REPORTS OF THE COUNCIL ON MEDICAL EDUCATION

The following reports, 1–10, were presented by Baretta R. Casey, MD, Chair:

1. ANNUAL REPORT ON AMA MEDICAL EDUCATION ACTIVITIES: 2010

Informational report. No reference committee hearing.

HOUSE ACTION: FILED (INFORMATIONAL)

This informational report summarizes the major activities of the Council on Medical Education and American Medical Association (AMA) Medical Education Group during 2010. For more information on the Council on Medical Education, see www.ama-assn.org/go/councilmeded.

THE COUNCIL ON MEDICAL EDUCATION

The Council on Medical Education was founded in 1904 to improve medical education in the US. The Council has four general functions:

- To study issues of importance in medical education and to propose policy and action on these areas to the AMA House of Delegates;
- To act as primary liaison between the AMA and other organizations with responsibility for medical education across the continuum;
- To collect and disseminate information about undergraduate, graduate, and continuing medical education/continuing physician professional development; and
- To ensure the quality of medical education and of the physician graduate.

Policy Development and Implementation

The Council submitted 15 reports for consideration by the House of Delegates at the Annual and Interim 2010 Meetings, as well as two informational reports. Reports typically are developed with advice and input from other areas in the AMA, especially the Section on Medical Schools, the Resident and Fellow Section, and the Medical Student Section.

Collaboration with AMA Advocacy Office

In 2010, the Council worked closely with staff in the AMA’s Washington, DC office on several key issues, including health system reform, medical student debt, graduate medical education funding, resident physician duty hours, and physician workforce issues.

Liaison and Collaboration with Other Organizations

One core activity of the Council is to identify and recommend qualified nominees to serve on accreditation and certification organizations and other medical education-related organizations. Nominations are reviewed and finalized by the AMA Board of Trustees. During 2010, the Council considered 68 individuals for appointment/nomination to fill 29 vacancies on medical education councils/committees. The nominations process involves solicitation of qualified individuals from across the Federation and a careful review to identify knowledgeable individuals who will work to enhance medical education. To further increase visibility of the AMA’s nomination process, a link to the Council’s Website was included in the AMA GME e-Letter to encourage nominations (primarily to Residency Review Committees), and the nominations solicitation was posted on the AMA’s medical education Twitter page.

In 2010, leaders of other health care organizations attended Council meetings to provide organizational updates and/or to discuss opportunities for collaboration. Organizations represented included:

- Accreditation Council for Continuing Medical Education (ACCME);
Council Task Forces

To proactively formulate policy and address current issues, the Council has three task forces:

1. Maintenance of Certification/Maintenance of Licensure—Recognizing the importance of a licensing certification process that works to improve the quality of patient care, the Council has actively supported the development and use of valid and reliable processes. Since the Guide to Good Medical Practice was finalized, the Council Task Force dealing with that issue was converted to the new Maintenance of Certification/Maintenance of Licensure Task Force, with seven Council members and two AMA staff assigned to this important work.

2. Reentry/Part-time Practice—This task force studied and presented information to the Council, serving as a basis for the Council’s comprehensive report on remediation, which was submitted to the House of Delegates at the 2009 Annual Meeting as well as a follow-up, informational report on physician reentry written for the 2009 Interim Meeting.

3. Physician Workforce—The task force prepared two reports for the AMA Board of Trustees on the Educational Implications of Health System Reform (May 2009) and Physician Workforce and Health System Reform (October 2009).

Activities in Support of Accreditation

In monitoring professional standards in medical education, the Council reviews and comments on proposed changes in accreditation standards for medical education programs. In 2010, the Council reviewed proposed revisions to one Liaison Committee on Medical Education (LCME) accreditation standard and reviewed and commented on 28 new/revised program requirements of the ACGME. The Council continues to review and monitor ACGME and ACCME proposals that impact the relationship between the AMA as a sponsoring organization and these accreditation bodies, including changes in the nomination procedures.

Information Collection and Dissemination

One of the Council’s responsibilities is to study areas of importance in medical education and make recommendations for AMA policy and action. The Council collects information under its own auspices and in collaboration with other AMA units and with other organizations such as the Association of American Medical Colleges (AAMC). For example, the LCME Annual Medical School Questionnaire, which is sent to all LCME-accredited US medical school programs with enrolled students, includes questions about medical students, faculty, curriculum structure, and medical student evaluation. Some of these data are used in Council reports; shared with faculty members, administrators, and researchers in medical schools; and published in the annual medical education issue of the Journal of the American Medical Association. The Council also receives data presentations from staff and experts on topics such as physician workforce and medical school expansion.

SECTION ON MEDICAL SCHOOLS

Established in 1976 by the AMA House of Delegates to improve communication between practicing physicians and medical educators, the AMA Section on Medical Schools (SMS) provides all medical schools accredited by the LCME or American Osteopathic Association (AOA) and their faculty a voice in House of Delegates deliberations.
and offers a forum for discussing and developing policies on medical education and national research and health care issues.

During the Annual and Interim Meetings, the Section provides education programs on issues of importance to the academic community. Detailed information on the AMA-SMS education sessions scheduled for the 2011 Annual Meeting is in the HOD Speakers’ Letter.

The AMA-SMS held its 34th Interim Meeting on November 5 at the Omni Shoreham Hotel in Washington, DC, in conjunction with the AAMC 2010 Annual Meeting, which took place at the same time as the Interim Meeting of the AMA House of Delegates. Keynote speaker Michael Reichgott, MD, director for conflict of interest and human subjects protection at Albert Einstein College of Medicine, presented at a well-attended education session on competition for clinical training sites. In addition, the deans of three new medical schools gave presentations about the challenges of starting a new school and highlighted curricular innovations at their respective schools. In addition, Veronica Crowe, AMA Assistant Director of Congressional Affairs, provided a Washington update. For presentation summaries, see www.ama-assn.org/go/sms.

The AMA-SMS Governing Council

Increasing AMA membership among academic physicians continues to be a top priority for the Governing Council. Significant time has been spent with membership staff on strategic planning and preparing AMA resources for academic physicians. The governing council and staff assisted in the development of the new AMA academic leadership group membership program that offers special group membership pricing to the medical school leadership.

At the 2010 Annual Meeting of the AAMC, the governing council and several members of the Council on Medical Education met with the AAMC Council of Deans Administrative Board to discuss issues of mutual interest and concern, such as New Horizons Conference follow-up activities; workforce and graduate medical education issues, including duty hours and funding for Graduate Medical Education slots; and how to jointly advocate for increases in GME funding. There were also updates on AMA’s Center for Transforming Medical Education activities as well as an update on AAMC academic affairs initiatives.

The AMA-SMS Office coordinated a session at the AAMC Annual Meeting highlighting the many AMA initiatives in medical education, including the new AMA group membership for academic physician leaders and the Innovative Strategies for Transforming the Education of Physicians (ISTEP) multi-school study on the medical education learning environment.

At the 2011 Annual Meeting, the AMA-SMS will again participate in the Medical Education Caucus—consisting of representatives from the AMA-SMS as well as the Medical Student Section and Resident and Fellow Section—to interview candidates for the AMA Board of Trustees and Council on Medical Education. This process ensures that issues of importance to the academic medical education community are seen as a priority by the candidates.

MEDICAL EDUCATION GROUP ACTIVITIES

Office of the Vice President

The Work of the Newly Formed Center of Expertise: Transforming Medical Education

In 2010, the AMA created a new Center of Expertise: Transforming Medical Education to provide a permanent structure for continuing the work of the AMA Initiative to Transform Medical Education (ITME), which was established by the Council in 2005. Through the work of the new Center, the Undergraduate Medical Education, Graduate Medical Education, and Continuing Physician Professional Development Centers of Expertise, as well as the Council and the AMA-SMS, the Medical Education Group is working to transform medical education.

The Center’s work in 2010 focused on medical school admissions and the learning environment, new strategies for graduate medical education funding, and new guidelines for physician reentry programs:
The AMA and AAMC jointly sponsored an invitational conference, “New Horizons in Medical Education: A Second Century of Achievement,” September 20-22, in Washington, DC. This seminal event, attended by nearly 300 leaders in medical and health professions education, residents and students and guests from private and public sectors, marked the 100th anniversary of the Flexner Report. Conference attendees developed recommendations for actions to continue to transform medical education over the next decade and into the future. A post-conference video was produced and is available on YouTube (and was shown at the House of Delegates meeting in San Diego) at www.youtube.com/watch?v=3GsUgvK1L1Y.

A companion edition of Academic Medicine, with descriptions of the educational programs at all US and Canadian medical schools (similar to the format of last century’s Flexner Report), was published in coordination with the conference; Susan Skochelak, MD, MPH, Barbara Barzansky, PhD, and other staff authored six articles for this historic issue as well as two articles in the February Flexner-themed issue of Academic Medicine.

To continue the dialogue from the New Horizons conference and advance ideas about transforming medical education, an AMA-hosted online discussion forum was launched in October (www.ama-assn.org/go/newhorizons). The online community has grown rapidly: The number of registered participants in the forum has grown to nearly 650. In addition, a new medical education Twitter page (http://twitter.com/#!/MedEdAMA) was developed in August, with more than 170 followers by year-end.

In May, the AMA held an invitational conference on regulatory and licensure barriers to reentry, in collaboration with the FSMB and the American Academy of Pediatrics. In attendance were 17 medical licensing stakeholders and 40 individual representatives, who developed a set of 16 recommendations. In addition, an education session on reentry, jointly sponsored with the Women Physicians Congress, was held at the 2010 Interim Meeting. These and other events, documents, and links are available on the newly developed reentry Web page, at www.ama-assn.org/go/reentry. A brochure outlining AMA Guidelines for Physician Reentry Programs was produced and is available at www.ama-assn.org/ama1/pub/upload/mm/40/physician-reentry-recommendations.pdf.

In 2010, the AMA-sponsored medical school research collaborative, ISTEP, launched a landmark multi-school longitudinal cohort study on the medical education learning environment. Fourteen medical schools are participating in the study, and data from more than 2,000 entering first year medical students were collected for the first phase of the cohort study in July 2010. Work is ongoing to identify factors in the learning environment that either inhibit or promote the acquisition of professional behaviors by medical students and resident physicians. In 2010, analysis of qualitative interviews with medical schools was completed, and data were analyzed and presented at the October meeting of the ISTEP collaborative. In addition, the ISTEP study design and early data were presented at the annual meeting of the AAMC, and a presentation and publication were accepted at the Society of Teachers of Family Medicine Annual Medical Education meeting.

Work continues on enhancing medical school admissions criteria in the interview and selection process to ensure that applicants have the appropriate interpersonal attributes that contribute to the development of professionalism and an ethic of compassion and caring. Recommendations on improving the medical school admissions process (www.ama-assn.org/ama1/pub/upload/mm/40/behavioral-competencies-medical-students.pdf) were published and widely disseminated in hardcopy and virtual formats, including to all medical school deans and deans of students and admissions. A session was held at the AAMC Annual Meeting to disseminate this work, and a manuscript on admissions was submitted to Academic Medicine.

The Center joined with the Graduate Medical Education Division and the AMA Advocacy Resource Center to host a summit in November on state and regional strategies to address physician workforce needs. Thirty invited leaders from GME programs and state and national medical societies were in attendance to discuss innovative ways to fund expansion of GME residency program slots and help ease physician shortages, especially for undersupplied specialties and in underserved geographic areas. The Summit’s goal was to develop an agenda of successful strategies that state and regional stakeholders can embrace for political action to expand GME funding and meet state and regional medical workforce needs.
Appointments to Other Organizations

Responsibilities of the Office of the Vice President include communicating and sending Council or staff representatives to physician credentialing organizations, such as the ABMS, FSMB, and NBME, where medical education issues are discussed. The Council serves as the critical link between these organizations and the AMA and obtains feedback from the representatives to assist in AMA policy development and implementation. Representation to physician assistant accrediting and certifying bodies and health professions accrediting organizations, such as the Commission on Accreditation of Allied Health Education Programs, are overseen by the Office of the Vice President, with feedback provided to the Council on Medical Education. Good working relationships with these entities are essential to the continued production of several medical education books and products that serve as references for the Council.

AMA Membership Activities

The Office of the Vice President serves as the liaison to other membership-related groups within the AMA as well as other units within the AMA Professional Standards Group. Staff have worked closely to support AMA membership activities, with special focus on the Medical Student Section, and AMA-SMS staff were instrumental in helping develop the new AMA Academic Leadership Group membership.

Undergraduate Medical Education

Accreditation Activities

The LCME is responsible for accrediting medical education programs in the US and, in collaboration with the Committee on the Accreditation of Canadian Medical Schools, in Canada. During 2010, two additional medical schools received LCME preliminary accreditation, bringing the total number of accredited medical schools in the United States to 133. In addition, seven developing medical schools have formally applied for accreditation but have not yet been reviewed by the LCME. Information on developing medical schools is available on the LCME Website, www.lcme.org.

During the AMA and AAMC Annual Meetings, the LCME Secretariat staff provide annual workshops for medical schools preparing for accreditation reviews. Annual workshops also are offered for survey team members, and two Webinars were offered for survey team chairs and members to update them on changes in the survey visit process. In addition, LCME informational materials are updated regularly and posted on the LCME Website. Finally, staff of the Division of Undergraduate Medical Education provided on-site consultation and support to medical schools preparing for accreditation reviews.

Research and Data Collection

Under the auspices of the LCME, an annual survey is sent to the deans of all LCME-accredited US medical schools. The 2010 survey had a 100% response rate. The survey allows the LCME to track trends related to the curriculum and evaluation methods used in medical schools. Data from the survey are published as Appendix tables in the annual medical education issue of *Journal of the American Medical Association* and shared with members of various stakeholder groups on request.

Graduate Medical Education

Advocacy on Duty Hours and Physician Workforce

Division of Graduate Medical Education staff drafted a letter to the ACGME on its proposed duty hour requirements, collating responses from the AMA Resident and Fellow Section, Young Physician Section, SMS, and CME. Staff also drafted a letter to the Occupational Safety and Health Administration (OSHA) to oppose a proposal that OSHA regulate resident physician duty hours, and provided an overview of the 2010 Match results to the AMA Board of Trustees. Staff also worked with the Council on Medical Education to assist with the review of 28 sets of ACGME residency program requirements, and collaborated with AMA Ethics Standards staff to host three Webinars on patient safety in medical education.
With growing consensus that the nation faces a shortage of physicians, especially in medically underserved regions and front-line specialties, and with health system reform legislation now enacted, the Council and division staff were active in developing policy and advocating actions, along with key stakeholders, to positively address both the number and mix of physicians being trained. In addition to the GME Summit noted above, this work included:

- Submitting comments on two MedPAC proposals with health care workforce implications.
- Advocating for federal legislation to expand GME funding by 15,000 positions and for training resident physicians in the patient-centered medical home model.
- Attending the Council on Graduate Medical Education (COGME) meeting and contributing to COGME’s 20th draft report about factors that influence physicians’ choice of primary care careers.
- Submitting comments on the 8th Report of the Advisory Committee on Training in Primary Care Medicine and Dentistry on the Redesign of Primary Care with Implications for Training.
- Preparing a letter to the AMA Board of Trustees to provide an overview of the 2010 National Resident Matching Program (NRMP) results.
- Collaborating with the AAMC to design a study about the number of US medical graduates completing core residency training programs.
- Advising the Macy Foundation/Association of Academic Health Centers Conference newly formed working group on GME and Workforce Needs.
- Developing programs for and participating in two international medical workforce meetings (International Medical Workforce Collaborative and World Health Professions’ Conference on Regulation).
- Participating in the CMSS Workforce Group.

Liaison Activities

Graduate Medical Education Division staff made 22 local, regional, national, and international presentations on GME, allied health, and workforce issues, and the Council on Medical Education and the division maintained active liaisons with the following organizations: ACGME (including several Residency Review Committees, e.g., Internal Medicine, Family Medicine, Pediatrics, and Psychiatry), American Academy of Family Practice (AAFP) (including its Commission on Education), AAMC (including its Center for Workforce Studies and Groups on Residency Affairs and Student Affairs), ECFMG, NRMP, COGME, CMSS (including its Organization of Program Directors Associations), Administrators in Medicine, Alliance of Independent Academic Medical Centers (AIAMC), National Association of Advisors for Health Professions, Health Professions Network, Association for Hospital Medical Education (AHME), and 25 allied health professions accrediting organizations.

Research and Publication

Along with the AAMC, the AMA administered the National GME Census, which collected key residency program and resident/fellow data; these data were published in the medical education issue of JAMA and via FREIDA Online®. In addition, division staff wrote and submitted for publication four manuscripts, with three accepted.

Direct Communications

GME e-Letter—This monthly e-mail newsletter, with 13,000 subscribers, provides a forum for sharing and soliciting information on GME (and promoting the AMA’s GME products/services). Key topics include duty hours, GME funding, medical workforce, and other information of interest to program directors, coordinators, and residents.

Medical Education Bulletin—The Bulletin, with a readership of more than 11,000, is published twice a year, providing a review of the actions of the House of Delegates of interest to medical educators and serving as a source of information about undergraduate and graduate medical education. In 2011, the Bulletin moved to an e-publication format.

Health Care Careers e-Letter—This monthly e-mail newsletter, with 16,000 readers, helps reinforce and strengthen AMA relationships with non-physician health professions accrediting agencies/professional organizations and serves to promote AMA products and initiatives, especially the Health Care Careers Directory.
Products/Services

FREIDA Online®—This Internet database provides access for medical students and residents to information on more than 8,900 ACGME-accredited and ABMS board-approved GME programs and 1,700 GME teaching institutions. Ongoing enhancements to the site’s functions continued in 2010.

Graduate Medical Education Directory—Now in its 95th edition, the 2010-2011 “Green Book” continues to be a key reference work for the GME community. This edition includes extensive data tables for specialties/sub-specialties, to help students determine which field is right for them.

Electronic State-level GME Data, 2009-2010—Statistics prepared for each state on ACGME-accredited programs and the residents and fellows training in them.

State Medical Licensure Requirements and Statistics—The 2011 edition provides updated information on licensing board requirements for the 54 allopathic and 13 osteopathic boards of medical examiners in the US and territories.

Health Care Careers Directory—The 2010-2011 edition of this annual book includes more than 8,600 educational programs in 82 health professions.

Continuing Physician Professional Development (CPPD)

The Division of CPPD provides support to the Council on Medical Education in relation to continuing medical education (CME) policies and trends. In addition, the Council has delegated responsibility for administering the AMA’s accredited CME program to the division. Activities in 2010 included the following:

Changes to AMA PRA Credit System Approved

After more than a year of reevaluating the requirements for designating and awarding AMA Physician’s Recognition Award (AMA PRA) credits and discussions with over 60 organizational stakeholders, the AMA Council on Medical Education approved changes to the AMA PRA Credit System at its June meeting, with the new requirements effective in July 2011. The revised AMA PRA informational booklet was published and widely disseminated in 2010, and annotated presentation materials on the new AMA PRA standards were developed and used for presentations to state medical societies recognized by the ACCME to accredit intrastate providers and accredited CME providers, as well as for seven live presentations at various CME stakeholder conferences.

Collaboration

CPPD continues to collaborate and engage in discussions with other organizations across the field of CME/CPPD, such as state medical societies, AAMC, AHME, CMSS, FSMB, and the AMA-convened Physician Consortium for Performance Improvement® (PCPI). Staff hold committee appointments for 12 such organizations and serve in defined leadership positions for five organizations.

Webinars

The AMA CPPD team presented nine Webinars in 2010, reaching more than 1,000 CME professionals; these included “The AMA PRA Credit System: 2010 Revisions” (presented by CPPD staff), “What CME Providers Should Know About CME Requirements for Licensure and Maintenance of Licensure” (provided in collaboration with the FSMB), “Implementing Performance Improvement CME in the Hospital Setting” (produced in collaboration with PCPI and AHME), and “Understanding the AAFP, AMA PRA and American Osteopathic Association (AOA) Credit Systems” (produced in collaboration with AAFP and AOA).

