Reference Committee C

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02 Update on Maintenance of Certification and Osteopathic Continuous Certification
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* Contained in Handbook Addendum
Subject: Council on Medical Education Sunset Review of 2007 House Policies

Presented by: Patricia Turner, MD, Chair

Referred to: Reference Committee C
(Kenneth M. Certa, MD, Chair)

AMA Policy G-600.110, “Sunset Mechanism for AMA Policy,” is intended to help ensure that the AMA Policy Database is current, coherent, and relevant. By eliminating outmoded, duplicative, and inconsistent policies, the sunset mechanism contributes to the ability of the AMA to communicate and promote its policy positions. It also contributes to the efficiency and effectiveness of House of Delegates deliberations. The current policy reads as follows:

1. As the House of Delegates adopts policies, a maximum ten-year time horizon shall exist. A policy will typically sunset after ten years unless action is taken by the House of Delegates to retain it. Any action of our AMA House that reaffirms or amends an existing policy position shall reset the sunset "clock," making the reaffirmed or amended policy viable for another 10 years.

2. In the implementation and ongoing operation of our AMA policy sunset mechanism, the following procedures shall be followed: (a) Each year, the Speakers shall provide a list of policies that are subject to review under the policy sunset mechanism; (b) Such policies shall be assigned to the appropriate AMA Councils for review; (c) Each AMA council that has been asked to review policies shall develop and submit a report to the House of Delegates identifying policies that are scheduled to sunset; (d) For each policy under review, the reviewing council can recommend one of the following actions: (i) Retain the policy; (ii) Sunset the policy; (iii) Retain part of the policy; or (iv) Reconcile the policy with more recent and like policy; (e) For each recommendation that it makes to retain a policy in any fashion, the reviewing Council shall provide a succinct, but cogent justification; (f) The Speakers shall determine the best way for the House of Delegates to handle the sunset reports.

3. Nothing in this policy shall prohibit a report to the HOD or resolution to sunset a policy earlier than its 10-year horizon if it is no longer relevant, has been superseded by a more current policy, or has been accomplished.

4. The AMA Councils and the House of Delegates should conform to the following guidelines for sunset: (a) when a policy is no longer relevant or necessary; (b) when a policy or directive has been accomplished; or (c) when the policy or directive is part of an established AMA practice that is transparent to the House and codified elsewhere such as the AMA Bylaws or the AMA House of Delegates Reference Manual: Procedures, Policies and Practices.

5. The most recent policy shall be deemed to supersede contradictory past AMA policies.

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

The Council on Medical Education’s recommendations on the disposition of the 2007 House policies that were assigned to it are included in the Appendix to this report.

RECOMMENDATION

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

Fiscal Note: $1,000.
APPENDIX
RECOMMENDED ACTIONS ON 2007 AND OTHER OR RELATED HOUSE OF DELEGATES POLICIES

<table>
<thead>
<tr>
<th>Policy Number, Title, Policy</th>
<th>Recommended Action</th>
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<tbody>
<tr>
<td><strong>H-150.996, Nutrition Courses in Medicine</strong>&lt;br&gt;Our AMA recommends the teaching of adequate nutrition courses in elementary and high schools and that the LCME work toward enhancement of the teaching of nutrition in medical schools. (Sub. Res. 66, I-77; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CME Rep. 2, A-10 )</td>
<td>Revise as follows; the excised portion is superseded by H-150.995, Basic Courses in Nutrition.&lt;br&gt;“Nutrition Courses in Medicine Education&lt;br&gt;“Our AMA recommends the teaching of adequate nutrition courses in elementary and high schools and that the LCME work toward enhancement of the teaching of nutrition in medical schools.”</td>
</tr>
<tr>
<td><strong>H-275.941, Out-of-State Residents in Training and State Licensing Board Requirements for Temporary Licenses</strong>&lt;br&gt;The AMA will work with the Federation of State Medical Boards (FSMB) to facilitate a timely process so that residents in a training program can meet the licensure requirements to avail themselves of opportunities for educational experiences in states other than that of their primary program location. (Sub. Res. 301, A-97; Reaffirmed: CME Rep. 2, A-07)</td>
<td>Sunset; no longer relevant.</td>
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<tr>
<td><strong>H-275.975, Qualifications of Health Professionals</strong>&lt;br&gt;(1) Private certifying organizations should be encouraged to continue certification programs for all health professionals and to communicate to the public the qualifications and standards they require for certification. Decisions concerning recertification should be made by the certifying organizations. (2) Working with state licensing and certifying boards, health care professions should use</td>
<td>Retain; still relevant.</td>
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the results of quality assurance activities to ensure that substandard practitioner behavior is dealt with in a professional and timely manner. Licensure and disciplinary boards, in cooperation with their respective professional and occupational associations, should be encouraged to work to identify "deficient Health care professionals. (BOT Rep. NN, A-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CME Rep. 2, A-07)

<table>
<thead>
<tr>
<th>H-295.870, Medical School Language Electives in Medical School Curriculum</th>
<th>Retain; still relevant.</th>
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<tr>
<td>Our AMA strongly encourages all Liaison Committee on Medical Education- and American Osteopathic Association-accredited US medical schools to offer medical second languages to their students as electives. (Res. 304, A-07)</td>
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<tr>
<th>H-295.871, Initiative to Transform Medical Education: Strategies for Medical Education Reform</th>
<th>Retain, still relevant, but with title change as shown below, as this work has been incorporated into the AMA’s Accelerating Change in Medical Education strategic focus area.</th>
</tr>
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<tbody>
<tr>
<td>Our AMA continues to recognize the need for transformation of medical education across the continuum from premedical preparation through continuing physician professional development and the need to involve multiple stakeholders in the transformation process, while taking an appropriate leadership and coordinating role. (CME Rep. 13, A-07)</td>
<td>Initiative to Transform Accelerating Change in Medical Education: Strategies for Medical Education Reform H-295.871</td>
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<tr>
<th>H-295.895, Progress in Medical Education: Structuring the Fourth Year of Medical School</th>
<th>Retain; still relevant.</th>
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<tr>
<td>It is the policy of the AMA that: (1) Trends toward increasing structure in the fourth year of medical school should be balanced by the need to preserve opportunities for students to engage in elective clinical and other educationally appropriate experiences. (2) The third and fourth years as a continuum should provide students with a broad clinical education that prepares them for entry into residency training. (3) There should be a comprehensive assessment of clinical skills administered at a time when the results can be used to plan each student's fourth-year program, so as to remedy deficiencies and broaden clinical knowledge. (4) Medical schools should develop policies and procedures to ensure that medical students receive counseling to assist them in their choice of electives. (5) Adequate and timely career counseling should be available at all medical schools. (6) The ability of medical students to choose electives based on interest or perceived academic need should not be compromised by the residency</td>
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The American Medical Association should work with the Association of American Medical Colleges, medical schools, and residency program directors groups to discourage the practice of excessive audition electives.

(7) Our AMA should continue to work with relevant groups to study the transition from the third and fourth years of medical school to residency training, with the goal of ensuring that a continuum exists in the acquisition of clinical knowledge and skills. (CME Rep. 1, I-98; Reaffirmed: CME Rep. 9, A-07)

**H-295.897, Enhancing the Cultural Competence of Physicians**

1. Our AMA continues to inform medical schools and residency program directors about activities and resources related to assisting physicians in providing culturally competent care to patients throughout their life span and encourage them to include the topic of culturally effective health care in their curricula.

2. Our AMA continues research into the need for and effectiveness of training in cultural competence, using existing mechanisms such as the annual medical education surveys and focus groups at regularly scheduled meetings.

3. Our AMA will form an expert national advisory panel (including representation from the AMA Minority Affairs Consortium and International Medical Graduate Section) to consult on all areas related to enhancing the cultural competence of physicians, including developing a list of resources on cultural competencies for physicians and maintaining it and related resources in an electronic database.

4. Our AMA will assist physicians in obtaining information about and/or training in culturally effective health care through development of an annotated resource database on the AMA home page, with information also available through postal distribution on diskette and/or CD-ROM.

5. Our AMA will seek external funding to develop a five-year program for promoting cultural competence in and through the education of physicians, including a critical review and comprehensive plan for action, in collaboration with the AMA Consortium on Minority Affairs and the

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<th>Revise as shown below:</th>
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<tr>
<td>1. Our AMA continues to inform medical schools and residency program directors about activities and resources related to assisting physicians in providing culturally competent care to patients throughout their life span and encourage them to include the topic of culturally effective health care in their curricula.</td>
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<tr>
<td>2. Our AMA continues to support research into the need for and effectiveness of training in cultural competence, using existing mechanisms such as the annual medical education surveys and focus groups at regularly scheduled meetings.</td>
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<tr>
<td>3. Our AMA will form an expert national advisory panel (including representation from the AMA Minority Affairs Consortium and International Medical Graduate Section) to consult on all areas related to enhancing the cultural competence of physicians, including developing a list of resources on cultural competencies for physicians and maintaining it and related resources in an electronic database.</td>
</tr>
<tr>
<td>4. Our AMA will assist physicians in obtaining information about and/or training in culturally effective health care through dissemination of currently available resources from the AMA and other relevant organizations, development of an annotated resource database on the AMA home page, with information also available through postal distribution on diskette and/or CD-ROM.</td>
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medical associations that participate in the consortium (National Medical Association, National Hispanic Medical Association, and Association of American Indian Physicians,) the American Medical Women's Association, the American Public Health Association, the American Academy of Pediatrics, and other appropriate groups. The goal of the program would be to restructure the continuum of medical education and staff and faculty development programs to deliberately emphasize cultural competence as part of professional practice.

6. Our AMA encourages training opportunities for students and residents, as members of the physician-led team, to learn cultural competency from community health workers, when this exposure can be integrated into existing rotation and service assignments. (CME Rep. 5, A-98; Reaffirmed: Res. 221, A-07; Reaffirmation A-11; Appended: Res. 304, I-16)

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<tr>
<th>H-295.901, Restrictive Covenants in Residency and Fellowship Training Programs</th>
<th>Sunset; this is reflected in the current institution requirements of the Accreditation Council for Graduate Medical Education.</th>
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<tbody>
<tr>
<td>Our AMA adopts as policy and publicizes to all teaching institutions the Current Opinion that it is unethical for a teaching institution to seek a non-competition guarantee in return for fulfilling its educational obligations. Physicians-in-training should not be asked to sign covenants not-to-compete as a condition of their entry into any residency or fellowship program. (Sub. Res. 305, I-97; Reaffirmed: CME Rep. 2, A-07)</td>
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<tr>
<td>H-295.903, Opposition to Legislation that Directs the Content of Medical School Curriculum</td>
<td>Sunset; superseded by Federal Intervention in the Setting of Educational Standards, H-295.921.</td>
</tr>
<tr>
<td>The AMA opposes efforts from all levels of government to dictate the content of medical school curricula either directly or as a condition for receipt of funding. (Res. 322, A-97 Reaffirmed: CME Rep. 2, A-07)</td>
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<tr>
<td>H-295.904, Commitment to Honor Resident Contracts</td>
<td>Sunset; superseded by Closing of Residency Programs, H-310.943, which reads: “The AMA: (1) encourages the Accreditation Council for Graduate Medical Education</td>
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closure, institutions should make every effort possible to allow residents already in the program to complete their education and, should honor the provisions of their existing contracts. (Res. 314, A-97; Reaffirmed: CME Rep. 2, A-07)

(ACGME) to address the problem of non-educational closing or downsizing of residency training programs; (2) reminds all institutions involved in educating residents of their contractual responsibilities to the resident; (3) encourages the ACGME and the various Residency Review Committees to reexamine requirements for "years of continuous training" to determine the need for implementing waivers to accommodate residents affected by non-educational closure or downsizing; (4) will work with the American Board of Medical Specialties Member Boards to encourage all its member boards to develop a mechanism to accommodate the discontinuities in training that arise from residency closures, regardless of cause, including waiving continuity care requirements and granting residents credit for partial years of training; (5) urges residency programs and teaching hospitals be monitored by the applicable Residency Review Committees to ensure that decreases in resident numbers do not place undue stress on remaining residents by affecting work hours or working conditions, as specified in Residency Review Committee requirements; (6) opposes the closure of residency/fellowship programs or reductions in the number of current positions in programs as a result of changes in GME funding; and (7) will work with the Centers for Medicare and Medicaid Services (CMS), ACGME, and other appropriate organizations to advocate for the development and implementation of effective policies to permit graduate medical education funding to follow the resident physician from a closing to the receiving residency program (including waivers of CMS caps), in the event of temporary or permanent residency program closure.”

