work with key stakeholders to (a) support ongoing ABMS member board efforts to allow multiple and diverse physician educational and quality improvement activities to qualify for MOC; (b) support ABMS member 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) encourage ABMS member boards to enhance the consistency of quality improvement programs across all boards; and (d) work with specialty societies and ABMS member boards to develop tools and services that help physicians meet MOC requirements. 13. Work with the ABMS and its member boards to collect data on why physicians choose to maintain or discontinue their board certification. 14. Work with the ABMS to study whether MOC is an important factor in a physician's decision to retire and to determine its impact on the US physician workforce. 15. Encourage the ABMS to use data from MOC to track whether physicians are maintaining certification and share this data with the AMA. 16. Encourage AMA members to be proactive in shaping MOC and OCC by seeking leadership positions on the ABMS member boards, American Osteopathic Association (AOA) specialty certifying boards, and MOC Committees. 17. Continue to monitor the actions of professional societies regarding recommendations for modification of MOC. 18. Encourage medical specialty societies' leadership to work with the ABMS, and its member boards, to identify those specialty organizations that have developed an appropriate and relevant MOC process for its members. 19. Continue to work with the ABMS to ensure that physicians are clearly informed of the MOC requirements for their specific board and the timelines for accomplishing those requirements. 20. Encourage the ABMS and its member boards to develop a system to actively alert physicians of the due dates of the multi-stage requirements of continuous professional development and performance in practice, thereby assisting them with maintaining their board certification. 21. Recommend to the ABMS that all physician members of those boards governing the MOC process be required to participate in MOC. 22. Continue to participate in the National Alliance for Physician Competence forums. 23. Encourage the PCPI Foundation, the ABMS, and the Council of Medical Specialty Societies to work together toward utilizing Consortium performance measures in Part IV of MOC. 24. Continue to assist physicians in practice performance improvement. 25. Encourage all specialty societies to grant certified CME credit for activities that they offer to fulfill requirements of their respective specialty board's MOC and associated processes. 26. Support the

American College of Physicians as well as other professional societies in their efforts to work with the American Board of Internal Medicine (ABIM) to improve the MOC program. 27. Oppose those maintenance of certification programs administered by the specialty boards of the ABMS, or of any other similar physician certifying organization, which do not appropriately adhere to the principles codified as AMA Policy on Maintenance of Certification. 28. Examine the activities that medical specialty organizations have underway to review alternative pathways for board recertification; and determine if there is a need to establish criteria and construct a tool to evaluate if alternative methods for board recertification are equivalent to established pathways. 29. Ask the ABMS to encourage its member boards to review their maintenance of certification policies regarding the requirements for maintaining underlying primary or initial specialty board certification in addition to subspecialty board certification, if they have not yet done so, to allow physicians the option to focus on maintenance of certification activities relevant to their practice. 30. Call for the immediate end of any mandatory, secured recertifying examination by the ABMS or other certifying organizations as part of the recertification process for all those specialties that still require a secure, high-stakes recertification examination. 31. Support a recertification process based on high quality, appropriate Continuing Medical Education (CME) material directed by the AMA recognized specialty societies covering the physician's practice area, in cooperation with other willing stakeholders, that would be completed on a regular basis as determined by the individual medical specialty, to ensure lifelong learning. 32. Continue to work with the ABMS to encourage the development by and the sharing between specialty boards of alternative ways to assess medical knowledge other than by a secure high stakes exam. 33. Continue to support the requirement of CME and ongoing, quality assessments of physicians, where such CME is proven to be cost-effective and shown by evidence to improve quality of care for patients. 34. Through legislative, regulatory, or collaborative efforts, will work with interested state medical societies and other interested parties by creating model state legislation and model medical staff bylaws while advocating that Maintenance of Certification not be a requirement for: (a) medical staff membership, privileging, credentialing, or recredentialing; (b) insurance panel participation; or (c) state medical licensure. 35. Increase its efforts to work with the insurance industry to ensure that maintenance of certification does not become a requirement for insurance panel participation.

H-275.926, Medical Specialty Board Certification Standards
Our AMA:
1. Opposes any action, regardless of intent, that appears likely to confuse the public about the unique credentials of American Board of Medical Specialties (ABMS) or American Osteopathic Association Bureau of Osteopathic Specialists (AOA-BOS) 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. Continues to work with other medical organizations to educate the profession and the public about the ABMS and AOA-BOS 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. 3. Opposes discrimination against physicians based solely on lack of ABMS or equivalent AOA-BOS board certification, or 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. Our AMA also opposes 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. 4. Advocates for nomenclature to better distinguish those physicians who are in the board certification pathway from those who are not. 5. Encourages member boards of the ABMS 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.

3. OBESITY EDUCATION

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: RECOMMENDATIONS ADOPTED
REMAINDER OF REPORT FILED
See Policy D-440.980

American Medical Association (AMA) Policy D-440.980 (5), "Recognizing and Taking Action in Response to the Obesity Crisis," directs the AMA to "encourage medical school accrediting bodies to study and report back on the current state of obesity education in medical schools and, through this report, identify organizations that currently provide educational resources/toolkits regarding obesity education for physicians in training and, in consultation with relevant specialty organizations and stakeholders, identify gaps in obesity education in medical schools and submit recommendations for addressing those gaps." This report is in response to that directive, which was adopted at the 2015 Annual Meeting of the AMA House of Delegates.

OBESITY: SCOPE OF THE PROBLEM, DEFINITIONS, DETERMINATES

Obesity is defined by the Centers for Disease Control and Prevention (CDC) as "Weight that is higher than what is considered as a healthy weight for a given height."[1] Body mass index (BMI) is the most commonly used screening tool for excess body weight, and correlates well with other methods to measure adiposity and with adverse health outcomes associated with increased adiposity. BMI is calculated as a person's weight in kilograms divided by the square of height in meters. Obesity is generally defined as a BMI greater than or equal to 30 kg/m2.

There is little doubt that obesity has become a prominent health concern in the United States. In 2011-2012, 34.9 percent of adults and 16.9 percent of 2- to 19-year-olds were obese.[2] Obesity in adulthood increases the risk for and morbidity from type 2 diabetes mellitus, hypertension, dyslipidemia, coronary heart disease, stroke, gallbladder disease, osteoarthritis, sleep apnea, some cancers, and other acute and chronic conditions. Obesity is also associated with increased risk in all-cause and cardiovascular disease (CVD) mortality.[3] In 2008, the estimated annual medical cost burden of obesity in the U.S. was $147 billion; the annual medical costs for people who are obese were $1,429 higher than those of normal weight.[4]

Obesity during childhood poses a greater risk of high blood pressure, high cholesterol, impaired glucose tolerance, insulin resistance, type 2 diabetes, sleep apnea, asthma, joint problems, fatty liver disease, gallstones, gastro-esophageal reflux (i.e., heartburn), depression, behavioral problems, low self-esteem, and social and emotional dysfunction. Children who are obese are more likely to become obese adults, and if children are obese, obesity and disease risk factors in adulthood are likely to be more severe.[5]

The cause of obesity is often multifactorial, but the usual common pathway is an energy balance mismatch—excess energy consumption in relation to energy use. Contributing factors include inactive or low-activity lifestyle; high-caloric food choices; food portion size; environmental factors such as availability of healthy food choices, work schedules, and access to activity; genetic factors; health conditions; medications; emotional and psychological factors; age; childbearing; and sleep and circadian rhythm disruptions. Consistent with the causes of obesity, the CDC notes: "There is no single or simple solution to the obesity epidemic. It's a complex problem and there has to be a multifaceted approach. Policy makers, state and local organizations, business and community leaders, school, childcare and healthcare professionals, and individuals must work together to create an environment that supports a healthy lifestyle."[6] The CDC, recognizing multifactorial causes of obesity, has published guides to community engagement strategies for the prevention of obesity, noting 24 strategies and recommendations for implementation.[7,8]

The health care education community has placed considerable effort into developing resources to guide health professionals in the prevention and treatment of obesity. A web search using the term "obesity guidelines" on the AHRQ National Guideline Clearinghouse search engine returned more than 200 guidelines from United States-based health care organizations.

One of the often-quoted evidence-based guidelines is the 2013 AHA/ACC/TOS Guideline for the Management of Overweight and Obesity in Adults: A Report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines and The Obesity Society,[3] which was endorsed by ten other related specialty societies. This document included 17 evidence-based recommendations for the evaluation and treatment of obesity. Most of these recommendations included evaluation, lifestyle counseling and intervention, prescribing activities, and surgical procedures. Another similar reference document is *The Practical Guide to Identification, Evaluation, and Treatment of Overweight and Obesity in Adults*,[9] published by the National Institutes of Health and also available online.

Despite the number and quality of guidelines on obesity prevention and treatment, a recent study based on a national sample of family physicians, internists, obstetrician-gynecologists, and nurse practitioners found that these health professionals reported needing more time to address patient obesity (70 percent), more training in obesity management (53 percent), improved reimbursement (53 percent), and better tools to help patients recognize obesity risks (50 percent).[10] A study by Frinter et al., presented at the Pediatric Academic Societies Annual Meeting in 2014, found that only 46 percent of senior pediatrics residents considered their medical school obesity education adequate.[11]

MEDICAL STUDENT EDUCATION ON OBESITY

There are few data on the current state of obesity education in U.S. medical schools. A study conducted in 2012 by Vitolins et al.[12] found only 11 publications pertinent to medical student obesity education, and only five of these included descriptions of interventions and evaluations of education effectiveness. A 2014 survey of medical schools by Adams et al. found that most did not provide nutrition education in the clinical portion of the curriculum, and concluded, "Many US medical schools still fail to prepare future physicians for everyday nutrition challenges in clinical practice. It cannot be a realistic expectation for physicians to effectively address obesity, diabetes, metabolic syndrome, hospital malnutrition, and many other conditions as long as they are not taught during medical school and residency training how to recognize and treat the nutritional root causes."[13] Beyond nutrition education, a literature review conducted by Dacey et al. found reports of 10 programs with physical activity counseling education that included evaluation of education effectiveness.[14] In structured interviews of allopathic and osteopathic medical school faculty (n=171), Stoutenburg noted that 31 programs felt that they offered a sufficient level of "physical activity-related" training for their students to successfully counsel their patients in the future, but that counseling was not noted to be specific to obesity prevention or treatment.[15]

The 2015-2016 Liaison Committee on Medical Education Part II Questionnaire, administered to all U.S. medical schools, asked respondents to "Indicate where in the curriculum the following subjects are covered during required experiences." Of the 142 schools responding, 91 percent included obesity prevention education in pre-clerkship courses, 31 percent in pre-clerkship clinical experiences, 80 percent in the required clerkships, and 18 percent in didactic sessions outside specific clerkships in the clinical years. Obesity treatment was included in the curriculum by 83 percent in pre-clerkship courses, 30 percent in pre-clerkship clinical experiences, 83 percent in the required clerkships, and 19 percent in didactic sessions outside specific clerkships in the clinical years. Only five schools (four percent) indicated that obesity prevention and obesity treatment were not included in the curriculum. Details on curricular content—such as pedagogy, depth of coverage and methods of assessment—were not part of the survey.[16] Of note, a number of studies have been published describing curricular offerings to address bias toward obese patients and bias recognition training for medical students. In addition, numerous sources note that medical school curricula often include the significance of obesity in the pathogenesis or confounding of common disease states, but it is not known if the same curricula offer any content on patient education, obesity prevention, or obesity treatment. Similarly, a recent analysis of questions from the United States Medical Licensing Examination (USMLE) found that a number of test items pertained to the diagnosis and management of obesity-related conditions, but the important concepts of obesity prevention and treatment were not represented on any of the three USMLE Step examinations.[17]

KEY STAKEHOLDERS AND SELECTED RESOURCES FOR HEALTH CARE PROVIDERS

When developing obesity curriculum for health care students, a number of resources are available from medical organizations and groups to guide curricular content and structured clinical encounters; these include the following:

- The Obesity Medicine Association offers a number of online clinical resources,[18] including an Obesity Algorithm and Pediatric Obesity Algorithm. The Obesity Society also provides adult and pediatric clinical and educational resources on its website.[19] The Obesity Medicine Association provides online a free 215-slide presentation covering the definition, prevention, diagnosis, and treatment of obesity.[20]

- The American Academy of Family Physicians' website features two bulletins on the management of obesity;[21,22] a Clinical Evidence handbook on Obesity in Adults;[23] and a collection of the content from American Family Physician (AFP), as identified by the AFP editors, on obesity and related issues.[24]

- The American Academy of Pediatrics provides a number of obesity educational resources online for AAP members and the public, including online courses, print materials, decision flow charts, and video materials.[25]

- The American College of Physicians offers online practice assessment tools to assist practices in providing high-value care for patients with obesity, practice guidelines for the evaluation and treatment of obesity, and patient resource materials.[26]

- The American College of Preventive Medicine makes resources available on its website, including an Adult Obesity Clinical Reference and an Adult Obesity Time Tool, to assist health professionals in developing efficient and effective strategies to address obesity concerns with their patients.[27]

- The American College of Sports Medicine offers a number of free online publications that address the prevention and management of obesity and obesity-related conditions.[28]

- The American Nutrition Association website provides access to numerous publications on the prevention and treatment of obesity, including non-traditional approaches and resources.[29]

- The CDC provides a comprehensive website on "obesity and overweight," with links to a number of topics.[30]

- The Fit for Residents project, a 3-year program coordinated by University of California, Los Angeles in collaboration with the American Academy of Pediatrics and American Academy of Family Medicine, resulted in a document with specific learning objectives across several domains of competence and levels of mastery.[31]

- The National Academies of Sciences, Engineering, and Medicine provides a number of free obesity prevention resources, including a comprehensive online toolkit for community-level obesity prevention.[32]

- The National Institutes of Health website provides information or links to publications, statistics, tools, and recommendations.[33]

SUMMARY AND RECOMMENDATIONS

Obesity is well-recognized as a burgeoning societal problem by way of co-morbidities and the costs associated with these co-morbidities, as well as premature loss of life and lifestyle impact. The causes of obesity are multifactorial; some are beyond the scope of undergraduate medical education or medical practice and require societal and community efforts. Most U.S. allopathic medical schools have incorporated some level of obesity education into the curriculum, but the emphasis on the subject appears to be quite variable, and evidence of effectiveness of these efforts is sparse. The health care education community has developed a number of resources to support the education of health care professionals, patients, and community leaders in their efforts to prevent obesity.

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

1. That our American Medical Association (AMA) make this report available on the AMA website for use by medical students, residents, teaching faculty, and practicing physicians.

2. That AMA Policy D-440.980 (5), "Recognizing and Taking Action in Response to the Obesity Crisis," be rescinded, as having been fulfilled by this report.

REFERENCES

1. Defining Adult Overweight & Obesity – Centers for Disease Control and Prevention. Available at: http://www.cdc.gov/obesity/adult/defining.html. Accessed January 4, 2017.
2. Ogden CL, Carroll MD, Kit BK, Flegal KM. Prevalence of Childhood and Adult Obesity in the United States, 2011-2012. *JAMA*.2014;311(8):806-814.
3. Jensen MD, Ryan DH, Apovian CM, et al. 2013 AHA/ACC/TOS guideline for the management of overweight and obesity in adults: a report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines and The Obesity Society. Circulation. 2013;00:000–000.
4. Finkelstein EA, Trogdon JG, Cohen JW, Dietz W. Annual Medical Spending Attributable To Obesity: Payer-And Service-Specific Estimates. Health Affairs 28, no.5 (2009):w822-w831. Originally published online July 27, 2009.
5. Childhood Obesity Causes and Consequences - Center for Disease Control and Prevention. Available at: http://www.cdc.gov/obesity/childhood/causes.html. Accessed January 4, 2017.
6. Strategies to Prevent Obesity. Available at: https://www.cdc.gov/obesity/strategies/index.html. Accessed January 4, 2017.
7. Keener, D., Goodman, K., Lowry A, et al. (2009). Recommended community strategies and measurements to prevent obesity in the United States: Implementation and measurement guide. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention.

8. Centers for Disease Control and Prevention. Recommended Community Strategies to prevent obesity in the United States. MMWR 2009;58(No. RR-7):1-27.
9. The Practical Guide to Identification, Evaluation, and Treatment of Overweight and Obesity in Adults Practical. Published by the National Institutes of Health National Heart Lung and Blood Institute. Available at: https://www.nhlbi.nih.gov/files/docs/guidelines/prctgd_c.pdf.
10. Petrin C, Kahan S, Turner M, et al. Current attitudes and practices of obesity counselling by health care providers. Obes Res Clin Pract. 2016 Aug 25.
11. Frintner MP, et al. Are graduating residents prepared to engage in obesity prevention and treatment? Poster presentation at the 2014 Pediatric Academic Societies Meeting.
12. Vitolins MZ, Crandall S, Miller D, et al. Obesity educational interventions in U.S. medical schools: a systematic review and identified gaps. Teach Learn Med. 2012;24(3):267-72.
13. Adams KM, Butsch WS, Kohlmeier M. The State of Nutrition Education at US Medical Schools. Journal of Biomedical Education, vol. 2015.
14. Dacey ML, Kennedy MA, Polak R, Phillips EM. Physical activity counseling in medical school education: a systematic review. Med Educ Online. July 24, 2014.
15. Stoutenberg M, Stasi S, Stamatakis E, et al. Physical activity training in US medical schools: Preparing future physicians to engage in primary prevention. Phys Sportsmed. 2015 Nov;43(4).
16. Unpublished data. Liaison Committee on Medical Education, 2016.
17. Kushner RF et al. Obesity coverage on medical licensing examinations in the United States: what is being tested? Teaching and Learning in Medicine. Published online 12/19/16.1-6.
18. Obesity Medicine Association. Available at: www.obesity medicine.org. Accessed January 4, 2017.
19. Obesity Society. Available at: www.obesity.org. Accessed January 4, 2017.
20. Seger JC, Horn DB, Westman EC, et al. Obesity Algorithm, presented by the Obesity Medicine Association. 2015-2016. Available at www.obesityalgorithm.org.
21. Smith MA. Management of obesity in adults. AAFP CME Bulletin. 2016. Available at: http://www.aafp.org/cme/cme-topic/all/bulletin-obesity-partII/bulletin.mem.html.
22. Smith MA. Management of obesity in adults. AAFP CME Bulletin. 2016. Available at: http://www.aafp.org/cme/cme-topic/all/bulletin-obesity/bulletin.mem.html.
23. Delaet D, Schauer D. Obesity in Adults. American Family Physician. 82(8). 974-75.
24. Obesity. Available at: http://www.aafp.org/afp/topicModules/viewTopicModule.htm?topicModuleId=19. Accessed January 4, 2017.
25. American Academy of Pediatrics. Available at: https://www.aap.org. Accessed January 4, 2017.
26. American College of Physicians. Available at: www.acponline.org. Accessed January 4, 2017.
27. Adult Obesity Clinical Reference. Available at: http://www.acpm.org/?AdultObesity_ClinRef. Accessed January 4, 2017.
28. American College of Sports Medicine. Available at: http://www.acsm.org. Accessed January 4, 2017.
29. ANA Info and Tools – American Nutrition Association. Available at: http://americannutritionassociation.org. Accessed January 4, 2017.
30. Obesity and Overweight – Centers for Disease Control and Prevention. Available at: https://www.cdc.gov/obesity/. Accessed January 4, 2017.
31. UCLA Fit for healthy Weight Program. Available at: http://fitprogram.ucla.edu. Accessed January 4, 2017.
32. The National Academies of Sciences, Engineering, Medicine. Available at: http://www.nationalacademies.org. Accessed January 4, 2017.
33. National Institute of Diabetes and Digestive and Kidney Diseases. Available at: https://www.niddk.nih.gov/health-information. Accessed January 4, 2017.