Roundtable Meeting

CPPD hosted the third annual roundtable meeting with representatives from state medical societies recognized by ACCME to accredit intrastate providers. This meeting provided an opportunity to discuss several AMA initiatives, including implementation of the AMA PRA credit system revisions, monitoring for compliance with AMA PRA requirements, and an update on AMA House of Delegates resolutions and reports.

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Conference of the National Task Force on CME Provider/Industry Collaboration

More than 425 participants attended the 21st Annual Conference of the National Task Force on CME Provider/Industry Collaboration, held in October in Baltimore, MD, and featuring keynote speaker Darrell G. Kirch, MD, President and CEO of the AAMC. The theme for this year’s conference was “Moving Forward in an Age of Uncertainty: Creating Innovative, Practical Educational Solutions.”

AMA CME Activities

With multiple departments within the AMA developing CME activities for thousands of physicians, CPPD has expanded the professional development curriculum for AMA staff who plan CME activities. Sessions covered the fundamentals of ACCME accreditation criteria and the AMA PRA credit system rules, incorporating adult learning principles into educational planning, identifying strategies for evaluating educational activities, and discussing implications of Maintenance of Certification and Maintenance of Licensure for CME.

AMA PRA Certificate Processing

CPPD has continued to make a concerted effort to expedite processing of CME certificates and AMA PRA certificates. As a result of the processing team’s dedication to customer service for physicians, this year’s average processing time for these certificates was 8.4 days. In addition, 2,910 applications for direct credit were processed in 2010—a record number for these certificates.

Conjoint Committee on CME

CPPD staff have participated in the CMSS meetings of the Conjoint Committee on CME, a group convened by the CMSS. The Committee’s goal is to galvanize action among stakeholder groups toward the evolution of CME. It helps to accomplish this through consensus recommendations from 16 of the principal stakeholders in CME (AAFP, AAMC, ABMS, ACCME, ACGME, ACME, American Hospital Association, AHME, AMA, AOA, CMSS, FSMB, The Joint Commission, Journal of Continuing Education in Health Professions [JCEHP], NBME, and the Society for Academic Continuing Medical Education [SACME].) The Conjoint Committee is currently addressing three important strategic goals: 1) Moving toward the integration of performance improvement into CME; 2) Moving toward a curriculum for CME that aligns across the continuum of medical education; and 3) Leading a national conversation about financing CME.

Communications

CPPD Website—The site provides information and links to AMA CME activities, as well as applications for the AMA PRA, direct credit, and European Accreditation Council for Continuing Medical Education (EACCME) credit conversion. Also available are resources for physicians and CME providers, including the AMA PRA booklet and FAQs. The site navigation and content continue to be revised to make it user-friendly for physicians and providers.

CPPD Report—This newsletter, published three times a year, provides information and updates to more than 4,500 subscribers.

CPPD Bulletin—This monthly newsletter, started in July 2009, provides CME information and updates to CME activity managers throughout the AMA.

Presentations

In 2010, members of the CPPD team gave presentations at more than 50 meetings, reaching more than 3,000 participants. Topics included Performance Improvement CME, AMA medical education initiatives, the AMA PRA Credit System, CME credit and licensure, globalization of CME, and the Physician Consortium for Performance Improvement measures.
Renewal of agreement with European medical specialty group

The Council approved in June 2010 the renewal of an agreement between the AMA and the European Union of Medical Specialists (UEMS). This agreement allows physicians to convert CME credit certified by the European Accreditation Council for Continuing Medical Education (EACCME)—the accrediting arm of the UEMS—to AMA PRA Category 1 Credit™. Originally instituted in 1999, the terms of the agreement have been expanded to include e-learning activities. The agreement also allows European physicians to convert AMA PRA Category 1 Credit™ to EACCME credit.

2. COUNCIL ON MEDICAL EDUCATION SUNSET REVIEW OF 2001
HOUSE OF DELEGATES POLICIES AND DIRECTIVES

Reference committee hearing: See Reference Committee C.

HOUSE ACTION: RECOMMENDATIONS ADOPTED AND REMAINDER OF REPORT FILED

At its 1984 Interim Meeting, the House of Delegates established a sunset mechanism for House policies (Policy G-600.110, AMA Policy Database). Under this mechanism, a policy established by the House ceases to exist after 10 years unless action is taken by the House to retain it.

The objective of the sunset mechanism is to help ensure that the AMA Policy Database is current, coherent, and relevant. By eliminating outmoded, duplicative, and inconsistent policies, the sunset mechanism contributes to the ability of the AMA to communicate and promote its policy positions. It also contributes to the efficiency and effectiveness of House of Delegates deliberations.

At its 2002 Annual Meeting, the House modified Policy G-600.110 to change the process through which the policy sunset is conducted. The process now includes the following steps:

- In the spring of each year, the House policies that are subject to review under the policy sunset mechanism are identified.
- Using the areas of expertise of the AMA Council as a guide, it is determined which policies should be reviewed by each Council.
- For the Annual Meeting of the House, each Council develops a separate policy sunset report that recommends how each policy assigned to it should be handled. For each policy it reviews, a Council may recommend one of the following actions: (a) retain the policy; (b) rescind the policy; or (c) retain part of the policy. A justification must be provided for the recommended action on each policy.
- The Speakers assign each policy sunset report for consideration by the appropriate Reference Committee.

Although the policy sunset review mechanism may not be used to change the meaning of AMA policies, minor editorial changes can be accomplished through the sunset review process.

The Council on Medical Education’s recommendations on the disposition of the 2001 House policies that were assigned to it are included in the Appendix to this report.

RECOMMENDATION

The Council on Medical Education recommends that the House of Delegates policies that are listed in the Appendix to this report be acted upon in the manner indicated and the remainder of this report be filed.
APPENDIX – Recommended Actions on 2001 House of Delegates’ Policies

<table>
<thead>
<tr>
<th>Policy Number</th>
<th>Title</th>
<th>Recommended Action and Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>H-40.994</td>
<td>Military Physicians in Graduate Medical Education Programs</td>
<td>Retain. The policy is still relevant.</td>
</tr>
<tr>
<td>H-40.995</td>
<td>Graduate Medical Education in the Military</td>
<td>Retain. The policy is still relevant.</td>
</tr>
<tr>
<td>H-140.977</td>
<td>Residency Training in Medical-Legal Aspects of End-of-Life Care</td>
<td>Retain. The policy is still relevant.</td>
</tr>
<tr>
<td>H-150.995</td>
<td>Basic Courses in Nutrition</td>
<td>Retain. The policy is still relevant.</td>
</tr>
<tr>
<td>H-250.996</td>
<td>Enhancing Young Physicians’ Effectiveness in International Health</td>
<td>Retain. The policy is still relevant.</td>
</tr>
<tr>
<td>H-255.997</td>
<td>Fifth Pathway</td>
<td>Rescind. As of 2009, the Fifth Pathway no longer provides eligibility to sit for Step 3 of the USMLE. Therefore, there are no new entrants to Fifth Pathway programs. The principle underlying this policy is valid, but the Fifth Pathway no longer is relevant.</td>
</tr>
<tr>
<td>H-255.998</td>
<td>Foreign Medical Graduates</td>
<td>Retain. The policy is still relevant.</td>
</tr>
<tr>
<td>H-260.978</td>
<td>Salary Equity for Laboratory Personnel</td>
<td>Retain. The policy is still relevant.</td>
</tr>
<tr>
<td>H-275.934</td>
<td>Alternatives to the Federation of State Medical Boards Recommendations on Licensure</td>
<td>Retain. The policy is still relevant.</td>
</tr>
<tr>
<td>H-275.993</td>
<td>Examinations for Medical Licensure</td>
<td>Retain. The policy is still relevant.</td>
</tr>
<tr>
<td>H-295.943</td>
<td>Issues Regarding Patient and/or Donor Transports by Resident Physicians and Medical Students</td>
<td>Retain. The policy is still relevant.</td>
</tr>
<tr>
<td>H-300.946</td>
<td>Inappropriate Use of Social Security Numbers in CME Accreditation</td>
<td>Retain. The policy is still relevant.</td>
</tr>
<tr>
<td>H-300.973</td>
<td>Promoting Quality Assurance, Peer Review, and Continuing Medical Education</td>
<td>Retain. The policy is still relevant.</td>
</tr>
<tr>
<td>H-300.974</td>
<td>Unification of Continuing Education Credits</td>
<td>Rescind #1. The activities have been accomplished. Retain #2. The policy is still relevant.</td>
</tr>
<tr>
<td>H-300.975</td>
<td>Fraudulent/Legitimate Continuing Medical Education Activities</td>
<td>Retain. The policy is still relevant.</td>
</tr>
<tr>
<td>H-300.992</td>
<td>National Accreditation of AMA as Provider of Continuing Medical Education</td>
<td>Retain. The policy is still relevant.</td>
</tr>
<tr>
<td>H-305.940</td>
<td>Tax Exemption for Federal Medical Profession Scholarships</td>
<td>Rescind. The policy no longer is relevant. According to the IRS, qualified scholarship and fellowship grants are treated as tax-free. Also, there is no need to include in gross income amount received for services that are required by the National Health Service Corps Program or the Armed Forces Health Professions Scholarship (IRS.gov, Topic 421).</td>
</tr>
<tr>
<td>H-305.955</td>
<td>Cost of Medical School and Educational Loan Interest</td>
<td>Rescind in favor of Policy H-305.962 and H-305.997 which are more general. Deductions are available for interest paid on a qualified student loan if conditions set by the IRS are met.</td>
</tr>
<tr>
<td>H-305.962</td>
<td>Taxation of Federal Student Aid</td>
<td>Retain. The policy is still relevant.</td>
</tr>
<tr>
<td>H-305.997</td>
<td>Income Tax Exemption for Medical Student Loans and Scholarships</td>
<td>Retain. The policy is still relevant.</td>
</tr>
<tr>
<td>H-310.957</td>
<td>Resident Working Conditions Reform Update</td>
<td>Retain. The policy is still relevant.</td>
</tr>
<tr>
<td>H-310.959</td>
<td>In-Service Training Examinations – Final Report</td>
<td>Retain. The policy is still relevant.</td>
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<tr>
<td>H-310.960</td>
<td>Resident Education in Laboratory Utilization</td>
<td>Retain. The policy is still relevant.</td>
</tr>
<tr>
<td>H-310.961</td>
<td>Residency/Fellowship Working Conditions and Supervision</td>
<td>Rescind. This report is vague and two more detailed reports already exist: H-310.979, Resident Physician Working Hours and Supervision (reaffirmed CME Report 2, A-08), and H-310.963, Resident/Fellowship Working Hours and Supervision (reaffirmed CME Report 2, I-00).</td>
</tr>
<tr>
<td>H-355.979</td>
<td>National Practitioner Data Bank</td>
<td>Retain. The policy is still relevant.</td>
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<td>H-355.983</td>
<td>Reporting of Malpractice Information in the National Practitioner Data Bank</td>
<td>Retain. The policy is still relevant.</td>
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<tr>
<td>H-355.985</td>
<td>National Practitioner Data Bank</td>
<td>Retain. The policy is still relevant.</td>
</tr>
<tr>
<td>H-355.992</td>
<td>Reporting Impaired Physicians to the National Practitioner Data Bank</td>
<td>Retain. The policy is still relevant.</td>
</tr>
<tr>
<td>H-355.993</td>
<td>National Practitioner Data Bank</td>
<td>Retain. The policy is still relevant.</td>
</tr>
<tr>
<td>H-410.986</td>
<td>Resident Involvement in Practice Parameters</td>
<td>Retain. The policy is still relevant.</td>
</tr>
<tr>
<td>H-450.950</td>
<td>Revise National Practitioner Data Bank Criteria</td>
<td>Retain. The policy is still relevant.</td>
</tr>
<tr>
<td>D-180.995</td>
<td>Physician Privileges Application – Timely Review by Managed Care</td>
<td>Retain. The directive is still relevant.</td>
</tr>
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<td>Retain. The directive is still relevant.</td>
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<tr>
<td>D-255.994</td>
<td>Report on the Fifth Pathway</td>
<td>Rescind. With the ending of the Fifth Pathway there are no developing programs or prospective students and the AMA no longer monitors adherence to its requirements.</td>
</tr>
<tr>
<td>D-275.990</td>
<td>Implementation of NBME Clinical Skills Assessment Exam</td>
<td>Rescind. The Step 2 Clinical Skills Examination has been implemented.</td>
</tr>
<tr>
<td>D-275.992</td>
<td>Unified Medical License Application</td>
<td>Retain. The directive is still relevant.</td>
</tr>
<tr>
<td>D-275.993</td>
<td>Reporting of Resident Physicians</td>
<td>Retain. The directive is still relevant.</td>
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<tr>
<td>D-275.994</td>
<td>Facilitating Credentialing for State Licensure</td>
<td>Retain. The directive is still relevant.</td>
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<tr>
<td>D-295.977</td>
<td>Implementation of NBME Clinical Skills Assessment Exam</td>
<td>Rescind. This has been accomplished. LCME standard ED-27 states that “A medical education program must include ongoing assessment activities that ensure that medical students have acquired and can demonstrate on direct observation the core clinical skills, behaviors, and attitudes that have been specified in the program’s educational objectives.”</td>
</tr>
<tr>
<td>D-295.978</td>
<td>Mid-Year and Retroactive Medical School Tuition Increases</td>
<td>Rescind. The activities specified in this directive have been accomplished. The report mandated in this directive resulted in the following policy: Medical School Tuition Increases (H-305.934), which states that “Our American Medical Association opposes the imposition of mid-year and retroactive tuition increases at both public and private schools.”</td>
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<td>D-295.979</td>
<td>Education for the Prevention of Professional Liability Lawsuits</td>
<td>Rescind. Our AMA has undertaken many activities related to this directive. For example, the Introduction to the Practice of Medicine program for residents includes modules on “Malpractice” and “Patient Safety.”</td>
</tr>
<tr>
<td>D-295.980</td>
<td>Web-Based AMCAS Application</td>
<td>Rescind. The activities in this directive have been accomplished.</td>
</tr>
<tr>
<td>D-295.982</td>
<td>Model Pain Management Program for Medical School Curricula</td>
<td>Retain. The directive is relevant and data are collected periodically.</td>
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<td>D-300.994</td>
<td>Reduced Continuing Medical Education (CME) Fees for Retired Physicians</td>
<td>Retain. The directive is still relevant.</td>
</tr>
<tr>
<td>D-300.995</td>
<td>Reducing Burdens of CME Accreditation and Documentation</td>
<td>Retain. The directive is still relevant.</td>
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<td>D-275.993</td>
<td>Reporting of Resident Physicians</td>
<td>Retain. The directive is still relevant.</td>
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<td>D-300.996</td>
<td>Model Pain Management Program for Medical School Curricula</td>
<td>Retain, with change in title to read, “Voluntary Continuing Education for Physicians in Pain Management.” The directive is still relevant and the change in title is suggested to reflect the content of the directive.</td>
</tr>
<tr>
<td>D-300.997</td>
<td>Use of Medical Education Numbers in Continuing Medical Education</td>
<td>Retain. The directive is still relevant.</td>
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<td>D-300.998</td>
<td>Attendance of Non-Physicians at Courses Teaching Complex Diagnostic,</td>
<td>Retain. The directive is still relevant.</td>
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<td>Therapeutic or Surgical Procedures</td>
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<tr>
<td>D-305.990</td>
<td>Impact of Health System Changes on Medical Education</td>
<td>Rescind. Legislation and regulations related to student loan interest tax deductibility have changed.</td>
</tr>
<tr>
<td>D-305.991</td>
<td>Tax Deductibility for Student Loan Interest</td>
<td>Rescind. This directive has been completed. More recent reports were adopted by the House of Delegates on resident work hours and patient safety, and existing policies include: H-310.926 Resident/Fellow Work and Learning Environment (Resolution 322, A-03), H-310.928 Resident/Fellow Work and Learning Environment (Resolution 322, A-03), and H-310.929 Principles for Graduate Medical Education CME Report 14, A-09). The Council on Medical Education is submitting an updated report on these issues at this meeting (Report 7).</td>
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<td>D-300.996</td>
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<td>D-310.992</td>
<td>Limits on Training Opportunities for J-1 Residents</td>
<td>Retain. The directive is still relevant.</td>
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<td>D-310.993</td>
<td>Fair Process for Physicians-In-Training</td>
<td>Rescind. The activity specified in this directive has been</td>
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<td>accomplished.</td>
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<td>D-355.997</td>
<td>Reporting of Resident Physicians</td>
<td>Retain. The directive is still relevant.</td>
</tr>
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<td>D-360.997</td>
<td>The Effect of Nursing Shortage on Medical Education</td>
<td>Rescind. This directive has been completed and replaced by more</td>
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<td>current AMA policies including: H-360.984, Nursing Shortage</td>
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<td>Reducing the Hospital Registered Nurse Shortage at the Bedside</td>
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<td>(BOT Report 27, A-08), H-360.995, Nursing Education and the Supply</td>
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</tr>
</tbody>
</table>

H-40.994 Military Physicians in Graduate Medical Education Programs
Our AMA opposes any arbitrary attempt to limit the percentage of resident physicians in military graduate education or training programs. (Res. 71, I-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00)

H-40.995 Graduate Medical Education in the Military
Our AMA: (1) strongly supports and endorses the graduate medical education programs of the military services and recognizes the potential benefit to the military services of recruitment, retention and readiness programs; and (2) is gravely concerned that closures of military medical centers and subsequent reduction of graduate medical education programs conducted therein will not only impede the health care mission of the Department of Defense, but also harm the health care of the nation by increasing the drain on trained specialists available to the civilian sector. (Sub. Res. 1, A-79; Reaffirmed: CLRPD Rep. B, I-89; Reaffirmed: Sunset Report, A-00)

H-140.977 Residency Training in Medical-Legal Aspects of End-of-Life Care
Our AMA encourages residency training programs, regardless of or in addition to current specialty specific ACGME requirements, to promote and develop a high level of knowledge of and ethical standards for the use of such documents as living wills, durable powers of attorney for health care, and ordering DNR status, which should include medical, legal, and ethical principles guiding such physician decisions. This knowledge should include aspects of medical case management in which decisions are made to limit the duration and intensity of treatment. (Res. 66, A-90; Reaffirmed: Sunset Report, I-00)

H-150.995 Basic Courses in Nutrition
H-250.996 Enhancing Young Physicians’ Effectiveness in International Health
It is the policy of the AMA to work with national medical specialty societies and other organizations in preparing materials which guide young physicians in the development of skills necessary for effectively promoting the health of poor populations both in the United States and abroad. (Res. 407, I-91; Reaffirmed: Sunset Report, I-01)

H-255.997 Fifth Pathway
Our AMA supports the principle that any existing or proposed alternative programs conducted by US medical schools to facilitate entry of US citizens studying in foreign medical schools into US programs should assure that those who complete such programs are reasonably comparable to the school’s regularly enrolled and graduated students. (CME Rep. D, A-81; Reaffirmed: CLRPD Rep. F, I-91; Modified: Sunset Report, I-01)

H-255.998 Foreign Medical Graduates
Our AMA supports the following principles, based on recommendations of the Ad Hoc Committee on Foreign Medical Graduates (FMGs): Our AMA supports the practice of US teaching hospitals and foreign medical educational institutions entering into appropriate relationships directed toward providing clinical educational experiences for advanced medical students who have completed the equivalent of US core clinical clerkships. Policies governing the accreditation of US medical education programs specify that core clinical training be provided by the parent medical school; consequently, the AMA strongly objects to the practice of substituting clinical experiences provided by US institutions for core clinical curriculum of foreign medical schools. Moreover, it strongly disapproves of the placement of any medical school undergraduate students in hospitals and other medical care delivery facilities which lack educational resources and experience for supervised teaching of clinical medicine. (CME Rep. F, A-81; Reaffirmed: CLRPD Rep. F, I-91; Modified: Sunset Report, I-01)

