REPORTS OF THE COUNCIL ON MEDICAL EDUCATION

The following reports, 1–12, were presented by David E. Swee, MD, Chair:

1. ANNUAL REPORT ON AMA MEDICAL EDUCATION ACTIVITIES: 2011

Informational report. No reference committee hearing.

HOUSE ACTION: FILED

This informational report summarizes the major activities of the Council on Medical Education and American Medical Association (AMA) Medical Education Group during 2011. 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 formulates policy on medical education by recommending educational policies to the AMA House of Delegates, through the AMA Board of Trustees. The Council's 12 members include a medical student and resident physician representative.

In 2011, the Council submitted 10 reports for consideration by the House of Delegates at the Annual and Interim 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. In addition, the Council continued to work 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. To proactively formulate policy and address current issues, the Council has two task forces: Maintenance of Certification/Maintenance of Licensure, and Physician Workforce.

In 2011, leaders of other health care organizations attended Council meetings to provide updates and/or to discuss opportunities for collaboration. Organizations represented included:

- Accreditation Council for Continuing Medical Education (ACCME);
- Alliance for Continuing Medical Education (ACME);
- American Academy of Family Physicians (AAFP);
- American Academy of Pediatrics (AAP);
- American Academy of Physician Assistants (AAPA);
- American Board of Medical Specialties (ABMS);
- Association of American Medical Colleges (AAMC);
- Council of Medical Specialty Societies (CMSS);
- Educational Commission for Foreign Medical Graduates (ECFMG);
- Federation of State Medical Boards of the United States (FSMB);
- National Board of Medical Examiners (NBME); and
- National Resident Matching Program (NRMP).

One core activity of the Council is to identify and recommend qualified nominees to serve on organizations involved in medical education, accreditation and certification. Nominations are reviewed by the AMA Board of Trustees. 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. During 2011, 58 individuals were considered for appointment and/or nomination to fill 35 vacancies. Among Council members, Richard Reiling, MD, has completed a two-year term as chair of the ACCME; Jeffrey Gold, MD, is co-chair of the LCME; and Baretta Casey, MD, was elected chair of the ACGME. In addition, Louis Ling, MD, has been hired by the ACGME to serve as Senior Vice President, and Patricia Turner, MD, is Director of Membership Services at the American College of Surgeons.

As part of its role in monitoring professional standards in medical education, the Council reviews and comments on proposed changes in accreditation standards for medical education programs. In 2011, the Council reviewed proposed revisions to one Liaison Committee on Medical Education (LCME) accreditation standard, and Council members served and participated in preparing a report of the LCME task force on reorganization of the LCME. The report is currently under consideration by the trustees of the AMA and Directors of the AAMC, the two parents of the LCME. Finally, the Council reviewed and commented on 20 sets of new or revised program requirements and one major proposed change of the common requirements of the ACGME.

SECTION ON MEDICAL SCHOOLS

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

During the Annual and Interim Meetings, the Section provides education programs on issues of importance to the academic community. In June 2011, the Section celebrated its 35th Anniversary with a special luncheon education session on the historical role it has played in enhancing communication between the AMA and the medical education community. Other sessions during the AMA Annual Meeting covered innovations in medical education as well as the issue of medical student mistreatment and how to optimize the learning environment. In November 2011, the AMA-SMS met in conjunction with the annual meeting of the Association of American Medical Colleges (AAMC). The AMA-SMS meeting included an education session on the need to expand graduate medical education (GME) to meet our nation's growing need for physicians. Innovative strategies to expand and distribute GME funds at the state and regional level were discussed by a spectrum of panelists. In addition, Richard Krugman, MD, the dean of the University of Colorado Anschutz Medical Campus School of Medicine, gave a presentation highlighting innovative curricular programs at the school.

Increasing AMA membership among academic physicians continues to be a top priority for the AMA-SMS and its governing council. The governing council and staff are assisting in promoting a new AMA academic leadership group membership program that offers special group membership pricing to the medical school leadership.

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

MEDICAL EDUCATION GROUP ACTIVITIES

The AMA is working to transform medical education through the work of the AMA's Center for Transforming Medical Education and the Undergraduate Medical Education, Graduate Medical Education, and Continuing Physician Professional Development Centers of Expertise, as well as the Council and the AMA-SMS.

In 2011, the AMA sponsored a medical education research collaborative, Innovative Strategies for Transforming the Education of Physicians (ISTEP), and entered the second year of its multi-school longitudinal cohort study on the medical education learning environment. Of the 42 ISTEP schools, a total of 30 from the US, Canada and Israel are participating in the learning environment study, and data from approximately 6,000 medical students are being collected. 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 2011, an update to the study was presented at the annual ISTEP meeting, and the study design and initial data were provided both nationally and internationally. At this meeting, Dr. Linda Pololi from Brandeis University and Dr. Louise Arnold of the University of Missouri-Kansas City helped shape the upcoming work of ISTEP, measuring professionalism with a special focus on the clinical years of medical school.

On the issue of physician re-entry to clinical practice following a period of inactivity, staff were invited to present at a conference in September held by the Society of Laparoendoscopic Surgeons that examined gaps in training for reintegration of surgeons into the medical workforce. In addition, staff collaborated with Drexel University to field a survey of physicians on barriers to re-entry. The survey was sent to MDs who inquired about the Drexel University Reentry/Refresher Course; data analysis is underway.

In response to a request to the LCME, the AMA is taking action to address the problem of medical student mistreatment at its roots and improve the medical education learning environment. During its June 2011 Meeting, the AMA held an education program, "Optimizing the Learning Environment: Exploring the Issue of Medical Student Mistreatment," that outlined the scope of the problem and suggested potential solutions. Cosponsored by the Council on Medical Education and AMA-SMS, along with the AMA Medical Student Section, the event brought together the perspectives of medical school deans, resident physicians, and medical students. In addition, the AMA held a conference in December, with invited guests from a variety of stakeholder groups, to identify ways to isolate the sources and causes of mistreatment and to develop strategies to address the issue.

With growing concern about physician burnout and stress, another physician health issue—physician suicide—was the topic in a series of three AMA Webinars, hosted by Medical Education and colleagues in the AMA's Physician Health unit. The second in the series examined some of the stressors in medical education that may contribute to a risk for suicide among medical students and resident physicians.

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

To help reach a wider audience about its work in improving medical education, in July 2011 the AMA combined four communications on medical education into one e-newsletter—*AMA MedEd Update* (www.ama-assn.org/go/amamededupdate). This monthly publication features news, updates, and information from four different areas—Medical School, Graduate Medical Education, Health Care Careers, and Continuing Physician Professional Development.

In addition, to encourage dialogue and advance ideas about transforming medical education, an AMA-hosted online discussion forum was launched in 2010 (www.ama-assn.org/go/newhorizons). The online community has continued to grow in 2011, with nearly 800 registered participants. Also, the popularity of AMA's medical education Twitter page (www.twitter.com/mededAMA) continues to increase, with more than 1,100 followers by year-end.

Undergraduate Medical Education

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 2011, three additional medical schools received LCME preliminary accreditation, bringing the total number of accredited medical schools in the United States to 136. In addition, seven applicant schools are in the pipeline for accreditation by the LCME. Information on developing medical schools is available at www.lcme.org.

Under the auspices of the LCME, an annual survey is sent to the deans of all LCME-accredited US medical schools. The 2011 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 (JAMA)* and shared with members of various stakeholder groups on request.

Graduate Medical Education

The AMA's Graduate Medical Education (GME) Division works to ensure the quality of graduate medical education and the appropriate number and mix of physicians. The Division continues to provide updates to FREIDA Online®, an Internet database with information on more than 9,000 ACGME-accredited and ABMS board-approved GME programs and 1,700 GME teaching institutions. During 2011, FREIDA Online® received over 1.5 million visits. Furthermore, the Division administered (in collaboration with the AAMC) the National GME Census, which collects key residency program and resident/fellow data; these data were published in the medical education issue of *JAMA* and via FREIDA Online®. Finally, staff developed and published new editions of the *Graduate Medical Education Directory*, *Electronic State-level GME Data*, *State Medical Licensure Requirements and Statistics*, and *Health Care Careers Directory*.

The Division also worked to raise awareness of the need to fund GME residency positions to meet the nation's current and coming needs for access to health care services. For example, a letter was written in support of the Resident Physician Shortage Reduction Act of 2011, introduced in fall 2011 in the US Senate, which would increase the number of Medicare-supported training positions for medical residents by 15 percent over five years. Additionally, the Division signed a joint letter, along with 39 other medical organizations, which called on the Joint Select Committee on Deficit Reduction to "protect Medicare beneficiary access to health care services by protecting existing Medicare financing for GME."

Continuing Physician Professional Development (CPPD)

The Division of CPPD (www.ama-assn.org/go/cppd) provides support to the Council on Medical Education in relation to continuing medical education (CME) policies and trends. In addition, the Council on Medical Education has delegated responsibility for administering the AMA's accredited CME program to the Division. To ensure effective liaison to key continuing medical education organizations, CPPD staff hold committee appointments for 12 such organizations and serve in defined leadership positions for five organizations.

The CPPD team presented six Webinars in 2011, reaching more than 700 CME professionals; these included "The AMA PRA Credit System: 2010 Revisions," "What CME Providers Should Know About CME Requirements for Licensure and Maintenance of Licensure" (in collaboration with the FSMB); "Implementing Performance Improvement CME in Medical Schools" (in collaboration with the AAMC); and "What CME Providers Need to Know About CEJA Report 1" (in collaboration with CEJA). In addition, members of the CPPD team gave presentations at more than 38 meetings in 2011, reaching more than 4,300 participants. Topics included Performance Improvement CME, AMA medical education initiatives, the AMA PRA Credit System, CME credit and licensure, and globalization of CME.

CPPD also hosted the fourth annual roundtable meeting with representatives from state medical societies recognized by ACCME to accredit intrastate providers. This meeting provided an opportunity to discuss several issues related to the AMA PRA credit system, including the new AMA PRA requirements that went into effect on July 1, 2011, implementation of CEJA Opinion E-9.0115, monitoring for compliance with AMA PRA requirements, and an update on AMA House of Delegates resolutions and reports.

In September 2011, more than 400 participants attended the 22nd Annual Conference of the National Task Force on CME Provider/Industry Collaboration, held in Baltimore, MD. The theme for the conference was "Collaborating to Improve Professional Education and Health Outcomes."

Finally, as physicians began to prepare for the fall/winter 2011 flu season, the AMA launched a pilot performance improvement continuing medical education (PI CME) activity aimed at increasing influenza immunizations in the office setting for adults age 50 and older.

PUBLICATIONS IN 2011 BY MEDICAL EDUCATION STAFF

1. Barzansky B, Etzel SI. Medical schools in the United States, 2010-2011. *JAMA*. 2011;306(9):1007-1014.

2. Brotherton SE, Etzel SI. Graduate medical education, 2010-2011. *JAMA*. 2011;306(9):1015-1030.

3. Donini-Lenhoff, F. Unknown unknowns: Health, healthcare, and the future. *Journal of Best Practices in Health Professions Diversity: Research, Education and Policy*. 2011;4(1):615-619.

4. Jewett EA, Brotherton SE, Ruch-Ross H. A national survey of "inactive" physicians in the United States of America: enticements to reentry. *Hum Resour Health*. 2011;9(7). Available at www.human-resources-health.com/content/9/1/7.

5. Kao AC, Braddock C 3rd, Clay M, Elliott D, Epstein SK, Filstead W, Hotze T, May W, Reenan J. Effects of educational interventions and institutional policies on medical students' attitudes towards pharmaceutical marketing practices. *Acad Med*. 2011;86(11):1454-62.

6. Kenagy G, Schneidman BS, Barzansky B, Dalton C, Sirio CA, Skochelak SE. Guiding principles for physician re-entry programs. *J Contin Educ Health Prof*. 2011;31(2):117-121.

7. Kenagy G, Schneidman BS, Barzansky B, Dalton C, Sirio CA, Skochelak SE. Physician reentry into clinical practice: Regulatory challenges. *J of Medical Regulation*. 2011;97(1):10-15.

8. Rockey PH. New GME funding sources are needed. Proceedings of Ensuring an Effective Physician Workforce for America: Recommendations for an Accountable Graduate Medical Education System; 2011 Oct; Atlanta, GA, pp 83-111, April 2011. Available at www.macyfoundation.org.

9. Rockey PH. Duty hours: where do we go from here? *Mayo Clin Proc*. 2011;86(3):176-178.

10. Wentz D, Aparicio A. Continuing medical education and the American Medical Association: An educational journey" in Continuing Medical Education Looking Back, Planning Ahead, Wentz D, ed. Dartmouth College Press, University Press of New England, Hanover, New Hampshire, 2011.

11. Wentz D, Aparicio A, Overstreet K. "Contemporary Organizations That Influence Continuing Medical Education in the United States: The National Task Force on CME Provider/Industry Collaboration and the North American Association of Medical Educational and Communication Companies" in Continuing Medical Education Looking Back, Planning Ahead, Wentz D, ed. Dartmouth College Press, University Press of New England, Hanover, New Hampshire, 2011.

PRESENTATIONS IN 2011 BY MEDICAL EDUCATION STAFF

1. "Measuring the medical school learning environment: a link to professionalism?" (panel presentation with representatives of three ISTEP schools)
   Society of Teachers of Family Medicine Conference on Medical Student Education, January 22

2. "Coming clean: the AMA, racism, and allied health"
   National Society for Allied Health, March 18

3. "Medical education and allied health: Past successes, future challenges"
   Commission on Accreditation of Allied Health Education Programs, April 11

4. "Studying the medical education learning environment: exploring international perspectives" (workshop presentation with representatives from three ISTEP schools)
   Association for Medical Education in Europe Annual Conference, August 30

5. "Three little words: Allied health, health care workforce, and physician recruiting"
   Association of Staff Physician Recruiters Annual Conference, August 16

6. "Physician reentry to the workforce: recommendations for a coordinated approach"
   Gap Analysis Workshop for Training for Reintegration of Surgical Skills, September 13

7. "The learning environment and patient centered communication: examining the connection in a research collaborative"
   International Conference for Communication in Healthcare biannual meeting, October 19

8. "Challenges and innovations in GME funding: the need to expand GME" (panel presentation)
   Section on Medical Schools Interim meeting, November 4

9. "Optimizing the learning environment: a multischool approach"
   "Behavioral and social sciences foundational to medical education"
   "Medical school preparation for LCME accreditation"
   "Diversity research forum: first institutional experiences with the new LCME IS-16 and MS-8 diversity standards"
   Association of American Medical Colleges' Annual Meeting, November 4-9

2. COUNCIL ON MEDICAL EDUCATION SUNSET REVIEW OF 2002 HOUSE POLICIES

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS 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:

1. In the spring of each year, the House policies that are subject to review under the policy sunset mechanism are identified.
2. Using the areas of expertise of the AMA Councils as a guide, it is determined which policies should be reviewed by each Council.
3. 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.
4. 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 2002 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

Policy Number	*Title*	*Recommended Action And Rationale*
H-210.980	Physicians and Family Caregivers: Shared Responsibility	Retain. The policy is still relevant.
H-255.971	J-1 Visas and Waivers	Rescind, at the recommendation of AMA-IMG Section staff. The AMA has other policies stating that the Conrad 30 should be permanently authorized and expanded to 50 positions per state.
H-275.932	Internal Medicine Board Certification Report--Interim Report	Retain. The policy is still relevant.
H-275.934	Alternatives to the Federation of State Medical Boards Recommendations on Licensure	Retain, with editorial corrections as noted below, as proposed by staff from the National Board of Osteopathic Medical Examiners. The four references to "Parts" 1 and 2 should be "Levels." In addition, "COMLEX" is now referred to by its proper name, which is "COMLEX-USA."

Policy Number	*Title*	*Recommended Action And Rationale*
H-295.884	Better Assisting our Patients with Near End of Life Decisions	Rescind. Newer training materials that cover these topics are available. In addition, this policy refers to a 1992 CEJA report; which has been superseded by more recent and relevant policy, including H-295.875 Palliative Care and End-of-Life Care, H-140.977 Residency Training in Medical-Legal Aspects of End-of-Life Care, and H-140.949 Physician-Assisted Suicide.
H-305.968	Medicare Direct and Indirect Medical Education Costs	Rescind.
H-310.927	Resident Physician Working Conditions	Retain in part. Retain paragraphs 1, 8, 9 and 10. Rescind remainder as definitions in this policy have been superseded by the ACGME Common Program Requirements.
H-360.984	Nursing Shortage	Retain. The policy is still relevant.
H-460.982	Availability of Professionals for Research	Amend paragraph 3 by deletion: (3) The current annual production of PhDs trained in the biomedical sciences should be maintained ~~into the 1990s~~.

H-210.980 Physicians and Family Caregivers: Shared Responsibility
Our AMA: (1) specifically encourages medical schools and residency programs to prepare physicians to assess and manage caregiver stress and burden; (2) continues to support health policies that facilitate and encourage health care in the home; (3) reaffirm support for reimbursement for physician time spent in educating and counseling caregivers and/or home care personnel involved in patient care; and (4) supports research that identifies the types of education, support services, and professional caregiver roles needed to enhance the activities and reduce the burdens of family caregivers, including caregivers of patients with dementia, addiction and other chronic mental disorders. (Res. 308-I-98; Reaffirmation A-02)

H-255.971 J-1 Visas and Waivers
It is the policy of the AMA to: (1) support the Conrad-30 program, a program authorizing states to place 30 physicians annually in either Health Professional Shortage Areas or Medically Underserved Areas, as one of several strategies to help alleviate physician shortages in underserved areas; and (2) recognize that the security interests of the US are of utmost importance and thorough background checks must be conducted on all visa applicants. (BOT Report 11-I-02)

H-275.932 Internal Medicine Board Certification Report--Interim Report
Our AMA opposes the use of recertification or Maintenance of Certification (MOC) as a condition of employment, licensure or reimbursement. (CME Report 7-A-02)

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 Levels 1 and 2 of the Comprehensive Osteopathic Medical Licensing Examination (COMLEX-USA) prior to entry into residency training. At a minimum, individuals entering residency training must have successfully completed Step 1 of the USMLE or Part Level 1 of COMLEX-USA. There should be provision made for students who have not completed Step 2 of the USMLE or Part Level 2 of the COMLEX-USA to do so during the first year of residency training. (2) All applicants for full and unrestricted licensure, whether graduates of US medical schools or international medical graduates, must have completed one year of accredited graduate medical education (GME) in the US, have passed all licensing examinations (USMLE or COMLEX-USA), 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 Level 1 of COMLEX-USA. (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 remediating 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 Report 8-A-99; Reaffirmed: CME Report 4-I-01; Reaffirmed: CME Report 2-A-11)

H-295.884 Better Assisting our Patients with Near End of Life Decisions
Our AMA encourages: (1) the American Association of Medical Colleges and residency program directors to make "Decisions Near the End of Life" an integral part of American undergraduate and graduate medical education; and (2) primary care and psychiatric medicine through their specialty societies to develop joint continuing medical education programs on "Decisions Near the End of Life" open to colleagues from all specialties. (Resolution 4-A-02)

H-310.927 Resident Physician Working Conditions
(1) Our AMA adopts the following definitions for resident physician education: (a) "Total duty hours" represents those scheduled hours of activity associated with a residency program and include: (i) scheduled time providing direct patient care or supervised patient care that contributes to the ability of the resident physician to meet educational goals and objectives; (ii) scheduled time to participate in formal educational activities; (iii) scheduled time providing administrative and patient care services of limited or no educational value, and (iv) time needed to transfer the care of patients; and (b) "Organized educational activities" are of two types: (i) "Formal educational activities" include scheduled educational programs such as conferences, seminars, and grand rounds and (ii) "Patient care educational activities" include individualized instruction with a more senior resident or attending physician and teaching rounds with an attending physician. (2) Resident physician total duty hours must not exceed 80 hours per week, averaged over a two-week period and that our AMA work with GME accrediting bodies to determine if an increase of 5% may be appropriate for some training programs. (3) Workdays that exceed 12 hours are defined as on-call. (4) Scheduled on-call assignments should not exceed 24 hours. Residents may remain on-duty for up to 30 hours to complete the transfer of care, patient follow-up, and education; however, residents may not be assigned new patients, cross-coverage of other providers' patients, or continuity clinic during that time. (5) On-call shall be no more frequent than every third night and there be at least one consecutive 24-hour duty-free period every seven days both averaged over a two-week period. (6) On-call from home shall be counted in the calculation of total duty hours and on-call frequency if the resident physician can routinely expect to get less than eight hours of sleep. (7) There should be a duty-free interval of at least 10 hours prior to returning to duty. (8) Limits on total duty hours must not adversely impact resident physician participation in the organized educational activities of the residency program. Formal educational activities must be scheduled and available within total duty hour limits for all resident physicians for at least eight hours per week averaged over a two-week period. (9) Scheduled time providing patient care services of limited or no educational value be minimized. (10) Program directors should establish guidelines for scheduled work outside of the residency program, such as moonlighting, and must approve and monitor that work. (CME Report 9-A-02)

H-360.984 Nursing Shortage
Our AMA supports proposals to increase basic nursing education opportunities, workforce incentives and similar efforts to increase the supply of registered nurses. (Resolution 313-A-02)

H-460.982 Availability of Professionals for Research
(1) In its determination of personnel and training needs, major public and private research foundations, including the Institute of Medicine of the National Academy of Sciences, should consider the future research opportunities in the biomedical sciences as well as the marketplace demand for new researchers. (2) The number of physicians in research training programs should be increased by expanding research opportunities during medical school, through the use of short-term training grants and through the establishment of a cooperative network of research clerkships for students attending less research-intensive schools. The number of physicians in research training programs should be increased by providing financial incentives for research centers. (3) The current annual production of PhDs trained in the biomedical sciences should be maintained into the 1990s. (4) The numbers of nurses, dentists, and other health professionals in research training programs should be increased. (5) Members of the industrial community should increase their philanthropic financial support to the nation's biomedical research enterprise. Concentration of support on the training of young investigators should be a major thrust of increased funding. The pharmaceutical and medical device industries should increase substantially their intramural and extramural commitments to meeting postdoctoral training needs. A system of matching grants should be encouraged in which private industry would supplement the National Institutes of Health and the Alcohol, Drug Abuse and Mental Health Administration sponsored Career Development Awards, the National Research Service Awards and other sources of support. (6) Philanthropic foundations and voluntary health agencies should continue their work in the area of training and funding new investigators. Private foundations and other private organizations should increase their funding for clinical research faculty positions. (7) The National Institutes of Health and the Alcohol, Drug Abuse and Mental Health Administration should modify the renewal grant application system by lengthening the funding period for grants that have received high priority scores through peer review. (8) The support of clinical research faculty from the National Institutes of Health Biomedical Research Support Grants (institutional grants) should be increased from its current one percent. (9) The academic medical center, which provides the multidisciplinary research environment for the basic and clinical research faculty, should be regarded as a vital medical resource and be assured adequate funding in recognition of the research costs incurred. (BOT Rep. NN, A-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CSA Rep. 13, I-99; Reaffirmed: CME Rep. 4, I-08)

3. UPDATE ON INTERPROFESSIONAL EDUCATION

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: REFERRED

The idea that students from a variety of health professions should train together has existed for many years. However, it is only relatively recently that the concept of interprofessional education (IPE) has been crystallized and has received widespread endorsement as a means to prepare physicians and other members of the health care team for practice in a collaborative care model.[1,2] For example, in 2005 the American Medical Association Initiative to Transform Medical Education (ITME) identified the need for physicians to be better prepared to work in teams.