### H-295.905, Promoting Culturally Competent Health Care
The AMA encourages medical schools to offer electives in culturally competent health care with the goal of increasing awareness and acceptance of cultural differences between patient and provider. (Res. 306, A-97; Reaffirmed: CME Rep. 2, A-07)

Sunset; superseded by Enhancing the Cultural Competence of Physicians, H-295.897.
<table>
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<tr>
<th><strong>H-295.908, Protection of Medical Students in the Event of Medical School Closure or Reduction in Enrollment</strong></th>
<th>Sunset; this role has been assumed by other organizations.</th>
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<tr>
<td>The AMA will continue to monitor medical school closures, mergers, and changes in ownership. In the case of medical school closure or decreases in class size that affect enrolled students, the AMA will provide appropriate assistance, where feasible, so that medical students will experience an orderly transition. (CME Rep. 4, A-97; Reaffirmed: CME Rep. 2, A-07)</td>
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<tr>
<th><strong>H-295.914, Instruction in Managed Care</strong></th>
<th>Sunset; superseded by Future Directions for Socioeconomic Education, H-295.924, which reads: “The AMA: (1) asks medical schools and residencies to encourage that basic content related to the structure and financing of the current health care system, including the organization of health care delivery, modes of practice, practice settings, cost effective use of diagnostic and treatment services, practice management, risk management, and utilization review/quality assurance, is included in the curriculum; (2) asks medical schools to ensure that content related to the environment and economics of medical practice in fee-for-service, managed care and other financing systems is presented in didactic sessions and reinforced during clinical experiences, in both inpatient and ambulatory care settings, at educationally appropriate times during undergraduate and graduate medical education; and (3) will encourage representatives to the Liaison Committee on Medical Education (LCME) to ensure that survey teams pay close attention during the accreditation process to the degree to which ‘socioeconomic’ subjects are covered in the medical curriculum.”</th>
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<tr>
<td>The AMA will communicate with medical school deans and residency program directors urging the inclusion in their curricula of appropriate instruction regarding the concept, implementation and impact of managed care on the practice of medicine. (Res. 309, A-96; Reaffirmed by CME Rep. 5, A-97; Reaffirmed: CME Rep. 2, A-07)</td>
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<tr>
<th><strong>H-295.921, Federal Intervention in the Setting of Educational Standards</strong></th>
<th>Retain; still relevant.</th>
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<tr>
<td>The AMA strongly opposes federal intervention, through legislative restrictions, that would limit the authority of professional accrediting bodies to design and implement appropriate educational standards for the training of physicians. The AMA strongly opposes infringements and mandates on medical school curricular requirements through state and federal legislative efforts, and also recommends that state medical societies should carefully monitor</td>
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such activities and notify the AMA when such intrusions take place. (Res. 323, A-95; Appended: CME Rep. 4, I-97; Reaffirmed: CME Rep. 2, A-07)

**H-295.922, Establishing Essential Requirements for Medical Education in Substance Abuse**
AMA policy states that alcohol and other drug abuse education needs to be an integral part of medical education; and that the AMA supports the development of programs to train medical students in the identification, treatment, and prevention of alcoholism and other chemical dependencies. Our AMA: (1) asks all residency review committees to review their training requirements in the treatment and management of substance abuse and addiction and to make recommendations for strengthening this provision as needed; and (2) encourages the development of specialty-specific needs assessment to determine whether targeted educational activities in substance abuse would be useful in their overall program of continuing medical education. (Res. 303, I-94; Reaffirmed and Appended: CME Rep. 10, I-98; Reaffirmed: CME Rep. 11, A-07)

Sunset; superseded by Prescription Drug Diversion, Misuse and Addiction H-95.945, which reads, in part, that our AMA “(5) will promote medical school and postgraduate training that incorporates curriculum topics focusing on pain medicine, addiction medicine, safe prescribing practices, safe medication storage and disposal practices, functional assessment of patients with chronic conditions, and the role of the prescriber in patient education regarding safe medication storage and disposal practices, in order to have future generations of physicians better prepared to contribute to positive solutions to the problems of prescription drug diversion, misuse, addiction and overdose deaths.” In addition, Substance Use and Substance Use Disorders D-95.984 states that our AMA “(2) will renew efforts to: (a) have substance use disorders addressed across the continuum of medical education; (b) provide tools to assist physicians in screening, diagnosing, intervening, and/or referring patients with substance use disorders so that they have access to treatment....”

**H-295.974, Regulation of Medical Student Educational Opportunities**
The AMA (1) reaffirms its support for the LCME standard for accreditation of undergraduate medical education programs that the curriculum be designed to instill in its graduates the knowledge and skills fundamental to the practice of medicine; and (2) opposes legislation or other efforts by state or federal regulatory agencies to define standards which limit educational opportunities in the training process of future physicians. (Res. 142, I-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CME Rep. 2, A-07)

Sunset; no longer relevant; item (2) is superseded by Federal Intervention in the Setting of Educational Standards, H-295.921.

**H-295.975, Educating Competent and Caring Health Professionals**
(1) Programs of health professions education should foster educational strategies that encourage students to be independent learners and problem-solvers. Faculty of programs of education for the health professions should ensure that the mission statements of the institutions in which they teach

Retain; still relevant.
include as an objective the education of practitioners who are both competent and compassionate.

(2) Admission to a program of health professions education should be based on more than grade point average and performance on admissions tests. Interviews, applicant essays, and references should continue to be part of the application process in spite of difficulties inherent in evaluating them. Admissions committees should review applicants' extra-curricular activities and employment records for indications of suitability for health professions education. Admissions committees should be carefully prepared for their responsibilities, and efforts should be made to standardize interview procedures and to evaluate the information gathered during interviews. Research should continue to focus on improving admissions procedures. Particular attention should be paid to improving evaluations of subjective personal qualities.

(3) Faculty of programs of education for the health professions must continue to emphasize than they have in the past on educating practitioners who are skilled in communications, interviewing and listening techniques, and who are compassionate and technically competent. Faculty of health professions education should be attentive to the environment in which education is provided; students should learn in a setting where respect and concern are demonstrated. The faculty and administration of programs of health professions education must ensure that students are provided with appropriate role models; whether a faculty member serves as an appropriate role model should be considered when review for promotion or tenure occurs. Efforts should be made by the faculty to evaluate the attitudes of students toward patients. Where these attitudes are found lacking, students should be counseled. Provisions for dismissing students who clearly indicate personality characteristics inappropriate to practice should be enforced.

(4) In spite of the high degree of specialization in health care, faculty of programs of education for the health professions must prepare students to provide integrated patient care; programs of education should promote an interdisciplinary experience for their students. (BOT Rep. NN, A-87; Modified: Sunset Report, I-97; Reaffirmed: CME Rep. 2, A-07)

H-295.988, Alcohol and Substance Abuse Education of Medical Students and Residents

In cooperation with other organizations, the AMA

Sunset; superseded by Prescription Drug Diversion, Misuse and Addiction H-95.945, which reads, in part, that our AMA “(5) will

promote medical school and postgraduate training that incorporates curriculum topics focusing on pain medicine, addiction medicine, safe prescribing practices, safe medication storage and disposal practices, functional assessment of patients with chronic conditions, and the role of the prescriber in patient education regarding safe medication storage and disposal practices, in order to have future generations of physicians better prepared to contribute to positive solutions to the problems of prescription drug diversion, misuse, addiction and overdose deaths.” In addition, Substance Use and Substance Use Disorders D-95.984 states that our AMA “(2) will renew efforts to: (a) have substance use disorders addressed across the continuum of medical education; (b) provide tools to assist physicians in screening, diagnosing, intervening, and/or referring patients with substance use disorders so that they have access to treatment….”

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<tr>
<th>H-300.948, Continuing Medical Education Activities for Procedural Skills</th>
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<tr>
<td>The AMA encourages the ACCME to require sponsors of courses in new procedures to provide documentation for physician attendees, using the following four levels of achievement: Level 1: Verification of attendance, Level 2: Verification of satisfactory completion of course objectives, Level 3: Verification of &quot;proctor readiness&quot;, and Level 4: Verification of physician competence to perform the procedure. (CME Rep. 12, A-97; Reaffirmed: CME Rep. 2, A-07)</td>
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Retain; still relevant.

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<thead>
<tr>
<th>H-300.949, The Ecology of Medical Education: Physician Self-Directed Learning and Continuing Medical Education</th>
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<tbody>
<tr>
<td>The AMA: (1) encourages medical schools and residency programs to define and educate the trainee on principles of self-directed learning, including self-assessment and how to use these principles to achieve continuing professional development; (2) supports efforts of the ACCME to develop ethical guidelines for the providers of CME, recognizing the unique needs of those funding CME and their potential to influence the direction of CME; and (3) will seek support for a national study of the future directions of continuing medical education so that effective strategies and policies are developed for</td>
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Retain; still relevant, with the edits shown below. The Standards for Commercial Support have been developed by the ACCME and are in place, so #2 has been accomplished.

The AMA: (1) encourages medical schools and residency programs to define and educate the trainee on principles of self-directed learning, including self-assessment and how to use these principles to achieve continuing professional development; and (2) supports efforts of the ACCME to develop ethical guidelines for the providers of CME, recognizing the unique needs of

those funding CME and their potential to influence the direction of CME; and (2) will seek support for a national study of the future directions of continuing medical education so that effective strategies and policies are developed for maintaining and improving the competence of physicians in caring for patients.

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<tr>
<th>H-305.927, Payment Cuts to Teaching Programs</th>
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<td>Our AMA opposes payment cuts to any teaching program on the basis that the attending physician is concurrently or sequentially supervising more than one resident, fellow or student. (Sub. Res. 719, I-07)</td>
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<td>Retain; still relevant.</td>
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<tr>
<th>H-305.935, Policy Options for Support of Graduate Medical Education</th>
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<td>Our AMA adopts the following principles:</td>
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<td>GRADUATE MEDICAL EDUCATION POSITIONS</td>
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<tr>
<td>(1) Planning for the number of residency positions should take into account the contributions to patient care made by other health professions and occupations, considering that other health professions and occupations do not substitute for physicians.</td>
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<tr>
<td>(2) Explicit immunity from antitrust constraints should be provided to private professional groups, to allow participation in the national debate on the physician workforce.</td>
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<tr>
<td>(3) Program quality, based on an assessment of educational program outcomes under the leadership of the Accreditation Council for Graduate Medical Education and its Residency Review Committees, should be a factor in the allocation of funded residency positions.</td>
</tr>
<tr>
<td>(4) Transitional funds should be provided to teaching institutions that lose residents as a result of cuts in the number of funded positions. (CME Rep. 10, A-99; Reaffirmed: CME Rep. 2, A-00; Modified: CME Rep. 2, I-03; Modified: CME Rep. 7, A-05; Reaffirmation I-07)</td>
</tr>
<tr>
<td>Sunset; superseded by other AMA policy, including H-200.955, Revisions to AMA Policy on the Physician Workforce, and H-305.929, Proposed Revisions to AMA Policy on the Financing of Medical Education Programs.</td>
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<tr>
<th>H-310.921, Credentialing Materials: Timely Submission by Residency and Fellowship Programs</th>
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<tbody>
<tr>
<td>1. Our AMA encourages residency programs and fellowship programs to submit credentialing and verification data requested on behalf of their</td>
</tr>
<tr>
<td>Sunset; superseded by D-310.965, Credentialing Materials: Timely Submission by Residency and Fellowship Programs.</td>
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1. Graduating residents and fellows to the requesting agency within thirty days of the request.
2. Our AMA encourages the Accreditation Council for Graduate Medical Education to establish an accreditation standard for residency and fellowship programs calling for submission of credentialing and recredentialing verification data requested on behalf of their graduating residents and fellows to the requesting agency within thirty days of the request. (Res. 312, A-07)

| H-360.995, Nursing Education and the Supply of Nursing Personnel in the United States |
| The AMA supports: (1) all levels of nursing education, at least until the crisis in the supply of bedside care personnel is resolved; (2) government and private initiatives that would facilitate the recruitment and education of nurses to provide care at the bedside; (3) economic and professional incentives to attract and retain high quality individuals to provide bedside nursing care; (4) hospital-based continuing education programs to promote the education of caregivers who assist in the implementation of medical procedures in critical care units, operating and emergency rooms, and medical-surgical care; and (5) cooperation with other organizations concerned with acute and chronic hospital care to develop quality educational programs and methods of accreditation of programs to increase the availability of caregivers at the bedside and to meet the medical needs of the public. (BOT Rep. CC, I-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CLRPD Rep. 2, A-07) |

| It is the policy of the AMA: (1) to continue to work with the federal government, specialty societies, and others, to develop guidelines for, and effective means of delivery of, clinical preventive services; and (2) to continue our efforts to develop and encourage continuing medical education programs in preventive medicine. (CME Rep. I, A-90; Reaffirmed by CME Rep. 5, I-95; Reaffirmed and Modified with change in title: CME Rep. 2, A-05; Reaffirmation A-07) |
| Retain; still relevant. |

| H-425.991, Support for Preventive Medicine |
| The AMA reaffirms its commitment to preventive medicine. (Res. 135, I-87; Modified: Sunset Report, I-97; Modified and Reaffirmed: CME Rep. 2, A-07) |
| Sunset; no longer needed, as preventive medicine is a mature specialty field. |
### HOUSE OF DELEGATES DIRECTIVES