H-260.978 Salary Equity for Laboratory Personnel
It is the policy of the AMA to promote adequate compensation for medical technologists, cytotechnologists and other medical laboratory personnel and to promote increased funding for their educational programs. (Sub. Res. 39, A-91; Reaffirmed: Sunset Report, I-01)

H-275.934 Alternatives to the Federation of State Medical Boards Recommendations on Licensure
Our AMA adopts the following principles: (1) Ideally, all medical students should successfully complete Steps 1 and 2 of the United States Medical Licensing Examination (USMLE) or Parts 1 and 2 of the Comprehensive Osteopathic Medical Licensing Examination (COMLEX) prior to entry into residency training. At a minimum, individuals entering residency training must have successfully completed Step 1 of the USMLE or Part 1 of COMLEX. There should be provision made for students who have not completed Step 2 of the USMLE or Part 2 of the COMLEX to do so during the first year of residency training. (2) All applicants for full and unrestricted licensure, whether graduates of U.S. medical schools or international medical graduates, must have completed one year of accredited graduate medical education (GME) in the U.S., have passed all licensing examinations (USMLE or COMLEX), and must be certified by their residency program director as ready to advance to the next year of GME and to obtain a full and unrestricted license to practice medicine. The candidate for licensure should have had education that provided exposure to general medical content. (3) There should be a training permit/educational license for all resident physicians who do not yet have a full and unrestricted license to practice medicine. To be eligible for an initial training permit/educational license, the resident must have completed Step 1 of the USMLE or Part 1 of COMLEX. (4) Residency program directors shall report only those actions to state medical licensing boards that are reported for all licensed physicians. (5) Residency program directors should receive training to ensure that they understand the process for taking disciplinary action against resident physicians, and are aware of procedures for dismissal of residents and for due process. This requirement for residency program directors should be enforced through Accreditation Council for Graduate Medical Education accreditation requirements. (6) There should be no reporting of actions against medical students to state medical licensing boards. (7) Medical schools are responsible for identifying and remedying and/or disciplining medical student unprofessional behavior, problems with substance abuse, and other behavioral problems, as well as gaps in student knowledge and skills. (8) The Dean’s Letter of Evaluation should be strengthened and standardized, to serve as a better source of information to residency programs about applicants. (CME Rep. 8, A-99; Reaffirmed: CME Rep. 4, I-01)

H-275.993 Examinations for Medical Licensure
Our AMA affirms its recommendation that medical school faculties continue to exercise the responsibilities inherent in their positions for the evaluation of students and residents, respectively. (CME Rep. B, I-81; Reaffirmed: CLRPD Rep. F, I-91; Modified: Sunset Report, I-01)

H-295.943 Issues Regarding Patient and/or Donor Transports by Resident Physicians and Medical Students
Our AMA (1) urges medical schools not to require medical students to participate in the air or ground transport of patients or organs during required clinical rotations; and (2) encourages all teaching institutions where medical students or resident physicians participate (compulsory or voluntarily) in the air or ground transport of patients or organs (a) to notify respective students and residents of all program requirements related to transports; (b) to include accident, disability, and life insurance as part of an available package for participating medical students and resident physicians, and to provide such insurance where participation is mandatory; (c) to include in the educational curriculum formal training on general and safety issues pertaining to emergency transport before students or residents participate in such activity; and (d) to adhere to the Association of Air Medical...
Our AMA encourages legislation to restore the tax deductibility of student loan interest. (Res. 305, I-92; Reaffirmation A-00; Reaffirmation I-01)

H-305.962 Taxation of Federal Student Aid
Our AMA opposes legislation that would make medical school scholarships or fellowships subject to federal income or social security taxes (FICA). (Res. 210, I-91; Reaffirmed: Sunset Report, I-01)

H-305.997 Income Tax Exemption for Medical Student Loans and Scholarships
The AMA supports continued efforts to obtain exemption from income tax on amounts received under medical scholarship or loan programs. (Res. 65, I-76; Reaffirmed: Sunset Report, I-98; Reaffirmation A-01)

H-310.957 Resident Working Conditions Reform Update
(1) Our AMA supports the following new language pertaining to resident work hours and environment for the “General Requirements” of the “Essentials of Accredited Residencies in Graduate Medical Education”: Each residency program must establish formal policies governing resident duty hours and working environment that are optimal for both resident education and the care of patients. (a) Special requirements relating to duty hours and on-call schedules shall be based on an educational rationale and patient need, including continuity of care. (b) The educational goals of the program and learning objectives of residents must not be compromised by excessive reliance on residents to fulfill institutional service obligations. Duty hours, however, must reflect the fact that responsibilities for continuing patient care are not automatically discharged at specific times.
Programs must ensure that residents are provided backup support when patient care responsibilities are especially difficult or prolonged. (c) Resident duty hours and on-call schedules must not be excessive. The structuring of duty hours and on-call schedules must focus on the needs of the patient, continuity of care, and the educational needs of the resident. Duty hours must be consistent with the General and Special Requirements that apply to each program. Detailed structuring of resident service is an integral part of the approval process and therefore close adherence to the General and Special Requirements is essential to program accreditation. (2) Our AMA supports the following: (a) the proposed revision of the “Special Requirements” for surgery. It is desirable that residents’ work schedule be designed so that on the average, excluding exceptional patient care needs, residents have at least one day out of seven free of routine responsibilities and be on-call in the hospital no more often than every third night. The ratio of hours worked and on-call time will vary, particularly at the senior levels, and therefore necessitates flexibility. (BOT Rep. YY, I-91; Reaffirmed: Sunset Report, I-01)

H-310.959 In-Service Training Examinations - Final Report
It is the policy of the AMA (1) to encourage entities responsible for in-service examinations and the ACGME to recognize that in-service training examinations should not be used in decisions concerning acceptance, denial, advancement, or retention in residency or fellowship training positions; should not be used by outside regulatory agencies for the purpose of assessing resident knowledge or the quality of training programs; and should not be used as a pretest to sit for specialty boards; (2) to encourage residency program directors to use the results of in-training examinations to counsel residents and as the basis for developing appropriate programs of remediation and also for the purpose of educational program evaluation; and (3) to urge that evaluation of residents for promotion or retention be based on valid and reliable measures of knowledge, skills, and behaviors, applied sequentially over time. In-training examinations should be administered under appropriate testing conditions. Residents should be relieved of on-call duty the night prior to and during the administration of the examination. The results, if used at all, should not be the sole factor in evaluation of residents. (CME Rep. A, I-91; Reaffirmed: Sunset Report, I-01)

H-310.960 Resident Education in Laboratory Utilization
Our AMA endorses the concept of practicing physicians devoting time with medical students and resident physicians for chart reviews focusing on appropriate test ordering in patient care. (Res. 84, A-91; Reaffirmed: Sunset Report, I-01)

H-310.961 Residency/Fellowship Working Conditions and Supervision
Our AMA will continue to work closely with the parties involved in the accreditation of graduate medical education programs to reaffirm the AMA’s position on resident working conditions and supervision, to further clarify the various concerns related to resident working conditions, and to explain why specific language is essential to the general issue of working conditions. (BOT Rep. KKK, A-91; Modified: Sunset Report, I-01)

H-355.979 National Practitioner Data Bank
It is policy of the AMA to improve patient access to reliable information and as an alternative to a federally operated national data repository, our AMA strongly supports and actively encourages the provision of accurate and relevant physician-specific information through a system developed and operated by state licensing boards or other appropriate state agencies. Our AMA: (1) supports requiring felony convictions of physicians to be reported to state licensing boards; (2) supports federal block grants that provide states with sufficient financial resources to develop and implement officially recognized, Internet accessible, physician-specific information systems that will assist patients in choosing physicians; and (3) believes that serious problems exist in correlating lawsuits with physician competence or negligence and some studies indicate lawsuits seldom correlate with findings of incompetence. Only a state licensing board should determine when lawsuit settlements and judgments should result in a disciplinary action, and public disclosure of lawsuit settlements and judgments should only occur in connection with a negative state medical board licensing action. (BOT Rep. 31, I-00; Reaffirmation & Reaffirmed: Res. 216, A-01)

H-355.983 Reporting of Malpractice Information in the National Practitioner Data Bank
Our AMA: (1) seeks opportunities to limit reports concerning residents to the National Practitioner Data Bank to only those situations where a final adverse action has been taken by a medical licensing jurisdiction; and (2) opposes attempts to extend reports concerning residents to the National Practitioner Data Bank beyond those covered in this policy. (CME Rep. 3, A-96; Reaffirmed & Appended: Res. 242, A-01; Reaffirmed: CME Rep. 4, I-01)

H-355.985 National Practitioner Data Bank
Our AMA: (1) opposes all efforts to open the National Practitioner Data Bank to public access; (2) strongly opposes public access to medical malpractice payment information in the National Practitioner Data Bank; and (3) opposes the implementation by the National Practitioner Data Bank of a self-query user fee. (Res. 824, I-93; Reaffirmed: BOT Rep. 31, I-00; Reaffirmation & Reaffirmed: Res. 216, A-01)

H-355.992 Reporting Impaired Physicians to the National Practitioner Bank
Our AMA will continue to monitor the issue of reporting impaired physicians to the National Practitioner Data Bank and will seek further clarification of ambiguities or misinterpretations of the reporting requirements for impaired physicians. (BOT Rep. J, A-91; Reaffirmed: Sunset Report, I-01)

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H-355.993 National Practitioner Data Bank
Our AMA: (1) urges HHS to retain an independent consultant to (a) evaluate the utility and effectiveness of the National Practitioner Data Bank, (b) evaluate the confidentiality and security of the reporting, processing and distribution of Data Bank information, and (c) provide the findings and recommendations to the National Practitioner Data Bank Executive Committee and the General Accounting Office; (2) will take appropriate steps to have Congress repeal Section 4752 (f) of OBRA 1990 requiring peer review organizations and private accreditation entities to report any negative action or finding to the Data Bank; (3) opposes any legislative or administrative efforts to expand the Data Bank reporting requirements for physicians, such as the reporting of a physician who is dismissed from a malpractice suit without any payment made on his or her behalf, or to expand the entities permitted to query the Data Bank such as public and private third party payers; (4) seeks to amend the Health Care Quality Improvement Act of 1986 to allow a physician, at the time the physician notifies the Data Bank of a dispute, to attach an explanation or statement to the disputed report; (5) urges HHS to work with the Federation of State Medical Boards to refine its National Practitioner Data Bank breakdown of drug violation reporting into several categories; (6) urges the HHS to analyze malpractice data gathered by the Physician Insurance Association of America and recommend to Congress that a threshold of at least $30,000 for the reporting of malpractice payments be established as soon as possible; (7) will continue to work with HHS to allow physicians an expanded time period to verify the accuracy of information reported to the Data Bank prior to its release in response to queries; (8) will work with HHS and the Office of Management and Budget to reduce the amount of information required on the request for information disclosure form; and (9) will continue to work with HHS to improve its mechanism to distribute revisions and clarifications of Data Bank policy and procedure; and (10) will review questions regarding reportability to the Data Bank and will provide periodic updates on reportability issues to the AMA House of Delegates. (Sub. Res. 7, A-91; Reaffirmation & Reaffirmed: Res. 216, A-01; Reaffirmed: Sunset Report, I-01)

H-410.986 Resident Involvement in Practice Parameters
Our AMA urges national medical specialty societies to work with resident physicians within their specialty in developing practice parameters. (Res. 52, A-91; Reaffirmed: Sunset Report, I-01)

H-450.950 Revise National Practitioner Data Bank Criteria
Our AMA: (1) communicates to legislators the fundamental unfairness of the civil judicial system as it now exists, whereby a jury, rather than a forum of similarly educated peers, determines if a physician has violated the standards of care and such results are communicated to the National Practitioner Data Bank; and (2) impresses on our national legislators that only when a physician has been disciplined by his/her state licensing agency should his/her name appear on the National Practitioner Data Bank. (Res. 809, I-99; Reaffirmed: BOT Rep. 31, I-00; Reaffirmation & Reaffirmed: Res. 216, A-01)

D-180.995 Physician Privileges Application - Timely Review by Managed Care
Our AMA will work with the American Association of Health Plans (AAHP), the American Hospital Association (AHA), the National Committee on Quality Assurance (NCQA), and other appropriate organizations to allow residents who are within six months of completion of their training to apply for hospital privileges and acceptance by health plans. (Res. 708, A-01)

D-255.994 Report on the Fifth Pathway
(1) The “Fifth Pathway Statement” (2001 revision) be disseminated to existing and developing programs, prospective students, and others on request and that adherence to its requirements continue to be monitored. (2) Our AMA will explore ways to collect and disseminate information on the general outcomes of the Fifth Pathway, including such things as graduate specialty choice, performance in residency training, board certification status, and record of disciplinary actions. (CME Rep. 2, I-01)

D-275.990 Implementation of NBME Clinical Skills Assessment Exam
Our AMA will: (1) request an itemized rationalization from the National Board of Medical Examiners (NBME) for the proposed cost of $1000 for the Clinical Skills Assessment Exam (CSAE) and the number and location of the testing sites; (2) take all steps necessary to delay implementation of the CSAE as the NBME has not developed an implementation plan that involves reasonable geographic and financial structures; and (3) express deep concern to the NBME that the proposed CSAE imposes unacceptable costs and travel burdens on examinees. (Res. 311, I-01)

D-275.992 Unified Medical License Application
Our AMA will request the Federation of State Medical Boards to examine the issue of a standardized medical licensure application form for those data elements that are common to all medical licensure applications. (Res. 308, I-01)

D-275.993 Reporting of Resident Physicians
Our AMA will: (1) work with appropriate groups, including the Federation of State Medical Boards, to attempt to increase the standardization of information about resident physicians that is reported to state medical licensing boards to obtain or renew the limited educational permit, consistent with existing AMA Policy H-265.934 (#4); (2) encourage state medical societies to act as a link between state medical licensing boards and medical schools/residency programs to ensure that educational programs are familiar with and have the opportunity to comment on proposed changes in reporting requirements for resident physicians; and (3) make relevant groups-- for example, medical schools, state medical societies, resident physicians--aware of what types of information must be supplied in order for resident physicians to obtain and renew a limited educational permit. (CME Rep. 4, I-01)
D-275.994 Facilitating Credentialing for State Licensure
Our AMA will: (1) encourage the Federation of State Medical Boards to urge its Portability Committee to complete its work on developing mechanisms for greater reciprocity between state licensing jurisdictions as soon as possible; (2) work with the Federation of State Medical Boards and the Association of State Medical Board Executive Directors to encourage the increased standardization of credentials requirements for licensure, and to increase the number of reciprocal relationships among all licensing jurisdictions; and (3) encourage the Federation of State Medical Boards and its licensing jurisdictions to widely disseminate information about the Federation’s Credentials Verification Service, especially when physicians apply for a new medical license. (Res. 302, A-01)

D-295.977 Implementation of NBME Clinical Skills Assessment Exam
Our AMA representatives to the Liaison Committee on Medical Education (LCME) will indicate that the teaching and assessment of clinical skills should be a high priority in the accreditation process. (Res. 311, I-01)

D-295.978 Mid-Year and Retroactive Medical School Tuition Increases
(1) Our AMA work with the Association of American Medical Colleges to discourage assessment of mid-year and retroactive increases in medical school tuition and fees. (2) Our AMA encourage state and county medical societies to develop policy and lobby state legislatures to help minimize medical school tuition increases in public or officially-designated state medical schools. (3) That medical schools provide entering students with an estimate of their future tuition costs and fees, possibly based on past history of the schools tuition. (4) Our AMA report back to the House of Delegates at the 2002 Interim Meeting on its progress in limiting mid-year and retroactive tuition increases. (Res. 312, I-01)

D-295.979 Education for the Prevention of Professional Liability Lawsuits
Our AMA will work with members of the Federation and other relevant groups to identify and disseminate information about effective programs for the education of medical students, interns, residents, fellows, and young physicians on the prevention of professional liability lawsuits. (Res. 306, I-01)

D-295.980 Web-Based AMCAS Application
Our AMA: (1) will strongly encourage the Association of American Medical Colleges (AAMC) to create a back-up application system that can be used in the event that the web-based American Medical College Application Service (AMCAS) proves inadequate and by applicants who have limited access to computer resources; (2) will strongly encourage the AAMC to work with medical school Admissions Offices to improve and simplify the web-based medical school application; and (3) work in conjunction with the AAMC to encourage medical schools around the country to remain part of the centralized AMCAS in order to avoid placing an undue burden on future applicants through multiple primary applications. (Res. 313, I-01)

D-295.982 Model Pain Management Program For Medical School Curricula
Our AMA will collect, synthesize, and disseminate information about effective educational programs in pain management and palliative care in medical schools and residency programs. (Res. 308, A-01)

D-300.994 Reduced Continuing Medical Education (CME) Fees for Retired Physicians
Our AMA will support reduce registration fees for retired physicians at all continuing medical education programs. (Res. 302, I-01)

D-300.995 Reducing Burdens of CME Accreditation and Documentation
Our AMA will work with the Accreditation Council for Continuing Medical Education to simplify the requirements for documentation and administration of accredited CME programs. (Res. 304, I-01)

D-300.996 Model Pain Management Program For Medical School Curricula
Our AMA will encourage appropriate organizations to support voluntary continuing education for physicians based on effective guidelines in pain management. (Res. 308, A-01)

D-300.997 Use of Medical Education Numbers In Continuing Medical Education
Our AMA will disseminate this policy widely and recommend that such policy be adopted by other organizations, including national certification boards and similar entities. (Res. 301, A-01)

D-300.998 Attendance of Non-Physicians at Courses Teaching Complex Diagnostic, Therapeutic or Surgical Procedures
Our AMA will encourage the Accreditation Council for Continuing Medical Education, the American Academy of Family Physicians, and other groups that accredit providers of continuing medical education to adopt the principle that continuing medical education should be focused on physicians (MDs/DOs). Courses teaching complex diagnostic, therapeutic or surgical procedures should be open only to those practitioners and/or sponsored members of the practitioner’s care team who have the appropriate medical education background and preparation to ensure patient safety. This should not be construed to limit access to or apply to programs leading to life support certification, e.g. ATLS, ACLS. (CME Rep. 2, A-01)
3. ENHANCING ATTENTION TO PERSONAL QUALITIES IN MEDICAL SCHOOL ADMISSION

Reference committee hearing: See Reference Committee C.

In 2010, the Center for Transforming Medical Education was formed to continue the goals established by the American Medical Association’s Initiative to Transform Medical Education (ITME), which began in 2005. The ITME goal for medical school admission was to “apportion more weight in admissions decisions to characteristics of applicants that predict success in the interpersonal domains of medicine.”

Medical educators (and the public) agree that being a “good doctor” is more than academic achievement and other measures of intellectual ability. There have been calls for a more “holistic assessment” of medical school applicants to include a wider variety of personal qualities, such as altruism, motivation for medicine, dedication, and intellectual curiosity, in the admissions process. A recent study of academic affairs officers and admissions officers at US MD-granting medical schools identified the most important attributes required for student success in medical
school (see Table 1 in the Appendix), including integrity, motivation for a career in medicine, and reliability (Association of American Medical Colleges, unpublished data, 2008). In this report, “personal qualities” will be used to describe the desirable characteristics or attributes, such as those listed in Table 1, in accordance with the term used in AMA Policy H-295.888 “Progress in Medical Education: the Medical School Admission Process” (AMA Policy Database).