APPENDIX - Relevant AMA Policy

D-440.980, “Recognizing and Taking Action in Response to the Obesity Crisis”
Our AMA will: (1) collaborate with appropriate agencies and organizations to commission a multidisciplinary task force to review the public health impact of obesity and recommend measures to better recognize and treat obesity as a chronic disease; (2) actively pursue, in collaboration and coordination with programs and activities of appropriate agencies and organizations, the creation of a "National Obesity Awareness Month"; (3) strongly encourage through a media campaign the re-establishment of meaningful physical education programs in primary and secondary education as well as family-oriented education programs on obesity prevention; (4) promote the inclusion of education on obesity prevention and the medical complications of obesity in medical school and appropriate residency curricula; and (5) encourage medical schools' accrediting bodies to study and report back on the current state of obesity education in medical schools, and through this report, identify organizations that currently provide educational resources/toolkits regarding obesity education for physicians in training and, in consultation with relevant specialty organizations and stakeholders, identify gaps in obesity education in medical schools and submit recommendations for addressing those gaps.

D-440.954, "Addressing Obesity"
1. Our AMA will: (a) assume a leadership role in collaborating with other interested organizations, including national medical specialty societies, the American Public Health Association, the Center for Science in the Public Interest, and the AMA Alliance, to discuss ways to finance a comprehensive national program for the study, prevention, and treatment of obesity, as well as public health and medical programs that serve vulnerable populations; (b) encourage state medical societies to collaborate with interested state and local organizations to discuss ways to finance a comprehensive program for the study, prevention, and treatment of obesity, as well as public health and medical programs that serve vulnerable populations; and (c) continue to monitor and support state and national policies and regulations that encourage healthy lifestyles and promote obesity prevention. 2. Our AMA, consistent with H-440.842, Recognition of Obesity as a Disease, will work with national specialty and state medical societies to advocate for patient access to and physician payment for the full continuum of evidence-based obesity treatment modalities (such as behavioral, pharmaceutical, psychosocial, nutritional, and surgical interventions).

H-440.902, "Obesity as a Major Health Concern"
The AMA: (1) recognizes obesity in children and adults as a major public health problem; (2) will study the medical, psychological and socioeconomic issues associated with obesity, including reimbursement for evaluation and management of obese patients; (3) will work with other professional medical organizations, and other public and private organizations to develop evidence-based recommendations regarding education, prevention, and treatment of obesity; (4) recognizes that racial and ethnic disparities exist in the prevalence of obesity and diet-related diseases such as coronary heart disease, cancer, stroke, and diabetes and recommends that physicians use culturally responsive care to improve the treatment and management of obesity and diet-related diseases in minority populations; and (5) supports the use of cultural and socioeconomic considerations in all nutritional and dietary research and guidelines in order to treat overweight and obese patients.

H-440-842, "Recognition of Obesity as a Disease"
Our AMA recognizes obesity as a disease state with multiple pathophysiological aspects requiring a range of interventions to advance obesity treatment and prevention.

H-150.953, "Obesity as a Major Public Health Problem"
Our AMA will: (1) urge physicians as well as managed care organizations and other third party payers to recognize obesity as a complex disorder involving appetite regulation and energy metabolism that is associated with a variety of comorbid conditions; (2) work with appropriate federal agencies, medical specialty societies, and public health organizations to educate physicians about the prevention and management of overweight and obesity in children and adults, including education in basic principles and practices of physical activity and nutrition counseling; such training should be included in undergraduate and graduate medical education and through accredited continuing medical education programs; (3) urge federal support of research to determine: (a) the causes and mechanisms of overweight and obesity, including biological, social, and epidemiological influences on weight gain, weight loss, and weight maintenance; (b) the long-term safety and efficacy of voluntary weight maintenance and weight loss practices and therapies, including surgery; (c) effective interventions to prevent obesity in children and adults; and (d) the effectiveness of weight loss counseling by physicians; (4) encourage national efforts to educate the public about the health risks of being overweight and obese and provide information about how to achieve and maintain a preferred healthy weight; (5) urge physicians to assess their patients for overweight and obesity during routine medical examinations and discuss with at-risk patients the health consequences of further weight gain; if treatment is indicated, physicians should encourage and facilitate weight maintenance or reduction efforts in their patients or refer them to a physician with special interest and expertise in the clinical management of obesity; (6) urge all physicians and patients to maintain a desired weight and prevent inappropriate weight gain; (7) encourage physicians to become knowledgeable of community resources and referral services that can assist with the management of overweight and obese patients; and (8) urge the appropriate federal agencies to work with organized medicine and the health insurance industry to develop coding and payment mechanisms for the evaluation and management of obesity.

4. EVALUATION OF DACA-ELIGIBLE MEDICAL STUDENTS, RESIDENTS, AND PHYSICIANS IN ADDRESSING PHYSICIAN SHORTAGES

Informational report; no reference committee hearing.

HOUSE ACTION: FILED

Policy D-350.986, "Evaluation of DACA-Eligible Medical Students, Residents and Physicians in Addressing Physician Shortages," directs our American Medical Association (AMA) to "study the issue of Deferred Action for Childhood Arrivals-eligible medical students, residents, and physicians and consider the opportunities for their participation in the physician profession and report its findings to the House of Delegates." This report is in response to that directive.

This policy was adopted at the 2015 Annual Meeting of the AMA House of Delegates. Unanimous supportive testimony at A-15 before Reference Committee C asserted that many Deferred Action for Childhood Arrivals (DACA)-eligible medical students want to meet the health care needs of their communities and have the potential to increase the physician workforce, particularly for underserved populations and in underserved areas. DACA allows individuals who came to the U.S. illegally as minor children, and who meet several guidelines, to apply for deferred deportation and be eligible for a renewable work authorization and Social Security number. While the ethnicity of eligible individuals varies by region, 77 percent of all DACA applicants by 2014 were of Mexican origin; individuals of Mexican, El Salvadoran, Guatemalan, Korean, and Honduran origin accounted for 87 percent of all applicants.[1]

This report offers background information regarding the DACA program; provides estimates of the number of medical students and resident trainees eligible for these opportunities; discusses their potential impact on the physician workforce; and reviews how the current political climate and the results of the 2016 presidential election may affect or eliminate this initiative. All information is current as of March 17, 2017.

DEFERRED ACTION FOR CHILDHOOD ARRIVALS

In June 2012, then-Secretary of Homeland Security Janet Napolitano issued a memorandum to U.S. Customs and Border Protection, U.S. Citizenship and Immigration Services, and U.S. Immigration and Customs Enforcement to set forth "how, in the exercise of our prosecutorial discretion, the Department of Homeland Security (DHS) should enforce the Nation's immigration laws against certain young people who were brought to this country as children and know only this country as home."[2] The memorandum explains the criteria these federal agencies should use when considering whether or not to remove non-citizens from the country. Later that day, then-President Barack Obama addressed this new inter-agency policy, remarking that "it makes no sense to expel talented young people, who, for all intents and purposes, are Americans—they've been raised as Americans; understand themselves to be part of this country—to expel these young people who want to staff our labs, or start new businesses, or defend our country simply because of the actions of their parents—or because of the inaction of politicians."[3] This policy action, which has become known as DACA, had been approved for almost 730,000 qualifying individuals by March 2016.[4] Despite the protections the memorandum appears to offer, however, it ends with a warning that "[t]his memorandum confers no substantive right, immigration status or pathway to citizenship. Only the Congress, acting through its legislative authority, can confer these rights. It remains for the executive branch, however, to set forth policy for the exercise of discretion within the framework of the existing law."

In November 2014, President Obama issued an executive action titled Immigration Accountability, which would have expanded the original DACA policy action and introduced a new initiative—Deferred Action for Parents of Americans and Lawful Permanent Residents (DAPA). These two actions were intended to keep families united and simultaneously increase tax revenue. In February 2015, the actions were blocked by a federal judge in Texas, effectively preventing the programs from being implemented. That decision was reaffirmed by the 5th Circuit Court of Appeals in New Orleans. The case ultimately was heard by the U.S. Supreme Court, which handed down a split decision in June 2016, preventing these programs from being implemented during the remainder of President Obama's term. The injunction did not affect the original DACA initiative, and beneficiaries of that program remained—as of June 2016—"low priorities for enforcement."[5]

DACA-ELIGIBLE TRAINEES IN UNDERGRADUATE MEDICAL EDUCATION

Medical schools traditionally may have been unwilling to offer admission to individuals who might not have been able to complete their training due to the uncertainty of their immigration status. DACA status is therefore key to opening doors to medical school for qualified non-citizen applicants, as achieving such status also secures work authorization—necessary for any individual who wants to eventually enter residency/fellowship training. According to the Association of American Medical Colleges (AAMC), 61 U.S. allopathic medical schools reported that they considered applications from students with DACA status for the 2016/2017 academic year.[6] In 2016, 108 students with DACA status applied to U.S. allopathic medical schools, and 34 of those individuals matriculated, bringing total allopathic medical school enrollment of DACA-eligible individuals to approximately 70 students.[7]

While DACA status might provide opportunities for entry into higher education, it does not confer eligibility for federal financial aid. This financial barrier has implications for students and schools. Like others, undocumented medical students may find the average cost of a medical school education out of reach: the AAMC estimates the

median cost of attending four years of medical school for the class of 2017 at $240,351 for public school and $314,202 for private school.[8]

Loyola University Chicago Stritch School of Medicine—the first U.S. medical school to accept DACA-eligible applicants—has taken steps to address financial barriers by working with local partners to create a program similar to public health service loans. No taxpayer funds are used, and recipients are required to dedicate one year of service to underserved populations/areas in the state of Illinois for each year of training during which the loans are used.[9]

California has pursued another pathway that seeks to assist undocumented individuals as they pursue training in health care (not limited to physician training). A 2016 bill signed into law permits individuals to apply for multiple sources of state training funding regardless of citizenship status, and further prohibits medical school and residency training programs from denying admission to individuals solely based on this status.[10]

DACA-ELIGIBLE TRAINEES IN GRADUATE MEDICAL EDUCATION

While the Accreditation Council for Graduate Medical Education (ACGME) does not currently track numbers of medical school graduates with DACA status who have entered ACGME-accredited residency training programs, the AAMC is currently aware of four DACA resident trainees at four different institutions.[11] Overall numbers of current DACA-eligible resident trainees/fellows therefore appear quite small; however, several impediments that might previously have prevented medical school graduates from entering residency training programs recently have been addressed. One barrier was removed in 2014, and strengthened in 2016, when the Veterans Health Administration (VA) agreed to allow DACA-eligible trainees to rotate through VA facilities, a required rotation for many residency training programs.[12] Also, the Electronic Residency Application System (ERAS)—the online application tool medical school graduates use to apply to most ACGME-accredited residency training programs—recently added a DACA category, thereby allowing DACA-eligible residency applicants to participate in this process.[13] The renewable work authorization granted under DACA allows recipients to be hired using customary I-9 verification.[14] Therefore, payment barriers are alleviated, and DACA recipients with work authorization are protected from employment discrimination as well.[15]

STATE LICENSURE

Eligibility for medical licensure of undocumented, U.S.-educated physicians who have completed residency training varies by state, and the Federation of State Medical Boards (FSMB) does not maintain a centralized repository of this information. While some states specifically allow medical licensure for qualified DACA-eligible individuals, others are silent on this issue.[16]

POTENTIAL PHYSICIAN WORKFORCE IMPLICATIONS

Because of a lack of data, due in large part to the relative youth of the DACA program, little is known about the potential impact of DACA-eligible medical students and trainees on the U.S. physician workforce. The Migration Policy Institute projected that of the 1.2 million immediately DACA-eligible youth in 2014, four percent had completed a bachelor's (three percent) or advanced degree (one percent).[17] This would imply that only a small number of individuals would be prepared to even consider application to medical school. Another model, however, predicts that the DACA initiative could introduce 5,400 previously ineligible physicians into the U.S. health care system in the coming decades (although "coming decades" is not defined).[18] Nevertheless, even if this projection is accurate, speculation regarding both specialty choice and practice location, and extrapolation regarding patient populations served, would be rash at this time.

IMPACTS OF THE 2016 PRESIDENTIAL ELECTION

All of the foregoing information is, of course, subject to any policy action taken by President Donald Trump and the 115th Congress. In the lead-up to the election, Mr. Trump referred to the DACA initiative as "one of the most unconstitutional actions ever undertaken by a president," and spoke of immediately expelling all undocumented immigrants.[19] As of the writing of this report, however, no official actions have been taken by the new administration to abolish DACA or punitively identify and deport individuals covered by the initiative, and comments offered during the administration's first official White House Press Briefing suggest that there will be no immediate effort to terminate DACA.[20,21] While the President generally has been expanding immigration

enforcement efforts, he still has not taken any action to rescind or roll back the DACA program. Furthermore, the recently issued executive orders and guidance memoranda do not address the DACA program.

A number of different groups have expressed concern for the status of DACA-eligible medical students and resident trainees. At the 2016 Interim Meeting, the House adopted a resolution in support of current U.S. health care professionals, including medical students and resident/fellow trainees, who are DACA recipients. In December 2016, the AAMC sent a letter to then President-Elect Trump "strongly" encouraging him not to eliminate the protections conferred by the DACA initiative.[22] The AMA expressed its concerns about the future of the DACA initiative in a letter to Department of Homeland Security Secretary John F. Kelly in February 2017, which urged the administration to carefully consider any future action related to individuals with DACA status. The AMA stated its strong support for medical students and physicians with DACA status and advocated that the administration retain the current DACA initiative until a permanent solution on lawful immigration status for DACA participants could be implemented.

Legislators also are addressing this concern. In January 2017, a bipartisan group of six senators—Lindsey Graham (R-SC), Richard Durbin (D-IL), Lisa Murkowski (R-AK), Dianne Feinstein (D-CA), Jeff Flake (R-AZ), and Charles Schumer (D-NY)—reintroduced the BRIDGE Act (Bar Removal of Individuals who Dream and Grow our Economy), S. 128. Provisions of this legislation—at the time of this report's writing—would amend Chapter 4 of Title II of the Immigration and Nationality Act to offer DACA-eligible individuals "provisional protected presence," which also includes employment authorization.[23, 24] The AMA subsequently sent a letter of support to Senators Graham and Durbin in February, which noted that DACA-eligible medical students "help contribute to a diverse and culturally responsive physician workforce, which in turn helps benefit not only traditionally underserved patients, but all patients as well."[25] This bill also was introduced in the House of Representatives as H.R. 496 by Representatives Mike Coffman (R-CO), Luis Gutiérrez (D-IL), and 18 cosponsors from both sides of the aisle. The AMA sent an additional letter of support to Representatives Coffman and Gutiérrez.

If DACA status were to be eliminated, previously DACA-eligible medical students might not be able to continue in their programs, and DACA-eligible medical school graduates would not be eligible to enter residency training in the United States. These individuals' status also would preclude them from entering residency training as international medical graduates (IMGs), a category officially recognized by U.S residency and fellowship training programs. In order to qualify as an IMG, an applicant is required to have a certificate from the Educational Commission for Foreign Medical Graduates (ECFMG). An individual who has graduated from a Liaison Committee on Medical Education (LCME)- or Commission on Osteopathic College Accreditation (COCA)-accredited medical school is not eligible to receive an ECFMG certificate. While the ECFMG does sponsor J-1 visas for non-IMGs (often graduates of Canadian medical schools), individuals pursuing this route would need to leave the country and reenter with a valid visa; this seems an unlikely path for individuals with current DACA status.

SUMMARY AND AREAS FOR FURTHER STUDY

Extensive AMA policy and previous Council on Medical Education reports support a diverse, well distributed physician workforce and promote access to care for underserved populations; for these reasons, our AMA should promote policies that enable individuals from diverse backgrounds to complete medical school and residency training and enter into U.S. practice. At this time, DACA-eligible individuals are not likely to have a significant impact on physician workforce shortages, and the effects of their entry into the workforce on physician maldistribution are unknown. Regardless, the practice patterns of DACA-eligible medical school graduates and trainees in residency training programs should be studied to better understand their future potential relationship to medically underserved areas and populations. The Council on Medical Education will continue to monitor this issue and its implications and report back as needed.

REFERENCES

1. National Center on Immigrant Integration Policy. DACA at the Two-Year Mark: a National and State Profile of Youth Eligible and Applying for Deferred Action. Available at http://www.migrationpolicy.org/research/daca-two-year-mark-national-and-state-profile-youth-eligible-and-applying-deferred-action. Accessed January 12, 2017.
2. Department of Homeland Security. Exercising Prosecutorial Discretion with Respect to Individuals Who Came to the United States as Children. Available at https://www.dhs.gov/xlibrary/assets/s1-exercising-prosecutorial-discretion-individuals-who-came-to-us-as-children.pdf. Accessed December 29, 2016.