This report will provide an update on the current status of IPE for physicians-in-training and will highlight the successes that have been achieved. This discussion will use the definition of interprofessional education proposed by the World Health Organization in 2010:

> When students from two or more professions learn about, from, and with each other to enable effective collaboration and improve health outcomes.[3]

TRENDS IN INTERPROFESSIONAL EDUCATION FOR MEDICAL STUDENTS

Based on data from the Liaison Committee on Medical Education Annual Medical School Questionnaire, the number of US medical schools that have required IPE experiences for medical students is steadily increasing (see Table 1).

Table 1: Number of Schools with Required Interprofessional Education Experiences for Medical Students

Academic Year	Number (%) of Schools
2007-2008*	56 (44%)
2008-2009*	67 (53%)
2009-2010**	81 (62%)
2010-2011***	85 (65%)
* 126 schools, ** 130 schools, *** 131 schools	

In addition to the overall increase, the number of schools where IPE experiences occur in the patient care setting increased from 18 (14%) in the 2007-2008 academic year to 41 (48%) in the 2010-2011 academic year. A number of medical schools provide IPE experiences in more than one year of the curriculum. Of the 85 schools that offered IPE experiences in the 2010-2011 academic year, 34 had experiences in two curriculum years, 14 had experiences in three curriculum years, and 8 had experiences in all four years of the curriculum.[4]

There are many indications that IPE is gaining attention and prominence. The Third Biennial Interprofessional Education Conference in 2011, sponsored by the US-Canadian Collaboration Across Borders initiative, was sold out with more than 800 participants. This represents a significant growth from the 300 participants at the first conference.

RECOMMENDATIONS FOR IPE COMPETENCIES AND STANDARDS

In order to build some consistency in the discourse about IPE and to stimulate IPE across professions, there have been recommendations for both competencies and accreditation standards.

IPE Competencies

In May 2011, the Interprofessional Education Collaborative issued the "Core Competencies for Interprofessional Collaborative Practice."[1] The collaborative consists of the following members: Association of American Medical Colleges, American Association of Colleges of Osteopathic Medicine, American Association of Colleges of Nursing, Association of Schools of Public Health, American Dental Association, and the American Association of

Colleges of Pharmacy. The collaborative utilized the definition for IPE from the World Health Organization, as included above. The competencies are organized under four competency domains:[1]

1. Values/Ethics: Work with individuals from other professions to maintain a climate of mutual respect and shared values.

2. Roles/Responsibilities: Use the knowledge of one's own role and those of other professions to appropriately assess and address the healthcare needs of the patients and populations served.

3. Interprofessional Communication: Communicate with patients, families, communities, and other health professions in a responsive and responsible manner that supports a team approach to the maintenance of health and the treatment of disease.

4. Teams and Teamwork: Apply relationship-building values and the principles of team dynamics to perform effectively in different team roles to plan and deliver patient-/population-centered care that is safe, timely, efficient, effective, and equitable.

Each of the competency areas includes a number of outcome-based objectives.

There also have been IPE competencies created by individual institutions.

IPE in Accreditation

The Canadian Accreditation of Interprofessional Health Education Initiative (AIPHE) is funded by HealthCanada and includes representation from Canadian education associations representing medicine, occupational therapy, nursing, social work, physiotherapy, and pharmacy, as well as accrediting bodies for medical schools (Committee on the Accreditation of Canadian Medical Schools) and graduate medical education (College of Family Physicians of Canada, Royal College of Physicians and Surgeons of Canada). The AIPHE has developed a set of accreditation standards and accompanying criteria that encompass the following areas:[2]

- Organizational commitment to IPE;
- Faculty/organizational unit preparation and commitment;
- Student engagement in IPE;
- IPE in the educational program; and
- Resources to support IPE.

Standards deriving from the AIPHE initiative have been submitted to the Liaison Committee on Medical Education (LCME), the accrediting body for US medical education programs, for consideration. The LCME already has a standard touching on interprofessional communication:

> ED-19. The curriculum of a medical education program must include specific instruction in communication skills as they relate to physician responsibilities, including communication with patients and their families, colleagues, and *other health professionals*.[5]

IMPLEMENTING IPE

What is Needed for Successful IPE

There is concern about the difficulty of implementing IPE programs due to such things as differing schedules across programs, "packed" curricula that do not permit addition of IPE experiences, and faculty and administrative resistance. A systematic review of the literature conducted in 2007 included a comprehensive bibliographic search of publications related to IPE that appeared between1990 and 2003. The following are some general areas identified as needing attention to allow successful implementation of IPE:[6]

- Resources such as time to develop and implement programs, funding support from internal or external sources, and management support were key in initiating and maintaining an IPE effort;
- Teacher characteristics, including role modeling of interprofessional collaboration;

- Learner issues, such as motivation, attention to stereotyping of other professions by learners, opportunities for informal learning (such as time for discussion during breaks), perceived relevance of the education;
- Coordination of schedules among the programs participating in the IPE sessions; and
- Curricular issues, including making the experience "count" through assessment and tailoring the experiences to the environment in which education is conducted (such as the specific clinical setting).

Recent examples of IPE programs also reflect some of these principles. In a review of three IPE initiatives, the authors note the following factors as "essential" to success:[7]

- Support by administration, including commitment of resources;
- Committed experienced faculty;
- Acknowledgement of student effort through grades or other, certificates; and
- Infrastructure support to facilitate coordination or schedules and resources.

Another published report also points to the importance of administrative support at the highest level of the institution to support, encourage, and facilitate the collaboration among the individual schools and colleges.[8]

Outcomes of IPE

Although the number of studies that credibly report outcomes of IPE programs are relatively small, in general the outcomes have been positive.[6] For example, IPE has a positive effect on learners' perceptions and attitudes toward other professions and team skills. There also have been some studies that document positive effects on the delivery of patient care, including such things as screening and illness prevention services, reduction in clinical errors, and patient satisfaction.

AMA POLICY ON IPE

AMA policy supports interprofessional education and partnerships as a priority for the American medical education system (Policy D-295.934, "Encouragement of Interprofessional Education Among Health Care Professions Students," AMA Policy Database). There also is support for ongoing collection of data on interprofessional education and for collaboration with other organizations to explore the possibility of developing pilot programs (D-295.976, "Education for Practice in Interprofessional Teams") and accreditation standards for IPE (D-295.934).

SUMMARY AND RECOMMENDATIONS

IPE is an important element in preparing physicians for practice in the evolving health care system. A number of practice models are emerging that could serve as sites for such education.

Given the increasing national and international attention to IPE, the Council on Medical Education recommends that the following statements be adopted and that the remainder of this report be filed:

1. That our American Medical Association (AMA) support the concept that medical education should prepare students for practice in interprofessional teams.

2. That our AMA encourage health care organizations that engage in a collaborative care model to provide access to an appropriate mix of role models and learners.

3. That our AMA encourage the Liaison Committee on Medical Education and the Accreditation Council for Graduate Medical Education to facilitate the incorporation of interprofessional education into the educational programs for medical students and residents in ways that support high quality medical education.

4. That our AMA encourage the development of competencies for interprofessional education that are applicable to and appropriate for each group of learners.

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1. Interprofessional Education Collaborative. Core Competencies for Interprofessional Collaborative Practice. Report of an Expert Panel. May 2011.
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4. USE OF USMLE AND COMLEX ITEMS FOR PURPOSES OTHER THAN THE ASSESSMENT OF PHYSICIANS AND PHYSICIANS-IN-TRAINING

Informational report. No reference committee hearing.

HOUSE ACTION: FILED

Policy H35.972[6] asks that our American Medical Association (AMA) "continue to monitor the use of questions developed for the USMLE and COMLEX by any group for purposes other than the assessment of physicians-in-training and report back to the House of Delegates by the 2012 Annual Meeting."

This informational report summarizes the literature that is publically available, for example from annual reports and on websites, related to the incorporation of items that were previously used in the United States Medical Licensing Examination (USMLE) or the Comprehensive Osteopathic Medical Licensing Examination (COMLEX-USA) in examinations for other health processionals.

THE NATIONAL BOARD OF MEDICAL EXAMINERS AND USMLE EXAMINATION ITEMS

The USMLE is a three-examination sequence that is sponsored by the Federation of State Medical Boards (FSMB) and the National Board of Medical Examiners (NBME®). The Composite Committee, which establishes policies for the USMLE program, has members representing the FSMB, the NBME, the Educational Commission for Foreign Medical Graduates (ECFMG®), and the public.[1]

According to the NBME Web site, testing, consultative, and research services are provided to a variety of organizations, including medical specialty boards and societies, the veterinary licensing board, and allied health professional organizations.[2] The non-physician organizations listed as working with the NBME, in addition to the veterinary licensing board, are the American Association of Medical Assistants; the American Board of Comprehensive Care; the American Board of Medical Genetics, which certifies both physicians and non-physicians; and the American Board of Physical Therapy Specialists.[2] Testing services include such things as exam development (conducting practice analyses, developing examination blueprints, selecting assessment methods) and item development (conducting item writing workshops, editing items, and facilitating item review meetings).[5]

Of the non-physician organizations working with the NBME, the only organization that is known to incorporate previous items from the USMLE is the American Board of Comprehensive Care (ABCC). The ABCC is an organization founded in 2007 to certify graduates of Doctor of Nursing Practice (DNP) programs.[3] The ABCC and the NBME reached an agreement in 2008 to develop and administer an examination for the certification of advanced practice registered nurses who are graduates of DNP programs.[3] According to the NBME, the certification examination uses items "retired from the USMLE" and states that the examination serves a different purpose.[4] The decision about test design is made by a committee appointed by the Council for the Advancement of Comprehensive Care.[4] The DNP certifying examination has been offered annually for three years. Data on the number of examinees and the pass rates follow in Table 1.

Table 1. Pass Rates for the DNP Certification Examination[3]

Year	Number Tested	Pass Rate for First-time Takers
2008	45	49%
2009	19	57%
2010	31	45%

There are no published data on whether retired USMLE examinations are being used in other examinations for non-physicians.

THE NATIONAL BOARD OF OSTEOPATHIC MEDICAL EXAMINERS AND COMLEX-USA EXAM ITEMS

The COMLEX-USA is a three-level examination developed by the National Board of Osteopathic Medical Examiners (NBOME).[6] There are no published data on the use of any COMLEX-USA test items in examinations for individuals who are not students in or graduates of colleges of osteopathic medicine.

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5. ADVANCE TUITION PAYMENT REQUIREMENTS FOR INTERNATIONAL STUDENTS ENROLLED IN US MEDICAL SCHOOLS (RESOLUTION 312-A-10)

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: RECOMMENDATIONS ADOPTED IN LIEU OF RESOLUTION 312-A-10 AND REMAINDER OF REPORT FILED
See Policy H-255.968

Resolution 312-A-10, "Advance Tuition Payment Requirements for International Students Enrolled in US Medical Schools," introduced by the Medical Student Section (MSS), asked that our American Medical Association (AMA) discourage US medical schools from requiring international students to pay more than a single term's tuition at each billing period, and encourage schools to instead allow international students to pay tuition in the same manner as US citizens and US residents.

Testimony in opposition to Resolution 312 was heard at Reference Committee C and focused on the possibility that medical schools might accept fewer international students if they did not have assurance that international students would be able to afford the cost of medical education. Further testimony illustrated the challenges that international students have securing funding for medical education. Based on testimony in opposition to Resolution 312, the HOD referred Resolution 312-A-10 for further study with a report back at the 2012 Annual Meeting.

BACKGROUND

International students are generally defined as students who are not US citizens. To ensure that international students will be able to afford the cost of medical education, medical schools often require international students to provide proof that they are able to meet either some or all of the cost of medical school, including living expenses. Students

who are non-US citizens, but who are permanent residents (i.e., green card holders) may be treated the same as US citizens and qualify as an in-state applicant for public, as well as some private, medical schools.[1]

This report: 1) presents an overview of data on international student applications and matriculation to medical school; 2) reviews cost of medical education and tuition requirements for international students by US medical schools; 3) discusses tuition requirement practices at osteopathic medical schools; and 4) provides a summary and recommendations.

US MEDICAL SCHOOLS THAT ACCEPT APPLICATIONS FROM INTERNATIONAL STUDENTS

In 2011, among the 130 medical schools in the US and its territories, 56% (n=73) accepted applications from international students. This figure includes medical schools (n=13) that only allow international students who are from Canada to apply.[2] (It may be that some medical schools do not consider the "financial status" of Canadian applicants to the extent as other international students.[3]) Therefore, not counting US schools that only accept international students from Canada, 38% of US medical schools consider applications from international students.[2] The list of allopathic schools that accept applications from international students can be found on the NAAHP website at www.naahp.org/Default.aspx?tabid=2559.

APPLICATIONS AND MATRICULATION OF INTERNATIONAL STUDENTS TO US MEDICAL SCHOOLS

There were 20,071 international applicants to US medical schools in 2011. Out of these, 228 (1%) matriculated to the first-year class.[2] Of the 54 medical schools that matriculated international students into the first year class, 35 (65%) were private schools and 19 (35%) were public schools.[2,4] Eleven percent (2,257) of international students applied to schools that had a policy of not accepting international students.[2]

COST OF MEDICAL EDUCATION

In 2010-2011, annual tuition and fees at state medical schools were $25,000 for state residents and $48,000 for non-residents; at private medical schools the costs were $42,000 and $43,000 for residents and non-residents respectively. Information on tuition and fees for individual medical schools is available online at services.aamc.org/30/msar/home. About 86% of medical students graduate with debt accrued during four years of medical school; in 2010, for example, the median debt accrued by medical students was $160,000.[5] As stated previously, international medical students are required to pay some or all of their medical education costs prior to starting medical school.

FINANCIAL ASSISTANCE FOR INTERNATIONAL STUDENTS

The options for international students seeking financial assistance for medical school are very limited. Loan programs from the US federal government are not available to international students. While previously loans from private banks were available to international students, due to current market conditions, these loans may no longer be a viable option (e.g., www.teri.org/). For the vast majority of international students, their only means of financing medical school is through self-pay.

International students may have the opportunity to receive financial assistance from schools if they are pursuing an MD/PhD. This dual degree program is for students with a strong research background who want to pursue a career in academic medicine. This is not an option for international students pursuing a career in clinical medicine seeking a way to finance an MD degree. While international students are not eligible for government funding for the MD/PhD degree, non-governmental funding is available at some institutions.[4] International students should check with individual medical schools before applying (more information on MD/PhD programs is available at www.md-phd.org/faq/).

TUITION REQUIREMENTS IN OSTEOPATHIC MEDICINE

Requiring international students to pay tuition prior to matriculation into the first year is not unique to allopathic schools of medicine. Among the 30 schools of Osteopathic Medicine, 18 consider applications from international students. Some schools require international students to pay all or part of their tuition in advance of matriculation to the first year. Other requirements, such as proof of residency, may be required as well.[6] The list of osteopathic

schools that accept applications from international students and details of tuition requirements can be found at www.aacom.org/resources/bookstore/cib/Documents/2012cib/2012cib-p14.pdf.

SUMMARY AND RECOMMENDATIONS

Medical schools have stringent tuition payment requirements for international students in comparison to US students. These requirements, however, are based on the lack of tuition assistance options available to international students. The ability of an international student to pay the high cost of medical education, including living expenses, must be considered carefully by medical schools to not only ensure that the schools recoup their costs, but to ensure that international students are able to complete their schooling and are not thwarted in their efforts by an inability to pay. On a related note, international students enrolled in US undergraduate institutions aiming to enter medical school in the US, encounter the same obstacles as other international students. Since international students are able to receive tuition assistance for undergraduate education in the US, there may be a misconception among these students that financial assistance also will be available for medical schools. It is important that undergraduate institutions, as well as medical schools, fully inform international students of the barriers they will face financing medical education in the US. Additionally, complete and accurate information on whether or not medical schools consider applications from international students should be readily available.

The Council on Medical Education recommends that the following recommendations be adopted in lieu of Resolution 312-A-10 and that the remainder of the report be filed.

1. That our American Medical Association (AMA) support the autonomy of medical schools to determine optimal tuition requirements for international students.

2. That our AMA encourage medical schools and undergraduate institutions to fully inform international students interested in medical education in the US of the limited options available to them for tuition assistance.

3. That our AMA support the Association of American Medical Colleges (AAMC) in its efforts to increase transparency in the medical school application process for international students by including school policy on tuition requirements in the Medical School Admission Requirements (MSAR®).

4. That our AMA encourage medical schools to explore alternative means of prepayment, such as a letter of credit, for four years of medical school.

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6. INTERSTATE LICENSE PORTABILITY (RESOLUTION 313-A-10)

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS IN LIEU OF RESOLUTION 313-A-10 AND REMAINDER OF REPORT FILED
See Policies H-160.940, H-160.953, H-275.922, H-275.978, H-480.969, D-275.992 and D-275.994

INTRODUCTION

At the 2010 Annual Meeting, the AMA House of Delegates referred Resolution 313, introduced by the Medical Student Section:

> RESOLVED, That our American Medical Association study: a) the need for interstate license portability to allow physicians to volunteer in free clinics; b) the implications of current state policy in Tennessee, Oklahoma, and Arizona that allows for licensed physicians from other states to volunteer in their free clinics; and c) the effects on physician demographics, as well as the medical, financial, and legal implications, of interstate license portability for physician volunteers in free clinics.

This report provides background information on free clinics and physician volunteers, details license barriers to physicians providing *pro bono* services in states in which they do not have a full license, identifies current systems of license portability, highlights relevant AMA policy, and presents recommendations.

BACKGROUND

Free clinics provide care for 1.8 million patients annually and are an important component of the safety net for the uninsured. The large medically underserved component of the nation's population tends to experience poor mental and physical health, are less likely to receive medical care and prescription medication, have lower health literacy rates, and have difficulty accessing care.

The National Association of Free Clinics (NAFC) defines free clinics as volunteer-based health care organizations that provide a range of medical, dental, pharmacy, and/or behavioral health services to economically disadvantaged individuals, who are predominately uninsured.[1] According to a 2010 nationwide survey, over 1000 free clinics operate throughout the United States, providing care for approximately 1.8 million individuals through over 3.5 million visits.[2]

Although free clinics currently are providing a significant portion of care for indigent populations, lack of readily available volunteer personnel and resource shortages limit their effectiveness. The average wait time to schedule an appointment for a new patient and an existing patient is 12 and 11 days, respectively.[2]

With an average operating budget of under $300,000 annually, free clinics are dependent on maintaining a sufficient number of physician volunteers. The removal of barriers and streamlining of processes necessary for physicians to volunteer in clinics in states where they do not possess a full medical license could help address this issue.[2]

LIABILITY COVERAGE

Prior to 1996, the risks of potential medical malpractice lawsuits and the costs of malpractice insurance were barriers to practicing physicians seeking to volunteer their services in free clinics. However, the federal government removed this obstacle in 1996 through passage and subsequent funding of the Health Insurance Portability and Accountability Act (HIPAA), which granted medical malpractice coverage through the Federal Tort Claims Act to physicians volunteering in free clinics. The Affordable Care Act, passed in 2010, expanded the availability of this coverage to employees, officers, board members, and contractors of qualifying free clinics.

LICENSING

The Federation of State Medical Boards (FSMB) represents the 70 state medical licensing and disciplinary boards of the United States and its territories. The licensing process, which is under the purview of each state, is designed to ensure patient safety by affirming that physicians are educated and trained appropriately for the independent practice of medicine and that they practice in accordance with medical ethics and codes of conduct when treating patients. Although there is some similarity from one state to the next, each state has unique requirements based upon the stipulations of their Medical Practice Acts and their individual legislative, media, and public expectations.

To practice medicine as a volunteer, physicians must have a valid medical license in the state in which they wish to volunteer. To obtain licensure in a state, a physician must complete the particular state educational requirements and pay licensure fees. The time and financial commitments needed to receive licensure may present a deterrent to physicians otherwise interested in volunteering in states whose free clinics face physician shortages. Several states, hoping to remove these potential barriers, have programs to encourage interstate physician volunteers.

LICENSE PORTABILITY

As a result of a need to encourage additional volunteers, Arizona, Oklahoma, and Tennessee allow out-of-state physicians to volunteer their time across state borders by obtaining licensure through a special application process. In other states, the application processes for volunteers to obtain a license differ greatly from one jurisdiction to the next and require extensive time and expense.

Arizona

An applicant for a pro bono registration to practice medicine needs to submit the following:

- Certified copy of the a medical degree;
- Certified copies of internship, residency, and fellowship certificates;
- Photocopy of any current license to practice medicine in another state, territory, or possession of the United States or the District of Columbia, along with a letter from the medical board issuing the license, certifying that the license is current and in good standing;
- Certified copy of ECFMG certificate, if applicable;
- Application fee;
- AMA physician profile;
- FSMB disciplinary search; and
- Verification of licensure from every state in which the applicant has ever held a license.[3]

Oklahoma

Physicians who wish to donate their expertise for medical care and treatment may apply for a Special Volunteer Medical License. Eligibility requirements:

- Have previously been issued a full and unrestricted medical license in Oklahoma or another state;
- Have never been the subject of disciplinary action;
- Only provide medical care to needy and indigent persons in Oklahoma or persons in medically underserved areas of Oklahoma; and
- Not receive or have the expectation to receive any payment or compensation, either direct or indirect, for any medical services provided.[4]

<u>Application requirements:</u>

- Completed application;
- Verification of education, and notarized copy of diploma must be completed and submitted (unless the applicant previously held an Oklahoma medical license) by the medical school of graduation;
- Verification of licensure must be completed and submitted by every state that has ever issued the applicant a medical license; and
- Volunteer practice setting information form must be completed, signed, and notarized.

Tennessee

Any physician licensed to practice medicine in any state who has not been disciplined by any medical licensure board may have their license converted to or receive a Special Volunteer License, which will entitle the licensee to practice without remuneration solely within a free health clinic at a specified site or setting by doing the following:

- Submission of a Special Volunteer License application, along with any required documentation; and
- Having the licensing authority of every state in which the physician holds or ever held a license to practice medicine submit directly to the board the equivalent of a "certificate of fitness" which shows that the licensee has never been subjected to any disciplinary action, and is free and clear of all encumbrances;
- For physicians who have not been licensed in Tennessee, comply with all the provisions and paragraphs of the Health Care Consumer Right-To-Know Act; and
- Submitting the specific location of the site of the free health clinic in which the licensee intends to practice along with proof of the clinic's private and not-for-profit status.[5]

Although each of these states have opened the door to physicians practicing in their clinics from other states, their data indicate that the majority of volunteer license applications come from physicians already licensed within that state.