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<tr>
<th>Policy Number, Title, Policy</th>
<th>Recommended Action</th>
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<td><strong>D-200.991, The Physician Workforce: Recommendations for Policy Implementation</strong>&lt;br&gt;To address current and predicted physician shortages, our AMA will work with members of the Federation and national and regional policymakers to develop mechanisms, including identification of funding sources, to create medical school and residency positions in or adjacent to physician shortage/underserved areas and in undersupplied specialties. (CME Rep. 8, A-05; Reaffirmation I-06; Reaffirmation I-07)</td>
<td>Sunset; superseded by D-305.967(17), The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education, which reads as follows: “Our AMA will work with interested state and national medical specialty societies and other appropriate stakeholders to share and support legislation to increase GME funding, enabling a state to accomplish one or more of the following: (a) train more physicians to meet state and regional workforce needs; (b) train physicians who will practice in physician shortage/underserved areas; or (c) train physicians in undersupplied specialties and subspecialties in the state/region.”</td>
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| **D-220.973, Effective AMA Leadership for Patient Safety: Reducing the Hospital Registered Nurse Shortage**<br>Our AMA: (1) will work with The Joint Commission to consider nurse staffing as a national patient safety goal and to examine the Hospital Accreditation Standards at NR.3.10 (regarding nursing policies and procedures, nursing standards, and nurse staffing plans), LD.3.15 (regarding management of the flow of patients to mitigate patient crowding and ensure appropriate care of patients in temporary locations), and HR.1.10-1.1.20 (regarding the hospital staffing plan and the qualifications of staff), to ensure that nursing staffs are adequate relative to patient number and acuity, are competent, and are appropriately oriented and trained in specialized departments; (2) supports professional nursing associations in their efforts to educate the public and advocate for programs aimed at protecting patient safety by ameliorating the RN shortage in hospitals; (3) encourages hospital organized medical staffs to take steps to improve the working environment and professional standing of nurses in hospitals in order to improve the quality and safety of patient care; (4) will provide reports to the House of Delegates at the 2008, 2009 and 2010 Annual Meetings detailing progress made in its efforts to address the nursing shortage. (Res. 534, A-07) | Sunset, due to directives that are outdated or have been accomplished, or are reflected in other AMA policy. The standards noted in item 1 have been updated multiple times since 2007 and require hospitals to confront staffing shortages. Item 2 is superseded by D-360.998(1), “The Growing Nursing Shortage in the United States,” which reads, in part: “Our AMA: (1) recognizes the important role nurses and other allied health professionals play in providing quality care to patients, and participate in activities with state medical associations, county medical societies, and other local health care agencies to enhance the recruitment and retention of qualified individuals to the nursing profession and the allied health fields.” Item 3 is superseded by D-360.998(2)(5), “The Growing Nursing Shortage in the United States,” which reads, in part: “Our AMA… (2) encourages physicians to be aware of and work to improve workplace conditions that impair the professional relationship between physicians and nurses in the collaborative care of patients; … (5) will work with nursing, hospital, and other appropriate organizations to seek to remove administrative burdens, e.g., excessive paperwork, to improve efficiencies in |
nursing and promote better patient care.”

Item 4 was accomplished by Board of Trustees Report 27-A-08, which resulted in AMA policy H-360.982, “Leadership for Patient Safety: Reducing the Hospital Registered Nurse Shortage at the Bedside.”

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<tr>
<th><strong>D-255.996, ECFMG Representation</strong></th>
<th>Sunset; directive fulfilled. Also, reflected in AMA Principles on International Medical Graduates H-255.988 (5), which states, in part, “An AMA member, who is an IMG, should be appointed regularly as one of the AMA’s representatives to the ECFMG Board of Trustees.”</th>
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<td><strong>Our AMA will strongly encourage the ECFMG to regularly appoint an international medical graduate as one of the at-large members on its Board of Trustees.</strong> (Res. 304, A-00 Reaffirmed: CME Rep. 2, A-10)</td>
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<td><strong>Our AMA will continue to work with the Association of American Medical Colleges and other national organizations to expedite, wherever possible, the standardization of requirements in regards to training on HIPAA, drug screening, and health requirements for medical students, and resident and fellow physicians who are being educated in hospitals and other health care settings.</strong> (Res. 811, I-07)</td>
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<th><strong>D-295.946, The Status of Education in Substance Use Disorders in America's Medical Schools and Residency Programs</strong></th>
<th>Sunset; items 1 and 2 superseded by D-95.984, Substance Use and Substance Use Disorders; items 3, 4, and 5 accomplished.</th>
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| **Our AMA will:**  
(1) advocate for in-depth qualitative studies to facilitate the preparation of physicians to care for patients with substance use disorders;  
(2) facilitate the identification, dissemination, and implementation of successful substance use disorder educational programs across the educational continuum;  
(3) encourage the Accreditation Council for Graduate Medical Education (ACGME) to include education about substance use disorders in their program accreditation requirements;  
(4) encourage the American Board of Medical Specialties (ABMS) to encourage its member boards to include substance use disorder questions in their certification process; and  
| D-295.990, **Nutritional and Dietetic Education for Medical Students**  
Our AMA will: (1) offer to assist the American Society for Clinical Nutrition in meeting its commitment to ensure that medical schools have appropriate faculty role models to teach clinical nutrition; and (2) identify and disseminate to medical schools new instructional initiatives that heighten the relevance of clinical nutrition content to medical practice. (CME Rep. 1, I-99; Reaffirmed: CME Rep. 2, A-09) | Sunset; superseded by H-150.995, Basic Courses in Nutrition. |
| --- | --- |
| D-305.968, **CMS to Pay for Residents’ Vacation and Sick Leave**  
Our AMA will lobby the Centers for Medicare and Medicaid Services to continue to reimburse the direct and indirect costs of graduate medical education for the time resident physicians are on vacation or sick leave. (Res. 321, A-07) | Retain; still relevant. |
| D-310.971, **The Residency Physician Shortage Reduction Act of 2007**  
Our AMA will vigorously support in its national legislative activities the passage of pending and future legislation which will increase physician residency positions throughout many states while not undermining existing physician residency positions in any of the states. (Res. 204, A-07); Reaffirmation I-07) | Sunset; refers to a specific piece of legislation, and year. Also, superseded by other AMA policy, such as D-305.958, Increasing Graduate Medical Education Positions as a Component to any Federal Health Care Reform Policy, which reads, in part:  
“1. Our AMA will ensure that actions to bolster the physician workforce must be part of any comprehensive federal health care reform.  
“2. Our AMA will work with the Centers for Medicare and Medicaid Services to explore ways to increase graduate medical education slots to accommodate the need for more physicians in the US.  
“3. Our AMA will work actively and in collaboration with the Association of American Medical Colleges and other interested stakeholders to rescind funding caps for GME imposed by the Balanced Budget Act of 1997.  
“4. Our AMA will actively advocate for expanded funding for entry and continued training positions in specialties and geographic regions with documented medical workforce shortages.  
“5. Our AMA will lobby Congress to find ways to increase graduate medical education funding to accommodate the projected need for more physicians.” |
Also superseded by D-305.967, The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education, which reads, in part:

“1. Our AMA will actively collaborate with appropriate stakeholder organizations, (including Association of American Medical Colleges, American Hospital Association, state medical societies, medical specialty societies/associations) to advocate for the preservation, stability and expansion of full funding for the direct and indirect costs of graduate medical education (GME) positions from all existing sources (e.g. Medicare, Medicaid, Veterans Administration, CDC and others)…. 

“4. Our AMA will strenuously advocate for increasing the number of GME positions to address the future physician workforce needs of the nation…. 

“8. Our AMA will vigorously advocate for the continued and expanded contribution by all payers for health care (including the federal government, the states, and local and private sources) to fund both the direct and indirect costs of GME…. 

“10. Our AMA staff and governance will continuously monitor federal, state and private proposals for health care reform for their potential impact on the preservation, stability and expansion of full funding for the direct and indirect costs of GME…. 

“11. Our AMA: (a) recognizes that funding for and distribution of positions for GME are in crisis in the United States and that meaningful and comprehensive reform is urgently needed; (b) will immediately work with Congress to expand medical residencies in a balanced fashion based on expected specialty needs throughout our nation to produce a geographically distributed and appropriately sized physician workforce; and to make increasing support and funding for GME programs and residencies a top priority of the AMA in its national political agenda; and (c) will continue to work closely with the
Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, American Osteopathic Association, and other key stakeholders to raise awareness among policymakers and the public about the importance of expanded GME funding to meet the nation's current and anticipated medical workforce needs.

“13. Our AMA will continue to strongly advocate that Congress fund additional graduate medical education (GME) positions for the most critical workforce needs, especially considering the current and worsening maldistribution of physicians.

“17. Our AMA will work with interested state and national medical specialty societies and other appropriate stakeholders to share and support legislation to increase GME funding, enabling a state to accomplish one or more of the following: (a) train more physicians to meet state and regional workforce needs; (b) train physicians who will practice in physician shortage/underserved areas; or (c) train physicians in undersupplied specialties and subspecialties in the state/region.

“18. Our AMA supports the ongoing efforts by states to identify and address changing physician workforce needs within the GME landscape and continue to broadly advocate for innovative pilot programs that will increase the number of positions and create enhanced accountability of GME programs for quality outcomes.

“19. Our AMA will continue to work with stakeholders such as Association of American Medical Colleges (AAMC), ACGME, AOA, American Academy of Family Physicians, American College of Physicians, and other specialty organizations to analyze the changing landscape of future physician workforce needs as well as the number and variety of GME positions necessary to provide that workforce....
REPORT 2 OF THE COUNCIL ON MEDICAL EDUCATION (A-17)
Update on Maintenance of Certification and Osteopathic Continuous Certification
(Resolution 315-A-16)
(Reference Committee C)

EXECUTIVE SUMMARY

The Council on Medical Education has monitored the implementation of Maintenance of Certification (MOC) and Osteopathic Continuous Certification (OCC) during the last year. This annual report, mandated by American Medical Association (AMA) Policy D-275.954, “Maintenance of Certification (MOC) and Osteopathic Continuous Certification (OCC),” provides an update on some of the changes that have occurred as a result of AMA efforts with the American Board of Medical Specialties (ABMS) to improve the MOC process.

New activities are highlighted in this report:
- New studies published during the last year, in addition to several hundred studies available in the ABMS Continuing Certification Reference Center™, support the value of MOC and demonstrate how new assessment models and practice improvement activities have resulted in improved quality and patient care as well as physician satisfaction.
- Several ABMS member boards have taken steps to make the MOC Part III examination more constructive and less onerous for physicians. Some boards are looking at ways to innovate assessment of medical knowledge, and are testing new models or have implemented alternatives to the traditional secure, high-stakes examination. The table at the end of this report summarizes the new models being piloted and board activities underway to improve MOC Part III.
- The ABMS member boards have broadened the range of acceptable activities that meet the Improvement in Medical Practice component (MOC Part IV). New activities are being implemented by the boards related to registries, systems-based practice, and practice audits.