3. White House Briefing Room. Remarks by the President on Immigration: June 15, 2012. Available at https://www.whitehouse.gov/the-press-office/2012/06/15/remarks-president-immigration. Accessed December 29, 2016.
4. Migration Policy Institute. DACA at Four: Participation in the Deferred Action Program and Impact on Recipients. Available at http://www.migrationpolicy.org/sites/default/files/publications/DACAatFour-FINAL.pdf. Accessed December 29, 2016.
5. White House Briefing Room. Live Updates: President Obama on the Supreme Court Ruling on Immigration Reform: June 23, 2016. Available at https://www.whitehouse.gov/blog/2016/06/23/president-obama-supreme-court-ruling-immigration-reform. Accessed December 29, 2016.
6. Geoff Young, Senior Director, Student Affairs and Programs, Association of American Medical Colleges. Personal communication. January 9, 2017.
7. Ibid.
8. AAMC. You can afford medical school. Available at https://students-residents.aamc.org/choosing-medical-career/article/you-can-afford-medical-school/. Accessed January 10, 2017.
9. Kuczewski MG, Brubaker L. Equity for "DREAMers" in Medical School Admissions. *AMA Journal of Ethics*. 2015;17(2): 152-156.
10. Pre-Health Dreamers. Governor Brown signs historic bill, opening a new door of educational opportunities to prospective health professionals in California. Available at http://www.phdreamers.org/blog/. Accessed January 11, 2017.
11. Geoff Young, Senior Director, Student Affairs and Programs, Association of American Medical Colleges. Personal communication. January 9, 2017.
12. Minutes of the National Academic Affiliations Council: July 13, 2016. Available at https://www.va.gov/ADVISORY/docs/AcadAff%20-%202016%20May%20Minutes.pdf. Accessed January 11, 2017.
13. Pre-Health Dreamers. Resources. Available at http://www.phdreamers.org/resources/residence-for-undocumented-medical-students/. Accessed January 11, 2017.
14. US Citizenship and Immigration Services. Consideration of Deferred Action for Childhood Arrivals: Guidance for Employers. Available at https://www.uscis.gov/sites/default/files/USCIS/Humanitarian/Deferred%20Action%20for%20Childhood%20Arrivals/DACA-Fact-Sheet-I-9_Guidance-for-employers_nov20_2012.pdf. Accessed February 9, 2017.
15. Fragomen. USCIS Issues I-9 Guidance for Employers of DACA Recipients. Available at https://www.fragomen.com/knowledge-center/immigration-alerts/uscis-issues-i-9-guidance-employers-daca-recipients. Accessed February 9, 2017.
16 New York State Department of Education. Board of Regents Permanently Adopts Regulations to Allow DACA Recipients to Apply for Teacher Certification and Professional Licenses. Available at http://www.nysed.gov/news/2016/board-regents-permanently-adopts-regulations-allow-daca-recipients-apply-teacher. Accessed January 11, 2017.
17. National Center on Immigrant Integration Policy. DACA at the Two-Year Mark: a National and State Profile of Youth Eligible and Applying for Deferred Action. Available at http://www.migrationpolicy.org/research/daca-two-year-mark-national-and-state-profile-youth-eligible-and-applying-deferred-action. Accessed January 12, 2017.
18. Anaya YB, del Rosario M, Doyle LH, Hayes-Bautista DE. Undocumented Students Pursuing Medical Education: the Implications of Deferred Action for Childhood Arrivals (DACA). *Acad Med*. 2014;89:1599-1602.
19. Guo Jeff. Hey, Donald Trump: It Turns Out that Immigrants Really Just Want to Work. *The Washington Post*. August 26, 2016. Available at https://www.washingtonpost.com/news/wonk/wp/2016/08/26/hey-donald-trump-it-turns-out-that-immigrants-really-just-want-to-work/?utm_term=.7c816f22ec48. Accessed December 29, 2016.
20. *The Washington Post.* Sean Spicer's Defense of Himself and Explanation of Donald Trump's Sensitivity, Annotated. Available at https://www.washingtonpost.com/news/the-fix/wp/2017/01/23/sean-spicers-defense-of-himself-and-explanation-of-donald-trumps-sensitivity-annotated/?utm_term=.4da153a92d93. Accessed January 24, 2017.
21. CNN. What We Learned at Sean Spicer's First Briefing. Available at http://www.cnn.com/2017/01/23/politics/sean-spicer-press-briefing-day-one/index.html. Accessed January 24, 2017.
22. Association of American Medical Colleges. AAMC Calls on President-Elect Trump Not to Revoke DACA Executive Action Without Permanent Fix. Available at https://news.aamc.org/press-releases/article/statement-daca-executive-action/. Accessed December 29, 2016.
23. Bar Removal of Individuals who Dream and Grow our Economy Act. Available at https://www.congress.gov/bill/114th-congress/senate-bill/3542/text?r=1. Accessed December 29, 2016.
24. Ignatian Solidarity Network. Bipartisan BRIDGE Act to Support Undocumented Students Introduced in New Congress by Jesuit Educated member of U.S. Senate. Available at https://ignatiansolidarity.net/blog/2017/01/12/bridge-act-undocumented-jesuit-member/. Accessed January 24, 2017.
25. American Medical Association. February 6, 2017. Available at https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2017-2-6-Letter-of-Support-to-Graham-re-S-128-Bridge-Act_DACA.pdf. Accessed February 9, 2017.

APPENDIX: Relevant AMA Policies

H-350.970, Diversity in Medical Education
Our AMA will: 1. Request that the AMA Foundation seek ways of supporting innovative programs that strengthen pre-medical and pre-college preparation for minority students; 2. Support and work in partnership with local state and specialty medical societies and other relevant groups to provide education on and promote programs aimed at increasing the number of minority medical school admissions; applicants who are admitted; and 3. Encourage medical schools to consider the likelihood of service to underserved populations as a medical school admissions criterion.

D-200.982, Diversity in the Physician Workforce and Access to Care
Our AMA will: 1. Continue to advocate for programs that promote diversity in the US medical workforce, such as pipeline programs to medical schools; 2. Continue to advocate for adequate funding for federal and state programs that promote interest in practice in underserved areas, such as those under Title VII of the Public Health Service Act, scholarship and loan repayment programs under the National Health Services Corps and state programs, state Area Health Education Centers, and Conrad 30, and also encourage the development of a centralized database of scholarship and loan repayment programs; and 3. Continue to study the factors that support and those that act against the choice to practice in an underserved area, and report the findings and solutions at the 2008 Interim Meeting.

H-295.874, Educating Medical Students in the Social Determinants of Health and Cultural Competence
Our AMA: (1) Supports efforts designed to integrate training in social determinants of health and cultural competence across the undergraduate medical school curriculum to assure that graduating medical students in the social determinants of health and cultural competence.

H-310.919, Eliminating Questions Regarding Marital Status, Dependents, Plans for Marriage or Children, Sexual Orientation, Gender Identity, Age, Race, National Origin and Religion During the Residency and Fellowship Application Process
Our AMA: 1. Opposes questioning residency or fellowship applicants regarding marital status, dependents, plans for marriage or children, sexual orientation, gender identity, age, race, national origin, and religion; 2. Will work with the Accreditation Council for Graduate Medical Education, the National Residency Matching Program, and other interested parties to eliminate questioning about or discrimination based on marital and dependent status, future plans for marriage or children, sexual orientation, age, race, national origin, and religion during the residency and fellowship application process; and 3. Will continue to support efforts to enhance racial and ethnic diversity in medicine. Information regarding race and ethnicity may be voluntarily provided by residency and fellowship applicants.

H-295.897, Enhancing the Cultural Competence of Physicians
1. Our AMA continues to inform medical schools and residency program directors about activities and resources related to assisting physicians in providing culturally competent care to patients throughout their life span and encourage them to include the topic of culturally effective health care in their curricula; 2. Our AMA continues research into the need for and effectiveness of training in cultural competence, using existing mechanisms such as the annual medical education surveys and focus groups at regularly scheduled meetings; 3. Our AMA will form an expert national advisory panel (including representation from the AMA Minority Affairs Consortium and International Medical Graduate Section) to consult on all areas related to enhancing the cultural competence of physicians, including developing a list of resources on cultural competencies for physicians and maintaining it and related resources in an electronic database; 4. Our AMA will assist physicians in obtaining information about and/or training in culturally effective health care through development of an annotated resource database on the AMA home page, with information also available through postal distribution on diskette and/or CD-ROM; 5. Our AMA will seek external funding to develop a five-year program for promoting cultural competence in and through the education of physicians, including a critical review and comprehensive plan for action, in collaboration with the AMA Consortium on Minority Affairs and the medical associations that participate in the consortium (National Medical Association, National Hispanic Medical Association, and Association of American Indian Physicians,) the American Medical Women's Association, the American Public Health Association, the American Academy of Pediatrics, and other appropriate groups. The goal of the program would be to restructure the continuum of medical education and staff and faculty development programs to deliberately emphasize cultural competence as part of professional practice; and 6. Our AMA encourages training opportunities for students and residents, as members of the physician-led team, to learn cultural competency from community health workers, when this exposure can be integrated into existing rotation and service assignments.

D-350.986, Evaluation of DACA-Eligible Medical Students, Residents and Physicians in Addressing Physician Shortages
1. Our American Medical Association will study the issue of Deferred Action for Childhood Arrivals-eligible medical students, residents, and physicians and consider the opportunities for their participation in the physician profession and report its findings to the House of Delegates; and 2. Our AMA will issue a statement in support of current US healthcare professionals, including those currently training as medical students or residents and fellows, who are Deferred Action for Childhood Arrivals recipients.

D-350.995, Reducing Racial and Ethnic Disparities in Health Care
Our AMA's initiative on reducing racial and ethnic disparities in health care will include the following recommendations: 1. Studying health system opportunities and barriers to eliminating racial and ethnic disparities in health care; 2. Working with public health and other appropriate agencies to increase medical student, resident physician, and practicing physician awareness of racial and ethnic disparities in health care and the role of professionalism and professional obligations in efforts to reduce health care disparities; and 3. Promoting diversity within the profession by encouraging publication of successful outreach programs that increase minority applicants to medical schools, and take appropriate action to support such programs, for example, by expanding the "Doctors Back to School" program into secondary schools in minority communities.

H-200.950, Retraining Refugee Physicians
Our AMA supports federal programs, and funding for such programs, that assist refugee physicians who wish to enter the US physician workforce, especially in specialties experiencing shortages and in underserved geographical areas in the US and its territories.

D-200.985, Strategies for Enhancing Diversity in the Physician Workforce
1. Our AMA, independently and in collaboration with other groups such as the Association of American Medical Colleges (AAMC), will actively work and advocate for funding at the federal and state levels and in the private sector to support the following: a. Pipeline programs to prepare and motivate members of underrepresented groups to enter medical school; b. Diversity or minority affairs offices at medical schools; c. Financial aid programs for students from groups that are underrepresented in medicine; and d. Financial support programs to recruit and develop faculty members from underrepresented groups; 2. Our AMA will work to obtain full restoration and protection of federal Title VII funding, and similar state funding programs, for the Centers of Excellence Program, Health Careers Opportunity Program, Area Health Education Centers, and other programs that support physician training, recruitment, and retention in geographically-underserved areas; 3. Our AMA will take a leadership role in efforts to enhance diversity in the physician workforce, including engaging in broad-based efforts that involve partners within and beyond the medical profession and medical education community; and 4. Our AMA will encourage the Liaison Committee on Medical Education to assure that medical schools demonstrate compliance with its requirements for a diverse student body and faculty.

H-350.960, Underrepresented Student Access to US Medical Schools
Our AMA: 1. Recommends that medical schools should consider in their planning: elements of diversity including but not limited to gender, racial, cultural and economic, reflective of the diversity of their patient population; and 2. Supports the development of new and the enhancement of existing programs that will identify and prepare underrepresented students from the high-school level onward and to enroll, retain and graduate increased numbers of underrepresented students.

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.

5. OPTIONS FOR UNMATCHED MEDICAL STUDENTS

Informational report; no reference committee hearing.

HOUSE ACTION: FILED

Policy D-310.977 (15), "National Resident Matching Program Reform," directs our American Medical Association (AMA) to "discuss with the National Resident Matching Program, Association of American Medical Colleges, American Osteopathic Association, Liaison Committee on Medical Education, Accreditation Council for Graduate Medical Education, and other interested bodies potential pathways for reengagement in medicine following an unsuccessful match and report back on the results of those discussions." This report is in response to that directive.

This policy was adopted at the 2015 Annual Meeting of the AMA House of Delegates. Testimony at A-15 before Reference Committee C reflected growing concern over the issue of unmatched medical students, with the continued growth in enrollments in medical schools. The AMA is committed to continued study and close monitoring of this issue—through the efforts of the Council on Medical Education and Academic Physicians Section, among others—to ensure the highest possible return on the nation's investment in our future physician workforce.

This report focuses primarily on those Match participants who are U.S. medical school seniors at allopathic, MD-granting programs accredited by the Liaison Committee on Medical Education. Graduates of osteopathic medical schools (DOs) can participate in both the osteopathic Match as well as the NRMP Match, and as such the data available on match rates of DOs versus MDs are not directly comparable. That said, we have included segments in this report noting some of the Match issues specific to DOs as well as to International Medical Graduates (IMGs).

BACKGROUND: THE HISTORICAL STABILITY OF MATCH RATES

Council on Medical Education Report 3-A-16, "Addressing the Increasing Number of Unmatched Medical Students," was adopted as amended by the AMA House of Delegates at its 2016 Annual Meeting (see Policy D-310.977). This report responded to Policy D-310.977 (14), "National Resident Matching Program Reform," which calls for the AMA to "study, in collaboration with the Association of American Medical Colleges, the National Resident Matching Program, and the American Osteopathic Association, the common reasons for failures to match." Some of the information in that report is relevant to this document and is incorporated where appropriate.

A key point is the historical stability in Match rates for U.S. allopathic medical school seniors. As noted by the authors of research published in the December 8, 2015 issue of *JAMA*,[1] "The percentage of US MD graduates entering GME the year of graduation has remained stable during the past decade despite an increase in the number of graduates."

These conclusions were highlighted in an interview with the article's lead author, Henry Sondheimer, MD.[2] "[I]n spite of the growth in U.S. MD graduates, the percent of graduates not beginning their GME the year they graduated has remained very stable around 3%." He adds that, after following the graduates for eight to 10 years after graduation, "more than 99% enter GME or begin practice in some other way"—for example, those with a joint medical/dental degree may obtain a dental residency slot versus a similar position in a medical residency.

WHY STUDENTS FAIL TO MATCH

Data provided by medical schools to the Liaison Committee on Medical Education (LCME) offer insight into the reasons students did not match into a residency program. The LCME Part II Annual Medical School Questionnaire

from 2015-2016 (with responses from 142 schools; 100 percent response rate) shows that academic shortcomings and inadequate Match preparation are two key reasons for failure to match.

The LCME data show that 18,442 potential 2016 graduates accepted appointments to first-year residency programs. An additional 473 potential 2016 graduates did not enter residency training in 2016-2017, for the following reasons:

#	%	Reason
273	57.7%	Did not find a residency position
75	15.9%	Research/pursuing additional degree or training
75	15.9%	Other
45	9.5%	Changing careers
5	1.1%	Family responsibilities/maternity/child care

Of these 473 potential 2016 graduates, medical schools provided data on the 332 individuals who sought but did not find a residency position:

Students who did not find a residency position:

#	%	Reason
203	61.1%	The student's academic performance (eg, clinical grades) and/or USMLE scores were below the norm
55	16.6%	The applications were limited to one specialty and did not include backup plans ("plan B" specialty)
24	7.2%	The number of applications was (relatively) limited
21	6.3%	There were nonacademic flags in the MSPE (eg, professional behavior)
29	8.7%	Reason not reported or unknown to school

Not having a backup plan ("plan B" specialty) may result from candidates' failure to fully and realistically evaluate their chances for matching into a given specialty field and/or residency program. Students who have not achieved high United States Medical Licensing Examination (USMLE) scores or class ranking may not be competitive applicants for such programs, and are likely to remain unmatched if their rank order lists include only highly competitive specialties. Indeed, as the authors of a recent study in *Academic Medicine* note, "U.S. seniors' Match outcomes may be affected by applicant characteristics that negatively influence their selection for interviews, and their difficulties may be exacerbated by disadvantageous ranking behaviors."[3]

FUTURE PLANS OF STUDENTS WHO FAIL TO MATCH

As to the plans of the 332 students who were unmatched in 2016, the LCME Questionnaire provides additional insight, as shown below (Note: One or more options could be marked for an individual student; total responses were 553):

#	%	Future Plans
246	44.4%	Will search for a residency position for entry in 2017
120	21.7%	Will continue searching for a residency position in 2016
120	21.7%	Will seek employment, such as a research position
32	5.8%	Will seek an additional degree
5	0.1%	Will seek a career outside of medicine
30	5.4%	Plans unknown by school

For these unmatched students, the odds of a future successful Match are not favorable. Historically, fewer than 50 percent of U.S. medical school graduates who did not match in their initial attempt obtained a position in a succeeding year's Match. This finding reinforces the need for individualized counseling by medical schools as well as rational and realistic decisions by medical students prior to entering their first match.

The 2016 GME compendium from the AMA[4] outlines options for unmatched medical students to consider, as well as the challenges/opportunities that these options may entail. These include a program-specific fifth year of medical school or research/clinical program or pursuing a master's degree. Other potential options are seeking employment in a research, clinical, or teaching environment; obtaining volunteer work; or pursuing a nonclinical career in such fields as public health and service, public policy and government, communications and journalism, informatics, pharmaceutical research, and consulting.[5] Some unmatched medical school graduates turn to other health professions, to become a nurse, nurse practitioner, or physician assistant.

Finally, an often unstated truism is that the Match serves as an additional filter for those medical school graduates who, due to poor academic performance or concerns about professional behavior, are not well-equipped to become competent, caring health care professionals. These numbers are small, to be sure—which reflects well on the medical school admissions process—but they represent a beneficial outcome, in that a given individual who may not be suitable to become a fully licensed practicing physician is removed from the system.

DOs AND THE MATCH

The American Association of Colleges of Osteopathic Medicine (AACOM) has been tracking Match rates for graduates of osteopathic medical schools (DOs) and communicating with its colleges on responses to the issue (personal communication, December 2016). Much of the discussion in the DO profession centers around Commission on Osteopathic College Accreditation (COCA) Standard 8 on GME Outcomes, which requires an osteopathic medical college to provide a retrospective GME accountability report on GME placement. Specifically, Standard 8.3[6] requires osteopathic medical colleges to report on:

> … the number of graduates entering GME, the positions available in the COM's affiliated OPTI [Osteopathic Postdoctoral Training Institution], the historic percentage of match participation (AOA, NRMP, military, etc.), final placement, the number/percentage of eligible students unsuccessful in the matches, and the residency choices of its graduates.
> *Guideline: COMs should strive to place 100% of their graduates into GME programs and devote the necessary resources to obtain that goal.*

Further, Standard 8.5.a requires colleges to "annually report publicly, beginning with the 2013-2014 academic year, from the previous four academic years, the following data…on its website, in its catalog, and in all COM promotional publications that provide information about the COM's education for prospective students…. The number of students from each graduating class who applied to and obtained or were offered placement in a graduate medical education program accredited by the American Osteopathic Association or the Accreditation Council for Graduate Medical Education or the military, and the number of students from each graduating class who applied to and were unable to obtain placement in an accredited graduate medical program."

COCA policy also states that, if an osteopathic medical school does not match 98 percent of students on its three-year rolling average, it will not be granted the same overage allowance for class sizes.