Research underscores the importance of finding ways to measure personal qualities. For example, a retrospective look at physicians sanctioned by state medical licensing boards for various types of professional misconduct showed a high correlation with similar behaviors during medical school. Assessing personal qualities of medical school applicants, however, is difficult. The Medical College Admission Test (MCAT) and the grade point average (GPA) are routinely relied upon by medical schools as predictors of applicants’ academic success during medical school and beyond. While quantitative tools such as the MCAT have been developed with great expertise, medical school admissions committees recognize that they do not capture all of the personal qualities needed to become a successful physician. Currently, tools to assess personal qualities are limited. The tools now used by many admissions committees to assess applicants’ personal qualities during the initial screening of applicants, including personal statements and other written materials, are not fully objective and are insufficient with regard to validity and reliability. Addressing this gap within the medical school admissions process is an on-going goal of the AMA.

This report: 1) summarizes relevant AMA policies on medical school admissions; 2) describes AMA activities on medical school admissions; and 3) describes other efforts to enhance assessment of personal qualities during the admissions process including those by the Association of American Medical Colleges (AAMC).

AMA POLICIES ON MEDICAL SCHOOL ADMISSIONS

- AMA policy advocates that medical schools give significant weight to personal qualities, such as empathy, integrity, and commitment to service, during the admissions process (Policy H-295.888, “Progress in Medical Education: the Medical School Admission Process”), as well as the ability to acquire the knowledge and skills required of a physician. (Policy H-295.995, “Recommendations for Future Directions for Medical Education”) The full text of H-295.888 and the relevant text (paragraphs 1 – 7) of H-295.995 are included as an attachment to this report.
- AMA policy supports research on ways to reliably evaluate personal qualities of applicants to medical school (Policy H-295.888).
- AMA policy supports the recommendations contained in Future Directions for Medical Education including:
  - Schools of medicine should accept the principle and should state in their requirements for admission that a broad cultural education in the arts, humanities, and social sciences, as well as in the biological and physical sciences, is desirable.
  - Medical schools should make their goals and objectives known to prospective students and premedical counselors in order that applicants may apply to medical schools whose programs are most in accord with their career goals. Medical schools should state explicitly in publications their admission requirements and the methods they employ in the selection of students (Policy H-295.995).

AMA ACTIVITIES ON MEDICAL SCHOOL ADMISSIONS

Furthering the AMA’s interest in improving assessment of personal qualities in the recruitment process for medical school applicants led to two AMA activities on medical school admissions: an ITME Conference on Medical School Admissions and a review of how personal qualities are assessed among medical school applicants.

Conference on Medical School Admissions

The AMA, with the collaboration of the AAMC, held the AMA ITME Conference on Medical School Admissions on December 9-10, 2009. This invitational conference was attended by a diverse group of 30 leaders from a variety of fields whose activities influence the admissions process. The main outcome of the conference was a set of recommendations for increasing attention to behavioral competencies in the admissions process. These recommendations have been widely circulated to the three key stakeholder groups for which they were developed: medical schools, admissions committees, and the medical education community. The conference executive summary and recommendations are available online at: http://www.ama-assn.org/ama1/pub/upload/mm/40/behavioral-competencies-medical-students.pdf.
Assessing behavioral competencies of medical school applicants

A review of the admission Websites of the 131 US LCME-accredited medical schools with a 2010 entering class was conducted to explore: 1) the extent to which medical schools specify the behavioral competencies that are assessed during the admissions process; 2) how behavioral competencies of applicants are assessed by medical schools; and 3) when, during the admissions process, behavioral competencies are assessed.

It was found that 65% (n = 85) of the 131 medical school admission Websites identified at least one personal quality desired of applicants. The five personal qualities with the highest frequencies were: motivation, maturity, compassion, leadership, and integrity. Sixty percent (n = 51) of Websites specified the tool or method (such as personal essay) used to assess at least one behavioral competency. Among the 51 schools that assessed behavioral competencies, 18 (35%) conducted the assessment solely at the interview. Based on this study, it is recommended that all medical schools specifically state on their Websites the behavioral competencies that are included among their criteria for admission as well as how and at what point during the application process that assessment takes place. Results from the review provide further support for AMA Policy H-295.995 (see AMA Policies on Medical School Admissions section above) and for continued collaboration with AAMC and other stakeholders working on the issue.

AAMC ACTIVITIES ON MEDICAL SCHOOL ADMISSIONS

The goal of the AAMC’s current activities on medical school admission is to “improve the selection process to create a diverse, capable, and caring physician workforce for the 21st century.” Currently, the AAMC is engaged in three projects directly related to assessing personal qualities of medical school applicants: 1) The Fifth Comprehensive Review of the MCAT (MR5), 2) the Holistic Review Project, and 3) the Social and Behavioral Sciences Project. A brief summary of each project follows. The full description of these and related AAMC admissions initiatives can be found online at: https://www.aamc.org/initiatives/54250/admissions/.

Fifth Comprehensive Review of the MCAT (MR5)

The AAMC is in the process of conducting a comprehensive review of the MCAT. This is the fifth time the MCAT exam has been evaluated since it was first administered in 1928. The MCAT is being reviewed by a 21-member committee charged with recommending changes aimed at increasing the MCAT’s value to medical school admissions committees. The committee is considering recent calls for new information about applicants’ professional competencies, such as cultural competence, communication skills, and professionalism; however, the committee has noted the difficulty of measuring personal characteristics. Additional information is available online at: http://www.aamc.org/meded/admissions/mr509.pdf.

Holistic Review Project

Holistic Review of applications approaches the application process in a wider context than using a single or a few factors to determine a cut-off for consideration. Many factors are considered as well as their relationship to one another. Holistic review affords admissions committees the opportunity to link the attributes and characteristics of applicants to their schools’ missions.

According to the project website, the purpose of the AAMC Holistic Review Project is to develop tools and resources that medical schools can use to create and sustain medical student diversity. Medical school staff serving on academic affairs committees and staff serving on diversity committees are the primary collaborators on the Holistic Review Project. The project focuses on the application and admissions process in the context of medical school mission and goals and other institutional efforts that promote diversity, such as outreach, recruitment, financial aid, and retention. A set of recommendations will be developed. Additional information is available online at: https://www.aamc.org/initiatives/opi/holisticreview/. Further, the AAMC 2010 resource for medical schools on holistic admissions, Roadmap to diversity: Integrating holistic review practices into medical school practices, is available at: https://services.aamc.org/publications/index.cfm?fuseaction=Product.displayForm&prd_id=294&prv_id=365.
Social and Behavioral Sciences Project

The Social and Behavioral Sciences Project is an AAMC initiative designed to create general consensus within the medical education community on the skills, attitudes, and knowledge that graduating medical students should possess. The goals of the project are to set forth program-level learning objectives that medical school deans and faculties can use as a guide in reviewing their medical student education programs (Phase I); and to suggest strategies that medical school deans and faculties might employ in implementing agreed-upon changes in their education programs (Phase II). Additional information is available online at: www.aamc.org/meded/msop/start.htm

INNOVATIVE ASSESSMENT PROJECT FROM THE FIELD

An innovative method for assessing personal qualities of medical applicants was identified and is described below.

Multiple Mini-Interview (MMI)

The Multiple Mini-Interview, developed at the Michael G. DeGroot School of Medicine, McMaster University in Hamilton, Ontario, Canada is an assessment tool which uses objective structured clinical examination (OSCE)-style format. The main purpose of the MMI is to assess cognitive and non-cognitive skills of medical school applicants. The MMI protocol consists of stations or “multiple, focused encounters” set up to assess specific skills and characteristics of applicants including communication, reasoning, and empathy that are considered desirable and important for applicant selection. Eight to ten stations are most often used by medical schools. Each station has a different interviewer(s) and lasts about 5-10 minutes. The MMI aims to overcome limitations of the traditional interview including the inability to identify optimal personal attributes. Individual studies have found the MMI reliable and valid. While originally developed at McMaster, medical schools in the United States have begun using some form of this approach. There has been no report to date of their experiences.

DISCUSSION AND RECOMMENDATIONS

While there is agreement within the medical profession and the public that personal qualities such as integrity, maturity, and compassion are integral to being a successful physician, currently there are limited ways to assess them in a valid and reliable manner. Since the majority of admissions committees process several thousand applications per year, they rely heavily on quantitative tools such as the MCAT and GPA, indicators of academic success in the first two years of medical school, that have been shown to be valid and reliable. Further understanding is needed of the personal qualities that are most important to becoming a successful physician. What specific qualities are needed during medical school? Do these qualities change over time? What qualities enhance the ability of learners to succeed despite changing conditions? For example, the learning environment has a strong effect on medical students which may operate regardless of the personal qualities students possess when they enter medical school. Perhaps admissions committees should emphasize resilience or adaptability among applicants as a predictor of ability to counter or ignore negative influences in the learning environment.

Work is ongoing to advance the medical school admission process, including developing innovative tools and measures to adequately assess relevant personal qualities of medical school applicants. These efforts must be supported and furthered so that medical schools admit and train future physicians who are proficient in knowledge and skills as well as who possess personal qualities that optimize their ability to provide compassionate care to patients.

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

1. That our American Medical Association (AMA) continue to work with the Association of American Medical Colleges (AAMC) and other relevant organizations to encourage improved assessment of personal qualities in the recruitment process for medical school applicants including types of information to be solicited in applications to medical school.

2. That our AMA work with the AAMC and other relevant organizations to explore the range of measures used to assess personal qualities among applicants, including those used by related fields.
3. That our AMA encourage the development of innovative methodologies to assess personal qualities among medical school applicants.

4. That our AMA work with medical schools and other relevant stakeholder groups to review the ways in which medical schools communicate the importance of personal qualities among applicants, including how and when specified personal qualities will be assessed in the admissions process.

5. That our AMA encourage continued research on the personal qualities most pertinent to success as a medical student and as a physician to assist admissions committees to adequately assess applicants.

6. That our AMA encourage continued research on the factors that impact negatively on humanistic and empathetic traits of medical students during medical school.


REFERENCES


APPENDIX

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Source: AAMC 2008 Survey of Academic Affairs Officers and Admissions Officers

* Double dashes indicate attributes that were added to Academic Affairs Officers’ survey based on feedback from the MR5 committee that some important attributes were missing from the Admissions Officers’ survey.

+ The table contains a subset of the data and the rating scale.

ATTACHMENT

H-295.888 Progress in Medical Education: the Medical School Admission Process

Our AMA encourages: (1) research on ways to reliably evaluate the personal qualities (such as empathy, integrity, commitment to service) of applicants to medical school and support broad dissemination of the results. Medical schools should be encouraged to give significant weight to these qualities in the admissions process; (2) premedical coursework in the humanities, behavioral sciences, and social sciences, as a way to ensure a broadly-educated applicant pool; and (3) dissemination of models that allow medical schools to meet their goals related to diversity in the context of existing legal requirements, for example through outreach to elementary schools, high schools, and colleges. (CME Rep. 8, I-99; Reaffirmed: CME Rep. 2, A-09)

H-295.995 Recommendations for Future Directions for Medical Education

The AMA supports the following recommendations relating to the future directions for medical education: (1) The medical profession and those responsible for medical education should strengthen the general or broad components of both undergraduate and graduate medical education. All medical students and resident physicians should have general knowledge of the whole field of medicine regardless of their projected choice of specialty. (2) Schools of medicine should accept the principle and should state in their requirements for admission that a broad cultural education in the arts, humanities, and social sciences, as well as in the biological and physical sciences, is desirable. (3) Medical schools should make their goals and objectives known to prospective students and premedical counselors in order that applicants may apply to medical schools whose programs are most in accord with their career goals. (4) Medical schools should state explicitly in publications their admission requirements and the methods they employ in the selection of students. (5) Medical schools should require their admissions committees to make every effort to determine that the students admitted possess integrity as well as the ability to acquire the knowledge and skills required of a physician. (6) Although the results of standardized admission testing may be an important predictor of the ability of students to complete courses in the preclinical sciences successfully, medical schools should utilize such tests as only one of several criteria for the selection of students. Continuing review of admission tests is encouraged because the subject content of such examinations has an influence on premedical education and counseling. (7) Medical schools should improve their liaison with college counselors so that potential medical students can be given early and effective advice. The resources of regional and national organizations can be useful in developing this communication.

4. PROGRESS IN TRANSFORMING THE MEDICAL EDUCATION LEARNING ENVIRONMENT

Informational report. No reference committee hearing.

HOUSE ACTION: FILED (INFORMATIONAL)

This informational report will summarize the activities of the Liaison Committee on Medical Education (LCME) and the AMA related to the medical education learning environment during the past several years.

ACTIVITIES OF THE LCME

The LCME approved a new accreditation standard on the medical education learning environment that went into effect in July 2009 (see the Attachment for the wording of standard MS-31-A and its explanatory annotation). In summary, the intent of the standard is for a medical school to:

1) Define the professional attributes that medical students are expected to develop;
2) Include education and student assessment related to these attributes as part of the educational program;
3) Evaluate the learning environment to identify positive and negative influences; and
4) Work with its partners to mitigate negative influences on medical students' development of the desired professional attributes.

To assist medical schools in identifying approaches to achieve compliance with this standard, the LCME sponsored a session during the 2009 Annual Meeting of the Association of American Medical Colleges (AAMC). Attended by about 250 medical school faculty members and administrators, the session included presentations by several medical schools that had successfully addressed the expectations in the standard.

The LCME has had an additional standard that expects medical schools to define and publicize the standards for the teacher-learner relationship and to develop written policies for addressing violations (see the Attachment for the wording of standard MS-32 and its annotation). The LCME monitors compliance with this standard in part through responses to the AAMC Annual Medical School Graduation Questionnaire (AAMC GQ), which is completed by fourth-year medical students in MD-granting schools. In 2010, about 13,100 fourth-year medical students completed the survey. Of these, 16.9% indicated that they had been personally mistreated during medical school and 17.8% reported that they witnessed another student being mistreated.1

The most frequent category of mistreatment reported was being publicly belittled or humiliated. Of the 2,226 students who reported mistreatment in the questionnaire, 50% noted that this type of mistreatment occurred occasionally and 5% that it occurred frequently.1 While the AAMC GQ is the most-commonly cited source of information about medical student mistreatment, some concerns have been expressed about the precision of the questions and the resulting validity of the data.

There is no doubt, however, about the need to address the issue of medical student and resident mistreatment. In response to this need, the LCME co-chairs wrote to the AMA and the AAMC to ask for assistance.

ACTIVITIES OF THE AMA

The AMA has been engaging in a number of activities related to promoting a positive learning environment.

Response to the Request from the LCME

In response to the request from the LCME to participate in addressing problems relating to medical student mistreatment, the AMA Council on Medical Education, the Section on Medical Schools, and the Medical Student Section will be holding a joint education session during the 2011 Annual Meeting of the AMA House of Delegates. It is planned that the session will result in some ideas and strategies for positive action.

The ISTEP Collaborative Study of the Learning Environment

Innovative Strategies for Transforming the Education of Physicians (ISTEP) is a multi-institutional consortium that is organizationally housed within the Center for Transforming Medical Education. In 2010, ISTEP initiated a longitudinal, multi-school study of the learning environment. Using a variety of measures, data were collected from over 2,000 entering medical students at 14 sites. This cohort of students will be followed throughout their medical education to identify factors that promote or inhibit the development of professional behaviors. New institutions will be added in the following years.
Follow-Up to the Initiative to Transform Medical Education (ITME) Recommendations on the Learning Environment

The following was one of the recommendations of the planning phase of ITME:

Ensure that the learning environment throughout the medical education continuum is conducive to the development of appropriate attitudes, behaviors, and values, as well as knowledge and skills.

In its implementation phase, ITME held two invitational conferences on the learning environment. ITME defined the learning environment as follows:

At any point in time, the learning environment is a social system that includes the learner (including the external relationships and other factors affecting the learner), the individuals with whom the learner interacts, the setting(s) and purpose(s) of the interaction, and the formal and informal rules/policies/norms governing the interaction.

Discussions during these meetings led to an action plan that is based on the importance to the learning environment of several related elements:

1. **Institutional culture**: The values and norms of the institution as embodied in formal policies and in organizational procedures and policies.
2. **Curriculum (Formal)**: The objectives and/or competencies of the educational program and the explicit learning experiences and methods of assessment designed to assure learners’ attainment of the objectives.
3. **Curriculum (Informal/Hidden)**: The actions, behaviors, and expressed or implied attitudes and values of faculty, supervisors, peers, and others with whom the learner interacts.
4. **Educational climate**: The perceptions of learners (students) about what it means to be and how to behave as a medical student and, most importantly, as a physician.

The new LCME standard addresses the element of curriculum, both formal and informal (hidden). The ISTEP activities are grounded in the element of the educational climate. To address institutional culture, a qualitative research study was carried out in the summer and fall of 2010. Since leadership is an important component of the institutional culture, 10 interviews were conducted with medical school deans or senior associate deans. During each 30-minute interview, respondents were asked the same questions:

1) What is a positive learning environment for medical students in the preclinical and clinical years?
2) What is the role of institutional leadership in creating this positive environment?
3) What barriers exist to a positive learning environment? How can leadership, directly or indirectly play a role in overcoming these barriers?

The interviews resulted in a series of concrete recommendations for what medical school leaders should do to contribute to a positive learning environment.

AMA POLICY ON THE LEARNING ENVIRONMENT

The actions described previously are highly consistent with existing AMA policy and directives for action. AMA policy states that medical schools should develop and implement policies that address sexual harassment and exploitation in the medical education environment. (Policy H-295.970, [1] “Sexual Harassment and Exploitation Between Medical Supervisors and Trainees.”)

Policy H-295.886 “Progress in Medical Education: Evaluation of Medical Students’ and Resident Physicians’ Professional Behavior,” supports medical schools regular evaluation of students’ professional behavior. There also are several directives for action related to teaching and evaluating professionalism in medical schools: D-295.954 “Teaching and Evaluating Professionalism in Medical Schools,” D-295.998 “Teaching Professionalism Across the
Continuum of Medical Education,” and D-295.983 “Fostering Professionalism During Medical School and Residency Training.”

FUTURE ACTIONS

Through the AMA’s Center for Transforming Medical Education and other partners, work on the medical education learning environment will continue.

- Through a review of the literature and the collection of expert opinion, the AMA Center for Transforming Medical Education will collaborate with the Association of American Medical Colleges to: a) develop a working definition of medical student and resident mistreatment; b) identify tools that can be used to determine if mistreatment is occurring; and c) develop proactive strategies that can be used to prevent and address mistreatment.

- The AMA’s Innovative Strategies for Transforming the Education of Physicians the collaborative will continue to follow the first cohort of medical students throughout their medical education program to determine how the learning environment affects their professional development and will add at least one additional cohort of students.

- The AMA Center for Transforming Medical Education will summarize and share the views of institutional leadership on their roles in promoting a positive learning environment.

- A summary of the deliberations and any recommendations from the AMA Council on Medical Education, Section on Medical Schools, and Medical Student Section joint session on medical student mistreatment will be distributed to relevant groups.

ATTACHMENT

LCME Accreditation Standards Related to the Medical Education Learning Environment

STANDARD MS-31-A: A medical education program must ensure that its learning environment promotes the development of explicit and appropriate professional attributes in its medical students (i.e., attitudes, behaviors, and identity).

Explanatory Annotation:

The medical education program, including its faculty, staff, medical students, residents, and affiliated instructional sites, shares responsibility for creating an appropriate learning environment. The learning environment includes both formal learning activities and the attitudes, values, and informal “lessons” conveyed by individuals who interact with the medical student. These mutual obligations should be reflected in agreements (e.g., affiliation agreements) at the institutional and/or departmental levels.

It is expected that a medical education program will define the professional attributes it wishes its medical students to develop in the context of the program’s mission and the community in which it operates. Such attributes should also be promulgated to the faculty and staff of the medical education program. As part of their formal training, medical students should learn the importance of demonstrating the attributes of a professional and understand the balance of privileges and obligations that the public and the profession expect of a physician. Examples of professional attributes are available from such resources as the American Board of Internal Medicine’s Project Professionalism or the AAMC’s Medical School Objectives Project.