CURRENT AMA POLICY

Our AMA has consistently supported a licensure system that is state-based rather than nationalized, (AMA Policy H-480.969, "The Promotion of Quality Telemedicine," AMA Policy Database) while also supporting mechanisms that enable physicians to move between licensing jurisdictions, so long as such movement does not have a detrimental impact on the health, safety and welfare of the public (AMA Policy H-275.978, "Medical Licensure").

Furthermore, our AMA recognizes the importance of free clinics as providers of care for the uninsured and indigent populations (AMA Policy H-160.953, "Free Clinics"), and has consistently acknowledged the existence of an ethical obligation for physicians to provide care for the indigent (AMA Ethical Opinion E-9.065).

Through these guiding policies, our AMA currently encourages the FSMB to develop a process among the various state licensure boards that would make it possible for a physician who holds an unrestricted license in one state/district/territory to participate in short term (less than 90-day) medical volunteerism in another state/district/territory in which the physician volunteer does not hold an unrestricted license (AMA Policy H-275.922, "Short-Term Physician Volunteer Opportunities Within the United States"). Additionally, our AMA supports reducing barriers to retired physicians practicing in free clinics (AMA Policy H-160.940, "Free Clinic Support").

CONCLUSION

Our AMA has consistently supported and encouraged the involvement of all physicians in volunteer activities to serve the indigent and uninsured through free clinics. In keeping with the AMA's firm belief that licensure should remain a state-based system, we support appropriate measures at the state level to initiate programs that permit out-of-state physicians to volunteer their professional services at free clinics and to increase the efficiency of existing state programs.

RECOMMENDATIONS

The Council of Medical Education, therefore, recommends the following be adopted in lieu of Resolution 313-A-10 and the remainder of this report be filed.

1. That our American Medical Association (AMA) reaffirm the following policies: H-160.953 "Free Clinics"; H-160.940 "Free Clinic Support"; H-275.978 "Medical Licensure"; H-480.969 "The Promotion of Quality Telemedicine"; D-275.994 "Facilitating Credentialing for State Licensure"; D-275.992 "Unified Medical License Application."

2. That our AMA amend Policies H-160.940 and H-275.922 by insertion and deletion as follows:

H-160.940 Free Clinic Support
Our AMA supports: (1) organized efforts to involve volunteer physicians, nurses and other appropriate providers in programs for the delivery of health care to the indigent and uninsured and underinsured through free clinics; and (2) efforts to reduce the barriers faced by physicians volunteering in free clinics, including medical liability coverage under the Federal Tort Claims Act, liability protection under state and federal law, and state licensure provisions for retired physicians and physicians licensed in other United States jurisdictions.

H-275.922 Short-Term Physician Volunteer Opportunities Within the United States
Our AMA encourages the Federation of State Medical Boards to develop ~~a process~~ model policy for ~~among the various~~ state licensure boards to streamline and standardize the process by which ~~that would make it possible for~~ a physician who holds an unrestricted license in one state/district/territory may ~~to~~ participate in ~~short-term (less than 90-day)~~ physician volunteerism in another US state/district/territory in which the physician volunteer does not hold an unrestricted license.

APPENDIX - Policy

H-160.940 Free Clinic Support
Our AMA supports: (1) organized efforts to involve volunteer physicians, nurses and other appropriate providers in programs for the delivery of health care to the indigent and uninsured and underinsured through free clinics; and (2) efforts to reduce the barriers faced by physicians volunteering in free clinics, including medical liability coverage under the Federal Tort Claims Act, liability protection under state and federal law, and state licensure provisions for retired physicians. (Sub. Res. 113, I-96; Reaffirmed: BOT 17, A-04; CMS Rep. 1, A-09)

H-160.953 Free Clinics
The AMA: (1) encourages the establishment of free clinics as an immediate partial solution to providing access to health care for indigent and underserved populations; (2) will explore the potential for a partnership with state and county medical societies to establish a jointly-sponsored free clinic pilot program to provide health services and information to indigent and underserved populations; and (3) will develop strategies that will allow the AMA, along with one or more state or county medical societies, to join in partnership with private sector liability insurers and government - especially at the state, county, and local levels - to establish programs that will have appropriate levels of government pay professional liability premiums or indemnify physicians who deliver free services in free clinics or otherwise provide free care to the indigent. (BOT Rep. 27-A-94; Reaffirmed: BOT 17, A-04)

H-275.978 Medical Licensure
The AMA: (1) urges directors of accredited residency training programs to certify the clinical competence of graduates of foreign medical schools after completion of the first year of residency training; however, program directors must not provide certification until they are satisfied that the resident is clinically competent; (2) encourages licensing boards to require a certificate of competence for full and unrestricted licensure; (3) urges licensing boards to review the details of application for initial licensure to assure that procedures are not unnecessarily cumbersome and that inappropriate information is not required. Accurate identification of documents and applicants is critical. It is recommended that boards continue to work cooperatively with the Federation of State Medical Boards to these ends; (4) will continue to provide information to licensing boards and other health organizations in an effort to prevent the use of fraudulent credentials for entry to medical practice; (5) urges those licensing boards that have not done so to develop regulations permitting the issuance of special purpose licenses. It is recommended that these regulations permit special purpose licensure with the minimum of educational requirements consistent with protecting the health, safety and welfare of the public; (6) urges licensing boards, specialty boards, hospitals and their medical staffs, and other organizations that evaluate physician competence to inquire only into conditions which impair a physician's current ability to practice medicine. (BOT Rep. I-93-13; CME Rep. 10 - I-94); (7) urges licensing boards to maintain strict confidentiality of reported information; (8) urges that the evaluation of information collected by licensing boards be undertaken only by persons experienced in medical licensure and competent to make judgments about physician competence. It is recommended that decisions concerning medical competence and discipline be made with the participation of physician members of the board; (9) recommends that if confidential information is improperly released by a licensing board about a physician, the board take appropriate and immediate steps to correct any adverse consequences to the physician; (10) urges all physicians to participate in continuing medical education as a professional obligation; (11) urges licensing boards not to require mandatory reporting of continuing medical education as part of the process of reregistering the license to practice medicine; (12) opposes the use of written cognitive examinations of medical knowledge at the time of reregistration except when there is reason to believe that a physician's knowledge of medicine is deficient; (13) supports working with the Federation of State Medical Boards to develop mechanisms to evaluate the competence of physicians who do not have hospital privileges and who are not subject to peer review; (14) believes that licensing laws should relate only to requirements for admission to the practice of medicine and to assuring the continuing competence of physicians, and opposes efforts to achieve a variety of socioeconomic objectives through medical licensure regulation; (15) urges licensing jurisdictions to pass laws and adopt regulations facilitating the movement of

licensed physicians between licensing jurisdictions; licensing jurisdictions should limit physician movement only for reasons related to protecting the health, safety and welfare of the public; (16) encourages the Federation of State Medical Boards and the individual medical licensing boards to continue to pursue the development of uniformity in the acceptance of examination scores on the Federation Licensing Examination and in other requirements for endorsement of medical licenses; (17) urges licensing boards not to place time limits on the acceptability of National Board certification or on scores on the United State Medical Licensing Examination for endorsement of licenses; (18) urges licensing boards to base endorsement on an assessment of physician competence and not on passing a written examination of cognitive ability, except in those instances when information collected by a licensing board indicates need for such an examination; (19) urges licensing boards to accept an initial license provided by another board to a graduate of a US medical school as proof of completion of acceptable medical education; (20) urges that documentation of graduation from a foreign medical school be maintained by boards providing an initial license, and that the documentation be provided on request to other licensing boards for review in connection with an application for licensure by endorsement; and (21) urges licensing boards to consider the completion of specialty training and evidence of competent and honorable practice of medicine in reviewing applications for licensure by endorsement. (CME Rep. A, A-87; Modified: Sunset Report, I-97; Reaffirmation A-04; Reaffirmed: CME Rep. 3, A-10; Reaffirmation I-10)

H-480.969 The Promotion of Quality Telemedicine
(1) It is the policy of the AMA that medical boards of states and territories should require a full and unrestricted license in that state for the practice of telemedicine, unless there are other appropriate state-based licensing methods, with no differentiation by specialty, for physicians who wish to practice telemedicine in that state or territory. This license category should adhere to the following principles: (a) application to situations where there is a telemedical transmission of individual patient data from the patient's state that results in either (i) provision of a written or otherwise documented medical opinion used for diagnosis or treatment or (ii) rendering of treatment to a patient within the board's state; (b) exemption from such a licensure requirement for traditional informal physician-to-physician consultations ("curbside consultations") that are provided without expectation of compensation; (c) exemption from such a licensure requirement for telemedicine practiced across state lines in the event of an emergent or urgent circumstance, the definition of which for the purposes of telemedicine should show substantial deference to the judgment of the attending and consulting physicians as well as to the views of the patient; and (d) application requirements that are non-burdensome, issued in an expeditious manner, have fees no higher than necessary to cover the reasonable costs of administering this process, and that utilize principles of reciprocity with the licensure requirements of the state in which the physician in question practices. (2) The AMA urges the FSMB and individual states to recognize that a physician practicing certain forms of telemedicine (e.g., teleradiology) must sometimes perform necessary functions in the licensing state (e.g., interaction with patients, technologists, and other physicians) and that the interstate telemedicine approach adopted must accommodate these essential quality-related functions. (3) The AMA urges national medical specialty societies to develop and implement practice parameters for telemedicine in conformance with: Policy 410.973 (which identifies practice parameters as "educational tools"); Policy 410.987 (which identifies practice parameters as "strategies for patient management that are designed to assist physicians in clinical decision making," and states that a practice parameter developed by a particular specialty or specialties should not preclude the performance of the procedures or treatments addressed in that practice parameter by physicians who are not formally credentialed in that specialty or specialties); and Policy 410.996 (which states that physician groups representing all appropriate specialties and practice settings should be involved in developing practice parameters, particularly those which cross lines of disciplines or specialties). (CME/CMS Rep., A-96; Amended: CME Rep. 7, A-99; Reaffirmed: CME Rep. 2, A-09; Reaffirmed: CME Rep. 6, A-10)

H-275.922 Short-Term Physician Volunteer Opportunities Within the United States
Our AMA encourages the Federation of State Medical Boards to develop a process among the various state licensure boards that would make it possible for a physician who holds an unrestricted license in one state/district/territory to participate in short-term (less than 90 day) physician volunteerism in another state/district/territory in which the physician volunteer does not hold an unrestricted license. (Sub. Res. 915, I-10)

D-275.991 License Reciprocity Between States
Our AMA will work jointly with the Federation of State Medical Boards, through its Committee on Portability, to examine license reciprocity between states in order to improve the ability of physicians to practice in other states. (Res. 307, I-01; Reaffirmation A-05)

D-275.984 Licensure and Liability for Senior Physician Volunteers
Our AMA (1) and its Senior Physician Group will inform physicians about special state licensing regulations for volunteer physicians; and (2) will support and work with state medical licensing boards and other appropriate agencies, including the sharing of model state legislation, to establish special reduced-fee volunteer medical license for those who wish to volunteer their services to the uninsured or indigent. (BOT Rep. 17, A-04)

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; Reaffirmed: CME Rep. 2, A-11)

D-275.980 Simplifying the State Medical Licensure Process
Our AMA Board of Trustees will assign appropriate individuals from within the AMA to work with the Federation of State Medical Boards and keep the AMA membership apprised of the FSMB's actions on developing a standardized medical licensure application, and the individuals assigned by the AMA Board of Trustees regarding the FSMB's work on standardized medical licensure application will report back to the AMA on a yearly basis beginning at the 2005 Annual Meeting, until decided by the Board of Trustees that this is no longer necessary. (Res. 324, A-04)

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; Reaffirmed: CME Rep. 2, A-11)

REFERENCES

1. The National Association of Free and Charitable Clinics. What is a Free Clinic. Accessed at http://www.nafcclinics.org
2. Darnell, J. Free Clinics in the United States: A Nationwide Survey. Archives of Internal Medicine 2010 (June 14). 946-953.
3. Arizona Revised Statutes. Arizona Administrative Code § R4 (16)(105). Available at http://www.azsos.gov/public_services/Title_04/4-16.htm#ARTICLE%202.%20DISPENSING%20OF%20DRUGS
4. Oklahoma Statutes §59-493.5. Available at http://www.oklegislature.gov/
5. Free Health Clinic, Inactive Pro Bono and Volunteer Practice Requirements. Rules of the Tennessee Board of Medical Examiners. 0880-02-.22 (2010) Available at http://www.state.tn.us/sos/rules/0880/0880-02.20100620.pdf

7. OPPOSITION TO INCREASED CME PROVIDER FEES

Informational report. No reference committee hearing.

HOUSE ACTION: FILED

This is an informational report that responds to Policy D-300.980 (AMA Policy Database), "Opposition to Increased Continuing Medical Education (CME) Provider Fees," which calls for: the Council on Medical Education to 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.

Policy D-300.980, "Opposition to Increased Continuing Medical Education (CME) Provider Fees," states that:

> Our AMA will (a) 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; (b) continue to work with the ACCME and the American Osteopathic Association to: (i) reduce the financial burden of institutional accreditation and state recognition; (ii) reduce bureaucracy in these processes; (iii) improve continuing medical education; and (iv) encourage the ACCME to show that the updated accreditation criteria improves patient care; and (c) continue to work with the ACCME to (i) mandate meaningful involvement of state medical societies in the policies that affect recognition; and (ii) reconsider the fee increases to be paid by the state accredited providers to ACCME.
>
> Our AMA will continue to work with the ACCME to accomplish the directives in Policy D-300.980, "Opposition to Increased Continuing Medical Education (CME) Provider Fees."
>
> The Council on Medical Education will 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. (CME Report 14-A-10; Appended: CME Report 9-A-11)

BACKGROUND

The AMA is a founding member of the ACCME. Since 1981 the AMA has required that US organizations that wish to designate and award *AMA PRA Category 1 Credits*™ first be accredited by the ACCME or a state medical society (SMS) recognized as a state accreditor by the ACCME. The AMA has not accorded this privilege to any other US

accreditation programs. Licensing boards, specialty certification boards and other credentialing bodies accept *AMA PRA Category 1 Credit*™ for the purpose of meeting CME requirements.

The ACCME's Executive Summary of its December 2011 Board of Director's (BOD) Meeting notes that there are 2,077 CME providers accredited through the entire ACCME system. Of these 695 (33.5%) are accredited directly by ACCME, and 1,382 (66.5%) are accredited by the 45 SMS recognized by ACCME to provide intrastate accreditation programs. According to the ACCME 2010 Annual Report, the last year for which summary data is currently available, SMS accredited CME providers produced approximately 46,337 (36.2%) of all activities that were certified for *AMA PRA Category 1 Credit*™. The majority of these SMS accredited providers are community hospitals that provide local programming for their affiliated physicians.

The ACCME had been charging an annual $40 fee for each SMS accredited provider since 1990. That fee increased to $80/year in 2005. In 2008, the ACCME announced that it would increase the annual charge for each state accredited provider from $80 to $550. That decision was later modified and the ACCME is phasing in the new fees annually: $250 in 2011; $450 in 2012; and $550 in 2013. It should be noted that state accredited CME providers also pay fees to the SMS that directly provides accreditation and support services within their jurisdictions.

This is the third report in as many years from the Council on Medical Education to the AMA HOD on this issue (previous reports were CME Report 14-A-10 in response to Resolution 302-A-09, and CME Report 9-A-11). 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," and 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." Similarly, among the conclusions from CME Report 9-A-11 was: "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 Credits*™." Both reports also acknowledged that actions taken by the ACCME BOD indicate that the ACCME is willing to work with the AMA and other CME stakeholders to address concerns regarding the costs/resources required for CME provider accreditation and state recognition. For each of these past reports the HOD asked the Council on Medical Education to continue to monitor and report back on this issue.

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 2006, intrastate CME providers have declined by 303 (1,684 providers in 2006 to 1,382 in December 2011), or 17.9%. The decrease for this past year is 68 CME providers (4.7%) [See Table 1].

Table 1. Decline of Intrastate Accredited CME Providers

Year	Number of Providers	% Change from 2006
2006	1684	
2007	1663	1.2%
2008	1601	4.9%
2009	1518	9.9%
2010	1450	13.8%
2011	1382	17.9%
2006-2010 data are from ACCME Annual Reports 2011 data are from ACCME's Executive Summary of its December 2011 Board of Director's Meeting.		

The ACCME Annual Reports also describe that from 2006 to 2010 aspects of programming by SMS accredited providers declined in terms of the number of activities presented (17.7%), hours of programming (16.1%), and

physician participants (24.1%). Again, this reflects what is happening with providers who produce certified-CME activities at the local level close to the point-of-care.

Historically, the level of commercial/industry funding for SMS accredited providers has been significantly lower than that for ACCME accredited providers. In 2006, ACCME-accredited providers received 50.3% of their revenues from commercial support while commercial support accounted for only 29.3% of the revenues for SMS accredited providers. In 2010, ACCME accredited providers received 37% of their revenues from commercial support while commercial support had dropped to 11.5% of the revenues for SMS accredited providers.

AMA AND ACCME ACTIONS RESPONDING TO POLICY D-300.980

Besides the actions described in the previous two reports, the AMA also communicated with the ACCME by letter on August 8, 2011 concerning the HOD's policy directive. Dialog concerning this policy continued throughout the year in meetings between ACCME and AMA Medical Education staff leadership, in ACCME meetings with staff liaisons of its member organizations, and at meetings of the ACCME BOD. The ACCME responded on December 16, 2011 to the various components of the policy (See Appendix).

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 produce CME activities that are certified for *AMA PRA Category 1 Credits*™. The Council on Medical Education has monitored results of the recommendations from Policy D-300.980 for the past three years and the ACCME BOD has been amenable to discussing AMA concerns.

While the fee increase announced in 2008 was not rescinded, its implementation is now being phased in through 2013, probably providing some relief to state accredited providers. Documenting/complying with all accreditation criteria continues to be a challenge for SMS accredited CME providers and the number of SMS accredited providers continues to decline as has the number of physicians who attend certified CME from these local CME providers. In December 2009, the ACCME BOD created a Board Task Force to explore strategies for clarifying the requirements, eliminating redundancies, and reducing the documentation requirements for providers. This Task Force reported back to the ACCME Board in November 2010. The ACCME reports that it continues to be actively engaged in ongoing discussions and that some of the "simplification" changes associated with the Task Force's work have already been implemented. For the past three years, the AMA has advocated for reduced fees and changes to the existing ACCME accreditation system. The Council on Medical Education will continue to monitor the activities and fees of the ACCME but does not have any recommendations for additional actions to be taken at this time.

APPENDIX - Letter to AMA from the Accreditation Council for Continuing Medical Education

December 16, 2011

David Swee, MD
Chair, Council on Medical Education and
Susan Skochelak, MD
Vice President for Education
American Medical Association
515 N. State Street
Chicago, Illinois, 60654

Dear Doctor Swee and Doctor Skochelak,

We are writing in follow up to the Council's letters of August 17, 2010 and August 8, 2011 to the Accreditation Council of Continuing Medical Education regarding the Council of Medical Education's follow up of the 2010 AMA Policy D-300.980. [Our AMA will (a) 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; (b) continue to work with the ACCME and the American Osteopathic Association: (i) reduce the financial burden of institutional accreditation and state recognition; (ii) reduce bureaucracy in these processes, (iii) improve continuing medical education, and (iv) encourage the ACCME to show that the updated accreditation criteria improve patient care; and (c) continue to work with the ACCME to (i) mandate meaningful involvement of state medical societies in the policies that affect recognition and (ii) reconsider the fee increases to be paid by the state accredited providers to ACCME.] The ACCME is very pleased with the open and constructive communications channels that have been established in the past two years between the ACCME and the Council on Medical Education. The information

contained herein is supplementary to that provided to the AMA in the ACCME's letter of February 27, 2011 (attached for your reference.) We are hopeful that the information we are submitting will assist you in providing a useful report to the AMA's House of Delegates.

1 Regarding, *"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. (Directive to take action)"*

The ACCME is grateful for the AMA's acknowledgment of the ACCME's responsiveness to the AMA's communications.

2 Regarding,*"2). That our AMA continue to work with the ACCME to: a) reduce the financial burden of institutional accreditation and state recognition" and "b) reduce bureaucracy in these processes and " ... the ongoing concern that increasing CME provider fees may cause local and state level providers to stop providing CME due to additional financial burdens."*

The ACCME allocates about 35% of its resources to the SMS system. In 2011, the ACCME received 8% of its revenue from the SMS system. By 2013, this recovery is projected to rise to 16%. In 2011 the nationally accredited providers covered 92% of the ACCME's costs incurred in support of the SMS system.

Regarding the $$ cost of institutional accreditation for ACCME accredited providers,

- The ACCME reduced the cost of an accreditation survey by about $1000 per provider when the ACCME switched in 2009 to telephone surveys for reaccreditation.
- ACCME supplies all its well used on-line educational resources and its well attended webinar sessions for free.
- Opportunity costs have been reduced by accreditation process improvements (e.g., simplified self study report for reaccreditation, less documentation required, automated file sampling process, rate of 2nd Progress Reports reduced through special and free educational interventions.)
- The ACCME has avoided large fee increases to the ACCME accredited providers by shifting a portion of the ACCME's overall expenses to the SMS system, as the beneficiary of approximately 35% of the ACCME's products and services.

Regarding the $$ cost of state medical society Recognition by the ACCME

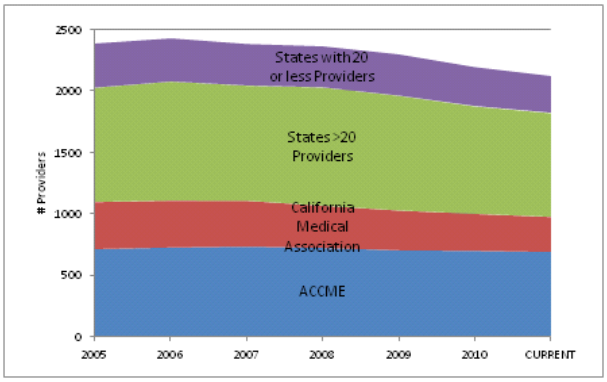
- There have been no ACCME fees charged to the SMS for Recognition since 2006.
- Opportunity costs have been reduced by process improvements to Recognition (e.g., simplifying requirements through the 2007 Markers of Equivalency; discontinuing the self-study report process for Recognition as a result of the new, 2011 Maintenance of Recognition process).
- Direct costs for the SMSs have been avoided because of the ACCME's donation of ACCME's staff, products and services to its SMS colleagues in accreditation (e.g., ACCME training of SMS staff, SMSs use ACCME accreditation resources, SMS providers use ACCME web resources for education.)
- The ACCME has donated its very well received Provider Activity Recording System (PARS) to the SMS system to replace their local solutions for collecting annual report and accreditation information. Already 700+ providers from 24 of the 44 Recognized states are moving to this platform at the ACCME's expense. The ACCME is not recovering any of the $300,000+ the ACCME spent developing this system.