IMGs AND THE MATCH

IMGs face additional challenges in securing a residency program placement. Foreign national IMGs, in particular, must surmount visa and immigration hurdles, aside from the need to obtain a residency slot. Furthermore, as they lack the institutional support and counsel of a domestic medical school's student affairs office, IMGs may have additional difficulties in learning about and employing successful Match strategies.

Helping to fill this gap are programs like the IMG Advisors Network (IAN) of the Educational Commission for Foreign Medical Graduates (ECFMG) and the AMA International Medical Graduates Section (AMA-IMGS). The AMA-IMGS, for example, advocates for the interests of IMGs and helps minimize the time it takes for IMGs to obtain visas and obtain credentials verification from educational and training programs in other countries. The section also provides model guidelines for establishing observership programs, to assist IMGs who wish to observe clinical practice in a U.S. setting as a preparatory step for residency application and placement. The AMA-IMGS has also collaborated with the ECFMG on webinars related to aiding IMGs as they seek a residency program slot.

The work of the AMA in this regard is important, in that the health workforce impact of IMGs vis-à-vis the Match cannot be understated. Foreign national IMGs, for example, are more likely to practice in underserved urban and rural communities.[7] If the increasing numbers of U.S. graduates displace IMGs from the Match over the next 10 or more years, current health workforce shortages affecting underserved populations could be exacerbated.

TOOLS AND INITIATIVES TO SUPPORT INFORMED MATCH CHOICES

As noted previously, the available data regarding unmatched medical students demonstrate that student behaviors likely contribute to the problem. In this regard, students bear the responsibility to make good choices before and during the match process, and medical schools and medical education organizations bear the responsibility to ensure that students are well-prepared and well-informed about realistic career path options and strategies for success.

At the organizational level, the AMA has been a leader in providing data/information to medical students and medical schools to inform Match decisions. One AMA tool for helping ensure a more successful match (not just to residency but to one's career as a physician) is the AMA's Career Planning Resource, which includes guidance on applying for residency, choosing a specialty, interviewing for residency, writing a C.V., and finding residency programs (through the AMA Residency and Fellowship Database, FREIDA Online).

Another useful tool is the AAMC's Careers in Medicine (CiM) online guide, which helps students make strategic decisions about residency training and beyond, and provides self-assessment tools and specialty-specific data to inform those decisions.

The AAMC has also embarked on its Optimizing Graduate Medical Education initiative, which encompasses development of resources and tools to support all parties involved in a learner's transition to residency. Goals of the Transition to Residency component of the initiative (aamc.org/initiatives/optimizinggme/phase-two/) include helping residency program applicants, program directors, and medical school advisors make more strategic decisions. Some of the specific projects supporting the Transition to Residency effort include the following:

- Development of a research study to evaluate the use of a standardized video interview as a potential tool in the residency application and selection process.
- Analysis of a national survey of residency program directors to understand their applicant evaluation and selection process, and pain points experienced in that process.
- Creation of an overview of interview practices and processes, to support program directors and allow a more efficient and informative interview for applicants and interviewers.
- Recommendations for a new format for the Medical Student Performance Evaluation (MSPE), which allows for a holistic approach to both evaluating and reviewing an applicant.

Meanwhile, the key theme for the May 2017 meeting of the National Resident Matching Program (NRMP) was "The Unmatched Applicant," intended to generate discussion about the medical education continuum (http://nrmpconference.org/themes.html). Themes covered include the following:

- Does the MSPE meet program director needs?
- How can the Match be flexible in accommodating competency-based programming?
- Ensuring readiness for residency: Innovations from the field.
- Goodness of fit: How can medical schools and GME programs quell application overload?
- What applicants need to inform specialty/program selection.
- Program director panel to explore criteria used to interview and rank applicants.
- What tools do program directors need/want to improve the selection process?
- Enhancing unmatched students' applications for next year's Match.
- Alternatives to clinical medicine: What options exist?
- Candid career counseling: When and how to guide academically underachieving students toward non-medical professions.
- IMG success rate: Trends over time and impact on training programs.
- Workforce: Current status and future trends.
- Resident resilience: Tips and tools to keep young physicians engaged for a long career.

SUMMARY AND POTENTIAL FUTURE RESEARCH

This report outlines a number of key points related to unmatched medical students, including the long-term stability of Match rates, common reasons for an unsuccessful match, options for students who do not match, the special Match concerns of DOs and IMGs, and tools/initiatives from medical schools and medical organizations (including the AMA) that are essential to ensuring an effective, efficient, and equitable Match process that balances the interests of applicants and programs and promotes rational, strategic decision making by all parties.

In general, medical students need up-front disclosures on Match potential and a realistic assessment of career possibilities. Students should be provided accurate data about graduation and Match rates, as well as projected Match rates for the institution, when they apply to a given medical school. From a systemic perspective, according to the authors of a 2016 article in *Academic Medicine*, potential improvements to the residency application and Match process include limiting the number of applications as well as "increasing the amount and/or types of information provided by applicants and by residency programs; shifting to holistic review, with standardization of metrics for important attributes; and fundamental reanalysis of the residency application process."[8]

A number of variables contribute to the complex supply/demand equation of Match rates, physician workforce, and the need for health care services; these areas offer important venues for research:

- The continued growth in the number of U.S. medical schools (both allopathic and osteopathic) and increased enrollments in existing schools.
- Limited growth in graduate medical education due to caps in federal funding, and the potential for further reductions in government funding levels, particularly with calls on the rise for more transparency in and accountability for public funding of GME.9
- Growth in the number of U.S. citizen international medical graduates (IMGs) who graduate from non-LCME-accredited medical schools and seek to enter residency programs in the United States—along with foreign national IMGs.
- Increased competition among medical students for certain specialty fields of medicine that offer attractive compensation and "controllable lifestyle."
- The large and increasingly burdensome debt load many medical graduates face, which may affect students' decisions.
- Changes in medical practice (for example, increased use of electronic medical records) and new clinical and administrative developments and technologies (i.e., telemedicine), which can lead to greater (or, reduced) efficiencies.
- Physician practice patterns, including the move towards employee settings (versus practice as a solo practitioner); cessation of and reentry into clinical practice, due to raising a family or other personal concerns; and earlier (or later) retirement from clinical practice.
- Increases in the number of non-physician clinicians (physician assistants, nurse practitioners10) that are providing health care and other services.
- The number of people seeking health care services, and the services needed—particularly as our population ages and the burden of chronic diseases and conditions grows.
- The health workforce impacts of students' specialty and program choices in the Match.
- The geographic distribution of physicians and the availability of health care services in underserved areas, both rural and urban.
- The impact of applicants' race/ethnicity on Match outcomes.

The Council on Medical Education will continue to monitor this issue and report back to the HOD as needed, and to work with other key stakeholders, as noted in this report, to ensure that our nation's investment in the future physician workforce is fully realized.

REFERENCES

1. Sondheimer HM, Xierali IM, Young GH, Nivet MA. Placement of US Medical School Graduates Into Graduate Medical Education, 2005 Through 2015. *JAMA*. 2015;314(22):2409-2410. Available at: http://jama.jamanetwork.com/article.aspx?articleid=2474417. Accessed April 10, 2017.
2. Most Medical School Graduates Get The Resident Education Required For Licensure. MedicalResearch.com Interview with Henry Sondheimer, MD. Available at: http://medicalresearch.com/author-interviews/most-medical-school-graduates-get-the-graduate-education-required-for-licensure/19806/. Accessed April 10, 2017.

3. Liang M, Curtin L, Signer M, Savoia M. Unmatched U.S. Allopathic Seniors in the 2015 Main Residency Match: A Study of Applicant Behavior, Interview Selection, and Match Outcome. *Academic Medicine*: November 29, 2016. Available at: http://journals.lww.com/academicmedicine/Abstract/publishahead/Unmatched_U_S__Allopathic_Seniors_in_the_2015_Main.98331.aspx. Accessed April 10, 2017
4. "Compendium of graduate medical education initiatives" report. American Medical Association. 2016. Available at: savegme.org/sites/default/files/graduate-medical-education-compendium.pdf. Accessed December 13, 2016.
5. Bumsted T, Schneider BN, Deiorio NM. Considerations for Medical Students and Advisors After an Unsuccessful Match. *Academic Medicine*, March 21, 2017. Available at: http://journals.lww.com/academicmedicine/Abstract/publishahead/Considerations_for_Medical_Students_and_Advisors.98256.aspx. Accessed on April 3, 2017.
6. Accreditation of Colleges of Osteopathic Medicine: COM Accreditation Standards and Procedures. Standard 8.3, GME Outcomes (pp. 26-27). Available at: http://www.osteopathic.org/inside-aoa/accreditation/COM-accreditation/Documents/com-accreditation-standards-8-29-2016.pdf. Accessed December 12, 2016.
7. International medical graduates in American medicine: Contemporary challenges and opportunities. AMA-IMG Section Governing Council, January 2013.
8. Katsufrakis P, Uhler T, Jones L. , Lee D. The Residency Application Process: Pursuing Improved Outcomes Through Better Understanding of the Issues. Academic Medicine. November 2016;91(11):1483-1487. Available at: http://journals.lww.com/academicmedicine/Fulltext/2016/11000/The_Residency_Application_Process___Pursuing.12.aspx. Accessed December 13, 2016.
9. Graduate Medical Education That Meets the Nation's Health Needs. National Academy of Medicine, 2014. Available at: http://iom.nationalacademies.org/Reports/2014/Graduate-Medical-Education-That-Meets-the-Nations-Health-Needs.aspx. Accessed April 10, 2017.
10. Van Vleet A, Paradise J. Tapping Nurse Practitioners to Meet Rising Demand for Primary Care. Kaiser Family Foundation, January 20, 2015. Available at: http://kff.org/medicaid/issue-brief/tapping-nurse-practitioners-to-meet-rising-demand-for-primary-care/. Accessed February 2, 2016.

APPENDIX - Relevant AMA Policies

D-310.977, National Resident Matching Program Reform
Our AMA:
(1) will work with the National Resident Matching Program to develop and distribute educational programs to better inform applicants about the NRMP matching process; (2) will actively participate in the evaluation of, and provide timely comments about, all proposals to modify the NRMP Match; (3) will request that the NRMP explore the possibility of including the Osteopathic Match in the NRMP Match; (4) will continue to review the NRMP's policies and procedures and make recommendations for improvements as the need arises; (5) will work with the Accreditation Council for Graduate Medical Education and other appropriate agencies to assure that the terms of employment for resident physicians are fair and equitable and reflect the unique and extensive amount of education and experience acquired by physicians; (6) does not support the current the "All-In" policy for the Main Residency Match to the extent that it eliminates flexibility within the match process; (7) will work with the NRMP, and other residency match programs, in revising Match policy, including the secondary match or scramble process to create more standardized rules for all candidates including application timelines and requirements; (8) will work with the NRMP and other external bodies to develop mechanisms that limit disparities within the residency application process and allow both flexibility and standard rules for applicant; (9) encourages the National Resident Matching Program to study and publish the effects of implementation of the Supplemental Offer and Acceptance Program on the number of residency spots not filled through the Main Residency Match and include stratified analysis by specialty and other relevant areas; (11) will work with the Association of American Medical Colleges (AAMC), American Osteopathic Association (AOA), American Association of Colleges of Osteopathic Medicine (AACOM), and National Resident Matching Program (NRMP) to evaluate the current available data or propose new studies that would help us learn how many students graduating from US medical schools each year do not enter into a US residency program; how many never enter into a US residency program; whether there is disproportionate impact on individuals of minority racial and ethnic groups; and what careers are pursued by those with an MD or DO degree who do not enter residency programs; (12) will work with the AAMC, AOA, AACOM and appropriate licensing boards to study whether US medical school graduates and international medical graduates who do not enter residency programs may be able to serve unmet national health care needs; (13) will work with the AAMC, AOA, AACOM and the NRMP to evaluate the feasibility of a national tracking system for US medical students who do not initially match into a categorical residency program; (14) will study, in collaboration with the Association of American Medical Colleges, the National Resident Matching Program, and the American Osteopathic Association, the common reasons for failures to match; and (15) will discuss with the National Resident Matching Program, Association of American Medical Colleges, American Osteopathic Association, Liaison Committee on Medical Education, Accreditation Council for Graduate Medical Education, and other interested bodies potential pathways for reengagement in medicine following an unsuccessful match and report back on the results of those discussions.

H-200.955, Revisions to AMA Policy on the Physician Workforce
It is AMA policy that: (1) any workforce planning efforts, done by the AMA or others, should utilize data on all aspects of the health care system, including projected demographics of both providers and patients, the number and roles of other health professionals in providing care, and practice environment changes. Planning should have as a goal appropriate physician

numbers, specialty mix, and geographic distribution. (2) Our AMA encourages and collaborates in the collection of the data needed for workforce planning and in the conduct of national and regional research on physician supply and distribution. The AMA will independently and in collaboration with state and specialty societies, national medical organizations, and other public and private sector groups, compile and disseminate the results of the research. (3) The medical profession must be integrally involved in any workforce planning efforts sponsored by federal or state governments, or by the private sector. (4) In order to enhance access to care, our AMA collaborates with the public and private sectors to ensure an adequate supply of physicians in all specialties and to develop strategies to mitigate the current geographic maldistribution of physicians. (5) There is a need to enhance underrepresented minority representation in medical schools and in the physician workforce, as a means to ultimately improve access to care for minority and underserved groups. (6) There should be no decrease in the number of funded graduate medical education (GME) positions. Any increase in the number of funded GME positions, overall or in a given specialty, and in the number of US medical students should be based on a demonstrated regional or national need. (7) Our AMA will collect and disseminate information on market demands and workforce needs, so as to assist medical students and resident physicians in selecting a specialty and choosing a career.

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.

D-305.967, The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education
… 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). ... 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. ... 13. Our AMA will 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. ... 19. Our AMA will continue to work with stakeholders such as Association of American Medical Colleges (AAMC), 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. … 22. Our AMA will advocate for the appropriation of Congressional funding in support of the National Healthcare Workforce Commission, established under section 5101 of the Affordable Care Act, to provide data and healthcare workforce policy and advice to the nation and provide data that support the value of GME to the nation.

D-305.992, Accounting for GME Funding
Our AMA will encourage: (1) department chairs and residency program directors to learn effective use of the information that is currently available on Medicare funding accounting of GME at the level of individual hospitals to assure appropriate support for their training programs, and publicize sources for this information, including placing links on our AMA web site; and (2) hospital administrators to share with residency program directors and department chairs, accounting and budgeting information on the disbursement of Medicare education funding within the hospital to ensure the appropriate use of those funds for Graduate Medical Education.

D-305.958, Increasing Graduate Medical Education Positions as a Component to any Federal Health Care Reform Policy
2. Our AMA will work with the Centers for Medicare and Medicaid Services to explore ways to increase graduate medical education slots to accommodate the need for more physicians in the US.

H-310.917, Securing Funding for Graduate Medical Education
Our American Medical Association will: (1) continue to be vigilant while monitoring pending legislation that may change the financing of medical services (health system reform) and advocate for expanded and broad-based funding for graduate medical education (from federal, state, and commercial entities); and (2) continue to advocate for graduate medical education funding that reflects the physician workforce needs of the nation.

6. STANDARDIZING THE ALLOPATHIC RESIDENCY MATCH SYSTEM AND TIMELINE (RESOLUTION 310-A-16)

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: RECOMMENDATION 1 ADOPTED
IN LIEU OF RESOLUTION 310-A-16
RECOMMENDATIONS 2 AND 3 REFERRED
REMAINDER OF REPORT FILED
See Policy D-310.977

INTRODUCTION

Resolution 310-A-16, "Standardizing the Allopathic Residency Match System and Timeline," introduced by the Michigan Delegation and referred by the American Medical Association (AMA) House of Delegates, asks that our AMA: 1) support the movement toward a single United States residency match system and notification timeline for all non-military allopathic specialties; and 2) work with the Association of University Professors in Ophthalmology, American Academy of Ophthalmology, Society of University Urologists, American Urological Association, and any other appropriate stakeholders to switch ophthalmology and urology to the National Resident Matching Program (NRMP).

Testimony heard by Reference Committee C at the 2016 Annual Meeting was largely in support of Resolution 310, despite some opposition. Testimony focused on such issues as: 1) the difficulties of couples attempting to navigate two different match systems, i.e., one run by the NRMP, and the other, taking place prior to the NRMP match, run by a specialty organization; 2) the relative transparency and quantity of data provided by the NRMP versus the specialty organizations, which allows individuals in the NRMP match to better gauge their competitiveness than individuals participating in a specialty match; and 3) concerns that the specialties that run their own matches have a potential financial conflict of interest.

Testimony in opposition to the resolution came mostly from the affected specialties, which expressed satisfaction with the current system and a reluctance to switch to a shared match and timeline. In addition, it was noted that applicants in these specialty match programs are afforded the opportunity to participate in an "early match."

Due to the conflicting testimony and the complexity of these issues, the resolution was referred for a report back to the House of Delegates and assigned to the Council on Medical Education. This report includes: 1) the history and processes of the urology match and the ophthalmology match; 2) the advantages of a separate, early match or a single match; and 3) examples of specialties that successfully left an early matching process to join the NRMP.

BACKGROUND

Currently, the vast majority of allopathic specialties use the application and matching services provided by the Electronic Residency Application Service (ERAS) and the NRMP. Urology and ophthalmology, however, do not, in part or wholly. In addition, the match process for these two specialties occurs earlier in the year than for the NRMP. (Note: While the resolution referred to an "allopathic" match system, all programs participating in the ophthalmology match, urology match, and the NRMP are accredited by the Accreditation Council for Graduate Medical Education [ACGME]. As osteopathic-focused programs become ACGME-accredited they will join these match systems.)

History and Process of the Ophthalmology Match

Training in ophthalmology requires three years of the field, preceded by one year of general medical training, typically while in a preliminary position. The ophthalmology residency matching program was established in 1977 by the Association of University Professors of Ophthalmology (AUPO), and is part of the San Francisco Match (SF Match).[1] Ophthalmology was the first specialty with a matching algorithm created by August Colenbrander, MD, who created matches for other specialties that eventually became the SF Match.[2] Applicants apply to ophthalmology programs through a common application system (CAS), also maintained by the SF Match. The SF Match matches applicants to graduate year 2 (GY2) positions in ophthalmology programs. This match occurs each January; therefore, successfully matched applicants will be able to tailor their applications in ERAS and rank order lists (ROLs) in the NRMP for a preliminary (GY1) position for the NRMP main match, which occurs in March.[3] Thus, students interested in ophthalmology must submit applications through two different application services and match services. This system was created before the NRMP added the process of creating a supplemental ROL in 1988, which allows for two simultaneous matches (GY1 and GY2) for one applicant.