The medical education program and its faculty, staff, medical students, and residents should also regularly evaluate the learning environment to identify positive and negative influences on the maintenance of professional standards and conduct and develop appropriate strategies to enhance the positive and mitigate the negative influences. The program should have suitable mechanisms available to identify and promptly correct recurring violations of professional standards.

STANDARD MS-32: A medical education program must define and publicize the standards of conduct for the faculty-student relationship and develop written policies for addressing violations of those standards.
Explanatory Annotation:
The standards of conduct need not be unique to the medical education program; they may originate from other sources (e.g., the parent institution). Mechanisms for reporting violations of these standards (e.g., incidents of harassment or abuse) should ensure that the violations can be registered and investigated without fear of retaliation.

The medical education program’s policies also should specify mechanisms for the prompt handling of such complaints and support educational activities aimed at preventing inappropriate behavior.


REFERENCE

5. MAINTAINING EDUCATIONAL QUALITY IN THE CONTEXT OF EMERGING MODELS OF MEDICAL SCHOOL ORGANIZATION AND GOVERNANCE

Reference committee hearing: See Reference Committee C.

HOUSE ACTION: RECOMMENDATIONS ADOPTED AND REMAINDER OF REPORT FILED
See Policy H-295.995.

Policy D-295.323 (AMA Policy Database), “Creation of Domestic For-profit Medical Schools,” was adopted as follows by the House of Delegates:

That our American Medical Association (AMA), in collaboration with the Association of American Medical Colleges (AAMC), the Liaison Committee on Medical Education (LCME), and the Commission on Osteopathic College Accreditation (COCA), will study new and emerging models of medical school organization and governance, including for-profit models and how medical school accreditation standards can protect the quality and integrity of the education, with a report back to the House of Delegates at the 2011 Annual Meeting.

BACKGROUND TO THE ISSUE

In his 1910 study, Abraham Flexner described his expectations for quality in medical education. Among these was the linkage of the medical school with the university. The medical sciences should, according to Flexner, be taught with the same rigor as university sciences and the university endowment should contribute to medical school funding.1

While Flexner and others espoused the model of a medical school as an integral component of a university, there were other organizational models in place at that time. For example, the then Medical University of the State of South Carolina was an example of an “independent” medical school without organizational ties to a “parent” university. In the century following the Flexner report, new models of medical school organization and governance have emerged. This report will: 1) summarize various organizational models currently in place in US MD- and DO-granting medical schools; 2) describe issues related to educational quality potentially raised by these models; and 3) discuss the activities and standards of accrediting bodies that act to ensure educational quality regardless of the institutional model of organization and governance.

MEDICAL SCHOOL ORGANIZATIONAL AND GOVERNANCE MODELS

This section provides an overview of some models of organization and governance in current MD- and/or DO-granting medical schools that differ from the Flexnerian model of a medical school as an integral and co-located part of a university. Unless indicated, the following data are derived from MD-granting medical schools.
Independent Academic Medical Centers

In this model, the medical school is part of an institution that may offer other health professions programs but is not an integral part of a comprehensive university. There may also be medical schools that are part of university systems but have a separate governance structure. That is, the medical school campus has a president or chancellor who reports to the chief executive officer of the system. (An example of this is the three medical schools that are part of the University of Texas System). In 2010, there were 27 fully-accredited medical schools and two developing medical schools within this category. As mentioned previously, some of these institutions have been in existence for a long period. The Medical University of South Carolina was founded in 1823 and Jefferson Medical College was founded in 1824.

Distributed Educational System

In a distributed educational system, a medical school has a regional campus located at a distance from the “main” campus which offers at least one year of the curriculum. A distributed campus may offer the preclinical portion of the curriculum, the clerkship years, or both. This model emerged with the expansion of medical education that occurred in the 1970s, and the number of medical schools with one or more distributed campuses has continued to grow. In 2010, approximately one-third of MD-granting medical schools had at least one distributed campus. With the current phase of medical school expansion, the use of distributed campuses is increasing. Of the 130 schools responding to the 2009-2010 LCME Annual Medical School Questionnaire-Part II, 11 schools were planning to create a new distributed campus where none had existed before, 2 were planning to expand an existing campus to offer more years of the curriculum, and 20 were planning to increase the number of students at an existing campus.

Partnerships Between Colleges/Universities and Health Systems

In Flexner’s model, the medical school or its parent university would own a teaching hospital or would affiliate with local hospitals to provide clinical training. In the partnership model, the medical school is a result of an equal partnership between a college/university and a health system. This relationship is often reflected in the name of the institution, for example, Hofstra North Shore-LIJ School of Medicine at Hofstra University, Oakland University William Beaumont School of Medicine, and Virginia Tech Carilion School of Medicine. This is a relatively new model; the three examples are schools recently-accredited by the LCME.

For-profit Medical Schools

The standards used by the American Medical Association Council on Medical Education in its 1906 review of medical schools included the following:

The extent to which the medical school was conducted for the profit of the faculty.

Concern about for-profit medical education persists to this day. Currently there is one for-profit DO-granting medical school which has attained accreditation by the Commission on Osteopathic College Accreditation (COCA). There is one for-profit institution that plans to grant the MD degree. It has applied for, but not yet been reviewed for, LCME accreditation.

ISSUES RELATED TO EDUCATIONAL QUALITY

There are some issues related to educational program quality that emerge from one or more of these models. The issues also may apply to medical schools of the “Flexnerian” (university-based) type.

Assuring Consistent Educational Quality at All Locations

A distributed medical education system adds complexity to assuring that all medical students have a quality medical education. This includes the need for students to be taught according to the same educational program and course/clerkship objectives, be exposed to similar educational resources (such as lectures, discussions, online programs) to help them achieve those objectives, and be evaluated consistently to determine if they have achieved the specified objectives. To bring this level of consistency at program sites that must be many miles apart requires a variety of strategies.
Effective Communication

There needs to be communication among educational sites at a variety of levels, including the educational program leadership, the course/clerkship leadership, and the individual faculty. Faculty at the sites should have information about their responsibilities as teachers and evaluators and be prepared for these roles.

Evaluation and Follow-up

Evaluation of student performance and satisfaction needs to be reviewed for each educational program site to determine if there are sites that require specific attention. These areas of concern then need to be effectively addressed by the central medical school administration and curriculum governance structure.

Effective Governance

There should be ways to link faculty at the distributed sites into the medical school governance process, such as the admissions committee and the curriculum committee. This allows the site faculty to have input into educational decision-making and makes it less likely that they will act autonomously to teach outside the educational program objectives and to set divergent standards.

Maintaining Medical Education as a Priority Mission

All medical schools have multiple missions. The relative importance of the educational mission may be influenced by the priorities of organizational leaders and the cultures of institutional partners. Explicit medical school policies and procedures, including faculty reward systems, can help keep education as a priority.

Maintaining Faculty Control of the Educational Program and Related Decisions

When income is a priority, there may be incentives to utilize instructional methods that allow a large class size to admit a large number of students so as to maximize tuition revenue, and to focus faculty time on revenue-generating activities rather than on scholarship. Faculty governance structures that assure faculty control of the curriculum and the admissions process may mitigate this concern.

Assuring Sufficient Resources for Medical Education

Flexner stated that “medical education is expensive to teach.” This is as true today as 100 years ago. Resources include adequate and appropriate space for the educational program, sufficient faculty with the desired expertise, and appropriate clinical resources. Medical schools and their institutional partners should assure that funding is available to provide such resources instead of being channeled into other areas, such as to investors, or to other medical school missions.

THE ROLE OF ACCREDITING BODIES

Accreditation Standards for MD- and DO-granting Schools

Among other accreditation standards of the LCME and the COCA, there are standards that address the following areas:

- The requirement of an explicit statement of medical school mission;
- An institutional commitment to scholarship;
- The requirement to develop and implement educational program objectives and to evaluate the attainment of the objectives at the level of the individual student and the educational program;
- Cooperation between the medical school and the affiliated sites in planning and implementing instruction;
  (Note: The LCME also requires that there be comparable educational experiences and equivalent methods of assessment at all sites within a given discipline.)
- The requirement for explicit and effective conflict of interest policies for board members, administrators, and faculty members;
The requirement that the medical school chief academic officer (the dean or the dean’s designate) has the responsibility for fiscal management and sufficient resources to fulfill his or her responsibilities for the educational program;

- Appropriate and sufficient faculty, facilities, and learning resources; and
- Explicit admissions policies and practices.

(Note: The LCME also states that admission is the responsibility of the faculty and must not be influenced by political or financial factors.)

The LCME also has an accreditation standard that states:

A medical education program should be, or be part of, a not-for-profit institution legally authorized under applicable law to provide medical education leading to the MD degree (standard IS-2).

The LCME defines the use of the word “should” in its standards as follows:

Use of the word “should” indicates that compliance with the standard is expected in the absence of extraordinary and justifiable circumstances that preclude full compliance.

Other Activities of the LCME

The role of accrediting bodies is to assure that medical education programs meet defined standards. The emerging models of medical school organization and governance stimulated the LCME to consider this issue. An internal LCME task force developed, and the LCME approved, a “white paper” titled “Accreditation Issues Arising from New Models of Medical School Organization and Governance,” which is attached. This discussion paper articulated a set of principles related to medical school organization and governance that are relevant for all medical schools. This discussion paper was posted on the LCME Web site in June 2010.

SUMMARY AND RECOMMENDATIONS

The emergence of a for-profit medical school has given rise to significant pro and con debate within the osteopathic medical community and calls for change in MD-granting medical schools to make education less costly and more efficient for individuals and institutions. However, not only for-profit educational programs pose challenges. The expansion of medical education has led to the emergence of new organizational and governance models that have the potential for positive innovation but also could present issues related to program quality. Accreditation standards need to be reviewed to assure that they are sufficiently comprehensive to address the implications for quality of all the models. This imperative has led to action by accrediting bodies. For example, the LCME has begun a process with its stakeholders to: 1) identify the core values that should underlie medical schools as organizations; 2) review accreditation standards and policies to assure that these values are reflected; and 3) revise, if necessary, standards and the data collected to support evaluation of compliance with standards.

AMA policy supports “continued efforts to review and define standards for medical education at all levels” and the “continued participation in the evaluation and accreditation of medical education…” (Policy H-295.995, [#34], “Recommendations for Future Directions for Medical Education.”)

In this context, the Council on Medical Education recommends that the following recommendations be adopted and that the remainder of this report be filed:

1. That our American Medical Association (AMA) encourage the accrediting bodies for MD- and DO-granting medical schools to review, on an ongoing basis, their accreditation standards to assure that they protect the quality and integrity of medical education in the context of the emergence of new models of medical school organization and governance.

2. That our AMA rescind HOD Policy D-295.323, “Creation of Domestic For-profit Medical Schools.”
Accreditation Issues Arising from New Models of Medical School Organization and Governance

The policies, procedures, and standards of the Liaison Committee on Medical Education (LCME) have, in a large part, been grounded in the context of what might be considered a “traditional” model of medical school organization and governance. This model, which crystallized in the first half of the twentieth century, has the following characteristics.

A single non-profit university or health science center includes a medical school that sponsors one complete medical education program. A variation is that the university or health science center may be part of a larger, state-based university system that includes other medical schools (such as the University of California or University of Texas systems). In the traditional medical school model, there is a chief academic officer responsible for the medical education program, which is delivered at a single site that includes a “main campus” and affiliated teaching hospitals.

Divergence from this model began to occur during the 1970s, when some medical schools developed distributed campuses located at a distance from the “main” campus. These campuses typically offered portions of the educational program that could be identical to or different from the curriculum offered at the “main” campus.

This document aims to explore the implications for accreditation of new models of medical school organization and governance that diverge even further from the traditional (see ATTACHMENT). Some of these models already exist in the United States or Canada. Other models are hypothetical but, potentially, feasible.

The models were used as a stimulus to consider what is required for the organization and governance of an educational program to be in compliance with accreditation standards. In general, standards require the following:

- A governance structure free from financial and other conflicts of interest.
- An administrative structure under the control of the medical school’s chief academic officer.
- An educational program under the control of the medical school’s faculty.
- A system to assure access to appropriate and sufficient resources to conduct the educational program according to the objectives developed by the faculty.

Core Principles

After review of the potential models, the LCME developed a set of core principles that are grounded in the LCME accreditation standards. Regardless of the model of organization/governance a medical school chooses to adopt, it must be able to demonstrate adherence to these principles and to the applicable standards.

1. Medical education is explicitly recognized as a key mission by the institutional sponsor(s) and members of the medical education community. The priority of education is codified and represented in medical school bylaws or other formal statements of organization and purpose, governing principles, planning activities, and institutional policies and procedures.

2. There are clear and appropriate policies for management of financial, educational, and other conflicts of interest in medical school governance and operations, and there is credible evidence that the policies are implemented and followed.

3. Regardless of the structure of the educational program or the locations where education is delivered, there are policies and practices that assure the medical school’s chief academic officer has ultimate authority to assure educational program quality.

4. The design, implementation, delivery, evaluation and management of the educational program, as well as the selection of students, are the responsibility of and under the sole control of the medical school faculty. The faculty, in turn, are responsible to the chief academic officer of the medical school for their role in the educational program.

5. The institutional governing board has the responsibility for the appointment of medical school leadership and, either directly or by delegation to the chief academic officer, the appointment of medical school faculty.

6. The medical school has control of, or has guaranteed access to, appropriate and sufficient resources to support the delivery of the educational program and the other medical school missions.

Implications of the Core Principles

The following describe the LCME’s interpretation of the implications of the core principles for medical education programs and how the principles relate to its accreditation standards. The principles should be considered in planning and implementing new models of institutional organization and governance. Regardless of the model(s) selected, medical schools and their institutional sponsors should be prepared to document compliance with relevant accreditation standards.
The full citations for the listed LCME accreditation standards are contained in Functions and Structure of a Medical school, which can be accessed through the LCME web site: www.lcme.org. Please note that the list of standards associated with each principle is meant to be illustrative, not exclusive.

1. Medical Education as a Priority Mission
   The medical education program must be based in an institution legally authorized to grant the MD-degree. The LCME expects that medical education is explicitly included among the missions of the medical school and that institutional planning and decision-making at all levels reflect the priority of the educational mission. The educational mission cannot be compromised by other institutional missions or imperatives, such as the need for the medical school or its institutional sponsor to generate revenue from research, clinical care, or other activities.

   Relevant Accreditation Standards: IS-1, IS-2, ER-3

   Implications: A medical school that cannot demonstrate the priority of and explicit support for education in its formal policies and in its operations would not be in compliance with accreditation standards.

2. Avoidance of Conflict of Interest
   There must be a clear description, codified in institutional by-laws or other formal policies, of how the educational program is governed. There must be formal policies that mitigate the possibility of conflict of interest in institutional decision-making at all the levels and evidence that these policies are followed. Policies to avoid the impact of financial, educational, and other conflicts of interest should apply to individuals involved in institutional governance (members of the governing board) and to medical school administrators and faculty in their various roles.

   Relevant Accreditation Standards: IS-4, IS-5, MS-7, FA-8

   Implications: A medical school that cannot demonstrate that there are policies to eliminate or manage conflicts of interest at the specified levels and also that these policies are followed would not be in compliance with accreditation standards.

3. Authority of the Chief Academic Officer for the Educational Program
   The role, authority, and responsibilities of the medical school’s chief academic officer (CAO) must be clearly articulated and widely understood, and he/she should have ready access to university/institutional officials to facilitate the fulfillment of his/her responsibilities. The CAO of the medical school (i.e., the dean or the dean’s designate) must be ultimately accountable for and must have corresponding authority over and access to resources to assure the quality of the educational program. The CAO must have authority for the educational program regardless of the sites where education occurs or the ways that the curriculum is organized and delivered.

   Relevant Accreditation Standards: IS-8, IS-9, ED-36, ED-39, ED-40

   Implications: A medical school where the chief academic officer does not have authority for the educational program at all sites and appropriate resources for the educational program is not in compliance with accreditation standards.

4. Faculty Control of the Educational Program
   Individuals formally designated as faculty of the medical school must be responsible for the educational program, including program planning, delivery, and evaluation. There must be mechanisms that allow the faculty to participate in institutional decision-making about the educational program and other medical school missions. The faculty, in turn, must be formally accountable to the medical school and, ultimately, to its chief academic officer for the quality of their work and the time that they spend related to the missions of the medical school. Faculty also must have responsibility for policies and practices related to admission to and progress through medical school.

   Relevant Accreditation Standards: ED-34, MS-3, MS-4, FA-6, FA-12, FA-13, ER-10

   Implications: A medical school that places limits on the responsibility of the faculty for the educational program is not in compliance with accreditation standards.

5. Authority for Faculty Appointment
   The leadership of the medical school (the CAO and/or the departmental leadership) should have authority to recruit and promote faculty appropriate to the needs of the educational program and other medical school missions.

   Relevant Accreditation Standards: IS-7, FA-3, FA-4, FA-7

   Implications: A medical school that does not have policies and practices to assure faculty quality and accountability is not in compliance with accreditation standards.
6. **Medical School Access to Sufficient Resources for the Educational Program**

The medical school must have access to the resources needed to achieve its educational and other institutional missions. These resources include faculty of the appropriate numbers and disciplines, funding, facilities, information and library resources, clinical sites, and patients.

**Relevant Accreditation Standards:** FA-2, ER-2, ER-4, ER-6, ER-11

**Implications:** A medical school that lacks access to any of the necessary resources is not in compliance with accreditation standards.

**ATTACHMENT – Potential Non-Traditional Models of Medical School Organization and Governance**

These models are not intended to be mutually exclusive. It cannot be assumed that each model would be in compliance with all LCME accreditation standards.

**Relationship Between the Medical School and its Institutional Sponsor(s)**

- A not-for-profit medical school with not-for-profit sponsor(s)
  - two or more universities
  - one or more universities and a hospital/health system
  - a hospital/health system

- A not-for-profit medical school with a for-profit sponsor
  - the medical school is a not-for-profit foundation within a for-profit organization (for example, a health system)

- A for-profit medical school
  - an independent medical school that is itself a for-profit entity
  - a for-profit medical school that is a component of a for-profit entity

**Relationship among Medical School Components**

- A medical school with two or more campuses where one or both does not offer the complete (four-year) educational program

- A medical school with two or more campuses that each offer the complete (four-year) educational program (a single degree is granted)
  - all campuses offer the same curriculum (e.g., Northern Ontario Medical School, University of British Columbia, emerging programs at Mercer/Texas A&M)
  - each campus offers a separate track (i.e., a distinct educational program)

- Two or more complete and independent medical education programs within a single institution (e.g., university)
  - both offer the MD degree
  - one offers the MD degree and one offers the DO degree

**Relationships Among Medical Schools**

- Two U.S./Canadian medical schools affiliate to share faculty/students/resources

- A U.S./Canadian medical school affiliates with an international medical school

**Contractual Relationships Between a Medical School and Other Entities (Schools/Colleges, Health Systems, Commercial Enterprises)**

- Medical school/medical school department contracts with another educational unit (e.g., school or college that is not a medical school) to provide educational resources (e.g., faculty)
  - within a different college in the same university, where faculty appointment is to the college/department
  - from another university

- Medical school/medical school department contracts with a non-university-based health system/group practice outside the sponsoring university to provide educational resources (e.g., faculty)

- Medical school/medical school department contracts with a for-profit entity to provide educational resources
REFERENCES

4. Liaison Committee on Medical Education. Functions and Structure of a Medical School, June 2010 edition.

6. IMPLEMENTATION OF ACCREDITATION STANDARDS RELATED TO MEDICAL SCHOOL DIVERSITY

Reference committee hearing: See Reference Committee C.

HOUSE ACTION: RECOMMENDATIONS ADOPTED AND REMAINDER OF REPORT FILED

Policy D-295.322, “Increasing Demographically Diverse Representation in Liaison Committee on Medical Education-accredited Medical Schools,” (AMA Policy Database), asks our American Medical Association (AMA) to undertake the following action:

To study medical school implementation of LCME standard IS-16 and report the results no later than the 2011 Annual Meeting of the AMA House of Delegates.