This report also includes updates on the following MOC activities:
- AMA participation in meetings and conferences to improve the MOC process (page 1)
- Implementation of the ABMS MOC Directory (page 4)
- Alternatives to the MOC Part III secure, high-stakes examination (page 5)
- Improvement in medical practice (MOC Part IV) (page 6)
- The ABMS Multi-Specialty Portfolio Program (page 7)
- Alternative pathways to board recertification (page 8)
- AMA policy related to discrimination due to nonparticipation in MOC (page 8)
- Osteopathic Continuous Certification (page 11)
- Recertification and assessment processes for other health care professions (page 12)

The Council on Medical Education is committed to ensuring that MOC and OCC support physicians’ ongoing learning and practice improvement as well as to assuring the public that physicians are providing high-quality patient care in their practice settings. The Council continues to work with the ABMS, American Osteopathic Association, and ABMS member boards to identify and suggest improvements to the MOC and OCC programs. During the next year, the Council will also engage in cross council collaborations with the Council on Legislation and/or Council on Medical Service to review MOC alignment with legislative activities and quality, patient safety, and value qualifiers.
REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 2-A-17

Subject: Update on Maintenance of Certification and Osteopathic Continuous Certification (Resolution 315-A-16)

Presented by: Patricia Turner, MD, Chair

Referred to: Reference Committee C (Kenneth Certa, MD, Chair)

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

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

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

INTRODUCTION

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

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

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MAINTENANCE OF CERTIFICATION (MOC): AN UPDATE

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

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

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

- An observational study showed that voluntary enrollment and participation in the Maintenance of Certification in Anesthesiology (MOCA) Minute program, featuring frequent knowledge assessments accompanied by targeted learning resources, is associated with improved performance in the subsequent MOCA Cognitive (high-stakes) Examination when compared to the performance of individuals who do not participate.9

- The American Board of Family Medicine (ABFM) examined the impact of module selection on examination performance. The study showed that permitting candidates to select the content category for portions of their examination has a tendency to bias their scores in a systematic way, which is psychometrically undesirable and makes the meaning of the scores dependent on the particular modules selected.10 However, selecting one module rather than two would likely increase both the psychometric stability of the examination and more closely align with the content of the physician’s practice.10

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

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

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

- An evaluation of the effectiveness of the American Board of Ophthalmology’s (ABO) practice improvement modules (PIMs) on processes such as primary open-angle glaucoma, surgical management of cataracts, age-related macular degeneration, etc., showed that after completing
the PIMs, performance improved on 80 percent of individual process measures and 38.9 percent of individual outcome measures. This retrospective analysis demonstrated that improvements in technology and data collection methods—for example, standardized documentation and the use of electronic health records—may contribute significantly to meaningful QI efforts.

- A study showed how participation in MOC Part IV by primary care pediatricians was associated with a significant increase in captured opportunities for improved vaccination coverage. In addition, results were achieved at a relatively modest cost and with high pediatrician satisfaction. This study demonstrated that MOC-required QI projects may have the benefits of engaging physicians in projects that they may not otherwise participate in, and allowing physicians to be involved in the project from inception to completion.

- A practice quality improvement project in thoracic imaging was undertaken to reduce the effective radiation dose of routine chest CT imaging in a busy clinical practice. In addition to demonstrating a significant reduction in the effective radiation dose of thoracic CT scans, this project had a direct benefit for patients.

Two studies examined MOC and quality reporting requirements:

- One study comparing changes in quality measures from the ABFM Performance in Practice Modules (PPMs), Physician Quality Reporting System (PQRS), and a combined PQRS/PPM for diabetes showed that combining PQRS and PPM resulted in improvement in the outcomes quality of care measures. This study showed that practice assessment combined with feedback improves care and that further aligning MOC with quality reporting may be beneficial.

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

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

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

- A study was conducted to understand how ABFM diplomates viewed their PPM participation, and their resulting experience with QI. In the study, which involved 29,755 diplomates who completed PPMs in topics such as diabetes, hypertension, and asthma, 78.7 percent of the respondents indicated that they would change patient care, and 90.2 percent indicated that they would continue QI activities after completing the PPM.

- A separate survey study showed that recent efforts by the American Academy of Pediatrics and the American Board of Pediatrics (ABP) to develop learning modules that integrate QI methods and projects have resulted in high participation rates in QI activities.

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

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

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

To accommodate and organize the growing body of literature regarding improvements in practice related to MOC, the ABMS Continuing Certification Reference Center™ replaced its Evidence Library™ in 2016 (http://ccrc.abms.org/). The latter was revised to accommodate the broad and continually growing variety of literature and internet resources relevant to the board certification community. While the format of the publicly accessible, web-based resource remains the same, new indexing and filtering options have been added that further divide the literature by study types and certification topics. Several hundred articles have been reviewed by ABMS staff and physician volunteers/consultants for inclusion in the Center.29

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

**ABMS MOC Directory**

In 2015, the ABMS, in collaboration with the Association of American Medical Colleges, developed the MOC Directory (http://mededportal.org/abmsmoc/continuingeducation/) to assist physicians by reducing the time required to find practice-relevant MOC activities acceptable to the ABMS member boards. The MOC Directory offers diplomates easy access to a comprehensive, centralized repository of approved MOC activities across medical specialties and subspecialties. A number of AMA continuing medical education (CME) activities are listed on the Directory as being eligible for Lifelong Learning and Self-Assessment (MOC Part II).
In addition, the Accreditation Council for Continuing Medical Education (ACCME) also announced collaborations with the American Board of Anesthesiology (ABA) and ABP, similar to its collaboration with the American Board of Internal Medicine (ABIM) in 2015 that allows accredited CME providers to identify CME activities that also meet the MOC requirements for each of the member boards (ABIM, ABP, and ABA) and facilitates reporting of learner data from the accredited provider to the relevant member board (http://accme.org/news/publications/news/accreditation-council-cme-american-board-anesthesiology-and-american-board).

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

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

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

Seven of the member boards will be utilizing CertLink™, a web-based platform that leverages smart mobile technology to support the design, delivery, and evaluation of assessment pilots. Other pilot projects will resemble the ABA’s MOCA Minute™, which encourages anesthesiologists to frequently assess and improve their specialty knowledge by answering 30 questions per quarter related to clinical practice. Pilot projects underway at several boards will integrate assessments based on curated articles focusing on important new evidence in the discipline, in addition to, or in lieu of, more traditional test questions. In addition, some boards are participating in an ABMS-led MOC Assessment Initiative to understand how emerging adult learning theories and technologies can be integrated into the MOC framework and to explore how more frequent, smaller-bite, longitudinal formative assessments can be used to make summative decisions regarding specialty certification.
Some of these assessment formats highlight the use of spaced repetition, a technique that promotes learning and retention by exposing examinees to the same or similar content over time to test and stimulate recall. This testing technique has been shown to improve knowledge retention over traditional approaches. In addition, physicians are provided with immediate feedback about their performance and offered a dashboard that displays areas of strength and weakness, which can encourage learning targeted to identified knowledge and practice gaps. In some cases, physicians will have the option of tailoring the assessment content based on the nature of their actual practices. The ABMS and its member boards are also reviewing how information regarding aggregate longitudinal assessment performance can be used by CME providers to develop activities for physicians that address their knowledge gaps.

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

**Update on Improvement in Medical Practice**

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

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

**Registries**

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

The member boards are aligning MOC activities with other organizations’ quality improvement (QI) efforts to reduce redundancy and physician burden while promoting meaningful participation. Twenty-one of the boards encourage participation in organizational QI initiatives through the ABMS Multi-Specialty Portfolio Program™ (described below). Many boards encourage involvement in the development and implementation of safety systems or the investigation and resolution of organizational quality and safety problems. Some boards encourage assessment and training in teamwork, for example, through Team Strategies and Tools to Enhance Performance and Patient Safety (TeamSTEPPS) training programs.31 Six boards accept physician activities related to hospital-based Ongoing and Focused Professional Practice Evaluation conducted under The Joint Commission standards. For physicians serving in research or executive roles, some boards have begun to give IMP credit for having manuscripts published, writing peer-reviewed reports, giving presentations, and serving in institutional roles that focus on QI (provided that an explicit Plan-Do-Study-Act process is used). Physicians who participate in QI projects resulting from morbidity and mortality conferences and laboratory accreditation processes resulting in the identification and resolution of quality and safety issues can also receive IMP credit from some boards.

Practice Audits

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

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

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

ABMS Multi-Specialty Portfolio Program

The Portfolio Program (www.mocportfolioprogram.org) continues to offer health care organizations opportunities to support and encourage physician involvement in internal QI projects and team-based initiatives while providing MOC Part IV credit to physicians actively participating in the program. Many of these MOC activities also satisfy other national, state, and private-sector QI and reporting activities. The Portfolio Program eases the burden on physicians by reducing duplication of QI projects, with no additional costs to physicians who participate in the program.
More than 1,800 types of QI projects have been approved by the Portfolio Program in areas such as prevention and screening, improvements in disease-specific care processes, patient-physician communication, patient safety, harm reduction, and interdisciplinary team-based care. The number of organizations participating in the program continues to grow. Currently, there are more than 80 portfolio sponsors, and additional organizations are exploring the opportunity to join. In 2016, the American Heart Association-The Guideline Advantage™ program, Boston Medical Center, Dartmouth-Hitchcock, Johns Hopkins Medicine, Oregon Health & Science University, Sharp Healthcare, Texas Children’s Hospital, University of Arkansas for Medical Sciences, University of Kansas School of Medicine, and Vanderbilt University Medical Center became portfolio sponsors. The AMA is approved as a portfolio sponsor and is developing some CME activities to be eligible for MOC Part IV. The program has engaged more than 9,300 physicians in practice improvement initiatives at hospitals and health systems across the country (many showing improvement in care outcomes). Twenty-one ABMS member boards participate in the program. Sponsoring relationships with medical societies and two specialty societies have also been developed to provide more support for physicians with practices that are not primarily hospital-based.

ALTERNATIVE PATHWAYS TO BOARD RECERTIFICATION

Policy D-275.954 (28), “Maintenance of Certification and Osteopathic Continuous Certification,” asked that the AMA: 1) examine the activities that medical specialty organizations have underway to review alternative pathways for board recertification; and 2) determine if there is a need to establish criteria and construct a tool to evaluate if alternative methods for board recertification are equivalent to established pathways. As a first step, the Council provided background information about recertification programs in CME Report 2-A-16, “Update on Maintenance of Certification and Osteopathic Continuous Certification.”

In its report, the Council noted that wide-scale use of long-standing traditional recertification programs, such as the ABMS MOC, are reflected in training and delivery systems, and based on core competencies developed and adopted by the ABMS and the Accreditation Council for Graduate Medical Education (ACGME). The MOC program was designed to provide a comprehensive approach to physician life-long learning, self-assessment, and practice improvement, and strives to identify those physicians capable of delivering high-quality specialized medical care. Newer alternative pathways to specialty board recertification, such as the National Board of Physicians and Surgeons (NBPAS), have been formed to address physician concerns about the rigorous MOC process. There are ongoing concerns about the administrative burdens, the value of the program, the relevance and cost of the examination, and the time it takes physicians away from patient care. Although there is variability among specialties, participation in the MOC program may require passing a secured, high-stakes examination every 10 years. The NBPAS does not require an external assessment or practice improvement.

Many hospitals have independently made the decision to require board recertification for staff privileges. Their leadership recognizes that diagnostic and treatment knowledge changes rapidly, and that learned skills in medicine can decline over time. They value the competencies for medical practice set by the profession and create procedures for their own institutions with respect to those competencies. Although newer recertification programs, such as the NBPAS, are gaining acceptance by some hospitals, many hospitals still rely on the traditional MOC and OCC programs.
The American Gastroenterological Association (AGA) addressed physician dissatisfaction with the current MOC process by convening a Task Force to identify their vision of the ideal pathway for recertification of gastroenterologists. After the Task Force conducted a scholarly review of educational theory and literature and considered current health care environmental and technology factors, they recommended that MOC be replaced with individual pathways that would integrate self-assessment activities, allowing physicians to achieve a high level of competency in one or more areas while maintaining a more modest level of competency in other areas. The individualized self-assessment activities would provide constant feedback and opportunities for learning and remove the secure high-stakes examination required every 10 years. The proposal is based on a broad agreement on competencies established by educational leaders from five gastroenterology societies. This alternative pathway, called “The Gastroenterologist: Accountable Professionalism in Practice (G-APP)” would allow physicians to receive credit for activities they already do in practice, research, or teaching. The AGA has communicated this proposal to the ABIM and acts as an intermediary between AGA members and the ABIM, since gastroenterology is a subspecialty of internal medicine.34

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

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

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

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

AMA POLICY RELATED TO DISCRIMINATION DUE TO NONPARTICIPATION IN MOC

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

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

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

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

• Policy H-275.926 (3) also states that the AMA “opposes discrimination against physicians based solely on lack of ABMS or equivalent AOA-BOS board certification, or where board certification is one of the criteria considered for purposes of measuring quality of care, determining eligibility to contract with managed care entities, eligibility to receive hospital staff, or other clinical privileges, ascertaining competence to practice medicine, or for other purposes. Our AMA also opposes discrimination that may occur against physicians involved in the board certification process, including those who are in a clinical practice period for the specified minimum period of time that must be completed prior to taking the board certifying examination.”

The AMA Council on Legislation has developed, and the AMA Board of Trustees approved, model state legislation intended to prohibit state boards of medicine and osteopathic medicine from requiring physicians to maintain certification for licensure or license renewal; prohibit hospitals
from denying staff privileges or admitting privileges to a physician solely based on the physician’s lack of participation in MOC or OCC; and prohibit insurers from denying reimbursement to a physician, or preventing a physician from participating in the insurer’s network, based solely on the physician’s lack of participation in MOC or OCC. The model bill is on file with the AMA Advocacy Resource Center, which will assist any interested state medical association in pursuing such legislation or any other legislation consistent with AMA policy.