Scheduling. The CAS for the SF Match opens in June. The first week of September is considered a good target date for applicants to have completed their application and uploaded documents. Some international medical graduates and all graduates of Canadian medical schools have to mail some of their documentation. The CAS only allows three letters of recommendation, and all three are distributed to the programs that the applicant is applying to; specifically tailored letters to individual programs are not possible. Meanwhile, medical schools are responsible for uploading the Medical Student Performance Evaluation (MSPE) for U.S. seniors of osteopathic and allopathic medical schools. It may take up to two weeks for CAS to distribute complete applications to programs. In December, programs and applicants may begin submitting their ROLs; the deadline is the first week in January. The following week, match results are available to medical schools, programs, and applicants, and vacancies (unfilled positions) are posted on the SF Match website.[1]

In conjunction with the SF Match scheduling, an applicant interested in ophthalmology training must find a GY1 position, most likely through ERAS and the NRMP, with different calendars and deadlines, which are described later in this report.

Fees for the SF Match. A $100 registration fee for applicants covers registration and matching. In addition, the CAS charges fees for the initial distribution of applications:

Number of CAS Distributions	Fees
1 - 10	$60 total
11 - 20	$10 per program
21 - 30	$15 per program
31 - 40	$20 per program
41 or more	$35 per program

Subsequent distributions of applications (after the initial distribution) cost $35 per program.

The registration fee for new ophthalmology programs is $325, which includes the membership fee for the current year. An annual membership fee for programs is $125, regardless of the number of positions the program offers.[1]

Match statistics. The SF Match website posts statistics for the ophthalmology match for the past 11 matches. Although these data are not as comprehensive as those provided by the NRMP, the viewer can get an estimate of the competitiveness of the ophthalmology match. For example, in the 2016 match, U.S. seniors (presumably both osteopathic and allopathic) made up 92% of those who matched. All but two of the 469 positions were filled, the average USMLE Step 1 score of matched applicants was 244 (average score of unmatched applicants was 229), the average number of applications per applicant was 68 (with approximately 110 programs participating), and the average number of interview offers received was 4.4 per applicant.[4]

History and Process of the Urology Match

Originally, students and urology residency programs did not use a centralized system of pairing up. In 1985, however, the American Urological Association (AUA) created the urology match, with advice from August Colenbrander, MD, who created the ophthalmology match; like ophthalmology, urology requires a prior year of training before a resident begins urology training in GY2. The AUA elected not to use the services of the NRMP, since at that time the NRMP did not manage simultaneous matches of GY1 and GY2 years, nor did it choose the services of the SF Match, as the AUA and the American Board of Urology desired to more closely monitor resident training from entry into the match through to board certification.[5] Applicants intending to match into a urology program must register with the Urology Residency Match Program (Urology Match) on the AUA's website. The AUA does not have its own application services; students are directed to ERAS to apply to urology programs. This match occurs each January. Successfully matched applicants must then obtain GY1 positions, generally in surgery. Unlike ophthalmology, urology programs tend to have arrangements for GY1 positions with local surgical programs. Students are advised that "applicants matched with certain urology training programs will have adequate time to go through the NRMP match for the general training which is required prior to beginning urological training. This is a formality required by some surgery department/divisions and they will provide the code to submit on the preference form for the NRMP match."[6]

Scheduling. In June, students register with the Urology Match on the AUA's website. Students must then apply to programs of interest; although most urology programs participate in ERAS, it is not a requirement of the AUA Match that they do so. Programs and students can submit their ROLs in November. The deadline occurs during the first week of January. During the second week, the match is held, and the results are announced to students, medical schools, and programs during the third week. Those matching into urology programs that do not have a GY1 surgical position "built-in" then need to register with the NRMP and submit their ROL.[6]

Fees for the Urology Match. Students registering with the Urology Match pay a $75 fee. Programs pay a $100 fee to register for the match, and $25 per position posted in the match.

Match statistics. The AUA website posts match statistics for six years, with more detailed statistics available for 2016.[7] Again, as with ophthalmology, the statistics provided are not as detailed as what the NRMP offers, but the viewer can get an estimate of the competitiveness of the Urology Match. For example, in the 2016 match, 77% of the 356 U.S. seniors (presumably both osteopathic and allopathic) who submitted a ROL matched into a program, and 51% of whom got their first or second choice. U.S. seniors made up 85% of those who matched. All but one of the 295 positions was filled, the average number of applications per applicant was 65 (with 124 programs participating), the average number of interviews taken by applicants was 10, and the average number of programs ranked by applicants who matched was 14.

ADVANTAGES OF SEPARATE AND COMBINED MATCHES

Advantages of a Separate Specialty Match System

Presumably many successful applicants to ophthalmology and urology programs are relieved to learn the news of their match earlier than their peers, and to have some or all of the guesswork involved in finding a GY1 position removed by an early match. Receiving interview offers for a GY2 position in a particular geographic area can help in application and interview strategies for a GY1 position. Once the match has occurred, submitting a precisely tailored ROL for the GY1 position reduces potential conflict in choices. Potentially unsuccessful candidates who do not receive interview offers from early match programs still have time to apply to programs in other specialties through ERAS. It is generally assumed, however, that the two specialties operating the matches are the main beneficiaries of an early match, both in the scheduling and in the ownership, which provide financial benefits as well.

The early match allows the two specialties to get an early view and pick of applicants who could also be successful candidates for other specialties, particularly other surgical specialties. Owning the process of the match can be financially remunerative as well, especially in the case of the SF Match, as it runs its own application service. The AUPO owns the SF Match, which runs several other matches as well, such as for plastic surgery (independent programs), and 23 fellowships. Revenue generated for the AUPO from the SF Match in 2014 was $1.4 million.[8] The ophthalmology match is by far the biggest match for the SF Match. There were 726 CAS registrants in the 2016

ophthalmology match. At the average number of 68 applications per applicant, those fees would have generated close to $1.1 million.

The AUPO could retain the CAS for ophthalmology programs but have the match run by the NRMP; unlike ERAS, which requires 80% of programs in a specialty to participate, the NRMP does not have minimum proportion of programs within a specialty to agree to use their matching services. Any number of ophthalmology programs could use the NRMP for matching.

Besides the Urology Match, the AUA also administers matches for five urology fellowships. Since the AUA does not manage the applications for the Urology Match or for the fellowships, the income generated by running the matches is not comparable to what the AUPO can realize. For example, there were 468 registrants in the 2015 Urology Match, paying $75 each, totaling $35,100. Program participation would have generated nearly $20,000 for registration and fees per vacancy. The main value of the match for the AUA is likely its stated interest in more closely monitoring resident training from entry into the match through to fellowship training.[5]

Advantages of Moving to a Single Match

The primary impetus of the early match for ophthalmology and urology, as well as other specialties that once had an early match (and do no longer), was the need to interview and match applicants for their GY2 year. There was still time after the early match for the applicant who did not match into one of these specialties to attempt to find a GY1 position in another specialty through the NRMP. For the applicant who did match into one of these specialties, there was adequate time to tailor an application for a GY1 position, apply through ERAS, and match into a GY1 position through the NRMP.

In 1988, however, the NRMP began offering GY2 positions through its match, and in turn providing the opportunity for applicants to create a supplemental ROL to match into a GY1 position. For every program with GY2 positions that an applicant is interested in pursuing, the applicant can pair preferences for programs that have GY1 positions. Applicants thus have the possibility of simultaneously securing GY1 and GY2 positions. It is possible to match into a GY2 position and not the corresponding GY1 position, in which case the applicant needs to obtain a GY1 position in the Supplemental Offer and Acceptance Program (SOAP). The NRMP matching algorithm will not place an applicant in a GY1 position until the applicant has matched into a GY2 position.[9]

In addition, beginning in 1984, the NRMP included another sophisticated match process that enables two applicants to link their ROLs. Commonly called the “couples match,” the two applicants’ ROLs form pairs of program choices that are considered in the algorithm. A match only occurs when both members of the couple match into a linked pair of programs; i.e., if partner A matches into a rank 1 program, but partner B does not match into a rank 1 program, a match does not occur, and the algorithm will continue processing until both partners are matched into similarly ranked programs.

In contrast, neither the SF Match nor the Urology Match can process linked ROLs. Applicants to urology or ophthalmology using the NRMP for matching into GY1 positions may link their ROLs with a partner. For couples in which one member is matching into a GY2 NRMP position, such as for radiology, and the other into a GY1 position, the “couples match” can aid the process, but only insofar as linking the primary ROL, not the supplemental ROL. For example, partner A ranks a radiology advanced program (GY2) in Boston as rank 1, with a supplemental ROL for a GY1 position in the Boston area. Partner B ranks a GY1 in the Boston area as rank 1. Both partners may match into their rank 1 programs, but there is no corresponding guarantee of partner A matching into the rank 1 GY1 position on the supplemental ROL. Partner A may match into a GY1 position farther down the ROL. To prepare for such possibilities, paired ROLs can be become fairly complicated and lengthy, particularly in cases of GY2 positions and supplemental ROLs.[10,11]

Nonetheless, despite this complexity, participants in the “couples match” are generally successful in the NRMP match. Match rates have been above 90 percent since the NRMP starting linking ROLs, and in 2016 the match rate was 95.7% for one or both members of the couple, the highest ever.[12]

In addition, the greater size and sophistication of the NRMP as a matching organization may protect it (and applicants) from error. In 2005, the Urology Match had to be re-run. Several programs found themselves unexpectedly unfilled. After review, it was found that one of the criteria in the match was not applied correctly,

skewing the outcome; namely, the ROLs of program directors had been considered more heavily than the ROLs of applicants. ROLs of applicants were always to be prioritized over the ROLs of program directors. The match was run again, and four days later new results were announced. Upon further review, it was found that the misapplication of the matching algorithm was secondary to human error, coupled by a lack of review of the results. More safeguards were applied, and no problems have been reported since.[5]

Additional benefits of the NRMP and ERAS over the Urology Match and the SF Match include the availability of additional data for review and consideration by students, program directors, and medical school advisors. The NRMP releases annual or semi-annual reports based on analysis of NRMP match data, as well as of surveys of program directors and applicants. Historical statistics and reports are posted on the NRMP website as well.[13] ERAS also has available statistics going back several years.[14] Although both the AUA and the SF Match post statistics on their website, what is available is not nearly as comprehensive and potentially helpful to applicants and their advisors as what is offered by the NRMP and ERAS.

The fact that these two specialties interview and match earlier than all other specialties may affect the ability of students to best utilize their 3rd and 4th years. Scheduling electives, sub-internships, etc., in ophthalmology or urology in the 3rd year may mean displacement of some fields into the 4th year. Some faculty have observed that the 4th year of medical school for many students appears squandered after the NRMP match; this period of "senioritis" starts even earlier for those successfully matched into urology or ophthalmology.[15]

Probably the most compelling advantages to applicants of standardizing the match process are cost and convenience. Ophthalmology applicants use two separate application and matching services. A few ophthalmology programs have an integrated GY1 year, but most do not. Therefore, applicants need to apply using ERAS, and match using the NRMP, for that position. It is recommended that ophthalmology applicants apply to 10 to 15 preliminary/transitional year programs.[16] Below are the application fees for ERAS. The registration fee for the NRMP of $75 covers the costs of ranking 20 different programs, including 20 on the primary ROL and 20 on the supplemental ROL. The NRMP charges $30 additional per program beyond the 20.

Programs per Specialty	Application Fees
Up to 10	$99
11 - 20	$12 each
21 - 30	$16 each
31 or more	$26 each

For the average applicant in the 2016 SF Match applying to 68 ophthalmology programs, the fees paid to the SF Match would be $1,590 (match registration plus application distribution). If that applicant then applied to 15 programs with GY1 preliminary positions (and not another specialty), the ERAS fee would be $239 (application distribution plus USMLE transcript fee). Adding in the NRMP fee of $75, the total paid for applying and matching for the average ophthalmology applicant would be $1,904.

If this process were housed within ERAS and the NRMP, and assuming the applicant applied to the same number of programs, and created a primary and supplemental ROL of 15 programs, the costs would be $1,447 to ERAS, and $75 to NRMP, for a total of $1,522.

Urology applicants use ERAS for applying to urology programs. Presumably they do not apply to programs for their GY1 training, as that is typically arranged through the urology residency program. The average number of applications submitted to programs in 2016 was 65 in the Urology Match. The ERAS fee would be $1,369 (application distribution plus USMLE transcript fee). Adding in the $75 Urology Match fee and the NRMP fee of $75 for matching into one program for the GY1, the total paid for applying and matching for the average urology applicant would be $1,519. The cost difference for a urology applicant if the urology match was run by the NRMP would be only $75, the Urology Match fee paid to the AUA.

Aside from costs, convenience is another factor, not only for medical students but also for student affairs deans and residency program directors and coordinators. The appendix shows a partial timeline covering residency application dates and events for rising 4th year medical students at one medical school. Not only are there additional deadlines and processes that early match students must follow, their student affairs deans must also be aware of the same

deadlines in their efforts to keep their students on track. One calendar for all specialties would greatly lessen confusion and anxiety.

PRECEDENT: SPECIALTIES THAT LEFT AN EARLY MATCH

Otolaryngology was in the SF Match until 2006, at which point it joined the NRMP. The specialty had decided to eliminate the required general surgery intern year and integrate that training into the otolaryngology program; thus, separate matching processes for surgery and otolaryngology were no longer necessary.[17] Some expressed concern that by leaving the early match, the specialty may have lessened its ability to attract highly competitive applicants, who might have found the chance of two matches (to include the NRMP, if not initially successful in the SF Match) a risk worth taking. A counterpoint to that concern was the NRMP option for applicants to attempt to match into otolaryngology and be part of the "couples match," thus attracting a different type of applicant, possibly more committed to the locale of the program. Analysis of the number of applicants, the match rate, and the Step 1 scores of successfully matched applicants before and after the switch from the SF Match to the NRMP shows no statistically significant differences that may be attributed to the different match, except that non-U.S. senior applicants had a lower match rate (34% vs. 21%).[17] In short, the match for prospective otolaryngology trainees and otolaryngology programs has become simplified, with minor effects.

Child neurology has several GME entry possibilities; one can enter a five-year training program that combines pediatrics and neurology training; a three-year program after having completed two years in pediatrics; or a three-year program after one year in pediatrics, plus one year in internal or family medicine or one year in neuroscience research. The SF Match had managed the child neurology match as an early match for years, but in 2010 the new software for SF Match could not manage a "three-tier match." The specialty switched in 2012 to the NRMP, which has managed the three types of positions in the main match (categorical, advanced, and reserved positions).[18]

Matching for neurosurgery had been managed by the SF Match as an early match until it joined the NRMP and ERAS for the 2009 match. A major impetus for the move to the NRMP was the full integration of the GY1 year into neurosurgery programs, rather than as preliminary training in general surgery programs. Other rationales provided by the Society of Neurological Surgeons included financial considerations and the ease with which other specialties had made the switch.[19] The majority of programs experienced an increase in the number of applications received, but also an increase in the quality of applicants. One perceived drawback is that students now select a "back-up" specialty in the circumstance of not matching into neurosurgery; this precludes them from participating in the SOAP for an unfilled position in neurosurgery. Given the competitiveness of neurosurgery, however, there are very few unfilled positions after the match. Overall, the transition has been considered successful.

CURRENT AMA POLICY

Currently, the AMA has several policies or directives that relate to matching into training programs, including the following, which speak to the advantages of Match process standardization.

D-310.977, "National Resident Matching Program Reform" - "Our AMA … (7) will work with the NRMP, and other residency match programs, in revising Match policy, including the secondary match or scramble process to create more standardized rules for all candidates including supplication timelines and requirements; (8) will work with the NRMP and other external bodies to develop mechanisms that limit disparities within the residency application process and allow both flexibility and standard rules for applicant."

H-310.925, "National Residency Matching Program Reform" - "Our AMA supports the National Resident Matching Program as an efficient and effective placement system for filling positions in graduate medical education in the US."

H-310.910, "Preliminary Year Program Placement" - "Our AMA encourages the Accreditation Council for Graduate Medical Education, the American Osteopathic Association, and other involved organizations to strongly encourage residency programs that now require a preliminary year to match residents for their specialty and then arrange with another department or another medical center for the preliminary year of training unless the applicant chooses to pursue preliminary year training separately."

D-310.958, "Fellowship Application Reform" - "Our AMA will (1) continue to collaborate with the Council of Medical Specialty Societies and other appropriate organizations toward the goal of establishing standardized application and selection processes for specialty and subspecialty fellowship training."

SUMMARY AND RECOMMENDATIONS

The two specialties that hold early matches are the primary beneficiaries of the current system. Ophthalmology and urology are able to control their own matches; peruse, interview and claim future residents before other specialties; and earn income from the process. Applicants may achieve an earlier sense of relief (if successfully matched) or dismay (if not) compared to their peers, and unsuccessful applicants have the opportunity to apply and match into another specialty, but all early match participants must undergo an overly long, complicated process that no longer is necessary. The NRMP successfully manages simultaneous matches into GY1 and GY2 positions for many specialties—some of which were previously with the SF Match. Applicants entering the ophthalmology and urology matches do not have the opportunity to fully participate in the NRMP "couples match," nor do they benefit from insight provided by the sophisticated data analysis and reports prepared by the NRMP. Furthermore, especially in the case of ophthalmology, the applicant faces added costs. To unduly burden the approximately 1,100 applicants annually to these two specialties during the already stressful period of attempting to enter GME, without a commensurate benefit, seems unwarranted.

The Council of Medical Education therefore recommends that the following recommendations be adopted in lieu of Resolution 310-A-16 and the remainder of this report be filed.

1. That our American Medical Association (AMA) support the movement toward a unified and standardized residency application and match system for all non-military residencies.

FOLLOWING RECOMMENDATIONS REFERRED

2. That our AMA encourage the Association of University Professors of Ophthalmology, the American Urological Association, and other appropriate stakeholders to move ophthalmology and urology to the National Resident Matching Program.

3. That our AMA encourage the National Resident Matching Program to develop a process by which sequential matches could occur for those specialties that require a preliminary year of training, allowing a match to the GY2 position, followed later in the year by a match to a GY1 position, thus reducing application and travel costs for applicants.