This report addresses Liaison Committee on Medical Education (LCME) accreditation standards IS-16 and MS-8, which are included as an attachment to this report. Standard IS-16 addresses diversity at the institutional level and standard MS-8 addresses the availability of a diverse national medical school applicant pool.

THE DEVELOPMENT OF STANDARDS IS-16 AND MS-8

Prior Accreditation Standards Related to Diversity

For many years, the LCME had accreditation standards addressing diversity. Prior to 2009, there were specific standards related to medical students and faculty:

Each medical school should have policies and practices ensuring the gender, racial, cultural, and economic diversity of its students.

The recruitment and development of a medical school’s faculty should take into account its mission, the diversity of its student body, and the population that it serves.

Both standards were “should” statements. According to LCME definitions, a “should” standard indicates that compliance with the standard is expected in the absence of “extraordinary and justifiable circumstances that preclude full compliance.”1, p1

Data collected from medical schools related to compliance with these standards focused almost exclusively on outcome (that is, the racial and ethnic diversity of the student body and faculty).
The Supreme Court Rulings on Diversity

The Supreme Court rulings in *Grutter v. Bollinger* (2003) and *Gratz, et al. v Bollinger, et al.* (2003) laid a framework for a reconsideration of how diversity can be considered in the context of recruitment and retention of medical students. Based on these decisions, medical schools could articulate that diversity is a compelling interest that contributes to the educational environment. This premise must be demonstrated in the policies and practices of institutions, not just articulated. Medical schools could, for example, demonstrate that they are working to enhance cultural competence among medical students, improve access to care for vulnerable populations, and mitigate racial and ethnic health care disparities. Based on a legal analysis in 2003, the Association of American Colleges (AAMC) provided the following recommendations to medical schools when considering the issue of diversity in medical student admissions:

- Specify the reasons why having a racially and ethnically diverse student body is educationally valuable;
- Adopt a definition of diversity that includes, but is not limited to, racial and ethnic diversity; and
- Ensure that applicants receive individualized, holistic consideration using a flexible policy in which race and ethnicity are one of a number of factors.

Response of the AAMC and the AMA

The AAMC has developed guidance documents to support medical schools in developing and implementing policies and practices consistent with the new legal definitions. In addition to the 2003 document describing the implications of the US Supreme Court rulings for medical school admission, the AAMC published informational reports summarizing approaches to research on the impact of diversity in education and on integrating holistic review into the medical school admission process. The AMA and the AAMC held a joint invitational conference on medical school admission in December 2009, which addressed, among other issues, the status of holistic review in broadening the pool of medical school applicants. For more information on the outcomes of the AMA/AAMC conference, consult Council on Medical Education Report 3-A-11.

Response of the LCME

In June 2005, the LCME and the Committee on the Accreditation of Canadian Medical Schools (CACMS) held a joint retreat on the subject of diversity. The LCME and the CACMS jointly accredit medical education programs in Canada. One of the recommendations from the retreat was to create a working group on diversity with membership from the two accrediting bodies. The working group, formed in the fall of 2005, was charged to: 1) clarify the aims of and evaluate the effectiveness of existing accreditation standards related to medical student and faculty diversity; 2) identify appropriate outcome measures to assist the committees in determining if the existing standards were achieving their intended aims; and 3) recommend new and/or modified standards related to student and faculty diversity. The working group met during the 2005-2006 and 2006-2007 academic years. As part of its preparation, the working group sought input from individuals representing a variety of perspectives related to diversity.

Also during that time, the two LCME Secretaries, along with staff from other health professions accrediting bodies, met with the Sullivan Alliance to Transform America’s Health Care Professions. The goal of the session was to discuss the role of accreditation in enhancing diversity in the health professions.

At the June 2007 LCME meeting, the working group on diversity presented a recommendation to replace the existing diversity standards with two new standards that would eventually become IS-16 and MS-8. The standards each contain explanatory annotations to assist medical schools and survey team members in understanding the meaning and expectations of the standards.

LCME Expectations for Institutional Diversity (IS-16)

The working group and the LCME conceptualized diversity as an institutional issue in that it was based in the mission and goals of the institution and articulated expectations for the environment in which education takes place. The new standard on student and faculty diversity (IS-16), therefore, was placed in the Institutional Setting section of the standards. The standard states the following expectations:
A medical education program and/or its parent institution must have formal policies and supporting practices that will achieve the diversity goals articulated by the institution for its medical students, faculty, staff and other members of the academic community; and

The institution must engage in ongoing and focused efforts to meet and maintain its diversity goals.

To determine if medical schools are in compliance with this standard, the LCME asks educational programs to provide the following information as part of the preparation for a regular accreditation review:

- A copy of the current institutional mission statement(s) and policies related to diversity, along with a description of how they were developed and how they are made widely known;
- A description of how the institution defines diversity for its students, faculty, and staff;
- A description of how, in the context of its definition of diversity, the institution implements policies related to: 1) student recruitment, selection, and retention; 2) financial aid; 3) the educational program; 4) faculty and staff recruitment, employment, and retention; 5) faculty development; and 6) liaison activities with community organizations; and
- A report on the percentage of enrolled students and employed faculty and staff in each of the diversity categories defined by the institution.

**LCME Expectations for Supporting a Diverse Applicant Pool (MS-8)**

The working group and the LCME also formalized the expectation that medical schools were responsible for developing and supporting diversity in the national pool of well-prepared applicants for medical school, not just for recruiting diverse applicants to their own institution. This expectation is stated in standard MS-8, which was placed in the section of the standards dealing with medical school admissions.

To determine if medical schools are in compliance with this standard, the LCME asks educational programs to provide the following information as part of the preparation for a regular accreditation review:

- The resources available to the medical school to enhance diversity in the applicant pool (such as an office and/or staff with dedicated time for diversity programs);
- The programs available at the medical school to enhance diversity in the applicant pool (for example, outreach programs to secondary schools and colleges), along with the enrollment in such programs, the length of time the programs have been in existence, the funding source(s) for such programs, and the community partnerships that support such programs; and
- The outcomes of the programs, including the number of participants that enrolled in any medical school.

**Approval of the Diversity Standards**

Consistent with the process for approval of new standards, the two standards were approved by the AMA Council on Medical Education and the AAMC Executive Council and then presented at a public hearing in the fall of 2007. After consideration of comments at the hearing, the two standards were approved by the LCME at its meeting of February 2008. They became effective in July 2009.

**OUTCOMES TO DATE**

**Medical School Actions**

Based on the 2003 Supreme Court rulings, medical schools can take diversity into account as part of a holistic review process for medical school admission. The 2009-2010 LCME Annual Medical School Questionnaire asked whether medical schools used specific criteria in screening applicants to receive a secondary application and to be selected for an interview. Of the 130 medical schools with students enrolled, 33 used potential contribution to diversity (e.g., distance traveled) as one of the criteria for applicants to receive a secondary application and 112 used this concept as one of the criteria for selecting applicants for an interview.

Council on Medical Education Report 3-A-11, “Medical School Admissions,” to be considered at this meeting of the AMA House of Delegates, will provide more information on current admissions practices, including the move to use a more holistic admissions process.
LCME Actions

Standards IS-16 and MS-8 were first applied to educational programs with accreditation reviews taking place during the 2009-2010 academic year and following. Of the 24 medical schools whose full survey reports were reviewed by the LCME during the four meetings held between October 2009 and October 2010, six were cited for partial or substantial non-compliance with one or both of the standards (three for IS-16 only, one for MS-8 only, and two for both). The LCME reviews of schools are held confidential. Therefore, it is not possible to report the specific concerns that triggered the citations. The 25% citation rate is not uncommon for new standards that have requirements that schools were not previously expected to meet.

In the 2009-2010 academic year, the LCME began to identify “exemplar practices” for commonly cited accreditation standards. This is a process that will allow the LCME to collect and share examples of how schools achieve compliance with standards. It is not meant to specify a “right way” to meet a standard; rather it aims to provide options for schools. When several exemplar practices are identified for the selected standards, medical schools with these practices will be asked to prepare a summary of their approach that will be available to other medical schools.

RELEVANT AMA POLICY

Our AMA has numerous polices and directives supporting diversity in the medical education learning environment, including faculty diversity (Policies H-350.968 “Medical School Diversity,” and H-350.960 “Underrepresented Student Access to US Medical Schools”). The AMA also supports programs to enhance diversity in the medical school applicant pool as a way to contribute to a diverse physician workforce (D-200.982 “Diversity in the Physician Workforce and Access to Care”). The AMA recognizes that such diversity could contribute to reducing racial and ethnic health care disparities (E-9.121, “Racial and Ethnic Health Care Disparities”).

SUMMARY AND RECOMMENDATIONS

The new LCME standards are broader than those formerly in place, in that they state the expectation for a systematic and coordinated process to enhance diversity at the institutional level and at the level of the national applicant pool. The standards are new, however, and most medical schools have not undergone a full review that includes an evaluation of how well they meet these expectations. 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) request that the Liaison Committee on Medical Education regularly share statistics related to compliance with accreditation standards IS-16 and MS-8 with medical schools and with other stakeholder groups.

2. That our AMA, in collaboration with the Association of American Medical Colleges, continue to monitor medical school implementation of processes to enhance the diversity of medical students, residents, and medical school faculty and report back on the results at the 2013 Annual Meeting of the AMA House of Delegates.

3. That our AMA rescind Directive D-295.322 [1], “Increasing Demographically Diverse Representation in Liaison Committee on Medical Education Accredited Medical Schools.”

ATTACHMENT

DIVERSITY STANDARDS (IS-16 and MS-8)

IS-16. An institution that offers a medical education program must have policies and practices to achieve appropriate diversity among its students, faculty, staff, and other members of its academic community, and must engage in ongoing, systematic, and focused efforts to attract and retain students, faculty, staff, and others from demographically diverse backgrounds.

Explanatory Annotation

The LCME and the CACMS believe that aspiring future physicians will be best prepared for medical practice in a diverse society if they learn in an environment characterized by, and supportive of, diversity and inclusion. Such an environment will facilitate physician training in:
Basic principles of culturally competent health care.

Recognition of health care disparities and the development of solutions to such burdens.

The importance of meeting the health care needs of medically underserved populations.

The development of core professional attributes (e.g., altruism, social accountability) needed to provide effective care in a multidimensionally diverse society.

The institution should articulate its expectations regarding diversity across its academic community in the context of local and national responsibilities, and regularly assess how well such expectations are being achieved. The institution should consider in its planning elements of diversity including, but not limited to, gender, racial, cultural, and economic factors. The institution should establish focused, significant, and sustained programs to recruit and retain suitably diverse students, faculty members, staff, and others.

MS-8. A medical education program must develop programs or partnerships aimed at broadening diversity among qualified applicants for medical school admission.

Explanatory Annotation

Because graduates of U.S. and Canadian medical schools may practice anywhere in their respective countries, it is expected that an institution that offers a medical education program will recognize its collective responsibility for contributing to the diversity of the profession as a whole. To that end, a medical education program should work within its own institutions and/or collaborate with other institutions to make admission to medical education programs more accessible to potential applicants of diverse backgrounds. Institutions can accomplish that aim through a variety of approaches, including, but not limited to, the development and institutionalization of pipeline programs, collaborations with institutions and organizations that serve students from disadvantaged backgrounds, community service activities that heighten awareness of and interest in the profession, and academic enrichment programs for applicants who may not have taken traditional pre-medical coursework.

REFERENCES

1. Liaison Committee on Medical Education. Functions and Structure of a Medical School, June 2010 edition.

7. RESIDENT/FELLOW DUTY HOURS, QUALITY OF PHYSICIAN TRAINING, AND PATIENT SAFETY

Reference committee hearing: See Reference Committee C.

HOUSE ACTION: RECOMMENDATIONS ADOPTED AND REMAINDER OF REPORT FILED

See Policy D-310.955

This report is a follow-up to Council on Medical Education (CME) Report 2-I-09, “Resident/ Fellow Duty Hours, Quality of Physician Training, and Patient Safety,” as adopted by the American Medical Association (AMA) House of Delegates (HOD), which asked, in part, that our AMA “continue to monitor the enforcement and impact of the ACGME duty hour standards, as they relate to the larger issue of the optimal learning environment for residents, and monitor relevant research on duty hours, sleep, and resident and patient safety,” (Policy D-310.995, AMA Policy Database).

BACKGROUND

The death of 18-year-old Libby Zion at New York Hospital in 1984—and the work of her father, journalist Sidney Zion—brought the issue of resident/fellow duty hours before the public eye. Subsequently, in 1989, New York state instituted duty hour regulations for resident physicians, limiting weekly hours to 80 and shift length to 24 hours, and requiring the physical presence of attending physicians to supervise trainees.
At the national level, duty hours legislation was introduced in the US Senate by Sen. Jon Corzine and in the US House of Representatives by Rep. John Conyers, Jr. in 2003. It was in this environment that the Accreditation Council for Graduate Medical Education (ACGME) developed and implemented duty hour standards, which went into effect in July 2003. These required:

- An 80-hour weekly limit, averaged over 4 weeks, inclusive of all in-house call activities*;
- A 10-hour rest period between duty periods and after in-house call;
- A 24-hour limit on continuous duty, with up to 6 additional hours for continuity of care and education;
- No new patients to be accepted after 24 hours of continuous duty;
- One day in 7 free from patient care and educational obligations, averaged over 4 weeks, inclusive of call; and
- In-house call no more than once every 3 nights, averaged over 4 weeks.

* Note: Programs in some specialties (neurological surgery, for example) were permitted to apply to the ACGME for an 8-hour increase in weekly duty hours.

THE INSTITUTE OF MEDICINE CALLS FOR CHANGES IN DUTY HOURS

In September 2007, the Institute of Medicine (IOM) appointed the Committee on Optimizing Graduate Medical Trainee (Resident) Hours and Work Schedules to Improve Patient Safety, at the request of Congress and the Agency for Healthcare Research and Quality. The Committee’s two primary objectives were to:

- Synthesize current evidence on medical resident schedules and healthcare safety; and
- Develop strategies for implementing optimal work schedules to improve safety in health care.

The Committee gathered testimony from the accreditation and certification community, organized medicine, medical students, residents, patient safety advocates, and researchers on sleep and patient outcomes, as well as program directors in primary and surgical specialties. Its report, released in December 2008, did not recommend further reducing residents’ work hours from the ACGME’s 80-hour limit (as some had speculated) but called for:

- Reducing the maximum number of hours that residents can work without time for sleep to 16;
- Allowing overnight call only with a required 5-hour sleep/nap period;
- Increasing the number of days residents must have off; and
- Restricting moonlighting during residents’ off-hours.

Other recommendations called for greater supervision of residents, limits on patient caseloads based on residents’ experience and specialty, increased interdisciplinary teamwork, and overlap in schedules during shift changes to reduce the chances for error during handoffs. The report noted that the major barriers to implementing these changes are cost and an insufficient health care workforce to substitute for the time of residents. Nonetheless, the report called for action on all recommendations within 24 months—that is, by December 2010.

ACGME RESPONSE TO THE IOM REPORT

At its February 2009 meeting, the ACGME Board of Directors endorsed a systematic review of duty hours and the learning environment, with a goal of creating more appropriate, flexible standards that recognize the challenges presented in the training of each specialty. Among its activities in this regard were:

- A duty hours symposium, held in March 2009, to help the ACGME obtain input from multiple perspectives and stakeholders and reconcile these viewpoints to design standards that promote an optimal learning environment as well as patient safety and quality;
- A duty hours congress, held in June 2009, to help determine the best strategy for responding to the IOM’s recommendations. Testimony was heard from 44 of the more than 120 professional associations, program director organizations, and other groups that submitted formal position papers to the ACGME on this topic; and
- Three comprehensive reviews of the literature on duty hours and related topics, which helped inform the ACGME’s response to the IOM, as well as consultations with leading ethicists on the issues of professionalism surrounding duty hours.
In June 2010, the ACGME released its proposed duty hour standards, for implementation in July 2011; these were subsequently approved by the ACGME Board at its September 2010 meeting. The standards retain the 80 hour per week limit, averaged over four weeks, but reduce shift lengths for first-year residents to no more than 16 hours and set stricter requirements for duty hour exceptions. In addition, they:

- Specify in greater detail than the existing standards the levels of supervision necessary for first-year residents;
- Set higher requirements for teamwork, clinical responsibilities, communication, professionalism, personal responsibility, and transitions of care;
- Establish graduated requirements for minimum time off between scheduled duty periods;
- Expand program and institutional requirements regarding patient care handovers; and
- Call for alertness management and fatigue mitigation strategies to ensure continuity of patient care and resident safety.

An analysis of the potential cost implications of these changes posted on the ACGME Web site arrived at a figure of $380 million annually (in 2008 dollars); the IOM estimated $1.7 billion per year for the changes it recommended in its report.

RESPONSE TO THE ACGME’S JULY 2011 STANDARDS

After releasing the draft standards in June 2010, the ACGME called for additional public comment over the succeeding 45 days. The AMA was among those providing comments, via a letter collating input from the AMA Resident and Fellow Section, Young Physicians Section, Section on Medical Schools, and Council on Medical Education (Appendix 1). The AMA expressed its approval of the standards, “which strike a balance among the many differing opinions on duty hour restrictions” as well as the need to balance effective training for physicians with improved patient safety. The AMA also commended the ACGME for “recognizing that it is not only the hours that resident physicians are on duty, but also their overall experience and level of training that play roles in physician performance.” In addition, the AMA applauded the ACGME “for not accepting verbatim” the IOM’s duty hour recommendations - in particular, the controversial mandatory “nap period” during overnight shifts.

After the comment period closed, the ACGME task force reviewed and considered comments submitted by more than 1,000 interested parties sharing a range of perspectives. Based on these comments the task force and the ACGME Requirements Committee made modifications in the proposed standards before presenting them to the Board for final approval.

OSHA REGULATION OF RESIDENT/FELLOW DUTY HOURS

Meanwhile, as the ACGME standards were becoming crystallized, the Occupational Safety and Health Administration (OSHA) received a petition calling for OSHA oversight of resident/fellow duty hours as an issue of worker safety. In their September 2010 letter, the Committee of Interns and Residents, American Medical Student Association, and Public Citizen argued that resident/fellow health and well-being were endangered by existing ACGME rules and that OSHA regulation was needed. The January 2011 Supreme Court decision that resident physicians must pay Social Security taxes was also cited by Public Citizen as additional evidence that OSHA’s involvement in this arena is warranted.

A similar request for OSHA regulation by these groups was rejected by OSHA in 2002. However, in its fall 2010 response, OSHA wrote, “We are very concerned about medical residents working extremely long hours.” The AMA (see Appendix 2) and other member organizations of the ACGME have written letters to OSHA to express strong support of the ACGME and its system of oversight, arguing that it is impossible to separate duty hours from the overall educational and clinical environment.

THE ISSUES

As in the past, a number of issues continue to rise to the forefront during any discussion of duty hour limits, including:
• Patient safety—From the patient’s perspective, having one physician dedicated to one’s care is optimal; patients, however, also want well-rested physicians, so a balance between continuity and appropriate rest must be maintained.

• Preparedness for practice—Are physicians training under current duty hour limits as well-prepared for the real-world rigors of practice as their predecessors? It may be that patient safety in the long term, as current trainees enter independent practice, is being sacrificed for the sake of short-term gains during residency training.

• Flexibility—It is a given that different people learn in different ways, and at different rates. The ACGME’s new regulations recognize this (through, for example, limited shift lengths for first-year residents), but additional flexibility in residency education may be warranted to allow for a more individualized, learner-centric approach to medical education.

• Biologic variation—Related to flexibility is the argument that different people have different tolerances for sleep deprivation and fatigue. These differences may be related to one’s choice of specialty as well, with individuals more willing and able to withstand long periods without sleep self-selecting by choosing, say, a career in a surgical field.