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

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

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

OSTEOPATHIC CONTINUOUS CERTIFICATION (OCC): AN UPDATE

The American Osteopathic Association Bureau of Osteopathic Specialists (AOA-BOS) (http://osteopathic.org/inside-aoa/development/aoa-board-certification/Pages/bos-history.aspx) was organized in 1939 as the Advisory Board for Osteopathic Specialists to meet the needs resulting from the growth of specialization in the osteopathic profession. Today, 18 AOA-BOS specialty certifying boards offer osteopathic physicians the option to earn board certification in a number of specialties. As of November 2016, over 28,000 osteopathic physicians held active board certification through the AOA (with some of these physicians holding multiple certifications). OCC was implemented on January 1, 2013 by all of the 18 specialty certifying member boards of the AOA-BOS. All osteopathic physicians who hold a time-limited certificate are required to
participate in the following five components of the OCC process in order to maintain osteopathic board certification:

- Component 1 - Active Licensure: physicians who are board certified by the AOA must hold a valid, active license to practice medicine in one of the 50 states, and adhere to the AOA’s Code of Ethics.
- Component 2 - Life Long Learning/Continuing Medical Education (CME): requires that all recertifying Diplomates fulfill a minimum number of hours of CME credit during each three-year CME cycle (15 certifying boards require 120 hours; three certifying boards require 150 hours). A minimum of 50 credit hours of this requirement must be in the specialty area of certification. Self-assessment activities are also designated by each of the 18 specialty certification boards. For osteopathic physicians who hold subspecialty certification(s), a percentage of their specialty credit hours must be in their subspecialty certification area.
- Component 3 - Cognitive Assessment: requires provision of one (or more) psychometrically valid and proctored examinations that assess a physician’s specialty medical knowledge as well as core competencies in the provision of health care.
- Component 4 - Practice Performance Assessment and Improvement: requires that physicians engage in continuous quality improvement through comparison of personal practice performance measured against national standards for their respective medical specialty.
- Component 5 - Continuous AOA Membership.

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

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

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

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

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

RECERTIFICATION AND ASSESSMENT PROCESSES FOR OTHER HEALTH CARE PROFESSIONS

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

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

Physician assistants

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

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

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

SUMMARY AND RECOMMENDATIONS

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

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

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

1. That the Council on Medical Education collaborate with the Council on Legislation and/or the
   Council on Medical Service to determine MOC alignment with legislative activities and
   quality, patient safety and value qualifiers, such as the Quality Payment Program (QPP) created
   by the Medicare Access and CHIP Reauthorization Act (MACRA). (Directive to Take Action)

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

Fiscal Note: $2,500
### TABLE 1. IMPROVEMENTS TO THE AMERICAN BOARD OF MEDICAL SPECIALTIES (ABMS) PART III, SECURE, HIGH-STAKES EXAMINATION*

<table>
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<tr>
<th>The American Board of:</th>
<th>Current Examination Format</th>
<th>New Models/Innovations</th>
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| Allergy and Immunology (ABAI) [www.abai.org](http://www.abai.org) | Computer-based, secure exam administered at a proctored test center once a year. Diplomates must pass the exam once every 10 years. | In 2018, ABAI-Continuous Assessment Pilot Program will be implemented in place of current exam:  
   - A 10-year program with two 5-year cycles.  
   - Diplomates take exam where and when it is convenient.  
   - Diplomates required to answer three questions for each of ten journal articles in each cycle. The articles will be posted in January and July and remain open for 6 months. Articles can be printed or downloaded for review.  
   - Questions can be answered for each article independently. Diplomate feedback on each question will be required.  
   - “Open-book” with a total of approximately 80 questions per year.  
   - Mostly article-based with some core questions during each 6-month cycle.  
   - Opportunity to drop the two lowest 6-month cycle scores during each 5-year period to allow for unexpected life events.  
   - Ability to complete questions on PC, laptop, MAC, tablet, and smart phone formats by using the new diplomate dashboard via the existing ABAI Web Portal page.  
   - The exam fee reduced by 50% to $1300. |

| Anesthesiology [www.theaba.org](http://www.theaba.org) | - Traditional Maintenance of Certification in Anesthesiology Program (MOCA): Computer-based, secure exam administered at a proctored test center. Diplomates must pass the exam once every 10 years.  
   - MOCA 2.0 introduced in 2014 to provide a tool for ongoing low-stakes | - Currently piloting a free web application known as MOCA Minute™—a longitudinal assessment tool that requires diplomats to answer 30 questions per calendar quarter, or 120 per year, in lieu of taking a 10-year exam.  
   - Analysis of the pilot data is underway to determine whether participants accessed the links to |
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<th>Area</th>
<th>Description</th>
<th>Additional Information</th>
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<tr>
<td>Colon and Rectal Surgery</td>
<td>Assessment and provide more extensive, question-specific feedback. Also provides focused content that could be reviewed periodically to refresh knowledge and document cognitive expertise.</td>
<td>All diplomates with time-limited certification that expired on or before Dec. 31, 2015 must complete the traditional MOCA® requirements before they can register for MOCA 2.0®.</td>
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| Dermatology (ABD)                | Computer-based secure exam administered at a proctored test center once a year (in May). Diplomates must pass the exam once every 10 years.                                                                 | - ABCRS is exploring ways to modify the exam experience to provide a more consistent evaluation process and to replace the exam as it presently is administered.  
- Participating in the ABMS Longitudinal Assessment pilot utilizing the CertLink™ platform. |
|                                  | • Computer-based secure modular exam administered at a proctored test center twice a year or by remote proctoring technology. Diplomates must pass the exam once every 10 years.  
• ABD makes test preparation material available 6 months before the exam. The material includes diagnoses from which the general dermatology clinical images will be drawn and questions that will be used to generate the subspecialty modular exams.  
• Examinees are required to take the general dermatology module, consisting of 100 clinical images designed to assess diagnostic skills, and can then choose among 50-item subspecialty modules. | - ABD successfully completed trials employing remote proctoring technology to monitor exam administration in the diplomates’ homes or offices.  
- Participating in the ABMS Longitudinal Assessment pilot utilizing the CertLink™ platform. |
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<th>Field</th>
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<tr>
<td>Emergency Medicine (ABEM)</td>
<td>ABEM’s ConCert™, computer-based, secure exam administered at a proctored test center once a year. Diplomates must pass the exam once every 10 years.</td>
<td>ABEM is monitoring recent efforts within the ABMS board community that have focused on pilots that assess knowledge, judgment, and skills using longitudinal assessments rather than an every-10-year exam. The alternative assessment method would have to show that its learning and assessment advantage is better than the current ABEM exam.</td>
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<tr>
<td>Family Medicine</td>
<td>Computer-based secure exam administered at a proctored test center twice a year or by remote proctoring technology. Diplomates must pass the exam once every 10 years.</td>
<td>Changes to the ABFM exam are not being considered at this time.</td>
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<tr>
<td>Internal Medicine (ABIM)</td>
<td>Computer-based secure exam administered at a proctored test center. Diplomates must pass the exam once every 10 years.</td>
<td>In 2018, ABIM plans to offer two assessment options: 1) Certified physicians will be eligible to take shorter more frequent assessments with continuous learning, feedback, and improvement. Assessments can be taken on their home or office computer instead of taking the long-form exam every 10 years at a testing facility. Diplomates who perform well on the shorter exam can test out of the current assessment taken every 10 years. Those who meet a performance standard on shorter assessments will not need to take the 10-year exam again to remain certified. 2) Diplomates can also choose to take a long-form assessment given every 10 years. This option is the same as the current 10-year exam, but it will include some new features that physicians requested. • New fidelity features may include a zoom feature for images, presentation of realistic laboratory reports with normal ranges, embedded audio clips of heart sounds, and video clips of patient presentations. • New web-based, geographic score report presents more clearly performance results for a given examinee, to highlight areas of strength and weakness for specific exam questions that were missed.</td>
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| Medical Genetics and Genomics\(^1\)  
www.abmgg.org | Some exams allow the examinee to select the best of two or best of three options instead of being limited to a single option response.  
ABIM is researching and developing the use of external or web resources during the exam, computer-based simulation with patient avatars, and the introduction of adaptive testing techniques, where the exam advances differently depending on an examinee’s response to each situation and where the examinees might be able to leave early based on their performance. |  |  |
| Neurological Surgery (ABNS)  
www.abns.org | Computer-based secure exam administered at a proctored test center once a year (August). Diplomates must pass the exam once every 10 years.  
| Participating in the ABMS Longitudinal Assessment pilot utilizing the CertLink™ platform.\(^1\) |  |  |
|  | The 10-year secure exam can be taken from any computer, i.e., in diplomate’s office or home. Access to reference materials is not restricted; it is an open book test. On applying to take the examination, a diplomate must assign a person to be his or her proctor. Prior to the exam, that individual will participate in an on-line training session and “certify” the exam computers. | In 2017, an adaptive MOC cognitive learning tool will be piloted:  
The tool will consist of updated knowledge that has evolved since the diplomate’s last certification and the tool will be far shorter, relevant, and more focused than the prior MOC exam.  
The ABNS will use the platform designed by the same company which delivers millions of American Heart Association exams, such as Basic Life Support, so the format will be familiar and easy to use.  
The exam will provide updated "evidence based" core neurological surgery knowledge in a web-based format.  
The web-based learning tool can be mastered in the diplomates’ home, or office, anytime 24/7.  
Immediate feedback to each question will be provided to the diplomate. References with links and/or articles will be provided. |  |  |
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<th>Specialty</th>
<th>Exam Description</th>
<th>Notes</th>
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<tr>
<td>Nuclear Medicine</td>
<td>Computer-based secure exam administered at a proctored test center once a year (October). Diplomates must pass the exam once every 10 years.</td>
<td>- Participating in the ABMS Longitudinal Assessment pilot utilizing the CertLink™ platform. 1</td>
</tr>
<tr>
<td>Obstetrics and Gynecology (ABOG)</td>
<td>The secure, external assessment is offered in the last year of each ABOG diplomate’s six-year cycle in a modular test format, and physicians are allowed to choose two selections that are the most relevant to their current practice.</td>
<td>In 2016, ABOG launched a pilot program to integrate the self-assessment and external assessment MOC requirements to allow diplomates to continuously demonstrate their knowledge of the specialty. The pilot allows diplomates to earn an exemption from the current computer-based exam in the sixth year of the program if they reach a threshold of performance during the first 5 years of the self-assessment program.</td>
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<tr>
<td>Ophthalmology (ABO)</td>
<td>Diplomates must successfully pass the Demonstration of Ophthalmic Cognitive Knowledge (DOCK) exam, a computer-based secure modular exam administered at a proctored test center once a year (September). Diplomates must pass the exam once every 10 years.</td>
<td>In 2017, a Quarterly Question Pilot Program will evaluate shorter, more frequent assessments. 1) Will deliver 40 multiple-choice questions (MCQs) on fundamental knowledge needed in the everyday practice of ophthalmology through computer, tablet or mobile apps. The MCQs should not require preparation in advance, but a content outline for the MCQs will be available. Users will see instant feedback and receive recommendations for resources related to gaps in knowledge. 2) Key ophthalmic journal articles with questions focused on the application of this information to patient care will be provided. The journal portion will require reading five articles from a list of 15 options. The articles will be available at the beginning of 2017 and the 10 article-based questions will be delivered in Q4 (October). Based on the performance of the pilots, these programs may replace the DOCK Exam.</td>
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<tr>
<td>Orthopaedic Surgery (ABOS)</td>
<td>Computer-based secure modular exam administered at a proctored test center. Diplomates must pass the exam once every 10 years. The optional oral exam is given in Chicago in July.</td>
<td>Changes to the ABOS exam are not being considered at this time.</td>
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<td>Specialty</td>
<td>Description</td>
<td>Changes</td>
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<td>Otolaryngology&lt;sup&gt;1&lt;/sup&gt;</td>
<td>Computer-based secure modular exam administered at a proctored test center. Diplomates must pass the exam once every 10 years.</td>
<td>• Participating in the ABMS Longitudinal Assessment pilot utilizing the CertLink™ platform.&lt;sup&gt;1&lt;/sup&gt;</td>
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| Pathology<sup>1</sup>           | • Computer-based secure modular exam administered at the ABP Exam Center in Tampa, Florida twice a year (March and August).  
  • Remote computer exams can be taken any time 24/7 that the registrant chooses during the assigned 2-week period (spring and fall) from their home or office.  
  *Diplomates must pass the exam once every 10 years.*  
  • New modules were added to make the exam more relevant to a diplomate’s practice.  
  • Participating in the ABMS Longitudinal Assessment pilot utilizing the CertLink™ platform.<sup>1</sup>                                                                                       |
| Pediatrics                     | Computer-based secure exam administered at a proctored test center. Diplomates must pass the exam once every 10 years.                                                                                                                                                                                                                      | In 2017, launching (pilot) Maintenance of Certification Assessment for Pediatrics (MOCA-Peds), a new testing platform with shorter and more frequent assessments.  
  • A series of questions will be released through mobile devices or a web browser at regular intervals.  
  • Twenty MCQs will be available every 2 months and may be answered anytime during the quarter.  
  • Provides immediate feedback and references.  
  • Allows for questions to be tailored to the pediatrician’s practice profile.  
  • Participants will provide feedback on individual questions so that the exam can be continuously improved. |
| Physical Medicine and Rehabilitation<sup>1</sup> | Computer-based secure exam administered at a proctored test center. Diplomates must pass the exam once every 10 years.                                                                                                                                                                                                                      | Participating in the ABMS Longitudinal Assessment pilot utilizing the CertLink™ platform.<sup>1</sup>                                                                                                                                                                                      |
| Plastic Surgery                | Computer-based secure exam administered at a proctored test center once a year (October). Diplomates must pass the exam once every 10 years.                                                                                                                                   | • Eliminated the 6-month case log requirement for the exam application.  
  • Reduced the exam fee by 10%.  
  • Offers an MOC Study Guide with more than 2,300 MCQ items derived from the same sources used by the primary examination.                                                                                     |
<table>
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<tr>
<th>Specialty</th>
<th>Exam Format and Administration</th>
<th>Changes to the Exam</th>
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<tr>
<td>Preventive Medicine (ABPM)</td>
<td>In-person, pencil-and-paper, secure exam administered at secure test facility. MOC exams follow the same content outline as the initial certification exam (without the core portion). <em>In 2016, new multispecialty subspecialty of Addiction Medicine was established.</em></td>
<td>Changes to the ABPM exam are not being considered at this time. <em>In 2017, Addiction Medicine subspecialty certification exam to be administered to diplomates of any of the 24 ABMS member boards who meet the eligibility requirements.</em></td>
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<tr>
<td>Psychiatry and Neurology (ABPN)</td>
<td>Computer-based secure exam administered at a proctored test center. Diplomates must pass the exam once every 10 years.</td>
<td>Changes to the ABPN exam are not being considered at this time.</td>
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<tr>
<td>Radiology (ABR)</td>
<td>Computer-based secure modular exam administered at a proctored test center. Diplomates must pass the exam once every 10 years.</td>
<td>ABR is developing a pilot that may replace the current 10-year traditional exam, with an online continuous assessment process. The online longitudinal assessment model that will be piloted incorporates modern and more relevant adult learning concepts to provide psychometrically valid sampling of diplomate knowledge. • Diplomates will create a practice profile of the subspecialty areas that most closely fit what they do in practice, as they do now for the modular exams. • Diplomates will receive weekly emails with links to questions relevant to their registered practice profile. • Questions may be answered singly or, for a reasonable time, in small batches, in a limited amount of time. • Diplomates will learn immediately whether they answered correctly or not and will be presented with the question’s rationale, a critique of the answers, and brief educational material. • Feedback will assist diplomates by guiding their CME (MOC Part II). • Those who answer questions incorrectly will receive future questions on the same topic to gauge whether they have learned the material.</td>
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<tr>
<td>Specialty</td>
<td>Exam Format</td>
<td>Requirements</td>
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<tr>
<td>Surgery (ABS)</td>
<td>Computer-based secure exam administered at a proctored test center. Diplomates must pass the exam once every 10 years.</td>
<td>ABS soliciting feedback from diplomates.</td>
</tr>
<tr>
<td>Thoracic Surgery (ABTS)</td>
<td>Remote, secure, computer exams can be taken any time 24/7 that the registrant chooses during the assigned 2-month period (September-October) from their home or office. Diplomates will be allowed to enter the online program 10 times for a total of 15 hours. Modular exam, based on specialty, and presented in a self-assessment format with critiques and resources made available to diplomates.</td>
<td>ABTS developed a web-based assessment available for immediate access upon purchase. The latest version (SESATS XI) includes all exam materials, instant access to questions, critiques, abstracts and references, plus hundreds of digital images and movies.</td>
</tr>
<tr>
<td>Urology</td>
<td>Computer-based secure exam administered at a proctored test center once a year (October). Diplomates must pass the exam once every 10 years.</td>
<td>In 2017, a modular MOC exam will be reinstituted. • Diplomates will be required to take the 40 question core module on general urology, and choose one of four 35 question content modules.</td>
</tr>
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*The information in this table is sourced from ABMS Member Board websites and is current as of February 15, 2017.