REFERENCES

1. SF Match. www.sfmatch.org. Accessed December 13, 2016.
2. Colenbrander A: August Colenbrander, M.D. The Smith-Kettlewell Eye Research Institute. Available at http://www.ski.org/Colenbrander/. Accessed December 13, 2016.
3. American Academy of Ophthalmology. Residency match basics for ophthalmology. https://www.aao.org/medical-students/residency-match-basics. Accessed December 13, 2016.
4. SF Match. https://www.sfmatch.org/SpecialtyInsideAll.aspx?id=6&typ=2&name=Ophthalmology#. Accessed December 13, 2016.
5. Weissbart, SJ, and Stock, JA. The history and rationale of the American Urological Association resident matching program. *Urology Practice.* 2014; 1: 205-210.
6. Matches. https://www.auanet.org/education/urology-and-specialty-matches.cfm. Accessed December 14, 2016.
7. 2016 Urology Residency Match statistics. https://www.auanet.org/common/pdf/education/specialty-match/Urology-Residency-Match-Statistics-2016.pdf. Accessed December 14, 2016.
8. 2014 Form 990 for the Association of University Professors of Ophthalmology, Inc. Available at http://www.guidestar.org/profile/42-6130779 (free registration required) Accessed December 15, 2016.
9. The National Resident Match Program. http://www.nrmp.org/match-process/create-and-certify-rol-applicants/create-a-rol-applicants/supplemental-rols/ Accessed December 15, 2016.
10. The National Resident Match Program. http://www.nrmp.org/match-process/couples-in-the-match/. Accessed December 15, 2016.
11. Ben White. Considerations for the couples match.2012. http://www.benwhite.com/medicine/considerations-for-the-couples-match/ Accessed August 26, 2016.
12. National Resident Matching Program, Results and Data: 2016 Main Residency Match®. National Resident Matching Program, Washington, DC. 2016.

13. http://www.nrmp.org/match-data/main-residency-match-data/. Accessed December 16, 2016.
14. https://www.aamc.org/services/eras/stats/359278/stats.html. Accessed December 16, 2016.
15. Aagard, EM, Abaza, M. The residency application process – burden and consequences. *NEJM.* 2016; 374(4): 303-305.
16. Vislisel, J. The Iowa Guide to the Ophthalmology Match. 2015. http://webeye.ophth.uiowa.edu/eyeforum/ tutorials/iowa-guide-to-the-ophthalmology-match.pdf. Accessed December 16, 2016.
17. Cabrera-Muffly, C, Sheeder, J, Abaza, M. State of otolaryngology match: has competition increased since the "early" match? *Otolaryngology–Head and Neck Surgery.* 2015;152(5): 838–842.
18. Singer, HS. The child neurology match: where have we been and we are we going? *Pediatric Neurology.* 2014;50: 443-446.
19. Weinstein, PR. Neurosurgery resident matching program ERAS/NRMP: AAMC. (2009) www.societyns.org/sns%20match09.ppt. Accessed December 20, 2016.

APPENDIX

2015	Residency timeline for all rising 4th year students. **Ophthalmology is bold.** Urology is underlined.
April 15th	MyERAS site opens to applicants to register and begin working on their applications.
April-May	**Review SF Match site for general information about the early match process.**
April-June	Urology Residency Match information is available on line, http://www.auanet.org Investigate on-line sources for specialty and program information, requirements and deadlines
April-July	Begin submitting application for USMLE Step 2 CS & CK. Must have Step 2 CS completed by end of December; Step 2 CK by the end of January. Register early! Put final touches on CV and personal statement
April- Sept	Begin residency program applications. Note: Individual programs set the deadlines. You should contact programs directly for their deadlines.
April- Oct	Track LoRs through ERAS Applicant Document Tracking System
May-June	**Gather SF Match CAS materials (LoRs, transcript, personal statement, application, CV)**
June	Urology registration is available through the AUA site at http://www.auanet.org/education/urology-and-specialty-matches.cfm **Early match registration is available through the SF Match site at http://www.SFMatch.org**
July 1st	Applicants may start searching for and selecting programs in MyEras.
July 15th	ERAS PostOffice opens. Residency Programs can start receiving applications.
July 18th	**An overview of the application process for early match. This session is REQUIRED.**
August 8th	An overview of the application process for regular match. This session is REQUIRED.
Aug-Sept September Sept 1st Sept 3rd	Early match students mock interviews Student review draft of MSPE (online) and review transcript Target date for ERAS applicants to register and have entered all MyERAS information. **CAS Target Date for Ophthalmology. Note: This is not a deadline. It's the target date to have your application submitted for central distribution.** NRMP registration and applicant user guide for the NRMP available at http://www.nrmp.org **Note: Students going through early match and need to secure a GY1 position must register with the NRMP.**
Sept 12th	Transcripts will be loaded to ERAS.
September 15th	ERAS PostOffice opens. Applicants may begin applying to ACGME accredited residency programs. Programs may begin contacting the ERAS PostOffice to download your application. This is also a target date to submit your application Registration for NRMP opens
Oct-Jan	Interview at residency programs
Oct 1st	MSPE release date for ERAS and CAS
November	Begin submitting rank order lists for AUA (Urology).

Nov 30th	11:59 PM Deadline to register for NRMP. Applicants who register after Nov 30th must pay an additional $50 late registration fee.
Dec-Jan	**Early match students go over RoL with advisor** **SF Match applicants submit RoL**
December	Complete Step 2 CK and CS
December 12th	Urology registration deadline
January 5th	Deadline for submitting rank order lists for AUA (Urology).
January 6th	**Deadline for submitting rank order lists for Ophthalmology**
January 13th	**Match results for Ophthalmology made available**
January 15th	Begin to enter rank order lists for NRMP.
January 21st	Match results for Urology made available
February 25th	Deadline for registration and ROL certification. NRMP ROL must be certified by 8:00 PM CST. NRMP staff will be available to answer questions during the final hours.
March 16th	Unmatched information posted on the NRMP Web site at 11:00 AM CST. Individual counseling will be available for all unmatched students.
March 20th	Match Day!

7. EXPANSION OF PUBLIC SERVICE LOAN FORGIVENESS

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS
REMAINDER OF REPORT FILED
See Policy D-305.993

INTRODUCTION

American Medical Association (AMA) Policy D-305.993 (10), "Expansion of Public Loan Forgiveness," asks that our AMA study mechanisms to allow residents and fellows working in for-profit institutions to be eligible for the Public Service Loan Forgiveness program (PSLF). This report is in response to that directive.

BACKGROUND

The PSLF allows debt relief for medical professionals who make 120 payments on their educational loans while working for a non-profit entity. Although most residency and fellowship programs are located in non-profit institutions, the for-profit or non-profit status of programs is not generally readily discernible to a medical student or resident investigating training options. Additionally, residents and fellows who are training in a non-profit university-based residency or fellowship program will be excluded from the PSLF if they are officially employees of an affiliated for-profit hospital or health system.

The PSLF is intended to encourage individuals to work in public service jobs. The remaining balance of educational loans is forgiven after a certain number of payments have been made while working for a qualified employer. Requirements for participating in the PSLF include: 1) type of loan, 2) timing of payments, 3) loan repayment program, and 4) qualifying employer.[1,2]

The only types of educational loans that qualify for the PSLF are Direct Loans (Direct Subsidized Loans, Direct Unsubsidized Loans, Direct PLUS Loans, and Direct Consolidation Loans). Other loans under another federal student loan program, such as Subsidized Federal Stafford Loans or Federal Perkins Loans, may be consolidated into a Direct Consolidated Loan, which would then be eligible for the PSLF.

Payments towards the loan that will qualify for the PSLF must have been made after October 1, 2007; they must also fulfill the required due amount and be made no later than 15 days after the due date. A total of 120 qualifying payments are required, but these payments do not have to be sequential.

The 120 payments have to be made through one of several loan repayment programs that qualify for the PSLF. Qualifying programs include any income-driven repayment plan, such as the Revised Pay As You Earn Repayment Plan (REPAYE Plan), Pay As You Earn Repayment Plan (PAYE Plan), the Income-Based Repayment Plan (IBR Plan), the Income-Contingent Repayment Plan (ICR Plan), or the 10-year Standard Repayment Plan. The PSLF will forgive loan balances after the 120 payments are made; most individuals will still have a balance if they are making payments through REPAYE, PAYE, IBR or ICR plans, as they are income-based.

Qualifying employers include the following:

- All federal, state, local, or tribal government agencies or organizations;
- Public colleges and universities, public child and family service agencies, and special governmental districts (including entities such as public transportation, water, bridge district, or housing authorities);
- Non-profit organizations that are tax-exempt under section 501(c)(3) of the Internal Revenue Code; and
- Non-profit organizations that are not tax-exempt under section 501(c)(3) of the Internal Revenue Code, but which provide a qualifying public service, including emergency management, public safety, public service for individuals with disabilities and the elderly, and public health (including full-time health care practitioners).

To be eligible for forgiveness after making 120 qualifying payments, the individual must be employed full-time (at least 30 hours per week) by a qualifying employer at the time each qualifying payment is made, at the time the application for loan forgiveness is made, and at the time loan forgiveness is received.

Prior to graduation, medical students are encouraged to request from the Office of Federal Student Aid of the U.S. Department of Education an income-based repayment plan (REPAYE, PAYE, IBR or ICR). After graduation, the applicant should consolidate qualifying loans into a Direct Loan. Once in a residency program, the resident should submit an Employment Certification Form to FedLoan Servicing, an organization approved by the Department of Education to service loans owned by the federal government, and the only organization that manages the PSLF. The resident will work with his or her employer to fill out the form, and the employer will need to certify that the organization is a qualifying public service organization, state the time frame of employment, and stipulate that the resident worked at least 30 hours per week. Although the form can be submitted retroactively, it is advised that the resident submit the form annually, and while employed by the qualifying employer. Residents should retain documents supporting qualifying employment, such as pay stubs and W2 forms.[3]

To date, no one has actually qualified for the PSLF. The earliest date an applicant can qualify is October 2017, at which point the program will have been in existence 120 months. Participants in any of the income-based repayment plans will have their loan paid back (with interest) and any balance forgiven after a maximum of 240 payments; the PSLF requires half the payments, after which time the balance is forgiven. A repayment plan such as the PAYE plan allows graduates—now residents—to pay a minimum 10 percent of their monthly discretionary income (total income minus any deductions minus 150 percent of the federal household poverty level) towards loan repayment.[4] Once the individual is out of training and receiving a more substantial salary compared to residency, the maximum loan payment is capped at the equivalent of a 10-year level repayment note. Student loan amounts forgiven under the PSLF are not considered income, and therefore are non-taxable.

Not surprisingly, the program is very popular among medical students, who, as a group, have particularly high educational indebtedness. In 2010, Friedman and colleagues found that 11 percent of medical school graduates responding to the Association of American Medical Colleges' (AAMC) Graduation Questionnaire indicated that they intended to participate in PSLF; by 2014, 25 percent intended to participate.[5] In each of the four years studied the rate of intended participation grew 21 percent.

CONCERNS ABOUT THE PSLF

Challenges for Residents and Fellows

Graduating medical students may intend to participate in the PSLF while employed as a resident, but be unable to for several reasons. During the match process, medical students rank residency programs based on the quality of training they perceive they are likely to receive, among other variables. They may not be aware of or have access to information about the for-profit status of the entity that will pay their salary. Graduate medical education often takes place within complicated institutional arrangements of "sponsoring" and "participating" institutions. Even if

residents and fellows rotate to several non-profit clinical sites, and funds are contributed to that salary by non-profit or government institutions, the institution writing the salary check may not be non-profit and thus not be a qualifying employer for the PSLF.[6]

Even if students are aware of the profit status of the programs to which they are applying, they may not feel they can only rank those programs that are non-profit in order to assure a match. Further, they are obligated by their binding agreement with the National Resident Matching Program (NRMP) to begin training at the institution to which they are matched, even if it precludes their participation in PSLF.[6]

Finally, mergers and takeovers of hospitals can create a situation in which trainees who had been working in a non-profit hospital may find their salaries subsequently paid by a for-profit organization, thus postponing or ending their eligibility to participate in the PSLF.[6]

Unintended Consequences of Loan Forgiveness Programs

Articles in the press have cautioned that students in graduate and professionals schools may borrow more than they normally would in anticipation of ultimately being relieved of the debt through loan forgiveness programs, such as the PSLF. These articles posit that this trend contributes to ever-increasing higher education costs that affect all students.[7,8] Indeed, it has been suggested that graduate and professional schools deliberately market the benefits of income-based repayment plans (and the PSLF) to students, rather than working to make graduate education more affordable.[9] The harshest critics suggest that these programs, by providing unlimited loans with the prospect of forgiveness, create a moral hazard for borrowers who acquire debt with little intention of completely repaying, while taxpayers are left subsidizing their education and educational institutions continue to charge high tuition.[7]

Friedman and colleagues' analysis of the workforce implications of loan forgiveness programs found that the highest proportion of graduating medical students intending to use loan forgiveness were those entering a specialty that could lead to a primary care career. However, these were followed closely by those planning surgical and medical subspecialty careers. Although the intent of the PSLF was not to increase the number of primary care physicians, it is a possible side benefit. Friedman et al. raise concerns that the PSLF may divert resources from the National Health Service Corps (NHSC) program, which has an explicit goal of increasing primary care physicians in underserved areas.[5] Indeed, analyses modeling prospective incomes of physicians in internal medicine who participate in the NHSC found that they may realize greater financial value over time compared to those who borrow and then repay their loans through the PSLF.[10] Accordingly, medical students may wish to consider service in the NHSC not only as an altruistic opportunity to provide health care to patients in need but as a wise career decision offering long-term financial benefits. Nonetheless, there are shortages of physicians in many specialty areas in the US and regional shortages in most specialties, thus physicians taking advantage of the PSLF and not entering primary care may still ultimately serve a population for which their specialty is in short supply.

Potential Costs to Taxpayers, Congressional Scrutiny, and Proposed Caps

An additional criticism of debt forgiveness programs is that they may disproportionately be used by people with potential to earn high incomes. This has led policymakers to explore ways to limit the resources required for the programs.

It is estimated that the federal cost of the PSLF for medical school graduates in 2014 alone, once they have completed their 120 payments, will be over $316 million.[5] The U.S. Department of Education estimates that the federal costs of all income-based repayment plans (and not just the PSLF) will be $74 billion for loans taken out between 1995 and 2017.[11] Thus, this program has received scrutiny by policymakers, with proposals to cap the amount of debt that can be forgiven. President Obama's 2016 budget proposal included a $57,500 cap on the amount of debt forgiven. This would put the maximum amount of debt forgiven more in line with the average debt of undergraduate education than graduate education, especially medical school. Another proposal would make only one income-based repayment plan available to new borrowers (as opposed to the current four) and target more generous benefits to those with lower incomes.[11] If such proposals were passed, they would be likely to affect future loan recipients and not those already participating in repayment programs.

Policymakers will likely continue to explore ways to reduce the cost of these programs and assure they are meeting the intended need.

POTENTIAL MODIFICATIONS TO PROTECT THE PSLF

Several different modifications have been suggested for the PSLF. As there are well described shortages in various medical specialties, especially primary care fields, some have proposed limiting the PSLF to those physicians who train and practice in primary care fields.[5] It is well established that future earning potential is one of many factors medical students consider when selecting their specialty, so this proposal might not only decrease the overall cost of the PSLF (by excluding participation by specialists), but could also increase the number of primary care physicians in the workforce.

However, this proposal has significant downsides. Definitions of primary care differ; some include surgical fields and some do not, and picking any single list could pit specialties against each other. Additionally, as some of the specialties omitted typically have longer training periods, this proposal would ask physicians with the longest period of low salary to pay back the full portion of their loans, while allowing those who have graduated from their residency and are now earning a salary in practice to receive significant loan reimbursement.

Other suggestions have focused on restricting loan reimbursement to those who practice in underserved areas (such as designated Health Professional Shortage Areas). This would allow physicians to practice in their area of interest without sacrificing the ability to participate in the PSLF, while still limiting reimbursement to those who are serving the nation's health care needs.

One other potential solution would be to appoint a non-partisan independent authority to supervise the program and its evolution, and provide course correction as necessary. A concern, however, is that a physician (or teacher) could be at year eight of ten in non-profit service under current conditions, only to have the authority change eligibility criteria and negate the previous years of service. This could be easily avoided by simply having all "course corrections" take effect in the future, allowing everyone who is grandfathered into the program to complete their payments and receive their loan forgiveness, although such a delay would also render these course corrections much less productive at reducing costs to taxpayers.

As medicine becomes more complex, more physicians are lengthening their training in the form of fellowships and "super-fellowships." This means that more physicians will change institutions during their training, putting them at risk for increasing the length of their loan repayment period, as loan payments made while working at a for-profit institution do not qualify for the PSLF. As trainees often pursue the best education available irrespective of salary and, certainly, of the profit status of the institution, the profit status of graduate medical education training institutions should not be a qualification for PSLF eligibility. A physician who provides primary care or needed subspecialty care in a federally designated Health Professional Shortage Area while training at a for-profit institution should certainly be eligible for the PSLF.

CURRENT AMA POLICY

The AMA has several policies or directives that relate to medical school debt and public loan forgiveness. In particular:

D-305.993, "Medical School Financing, Tuition, and Student Debt," states that the AMA will advocate for ongoing, adequate funding for programs that provide scholarship or loan repayment funds in return for service; urge the Accreditation Council for Graduate Medical Education to revise its Institutional Requirements to include financial planning/debt management counseling for residents; and advocate against a cap on federal loan forgiveness programs but also advocate that any cap on loan forgiveness under the PSLF program be at least equal to the principal amount borrowed.

H-305.928, "Proposed Revisions to AMA Policy on Medical Student Debt," states that our AMA support new and expanded medical education assistance programs from the federal government; support legislation and regulation that produce favorable terms and conditions for borrowing and loan repayment; and support expansion and increase of medical student and physician benefits under PSLF.

H-305.991, "Repayment of Education Loans," states that the AMA will encourage medical schools to counsel medical student borrowers on the status of indebtedness and payment schedules prior to graduation.

D-305.975, "Long-terms Solutions to Medical Student Debt," states that our AMA will advocate for increased funding for the NHSC Loan Repayment Program to assure adequate funding of primary care within the NHSC; and encourage the NHSC to have repayment policies consistent with other federal loan forgiveness programs, to decrease the amount or loans in default and increase the number of physicians practicing in underserved areas.

SUMMARY AND RECOMMENDATIONS

Overall, the physician community may be forced to recognize that its training paradigm is outside the initial scope of the PSLF. Although the training period is long and arduous, and residents and fellows are relatively poorly reimbursed, physician salaries remain substantial, making the argument for loan forgiveness a delicate one. When focusing on improvements to the PSLF, we must remain cognizant of these facts.

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

1. That our American Medical Association (AMA) encourage the Accreditation Council for Graduate Medical Education (ACGME) to require programs to include within the terms, conditions, and benefits of appointment to the program (which must be provided to applicants invited to interview, as per ACGME Institutional Requirements) information regarding the Public Service Loan Forgiveness (PSLF) program qualifying status of the employer.