• Workload—The limits for the number of hours worked may be set, but the number of patients is not so easily controlled. With increased use of night-float and at-home call, fewer residents may be responsible for more patients; without adequate supervision, this can be a recipe for disaster.

• Handoffs—Teamwork, interdisciplinary communication, and appropriate electronic systems are essential to ensuring safe, informative handoffs, which have become even more critical as the lengths of shifts have decreased and the frequency of handoffs has risen.

• Professionalism and personal responsibility—the unintended consequence of the shift-work mentality must be addressed; the requirements of patient care and devotion to one’s education must supersede the resident’s personal needs. At the same time, professionalism also extends to the resident’s honest, accurate reporting of actual hours worked.

• Resident physician well-being—Residents who have trained since duty hour limits were implemented are more satisfied with their work-life balance and less susceptible to burnout and depression. We do not know, however, whether these gains have come at the expense of other “competing goods” (quality of education, continuity of care).

• Costs—As health care reform advocates urge cost containment, what are the financial consequences of further limiting duty hours, and which entity (or entities) should bear these costs?

Other questions that may merit further study and research:

• What has been the impact on the workload and learning of students?

• What has been the impact on attendings? Will duty hour limits extend to practicing physicians as well (as in Europe)? A December 2010 New England Journal of Medicine article, for example, calls for patients awaiting elective surgery to be “explicitly informed about possible impairments induced by sleep deprivation and the increased risk of complications.”

• Will some specialties extend the length of training programs because of the need for more clinical exposure? If so, what effect does this have on workforce? Will students be less likely to choose a field with such extended residency periods?

• Will the transition into real-world practice (in which duty hour limits do not apply) become more difficult for young physicians who trained with duty hour limits?

• Do residents learn to function in a sleep-deprived environment and to recognize and compensate for their limits?

In conclusion, as we re-examine the pivotal event that brought us to where we are today (the death of Libby Zion), most believe that inadequate supervision was a greater contributing factor than resident fatigue to her death. In the court of public opinion, regarding the ACGME’s regulations, the most easily quantified metric of duty hours gets all the press, but appropriate, individualized supervision and a better learning environment should be the real focus of our attention. Despite many questions that will require more data and longer-term analysis, the 2011 iteration of duty hour requirements is a well-considered alternative to the IOM recommendations and the 2003 standards. These new requirements represent an advance beyond simply counting hours towards a focus on patient safety and the quality of education, supervision, and patient care, both today (during training) and tomorrow (in practice).
RECOMMENDATIONS

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

1. That our American Medical Association (AMA) continue to monitor the enforcement and impact of the Accreditation Council for Graduate Medical Education duty hour standards, as they relate to the larger issues of patient safety and the optimal learning environment for residents, and to track relevant research on duty hours, sleep, and resident and patient safety, with a report back no later than the 2014 Annual Meeting of the AMA House of Delegates (HOD).

2. That our AMA (through the AMA GME e-Letter and other communications) encourage publication of studies (in peer-reviewed publications, including the ACGME’s newly developed Journal of Graduate Medical Education) and promote educational sessions about the impact of duty hour limits, extended work shifts, handoffs, protected sleep periods during in-house call, sleep deprivation, and fatigue on patient safety, medical error, continuity of care, resident well-being, and resident learning outcomes. Further, our AMA should facilitate wide dissemination of this information to the GME community.

3. That our AMA strongly advocate to all Designated Institutional Officials (DIOs), program directors, resident/fellow physicians, and attending faculty the importance of accurate, honest, and complete reporting of resident duty hours as an essential element of medical professionalism and ethics.

4. That our AMA ensure that the medical profession maintains the right and responsibility for self-regulation, one of the key tenets of professionalism, and categorically reject involvement by the Occupational Safety and Health Administration in the monitoring and enforcement of duty hour regulations. (Directive to Take Action)

5. That our AMA lobby against any regulatory or legislative proposals to limit the duty hours of practicing physicians.

6. That our AMA collaborate with other key stakeholders to educate the general public about the many contributions of resident/fellow physicians to high-quality patient care and the importance of trainees’ realizing their limits (under proper supervision) so that they can competently and independently practice under real-world medical situations.

7. That our AMA urge that the costs of duty hour limits be borne by all health care payers.

8. That our AMA encourage the American Osteopathic Association to monitor duty hours and related issues in collaboration with the ACGME.

8. RESIDENTS AND FELLOWS’ BILL OF RIGHTS (RESOLUTION 901-I-09)

Reference committee hearing: See Reference Committee C.


Resolution 901-I-09, introduced by the Resident and Fellow Section and referred to the Board of Trustees, asked:

1) That our American Medical Association (AMA) adopt a “Residents and Fellows’ Bill of Rights” that will serve as a testament to the organization’s support for and commitment to the education and training of competent, conscientious residents and fellows by illuminating their rights and advocating for provisions that it believes all residents should be afforded, and that have not yet been designated as rights;
2) That the “Residents and Fellows’ Bill of Rights” shall address the following 10 core themes spanning the aggregate of the graduate medical education experience: Education, Supervision, Evaluations of Trainees and Assessment of Faculty and Training Program, Workplace, Contracts, Compensation, Benefits, Duty Hours, Complaints and Appeals Process and Reporting Violations to Accreditation Council for Graduate Medical Education (ACGME); and

3) That our AMA work with the ACGME and other professional organizations to distribute this “Residents and Fellows’ Bill of Rights” to residents and fellows in training at ACGME-accredited training programs.

Reference committee testimony strongly supported adoption of this resolution but also called for analysis of provisions to ensure they are both optimal and realistic, as well as applicable to resident physicians not educated in LCME-accredited medical schools. In addition, while almost all of the provisions are supported by ACGME requirements, the ACGME has issued new Common Requirements since Resolution 901 was written; therefore, citations to support the Bill of Rights have been updated. This report transcribes the proposed “Residents and Fellows’ Bill of Rights,” consolidates some of the rights, and annotates areas not currently supported by ACGME requirements and/or AMA policy. The report also supports the inclusion of graduates of osteopathic or international medical schools under this proposal.

Residents and fellows have a right to:

1. An education that fosters professional development, takes priority over service, and leads to independent practice.
2. Appropriate supervision by qualified faculty with progressive resident responsibility toward independent practice.
3. Regular and timely feedback and evaluation based on valid assessments of resident performance.
4. A safe and supportive workplace with appropriate facilities.
5. Adequate compensation and benefits that provide for resident well-being and health.
6. Duty hours that protect patient safety and facilitate resident well-being and education.
7. Due process in cases of allegations of misconduct or poor performance.
8. Access to and protection by institutional and accreditation authorities when reporting violations.

Notes on Right 1:
The provisions are all included in the Common Requirements, with one exception. “Financial support and education leave to attend professional meetings” is supported by AMA Policy H-310.999 [II.H], “Guidelines for Housestaff Contracts or Agreements” (AMA Policy Database). The ACGME requirements support residents’ scholarly activities but do not specify any financial support. Furthermore, based on reference committee testimony, guaranteeing “access to educational programs and curriculum as necessary to facilitate understanding of the US health care system and to increase communication skills” is a potential additional right.1,2

Notes on Right 3:
AMA Policies D-310.965, “Credentialing Materials: Timely Submission by Residency and Fellowship Programs,” and H-310.921, “Credentialing Materials: Timely Submission by Residency and Fellowship Programs,” request that the ACGME incorporate into its standards the submission of verification and credentialing information to requesting agencies within 30 days of the request; the ACGME currently requires “timely” submission.

Notes on Right 5:
AMA policy advocates for compensation during orientation and recommends that compensation overall be based on years of experience (Policies H-310.999 [II.E.1-3], “Guidelines for Housestaff Contracts or Agreements,” H-310.988, “Adequate Resident Compensation,” H-305-930, “Residents’ Salaries,” and D-310.967, “Resident Pay During Orientation”). AMA policy does not specify compensation adjusted to cost of living differences based on geographic differences, although this may be covered by H-310.988, which calls for “adequate compensation.” The ACGME requires “appropriate financial support” but does not provide for differing levels of experience or region of the country.
AMA Policy H-295.942, “Providing Dental and Vision Insurance to Medical Students and Resident Physicians,” specifically covers dental and vision services for residents and fellows, while ACGME requirements do not. The ACGME does not mention guaranteed predetermined educational leave, paid or otherwise. The total amount for all leave is not included in ACGME requirements, although they do specify that leave policies must comply with applicable laws.

Notes on Right 6:
Council on Medical Education Report 7-A-11 updates all AMA and ACGME actions on duty hours.

Notes on Right 7:
There are ACGME requirements addressing grievance procedures and due process; however, they are not as extensive as AMA due process guidelines.

Notes on Right 8:
The original language in this section requested “anonymous channels” of communication for reporting violations. The AMA does not have policy to support “anonymous” reporting, but has strong policy supporting “confidential” reporting, which is in congruence with Accreditation Council for Graduate Medical Education requirements that residents can address concerns “in a confidential and protected manner.”

RECOMMENDATIONS
The Council of Medical Education recommends that the following recommendations be adopted in lieu of Resolution 901-I-09 and that the remainder of this report be filed.

1. That our American Medical Association (AMA) continue to advocate for improvements in the ACGME Institutional and Common Program Requirements that support AMA policies as follows: a) adequate financial support for and guaranteed leave to attend professional meetings; b) submission of training verification information to requesting agencies within 30 days of the request; c) adequate compensation with consideration to local cost-of-living factors and years of training, and to include the orientation period; d) health insurance benefits to include dental and vision services; e) paid leave for all purposes (family, educational, vacation, sick) to be no less than six weeks per year; and f) stronger due process guidelines.

2. That our AMA encourage the ACGME to ensure access to educational programs and curricula as necessary to facilitate a deeper understanding by resident physicians of the US health care system and to increase their communication skills.

3. That our AMA regularly communicate to residency and fellowship programs and other GME stakeholders through various publication methods (e.g., the AMA GME e-letter) this Residents and Fellows’ Bill of Rights.

4. That our AMA adopt the following “Residents and Fellows’ Bill of Rights” as applicable to all resident and fellow physicians in ACGME-accredited training programs.

RESIDENTS AND FELLOWS’ BILL OF RIGHTS

Residents and fellows have a right to:

1. An education that fosters professional development, takes priority over service, and leads to independent practice.

   With regard to education, residents and fellows should expect:

   • A graduate medical education experience that facilitates their professional and ethical development, to include regularly scheduled didactics for which they are released from clinical duties. Service
obligations should not interfere with educational opportunities and clinical education should be given priority over service obligations;3
- Faculty who devote sufficient time to the educational program to fulfill their teaching and supervisory responsibilities;4
- Adequate clerical and clinical support services that minimize the extraneous, time-consuming work that draws attention from patient care issues and offers no educational value;5
- 24-hour per day access to information resources to educate themselves further about appropriate patient care;6 and
- Resources that will allow them to pursue scholarly activities to include financial support and education leave to attend professional meetings.7,8

2. Appropriate supervision by qualified faculty with progressive resident responsibility toward independent practice.

With regard to supervision, residents and fellows should expect supervision by physicians and non-physicians who are adequately qualified and which allows them to assume progressive responsibility appropriate to their level of education, competence, and experience.9

3. Regular and timely feedback and evaluation based on valid assessments of resident performance.

With regard to evaluation and assessment processes, residents and fellows should expect:10

- Timely and substantive evaluations during each rotation in which their competence is objectively assessed by faculty who have directly supervised their work;
- To evaluate the faculty and the program confidentially and in writing at least once annually and expect that the training program will address deficiencies revealed by these evaluations in a timely fashion;
- Access to their training file and to be made aware of the contents of their file on an annual basis; and
- Training programs to complete primary verification/credentialing forms and recredentialing forms, apply all required signatures to the forms, and then have the forms permanently secured in their educational files at the completion of training or a period of training and, when requested by any organization involved in credentialing process, ensure the submission of those documents to the requesting organization within thirty days of the request.11,12

4. A safe and supportive workplace with appropriate facilities.

With regard to the workplace, residents and fellows should have access to:

- A safe workplace that enables them to fulfill their clinical duties and educational obligations;13
- Secure, clean, and comfortable on-call rooms and parking facilities which are secure and well-lit;14
- Opportunities to participate on committees whose actions may affect their education, patient care, workplace, or contract.15

5. Adequate compensation and benefits that provide for resident well-being and health.

A) With regard to contracts, residents and fellows should receive:

- Information about the interviewing residency or fellowship program including a copy of the currently used contract clearly outlining the conditions for (re)appointment, details of remuneration, specific responsibilities including call obligations, and a detailed protocol for handling any grievance;16 and
- At least four months advance notice of contract non-renewal and the reason for non-renewal.17

B) With regard to compensation, residents and fellows should receive:

- Compensation for time at orientation;18 and
- Salaries commensurate with their level of training and experience, and that reflect cost of living differences based on geographical differences.19,20,21,22,23
C) With Regard to Benefits, Residents and Fellows Should Receive:

- Quality and affordable comprehensive medical, mental health, dental, and vision care;\(^{24}\)
- Education on the signs of excessive fatigue, clinical depression, and substance abuse and dependence;\(^{25,26,27}\)
- Confidential access to mental health and substance abuse services;\(^{31}\)
- A guaranteed, predetermined amount of paid vacation leave, sick leave, maternity and paternity leave and educational leave during each year in their training program\(^{32}\) the total amount of which should not be less than six weeks;\(^{33}\) and
- Leave in compliance with the Family and Medical Leave Act.\(^{34}\)

6. Duty hours that protect patient safety and facilitate resident well-being and education.

With regard to duty hours, residents and fellows should experience:

- A reasonable work schedule that is in compliance with duty-hour requirements set forth by the ACGME or other relevant accrediting body;\(^{35}\) and
- At-home call that is not so frequent or demanding such that rest periods are significantly diminished\(^{36}\) or that duty-hour requirements are effectively circumvented.\(^{37}\)

7. Due process in cases of allegations of misconduct or poor performance.

With regard to the complaints and appeals process, residents and fellows should have the opportunity to defend themselves against any allegations presented against them by a patient, health professional, or training program in accordance with the due process guidelines established by the AMA.\(^{38}\)

8. Access to and protection by institutional and accreditation authorities when reporting violations.

With regard to reporting violations to the ACGME, residents and fellows should:

- Be informed by their program at the beginning of their training and again at each semi-annual review of the resources and processes available within the residency program for addressing resident concerns or complaints, including the program director, Residency Training Committee, and the designated institutional official;\(^{39}\)
- Be able to file a formal complaint with the ACGME to address program violations of residency training requirements without fear of recrimination and with the guarantee of due process;\(^{40,41}\) and
- Have the opportunity to address their concerns about the training program through confidential channels, including the ACGME concern process and/or the annual ACGME Resident Survey.\(^{42}\)

REFERENCES

1. Common Program Requirements. ACGME. Sections VI.A.5.e. and IV.A.5.g.
5. Common Program Requirements. ACGME. Section II.C.
6. Common Program Requirements. ACGME. Section II.E.
7. Common Program Requirements. ACGME. Section IV.B.3.
10. Common Program Requirements. ACGME. Sections V.A., V.C.
13. Institutional Requirements. ACGME. Section II.F.3.
15. Institutional Requirements. ACGME. Section II.E.2.a.

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9. OPPOSITION TO INCREASED CME PROVIDER FEES

Reference committee hearing: See Reference Committee C.

HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS AND REMAINDER OF REPORT FILED
See Policy D-300.980.

This is an informational report [Editor’s note: recommendations added in reference committee hearing.] that responds to Policy D-300.980, (AMA Policy Database), “Opposition to Increased Continuing Medical Education (CME) Provider Fees,” adopted by the House of Delegates (HOD) that asked:

That our American Medical Association (AMA) communicate its appreciation to the Accreditation Council for Continuing Medical Education (ACCME) Board of Directors for their responsiveness to AMA’s requests this past year;

That our AMA continue to work with the ACCME and the American Osteopathic Association to: a) reduce the financial burden of institutional accreditation and state recognition; b) reduce bureaucracy in these processes; c) improve continuing medical education; and d) encourage the ACCME to show that the updated accreditation criteria improve patient care;

That our AMA work with the ACCME to: a) mandate meaningful involvement of state medical societies in the policies that affect recognition; and b) reconsider the fee increases to be paid by the state-accredited providers to ACCME; and

That the Council on Medical Education monitor the results of the aforementioned recommendations with a report back to the HOD at the 2011 Annual Meeting.

BACKGROUND

The AMA is a founding member of the ACCME and has linked its American Medical Association Physicians Recognition Award (AMA PRA) Category 1 credit system to ACCME by requiring that US organizations that wish
to designate and award *AMA PRA Category 1 Credit™* be first accredited by the ACCME or a state medical society (SMS) recognized as a state accreditor by the ACCME. This privilege is not accorded to any other US accreditation programs.

There are 2,161 CME providers accredited through the ACCME system. While 695 (32%) are accredited directly by ACCME, 1,466 (68%) intrastate CME providers are accredited by the 45 SMS recognized by ACCME. The majority of SMS-accredited providers are community hospitals. According to ACCME, in 2009 SMS-accredited CME providers produced approximately 33.6% (48,212) of all activities that were certified for *AMA PRA Category 1 Credit™*. Licensing boards, specialty certification boards, and other credentialing bodies accept *AMA PRA Category 1 Credit™* for the purpose of meeting their CME requirements.

Council on Medical Education Report 14-A-10 responded to Policy D-300.982, “Opposition to Increase CME Provider Fees,” that asked for the AMA to study and report back at the 2009 Interim Meeting on the system of intrastate accreditation, including the ACCME fee structure for state accreditors and their providers, the concept of equivalency and new criteria for compliance, and the impact these changes will have on state accreditors and their CME providers. CME Report 14-A-10 concluded that, “the studies show that the threat to the continued sustainability of the intrastate CME accreditation system is real.” The report also stated that, “the combined effect of the ACCME updated criteria, markers of equivalency, and increased fees for intrastate providers is that a significant number of local CME providers have left the system or are contemplating doing so in the future.” The report also acknowledged that, “the recent actions taken by the ACCME Board of Directors (BOD) indicate that the ACCME is serious about working with CME stakeholders, including the AMA and other ACCME member organizations, to address concerns regarding the costs/resources required for CME provider accreditation and state recognition, the complexity/bureaucracy associated with these processes, the efficacy of the accreditation criteria and markers of equivalency, and the connection of ACCME accreditation to the AMA PRA credit system.”

**CURRENT STATE OF THE INTRASTATE CME ACCREDITATION SYSTEM**

The number of intrastate CME providers accredited through the SMS intrastate system has continued to decline. Data provided by the ACCME indicate that since 2003, intrastate CME providers have declined by 318 (1,784 providers in 2003 to 1,466 in January 2011), or 17.9%. The decrease for this past year is 52 CME providers (3.5%) (See Table 1).

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of Providers</th>
<th>% Change from 2003</th>
</tr>
</thead>
<tbody>
<tr>
<td>2003</td>
<td>1,784</td>
<td></td>
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<tr>
<td>2004</td>
<td>1,724</td>
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<tr>
<td>2005</td>
<td>1,693</td>
<td>-5.2%</td>
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<tr>
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<td>-5.6%</td>
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<tr>
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<td>1,663</td>
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<tr>
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<td>1,600</td>
<td>-11.3%</td>
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<tr>
<td>2009</td>
<td>1,518</td>
<td>-14.9%</td>
</tr>
<tr>
<td>2010</td>
<td>1,466</td>
<td>-17.9%</td>
</tr>
</tbody>
</table>

2003-2005 data are from ACCME correspondence to AMA; 2006-2009 data are from ACCME Annual Reports; and 2010 data are from an ACCME Web site posting as of January 2011

The ACCME’s most recent annual report for 2009 discloses that from 2008 and 2009, aspects of programming by intrastate providers also continued to decline in terms of the number of activities presented (5.7%), hours of programming (10.3%), and physician participants (1%).