Regarding the $$ cost of institutional accreditation for state medical society accredited providers

- Since the 1990's the ACCME has charged the SMS a fee for each accredited provider. It was $40 in 1990, it was $80 in 2005, and it was $250 in 2011 and will be $550 in 2013. In 2008, 2009 and 2010 we were offered the opportunity to make the business case for these fees to SMS CEO's, SMS CME committees and to the SMS accredited providers themselves. In 2011, these fees were submitted by the accredited providers from all the Recognized state medical societies.
- During the 2009, 2010 and 2011 budgeting processes at the ACCME, all ACCME fees were examined. In 2009, the ACCME did delay the implementation of the $550 fee by using a stepwise strategy of $250, $450 and then $550 in 2013. In 2010 and 2011, the ACCME reconsidered these fees again and decided to continue as planned in 2011 and 2012 despite raising fees to the nationally accredited providers.
- In 2011, the ACCME allocated about 35% of its resources to the SMS system and received 8% of its revenue from the SMS system. As an example of the supports available, a catalogue of the educational resources provided by the ACCME to the SMS is attached.
- By 2013, this recovery is projected to rise to 16% of ACCME expenses with the implementation of the $450 and the $550 fee in 2012 and 2013.
- The ACCME does not control, or monitor, the fees the state accredited providers pay to the state medical societies to support the SMS's accreditation program.
- The ACCME has contributed to subsidizing the $$ cost of accreditation for state medical society accredited providers through the provision of ACCME's donation of $1 Million+ in products and services.

Overall, since 2009, the ACCME has removed $500,000 of programming expenses from the ACCME budget.

Regarding the " ... the ongoing concern that increasing CME provider fees may cause local and state level providers to stop providing CME due to additional financial burdens."



The ACCME's state medical society system has lost 15% of its providers since 2005. Most SMS CEO's that we have spoken to say that most of their attrition is from a new wave of mergers occurring in the state. Also, during that period, the leadership of five SMSs made the decision to stop accrediting CME providers in their state, as a cost saving strategy. Most providers that drop ACCME accreditation say it is more efficient for them to provide the education through joint sponsorship with another provider. To date, no provider has reported to the ACCME that the $250, or the $450, fee is the reason a provider has ended their accreditation.

3 Regarding, *"2). That our AMA continue to work with the ACCME to: "c) improve continuing medical education."*

The ACCME's accreditation requirements were rewritten in 2006 to improve continuing medical education as the result of the work of its own task force's report that stated,

> *"To meet the needs of the 21st century physician, CME will provide support for the physicians' professional development that is based on continuous improvement in the knowledge, strategies and performance-in-practice necessary to provide optimal patient care."*
>
> *Final Report from the ACCME Task Force on Competency and the Continuum, April 2004*

We are pleased to be able to say that the ACCME and its requirements have increased the perceived value of, continuing medical education – as exemplified in the following testimonials.

> *"We applaud the Accreditation Council for Continuing Medical Education's efforts to provide additional guidance for ensuring research independence and a free flow of scientific exchange, while safeguarding accredited CME from commercial influence. Your vigilance in this important matter contributes to the best practices of unbiased information-sharing and will benefit, ultimately, the health of the American public."*
>
> *Dr. Raynard Kington, Deputy Director, National Institutes of Health (NIH) June 2010*

> *"The new system marries quality with the research. It is very rewarding and gratifying to me to see all of the years of so many of us have contributed to building a knowledge base transformed so well into criteria that will improve the learning and performance of clinicians and the health of patients….. I can now see an alignment of research, ACCME standards, and financial support. What is next for all of us is to enhance the competencies of CPD providers. With that coming in the future, it will all line up and patients will benefit most of all."*
>
> *Robert D. Fox, Professor, Adult and Higher Education, University of Oklahoma, 2006*

> *"In 2005, in an effort to strengthen the role of CME in physician performance improvement and lifelong learning, the ACCME proposed a model for CME based on practice-based, self-directed physician learning and change. September 2006, the ACCME released new standards for the accreditation of CME providers that focus on learning and change for both CME providers and learners. The new standards aim to improve physician practice and, thus, the quality of patient care by requiring CME providers to develop and implement CME programs that focus on improving physician competence, physician performance and/or patient outcomes.*
>
> *Federation of State Medical Boards Board Report 10-3: Maintenance of Licensure, April 2010*

> *"The MOC program should provide evidence of ongoing professional development, clinical competence, quality of practice, and measurement of improvement in practice. The MOC Committee might explore the following approaches to achieving this……Reshape Part II and Part IV of MOC to meaningfully align with the ACCME CME rubric for content that is learner-centered, addresses practice gaps, and addresses the six core competencies.*
>
> *Conceptual Framework for MOC Standards 2015, American Board of Medical Specialties, ABMS Board of Directors on September 2011*

Also, when the Food and Drug Administration was seeking advice in 2010 it heard that the type of CME it was looking for was that which was already imbued in the ACCME's accreditation Criteria, when its own working group wrote,

> *"Therefore, the stakeholders and the [working group] recommend that the REMS prescriber training be designed to exceed the goal of traditional CME methods (knowledge acquisition) and instead aim to demonstrate optimized practitioner performance and improved patient outcomes."*
>
> *Final Report of the [FDA] Prescriber Education Working Group, June 2010*

As recognized in the above, the ACCME has intentionally and successfully positioned accredited CME, and therefore also certified CME that is accredited, as a highly valued component of the emerging continuing professional development for

physicians (e.g., MOC, MOL) as well as other uses of accredited CME within programs intended to improve the health of the public (ex., the FDA's Risk Elimination and Mitigations Strategies.)

4 Regarding, *"2). That our AMA continue to work with the ACCME to: "d) encourage the ACCME to show that the updated accreditation criteria improve patient care."*

The ACCME Criteria have improved continuing medical education, however the ACCME does not require CME providers, or continuing medical education, to prove that it improves patient care. The evidence-base from which the Criteria were developed has already, and unequivocally, shown that CME – when designed and presented properly – changes what it is designed to change, be it knowledge, competence, performance or patient outcomes. [Paul E. Mazmanian, PhD, David A. Davis, MD, "Continuing Medical Education and the Physician as a Learner: Guide to the Evidence." The Journal of the American Medical Association 2002; 288(9):1188.doi:10.1001/jama.288.9.1188; Robertson, M. K., Umble, K. E. and Cervero, R. M. (2003), Impact Studies in Continuing Education for Health Professions: Update. Journal of Continuing Education in the Health Professions, 23: 146–156. doi: 10.1002/chp.1340230305; Marinopoulos SS, Dorman T, Ratanawongsa N, Wilson LM, Ashar BH, Magaziner JL, Miller RG, Thomas PA, Prokopowicz GP, Qayyum R, Bass EB. Effectiveness of Continuing Medical Education. Evidence Report/Technology Assessment No. 149 (Prepared by the Johns Hopkins Evidence-based Practice Center, under Contract No. 290-02-0018.) AHRQ Publication No. 07-E006. Rockville, MD: Agency for Healthcare Research and Quality. January 2007; Forsetlund L, Bjørndal A, Rashidian A, Jamtvedt G, O'Brien MA, Wolf F, Davis D, Odgaard-Jensen J, Oxman AD. Continuing education meetings and workshops: effects on professional practice and health care outcomes. Cochrane Database of Systematic Reviews 2009, Issue 2. Art. No.: CD003030. DOI: 10. 1002 / 14651858.CD003030.pub2] The ACCME recognizes that there are many barriers and system factors in place that prevent changes in physician performance, that prevent changes in patient care, and that prevent changes in the health of people. We do not feel that this reflects badly on the physicians, on the CME, or on the ACCME's accreditation requirements.

5 Regarding, *"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.*

The ACCME provides meaningful involvement of the state medical societies in the development and implementation of all ACCME policies, including those that affect recognition.

Our Committee for Review and Recognition (CRR) is constituted solely from persons nominated by Recognized state medical societies. It was recently expanded to nine from seven persons. Two persons from the CRR are full voting members of the ACCME's Board of Directors. One SMS-nominated CRR member on the Board of Directors is also on the ACCME's Executive Committee. The 2011 draft ACCME bylaws amendments propose making the SMS-nominated CRR members on the ACCME Board of Directors eligible for election as officers of the ACCME.

The ACCME also uses a call-for-comment in its formal policy development process through which the SMSs can be involved in the due-process of policy development.

There is also more informal, but yet meaningful involvement of the SMSs in ACCME policy development and implementation. On a monthly basis staff and volunteers of 25 to 35 SMSs meet in webinar format to discuss SMS and ACCME based issues. The same group meets in December of each year at the ACCME State and Territorial Medical Society Conference. The whole CRR attends this annual conference and AMA staff and members of the Council of Medical Education are invited. This collegial and interactive process was utilized by the ACCME a) in 2006 and 2007 to create the new "ACCME Markers of Equivalency" that form the policy under which Recognition decision are made, and b) in 2009 and 2010 to create the new "Maintenance of Recognition", that constitutes the new process used by the ACCME for Recognition.

In conclusion: The ACCME has been actively engaged in reducing costs, increasing efficiency and supporting the state medical societies and their providers. Through its updated requirements the ACCME has positioned accredited CME as a valid and important resource for physicians involved in continuing professional development that is appropriate to their professional practice.

We thank the AMA for this opportunity to respond to the concerns raised by the AMA's House of Delegates, and look forward to continuing to work with you and the Council of Medical Education, in service of this nation's CME enterprise.

Yours truly,

Sandra Norris, MBA
2012 ACCME Chair

Murray Kopelow, MD
Chief Executive and Secretary

Supporting Your Practices as a Recognized Accreditor

Accreditor Webinars
Series of Monthly Webinars Hosted by the ACCME
We look forward to continuing our monthly conversations with you to address topics relevant to accreditors. Each webinar offers an opportunity to discuss hot topics and ask questions related to accreditation practices, Recognition requirements and the CME environment. Accreditors are encouraged to invite their committee members, volunteers and executive leadership to participate in the discussion. We will continue to make the webinars available in recorded format after the live sessions are held.

Regional Accreditor Meetings
Live Seminars for Recognized Accreditors and Accreditation Volunteers
The ACCME invites state accreditors and accreditation volunteers to participate in regional seminars led by ACCME's senior staff.

ACCME State/Territory Medical Society Conference
National Meeting of Intrastate Accreditors and Accreditation Volunteers
Our interactions over the entire year will culminate with our Annual Conference in Chicago. Our focus is the professional development of SMS staff and accreditation volunteers with the goal of promoting a valid and effective national CME system.

State Medical Society Accreditor Web Forum
A Platform for Document Sharing and State System Announcements
This ACCME-hosted platform allows greater flexibility in the exchange of documents and ideas between ACCME and recognized SMS.

Accreditor Self-Assessment Exercises and Survey
Participate in a Skills Exercise to Assess Equivalency Across the System
At the request of participants that attended the 2010 State/Territory Medical Society Conference, the ACCME has developed a self-assessment exercise for accreditors and their volunteers to measure and improve their practice of accreditation. Participation in this professional development exercise will provide insight to serve the equivalency of our national system and identify areas of need to target with education and training.

Support for State Medical Society Staff in Transition
ACCME is a Partner to Ensure the Success of SMS During Staff Transitions
The ACCME provides a number of approaches to support staff transitions within Recognized SMS. The ACCME routinely provides a range of services from staff-to-staff orientation and training to support for accreditation committees. Contact ACCME's Manager of Recognition Services, Sharon Nordling at snordling@accme.org or (312) 527-9200 for more information about how ACCME can provide assistance to meet your needs.

Support for Strategic Communications
ACCME Staff Available to Support Your Communications Efforts
ACCME is available to support collaborative approaches to enhance communications with CME system stakeholders. Inquire about working with ACCME communications staff to develop joint communications for your audiences by contacting ACCME's Director of Communications at thosansky@accme.org or (312) 245-4066.

Supporting Your Efforts in Working with Your Providers and Volunteers

ACCME Educational Offerings for Accredited Providers
Join us for Education that ACCME Offers to the Provider Community
ACCME offers a range of educational support to the CME provider community – including "CME as a Bridge to Quality" workshops (offering a 50% discount on registration for SMS staff and volunteers). Programs that are open for the general CME community, including SMS staff and volunteers, can be found on the ACCME Workshops webpage at education.accme.org/Workshops. SMS staff are also welcome to observe programs offered "by invitation only," these sessions will be announced as they become available.

Request an ACCME Speaker
ACCME Speakers Available for your Provider Conferences
The ACCME will continue to provide speakers for state accreditors' provider conferences or outreach to other stakeholders — whether on site, via phone or webinar. Customized to meet the needs of your audience, these presentations can address a variety of topics, including the role of accredited CME as a strategic partner in health care quality and safety initiatives and communicating accredited CME's value to health care executives and other stakeholders. Speaking engagements are made on the basis of staff availability. Reserve your date now by contacting Katie Swimm at kswimm@accme.org or call (312) 527-9200.

ACCME New Surveyor Training
Participate in ACCME-led Volunteer Training
The ACCME will continue to invite state medical society staff and state volunteers to participate in the ACCME's two-part intensive surveyor trainings including a one hour webinar and full day interview observation training at the ACCME offices in Chicago. There will be no cost for SMS staff/volunteers to participate. However, pre-registration is required and participants will be responsible for their own travel and lodging expenses.

Ongoing Surveyor Training for National ACCME Surveyors
SMS Staff and Volunteers Can Take Advantage of ACCME Training and Resources Developed for the National ACCME Surveyor Pool
The comprehensive Web page at education.accme.org/surveyors contains professional development materials to support ACCME surveyors. Links to newsletters, forms, recorded webinars and accreditation resources are available for quick reference. Additionally, we will continue to alert the intrastate system to the development of new surveyor training materials.

ACCME "Education and Training" Web Pages
Take Advantage of the ACCME's Web-Based Multimedia Educational Resources for Multiple Audiences
The ACCME Education and Training Web pages are accessed from the ACCME homepage (www.accme.org), or directly by going to education.accme.org. The multimedia resources include Video FAQs (Frequently Asked Questions) addressing compliance with the Accreditation Criteria; Perspectives interviews with CME leaders about initiatives that demonstrate the value of accredited CME; educational tutorials, and more.

The ACCME Report – ACCME's Monthly e-Newsletter
Monthly E-Newsletter for Important Updates, News, Resources and Education
The *ACCME Report*, is a monthly newsletter that keeps all of the stakeholders of our national CME system informed about news, policy, and education to support *CME That Matters to Patient Care*™. We encourage SMS volunteers and intrastate providers to subscribe to the free *ACCME Report*. To register for the *ACCME Report*, please click here. Archived editions of the newsletter can be found by navigating to the *ACCME Report* link found under "What's New" on the home page at www.accme.org.

Accreditation Findings Based on the 2006 Criteria: A Compendium of Case Examples
Invaluable Resource to Support Provider Education and Accreditor Decision Making
The ACCME offers a compendium of case examples drawn from the accreditation review process. Accreditation Findings Based on the 2006 Accreditation Criteria (found at www.accme.org) includes examples from the review of more than 400 nationally-accredited providers that have been evaluated under the 2006 Criteria. The compendium includes actual examples of provider practices that were found either in Compliance or Noncompliance with the ACCME Criteria, and includes explanatory comments.

To: Susan Skochelak MD and Alejandro Aparicio MD

From: Murray Kopelow MD, Chief Executive **Date:** February 27, 2011 **Re:** Our Progress

Excuse the formality of this memorandum. I started an email, but the list below became so long that it did not seem appropriate for an email. I am writing in following up to the conversations we have had about AMA's August 2010 letter to the ACCME. Our governance representatives met on the phone in 2010 to discuss it. Subsequently,

- There was our 2010 SMS Conference to which we issued special invitations to the AMA
- The ACCME has created a Task Force to address the AMA's request for assistance on the PRA. This task force is seeking an opportunity to engage with the AMA's Council on Medical Education.
- The ACCME has provided representation (Dr. Tim Holder) to the AMA PRA working group discussing the required evidence base for accredited and certified continuing medical.
- The ACCME (Dr. Steve Singer) and the AMA are collaborating on a project with the AAMC on 'Credit for Teaching' in medical schools.
- The ACCME was responsive to the AMA's concerns about SMS fees and the issue of 'knowledge' within accredited and certified continuing medical education. Invoices reflecting the lowered fees have been distributed. A clarification on 'knowledge' was issued.

- The ACCME is at the halfway point of implementing accreditation using the 2006 Criteria and the results show a successful transition to the 2006 Criteria by the providers.
- The ACCME data does not show a large attrition of accredited providers at the ACCME, or in the state medical society system, that some had feared.
- Soon, as a member organization, you will be getting an invitation to join us for special town hall/roundtable discussion at the March 2011 Board meetings.

We continue to have the state medical societies fully engaged in our, education, our leadership and our strategic planning.

- Since 2007, the ACCME has had two Directors that were originally nominated by state medical societies.
- In 2009 and 2010, through our regional meetings and the annual conference with SMSs, we engaged the SMSs in ACCME's strategic planning.
- The ACCME shared ACCME drafts of SMS survey documents that we suggested could form the basis for collaboration.
- The ACCME has been holding monthly phone meetings with SMS staff and volunteers.
- We are including SMSs in our training sessions for ACCME accredited providers and working one on one with several SMS Accreditors, and individual state accredited providers to clarify a simple approach to accreditation, for them. The 2011 ACCME educational support schedule for the state medical societies has been released.

We have accomplished a great deal as organizations, together, and individually.
We were wondering how this was all going to be reflected in your report to the HOD in the spring – and if you thought there were additional opportunities for us, in follow up to your August 2010 letter. Perhaps we could discuss all this at our next scheduled 'coffee', or earlier, if that would be helpful?

8. EVALUATION OF INCOME-CONTINGENT MEDICAL EDUCATION LOANS (RESOLUTION 306-A-11)

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: RECOMMENDATIONS ADOPTED IN LIEU OF RESOLUTION 306-A-11 AND REMAINDER OF REPORT FILED
See Policy H-305.928

Resolution 306-A-11, which was submitted by the Medical Student Section and referred to the Board of Trustees, asked that our American Medical Association (AMA):

1. Study the feasibility of medical school-initiated income-contingent loans, including the Strategic Alternative for Funding Education proposal, as a mechanism to alleviate medical education debt.

2. Sponsor a national request for proposals aimed at recruiting additional innovative initiatives focused on alleviating medical student debt, and support the best proposal(s), following feasibility studies, at the highest lobbying and legislative priority.

INCOME-CONTINGENT MEDICAL EDUCATION LOANS

Income-contingent loans can be included under the general heading of human capital contracts (HCCs). As applied to higher education, in HCCs investors cover the costs of a program for a student in return for a percentage of that student's future earnings for a fixed period of time.[1] Conceptually, this is similar to service-related scholarship programs such as the National Health Service Corps scholarship, where medical students receive financial aid in return for the promise of future service. The major difference is that HCCs do not, in themselves, limit the occupational choices or location of the "borrower."

Background of HCCs

The concept of HCCs originated with the economist Milton Friedman in the 1950s.[2] A number of years ago, Yale University introduced a program that allowed students to pay their tuition after graduation by providing the school with a defined fraction of their income. This program ended when federally subsidized loans became available.[2]

There currently are a limited number of HCC programs in operation. For example, a company known as Lumni operates for-profit and nonprofit funds that finance the college education of students in Chile, Colombia, Mexico, and the US.[3,4] Lumni has supported over 2,000 students, most of whom are from low-income backgrounds, with a default rate, to date, of three percent.[3, 4] Another example is the Germany-based Career Concept, which finances about 2,000 students in more than 20 countries, mostly in the European Union.[1]

Issues in Implementing HCCs

Much of the information about the structure and implications of human capital contracting that relates to higher education (college and beyond) comes from blogs or other online resources and is theoretical, since no large-scale models have been implemented. The following analysis is adapted from writings that focused mainly on college students.

A debate exists as to whether HCCs would be more effective if based in the public or private sectors.[5] An HCC could, for example, be sponsored by the educational institution in which the student is enrolled,[5-7] as in the Yale example.

Another implementation issue is the feasibility of prospectively calculating the percent of the borrower's salary that would be paid to the "lender" and the length of the "loan." HCCs permit flexibility in the student's choice of profession or occupation. However, they are reported to work best when there is some predictability about the student's future salary. For example, Lumni funds students who plan to be teachers, nurses, and social workers, whose future salaries can be prospectively determined.[2]

Commentators note that there might be less interest in funding future careers with low-income potential or a high risk of unemployment.[2] Also, "lenders" would have a higher return when the student enters a well-paying field, since repayment is not a fixed amount but is based on the "borrowers" salary. For example, it was noted that colleges sponsoring HCCs might have an incentive to channel their students into lucrative careers so as to maximize their returns.[6]

Application of the HCC Concept to Medical Education

In theory, it seems that HCCs could be appropriate for medical students, since physicians are likely to continue in their careers and have a relatively high earning potential. A proposal related to medical education, the Strategic Alternative for Funding Education, recommends that practicing physicians pay for their medical education by contributing a fixed percent of their professional income (higher for private school graduates) to their medical school over a 10-year period beginning after the completion of residency. It also was suggested in the model that payback to medical school could be made tax deductible or paid on a pre-tax basis.[8]

While attractive in concept, implementation of such a plan would be complex in a number of ways. There are logistical issues related to implementation at individual medical schools, such as the need to develop a contracting mechanism, create repayment parameters that would allow the recoup of the loan plus overhead costs, identify processes to monitor the amount of repayment over the life of the repayment period based on the individual's salary/reimbursement level over time, and determine strategies in case of "default." The operating costs of setting up such a system would only be covered if a large number of students participated in the program. Also, schools beginning such a program would not see a financial return until the first cohort of students entered practice (at least seven years), so that a school would be operating for a significant period of time without tuition revenue from some or all students. Instead of depending on individual medical schools to create programs for their own students, a national or regional consortium might be more efficient, based either in the public or private sector. Also, attempts could be made to allow pay-back of such loans on a pre-tax basis.

The HCC concept does not alleviate debt,[8] it just makes "repayment" more predictable and ties the level of repayment to earnings. The main success of HCCs now in operation has been to allow individuals with limited financial resources to attend college[1] and to select careers of interest as well as of social value.[1]

STRATEGIES TO CONTROL MEDICAL STUDENT DEBT

Debt Levels and Medical School Tuition

Medical student debt continues to be high. According to data from the Association of American Medical Colleges,[9] (AAMC) the average debt of 2010 indebted graduates of private schools was $158,526 and of public school graduates was $136,093. About 14% of all graduates had no debt (12% of public school graduates and 17% of private school graduates), and about 19% had debt of over $200,000. However, the percent of graduates with debt over $200,000 varied by type of school (11% of graduates of public schools and 29% of graduates of private schools).[9]

Tuition is an important contributor to debt. While the median tuition and fees for private schools remain higher than for public schools, the difference has narrowed over time (see Table 1). In fact, the median tuition and fees for nonresident students in public schools now exceeds that for private schools. The average percent of nonresident students in public schools also has been increasing (11% in 2000-2001 and 17% in 2010-2011),[11] perhaps contributing to the rising median debt of public school graduates.