2. That our AMA rescind Policy D-305.993 (10), as having been fulfilled by this report.

3. That our AMA reaffirm Policy D-305.993 (1-9), which asks that the AMA advocate against a cap on federal loan forgiveness.

4. That our AMA advocate that the profit status of a physician's training institution not be a factor for PSLF eligibility.

5. That our AMA encourage medical school financial advisors to counsel wise borrowing by medical students, in the event that the PSLF program is eliminated or severely curtailed.

6. That our AMA encourage medical school financial advisors to promote to medical students service-based loan repayment options, and other federal and military programs, as an attractive alternative to the PSLF in terms of financial prospects as well as providing the opportunity to provide care in medically underserved areas.

7. That our AMA strongly advocate that the terms of the PSLF that existed at the time of the agreement remain unchanged for any program participant in the event of any future restrictive changes.

REFERENCES

1. U.S. Department of Education's Office of Federal Student Aid. Public Service Loan Forgiveness Program. https://studentaid.ed.gov/sa/sites/default/files/public-service-loan-forgiveness.pdf. Accessed January 9, 2017.
2. U.S. Department of Education's Office of Federal Student Aid. Public Service Loan Forgiveness: Questions and Answers for Federal Student Loan Borrowers. https://studentaid.ed.gov/sites/default/files/public-service-loan-forgiveness-common-questions.pdf. Accessed January 9, 2017.
3. AAMC. 2016. Public Service Loan Forgiveness (PSLF): Eligibility and Action Plan. https://aamc-orange.global.ssl.fastly.net/production/media/filer_public/04/6b/046b203d-0d89-48da-9ecd-74b62b8622cd/2016_pslf_eligibility_and_action_plan__2_pages.pdf. Accessed August 22, 2016.
4. Moldrem C. Medical student loan forgiveness: programs exist to wipe away debt. *Medical Economics*, May 8, 2014 http://medicaleconomics.modernmedicine.com/medical-economics/content/tags/debt/medical-student-loan-forgiveness-programs-exist-wipe-away-debt. Accessed August 4, 2016.
5. Friedman AB, Grischkan JA, Dorsey ER, George BP. Forgiven but not relieved: US physician workforce consequences of changes to public service loan forgiveness. *JGIM* 2016 Oct;31(10):1237-41.
6. Daily M. Docs push for loan forgiveness. MD Magazine. June 27, 2016. http://www.mdmag.com/medical-news/docs-push-for-loan-forgiveness. Accessed August 2, 2016.
7. Mitchell J. Grad-school loan binge fans debt worries. The Wall Street Journal, August 18, 2015. http://www.wsj.com/articles/loan-binge-by-graduate-students-fans-debt-worries-1439951900. Accessed August 22, 2016.

8. Leef G. Our generous Uncle Sam: lenient college debt encourages students to keep borrowing and hunt for "public service" jobs. Forbes, May 8, 2014. http://www.forbes.com/sites/georgeleef/2014/05/08/our-generous-uncle-sam-lenient-college-debt-rules-encourage-students-to-keep-borrowing-and-hunt-for-public-service-jobs/#71decd0f104b. Accessed August 22, 2016.
9. Delisle J, Holt A. Safety net or windfall? Examining changes to income-based repayment for Federal student loans. New American Foundation, October 2012.
10. Marcu MI, Kellerman AL, Hunter C, Curtis J, Rice C, Wilensky GR. Borrow or serve? An economic analysis of options for financing a medical school education. *Acad Med*, January 24, 2017, doi: 10.1097/ACM.0000000000001572
11. GAO. Federal student loans. Education needs to improve its income-driven repayment plan budget estimates. November 2016. http://www.gao.gov/assets/690/681064.pdf. Accessed November 10, 2016.

8. ACCME® PROPOSED CHANGES IN "ACCREDITATION WITH COMMENDATION" CONTINUING MEDICAL EDUCATION CRITERIA ASSESSMENT METHODOLOGY

Informational report; no reference committee hearing.

HOUSE ACTION: FILED

American Medical Association (AMA) Policy D-300.977, "ACCME Proposed Changes in 'Accreditation with Commendation' Continuing Medical Education Criteria Assessment Methodology," asks that the AMA continue to monitor the proposed Accreditation Council for Continuing Medical Education (ACCME®) "Accreditation with commendation" criteria, provide input to the ACCME Board of Directors, and report to the AMA HOD once the criteria are approved and implemented.

The new criteria and an implementation timeline have now been approved by the ACCME. This informational report will: 1) provide background on the ACCME's development of the recently adopted Menu of New Criteria for Accreditation with Commendation and the role of the Council on Medical Education in monitoring the process; 2) describe the Menu of New Criteria for Accreditation with Commendation and provide information about additional ACCME documents available for use by providers; and 3) describe the implementation timeline.

BACKGROUND

In 2011, the Board of Directors of the ACCME, as part of its strategic planning, reviewed accreditation data that included how continuing medical education (CME) providers had been implementing the 2006 Accreditation Criteria. After that review the Board set a goal to further "simplify and evolve the accreditation requirements and process." The ACCME Board used feedback from stakeholders to help formulate this goal and throughout 2012 sought information from the CME community on how to proceed. In May 2013, based in part on that information and other discussions, the ACCME published a 27-page document describing the accreditation process and incorporating a set of recommended changes to streamline the process and requirements, including changes to the commendation requirements. As part of the continuing effort of engagement with the CME community, the Board requested feedback on the proposed changes prior to voting on them.[1]

On December 17, 2013, after approval by its Board at their December 5-6, 2013 meeting, the ACCME announced a public call for comment on its Simplification Proposal. The proposed changes in this document were almost identical to those found in the March 2013 document but did not include changes to the Accreditation with Commendation requirements. These were omitted "in order to expedite the simplification process, in response to stakeholders' requests."[2] On February 25, 2014, the ACCME announced that the Board had adopted the Simplification Proposal and was developing a menu of potential new commendation criteria to be shared with the CME community when available.[3]

On April 23, 2014, the ACCME released a new proposal for evolving the criteria for Accreditation with Commendation, which incorporated feedback received up to that point. This new proposal introduced the idea of giving accredited CME providers the ability to choose criteria that would be appropriate for their organization from a menu of options. The ACCME again engaged the CME community by seeking feedback on the evolving Accreditation with Commendation documents, and a video tutorial was also provided. A webinar to discuss the

proposal was offered on May 13; participants were encouraged to review the documents and video tutorial, complete a pre-webinar survey, and submit questions.[4]

On January 12, 2016, the ACCME issued a new call for comments, to be submitted by February 16. The document released at that time provided a menu of options that incorporated feedback to the draft proposal that was circulated in 2014.[5] On March 31, 2016, the ACCME reported that it had received comments from 245 respondents, who submitted 2,615 comments;[6] the ACCME also published the 320 pages that constituted the full set of comments.[7]

The ACCME published the Menu of New Criteria for Accreditation with Commendation on September 29, 2016.[8] It was the culmination of several years of work and engagement with the CME community in multiple ways and venues and included several calls for comment over the years as already described. Throughout this process, the Council on Medical Education, on behalf of the AMA, has monitored the ACCME's proposed criteria and has availed itself, when appropriate, of opportunities to provide input to the ACCME Board of Directors.

In addition to regular attendance at the general sessions of the ACCME Board of Directors meetings three times a year by an AMA staff liaison, the ACCME Board also includes two members of the Council on Medical Education, nominated by the AMA and elected by the ACCME. They provide their own perspective during the discussions of the Board as well as convey information from the Council on Medical Education. The ACCME's engagements with the CME community provided additional opportunities for the AMA to provide feedback. The Council on Medical Education will continue to monitor the implementation of the Menu of New Criteria for Accreditation with Commendation and provide input as necessary.

MENU OF NEW CRITERIA FOR ACCREDITATION WITH COMMENDATION

In conjunction with the announcement noted above, other documents released by the ACCME provided additional details about the Menu of New Criteria for Accreditation with Commendation.[9]

The Menu of New Criteria for Accreditation with Commendation is sorted into five groupings, each one with three or, in one case, four criteria for a total of 16 criteria, C23 to C38. Each criterion includes a rationale for its inclusion, critical elements that would be required to show compliance, and the standard used to measure compliance. A table, published by the ACCME, is attached in the Appendix to this report and includes all the elements listed above. Some of the criteria apply to individual CME activities while other criteria relate to the CME program of the CME provider as a whole. The standards on how to demonstrate compliance provide information for each criterion as well as quantifying, where appropriate, how many activities in which providers have to demonstrate compliance to consider the criterion met.

Grouping: Promotes Team-Based Education

- C23. Members of interprofessional teams are engaged in the planning and delivery of interprofessional continuing education (IPCE).
- C24. Patient/public representatives are engaged in the planning and delivery of CME.
- C25. Students of the health professions are engaged in the planning and delivery of CME.

Grouping: Addresses Public Health Priorities

- C26. The provider advances the use of health and practice data for healthcare improvement.
- C27. The provider addresses factors beyond clinical care that affect the health of populations.
- C28. The provider collaborates with other organizations to more effectively address population health issues.

Grouping: Enhances Skills

- C29. The provider designs CME to optimize communication skills of learners.
- C30. The provider designs CME to optimize technical and procedural skills of learners.
- C31. The provider creates individualized learning plans for learners.
- C32. The provider utilizes support strategies to enhance change as an adjunct to its CME.

Grouping: Demonstrates Educational Leadership

C33. The provider engages in CME research and scholarship.
C34. The provider supports the continuous professional development of its CME team.
C35. The provider demonstrates creativity and innovation in the evolution of its CME program.

Grouping: Achieves Outcomes

C36. The provider demonstrates improvement in the performance of learners.
C37. The provider demonstrates healthcare quality improvement.
C38. The provider demonstrates the impact of the CME program on patients or their communities.

REQUIREMENTS TO ACHIEVE ACCREDITATION WITH COMMENDATION

As is the case currently, a provider may choose to be accredited, and retain accreditation, by demonstrating compliance with Accreditation Criteria 1-13 without meeting any of the items in the Menu of New Criteria for Accreditation with Commendation. Those CME providers wishing to pursue Accreditation with Commendation under the new menu format will need to demonstrate compliance with eight Criteria out of the 16 listed above, with at least one from the "Achieves Outcomes Grouping" (C36, C37 or C38). That is in contrast to the current requirements, which state that to achieve Accreditation with Commendation all seven Commendation criteria, C16-22, must be met.

This new approach with the Menu of New Criteria for Accreditation with Commendation will offer CME providers flexibility in that they can choose with which criteria they will aim to demonstrate compliance.

ADDITIONAL RESOURCES

Besides the two documents already referenced, the ACCME has provided or will provide in the future additional opportunities for information about the Menu of New Criteria for Accreditation with Commendation:

- Introduction to the Menu of New Criteria for Accreditation with Commendation: Video commentary with Graham McMahon, MD, MMSc, President and CEO, ACCME[10]
- Ask ACCME about the Menu of New Criteria for Accreditation with Commendation[11]
- FAQs available on the ACCME website[11]
- Introductory Webinar — Menu of New Criteria for Accreditation with Commendation: October 13 from 10:30 am-11:30 am Central – Archived[12]
- ACCME 2017 Meeting: April 24–27 in Chicago; includes sessions focused on the Menu of New Criteria for Accreditation with Commendation[13]
- The ACCME has announced that it will also produce an Outline for the Self-Study Report, providing specific guidance for all of the new criteria.

IMPLEMENTATION TIMELINE

The new criteria assessment methodology is gradually being implemented, and accredited CME providers will fall into one of two categories. Those that will receive accreditation decisions between November 2017 and November 2019 can choose between Option A (Commendation Criteria) or Option B (Menu of New Criteria for Accreditation with Commendation) to be considered for accreditation with commendation; those that receive accreditation decisions after November 2019 will be required to pursue Option B only to be considered for accreditation with commendation. Consider, for example, an accredited provider whose accreditation period runs from 2014 to 2020. While the span of that provider's accreditation period covers both time periods outlined in Option A and Option B, the end date—2020—falls after the November 2019 cut-off. This provider therefore has only the choice of pursuing Option B—demonstrating compliance with a menu of eight criteria—to be considered for accreditation with commendation. This hypothetical provider should think carefully about which data it will need to accumulate to demonstrate the standards for compliance determined by the menu items it selects, and this self-evaluation may lead the provider to change its planned offerings for the remainder of the evaluation period so that these offerings achieve their intended target.

State-accredited providers should check with their recognized state medical society for more information about the timeline for their state.

SUMMARY

The ACCME's Menu of New Criteria for Accreditation with Commendation, developed and introduced after soliciting and incorporating multiple rounds of feedback from the wider CME community, is intended to offer CME providers flexibility by allowing them to choose the criteria with which they feel best prepared to demonstrate compliance. As it was only released on September 29, 2016, however, there are no data yet to report regarding providers' use of the New Criteria. As providers begin to move through this new process, the Council on Medical Education will, and the CME community should also, continue to monitor successes and challenges to ensure that the results are beneficial for educators, physicians and patients alike. The Council on Medical Education will report back to the House of Delegates when new information becomes available.

REFERENCES

1. Proposal for Simplifying and Evolving the Accreditation Requirements and Process. ACCME. Available at: http://www.accme.org/sites/default/files/2013_05_Simplification_Proposal_Public_Release.pdf (accessed 4-12-17).
2. Accreditation Council for CME Releases Call for Comment on Simplification Proposal. ACCME. Available at: http://www.accme.org/news-publications/news/accreditation-council-cme-releases-call-comment-simplification-proposal (accessed 4-12-17).
3. Accreditation Council for CME Announces Simplification of Accreditation Requirements and Process. ACCME. Available at: http://www.accme.org/news-publications/news/accreditation-council-cme-announces-simplification-accreditation-requirements (accessed 4-12-17).
4. Accreditation Council for CME Presents Proposal for new Criteria for Accreditation with Commendation. ACCME. Available at: http://www.accme.org/news-publications/news/accreditation-council-cme-presents-proposal-new-criteria-accreditation (accessed 4-12-17).
5. Proposal for a Menu of new Criteria for Accreditation with Commendation, January 2016. ACCME. Available at: http://www.accme.org/sites/default/files/718_20160112_Proposal_for_a_Menu_of_New_Criteria_for_Accreditation_with_Commendation.pdf (accessed 4-12-17).
6. Call for Comment Summary, Proposal for a Menu of New Criteria for Accreditation with Commendation. ACCME. Available at: http://www.accme.org/sites/default/files/724_2016_03_Commendation_Criteria_Call_for_Comment_Summary_0.pdf (accessed 4-12-17).
7. Call for Comment Responses: Proposal for a Menu of new Criteria for Accreditation with Commendation. ACCME. Available at: http://www.accme.org/news-publications/publications/call-comment-summaries/call-comment-responses-proposal-menu-new (accessed 4-12-17).
8. Accreditation Council for CME Announces New Commendation Criteria. ACCME. Available at: http://www.accme.org/printpdf/news-publications/news/accreditation-council-cme-announces-new-commendation-criteria (accessed 4-12-17).
9. Menu of New Criteria for Accreditation with Commendation. ACCME. Available at: http://www.accme.org/sites/default/files/731_20160929_Menu_of_New_Criteria_for_Accreditation_with_Commendation_3.pdf (accessed 4-12-17).
10. Introduction to the Menu of New Criteria for Accreditation: Video Commentary with Graham McMahon, MD, MMSc, President and CEO, ACCME. ACCME. Available at: http://www.accme.org/education-and-support/video/commentary/new-commendation-criteria (accessed 4-12-17).
11. Ask ACCME Category: Menu of Criteria for Accreditation with Commendation (Option B). ACCME. Available at: http://www.accme.org/ask-accme/all?term_node_tid_depth=8060&search= (accessed 4-12-17)
12. Introductory Webinar – Menu of New Criteria for Accreditation with Commendation (ARCHIVED). ACCME. Available at: http://www.accme.org/education-and-support/video/commentary/introductory-webinar-menu-new-criteria-accreditation (accessed4-12-17).
13. ACCME 2017 Meeting. ACCME. Available at: http://www.accme.org/ACCME2017meeting (accessed 4-12-17).

Menu of New Criteria for Accreditation with Commendation

Criterion		Rationale	Critical Elements	The Standard
Promotes Team-Based Education				
C23	Members of interprofessional teams are engaged in the planning and delivery of interprofessional continuing education (IPCE).	Interprofessional continuing education (IPCE) occurs when members from two or more professions learn with, from, and about each other to enable effective interprofessional collaborative practice and improve health outcomes. This criterion recognizes accredited providers that work collaboratively with multiple health professions to develop IPCE.	☐ Includes planners from more than one profession (representative of the target audience) AND ☐ Includes faculty from more than one profession (representative of the target audience) AND ☐ Activities are designed to change competence and/or performance of the healthcare team.	Attest to meeting this criterion in at least 10% of activities (but no less than two) during the accreditation term. At review, submit evidence for this many activities:* S: 2; M: 4; L: 6; XL: 8
C24	Patient/public representatives are engaged in the planning and delivery of CME.	Accredited continuing medical education (CME) is enhanced when it incorporates the interests of the people who are served by the healthcare system. This can be achieved when patients and/or public representatives are engaged in the planning and delivery of CME. This criterion recognizes providers that incorporate patient and/or public representatives as planners and faculty in the accredited program.	☐ Includes planners who are patients and/or public representatives AND ☐ Includes faculty who are patients and/or public representatives	Attest to meeting this criterion in at least 10% of activities (but no less than two) during the accreditation term. At review, submit evidence for this many activities:* S: 2; M: 4; L: 6; XL: 8
C25	Students of the health professions are engaged in the planning and delivery of CME.	This criterion recognizes providers for building bridges across the healthcare education continuum and for creating an environment that encourages students of the health professions and practicing healthcare professionals to work together to fulfill their commitment to lifelong learning. For the purpose of this criterion, students refers to students of any of the health professions, across the continuum of healthcare education, including professional schools and graduate education.	☐ Includes planners who are students of the health professions AND ☐ Includes faculty who are students of the health professions	Attest to meeting this criterion in at least 10% of activities (but no less than two) during the accreditation term. At review, submit evidence for this many activities:* S: 2; M: 4; L: 6; XL: 8

*Program Size by Activities per Term: S (small): <39; M (medium): 40 -100; L (large): 101-250; XL (extra large): >250

Criterion		Rationale	Critical Elements	The Standard
Addresses Public Health Priorities				
C26	The provider advances the use of health and practice data for healthcare improvement.	The collection, analysis, and synthesis of health and practice data/information derived from the care of patients can contribute to patient safety, practice improvement, and quality improvement. Health and practice data can be gleaned from a variety of sources; some examples include electronic health records, public health records, prescribing datasets, and registries. This criterion will recognize providers that use these data to teach about health informatics and improving the quality and safety of care.	☐ Teaches about collection, analysis, or synthesis of health/practice data AND ☐ Uses health/practice data to teach about healthcare improvement	Demonstrate the incorporation of health and practice data into the provider's educational program with examples from this number of activities:* S: 2; M: 4; L: 6; XL: 8
C27	The provider addresses factors beyond clinical care that affect the health of populations.	This criterion recognizes providers for expanding their CME programs beyond clinical care education to address factors affecting the health of populations. Some examples of these factors include health behaviors; economic, social, and environmental conditions; healthcare and payer systems; access to care; health disparities; or the population's physical environment.	☐ Teaches strategies that learners can use to achieve improvements in population health	Attest to meeting this criterion in at least 10% of activities (but no less than two) during the accreditation term. At review, submit evidence for this many activities:* S: 2; M: 4; L: 6; XL: 8
C28	The provider collaborates with other organizations to more effectively address population health issues.	Collaboration among people and organizations builds stronger, more empowered systems. This criterion recognizes providers that apply this principle by building collaborations with other organizations that enhance the effectiveness of the CME program in addressing community/population health issues.	☐ Creates or continues collaborations with one or more healthcare or community organization(s) AND ☐ Demonstrates that the collaborations augment the provider's ability to address population health issues	Demonstrate the presence of collaborations that are aimed at improving population health with four examples from the accreditation term.