APPENDIX

H-275.924, Maintenance of Certification
AMA Principles on Maintenance of Certification (MOC)
1. Changes in specialty-board certification requirements for MOC programs should be longitudinally stable in structure, although flexible in content.
2. Implementation of changes in MOC must be reasonable and take into consideration the time needed to develop the proper MOC structures as well as to educate physician diplomates about the requirements for participation.
3. Any changes to the MOC process for a given medical specialty board should occur no more frequently than the intervals used by that specialty board for MOC.
4. Any changes in the MOC process should not result in significantly increased cost or burden to physician participants (such as systems that mandate continuous documentation or require annual milestones).
5. MOC requirements should not reduce the capacity of the overall physician workforce. It is important to retain a structure of MOC programs that permits physicians to complete modules with temporal flexibility, compatible with their practice responsibilities.
6. Patient satisfaction programs such as The Consumer Assessment of Healthcare Providers and Systems (CAHPS) patient survey are neither appropriate nor effective survey tools to assess physician competence in many specialties.
7. Careful consideration should be given to the importance of retaining flexibility in pathways for MOC for physicians with careers that combine clinical patient care with significant leadership, administrative, research and teaching responsibilities.
8. Legal ramifications must be examined, and conflicts resolved, prior to data collection and/or displaying any information collected in the process of MOC. Specifically, careful consideration must be given to the types and format of physician-specific data to be publicly released in conjunction with MOC participation.
9. Our AMA affirms the current language regarding continuing medical education (CME): "Each Member Board will document that diplomates are meeting the CME and Self-Assessment requirements for MOC Part II. The content of CME and self-assessment programs receiving credit for MOC will be relevant to advances within the diplomate’s scope of practice, and free of commercial bias and direct support from pharmaceutical and device industries. Each diplomate will be required to complete CME credits (AMA PRA Category 1 CreditTM, American Academy of Family Physicians Prescribed, American College of Obstetricians and Gynecologists, and/or American Osteopathic Association Category 1A)."
10. In relation to MOC Part II, our AMA continues to support and promote the AMA Physician’s Recognition Award (PRA) Credit system as one of the three major credit systems that comprise the foundation for continuing medical education in the U.S., including the Performance Improvement CME (PICME) format; and continues to develop relationships and agreements that may lead to standards accepted by all U.S. licensing boards, specialty boards, hospital credentialing bodies and other entities requiring evidence of physician CME.
11. MOC is but one component to promote patient safety and quality. Health care is a team effort, and changes to MOC should not create an unrealistic expectation that lapses in patient safety are primarily failures of individual physicians.
12. MOC should be based on evidence and designed to identify performance gaps and unmet needs, providing direction and guidance for improvement in physician performance and delivery of care.
13. The MOC process should be evaluated periodically to measure physician satisfaction, knowledge uptake and intent to maintain or change practice.
14. MOC should be used as a tool for continuous improvement.
15. The MOC program should not be a mandated requirement for licensure, credentialing, recredentialing, privileging, reimbursement, network participation, employment, or insurance panel participation.
16. Actively practicing physicians should be well-represented on specialty boards developing MOC.
17. Our AMA will include early career physicians when nominating individuals to the Boards of Directors for ABMS member boards.
18. MOC activities and measurement should be relevant to clinical practice.
19. The MOC process should not be cost prohibitive or present barriers to patient care.
20. Any assessment should be used to guide physicians’ self-directed study.
21. Specific content-based feedback after any assessment tests should be provided to physicians in a timely manner.
22. There should be multiple options for how an assessment could be structured to accommodate different learning styles.
23. Physicians with lifetime board certification should not be required to seek recertification.
24. No qualifiers or restrictions should be placed on diplomates with lifetime board certification recognized by the ABMS related to their participation in MOC.
25. Members of our House of Delegates are encouraged to increase their awareness of and participation in the proposed changes to physician self-regulation through their specialty organizations and other professional membership groups.


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

29. Ask the ABMS to encourage its member boards to review their maintenance of certification policies regarding the requirements for maintaining underlying primary or initial specialty board certification in addition to subspecialty board certification, if they have not yet done so, to allow physicians the option to focus on maintenance of certification activities relevant to their practice.

30. Call for the immediate end of any mandatory, secured recertifying examination by the ABMS or other certifying organizations as part of the recertification process for all those specialties that still require a secure, high-stakes recertification examination.

31. Support a recertification process based on high quality, appropriate Continuing Medical Education (CME) material directed by the AMA recognized specialty societies covering the physician’s practice area, in cooperation with other willing stakeholders, that would be completed on a regular basis as determined by the individual medical specialty, to ensure lifelong learning.

32. Continue to work with the ABMS to encourage the development by and the sharing between specialty boards of alternative ways to assess medical knowledge other than by a secure high stakes exam.

33. Continue to support the requirement of CME and ongoing, quality assessments of physicians, where such CME is proven to be cost-effective and shown by evidence to improve quality of care for patients.

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

35. Increase its efforts to work with the insurance industry to ensure that maintenance of certification does not become a requirement for insurance panel participation.


**H-275.926, Medical Specialty Board Certification Standards**

Our AMA:

1. Opposes any action, regardless of intent, that appears likely to confuse the public about the unique credentials of American Board of Medical Specialties (ABMS) or American Osteopathic Association Bureau of Osteopathic Specialists (AOA-BOS) board certified physicians in any medical specialty, or take advantage of the prestige of any medical specialty for purposes contrary to the public good and safety.

2. Continues to work with other medical organizations to educate the profession and the public about the ABMS and AOA-BOS board certification process. It is AMA policy that when the equivalency of board certification must be determined, accepted standards, such as those adopted by state medical boards or the Essentials for Approval of Examining Boards in Medical Specialties, be utilized for that determination.

3. Opposes discrimination against physicians based solely on lack of ABMS or equivalent AOA-BOS board certification, or where board certification is one of the criteria considered for purposes of measuring quality of care, determining eligibility to contract with managed care entities, eligibility to receive hospital staff or other clinical privileges, ascertaining competence to practice medicine, or for other purposes. Our AMA also opposes discrimination that may occur against physicians involved in the board certification process, including those who are in a clinical practice period for the specified minimum period of time that must be completed prior to taking the board certifying examination.
4. Advocates for nomenclature to better distinguish those physicians who are in the board certification pathway from those who are not.
5. Encourages member boards of the ABMS to adopt measures aimed at mitigating the financial burden on residents related to specialty board fees and fee procedures, including shorter preregistration periods, lower fees and easier payment terms.
REFERENCES


37. Wynia MK. The Role of Professionalism and Self-regulation in Detecting Impaired or Incompetent Physicians. *JAMA.* 2010;304(2):210-211.

Subject: Obesity Education

Presented by: Patricia Turner, MD, Chair

Referred to: Reference Committee C
(Kenneth Certa, MD, Chair)

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

OBESITY: SCOPE OF THE PROBLEM, DEFINITIONS, DETERMINATES

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

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

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

The cause of obesity is often multifactorial, but the usual common pathway is an energy balance mismatch—excess energy consumption in relation to energy use. Contributing factors include inactive or low-activity lifestyle; high-caloric food choices; food portion size; environmental...
factors such as availability of healthy food choices, work schedules, and access to activity; genetic factors; health conditions; medications; emotional and psychological factors; age; childbearing; and sleep and circadian rhythm disruptions. Consistent with the causes of obesity, the CDC notes: “There is no single or simple solution to the obesity epidemic. It’s a complex problem and there has to be a multifaceted approach. Policy makers, state and local organizations, business and community leaders, school, childcare and healthcare professionals, and individuals must work together to create an environment that supports a healthy lifestyle.” The CDC, recognizing multifactorial causes of obesity, has published guides to community engagement strategies for the prevention of obesity, noting 24 strategies and recommendations for implementation. The health care education community has placed considerable effort into developing resources to guide health professionals in the prevention and treatment of obesity. A web search using the term “obesity guidelines” on the AHRQ National Guideline Clearinghouse search engine returned more than 200 guidelines from United States-based health care organizations.