Table 1 MEDIAN TUITION AND FEES FOR FIRST-YEAR MEDICAL STUDENTS[10]

School Year	Median Tuition/Private		Median Tuition/Public	
	Resident	Nonresident	Resident	Nonresident
2000-2001	29,566	30,050	11,530	25,774
2005-2006	38,080	39,225	20,297	37,384
2010-2011	46,339	47,634	28,214	49,438

Resolution 306-A-11 asks that our AMA set up a system to identify and evaluate innovative mechanisms to alleviate medical student debt. There already has been significant work in this area, including a number of reviews of the literature in support of previous Council on Medical Education reports that have led to AMA policy.

In general, mechanisms to reduce or eliminate debt can be categorized into three categories.

Medical School Strategies

Strategies utilized by medical schools include limiting tuition, providing scholarship support, providing debt management counseling, and assisting students to gain access to external funding sources. In general, such mechanisms have been the most influential in limiting debt for the largest number of students. These strategies require resources at the medical school level, including the availability of support personnel and the identification of sources of revenue, such as new philanthropy and the use of existing endowment, to offset tuition revenues. Support for these strategies is included, for example, in the following AMA policies: D-305.988, Strategies to Address Medical School Tuition Increases, (AMA Policy Database) and D-305.970, Proposed Revisions to AMA Policy on Medical Student Debt.

In the 2009-2010 academic year, medical schools reported providing school-funded, need-based scholarship support to over 32,000 students, as well as other types of scholarship support (including support for students in MD-PhD programs).[12]

National and Regional Public Sector Strategies

There are a number of programs at the federal level that offer scholarships or loan repayment in return for clinical service after the completion of training. In addition, the National Institutes of Health offers loan repayment for physicians and others engaging in targeted areas of research.

In general, the number of medical students who are supported by the individual, service-related scholarship programs is relatively low. For example, in the 2009-2010 academic year, 103 students received support from the National Health Service Corps scholarship program, and 197 received scholarship support through state-funded programs with a service commitment.[12] In addition, there is the Scholarships for Disadvantaged Students program that supported over 1,700 students in the 2009-2010 academic year.[12]

These strategies are addressed, for example, in the following AMA policies: D-305.975, Long-term Solutions to Medical Student Debt, D-305.970, Proposed Revisions to AMA Policy on Medical Student Debt, and D-305.979, State and Local Advocacy on Medical Student Debt.

Private Sector Strategies

Our AMA has encouraged state and specialty societies to establish or enhance scholarship programs. Other foundations might provide funding for scholarships, either directly or through philanthropy to medical schools.

These strategies are captured, for example, in the following AMA policy: D-305.979, State and Local Advocacy on Medical Student Debt.

Identifying Innovative Strategies

The AMA's collaboration with the AAMC is particularly helpful in monitoring issues related to medical student debt. The AAMC is uniquely positioned to collect information about debt levels and the strategies used by medical schools and others to alleviate it.

SUMMARY AND RECOMMENDATIONS

Medical student debt continues to be a serious issue. Our AMA has expressed a commitment to the issue. AMA Policy H-305.928, "Proposed Revisions to AMA Policy on Medical Student Debt," states, in part, that:

> Our AMA will make reducing medical student debt a high priority for legislative and other action and will collaborate with other organizations to study how costs to students of medical education can be reduced.

In addition, AMA Policy H-305.928 includes a number of strategies to address debt levels. These include the availability of sufficient state and other funding for medical schools to reduce their need to increase tuition; increased availability of scholarship and loan repayment programs from school, state, and federal sources; and legislation and regulation to create favorable conditions for borrowing.

Therefore, the Council on Medical Education recommends that the following recommendation be adopted in lieu of Resolution 306-A-11 and the remainder of this report be filed:

> That our American Medical Association reaffirm AMA Policy H-305.928, Proposed Revisions to AMA Policy on Medical Student Debt.

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9. MEDICAL SCHOOL INTERNATIONAL SERVICE-LEARNING OPPORTUNITIES AND GLOBAL HEALTH EDUCATION (RESOLUTIONS 307-A-11 AND 310-A-11)

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: RECOMMENDATIONS ADOPTED IN LIEU OF RESOLUTIONS 307-A-11 AND 310-A-11 AND REMAINDER OF REPORT FILED
See Policy H-250.993

Resolution 307-A-11, introduced by the Medical Student Section (MSS), asked:

1. That our American Medical Association (AMA) work with the Association of American Medical Colleges (AAMC), the American Association of Colleges of Osteopathic Medicine (AACOM), and other relevant organizations to ensure that medical school international service-learning opportunities are structured to contribute meaningfully to medical education and that medical students are appropriately prepared for these experiences; and

2. That our AMA work with AAMC, AACOM, and other relevant organizations to ensure that medical students participating in international service-learning opportunities are held to the same ethical and professional standards as students participating in domestic service-learning opportunities.

Reference committee testimony was generally in favor of the intent of Resolution 307-A-11; however, concerns were raised about the educational quality of international electives. Testimony addressed the need for more work on uniform standards. Additional testimony noted that the Liaison Committee on Medical Education (LCME) was working on language for new standards in the area of global health education. Based on this testimony, the HOD referred Resolution 307-A-11 for further study with a report back at the 2012 Annual Meeting.

Resolution 310-A-11, introduced by the Medical Student Section, asked:

1. That our American Medical Association (AMA) recognize the importance of global health education for medical students; and

2. That our AMA encourage medical schools to include global health learning opportunities in their medical education curricula.

Reference committee testimony was generally in favor of the intent of Resolution 310-A-11. Concern was expressed, however, that the intent of the resolution was counter to the AMA's belief that mandating specific curriculum is the role of the LCME and the individual school's faculty. Testimony noted that Resolution 307-A-11 covers related topics. Based on this testimony, the HOD referred Resolution 310-A-11 for further study with a report back at the 2012 Annual Meeting.

Due to the overlapping aims of Resolution 307-A-11 and Resolution 310-A-11, they are addressed jointly in this report.

BACKGROUND

Medical students are becoming increasingly interested in pursuing education and training in global health. Factors that have led to increased interest in international service-learning opportunities among medical students include increases in international travel; immigration; multinational health efforts, such as HIV/AIDS; and technology that allows for information sharing.[1,2] Over the past two decades, medical schools have developed international electives to meet medical student demand. Goals of international electives include enhancing students' clinical skills and increasing students' social accountability within a global health environment. Global health education and training have been shown to be positive experiences for medical students.[1] Benefits of international electives include increases in clinical skills, professionalism, and understanding of health care costs.[3] Despite the positive experiences of some students, questions remain regarding the overall quality of international electives. There is growing concern

among medical experts in global health that service-learning opportunities, such as international electives offered by medical schools, are inconsistent with regard to program structure. International service-learning opportunities should ensure that students are prepared to provide care within a different cultural context and that these programs maximize clinical training and professional development opportunities for students.[4]

Definitions of global health education and international elective

There are many definitions of global health education. The following two definitions capture the main intent of global health within the context of medical schools: "the study and practice of improving health and health equity for all people world-wide through international and interdisciplinary collaboration," and "an area for study, research, and practice that places a priority on improving health and achieving equity in health for all people world-wide."[5-6] Further, an international elective is an applied experience undertaken by medical students to improve knowledge and practice skills in a new health care culture. The ways in which the terms global health and international elective are defined and operationalized may be distinct to individual medical schools and health organizations.

This report addresses aspects of global health learning opportunities provided by medical schools as well as other health organizations. Specifically, this report will: 1) provide information on international electives at medical schools including data on schools offering and medical students participating in international electives, resources for information on international electives, and ways in which medical schools are addressing curriculum and outcomes with regard to international electives; 2) present newly revised LCME Standard MS-20 on electives; 3) provide examples of global health learning competencies; 4) present initiatives to improve global health learning; 5) provide resources for international service-learning opportunities; and 6) provide a summary and recommendations.

MEDICAL SCHOOLS AND INTERNATIONAL ELECTIVES

Of the 131 LCME-accredited medical schools that responded to the 2010-2011 LCME Annual Medical School Questionnaire, 129 schools offered students the opportunity to take elective courses internationally (i.e., outside the US, including Puerto Rico). In 2011, more than 30 percent of US and Canadian medical students participated in an international elective. In the US alone, about 17 percent (3,101) of graduating students (17,478) took global health electives during the 2010-2011 academic year.[7-8]

International health electives: Curriculum development

While there are examples of global health curricula[1] in the literature, more information on curricula is needed. Further, there is little coordination among the programs that do exist; therefore, information sharing on global health curricula is limited.[2] For the curricula that do exist, examples of specific content areas include cultural competence, critical thinking, ethical reasoning, and ability to work collaboratively in a multitude of settings. Additionally, the Global Health Education Consortium (GHEC) has developed an online global health education module. More information can be found online at globalhealtheducation.org/Modules/SitePages/Home.aspx.

Implementation of international electives

Two important areas of implementation of international electives include training prior to departure and debriefing after return.[4,9] In 2007, 35 percent (6/17) Canadian medical schools had mandatory pre-departure programs and 35 percent (6/17) had post-return debriefings. Canadian guidelines for pre-departure training, including recommendations for implementation, are available online at www.cfms.org/downloads/Pre-Departure%20Guidelines%20Final.pdf. Aggregate information on pre-departure programs and post-return debriefings among US medical schools was not found in the literature.

International health electives and outcomes

Studies cite enhancement of clinical skills as well as development in areas such as professionalism, functioning as part of a team, and critical thinking skills as important outcomes for international electives. Assessment of students participating in international electives may include written feedback and peer review.[9] There is little in the literature about outcomes and information is needed on changes in student knowledge and professional development as a result of participation in international electives to ensure students are receiving adequate learning experiences and to ensure that patients are receiving quality care.

LCME STANDARD MS-20 REGARDING MEDICAL SCHOOL ELECTIVES

In November 2011, the LCME held a hearing for public comment on three of its accreditation standards, including Standard MS-20 on medical school electives. It stated:

> The issue of students completing "learning experiences in low resource and marginalized communities, including international settings, which may place them or others at increased risk" was brought to the LCME's attention by the Global Health Education Consortium and several academic and student organizations. They requested an annotation to existing Standard MS-20 that would address the issues of (1) student safety and (2) patient safety in situations during elective learning experiences in which a student may be asked to participate in patient care activities under less-than-adequate supervision or for which the student has not yet developed full competence.

The LCME document, including the above information, is available online at www.lcme.org/publichearing2011.htm.

The revised LCME Standard MS-20, approved February 2012, states:

> If a medical student at a medical education program is permitted to take an elective under the auspices of another medical education program, institution, or organization, there should be a centralized system in the dean's office at the home program to review the proposed extramural elective prior to approval and to ensure the return of a performance assessment of the student and an evaluation of the elective by the student.
>
> Approved Annotation to Standard MS-20: Information about issues such as the following should be available, as appropriate, to inform the program's review of the learning experience prior to its approval:
>
> - potential risks to health and safety of patients, students, and the community;
> - the availability of emergency care;
> - the possibility of natural disasters, political instability, and exposure to disease;
> - the need for additional preparation prior to, support during, and follow-up after the elective;
> - the level and quality of supervision; and
> - any potential challenges to the code of medical ethics adopted by the home institution.

The Council on Medical Education reviewed and expressed support for Standard MS-20 prior to its adoption.

ORGANIZATIONS WORKING TO DEVELOP CORE COMPETENCIES IN GLOBAL HEALTH EDUCATION

A study of the medical education literature identified 15 competencies in global health education.[9] Competencies included understanding the global burden of disease, health care disparities, immigrant health, and delivery of primary care in diverse settings. Additionally, medical schools are beginning to document competencies in global health needed for medical students undertaking global health electives.[2] There remains a need to develop a consensus of these competencies.[10]

The Global Health Education Consortium and the Association of Faculties of Medicine of Canada

Consensus on global health training for medical students is underway by several organizations. The Global Health Education Consortium (GHEC) and the Association of Faculties of Medicine of Canada (AFMC) Resource Group on Global Health created a committee to address core competencies in global health for medical students. Information on these global health competencies can be found online at globalhealthcompetencies.wikispaces.com/.

ORGANIZATIONS WORKING TO IMPROVE GLOBAL HEALTH EDUCATION

The Consortium of Universities for Global Health and the GHEC

The Consortium of Universities for Global Health (CUGH), is a North American university consortium for global health. CUGH has developed 10 recommendations that address global health, including advancing global health

education and training. These recommendations are available online at www.cugh.org/about/background#ten-recommendations.

The GHEC "is a consortium of faculty and health care educators dedicated to global health education in health professions schools and residency programs." Information on GHEC can be found at globalhealtheducation.org/aboutus/SitePages/Home.aspx. GHEC is committed to curriculum and training materials development, career development, education policy, and clinical training including facilitating short-term global health learning opportunities for students.

The GHEC and CUGH are working towards a merger. Their first joint meeting will be held in 2013. Updates on the merger and the 2013 meeting will be available on the CUGH homepage at www.cugh.org/.

Global Consensus for Social Accountability of Medical Schools

The Global Consensus for Social Accountability of Medical Schools developed a consensus document to address social accountability of medical schools that included a goal to "respond to current and future health needs and challenges in society and further, to promote "research to design standards reflecting social accountability" at a global level. The group's full report is available online at healthsocialaccountability.sites.olt.ubc.ca/files/2011/06/11-06-07-GCSA-English-pdf-style.pdf.

RESOURCES FOR GLOBAL HEALTH SERVICE-LEARNING OPPORTUNITIES

Medical schools should be contacted individually for their offerings on international electives and other global health learning opportunities. Due to funding constraints, medical schools are not always able to offer support to students for international electives. Therefore, most medical students find international service-learning opportunities on their own.[2-3] Operation Giving Back, sponsored by the American College of Surgeons, provides medical students the opportunity to volunteer in surgery in an international location. There is a general listing of resources for global health learning that is available online at www.operationgivingback.facs.org /content2272.html. Further, the American Medical Student Association (AMSA) has an online International Health Opportunities directory and can be accessed at www.amsa.org/AMSA/Homepage/EducationCareerDevelopment/IntlHealthOpps.aspx.

The following are examples of initiatives to ease funding constraints on, and develop global health opportunities for, medical students.

Global Health Learning Opportunities

The AAMC Global Health Learning Opportunities (GHLO™) is an application service for medical students in their final year who want to participate in an international elective. Eight US medical schools, as well as 15 international medical schools, are collaborating in the GHLO pilot phase from 2012-2013. More information on this global health initiative is available online at www.aamc.org/students/medstudents/ghlo/.

SUMMARY

Interest in global health education and international service learning are increasing among US medical students. Medical schools are having difficulty meeting the increased demand for global health education and training. While there are efforts to improve the quality of global health learning by individual medical schools and health consortiums, there is a lack of coordination among these organizations.[2] Further, medical students, faculty, and global health education experts are becoming increasingly concerned about the quality of international electives. There is still not enough known about the extent to which medical students are prepared in advance for global health learning opportunities. Additional information on students' clinical and professional enhancement as a result of participation in international electives is also needed.[3] Successful training and education of faculty and staff located at the site of the international elective should be considered as a desirable outcome of global health programs so that these faculty and staff can provide care independently.

RECOMMENDATIONS

The Council on Medical Education recommends that the following recommendations be adopted in lieu of Resolutions 307-A-11 and 310-A-11 and that the remainder of the report be filed.

1. That our American Medical Association (AMA) work with the Association of American Medical Colleges (AAMC) and the American Association of Colleges of Osteopathic Medicine (AACOM) to ensure that medical students participating in international electives are held accountable to the same ethical and professional standards as students participating in domestic service-learning opportunities.

2. That our AMA work with the AAMC to ensure that international electives provide measureable and safe educational experiences for medical students, including appropriate learning objectives and assessment methods.

3. That our AMA communicate support for a coordinated approach to global health education, including information sharing between and among medical schools, and for activities, such as the AAMC Global Health Learning Opportunities (GHLO™), to increase student participation in international electives.

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Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS IN LIEU OF RESOLUTIONS 331-A-11, 326-A-11, 316-A-11 and 911-I-11 AND REMAINDER OF REPORT FILED
See Policies H-275.923, H-275.924, H-405.974, D-275.960 and D-275.961

This report responds to four resolutions and two policies of the American Medical Association (AMA) related to maintenance of certification (MOC), osteopathic continuous certification (OCC), and maintenance of licensure (MOL).

Resolution 331-A-11, Legitimacy of the American Board of Medical Specialties (ABMS), introduced by the Connecticut Delegation, asked that our AMA study the validity, the methodology, cost, and effectiveness in

documenting physician competence, of the re-credentialing system for board certification and report back to the House of Delegates (HOD) at the 2012 Annual Meeting.

Resolution 326-A-11, AMA Facilitation of MOL, introduced by the Young Physicians Section, asked that our AMA:

1. In coordination with state and specialty societies, study the feasibility and potential impact of an AMA member benefit program designed to: (1) act as a central repository for MOL, MOC, and/or OCC completion activities for an individual physician; and (2) facilitate an individual physician's efforts to complete required MOL, MOC, and/or OCC activities; and

2. Examine those state and specialty societies who have become actively engaged in facilitating the MOL implementation processes with a goal of identifying "best practices" regarding policy language, implementation programs, coordination activities, and other useful information that could be used by federation societies as they examine MOL implementation as it pertains to their society and report back to the HOD at the 2012 Annual Meeting.

Resolution 316-A-11, Continuing Medical Education (CME) for MOC, introduced by the New York Delegation, asked that our AMA:

1. Support the current CME accrediting system which provides high quality CME activities, thus ensuring continuous professional development as well as educational and practice improvement tools and resources;

2. Support the position of the Alliance for CME, which opposes the ABMS plan as stated because it would undermine the existing interdisciplinary approach to education and would also redirect important resources away from existing educational programs; and

3. Support the position of the Accreditation Council for Continuing Medical Education (ACCME), which opposes the creation of new systems that would impose unnecessary burdens upon ACCME-accredited providers, recognized accreditors, intrastate providers, and physician learners.

Resolution 911-I-11, Elimination of the Secured Examination Requirement for MOC, introduced by the Minnesota Delegation, asked that our AMA work with the ABMS to remove the requirement for a secure examination as part of their MOC program.

Policy D-275.961, Coordinated Efforts of Federation of State Medical Boards (FSMB), ABMS, and American Osteopathic Association (AOA) regarding MOL, directs our AMA to:

1. Encourage state medical boards to accept enrollment and participation in MOC and OCC as satisfactorily meeting the requirements of MOL, despite varying certification and licensing timeframes;

2. Continue to communicate with the FSMB, ABMS, and AOA the extent to which these organizations are working together (with regards to MOC and MOL) and report back to the HOD at the 2012 Annual Meeting; and

3. Encourage the FSMB and state medical boards to recognize, with regards to MOL, that active allopathic and osteopathic licenses should not be revoked on the basis of MOC or OCC requirements not being fulfilled in a timely fashion because of the varying time frames for certification and licensure.

Policy H-406.989, Work of the Task Force on the Release of Physician Data, calls for our AMA to:

1. Oppose the public reporting of individual physician performance data collected by certification and licensure boards for purposes of MOC and MOL;

2. Support the principle that individual physician performance data collected by certification and licensure boards should only be used for the purposes of helping physicians to improve their practice and patient care unless specifically approved by the physician; and

3. Report on how certification and licensure boards are currently using, or may potentially use, individual physician performance data (other than for individual physician performance improvement) that is reported for purposes of MOC, OCC, and MOL and report back to the HOD at the 2012 Annual Meeting.

INTRODUCTION

In an effort to address the resolutions and policies in this report, it became apparent that the requirements for MOC, OCC, and MOL should be aligned and that the activities that would meet a requirement for one process should also be accepted for meeting similar or identical requirements of the others. However, MOC, OCC, and MOL are distinctly different processes, designed by independent organizations with different purposes and mandates. Currently, the guiding principles for MOL, adopted by the FSMB, recognize the value of active engagement in meeting MOC and OCC requirements. MOC and OCC are not intended to become mandatory requirements for medical licensure but should be recognized as meeting some or all of a state's requirements for MOL to avoid unnecessary duplication of work.[1] The FSMB guiding principles and framework developed for MOL will be pilot tested with 11 state medical and osteopathic boards in the near future. Implementation of MOL is several years away, and the pilots will likely be designed to determine and identify multiple options and pathways by which physicians, including those who are not specialty-certified or not engaged in MOC or OCC, may fulfill a state board's MOL requirements.[1]

The MOC, OCC, and MOL processes will be unfolding over the next decade; the AMA has provided strong input and policy related to MOC, OCC, and the principles of MOL. This report builds on the information provided in two previous Council reports to the HOD (Council on Medical Education Report 3-A-10 and Report 16-A-09) and addresses the resolutions and policies listed above by providing:

1. An update on professional and regulatory bodies that are conducting research on methodologies to measure physician competency and to regulate certification examinations.
2. An update on how the ABMS is taking steps to improve the security of certifying examinations and how the ABMS member boards are utilizing standardized simulation-based competencies and modular examinations to accommodate for relevancy to practice.
3. An update on the progress that has been made in developing MOC, OCC, and the policies and framework for MOL, which is intended to provide guidance to state medical boards as they consider participation in MOL pilot projects.
4. A description of the purposes for which physician practice performance data will be collected and used for MOC, OCC, and MOL.
5. An update on some of the tools and resources available to physicians to facilitate their completion of MOC and OCC, as well as an update on how state medical societies, in collaboration with state medical boards, are collaborating to develop an awareness campaign for MOL pilot projects.
6. An update on CME requirements for MOC, OCC, and MOL.

PHYSICIAN COMPETENCE

The AMA has extensive policy on MOC as well as policy to support the principles of MOL. The AMA advocates for balancing these requirements with a sensitivity to physicians' valuable time and resources, ensuring physician input into the ongoing development of MOC and MOL, and making both processes as efficient, effective, and evidence-based as possible.

Competence is assessed in a number of ways and can vary from specialty to specialty. Board certification generally includes successful completion of an approved core residency training program and both written and oral examinations. The ABMS partnered with the Accreditation Council for Graduate Medical Education (ACGME) to develop a set of six competencies that are important for physicians to possess and maintain throughout their professional careers: Professionalism, Patient Care and Procedural Skills, Medical Knowledge, Practice-based Learning and Improvement, Interpersonal and Communications Skills, and System-based Practice. Although specialty board certification is not required to practice medicine, this measurement provides assurance to hospitals and health plans, government and the public that the physician has met specific criteria. The AMA supports this process and its intent but is not responsible for regulating the process.

As representatives of the people of the state, usually appointed by state officials (e.g., governor), state medical and osteopathic boards are sworn to protect the public and promote quality medical licensure and discipline. Any improvements or changes in licensure renewal should logically and appropriately be led and guided by state medical and osteopathic boards.[2] Other professional and regulatory organizations include: The Joint Commission, National Committee for Quality Assurance (NCQA), Agency for Health Care Research and Quality (AHRQ), Ambulatory Care Quality Alliance (AQA), National Quality Forum (NQF), Physician Consortium for Performance Improvement (PCPI/AMA), and the federal government (Centers for Medicare and Medicaid Services [CMS]).