Council on Medical Education Report 14-A-10 summarized the results of surveys of intrastate- accredited CME providers (1,323 surveyed/41% response rate) and recognized SMS (46 surveyed/83% response rate) conducted in 2009. Significant findings from the intrastate accredited CME providers survey were that:

1. 86% of intrastate CME provider respondents indicated that it was “very important” to their organization to be able to provide *AMA PRA Category 1 Credit™* to the physicians they serve. Only 1 CME provider (less than 1%) answered that providing AMA PRA credit was not important.
2. 60% of intrastate CME provider respondents indicated that the new ACCME criteria would make it more difficult to provide quality CME activities.

3. 59% of intrastate CME provider respondents indicated that accreditation fee increases were a factor that were very likely or somewhat likely to cause their organization to consider not being accredited in the future.

4. 34% of intrastate CME provider respondents reported that their organizations were “discussing whether or not to maintain CME accreditation.”

To determine whether these findings had changed significantly since the 2009 surveys, in December 2010 and January 2011, the AMA surveyed the 45 SMS currently recognized by ACCME to accredit intrastate CME providers. Thirty-five of the 45 SMS accreditors (78%) replied to this survey. SMS representatives were asked to answer questions based on their knowledge of the multiple CME providers accredited through their intrastate accreditation programs in terms of whether certain statements were/were not issues in their state. Analysis of the responses from the recognized SMS accreditors indicates that:

1. CME providers documenting/complying with all accreditation criteria is a major issue for 40% of SMS and somewhat an issue for 57%. Only one SMS reported that this was not an issue.

2. ACCME fee increases scheduled for intrastate CME providers is a major issue for 35% of SMS and somewhat an issue for 41%.

3. Decrease in SMS-accredited CME providers in the state is a major issue for 26% of SMS and somewhat an issue for 57%.

4. SMS documenting/complying with equivalency requirements is a major issue for 15% of SMS, somewhat an issue for 32% and not an issue for 53%.

The Council notes that the activities produced by these intrastate CME providers are critical to a physician’s professional development because they address local educational and practice needs that are specific to the patient populations where the physician actually practices. As noted previously, intrastate CME providers produce over one-third of all activities that are certified for AMA PRA Category 1 Credit™.

It is of significant concern that the decline in the number of intrastate accredited providers, which are mostly community hospitals, is occurring at a time when hospital and other local CME providers, which have access to performance data, could be offering assistance to the physicians by implementing performance improvement continuing medical education (PI CME) that contributes to improving patient care and may be recognized for multiple data reporting purposes, including Maintenance of Certification (MoC®) and Maintenance of Licensure (MoL). It is conceivable that a further decline of the SMS accreditation system in the future may impede the delivery of cost-effective, quality, accessible certified CME that deals with local health care issues and impedes the ability of physicians to stay properly credentialed.

EXISTING AMA POLICY

Policy D-300.980, Recommendation 1: “That our AMA communicate its appreciation to the Accreditation Council for Continuing Medical Education (ACCME) Board of Directors for their responsiveness to AMA’s requests this past year.”

Response to Recommendation 1: The AMA has made a consistent effort to acknowledge and thank the ACCME for their efforts in writing (August 17, 2010), in the opening statement by the Council on Medical Education Chair at the joint meeting with ACCME leadership on October 11, 2010, in presentations to the ACCME BOD by AMA’s Director of Continuing Physician Professional Development (CPPD), and in regular meetings between ACCME staff leadership and the AMA’s Vice President of Medical Education and CPPD Director.

Policy D-300.980, Recommendation 2: “That our AMA continue to work with the ACCME to: a) reduce the financial burden of institutional accreditation and state recognition; b) reduce bureaucracy in these processes; c)
improve continuing medical education; and d) encourage the ACCME to show that the updated accreditation criteria improve patient care.”

Response to Recommendation 2: All of the issues outlined in this recommendation were conveyed to the ACCME in the Council’s letter of August 17, 2010 and also were subjects of discussion in the October 11, 2010 meeting of the ACCME’s and AMA’s Council leadership. The issue of the financial burden is covered further in the next section of this report related to Recommendation 3.

AMA acknowledged at the October 11, 2010 meeting that ACCME had previously taken action to reduce bureaucracy in the accreditation process by eliminating duplicate questions in the self-study process related to the commendation criteria, but AMA representatives suggested that more work was needed to provide relief to CME providers by eliminating redundancy in the accreditation process and decreasing the documentation burden, while at the same time monitoring to ensure quality education.

The AMA noted changes made to the AMA PRA credit system to improve certified CME and offered to work with ACCME to evolve and align the accreditation and credit systems to improve physician CME. The AMA also noted at this meeting that, while the research supports that CME improves knowledge, skills and patient outcomes, additional research is needed related to the impact of the accreditation criteria on patient care. The spirit of this meeting was cordial and productive, and the AMA awaits the changes or initiatives that ACCME will undertake related to these issues as a result of the work of the ACCME’s Accreditation Requirements Task Force.

On October 14, 2009, the Council relayed to ACCME its concerns with ACCME’s interpretation related to what constitutes appropriate CME, which stated that: “Providers must understand that a ‘knowledge’ need must be translated into a change in competence or performance or patient outcomes in order to generate a finding of compliance.” The Council expressed its concern that such interpretation would exclude important knowledge-based, academic, research-related CME as compliant with the accreditation criteria. Subsequently, ACCME communicated with the Council (January 4, 2010) that it shared the Council’s view that education designed to change knowledge is valued and of great importance. The ACCME then proceeded, in January 2010, to issue a call for comments from the CME community to look at whether the word “knowledge” should be added to Criteria 1, 3 and 11. The overwhelming response (64%), which included a response from the AMA to the call for comments, indicated that the word “knowledge” should be added to Criteria 1, 3 and 11. In July 2010, AMA reiterated its request to add ‘knowledge’ to the criteria in correspondence related to Policy D-300.980.

The word “knowledge” was not added to criteria 1, 3 and 11. Instead, the Executive Summary of the ACCME BOD meeting of July 2010 states that, “With respect to Criteria 3 and 11, even if the preponderance of a provider’s activities is focused solely on changing knowledge, the provider must still show that these activities contribute to the overall program’s efforts to change learner’s competence, or performance or patient outcomes.” As an example of “Noncompliance’ with Criterion 3, ACCME has posted on its Web site (as of September 22, 2010) the following finding: “Although the provider describes in its self-study report the generation of activities designed to change patterns of care and the application of new information, the examples presented in the self-study report and in the activities reviewed show evidence only of activities designed to change knowledge, not competence, performance or patient outcomes.” Thus, while ACCME has indicated that knowledge-based activities are valuable CME, to date no changes have been made to the criteria and CME providers are still expected to evaluate a change in physician competence rather than a change in knowledge to demonstrate compliance with the accreditation criteria for knowledge-based activities. Continued concern regarding ACCME’s interpretation of knowledge-based CME also was noted by 45% of the SMS responding to AMA’s December 2010/January 2011 survey. Therefore, the issue may not be fully resolved.

Ongoing discussion between the AMA and the ACCME related to the ACCME’s monitoring for compliance with AMA PRA Category 1 Credit™ requirements continues. In June 2008, the AMA requested that collaborative discussions be initiated noting that as the AMA PRA credit system and the ACCME accreditation systems have evolved over the years, it was no longer clear that the ACCME accreditation processes included sufficient monitoring for AMA PRA Category 1 Credit™ requirements. This is an issue since AMA has represented to stakeholders that certification of activities for AMA PRA Category 1 Credit™ represents that the activities meet the stated AMA PRA requirements.
In December 2009, the ACCME approved, in principle, the incorporation of the review of “Monitoring of Activity-Specific PRA Requirements” and discussions were initiated between AMA CPPD staff and ACCME staff. In June 2010, the Council followed up with the ACCME offering a “Proposed Pilot for ACCME to Enhance the AMA PRA Category 1 Credit™.” The AMA offered to meet with the ACCME to explain the proposal and outline collaborative tasks. The ACCME has commissioned a Task Force to consider this issue. The AMA looks forward to being invited to participate in the ACCME’s Task Force discussions and being apprised of any results from these deliberations.

Policy D-300.980, Recommendation 3: “That our AMA continue to work with the ACCME to: a) mandate meaningful involvement of state medical societies in the policies that affect recognition; and b) reconsider the fee increases to be paid by the state-accredited providers to ACCME.”

Response to Recommendation 3: The issue of meaningful involvement of the SMS in developing policies for recognition was another subject of the October 11, 2010 joint leadership meeting referenced previously. AMA Council on Medical Education representatives encouraged the ACCME at that meeting to insure such involvement of all recognized SMS in the standards setting/policy development process. Results from the December 2010/January 2011 SMS survey indicate that 24 (73%) of the 33 states that responded to the question indicated that state involvement into accreditation standard setting is still either somewhat an issue or a major issue for their states.

During the October 11, 2010 meeting, Council representatives also noted the AMA’s concerns that the ACCME’s delay in implementing proposed fees had not mitigated concerns of intrastate CME providers regarding the financial burden of accreditation and recognition. Council representatives specifically asked that the ACCME review the new fees for intrastate accredited CME providers and consider how they may be reduced or eliminated.

SUMMARY AND CONCLUSIONS

The AMA has a long history of advocating for local CME and for the SMS system that accredits intrastate CME providers that, in turn, produce CME activities that are certified for AMA PRA Category 1 Credit™. The Council on Medical Education has monitored results of the recommendations from its Report 14-A-10 and recognizes that the ACCME Board of Directors has been amenable to discussing AMA concerns and has even appointed workgroups to address solutions. That said, the new fees for intrastate-accredited providers that the ACCME has proposed, though delayed, have not been reduced or eliminated.

While some actions have been taken to eliminate some documentation for commendation criteria, the Council agrees with the ACCME BOD that documenting/complying with all accreditation criteria continues to be an issue for CME providers and looks forward to further improvement. Although the ACCME has agreed that knowledge-based CME may be included in an accredited CME program, changes to the ACCME criteria to reflect this have not been implemented, and as a result CME providers continue to struggle with how they will document a change in competence for these activities. Finally, the ACCME work to establish a monitoring program that includes an audit of compliance with AMA PRA Category 1 Credit™ requirements is still in its early stages.

Previous AMA studies showed that the combined effect of the ACCME-updated criteria and increased fees for intrastate providers was the reason many local CME providers were considering withdrawing from accreditation. The continued annual decrease in the numbers of state CME providers confirms that this is, in fact, occurring. The Council recognizes that if the ACCME/SMS accreditation process is too costly or burdensome, there may be fewer local CME providers willing to maintain accreditation in order to provide CME activities that are certified for AMA PRA Category 1 Credit™. Further, if the ACCME/SMS accreditation process does not demonstrate that AMA PRA standards and the educational value that they bring to certified CME activities, as has been represented to physicians, credentialing bodies, and the public, are being met through the accreditation process, it is conceivable that the credibility and utility of the AMA credit system could be negatively impacted in the future. While the AMA is very gratified with the communication from the ACCME BOD and its expressed desire to make changes to address these issues, given the slow pace of change, we will have to be diligent in tracking the ACCME’s progress in these areas.
RECOMMENDATIONS

Our AMA needs to continue to advocate for efficiencies in the ACCME process to minimize its financial burden and should continue to communicate our ongoing concerns regarding the negative impact of increasing costs on the availability of local CME for physicians.

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

1. That our AMA continue to work with the ACCME to accomplish the directives in Policy D-300.980, “Opposition to Increased Continuing Medical Education (CME) Provider Fees.”

2. That the Council on Medical Education monitor the results of the activities addressing Policy D-300.980 with a report back to the House of Delegates at its 2012 Annual Meeting as to the status of the costs of CME and what further actions, if any, need to be taken.

10. INTEGRATION OF IMGS INTO THE US PHYSICIAN WORKFORCE
(RESOLUTIONS 306-A-10 AND 903-I-10)

Reference committee hearing: See Reference Committee C.

HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS AND REMAINDER OF REPORT FILED
See Policies D-255.991 and D-275.989.

Resolution 306-A-10, introduced by the AMA International Medical Graduates (IMG) Section, asked our AMA to encourage state medical licensing boards to accept certification by the Educational Commission for Foreign Medical Graduates (ECFMG) as primary source verification of medical education credentials, and to recognize that the ECFMG certification is the primary source of medical education credentials for IMGs. Based on testimony at Reference Committee C, which revolved around the complexity of the issues and the need to clarify the resolution’s intent, the HOD referred Resolution 306 for further study with a report back at the 2011 Annual Meeting.

Resolution 903-I-10, introduced by the AMA IMG Section, asked “That our AMA seek federal legislation to create a pathway for J-1 visa waiver status for IMGs who are appointed as US medical school faculty members and agree to serve in that capacity for a minimum of three years of full-time employment.” The question was raised as to whether the J-1 visa waiver is the appropriate program to achieve this goal, and the resolution was referred.

Policy D-255.981 (AMA Policy Database), asked our AMA to continue to monitor issues for IMGs in the US under H status visas who are not able to complete their residency/fellowship training within the H-1’s six-year time limit. The Policy also calls for a follow up report to the House of Delegates no later than the 2012 Annual Meeting.

THE US PHYSICIAN WORKFORCE AND IMGS

Because of the many contributions of IMGs to the US physician workforce, it is important to frame these items in the context of the current and growing shortage of physicians in many states and specialties/subspecialties. IMGs represent 25 percent of the physician population and in several states provide more than 33% percent of health care services. IMGs also account for 27 percent of the resident and fellow physicians in the US. Furthermore, IMGs play a critical role in filling gaps in the US physician workforce. For example, they comprise more than 30 percent of the primary care workforce in the US.

The Association of American Medical Colleges’ (AAMC) Center for Workforce Studies estimates that the US will face a shortage of 124,000 to 159,000 physicians by 2025. A shortage of this magnitude would affect those in vulnerable and underserved populations, which includes the 20 percent of Americans who live in a health professional shortage area.
Further, the pace of the shortfall has been escalating over the past decade, with reports of current physician workforce shortages since 2000 from at least 22 states, with five additional states having predicted future shortages. Twenty-two specialty groups are reporting shortages now or in the very near future, including gastroenterology, thoracic surgery, general surgery, generalist physicians, geriatric medicine, oncology, pediatric subspecialties, public health, rheumatology, allergy and immunology, child psychiatry, critical care, emergency medicine, family medicine, neurosurgery, cardiology, dermatology, medical genetics, anesthesiology, endocrinology, psychiatry and hospice/palliative medicine.

IMGs AND GRADUATE MEDICAL EDUCATION IN THE US

In light of these current and projected shortages of physicians, the nation’s medical schools have responded to calls by the Council on Graduate Medical Education, AAMC, AMA, and other organizations to increase class enrollments and to develop new medical schools. These efforts have been successful. Unfortunately, Medicare support for graduate medical education (GME) has been frozen since 1997. Without an increase in the number of available, funded residency slots, the size of the US workforce will remain stagnant. In addition, thousands of eligible and qualified IMGs will be unable to secure a residency position and to practice medicine in the US.

Looking at the specialty choices of IMGs over the past several years, IMGs often select residency/fellowship positions in disciplines that have fallen out of favor with US-trained MDs and DOs, while being displaced from the specialties that have gained in popularity with US medical graduates. For example, there have been substantial increases of IMGs in primary care specialties, and major decreases of IMGs in anesthesiology, pathology, psychiatry, and physical medicine and rehabilitation.

J-1 VISA WAIVERS

One program that is vital for addressing physician shortages in underserved areas is the J-1 visa waiver program, which allows IMGs to remain in the US after completing a residency/fellowship if they have agreed to practice in a medically underserved location for at least three years.

The H1-B employer-sponsored visa, however, limits IMGs to six years of residency/fellowship training. With training in some fields as long as eight years in length, some IMGs have been denied visa extensions and were unable to complete their residency education. These denials were the impetus for CME Report 11-A-10. Since that time, however, no additional visa denials have been brought to the attention of the AMA IMG Section.

Academic medicine shares some of the same workforce concerns noted above. Many IMGs are well-qualified for medical school faculty positions but cannot accept these appointments because J-1 visa waivers are available only to clinicians, not faculty. As medical school class sizes continue to increase, and as more new medical schools are developed, IMGs could significantly contribute to helping educate the physician workforce of tomorrow, as called for by Resolution 903-I-10. With respect to the medical workforce shortages in specific states and specialties, as noted above, it would be wise to tie any expansion of J-1 waivers to these needs. This would be an extension of the Conrad State 30 J-1 Visa Waiver Program, which authorizes state health agencies to place physicians in federally designated underserved areas where it is difficult to recruit and retain physicians. Existing AMA policy supports permanent reauthorization of the program and its expansion from 30 to 50 positions per state.

REDUCING THE ADMINISTRATIVE BURDEN ON IMGs

Resolution 306-A-10 called for the AMA to encourage state medical licensing boards to accept ECFMG certification as primary source verification of medical education credentials, and to recognize that the standard ECFMG certificate is proof of medical education credentials verified from primary sources for all IMGs. Currently, IMGs who wish to enter an ACGME-accredited residency or fellowship program in the US must obtain ECFMG certification prior to program entry. Since the ECFMG issues the standard ECFMG certificate to applicants who meet all of the examination and medical education credential requirements, this organization would be the appropriate entity to be recognized as the source for primary source verification of an IMG’s medical education credentials. State licensing boards could then accept ECFMG certification in lieu of requiring IMGs to submit original documentation again. Taking this action would significantly reduce a duplicative and onerous administrative burden on IMGs as well as licensing boards, hospitals, employers, and payers, and would facilitate IMGs’ ability to obtain licensure and begin providing health care services.
The Federation Credentials Verification Service (FCVS) of the Federation of State Medical Boards (FSMB) also ensures primary source verification of IMGs’ medical education credentials. The majority of state licensing boards accept FCVS verification of credentials for the purpose of medical licensure. The ECFMG and FSMB’s FCVS have an agreement to cooperate in the primary source verification of the medical education credentials of IMGs. Under the terms of the agreement, since September 2004, the ECFMG has used a mutually acceptable process to obtain primary source verification of the medical diploma and final medical school transcript of IMG’s applying for ECFMG certification. If those applicants apply to the FCVS, the ECFMG is able to provide verification of their credentials immediately to FCVS, eliminating the time involved in obtaining primary source verification from foreign medical schools as part of the licensure process. If an applicant’s medical education credentials were not verified using the mutually acceptable process, the ECFMG obtains primary source verification of the credentials for the FCVS. In either event, IMGs should check with their state medical board to make sure they meet the board’s requirements first and foremost.

RECOMMENDATIONS

For the past 75 years, international medical graduates have made a consistent and significant contribution to American medicine and helped our nation meet its need for health care services. Ensuring that IMGs can continue to play a key role in our country is especially timely as predictions of physician workforce shortages grow more critical. Working for more appropriate, evidence-based changes in state and national regulations and programs can help IMGs as well as our nation’s citizens.

The Council on Medical Education therefore recommends that the following recommendations be adopted in lieu of Resolution 306-A-10 and Resolution 903-I-10 and that the remainder of the report be filed.

1. That our American Medical Association (AMA) International Medical Graduates Section continue to monitor any H-1B visa denials as they relate to IMGs’ inability to complete accredited GME programs.

2. That our AMA revise HOD Policy D-255.985 to include a new third resolved: “(3) Advocate for expansion of the J-1 Visa Waiver program to allow IMGs to serve on the faculty of medical schools and residency programs in geographic areas or specialties with workforce shortages.”

3. That our AMA encourage state medical licensing boards, the Federation of State Medical Boards, and other credentialing entities to accept the Educational Commission for Foreign Medical Graduates certification as proof of primary source verification of an IMG’s international medical education credentials.

4. That Policy D-255.981 be rescinded, having been accomplished by preparation of this report.