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

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

MEDICAL STUDENT EDUCATION ON OBESITY

There are few data on the current state of obesity education in U.S. medical schools. A study conducted in 2012 by Vitolins et al. found only 11 publications pertinent to medical student obesity education, and only five of these included descriptions of interventions and evaluations of education effectiveness. A 2014 survey of medical schools by Adams et al. found that most did not provide nutrition education in the clinical portion of the curriculum, and concluded, “Many US medical schools still fail to prepare future physicians for everyday nutrition challenges in clinical practice. It cannot be a realistic expectation for physicians to effectively address obesity, diabetes, metabolic syndrome, hospital malnutrition, and many other conditions as long as they are not taught during medical school and residency training how to recognize and treat the nutritional root causes.” Beyond nutrition education, a literature review conducted by Dacey et al. found reports of 10 programs with physical activity counseling education that included evaluation of education effectiveness. In structured interviews of allopathic and osteopathic medical school faculty (n=171), Stoutenburg noted that 31 programs felt that they offered a sufficient level of “physical activity-related” training for their students to successfully counsel their patients in the future, but that counseling was not noted to be specific to obesity prevention or treatment.
The 2015-2016 Liaison Committee on Medical Education Part II Questionnaire, administered to all U.S. medical schools, asked respondents to “Indicate where in the curriculum the following subjects are covered during required experiences.” Of the 142 schools responding, 91 percent included obesity prevention education in pre-clerkship courses, 31 percent in pre-clerkship clinical experiences, 80 percent in the required clerkships, and 18 percent in didactic sessions outside specific clerkships in the clinical years. Obesity treatment was included in the curriculum by 83 percent in pre-clerkship courses, 30 percent in pre-clerkship clinical experiences, 83 percent in the required clerkships, and 19 percent in didactic sessions outside specific clerkships in the clinical years. Only five schools (four percent) indicated that obesity prevention and obesity treatment were not included in the curriculum. Details on curricular content—such as pedagogy, depth of coverage and methods of assessment—were not part of the survey. Of note, a number of studies have been published describing curricular offerings to address bias toward obese patients and bias recognition training for medical students. In addition, numerous sources note that medical school curricula often include the significance of obesity in the pathogenesis or confounding of common disease states, but it is not known if the same curricula offer any content on patient education, obesity prevention, or obesity treatment. Similarly, a recent analysis of questions from the United States Medical Licensing Examination (USMLE) found that a number of test items pertained to the diagnosis and management of obesity-related conditions, but the important concepts of obesity prevention and treatment were not represented on any of the three USMLE Step examinations.

KEY STAKEHOLDERS AND SELECTED RESOURCES FOR HEALTH CARE PROVIDERS

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

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

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

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

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

- The American College of Preventive Medicine makes resources available on its website, including an Adult Obesity Clinical Reference and an Adult Obesity Time Tool, to assist health professionals in developing efficient and effective strategies to address obesity concerns with their patients.
The American College of Sports Medicine offers a number of free online publications that address the prevention and management of obesity and obesity-related conditions.

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

The CDC provides a comprehensive website on “obesity and overweight,” with links to a number of topics.

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

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

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

**SUMMARY AND RECOMMENDATIONS**

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

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

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

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

Fiscal Note: $1,000
APPENDIX: RELEVANT AMA POLICY

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

D-440.954, “Addressing Obesity”
1. Our AMA will: (a) assume a leadership role in collaborating with other interested organizations, including national medical specialty societies, the American Public Health Association, the Center for Science in the Public Interest, and the AMA Alliance, to discuss ways to finance a comprehensive national program for the study, prevention, and treatment of obesity, as well as public health and medical programs that serve vulnerable populations; (b) encourage state medical societies to collaborate with interested state and local organizations to discuss ways to finance a comprehensive program for the study, prevention, and treatment of obesity, as well as public health and medical programs that serve vulnerable populations; and (c) continue to monitor and support state and national policies and regulations that encourage healthy lifestyles and promote obesity prevention.

2. Our AMA, consistent with H-440.842, Recognition of Obesity as a Disease, will work with national specialty and state medical societies to advocate for patient access to and physician payment for the full continuum of evidence-based obesity treatment modalities (such as behavioral, pharmaceutical, psychosocial, nutritional, and surgical interventions).

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

H-440-842, “Recognition of Obesity as a Disease”
Our AMA recognizes obesity as a disease state with multiple pathophysiological aspects requiring a range of interventions to advance obesity treatment and prevention.
H-150.953, “Obesity as a Major Public Health Problem”
Our AMA will: (1) urge physicians as well as managed care organizations and other third party
payers to recognize obesity as a complex disorder involving appetite regulation and energy
metabolism that is associated with a variety of comorbid conditions; (2) work with appropriate
federal agencies, medical specialty societies, and public health organizations to educate physicians
about the prevention and management of overweight and obesity in children and adults, including
education in basic principles and practices of physical activity and nutrition counseling; such
training should be included in undergraduate and graduate medical education and through
accredited continuing medical education programs; (3) urge federal support of research to
determine: (a) the causes and mechanisms of overweight and obesity, including biological, social,
and epidemiological influences on weight gain, weight loss, and weight maintenance; (b) the long-
term safety and efficacy of voluntary weight maintenance and weight loss practices and therapies,
including surgery; (c) effective interventions to prevent obesity in children and adults; and (d) the
effectiveness of weight loss counseling by physicians; (4) encourage national efforts to educate the
public about the health risks of being overweight and obese and provide information about how to
achieve and maintain a preferred healthy weight; (5) urge physicians to assess their patients for
overweight and obesity during routine medical examinations and discuss with at-risk patients the
health consequences of further weight gain; if treatment is indicated, physicians should encourage
and facilitate weight maintenance or reduction efforts in their patients or refer them to a physician
with special interest and expertise in the clinical management of obesity; (6) urge all physicians
and patients to maintain a desired weight and prevent inappropriate weight gain; (7) encourage
physicians to become knowledgeable of community resources and referral services that can assist
with the management of overweight and obese patients; and (8) urge the appropriate federal
agencies to work with organized medicine and the health insurance industry to develop coding and
payment mechanisms for the evaluation and management of obesity.
REFERENCES


16 Unpublished data. Liaison Committee on Medical Education, 2016.
17 Kushner RF et al. Obesity coverage on medical licensing examinations in the United States: what is being tested? Teaching and Learning in Medicine. Published online 12/19/16.1-6.


EXECUTIVE SUMMARY

This report is in response to Resolution 310-A-16, “Standardizing the Allopathic Residency Match System and Timeline,” which asks that the American Medical Association (AMA) support the movement toward a single United States residency match system and notification timeline for all non-military allopathic specialties, and work with the Association of University Professors in Ophthalmology, American Academy of Ophthalmology, Society of University Urologists, American Urological Association, and any other appropriate stakeholders to switch ophthalmology and urology to the National Resident Matching Program (NRMP).

The specialties of ophthalmology and urology have had their own match programs for many years, primarily because both specialties require a preliminary year of training (GY1). The matches occur earlier in the academic year than for specialties in the NRMP, which allows applicants successfully matched into GY2 positions to then attempt to match into GY1 positions in the NRMP. For some applicants, this system can be advantageous.

For example, successful applicants to early match programs will have resolved some or all of the guesswork involved in finding a GY1 position. Receiving interview offers for a GY2 position in a particular geographic area can help in application and interview strategies for a GY1 position, and once the match has occurred, the applicant can submit a tailored rank order list for the GY1 position. Potentially unsuccessful candidates who do not receive interview offers from early match programs will still have time to apply to programs in other specialties.

The limitations of the early match process, however, include additional planning, a drawn-out application and interview season, and substantial financial costs for the applicant (especially for ophthalmology applicants), without the advantages available through the NRMP. Since 1988 the NRMP has had the capability to match applicants simultaneously into GY1 and GY2 positions—the same process for many applicants to radiology programs that require a preliminary GY1 position. Furthermore, the NRMP allows two applicants to link their rank order lists in such a way as to maximize their opportunity to match into programs in the same geographic area—the so-called “couples match.” Neither of these more sophisticated matching processes is available in the early match programs. Finally, the NRMP offers far more detailed match analyses and statistics that can assist applicants and their advisors in crafting match strategy.

The two specialties that hold early matches are the primary beneficiaries of the current system. Ophthalmology and urology are able to control their own matches; peruse, interview, and claim future residents before other specialties; and earn income from the process. To unduly burden the approximately 1,100 applicants annually to these two specialties during the already stressful period of attempting to enter GME, without a commensurate benefit, seems unwarranted.

Accordingly, the Council’s recommendations include encouraging the specialty stakeholders to move their matches into the NRMP and encouraging the NRMP to consider developing sequential matches to accommodate specialties that require preliminary training.
Subject: Standardizing the Allopathic Residency Match System and Timeline
(Resolution 310-A-16)

Presented by: Patricia Turner, MD, Chair

Referred to: Reference Committee C (Kenneth M. Certa, MD, Chair)

INTRODUCTION

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

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

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

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

BACKGROUND

Currently, the vast majority of allopathic specialties use the application and matching services provided by the Electronic Residency Application Service (ERAS) and the NRMP. Urology and ophthalmology, however, do not, in part or wholly. In addition, the match process for these two

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specialties occurs earlier in the year than for the NRMP. (Note: While the resolution referred to an “allopathic” match system, all programs participating in the ophthalmology match, urology match, and the NRMP are accredited by the Accreditation Council for Graduate Medical Education [ACGME]. As osteopathic-focused programs become ACGME-accredited they will join these match systems.)

History and Process of the Ophthalmology Match

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

Scheduling. The CAS for the SF Match opens in June. The first week of September is considered a good target date for applicants to have completed their application and uploaded documents. Some international medical graduates and all graduates of Canadian medical schools have to mail some of their documentation. The CAS only allows three letters of recommendation, and all three are distributed to the programs that the applicant is applying to; specifically tailored letters to individual programs are not possible. Meanwhile, medical schools are responsible for uploading the Medical Student Performance Evaluation (MSPE) for U.S. seniors of osteopathic and allopathic medical schools. It may take up to two weeks for CAS to distribute complete applications to programs. In December, programs and applicants may begin submitting their ROLs; the deadline is the first week in January. The following week, match results are available to medical schools, programs, and applicants, and vacancies (unfilled positions) are posted on the SF Match website. In conjunction with the SF Match scheduling, an applicant interested in ophthalmology training must find a GY1 position, most likely through ERAS and the NRMP, with different calendars and deadlines, which are described later in this report.

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

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<thead>
<tr>
<th>Number of CAS Distributions</th>
<th>Fees</th>
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<tr>
<td>1 - 10</td>
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<tr>
<td>11 - 20</td>
<td>$10 per program</td>
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<tr>
<td>21 - 30</td>
<td>$15 per program</td>
</tr>
<tr>
<td>31 - 40</td>
<td>$20 per program</td>
</tr>
<tr>
<td>41 or more</td>
<td>$35 per program</td>
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Subsequent distributions of applications (after the initial distribution) cost $35 per program.
The registration fee for new ophthalmology programs is $325, which includes the membership fee for the current year. An annual membership fee for programs is $125, regardless of the number of positions the program offers.

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

History and Process of the Urology Match

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

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

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

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

ADVANTAGES OF SEPARATE AND COMBINED MATCHES

Advantages of a Separate Specialty Match System

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

The early match allows the two specialties to get an early view and pick of applicants who could
also be successful candidates for other specialties, particularly other surgical specialties. Owning
the process of the match can be financially remunerative as well, especially in the case of the SF
Match, as it runs its own application service. The AUPO owns the SF Match, which runs several
other matches as well, such as for plastic surgery (independent programs), and 23 fellowships.
Revenue generated for the AUPO from the SF Match in 2014 was $1.4 million. The
ophthalmology match is by far the biggest match for the SF Match. There were 726 CAS
registrants in the 2016 ophthalmology match. At the average number of 68 applications per
applicant, those fees would have generated close to $1.1 million.