There is a body of literature on the research being conducted in this area, and the ABMS has begun to compile the list of references (Appendix). More studies will be needed to determine the full impact of MOC.

MOC SECURED EXAMINATION REQUIREMENT

Certification examinations are intended to confirm that the physician has the necessary knowledge and in some cases competence to claim expertise in the respective specialty area. Accordingly, the examinations cover both core and the more focused content of a specialty practice. The general purpose is to ascertain whether there is a sound base of specialty-relevant knowledge and skills and the ability to exercise discernment and judgment. It is the responsibility of the certification boards to ensure that their examinations are relevant, meaningful, and measure competence.[3] Furthermore, the ABMS and certification boards should be encouraged to continue to explore other ways to measure the ability of physicians to access and apply knowledge to care for patients as an alternative to high stakes closed book examinations.

AMA HOD Policy H-405.974, Specialty Recertification Examinations, (AMA Policy Database) states (1): that our AMA encourages the ABMS and its member boards to continue efforts to improve the validity and reliability of procedures for the evaluation of candidates for certification.

Integrity of Secured Examinations

Recently, there have been concerns about the integrity of secured high-stakes examinations. This may be due to identity theft, cheating on certification examinations, and copyright infringement that has occurred. Two recent examples include:

- In February 2009, the FSMB and the National Board of Medical Examiners (NBME), joint sponsors of the United States Medical Licensing Examination (USMLE) filed a federal suit requesting an injunction and other relief against Optima University for using test preparation materials that were obtained illegally. The federal complaint claimed that Optima exposed the students who attended review courses to examination questions that were improperly obtained by using examinees who recorded the tests' questions.[4] As a result, individuals who attended Optima's programs or who are considering doing so, risk having their USMLE scores delayed and/or classified as indeterminate. They may also be subject to other consequences, including charges of irregular behavior, as a result of their participation.[5]

- In 2009, the American Board of Internal Medicine (ABIM) sued a test-prep firm, Arora Board Review, for soliciting and compiling copyrighted test questions from the ABIM certification examination.[6]

The USMLE Committee on Irregular Behavior has taken steps to maintain the integrity of its examination so that state medical boards may continue to rely on it as an integral part of their decision-making process for licensure. The Committee recently reviewed cases that involved falsified information (including misrepresentation of educational status), dissemination of test content (including reconstruction of questions from memory and communication of test material to other examinees), solicitation of test content through Internet posting, and disruptive behavior.[7]

The ABMS has also taken steps to address security and copyright issues, and on its website states that, "It should be made abundantly clear that recalling and sharing questions from exams violates exam security, professional ethics, and patient trust in the medical profession. When it happens, the practice should be addressed swiftly and decisively. Whether someone is providing or using test questions, ABMS member boards enforce sanctions that may include permanent barring from certification, and/or prosecution for copyright violation."[8]

Technology and Resources for Secured Examinations

Traditional assessment methods have relied mostly on multiple-choice examinations or continuing medical education exercises. However, the certification boards are beginning to incorporate standardized simulation-based competencies assessment and examinations that more closely represent how practicing physicians diagnose and treat patients. Levine et al. noted that "Simulation enables assessment of physician competencies in real time and represents the next step in physician certification in the modern age of healthcare."[9]

Currently, only the American Board of Anesthesiology (ABA) requires participation in a simulation-based educational course for recertification.[10] Other certification boards provide these activities as an option to satisfy MOC requirements. For example, in 2008, ABIM introduced interventional-cardiology simulations as an option for diplomates to earn credit toward completion of the self-evaluation of medical knowledge requirement of MOC.[11] MOC for family physicians uses a computer-based simulation system similar to the USMLE system to facilitate comprehensive candidate evaluation.[12]

Approximately one-third of the ABMS member boards who responded to an ABMS survey conducted in October 2011 said they use a modular examination approach to accommodate for relevancy to practice. These boards administer an MOC Part III examination that represents the practice content of that particular specialty and includes a combination of core content of their specialty and modules that focus on specific practice area(s). The number of modules incorporated into the MOC Part III examination varies among the member boards that utilize the modular approach. In some cases, the number of modules incorporated into one MOC examination may be dependent on the subspecialty characteristics of a diplomate's practice. Modules may vary in length dependent upon the number of questions needed to satisfy reliability and validity requirements. Some of the boards offering modular examination choices allow diplomates to choose which modules to take along with the core exam.

Although the certification board examinations are purposely designed to test cognitive processing, not factual recall, certification boards, such as the ABIM, recognize that there are times resources within an examination may be useful. The ABIM recognizes that the current research in this area is conflicting and plans to study the effects of providing selected resources to examinees.[13]

PROGRESS REPORT ON MOC, OCC, AND THE MOL INITIATIVE

The Council on Medical Education is committed to monitoring the development of MOC, OCC, and the MOL initiative on a regular basis. AMA staff, Council members, and the Board of Trustees have participated in meetings to discuss the development of MOL that date back to 2003 and include: the Special Committee on Maintenance of Licensure (2003 – 2008), the Advisory Group on Continued Competence of Licensed Physicians (2009 – 2010), Maintenance of Licensure Implementation Group (2010 – present), MOL Workgroup on Non-Clinical Physicians (2011 – present), and CEO Advisory Council conference calls (2010 – present).

In 2009, the AMA provided a constructive critique of the modified MOC standards to the ABMS. The concerns identified by the AMA included costs to physicians, the compressed timeline for implementation of MOC, continuous documentation of measures, the impact on the physician workforce, flexibility in career pathways, flexibility with competing MOC modules, physician-specific data collection, the patient satisfaction survey, redundancy of physician reporting requirements to multiple venues, team performance, and patient safety. Similarly, in 2010 the AMA provided comments to the FSMB MOL Implementation Group.

During the November 11, 2011 Council on Medical Education General Session Meeting, the Council held an interactive session on MOC/MOL with representatives from the American Academy of Family Physicians, Alliance for Continuing Medical Education, FSMB, Council of Medical Specialty Societies, Accreditation Council for Continuing Medical Education, National Board of Medical Examiners, American Academy of Pediatrics (AAP), AAMC, National Resident Matching Program (NRMP), and ABMS. During the session, participants discussed their responses to MOC/MOL initiatives.

Future Direction for ABMS MOC

To guide the next iteration of the MOC program, a MOC Committee comprised of the ABMS and its member boards are proposing to periodically reassess the MOC program. The Committee developed a conceptual framework

for MOC program standards by 2015 to reduce burdens for diplomates who must meet multiple demands for professional accountability by professional and regulatory organizations that share the same goal of promoting patient-care safety and quality and reducing burdens for diplomates that underlie the proposed changes to MOC.

The ABMS MOC Committee's main principles underlying the next iteration of MOC Elements and Standards include:

- Aligning with other professional and regulatory requirements for physician accountability;
- Providing evidence of ongoing professional development, clinical competence, quality of practice, and measurement of improvement in practice;
- Enabling diplomates to communicate meaningful and valid information to the public regarding the assessment of their continuing professional development and the quality of care;
- Facilitating diplomates as they obtain useful and specialty appropriate feedback from peers, patients, and other users about the services provided (with respect to their professionalism and communication);
- Facilitating public disclosure of important conflicts of interest in the physician-patient relationship; and
- Helping diplomates meet their needs for guided self assessment, providing evidence of ongoing competence, and pursuing continuous quality improvement.

American Osteopathic Association's Bureau of Osteopathic Specialists Board Certification

Each of the 18 specialty certifying member boards of the American Osteopathic Association's Bureau of Osteopathic Specialists (AOA-BOS) is currently developing OCC, and they will have the OCC process in place and implemented by January 1, 2013. All osteopathic physicians who hold a time-limited certificate will be required to participate in the following five components of the OCC process in order to maintain osteopathic board certification:

- Component 1 - Unrestricted Licensure: requires that physicians who are board certified by the AOA hold a valid, unrestricted license to practice medicine in one of the 50 states, and adhere to the AOA's Code of Ethics.

- Component 2 - Life Long Learning/CME: requires that all recertifying diplomates fulfill a minimum of 120 hours of CME credit during each 3-year CME cycle (some certifying boards have higher requirements). Of these 120+ CME credit hours, a minimum of 50 credit hours must be in the specialty area of certification. Self-assessment activities will be designated by each of the 18 specialty certification boards.

- Component 3 - Cognitive Assessment: requires provision of one (or more) psychometrically valid and proctored examinations that assess a physician's specialty medical knowledge as well as core competencies in the provision of healthcare.

- Component 4 - Practice Performance Assessment and Improvement: requires that physicians engage in continuous quality improvement through comparison of personal practice performance measured against national standards for his or her medical specialty.

- Component 5 - Continuous AOA Membership.

Osteopathic physicians who hold non-expiring certificates will not be required to participate in OCC at this time. However, AOA is strongly encouraging physicians to participate because the FSMB has agreed to accept OCC for MOL. Physicians who do not participate may have additional requirements for MOL as prescribed by the state(s) where physicians are licensed.[14]

Federation of State Medical Boards – MOL Initiative

The FSMB has adopted policy and a framework for MOL that is intended to provide guidance to the state medical boards about how to assure the continued competence of licensed physicians. The framework consists of three major components reflecting what is known about effective lifelong learning in medicine:

1. Reflective Self-Assessment (What improvements can I make?): Physicians must participate in an ongoing process of reflective self-evaluation, self-assessment, and practice assessment, with subsequent successful completion of appropriate educational or improvement activities.

2. Assessment of Knowledge and Skills (What do I need to know and be able to do?): Physicians must demonstrate the knowledge, skills and abilities necessary to provide safe, effective patient care within the framework of the six general competencies as they apply to their individual practice.

3. Performance in Practice (How am I doing?): Physicians must demonstrate accountability for performance in their practice using a variety of methods that incorporate reference data to assess their performance in practice and guide improvement.

In May 2010, the FSMB established a CEO Advisory Council comprised of CEOs and other executive staff from 14 key stakeholder organizations within the medical community to serve as an advisory body to the FSMB Board of Directors and the MOL Implementation Group. The Group began development of a template proposal for state medical boards' use to implement MOL, identified potential challenges to implementation of MOL programs, and proposed possible solutions to overcome these challenges. The Group also conducted, collected, and disseminated research on the evidence for the need to initiate a MOL program and the effects of such a program on patient care and physician practice.

In November 2010, the draft report of the MOL Implementation Group was distributed to FSMB member medical and osteopathic boards and external stakeholders, including the AMA, for comment. The AMA Council on Medical Education and the AMA Young Physicians Section provided the following comments to the MOL Implementation Group.

- The AMA supports the concept of accepting MOC/OCC as meeting MOL requirements for relicensure.
- The AMA agrees with the FSMB's description of the challenges that will be encountered in the implementation of MOL, even with a phased approach; the description reads:

  "Maintenance of Licensure:

  - will impact every licensed physician in the United States;
  - must reasonably address a more heterogeneous physician population;
  - relies upon financial resources and support that are in short supply at this time; and
  - is subject to variable state laws and regulations that may require medical practice act amendments to permit MOL."

- The AMA recommended that the term "certified CME" be used in place of "accredited CME" when referring to the three CME Credit Systems (the *AMA Physician Recognition Award Category 1 Credit*™, American Academy of Family Physicians Prescribed Credit, and AOA Category 1A and Category 1B Credit) that meet MOL requirements.
- The AMA recommended that the FSMB clarify the terms "*germane* to his or her actual practice" and "*a substantial portion* of which is relevant and supports performance improvement" when referring to the CME requirements for MOL.
- The AMA opposes clinical skills examinations for the purpose of physician medical relicensure; however, AMA supports continuous quality improvement of practicing physicians, and supports research into methods to improve clinical practice, including practice guidelines, and quality improvement through local professional, non-governmental oversight.
- The AMA recommended that MOL component III, which references national benchmark data, be clarified.
- The AMA recommended that the need for additional data from physicians not involved in patient care not place an undue burden on physicians or further increase the cost of MOL to the licensing boards and physicians.
- The AMA recommended that the periodicity of MOL requirements be consistent across states and in line with current MOC requirements, and avoid licensure revocation due to MOC and OCC timeframes.
- The AMA recommended that the costs of implementing MOL not place a significant burden on physicians.

In February 2011, the FSMB Board of Directors approved the final Report of the Maintenance of Licensure Implementation Group: A MOL Proposal Template available at www.fsmb.org/pdf/mol-implementation.pdf.

Pilot Projects

Currently, a variety of pilot projects that will advance the FSMB's understanding of the process, structure, and resources necessary to develop an effective and comprehensive MOL system are in development. The MOL initiative is being advanced under the leadership of the FSMB. Current discussions are focused on ten potential pilot projects, which will be presented to interested state medical boards in early 2012, with implementation anticipated to start in early-to-mid 2012.

To date, 11 state medical and osteopathic boards have expressed an interest in participating in pilot projects, including: Osteopathic Medical Board of California, Colorado Medical Board, Delaware Board of Medical Practice, Iowa Board of Medicine, Massachusetts Board of Registration in Medicine, Mississippi State Board of Medical Licensure, State Medical Board of Ohio, Oklahoma State Board of Osteopathic Examiners, Oregon Medical Board, Virginia Board of Medicine, and Wisconsin Medical Examining Board.

Through the Implementation Group and future pilot projects with individual state medical boards, the FSMB expects to develop recommendations that will be consistent across state lines. MOL will be an "evolutionary" process and will require much thought such that it provides public protection while paying attention to the concerns of physicians and the resources available to state medical boards.[15] The FSMB will be developing a toolbox of resources to aid state licensing boards and licensees to better understand and implement MOL. Examples of some of the resources that may satisfy the various MOL component requirements are listed in the FSMB Maintenance of Licensure Implementation Group Final Report (available at www.fsmb.org/pdf/BD_RPT_1103_%20MOL.pdf).

Other MOL Work

In addition to the participating pilot boards, numerous other groups are working with the FSMB to guide and develop MOL policy and pilot processes and to ensure that the concerns and input of the broad spectrum of physician education, training, and practice, as well as the public, are considered as the implementation of MOL progresses. In 2011, FSMB Chair, Janelle Rhyne, MD, established a MOL Workgroup on Non-Clinical Physicians to define the non-clinical physician and develop pathway(s) that non-clinical physicians may follow to successfully participate in a state member board's MOL program. The workgroup's report is expected to be available for comment in late 2012.

INDIVIDUAL PRACTICE PERFORMANCE DATA

To comply with MOC Part IV—Practice Performance Assessment, physicians are required to look at data in their practice and develop and implement a plan to improve. The AMA is opposed to public reporting of performance data. AMA HOD Policy H-275.924 (8), Maintenance of Certification, states "Legal ramifications must be examined, and conflicts resolved, prior to data collection and/or displaying any information collected in the process of MOC. Specifically, careful consideration must be given to the types and format of physician-specific data to be publicly released in conjunction with MOC participation."

Report on Current Uses of Practice Performance Data by Certifying Boards and Licensing Boards

In August 2011, the ABMS began to display the MOC status of member board certified physicians online (*www.CertificationMatters.org*). This information is an enhancement to board certification status data that has been posted on the ABMS Web site. Patients can see if their doctors are working to maintain their board certification by meeting the requirements of the ABMS MOC program for a particular member board. The information displayed includes the physician's name, certifying boards and "yes" or "no" as to whether the physician is meeting MOC standards. Information is currently available on physicians who are board certified by the member boards of Dermatology, Family Medicine, Nuclear Medicine, Otolaryngology, Pediatrics, Physical Medicine and Rehabilitation, Plastic Surgery, and Surgery. The remaining members boards will make MOC status information on their physicians available on the ABMS website by August 2012.[16]

To date, all of the committees and workgroups that FSMB has convened to explore the issue of MOL have been very sensitive to the concerns of physicians about the privacy of their data. The FSMB's MOL recommendations emphasize physicians' privacy. Work to date has recommended that physicians would use their own practice data as a way to compare their performance with peers locally and nationally and for identifying opportunities for

improvement (or as a demonstration of improvement). Comparison of data is something that physicians would do on their own; an individual physician's practice data would not be used by the state board to compare his/her performance with other physicians.[15] As a result, the final report and MOL recommendations that were adopted by FSMB as policy included the following statement:

> Practice performance data collected and used by physicians to comply with MOL requirements should not be reported to state medical boards. Third party attestation of collection and use of such data (as part of a professional development program) will satisfy reporting requirements.

The proposed system would eliminate redundancy by allowing MOC and OCC, as well as other defined educational activities to count toward fulfillment of MOL. Physicians could comply with MOL through participation in the same activities in which they are already participating (e.g., CME, procedural hospital privileging, 360 evaluations, medical professional society/organization clinical assessment/practice improvement programs, CMS, and other similar institutional-based measures). Participation in these activities could be verified by the state medical board through third-party attestation, rather than direct reporting of performance data. A more detailed listing of proposed activities that physicians could use to comply with each of the three components of MOL are provided in the MOL Advisory Group report (see pages 79-80 of the adopted MOL policy report available at www.fsmb.org/pdf/mol-board-report-1003.pdf).

FACILITATING INDIVIDUAL PHYSICIAN EFFORTS TO COMPLETE MOC, OCC, AND MOL

AMA HOD Policy H-275.923 (7), Maintenance of Certification/Maintenance of Licensure, encourages members of our House of Delegates to increase their awareness of and participation in the proposed changes to physician self-regulation through their specialty organizations and other professional membership groups.

The ABMS and many of the certification boards have developed tools to assist physicians with completing MOC Part IV—Practice Performance Assessment. Examples include:

- Practice Improvement Modules (PIMs[SM]), developed by the ABMS in 2003, to help physicians apply quality improvement principles in practice to evaluate the ABMS and ACGME competencies of system-based practice and practice-based learning and improvement. PIMs[SM] is a Web-based learning and self-administered tool that utilizes medical record audits and patient feedback. Completion of the ABIM PIM has the benefits of 20 *AMA PRA Category 1 Credits*™, the option of using data collected through the Diabetes PIM to apply for NCQA's Diabetes Physician Recognition Program (DPRP), and possible pay for performance rewards.[17, 18]

- The American Board of Family Medicine (ABFM) Part IV Performance in Practice Modules (PPMs), are Web-based, quality improvement modules in health areas that generally correspond to the self-assessment modules. With these modules, a physician can assess his or her care of patients using evidence-based quality indicators. Using a menu of interventions available from various online sources, the physician designs a plan of improvement, submits the plan, and implements the plan in practice. The physician is then able to compare pre- and post-intervention performance, and compare his or her results to those of his or her peers. Evidence of improvement is not required to satisfy this MOC-Family Practice requirement.[18] Completed PPMs may be submitted as a Best Practice Initiative in the Highmark Blue Cross Blue Shield Quality BLUE program. Currently, 20 CME credits (AAFP Prescribed Credits) are awarded for successfully completing each PPM.[19]

- Diplomates of the American Board of Surgery (ABS) who hold multiple certificates do not have to repeat Part IV for each certificate; their Part IV activity should be related to their current practice. Diplomates are encouraged to find out what programs are available through their hospital. Many hospitals participate in national programs such as the Surgical Care Improvement Project (a list is available on the ABS website at www.absurgery.org/default.jsp?exam-mocpa). If there are absolutely no hospital-based or other programs available, then diplomates maintain their own log of cases and morbidity outcomes for 30 days to assess their performance.[20]

- The American Academy of Pediatrics sponsors Education in Quality Improvement for Pediatric Practice (eQIPP) online courses to identify and close the gaps in a physician's practice using practical tools. Physicians can learn to document improved quality care on a continuous basis, earn CME credit, and meet MOC Part IV requirements all at once.[21]

- Under a contract from the US Department of Health and Human Services and the Office of the National Coordinator, ABMS and the primary care member Boards of Family Medicine, Internal Medicine and Pediatrics developed tools and activities for the ABMS MOC program to enhance physician knowledge and use of health information technology (HIT) to improve care and outcomes. The American Board of Pediatrics developed knowledge self-assessment modules; the ABIM enhanced its PIMs to incorporate measures of meaningful use of HIT and use of electronic health records; and the ABFM created a simulation tool for the development of a registry. The modules were designed to educate physicians about the basics of HIT and how it can be used to improve care.[16]

In addition to providing tools to assist physicians with completing MOC Part IV, many of the certification boards, state/specialty medical societies, and AOA provide services that facilitate individual physician efforts to complete MOC and OCC. Examples include CME live educational sessions, self-assessment programs, Webinars, and publications (journals, enduring material, etc.).

The Colorado Medical Society (CMS) established a Subcommittee on Maintenance of Licensure to work with the Colorado Medical Board to create a phased-in Colorado-specific pilot. CMS has taken the initiative to shape the program to reflect Colorado physicians' input and needs, and the Subcommittee has begun to develop a comprehensive awareness campaign as MOL takes on additional importance in the state.[22]

The AMA will continue to monitor state and specialty implementation programs as the MOL pilot projects are implemented. The AMA is also looking for ways to develop unique products and services that fill gaps and benefit AMA members. The AMA publishes state licensure requirements annually in its publication, *State Medical Licensure Requirements and Statistics.*

CONTINUING MEDICAL EDUCATION

The current CME system in the United States provides high quality certified CME activities to ensure the continuous professional development of physicians as well as providing them with educational practice improvement tools and resources.

Since 1968, the AMA Physician Recognition Award (PRA) has been awarded to recognize physicians who demonstrate their commitment to staying current with advances in medicine by accumulating a minimum of 50 CME credits per year. The credit system derived to support this award, which includes *AMA PRA Category 1 Credit*™ and *AMA PRA Category 2 Credit*™, has become a "common currency" for physicians of any specialty in the United States to meet CME requirements for multiple purposes and institutions. The AMA PRA credit system has evolved over time, particularly through the approval of additional certified learning formats to reflect physicians' needs, the changing practice environment, and new technologies. The two most recent examples include performance improvement continuing medical education (PI CME) and Internet Point-of-Care. The *AMA PRA Category 1 Credits*™ can fulfill Parts II and IV of MOC if approved by the specific specialty board.

The American Academy of Family Physicians (AAFP) credit system, instituted in 1948, awards "Prescribed" or "Elective" credit to family physicians for approved CME activities. The AOA, since 1971, allows its accredited organizations to award AOA CME credits, 1-A, 1-B, 2-A, and 2-B, to physicians. There is strong communication and cooperation among the AMA, AOA, and AAFP, and their CME rules are similar in many ways.

The three established credit systems facilitate the current renewal of licensure process by providing evidence that a physician has maintained a commitment to study, apply, and advance scientific knowledge through participation in appropriate CME activities. Furthermore, these activities, by one, two or all three credit systems, are currently accepted by 63 out of 69 licensing jurisdictions, states/territories, that require certified CME credits for renewal of medical licenses. In some cases, licensing jurisdictions may have specific requirements on the type of credit.