*Program Size by Activities per Term: S (small): <39; M (medium): 40 -100; L (large): 101-250; XL (extra large): >250

Menu of New Criteria for Accreditation with Commendation
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Criterion		Rationale	Critical Elements	The Standard
Enhances Skills				
C29	The provider designs CME to optimize communication skills of learners.	Communication skills are essential for professional practice. Communication skills include verbal, nonverbal, listening, and writing skills. Some examples are communications with patients, families, and teams; and presentation, leadership, teaching, and organizational skills. This criterion recognizes providers that help learners become more self-aware of their communication skills and offer CME to improve those skills.	☐ Provides CME to improve communication skills AND ☐ Includes an evaluation of observed (e.g., in person or video) communication skills AND ☐ Provides formative feedback to the learner about communication skills	At review, submit evidence for this many activities:* S: 2; M: 4; L: 6; XL: 8
C30	The provider designs CME to optimize technical and procedural skills of learners.	Technical and procedural skills are essential to many aspects of professional practice, and need to be learned, updated, reinforced, and reassessed. Some examples of these skills are operative skill, device use, procedures, physical examination, specimen preparation, resuscitation, and critical incident management. This criterion recognizes providers that offer CME to help learners gain, retain, or improve technical and/or procedural skills.	☐ Provides CME addressing technical and or/procedural skills AND ☐ Includes an evaluation of observed (e.g., in person or video) technical or procedural skill AND ☐ Provides formative feedback to the learner about technical or procedural skill	At review, submit evidence for this many activities:* S: 2; M: 4; L: 6; XL: 8
C31	The provider creates individualized learning plans for learners.	This criterion recognizes providers that develop individualized educational planning for the learner; customize an existing curriculum for the learner; track learners through a curriculum; or work with learners to create a self-directed learning plan where the learner assesses their own gaps and selects content to address those gaps. The personalized education needs to be designed to close the individual's professional practice gaps over time.	☐ Tracks the learner's repeated engagement with a longitudinal curriculum/plan over weeks or months AND ☐ Provides individualized feedback to the learner to close practice gaps	At review, submit evidence of repeated engagement and feedback for this many learners:* S: 25; M: 75; L: 125; XL: 200
C32	The provider utilizes support strategies to enhance change as an adjunct to its CME.	This criterion recognizes providers that create, customize, or make available supplemental services (e.g., reminders) and/or resources (e.g., online instructional material, apps) that are designed to reinforce or sustain change.	☐ Utilizes support strategies to enhance change as an adjunct to CME activities AND ☐ Conducts a periodic analysis to determine the effectiveness of the support strategies, and plans improvements	Attest to meeting this criterion in at least 10% of activities (but no less than two) during the accreditation term.* At review, submit evidence for this many activities: S: 2; M: 4; L: 6; XL: 8

*Program Size by Activities per Term: S (small): <39; M (medium): 40 -100; L (large): 101-250; XL (extra large): >250

Criterion		Rationale	Critical Elements	The Standard
Demonstrates Educational Leadership				
C33	The provider engages in CME research and scholarship.	Engagement by CME providers in the scholarly pursuit of research related to the effectiveness of and best practices in CME supports the success of the CME enterprise. Participation in research includes developing and supporting innovative approaches, studying them, and disseminating the findings.	☐ Conducts scholarly pursuit relevant to CME AND ☐ Submits, presents, or publishes a poster, abstract, or manuscript to or in a peer-reviewed forum	☐ At review, submit description of at least two projects completed during the accreditation term and the dissemination method used for each.
C34	The provider supports the continuous professional development of its CME team.	The participation of CME professionals in their own continuing professional development (CPD) supports improvements in their CME programs and advances the CME profession. This criterion recognizes providers that enable their CME team to participate in CPD in domains relevant to the CME enterprise. The CME team are those individuals regularly involved in the planning and development of CME activities, as determined by the provider.	☐Creates a CME-related continuous professional development plan for all members of its CME team AND ☐ Learning plan is based on needs assessment of the team AND ☐ Learning plan includes some activities external to the provider AND ☐ Dedicates time and resources for the CME team to engage in the plan	☐ At review, submit description showing that the plan has been implemented for the CME team during the accreditation term.
C35	The provider demonstrates creativity and innovation in the evolution of its CME program.	This criterion recognizes CME providers that meet the evolving needs of their learners by implementing innovations in their CME program in areas such as education approaches, design, assessment, or use of technology.	☐ Implements an innovation that is new for the CME program AND ☐ The innovation contributes to the provider's ability to meet its mission.	☐ At review, submit descriptions of four examples during the accreditation term.

*Program Size by Activities per Term: S (small): <39; M (medium): 40 -100; L (large): 101-250; XL (extra large): >250

Menu of New Criteria for Accreditation with Commendation

Criterion		Rationale	Critical Elements	The Standard
Achieves Outcomes				
C36	The provider demonstrates improvement in the performance of learners.	Research has shown that accredited CME can be an effective tool for improving individuals' and groups' performance in practice. This criterion recognizes providers that can demonstrate the impact of their CME program on the performance of individual learners or groups.	☐ Measures performance changes of learners AND ☐ Demonstrates improvements in the performance of learners	☐ Demonstrate that in at least 10% of activities the majority of learners' performance improved.
C37	The provider demonstrates healthcare quality improvement.	CME has an essential role in healthcare quality improvement. This criterion recognizes providers that demonstrate that their CME program contributes to improvements in processes of care or system performance.	☐ Collaborates in the process of healthcare quality improvement AND ☐ Demonstrates improvement in healthcare quality	☐ Demonstrate healthcare quality improvement related to the CME program at least twice during the accreditation term.
C38	The provider demonstrates the impact of the CME program on patients or their communities.	Our shared goal is to improve the health of patients and their families. This criterion recognizes providers that demonstrate that the CME program contributed to improvements in health-related outcomes for patients or their communities.	☐ Collaborates in the process of improving patient or community health AND ☐ Demonstrates improvement in patient or community outcomes	☐ Demonstrate improvement in patient or community health in areas related to the CME program at least twice during the accreditation term.

*Program Size by Activities per Term: S (small): <39; M (medium): 40 -100; L (large): 101-250; XL (extra large): >250

9. FEASIBILITY AND APPROPRIATENESS OF TRANSFERRING JURISDICTION OVER REQUIRED CLINICAL SKILLS EXAMINATIONS TO LCME-ACCREDITED AND COCA-ACCREDITED MEDICAL SCHOOLS

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS
REMAINDER OF REPORT FILED
See Policy D-295.988

Policy D-295.988 (2,3), "Clinical Skills Assessment During Medical School," directs our American Medical Association (AMA) to "work with the Federation of State Medical Boards, National Board of Medical Examiners (NBME), state medical societies, state medical boards, and other key stakeholders to pursue the transition from and replacement for the current United States Medical Licensing Examination (USMLE) Step 2 Clinical Skills (CS) examination and the Comprehensive Osteopathic Medical Licensing Examination (COMLEX) Level 2-Performance Examination (PE) with a requirement to pass a Liaison Committee on Medical Education-accredited or Commission on Osteopathic College Accreditation-accredited medical school-administered, clinical skills examination."

In addition, this policy directs our AMA to "work to: (a) ensure rapid yet carefully considered changes to the current examination process to reduce costs, including travel expenses, as well as time away from educational pursuits, through immediate steps by the Federation of State Medical Boards and National Board of Medical Examiners; (b) encourage a significant and expeditious increase in the number of available testing sites; (c) allow international students and graduates to take the same examination at any available testing site; (d) engage in a transparent evaluation of basing this examination within our nation's medical schools, rather than administered by an external organization; and (e) include active participation by faculty leaders and assessment experts from U.S. medical schools, as they work to develop new and improved methods of assessing medical student competence for advancement into residency."

These directives were adopted at the 2016 Annual Meeting of the AMA House of Delegates. Testimony at A-16 before Reference Committee C reflected medical students' concerns over the significant costs and burden of the current examination; the lack of meaningful feedback provided for learning and improvement; and questions regarding the predictive ability of the exam for success or enhanced patient safety in clinical practice. In addition, it was argued that the responsibility for clinical skills testing could and should be maintained by medical schools, with elimination of the USMLE Step 2 CS examination from the requirements for certification by the NBME and subsequent state medical licensure. Testimony in opposition focused on the importance of physician self-regulation and maintenance of the public trust, medical school resources and costs to support the examination, and the reliability of a school-based clinical skills examination.

BACKGROUND

In 2004, the NBME implemented the USMLE Step 2 examination, which "assesses the ability of examinees to apply medical knowledge, skills, and understanding of clinical science essential for the provision of patient care under supervision, and includes emphasis on health promotion and disease prevention. Step 2 ensures that due attention is devoted to the principles of clinical sciences and basic patient-centered skills that provide the foundation for the safe and effective practice of medicine."[1]

Medical students typically take USMLE Step 2 CS during the final year of medical school. The USMLE website indicates the examination fee is $1,280 for applications received after January 1, 2017. The examination is currently administered at six test centers (Atlanta, Chicago, Houston, Los Angeles, and two centers in Philadelphia).[2] The NBME estimates that 70 percent to 75 percent of test takers will reside within a four-hour drive of at least one USMLE Step 2 CS testing center.[3] For many students, total test costs will also include air and/or ground travel costs and overnight accommodations.[3]

The table below shows that the USMLE Step 2 CS examination was administered 20,668 times to U.S. medical school students or graduates between July 1, 2015 and June 30, 2016, with a pass rate of 97 percent, and 14,351 times to international medical graduates (IMGs), with a pass rate of 81 percent.[4]

Step 2 CS Administrations, 2015-2016

Examinees from US/Canadian Schools:

	Number Tested	Percent Passing
MD Degree	20,622	97 percent
1st Takers	19,906	97 percent
Repeaters*	716	85 percent
DO Degree	46	91 percent
1st Takers	46	91 percent
Repeaters*	0	N/A
Total	20,668	97 percent

Examinees from Non-US/Canadian Schools:

	Number Tested	Percent Passing
1st Takers	12,051	82 percent
Repeaters*	2,300	71 percent
Total	14,351	81 percent

* "Repeaters" represents examinations given, not number of examinees.

While the total costs for the development and staffing of additional centers have not been published, the known costs and cost centers include structure acquisition (variable, based on location); initial costs for retrofitting an existing structure (estimated at $4 million); and recurrent costs (case development costs for 200+ cases, 200 hours of training for 500 standardized patients for each case, and 100 or more physician raters rating a total of 4,000 encounters/month). These costs are in addition to central costs including scheduling, verification, staffing (both on-site and central staff at NBME headquarters), quality assurance, security measures, etc.[3] It should be noted as well that, based on the data table shown above, administration of the examination to IMGs would comprise an additional examinee load of more than 14,000 individuals.

The USMLE Management Committee is currently in the planning stages for improvements to the USMLE Step 2 CS process, including a universal list of chief complaints, score interpretation videos, and options for more meaningful performance reporting to examinees.

Proponents of the current system state the need for: 1) a standardized exam to assess the clinical skills of graduates; 2) a valid and reliable single standard for assessment (due to the poor correlation between school-based and USMLE clinical skills examinations and potential conflicts of interest for medical schools); and 3) a single pathway for licensure across the states.

Opponents of the current USMLE Step 2 CS structure note concerns regarding the cost of the examination, lack of meaningful scoring feedback to test takers, perceived subjectivity and variability among testers and test centers, and the limited number and geographically disparate locations of testing sites, and point to the low failure rate as an indicator that the exam is not cost-effective in discerning competency.

AMA WORK IN ADDRESSING THE NEW POLICY

In response to the newly adopted policy, members of the AMA's Academic Physicians Section, Council on Medical Education and AMA staff have gathered information to explore the viability of transferring jurisdiction of clinical skills testing from the NBME to medical schools.

Discussions with the Liaison Committee on Medical Education (LCME)[5] and Commission on Osteopathic College Accreditation (COCA) revealed that neither organization believes that it is appropriate to assume this role. Both organizations have the responsibility of accrediting educational programs, rather than developing or administering certification examinations or certifying individuals enrolled in LCME- or COCA-accredited programs. Neither the LCME[5] nor COCA (personal verbal communication from COCA secretary, Alissa Craft, November 2016) has the resources or expertise that would be needed to develop, administer, oversee, and certify a school-based examination.

State medical boards believe that a school-based examination would not be an acceptable alternative, according to a Federation of State Medical Boards' membership survey.[3] More than 70 percent of those surveyed indicated that the USMLE should continue Step 2 CS and explore how the exam could be of further value to state medical boards. In addition to the concerns about the reliability of a school-based exam, the FSMB relies on a single-tiered system and common standard for all potential licensees—from U.S. or foreign medical schools alike. The FSMB House of Delegates passed resolutions in 1989, 1999, and 2012 affirming or reaffirming its commitment to a single pathway to licensure for all licensees.[6] Furthermore, the state medical boards require "equivalent" assessment for licensure (same case pool, test standards, scoring mechanisms, minimal passing standard). Less stringent criteria would result in "comparable" assessment, which in addition to being unacceptable to the state medical boards, would likely subject the boards to legal challenges and an increased level of risk, due to state medical boards' primary purpose of public protection.[3]

Discussions with medical school leaders have yielded divergent opinions. While there is uniform concern regarding the cost of the examination to students, some leaders feel it is important that there be an external, impartial validation of the clinical skills competence of their graduates and their curriculum, and acknowledge the value of Step 2 CS in protection of the public. Some leaders expressed concern about the availability of resources and total costs for delivering a standardized exam, noting that the costs would be passed on to students through increases in tuition and fees. Some leaders also acknowledge the difficulty that faculty may encounter in failing their students—a perspective described in the medical literature.[7-9] Others believe that their respective institutions have the requisite resources to develop and administer a standardized clinical skills examination in partnership with the NBME. At the time of this report, the Council on Medical Education is collecting additional information on this topic, including feedback from the AAMC Council of Deans.

SUMMARY AND RECOMMENDATIONS

At present, the proposal to transition jurisdiction of USMLE Step 2 CS to a medical school-based examination faces considerable and perhaps insurmountable challenges. Accrediting agencies are not organized or recognized for certification of examinations to test the competency of individuals enrolled in accredited programs. The FSMB and its member state medical boards do not support school-based examinations as an acceptable substitute for a national examination to assess clinical skills competency. Medical school support for the proposal to transfer jurisdiction has been mixed, and the absence of a national consensus favoring a medical school assessment model threatens the feasibility of such an approach. Data are being collected with regard to the resources that would be needed by medical schools to administer equivalent school-based clinical skills assessments as part of NBME certification, and how those resources might impact student tuition and fees. Further information is needed regarding the operational costs associated with a USMLE Step 2 CS test center and the costs to examinees if additional test centers were to be added.

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

1. Our American Medical Association (AMA) is committed to assuring that all medical school graduates entering graduate medical education programs have demonstrated competence in clinical skills.

2. Our AMA will continue to work with appropriate stakeholders to assure the processes for assessing clinical skills are evidence-based and most efficiently use the time and financial resources of those being assessed.

3. That our AMA encourage development of a post-examination feedback system for all USMLE test-takers that would: (a) identify areas of satisfactory or better performance; (b) identify areas of suboptimal performance; and (c) give students who fail the exam insight into the areas of unsatisfactory performance on the examination.

4. That our AMA, through the Council on Medical Education, continue to monitor relevant data and engage with stakeholders as necessary should updates to this policy become necessary.

REFERENCES

1. Step 2 CS. United States Medical Licensing Examination. Available at: www.usmle.org/step-2-cs. Accessed March 22, 2017.

2. USMLE Examination Fees. United States Medical Licensing Examination. Available at: www.nbme.org/students/examfees.html. Accessed March 22, 2017.
3. Katsufrakis P, Johnson D. Resolution 311: An impractical model. Presented to the American Medical Association Council of Medical Education, March 10, 2017. Chicago, IL.
4. Performance data. United States Medical Licensing Examination. Available at: www.USMLE.org/performance-data/default.aspx#2015_step-2-cs. Accessed March 22, 2017.
5. Lindemann, J. Letter from the Liaison Committee on Medical Education to Susan Skochelak, MD, MPH, group vice president, medical education, American Medical Association. October 25, 2016.
6. Federation of State Medical Boards Public Policy Compendium 2016. Available at: http://www.fsmb.org/Media/Default/PDF/Advocacy/Public%20Policy%20Compendium1.pdf. Accessed March 22, 2017.
7. Speer AJ, Solomon DJ, Fincher R-M E. Grade Inflation in the Internal Medicine Clerkship: A National Survey. *Teaching and Learning in Medicine*, November 20, 2009. Available at: http://www.tandfonline.com/doi/abs/10.1207/S15328015TLM1203_1. Accessed March 28, 2017.
8. Fazio SB, Papp KK, Torre DM, DeFer TM. Grade Inflation in the Internal Medicine Clerkship: A National Survey. *Teaching and Learning in Medicine*, January 18, 2013. Available at: http://www.tandfonline.com/doi/abs/10.1080/10401334.2012.741541. Accessed March 28, 2017.
9. Guerrasio J, Furfari KA, Rosenthal LD, Nogar CL, Wray KW, Aagaard EM. Failure to fail: The institutional perspective. *Medical Teacher*, May 20, 2014. Available at: http://www.tandfonline.com/doi/abs/10.3109/0142159X.2014.910295. Accessed March 28, 2017.