ABMS/ACCME Joint Working Group White Paper: CME for MOC

In spring 2011, the ABMS released a white paper developed by the joint ABMS and Accreditation Council for Continuing Medical Education (ACCME) working group, which was charged to serve as a "think-tank" to explore the concept of CME for MOC. The AMA Council on Medical Education, along with the Alliance for Continuing

Medical Education, Council of Medical Specialty Societies, and the Society for Academic CME, among others, provided formal feedback on this document.[23]

The AMA provided the ABMS/ACCME working group with constructive comments to address concerns about language in the document that could be interpreted as suggesting a new category of CME credit, "MOC-CME."

> The language about a "standard currency" is unclear to us. It could refer to a de facto new credit system or to another layer of measurement or quantification beyond the one already supplied by the CME credit systems. We suggest that a "standard currency" for CME for MOC already exists through the harmonization of the three credit systems (AAFP, AMA, and AOA), which have similar requirements for credit and learning formats. This "currency" already enjoys widespread acceptance within the profession as well as "consumers" of credit such as licensing boards, the Joint Commission, and certifying specialty boards and specialty societies.

Additional comments in the letter highlighted how the *AMA PRA Category 1 Credit*™ system can meet the standards of MOC as well as suggestions on further work on the discussion of CME for MOC. The AMA continues to work actively with the ABMS to clarify the role the *AMA PRA Category 1 Credit*™ system will have in the future of MOC. Currently, some boards are requiring preapproval of certified CME activities before they can be accepted for MOC, and some boards are providing their own educational activities.

A new joint ABMS/ACCME working group was formed comprised of ABMS and ACCME representatives and individuals from within the CME provider community and CME stakeholders, including the AMA. This group has begun a series of meetings and its work is expected to take 1-to-2 years to complete. The group's work will be informed by the results of a comprehensive survey on CME and self-assessment that each ABMS member board will be completing. In addition, focus groups reflecting on ABMS member boards and their educational collaborators will be asked to comment on several issues dealing with CME and the various components of the MOC program.

DISCUSSION

The AMA has extensive policy on MOC, OCC, and the principles of MOL and supports the intent of these programs. The requirements for MOC, OCC, and MOL should be aligned, and the activities that would meet a requirement for one process should also be accepted for meeting similar or identical requirements of the others. However, MOC, OCC, and MOL are distinctly different processes, designed by independent organizations with different purposes and mandates. The AMA continues to advocate for balancing these requirements and ensuring physician input to ensure that these processes are efficient, effective, and evidence-based. The AMA is not responsible for regulating the certification and licensure processes but will continue to monitor studies that are being conducted in these areas.

Certification examinations are intended to confirm that the physician has the necessary knowledge and in some cases competence to claim expertise in the respective specialty area. Although there have been concerns about the integrity of secured "high stakes" examinations, steps are being taken to address security and copyright issues. Some certification boards are beginning to utilize standardized simulation-based competencies and modular examinations that more closely represent how practicing physicians diagnose and treat patients. The ABMS and certification boards should be encouraged to continue to explore other ways to measure the ability of physicians to access and apply knowledge to care for patients.

In 2011, the AMA provided comments to the MOL Implementation Group and strongly recommended that, if state medical or osteopathic boards move forward with the more intense MOL program, the periodicity of MOL requirements should be consistent across states and in line with current MOC requirements and avoid licensure revocation due to MOC and OCC timeframes for certification and licensure. The AMA will continue to work with the FSMB and the state medical and osteopathic boards to ensure that these processes do not cause an additional burden on physicians.

AMA policy opposes the public reporting of individual practice performance data that is collected to comply with the MOC Part IV Practice Performance Assessment. The AMA will continue to work with the appropriate accrediting and certification organizations to monitor the development of MOC, OCC, and MOL to ensure that the concerns of physicians related to the privacy of their data are addressed.

The ABMS, many of the certification boards, the state/specialty medical societies, AMA, and AOA have developed tools and/or services to assist physicians with completing components for MOC and OCC. In states where MOL pilot projects are being planned, some state medical societies are collaborating with their state medical boards (e.g. Colorado) to develop awareness campaigns and shape the pilot projects to reflect physicians' input and needs. On behalf of its members, the AMA will also continue to look for ways to develop unique products and services to fill gaps and help facilitate individual physician efforts to complete MOC, OCC, and MOL. The AMA will also continue to monitor state and specialty implementation programs as the MOL pilot projects are implemented.

The FSMB and the licensing boards are moving toward a process of MOL that is similar in some aspects to the ABMS MOC process. Current CME credit systems should be considered in the re-licensure process by the individual licensure boards, as suggested in the FSMB Maintenance of Licensure Implementation Group in "A MOL Proposal Template" to avoid duplication of work as physicians meet multiple requirements for licensure and board certification.

SUMMARY AND RECOMMENDATIONS

The Council on Medical Education recommends that the following recommendations be adopted in lieu of Resolutions 331-A-11, 326-A-11, 316-A-11 and 911-I-11 and that the remainder of the report be filed.

1. That our American Medical Association (AMA) encourage the American Board of Medical Specialties and the specialty certification boards to continue to explore other ways to measure the ability of physicians to access and apply knowledge to care for patients as an alternative to high stakes closed book examinations.

2. That our AMA reaffirm Policy H-405.974, Specialty Recertification Examinations, to reinforce that AMA encourages the American Board of Medical Specialties and its member boards to continue efforts to improve the validity and reliability of procedures for the evaluation of candidates for certification.

3. That our AMA amend Section 3 of Policy D-275.961, Coordinated Efforts of Federation of State Medical Boards, American Board of Medical Specialties and American Osteopathic Association Regarding Maintenance of Licensure, by addition and deletion to read as follows:

   Encourages the FSMB and state ~~licensing~~ medical and osteopathic boards to recognize that, if state medical or osteopathic boards move forward with the Maintenance of Licensure program, each state medical board should not revoke ~~, with regards to MOL, that~~ active allopathic and osteopathic licenses ~~should not be revoked~~ on the basis of MOC or OCC requirements not being fulfilled ~~in a timely fashion because of the varying timeframes for certification and licensure~~.

4. That our AMA amend Section 8 of Policy H-275.924, Maintenance of Certification (MOC), by addition to read as follows:

   Legal ramifications must be examined, and conflicts resolved, prior to data collection and/or displaying any information collected in the process of MOC. Specifically, careful consideration must be given to the types and format of physician-specific data to be publicly released in conjunction with MOC participation to ensure that information released not violate the privacy or integrity of the patient-physician relationship.

5. That our AMA Reaffirm Policy H-275.923, Maintenance of Certification/Maintenance of Licensure, to reinforce that our AMA encourages members of our House of Delegates to increase their awareness of and participation in the proposed changes to physician self-regulation through their specialty organizations and other professional membership groups.

6. That our AMA Reaffirm Policy H-275.923, Maintenance of Certification/Maintenance of Licensure (MOL), that our AMA will 1) advocate that if state medical boards move forward with the more intense MOL program, each state medical board be required to accept evidence of successful ongoing participation in the American Board of Medical Specialties Maintenance of Certification and American Osteopathic Association-Bureau of Osteopathic Specialists Osteopathic Continuous Certification to have fulfilled all three components of the MOL if performed; and 2) also advocate to require state medical boards accept programs created by specialty societies

as evidence that the physician is participating in continuous lifelong learning and allow physicians choices in what programs they participate to fulfill their MOL criteria.

7. That the AMA Council on Medical Education continue to monitor the evolution of Maintenance of Certification, Osteopathic Continuous Certification, and Maintenance of Licensure, continue its active engagement in the discussions regarding their implementation, and report back to the House of Delegates on these issues at the 2013 Annual Meeting.

APPENDIX 1 - References on Value of Certification and ABMS Maintenance of Certification® (ABMS MOC®)

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APPENDIX 2 - AMA HOD Policies regarding Maintenance of Certification and Maintenance of Licensure

H-405.974 Specialty Recertification Examinations
Our AMA (1) encourages the American Board of Medical Specialties and its member boards to continue efforts to improve the validity and reliability of procedures for the evaluation of candidates for certification; and (2) believes that the holder of a certificate without time limits should not be required to seek recertification. (CME Rep. E, A-92; Reaffirmed: CME Rep. 7, A-02; Reaffirmed: CME Rep. 7, A-07; Reaffirmed: CME Rep. 16, A-09)

H-275.924 Maintenance of Certification
AMA Principles on Maintenance of Certification (MOC): 1.Changes in specialty-board certification requirements for MOC programs should be longitudinally stable in structure, although flexible in content. 2. Implementation of changes in MOC must be reasonable and take into consideration the time needed to develop the proper MOC structures as well as to educate physician diplomates about the requirements for participation. 3. Any changes to the MOC process for a given medical specialty board should occur no more frequently than the intervals used by each board for MOC. 4. Any changes in the MOC process should not result in significantly increased cost or burden to physician participants (such as systems that mandate continuous documentation or require annual milestones). 5. MOC requirements should not reduce the capacity of the overall physician workforce. It is important to retain a structure of MOC programs that permit physicians to complete modules with temporal flexibility, compatible with their practice responsibilities. 6. Patient satisfaction programs such as The Consumer Assessment of Healthcare Providers and Systems (CAHPS) patient survey would not be appropriate nor effective survey tools to assess physician competence in many specialties. 7. Careful consideration should be given to the importance of retaining flexibility in pathways for MOC for physicians with careers that combine clinical patient care with significant leadership, administrative, research, and teaching responsibilities. 8. Legal ramifications must be examined, and conflicts resolved, prior to data collection and/or displaying any information collected in the process of MOC. Specifically, careful consideration must be given to the types and format of physician-specific data to be publicly released in conjunction with MOC participation. 9. The AMA affirms the current language regarding continuing medical education (CME): “By 2011, each Member Board will document that diplomates are meeting the CME and Self-Assessment requirements for MOC Part 2. The content of CME and self-assessment programs receiving credit for MOC will be relevant to advances within the diplomate’s scope of practice, and free of commercial bias and direct support from pharmaceutical and device industries. Each diplomate will be required to complete CME credits (AMA Physician’s Recognition Award (PRA) Category 1, American Academy of Family Physicians Prescribed, American College of Obstetricians and Gynecologists, and or American Osteopathic Association Category 1A).” 10. MOC is an essential but not sufficient component to promote patient-care safety and quality. Health care is a team effort and changes to MOC should not create an unrealistic expectation that failures in patient safety are primarily failures of individual physicians. (CME Rep. 16, A-09)

H-275.923 Maintenance of Certification / Maintenance of Licensure
Our AMA will: 1. Continue to work with the Federation of State Medical Boards (FSMB) to establish and assess maintenance of licensure (MOL) principles with the AMA to assess the impact of MOC and MOL on the practicing physician and the FSMB to study the impact on licensing boards. 2. Recommend that the American Board of Medical Specialties (ABMS) not introduce additional assessment modalities that have not been validated to show improvement in physician performance and/or patient safety. 3. Encourage rigorous evaluation of the impact on physicians of future proposed changes to the MOC and MOL processes including cost, staffing, and time. 4. Review all AMA policies regarding medical licensure; determine if each policy should be reaffirmed, expanded, consolidated or is no longer relevant; and in collaboration with other stakeholders, update the policies with the view of developing AMA Principles of Maintenance of Licensure in a report to the HOD at the 2010 Annual Meeting. 5. Urge the National Alliance for Physician Competence (NAPC) to include a broader range of practicing physicians and additional stakeholders to participate in discussions of definitions and assessments of physician competence. 6. Continue to participate in the NAPC forums. 7. Encourage members of our House of Delegates to increase their awareness of and participation in the proposed changes to physician self-regulation through their specialty organizations and other professional membership groups. 8. Continue to support and promote the AMA Physician’s Recognition Award (PRA) Credit system as one of the three major CME credit systems that comprise the foundation for post graduate medical education in the US, including the Performance Improvement CME (PICME) format; and continue to develop relationships and agreements that may lead to standards, accepted by all US licensing boards, specialty boards, hospital credentialing bodies, and other entities requiring evidence of physician CME. 9. Collaborate with the American Osteopathic Association and its eighteen specialty boards in implementation of the recommendations in CME Report 16-A-09, Maintenance of Certification / Maintenance of Licensure.

10. Continue to support the AMA Principles of Maintenance of Certification (MOC). 11. Monitor MOL as being led by the Federation of State Medical Boards (FSMB), and work with FSMB and other stakeholders to develop a coherent set of principles for MOL. 12. Our AMA will 1) advocate that if state medical boards move forward with the more intense MOL program, each state medical board be required to accept evidence of successful ongoing participation in the American Board of Medical Specialties Maintenance of Certification and American Osteopathic Association-Bureau of Osteopathic Specialists Osteopathic Continuous Certification to have fulfilled all three components of the MOL if performed, and 2) also advocate to require state medical boards accept programs created by specialty societies as evidence that the physician is participating in continuous lifelong learning and allow physicians choices in what programs they participate to fulfill their MOL criteria. (CME Rep. 16, A-09; Appended: CME Rep. 3, A-10; Reaffirmed: CME Rep. 3, A-10; Appended: Res. 322, A-11)

D-275.961 Coordinated Efforts of Federation of State Medical Boards, American Board of Medical Specialties and American Osteopathic Association Regarding Maintenance of Licensure
Our AMA: 1. Encourages state medical boards to accept enrollment and participation in Maintenance of Certification (MOC) and Osteopathic Continuous Certification (OCC) as satisfactorily meeting the requirements of Maintenance of Licensure (MOL), despite varying certification and licensing timeframes. 2. Continues to communicate with the Federation of State Medical Boards (FSMB), American Board of Medical Specialties (ABMS) and American Osteopathic Association (AOA) and report back the extent to which these organizations are working together (with regards to Maintenance of Certification and Maintenance of Licensure) no later than the 2012 Annual Meeting. 3. Encourages the FSMB and state licensing boards to recognize, with regards to MOL, that active allopathic and osteopathic licenses should not be revoked on the basis of MOC or OCC requirements not being fulfilled in a timely fashion because of the varying timeframes for certification and licensure. (Res. 325, A-11)

H-406.989 Work of the Task Force on the Release of Physician Data
1. Our AMA Council on Legislation will use the Release of Claims and Payment Data from Governmental Programs as a basis for draft model legislation. 2. Our AMA will create additional tools to assist physicians in dealing with the release of physician data. 3. Our AMA will continue to monitor the status of, and take appropriate action on, any legislative or regulatory opportunities regarding the appropriate release and use of physician data and its use in physician profiling programs. 4. Our AMA will monitor new and existing Web sites and programs that collect and use data on patient satisfaction and take appropriate action when safeguards are not in place to ensure the validity of the results. 5. Our AMA will continue and intensify its extensive efforts to educate employers, healthcare coalitions and the public about the potential risks and liabilities of pay-for-performance and public reporting programs that are not consistent with AMA policies, principles, and guidelines. 6. Our AMA: A) opposes the public reporting of individual physician performance data collected by certification and licensure boards for purposes of MOC and MOL; B) supports the principle that individual physician performance data collected by certification and licensure boards should only be used for the purposes of helping physicians to improve their practice and patient care, unless specifically approved by the physician; and C) will report how certification and licensure boards are currently using, or may potentially use, individual physician performance data (other than for individual physician performance improvement) that is reported for purposes of Maintenance of Certification (MOC), Osteopathic Continuous Certification (OCC) and Maintenance of Licensure (MOL) and report back to the HOD no later than the 2012 Annual Meeting. (BOT Rep. 18, A-09; Reaffirmed: BOT action in response to referred for decision Res. 709, A-10, Res. 710, A-10, Res. 711, A-10 and BOT Rep. 17, A-10; Reaffirmed in lieu of Res. 808, I-10; Appended: Res. 327, A-11)

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11. IMPACT OF MAINTENANCE OF CERTIFICATION, OSTEOPATHIC CONTINUOUS CERTIFICATION, MAINTENANCE OF LICENSURE ON THE PHYSICIAN WORKFORCE (RESOLUTION 328-A-11)

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: RECOMMENDATIONS ADOPTED IN LIEU OF RESOLUTION 328-A-11 AND REMAINDER OF REPORT FILED
See Policies H-275.920 and D-300.984

At the 2011 Annual Meeting, the AMA House of Delegates referred Resolution 328, Impact of Maintenance of Certification (MOC), Osteopathic Continuous Certification (OCC), and Maintenance of Licensure (MOL) on the Physician Workforce, which was introduced by the Young Physicians Section. Resolution 328-A-11 asked our American Medical Association (AMA) to actively work with stakeholder organizations (i.e., Association of American Medical Colleges [AAMC], Federation of State Medical Boards [FSMB], American Board of Medical Specialties [ABMS], American Osteopathic Association [AOA], and Accreditation Council for Graduate Medical Education [ACGME]) to study the potential impact of MOC, OCC, and MOL on the physician workforce, including medical students entering into residency; resident physicians entering into unsupervised practice; and practicing physicians who are near retirement, are not board certified, or do not actively practice clinical medicine but may wish to re-enter the physician workforce in the future and to report back to the House of Delegates (HOD) on an ongoing basis with regular updates starting at the 2012 Interim Meeting, for a period of 5 years.

This report builds on the information provided in two previous Council on Medical Education (CME) reports to the HOD (CME Report 3-A-10 and CME Report 16-A-09) and addresses the potential impact of MOC, OCC, and MOL on the physician workforce.

BACKGROUND

The MOC, OCC, and MOL processes will be unfolding over the next decade, and their impact on the physician workforce is still unknown. The requirements for MOC, OCC, and MOL should be aligned, but these requirements are distinctly different processes, designed by independent organizations with different purposes and mandates. Currently, the guiding principles for MOL, adopted by the FSMB, recognize the value of meeting MOC and OCC requirements. MOC and OCC are not intended to become mandatory requirements for state licensure renewal but should be recognized as meeting some or all of a state's requirements for MOL to avoid unnecessary duplication of work. The guiding principles and framework developed for MOL will be pilot tested with 11 state medical and osteopathic boards in the near future. Implementation of MOL is several years away, and the pilots will likely be designed to determine and identify multiple options and pathways by which physicians, including those who are not specialty-certified or are not engaged in MOC or OCC, may fulfill a state board's MOL requirements.[1] The AMA has provided significant input and policy related to MOC, OCC, and the principles of MOL, and the Council is committed to monitoring these issues on a regular basis.

AMA staff, Council members, and the Board of Trustees have participated in meetings to discuss the development of MOL that date back to 2003 and include: the Special Committee on Maintenance of Licensure (2003 – 2008), the Advisory Group on Continued Competence of Licensed Physicians (2009 – 2010), Maintenance of Licensure Implementation Group (2010 – present), MOL Workgroup on Non-Clinical Physicians (2011 – present), and CEO Advisory Council conference calls (2010 – present).

In 2009, the AMA provided a constructive critique of the modified MOC standards to the ABMS. The AMA raised concerns in the following areas: costs to physicians, the compressed timeline for implementation of MOC, continuous documentation of measures, the impact on the physician workforce, inflexibility in career pathways, competing MOC modules, physician-specific data collection, patient satisfaction surveys, redundancy of physician reporting requirements to multiple venues, team performance criteria, and patient safety issues. In December 2010, the AMA also provided comments to the MOL Implementation Group in support of their efforts to refine the framework and process of MOL to meet the needs of the public as well as to avoid unnecessary burdens on physicians to maintain their licenses while serving their patients and the public.

During the November 11, 2011 Council on Medical Education General Session Meeting, the Council held an interactive session on MOC/MOL with representatives from the American Academy of Family Physicians, Alliance for Continuing Medical Education, FSMB, Council of Medical Specialty Societies, Accreditation Council for Continuing Medical Education, National Board of Medical Examiners, American Academy of Pediatrics (AAP), AAMC, National Resident Matching Program (NRMP), and ABMS. During the session, participants discussed their responses to MOC/MOL initiatives.

AMA HOD POLICY

AMA Policy H-275.924 (5), "Maintenance of Certification," (AMA Policy Database) states that MOC requirements should not reduce the capacity of the overall physician workforce, and that it is important to retain a structure of MOC programs that permit physicians to complete modules with temporal flexibility, compatible with their practice responsibilities.

BARRIERS TO INITIAL BOARD CERTIFICATION

The AAMC projects that the United States faces a shortage of 62,900 physicians in 2015 that will double to 130,000 across all specialties by 2025. Contributing to the physician shortage is continued growth of the US population; a projected 36% increase in the Medicare population; expansion of insurance coverage to more than 32 million US citizens under the Affordable Care Act; and nearly one-third (250,000) of currently practicing physicians will reach age 60 and likely retire in the next 10 years.[2] Although new medical schools are opening and many existing schools are expanding their enrollments to meet the increased need for physicians, graduate medical education (GME) core training programs leading to initial board certification have not grown due to limited funding—a problem that will exacerbate the existing physician shortage.

Because the 1997 Balanced Budget Act capped the number of Medicare-funded GME positions at 1996 levels, competition for initial residency slots has intensified.[3] Currently, the number of applicants seeking residency

training outnumbers available residency positions. In the 2012 initial NRMP, there were 815 graduating MD seniors and 757 previous MD graduates from US medical schools as well as 596 graduates of osteopathic medical schools who did not match to a residency program. In addition, there were 2,177 US citizen graduates of international medical schools and 4,053 non-US citizen students/graduates of international medical schools that were eligible to enter a residency program but did not match.[4] For individuals who were not matched to a residency position, the NRMP debuted the Supplemental Offer and Acceptance Program℠ (SOAP℠), a new process developed to streamline, equalize, and automate the process for applicants who are not matched initially. After processing the matching algorithm, 1,131 positions were placed in the SOAP, and of these, 1,033 were filled, mostly by US seniors, leaving many other applicants without a residency position.

Although physicians must complete a core residency training program as a requirement for initial certification by a specialty board, specialty board certification is not required for physician licensure. Furthermore, 50 of 68 state licensing authorities currently will grant a license to US-trained MDs and DOs who have completed only 1 year of GME.[5]

A 2010 analysis of FSMB data showed that 25.5% of actively licensed physicians (MDs and DOs) were not certified by an ABMS specialty board.[6] The analysis did not indicate whether the noncertified physicians had ever been certified or recertified. Depending on the physician's professional activities, some physicians may have chosen not to proceed with specialty board certification even though they may have fulfilled all requirements to do so.[7]

IMPACT OF MOC ON PHYSICIANS' DECISION TO RETIRE

Most physicians with time-unlimited ("grandfathered") specialty certificates issued prior to circa 1990 have chosen not to become recertified, perhaps due to the time and expense involved.[8,9] A recent AAMC/AMA survey found that more than one third (36%) of US physicians in practice are age 55 or older and likely to retire in the next 10 to 15 years.[10] Of currently active physicians aged 50 or older, 61% anticipate they will stop providing patient care by the age of 65. However, only 15% cited "recertification requirements" as a very important factor in the decision to retire.[10] This study was conducted before the economic downturn, and no recent studies were found in the literature.

Published studies on the impact of MOC on an older physician's decision to retire are limited. However, certifying agencies, such as the American Board of Orthopaedic Surgery, have not seen evidence that the MOC process is forcing surgeons into retirement.[11] A national survey of "inactive" physicians in the United States showed that a majority of fully retired (56.1%) physicians kept their specialty/subspecialty board certifications current.[12]

PHYSICIAN RE-ENTRY INTO CLINICAL PRACTICE

A growing number of physicians are leaving the clinical practice of medicine for various reasons, including family leave, caretaking responsibilities, personal relationship issues, health issues, career dissatisfaction, pursuit of alternative careers, and humanitarian leave. Following a break in practice, many seek to return at some point.[13,14] The status of a physician's medical license is a key factor in the re-entry process. Those with an active license have more options. Physicians whose licenses are inactive or have lapsed, or physicians who are not currently active in clinical practice may need to meet state licensure requirements as part of their re-entry process.[13]

The AMA has published recommendations on physician re-entry (available at www.ama-assn.org/resources/doc/med-ed-products/physician-reentry-recommendations.pdf). The recommendations are a product of a 2010 conference titled, "Physician Re-Entry to Clinical Practice: Overcoming Regulatory Challenges," sponsored by the AMA, in collaboration with the FSMB and AAP. The overall goal of these recommendations is to ensure that there is a comprehensive, transparent, and feasible regulatory process that also ensures public safety for use with physicians who desire to return to clinical practice. The recommendations are designed for medical licensing boards to consider as they develop and implement physician re-entry policies.

The FSMB is currently working with state licensing agencies to develop re-entry guidelines to avoid unnecessary duplication with its plans for MOL.[13] Additionally, 58% of state licensing boards have developed a policy on re-entry in order to assure citizens of their respective states that physicians who leave clinical practice are qualified to return.[15]

DISCUSSION

On February 8, 2012, the AMA Physician Masterfile showed that 77.8% (638,249) of the approximately 820,465 active practicing physicians (not including resident physicians) were certified by one of the 24 Member Boards of the ABMS. Of the total certified, 58.6% were initial certifications, 31.7% were recertifications, and 9.6% had multiple certifications.[16] In addition, nearly 40% of DOs are certified through one of the 18 specialty boards of the American Osteopathic Association's Bureau of Osteopathic Specialists.[6]

Specialty board certification is becoming a frequent requirement for credentialing by hospitals, health systems, and health insurance plans. Physicians without specialty boards have difficulty obtaining hospital privileges and are usually precluded from serving on medical school faculties. Board certification is usually a requirement to serve on committees or boards that accredit medical education programs (e.g., ACGME's Residency Review Committees).[7,9]

Lack of certification might reflect a delay or break in training or the fact that some boards require documentation of actual practice before board certification. For some physicians, participation in MOC and OCC may ultimately fulfill requirements for MOL and avoid unnecessary duplication of work.[6]

SUMMARY AND RECOMMENDATIONS

The Council on Medical Education recommends that the following recommendations be adopted in lieu of Resolution 328-A-11 and that the remainder of the report be filed.

1. That our American Medical Association (AMA) reaffirm Policy H-275.924 (5), Maintenance of Certification (MOC), to reinforce that MOC requirements should not reduce the capacity of the overall physician workforce, and that it is important to retain a structure of MOC programs that permit physicians to complete modules with temporal flexibility, compatible with their practice responsibilities.

2. That our AMA encourage the Federation of State Medical Boards to continue to work with state licensing boards to accept physician participation in maintenance of certification (MOC) and osteopathic continuous certification (OCC) as meeting the requirements for MOL and to develop alternatives for physicians who are not certified/recertified, and that MOC or OCC not be the only pathway to MOL for physicians.

3. That our AMA encourage the American Board of Medical Specialties to use data from maintenance of certification to track whether physicians are maintaining certification and share this data with the AMA.

4. That our AMA reaffirm Policy D-300.984, Physician Re-entry, to reaffirm AMA's Guiding Principles on Re-entry and ensure that the AMA takes a leadership role to assure that its re-entry recommendations, including studying the workforce implications of a system that supports re-entry, are fully considered in any future initiatives on physician re-entry.

APPENDIX - AMA HOD Policies regarding Maintenance of Certification and Physician Re-entry

H-275.924 Maintenance of Certification
AMA Principles on Maintenance of Certification (MOC): 1.Changes in specialty-board certification requirements for MOC programs should be longitudinally stable in structure, although flexible in content. 2. Implementation of changes in MOC must be reasonable and take into consideration the time needed to develop the proper MOC structures as well as to educate physician diplomates about the requirements for participation. 3. Any changes to the MOC process for a given medical specialty board should occur no more frequently than the intervals used by each board for MOC. 4. Any changes in the MOC process should not result in significantly increased cost or burden to physician participants (such as systems that mandate continuous documentation or require annual milestones). 5. MOC requirements should not reduce the capacity of the overall physician workforce. It is important to retain a structure of MOC programs that permit physicians to complete modules with temporal flexibility, compatible with their practice responsibilities. 6. Patient satisfaction programs such as The Consumer Assessment of Healthcare Providers and Systems (CAHPS) patient survey would not be appropriate nor effective survey tools to assess physician competence in many specialties. 7. Careful consideration should be given to the importance of retaining flexibility in pathways for MOC for physicians with careers that combine clinical patient care with significant leadership, administrative, research, and teaching responsibilities. 8. Legal ramifications must be examined, and conflicts resolved, prior to data collection and/or displaying any information collected in the process of MOC. Specifically, careful consideration must be given to the types and format of physician-specific data to be publicly released in conjunction with MOC participation. 9. The AMA affirms the current language regarding continuing medical education (CME): "By 2011, each Member Board will document that diplomates are

meeting the CME and Self-Assessment requirements for MOC Part 2. The content of CME and self-assessment programs receiving credit for MOC will be relevant to advances within the diplomate's scope of practice, and free of commercial bias and direct support from pharmaceutical and device industries. Each diplomate will be required to complete CME credits (AMA Physician's Recognition Award (PRA) Category 1, American Academy of Family Physicians Prescribed, American College of Obstetricians and Gynecologists, and or American Osteopathic Association Category 1A)." 10. MOC is an essential but not sufficient component to promote patient-care safety and quality. Health care is a team effort and changes to MOC should not create an unrealistic expectation that failures in patient safety are primarily failures of individual physicians. (CME Rep. 16, A-09)

D-300.984 Physician Re-entry
Our AMA: 1. Will continue to collaborate with other appropriate organizations on physician reentry issues including research on the need for and the effectiveness of reentry programs. 2. Will work collaboratively with the American Academy of Pediatrics and other interested groups to convene a conference on physician reentry which will bring together key stakeholders to address the development of reentry programs as well as the educational needs of physicians reentering clinical practice. 3. Will work with interested parties to establish a physician reentry program (PREP) information data base that is publicly accessible to physician applicants and which includes information pertaining to program characteristics. 4. Will support efforts to ensure the affordability and accessibility, and to address the unique liability issues related to PREPs. 5. Will make available to all interested parties the physician reentry program (PREP) system Guiding Principles for use as a basis for all reentry programs: a. Accessible: The PREP system is accessible by geography, time and cost. Reentry programs are available and accessible geographically across the United States and include national and regional pools of reentry positions. Reentering physicians with families or community ties are not burdened by having to relocate to attend a program. The length of time of reentry programs is standardized and is commensurate with the assessed clinical and educational needs of reentering physicians. The cost of reentry programs is not prohibitive to the physician, health care institutions or the health care system. b. Collaborative: The PREP system is designed to be collaborative to improve communication and resource sharing. Information and materials including evaluation instruments are shared across specialties, to the extent possible, to improve program and physician performance. A common nomenclature is used to maximize communication across specialties. Reentry programs share resources and create a common repository for such resources, which are easily accessible. c. Comprehensive: The PREP system is comprehensive to maximize program utility. Physician reentry programs prepare physicians to return to clinical activity in the discipline in which they have been trained or certified and in the practice settings they expect to work including community-based, public health, and hospital-based or academic practice. d. Ethical: The PREP system is based on accepted principles of medical ethics. Physician reentry programs will conform to physician licensure statues. The standards of professionalism, as stated in the AMA Code of Medical Ethics, must be followed. e. Flexible: The PREP system is flexible in structure in order to maximize program relevancy and usefulness. Physician reentry programs can accommodate modifications to program requirements and activities in ways that are optimal to the needs of reentering physicians. f. Modular: Physician reentry programs are modularized, individualized and competency-based. They are tailored to the learning needs of reentering physicians, which prevents the need for large, expensive, and standardized programs. Physicians should only be required to take those modules that allow them to meet an identified educational need. g. Innovative: Innovation is built into a PREP system allowing programs to offer state of the art learning and meet the diverse and changing needs of reentry physicians. Physician reentry programs develop and utilize learning tools including experimenting with innovative and novel curricular methodologies such as distance learning technologies and simulation. h. Accountable: The PREP system has mechanisms for assessment and is open to evaluation. Physician reentry programs have an evaluation component that is comparable among all specialties. Program assessments use objective measures to evaluate physician's competence at time of entry, during the program and at time of completion. Program outcomes are measured. Reliability and validity of the measures are established. Standardization of measures exist across programs to assess whether or not national standards are being met. i. Stable: A funding scheme is in place to ensure the PREP system is financially stable over the long-term. Adequate funding allows physician reentry programs to operate at sufficient and appropriate capacity. j. Responsive: The PREP system makes refinements, updates and other changes when necessary. Physician reentry programs are equipped to address systemic changes such as changes in regulations. Additionally, the PREP system is prepared to respond efficiently to urgent health care needs within society including mobilizing clinically inactive physicians temporarily into the workforce to attend to an acute public health crisis, such as a terrorist, biological, chemical, or natural disaster. 6. Will, as part of its Initiative to Transform Medical Education strategic focus and in support of its members and Federation partners, develop model program standards utilizing PREP system Guiding Principles with a report back at the 2009 Interim Meeting. (CME Rep. 6, A-08)

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12. TRANSPARENCY IN THE NATIONAL RESIDENT MATCHING PROGRAM MATCH AGREEMENT (RESOLUTION 918-I-11, RESOLVE 2)

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS IN LIEU OF RESOLVE 2 OF RESOLUTION 918-I-11 AND REMAINDER OF REPORT FILED
See Policy D-310.974

Resolution 918-I-11, Transparency in the National Resident Matching Program Match Agreement, introduced by the Medical Student Section, asked that our American Medical Association (AMA):

1. Ask the National Resident Matching Program (NRMP) to publish data regarding waivers and violations with subsequent consequences for both programs and applicants while maintaining the integrity of the Match and protecting the identities of both programs and participants; and

2. Advocate for the word "training" in section 7.2.1 of the NRMP Match agreement be changed to "residency training" and specifically state that NRMP cannot prevent an applicant from maintaining their education through rotating, researching, teaching, or otherwise working in positions other than resident training at NRMP affiliated programs.

The House of Delegates (HOD) adopted the first resolve that addresses concerns expressed in testimony about the inadvertent release of identifiable personal data on individual students (Policy D-310.974 [4], Policy Suggestions to Improve the National Resident Matching Program, AMA Policy Database). However, the second resolve was referred for further study with the purpose to increase the transparency of the Match process to protect medical students who might seek a different career path within health care, research, or medical education.

BACKGROUND

Over the past several years, the competition for residency positions has heightened. In the 2012 NRMP Main Residency Match, more than 4,400 GME programs offered 24,034 first-year and 2,738 second-year positions. More than 31,000 applicants registered for the 2012 Match; of those, 31,355 submitted rank order lists of programs and 22,934 matched to first-year positions.[1]

It is possible for a medical student to not be matched to a GME program. Prior to 2012, students who did not match went through a process called the "Scramble." In this process, students were forced to apply en masse to whatever programs remained available, frequently having to change their intended specialty in the process. Most residencies filled within the first few hours of the Scramble, and nearly all in the first 48 hours. In 2012, the NRMP debuted the Supplemental Offer and Acceptance Program℠ (SOAP℠), a new process developed to streamline, equalize, and automate the process for applicants who are not matched initially. After processing the matching algorithm, 1,131 positions were placed in the SOAP, and of these, 1,033 were filled, mostly by US seniors, leaving many other applicants without a residency position.[2]

The NRMP has established principles and policies to guide participants (sponsoring institutions, residency programs, medical schools, and applicants) through the Match application and rank ordering process. SOAP will be covered by the same NRMP policies.

NRMP MATCH AGREEMENT

All applicants to GME residency positions and sponsoring institutions that register for any programs in the Matching Program must sign a binding agreement with the NRMP.[3] The NRMP is responsible for monitoring compliance and adherence to the NRMP agreements and its policies. When registering for the Match, all participants must agree to conduct their match-related affairs in a manner consistent with those policies. The agreement has strict terms and conditions, and failure of a Match participant to comply with one or more of the policies is referred to as a "Match violation." The NRMP's Policy and Procedures for the Reporting, Investigation, and Disposition of Violations of NRMP Agreements governs the NRMP's handling of Match violations.[4]

Match Violations

Some match violations are committed with full awareness that the action is a violation. However, in many cases the violation occurs because the participants are unaware of what constitutes a violation of the Match Participation Agreement. Section 8.2 (formerly 7.2.1) of the Agreement holds participants responsible for being informed about Match violations.

Examples of Match violations cited on the NRMP website that can occur before the Match include:

- "A program accepts and signs an agreement with a senior student in a US allopathic medical school before Match Day.
- An applicant requests a contract before the announcement of Match results.
- An applicant commits to a concurrent year training position outside the NRMP Match and does not withdraw from the NRMP Match. (This includes an applicant who matches to a concurrent year PGY-1 position in another match that precedes the NRMP Match.)
- A program director guarantees an applicant that he/she will rank the applicant within the program's quota, but only if the applicant will rank the program first on his or her rank order list.
- An applicant guarantees a program director that he/she will rank the program first on his or her rank order list, but only if the program director will rank the applicant within the program's quota."[5]

Examples of violations cited on the NRMP website that could occur during Match week include:

- "An unmatched applicant contacts a program to seek a position before 2:00 p.m. eastern time on Monday of Match Week, or uses a method other than ERAS to apply to programs.
- A program director, anticipating that the program will not fill all of its positions, contacts a student affairs dean prior to 2:00 p.m. eastern time on Monday of Match Week to find out which students did not match.
- A student affairs dean consults with the directors of unfilled programs, faculty, and/or other colleagues about possible openings before the beginning of the Match Week Supplemental Offer and Acceptance Program (SOAP).
- A student affairs dean consults with students about their match status prior to the release of applicants' Match results at 12:00 noon on Monday of Match Week.
- An applicant or program distributes or posts proprietary match information to a website or non-NRMP-related matching service."[5]

Examples of not honoring the results of the Match cited on the NRMP website include:

- "An applicant who matched to a position or who accepted a position during SOAP decides not to honor the binding commitment and does not seek a waiver from the NRMP.
- An applicant who matched to a position or who accepted a position during SOAP accepts a concurrent year position in another program.
- An institution adds new appointment requirements that were not communicated to applicants prior to the rank order list deadline or during SOAP.
- A program director interviews an applicant who matched to or accepted a concurrent year position in another program and who has not obtained a waiver from the NRMP.
- A program director approaches an applicant who has a concurrent year binding commitment to explore the possibility of having the applicant switch programs.
- A program decides not to honor its binding commitment to an applicant who matched to or accepted a position during SOAP and who satisfies all the appointment requirements.
- A program involved in a waiver investigation fills the position prior to the NRMP approving the waiver request.
- A program offers a position to an applicant whose waiver request was denied, and training commences during the applicant's one-year prohibition from accepting or starting a position in any program sponsored by an NRMP match-participating institution."[5]

The examples of Match violations noted are not all-inclusive. The NRMP maintains the authority to answer questions and provide clarifications about Match violations.

The consequences of Match violations can result in:

- "An applicant being pressured by a program director to reveal the program's place on the applicant's rank order list or to identify the names of other programs with which the applicant has interviewed.
- A program director being notified that a matched applicant will be a no show and finding that no other suitable candidates are available.
- An IMG being pressured by (or pressuring) a program director to sign a contract before Match Day.
- A student affairs dean counseling an unmatched student who believed a program director's promise that he/she would be ranked first.
- A matched applicant who could have matched to a more preferred program because that program now has an open position because another applicant was a no show."[5]

Waiver

The Match Participation Agreement stipulates that programs and applicants can receive a waiver from their commitments when there is a serious and extreme hardship. The NRMP defines serious and extreme hardship as the occurrence of a highly unusual, unexpected, and unpredictable situation or circumstance that renders the fulfillment of the Match obligation impossible or would result in irreparable harm to any one of the committed Match participants. Examples of serious and extreme hardship include an applicant who failed to graduate on time; the closing of a program or institution; the death or serious illness of a family member that requires the applicant to alter the choice of residency location; or the loss of accreditation by a program or institution. However, programs and applicants are not authorized to release each other from their binding commitment. Once a party has matched or a position has been offered and accepted during SOAP, a waiver of the binding commitment may be obtained only by petitioning the NRMP.[5]

Consequences of a confirmed violation

Although the NRMP is only responsible for matching into residency training positions, Section 8.2 of the NRMP Match Agreement states that the NRMP can ban a violating applicant from accepting a training position at participating institutions. As a result, applicants could be prevented from pursuing research and non-residency positions at the participating institution.

The NRMP investigates all suspected violations and, if confirmed, a final report of the violation is delivered to:

- the applicant's medical school official, with a request that the report be placed in the applicant's permanent file;

- the Educational Commission for Foreign Medical Graduates if the applicant is a student/international medical graduate (IMG);
- the NRMP institutional official and the director of the program to which the applicant matched;
- the NRMP institutional official and director of the program to which the applicant has applied or switched (if known);
- the party who originally reported the violation;
- the NRMP Executive Committee;
- the American Board of Medical Specialties;
- the applicant's residency program director if the violation occurred in a fellowship match;
- the Federation of State Medical Boards if the applicant is to be permanently identified as a match violator or has been permanently barred from future NRMP matches; and
- any parties whom the NRMP has determined are relevant to its investigation.[4]

In addition, NRMP policy states that "the applicant may be barred from subsequent NRMP matches and/or identified as a match violator to participating programs for a period of one-to-three years or permanently, as determined by the NRMP. Violations committed prior to Match Day may result in the applicant being withdrawn from the Match."[4]

NRMP policy also states that "the applicant also may be barred from accepting or starting a position in any program sponsored by an institution that participates in the Matching Program if the position has a start date within one year from the date of the final report. If any of the programs sponsored by the institution offers a position to that applicant to commence training during the one-year period or if the applicant accepts or starts such a position, the NRMP will initiate an investigation to determine whether the applicant, the program, and/or the institution has violated the terms of the Participation Agreement."[4]

The NRMP also decides if the decision conveyed in the final report should be displayed in the Registration, Ranking, and Results (R3) System Applicant Match History for one-to-three years or permanently.

AMA HOD POLICY

AMA Policy D-310.974 (4), Policy Suggestions to Improve the National Resident Matching Program, directs the AMA to ask the NRMP to publish data regarding waivers and violations with subsequent consequences for both programs and applicants while maintaining the integrity of the Match and protecting the identities of both programs and participants.

DISCUSSION

The AMA has passed resolutions as early as the 1920s that led to the development of the NRMP in 1952.[6] The AMA Council on Medical Education continues to support the NRMP as an efficient and effective placement system for filling positions in GME. A growing number of residents and fellows successfully match each year. However, the current Match process provides the NRMP the authority to implement wide-ranging repercussions for violations of its Match agreement, including up to a permanent ban from the Match, as determined by the NRMP Review Panel. These sanctions have extremely serious consequences for both applicants seeking residencies and institutions seeking residents. A better understanding of the gradation of offenses and penalties imposed is needed to ensure the integrity of the Match process. For IMGs, transparency and clarification is most important to make cultural interpretation more apparent.

SUMMARY AND RECOMMENDATIONS

The Council on Medical Education recommends that the following recommendations be adopted in lieu of Resolve 2 of Resolution 918-I-11 and that the remainder of the report be filed.

1. That our American Medical Association (AMA) reaffirm Policy D-310.974 (4), Policy Suggestions to Improve the National Resident Matching Program (NRMP).

2. That our AMA advocate that the words "residency training" in section 8.2.10 of the NRMP Match agreement be added to the second sentence so that it reads, "The applicant also may be barred from accepting or starting a

position in any residency training program sponsored by a match-participating institution that would commence training within one year from the date of issuance of the Final Report" and specifically state that NRMP cannot prevent an applicant from maintaining his or her education through rotating, researching, teaching, or otherwise working in positions other than resident training at NRMP affiliated programs.

3. That our AMA work with the Educational Commission for Foreign Medical Graduates, Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, and other graduate medical education stakeholders to encourage the NRMP to make the conditions of the Match agreement more transparent while assuring the confidentiality of the match and to use a thorough process in declaring that a violation has occurred.

APPENDIX - AMA HOD Policies regarding the National Resident Matching Program

H-310.925 National Resident Matching Program Reform – Our AMA supports the National Resident Matching Program as an efficient and effective placement system for filling positions in graduate medical education in the US. (CME Rep. 4, A-05; Reaffirmed: CME Rep. 15, A-06)

D-310.974 Policy Suggestions to Improve the National Resident Matching Program – Our AMA will: (1) request that the National Resident Matching Program review the basis for the extra charge for including over 15 programs on a primary rank order list and consider modifying the fee structure to minimize such charges; (2) work with the NRMP to increase awareness among applicants of the existing NRMP waiver and violations review policies to assure their most effective implementation; (3) request that the NRMP continue to explore measures to maximize the availability of information for unmatched applicants and unfilled programs including the feasibility of creating a dynamic list of unmatched applicants; and (4) ask the National Resident Matching Program (NRMP) to publish data regarding waivers and violations with subsequent consequences for both programs and applicants while maintaining the integrity of the match and protecting the identities of both programs and participants. (CME Rep. 15, A-06; Appended: Res. 918, I-11)

D-310.977 National Resident Matching Program Reform - Our AMA: (1) will work with the National Resident Matching Program to develop and distribute educational programs to better inform applicants about the NRMP matching process; (2) will actively participate in the evaluation of, and provide timely comments about, all proposals to modify the NRMP Match; (3) will request that the NRMP explore the possibility of including the Osteopathic Match in the NRMP Match; (4) will continue to review the NRMP's policies and procedures and make recommendations for improvements as the need arises; (5) will work with the Accreditation Council for Graduate Medical Education and other appropriate agencies to assure that the terms of employment for resident physicians are fair and equitable and reflect the unique and extensive amount of education and experience acquired by physicians; (6) does not support the current the "All-In" policy for the Main Residency Match to the extent that it eliminates flexibility within the match process; (7) will work with the NRMP, and other residency match programs, in revising Match policy, including the secondary match or scramble process to create more standardized rules for all candidates including application timelines and requirements; (8) will work with the NRMP and other external bodies to develop mechanisms that limit disparities within the residency application process and allow both flexibility and standard rules for applicant; and (9) encourages the National Resident Matching Program to study and publish the effects of implementation of the Supplemental Offer and Acceptance Program on the number of residency spots not filled through the Main Residency Match and include stratified analysis by specialty and other relevant areas. (CME Rep. 4, A-05; Appended: Res. 330, A-11; Appended: Res. 920, I-11)

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