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

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

Advantages of Moving to a Single Match

The primary impetus of the early match for ophthalmology and urology, as well as other specialties
that once had an early match (and do no longer), was the need to interview and match applicants
for their GY2 year. There was still time after the early match for the applicant who did not match
into one of these specialties to attempt to find a GY1 position in another specialty through the
NRMP. For the applicant who did match into one of these specialties, there was adequate time to
tailor an application for a GY1 position, apply through ERAS, and match into a GY1 position
through the NRMP.
In 1988, however, the NRMP began offering GY2 positions through its match, and in turn providing the opportunity for applicants to create a supplemental ROL to match into a GY1 position. For every program with GY2 positions that an applicant is interested in pursuing, the applicant can pair preferences for programs that have GY1 positions. Applicants thus have the possibility of simultaneously securing GY1 and GY2 positions. It is possible to match into a GY2 position and not the corresponding GY1 position, in which case the applicant needs to obtain a GY1 position in the Supplemental Offer and Acceptance Program (SOAP). The NRMP matching algorithm will not place an applicant in a GY1 position until the applicant has matched into a GY2 position.\(^9\)

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

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

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

In addition, the greater size and sophistication of the NRMP as a matching organization may protect it (and applicants) from error. In 2005, the Urology Match had to be re-run. Several programs found themselves unexpectedly unfilled. After review, it was found that one of the criteria in the match was not applied correctly, skewing the outcome; namely, the ROLs of program directors had been considered more heavily than the ROLs of applicants. ROLs of applicants were always to be prioritized over the ROLs of program directors. The match was run again, and four days later new results were announced. Upon further review, it was found that the misapplication of the matching algorithm was secondary to human error, coupled by a lack of review of the results. More safeguards were applied, and no problems have been reported since.\(^5\)

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

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

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

<table>
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<tr>
<th>Programs Per Specialty</th>
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<tbody>
<tr>
<td>Up to 10</td>
<td>$99</td>
</tr>
<tr>
<td>11 - 20</td>
<td>$12 each</td>
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<tr>
<td>21 - 30</td>
<td>$16 each</td>
</tr>
<tr>
<td>31 or more</td>
<td>$26 each</td>
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For the average applicant in the 2016 SF Match applying to 68 ophthalmology programs, the fees
paid to the SF Match would be $1,590 (match registration plus application distribution). If that
applicant then applied to 15 programs with GY1 preliminary positions (and not another specialty),
the ERAS fee would be $239 (application distribution plus USMLE transcript fee). Adding in the
NRMP fee of $75, the total paid for applying and matching for the average ophthalmology
applicant would be $1,904.

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

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

Aside from costs, convenience is another factor, not only for medical students but also for student
affairs deans and residency program directors and coordinators. The appendix shows a partial
timeline covering residency application dates and events for rising 4th year medical students at one
medical school. Not only are there additional deadlines and processes that early match students
must follow, their student affairs deans must also be aware of the same deadlines in their efforts to
keep their students on track. One calendar for all specialties would greatly lessen confusion and
anxiety.

PRECEDENT: SPECIALTIES THAT LEFT AN EARLY MATCH

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

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

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

CURRENT AMA POLICY

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

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

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

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

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

SUMMARY AND RECOMMENDATIONS

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

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

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

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

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

Fiscal Note: $1,000
## APPENDIX

<table>
<thead>
<tr>
<th>Year</th>
<th>Residency timeline for all rising 4th year students. <strong>Ophthalmology is bold.</strong> Urology is underlined.</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 15th</td>
<td>MyERAS site opens to applicants to register and begin working on their applications.</td>
</tr>
<tr>
<td>April-May</td>
<td><strong>Review SF Match site for general information about the early match process.</strong></td>
</tr>
</tbody>
</table>
| April-June | Urology Residency Match information is available online, [http://www.auanet.org](http://www.auanet.org)  
Investigate online sources for specialty and program information, requirements and deadlines |
| April-July | Begin submitting application for USMLE Step 2 CS & CK. Must have Step 2 CS completed by end of December; Step 2 CK by the end of January. Register early! Put final touches on CV and personal statement |
| April-Sept | Begin residency program applications. Note: Individual programs set the deadlines. You should contact programs directly for their deadlines. |
| April-Oct | Track LoRs through ERAS Applicant Document Tracking System |
| May-June | **Gather SF Match CAS materials (LoRs, transcript, personal statement, application, CV)** |
| June | Urology registration is available through the AUA site at [http://www.auanet.org/education/urology-and-specialty-matches.cfm](http://www.auanet.org/education/urology-and-specialty-matches.cfm)  
**Early match registration is available through the SF Match site at [http://www.SFMatch.org](http://www.SFMatch.org)** |
| July 1st | Applicants may start searching for and selecting programs in MyEras. |
| July 15th | ERAS PostOffice opens. Residency Programs can start receiving applications. |
| July 18th | **An overview of the application process for early match. This session is REQUIRED.** |
| August 8th | An overview of the application process for regular match. This session is REQUIRED. |
| Aug-Sept September | Early match students mock interviews  
Student review draft of MSPE (online) and review transcript  
Target date for ERAS applicants to register and have entered all MyERAS information. |
| Sept 1st | **CAS Target Date for Ophthalmology. Note: This is not a deadline. It’s the target date to have your application submitted for central distribution.** |
| Sept 3rd | NRMP registration and applicant user guide for the NRMP available at [http://www.nrmp.org](http://www.nrmp.org)  
**Note: Students going through early match and need to secure a GY1 position must register with the NRMP.** |
| Sept 12th | Transcripts will be loaded to ERAS. |
| September 15th | ERAS PostOffice opens. Applicants may begin applying to ACGME accredited residency programs. Programs may begin contacting the ERAS PostOffice to download your application. This is also a target date to submit your application Registration for NRMP opens |
| Oct-Jan | Interview at residency programs |
| Oct 1st | MSPE release date for ERAS and CAS |
| November | Begin submitting rank order lists for AUA (Urology) |
| Nov 30th | 11:59 PM Deadline to register for NRMP. Applicants who register after Nov 30th must pay an additional $50 late registration fee. |
| Dec-Jan | Early match students go over RoL with advisor SF Match applicants submit RoL |
| December | Complete Step 2 CK and CS |
| December 12th | Urology registration deadline |
| January 5th | Deadline for submitting rank order lists for AUA (Urology) |
| January 6th | Deadline for submitting rank order lists for Ophthalmology |
| January 13th | Match results for Ophthalmology made available |
| January 15th | Begin to enter rank order lists for NRMP |
| January 21st | Match results for Urology made available |
| February 25th | Deadline for registration and ROL certification. NRMP ROL must be certified by 8:00 PM CST. NRMP staff will be available to answer questions during the final hours. |
| March 16th | Unmatched information posted on the NRMP Web site at 11:00 AM CST. Individual counseling will be available for all unmatched students. |
| March 20th | Match Day! |
REFERENCES


18 Singer, HS. The child neurology match: where have we been and we are we going? Pediatric Neurology. 2014;50: 443-446.

Subject: Expansion of Public Service Loan Forgiveness

Presented by: Patricia Turner, MD, Chair

Referred to: Reference Committee C
(Kenneth M. Certa, MD, Chair)

INTRODUCTION

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

BACKGROUND

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

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

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

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

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

Qualifying employers include the following:

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

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

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

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

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

CONCERNS ABOUT THE PSLF

Challenges for Residents and Fellows

Graduating medical students may intend to participate in the PSLF while employed as a resident, but be unable to for several reasons. During the match process, medical students rank residency programs based on the quality of training they perceive they are likely to receive, among other variables. They may not be aware of or have access to information about the for-profit status of the entity that will pay their salary. Graduate medical education often takes place within complicated institutional arrangements of “sponsoring” and “participating” institutions. Even if residents and fellows rotate to several non-profit clinical sites, and funds are contributed to that salary by non-profit or government institutions, the institution writing the salary check may not be non-profit and thus not be a qualifying employer for the PSLF.

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

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

Unintended Consequences of Loan Forgiveness Programs

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

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

**Potential Costs to Taxpayers, Congressional Scrutiny, and Proposed Caps**

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

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

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

**POTENTIAL MODIFICATIONS TO PROTECT THE PSLF**

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

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

Other suggestions have focused on restricting loan reimbursement to those who practice in underserved areas (such as designated Health Professional Shortage Areas). This would allow physicians to practice in their area of interest without sacrificing the ability to participate in the PSLF, while still limiting reimbursement to those who are serving the nation’s health care needs.
One other potential solution would be to appoint a non-partisan independent authority to supervise
the program and its evolution, and provide course correction as necessary. A concern, however, is
that a physician (or teacher) could be at year eight of ten in non-profit service under current
conditions, only to have the authority change eligibility criteria and negate the previous years of
service. This could be easily avoided by simply having all “course corrections” take effect in the
future, allowing everyone who is grandfathered into the program to complete their payments and
receive their loan forgiveness, although such a delay would also render these course corrections
much less productive at reducing costs to taxpayers.

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

CURRENT AMA POLICY

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

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

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

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

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

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

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

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

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

3. That our AMA reaffirm Policy D-305.993 (1-9), which asks that the AMA advocate against a cap on federal loan forgiveness programs but also advocate that any cap on loan forgiveness under the PSLF program be at least equal to the principal amount borrowed. (Reaffirm HOD policy)

4. That our AMA advocate that the profit status of a physician's training institution not be a factor for PSLF eligibility. (Directive to Take Action)

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

6. That our AMA encourage medical school financial advisors to promote to medical students the Students to Service Loan Repayment Program of the National Health Service Corps (NHSC) as an attractive alternative to the PSLF in terms of financial prospects as well as providing the opportunity to provide care in medically underserved areas. (Directive to Take Action)

7. That our AMA strongly advocate that any restrictive changes to the PSLF take effect after all individuals currently within their PSLF eligibility period are “aged out” of the PSLF program under the conditions in place when they began their eligibility. (Directive to Take Action)

Fiscal note: $2,000
REFERENCES


REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 9-A-17

Subject: Feasibility and Appropriateness of Transferring Jurisdiction over Required Clinical Skills Examinations to LCME-Accredited and COCA-Accredited Medical Schools

Presented by: Patricia Turner, MD, Chair

Referred to: Reference Committee C
(Kenneth M. Certa, MD, Chair)

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

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

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

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BACKGROUND

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

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

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

<table>
<thead>
<tr>
<th>Examinees from US/Canadian Schools:</th>
<th>Number Tested</th>
<th>Percent Passing</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st Takers</td>
<td>19,906</td>
<td>97 percent</td>
</tr>
<tr>
<td>Repeaters*</td>
<td>716</td>
<td>85 percent</td>
</tr>
<tr>
<td>DO Degree</td>
<td>46</td>
<td>91 percent</td>
</tr>
<tr>
<td>1st Takers</td>
<td>46</td>
<td>91 percent</td>
</tr>
<tr>
<td>Repeaters*</td>
<td>0</td>
<td>N/A</td>
</tr>
<tr>
<td>Total</td>
<td>20,668</td>
<td>97 percent</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Examinees from Non-US/Canadian Schools:</th>
<th>Number Tested</th>
<th>Percent Passing</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st Takers</td>
<td>12,051</td>
<td>82 percent</td>
</tr>
<tr>
<td>Repeaters*</td>
<td>2,300</td>
<td>71 percent</td>
</tr>
<tr>
<td>Total</td>
<td>14,351</td>
<td>81 percent</td>
</tr>
</tbody>
</table>

* “Repeaters” represents examinations given, not number of examinees.

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

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

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

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

AMA WORK IN ADDRESSING THE NEW POLICY

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

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

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

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

SUMMARY AND RECOMMENDATIONS

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

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

   Assessment During Medical School D-295.988,” due to inadequate stakeholder support for
   transferring jurisdiction of clinical skills examinations to medical schools, unless and until a
   viable alternative can be identified. (Rescind HOD Policy)

2. That AMA Policy D-295.988 (3) be amended by addition and deletion to read as follows:
   “3. Our AMA will work to: (a) ensure rapid yet carefully considered changes to the current
   examination process to reduce costs, including travel expenses, as well as time away from
   educational pursuits, through immediate steps by the Federation of State Medical Boards and
   National Board of Medical Examiners; (b) encourage a significant and expeditious increase in
   the number of available testing sites; (c) allow international students and graduates to take the
   same examination at any available testing site; and (d) engage in a transparent evaluation of
   basing this examination within our nation's medical schools, rather than administered by an
   external organization; and (e) include active participation by faculty leaders and assessment
   experts from U.S. medical schools, as they work to develop new and improved methods of
   assessing medical student competence for advancement into residency.” (Modify Current HOD
   Policy)

3. That our AMA encourage development of a post-examination feedback system for all USMLE
   test-takers that would: (a) identify areas of satisfactory or better performance; (b) identify areas
   of suboptimal performance; and (c) give students who fail the exam insight into the areas of
   unsatisfactory performance on the examination. (New HOD Policy)
4. That our AMA, through the Council on Medical Education, continue to monitor relevant data and engage with stakeholders as necessary should updates to this policy become necessary. (New HOD Policy)

Fiscal note: $1,000
REFERENCES


5. Lindemann, J. Letter from the Liaison Committee on Medical Education to Susan Skochelak, MD, MPH, group vice president, medical education, American Medical Association. October 25, 2016.


Whereas, A 2007 study of state medical boards (SMB) in the Journal of Medical Licensing and Discipline found that 40% of physician license applications ask directly about mental illness, with 20% asking about impairment due to mental illness and 20% asking about diagnosis, treatment, admission to a treatment facility or a combination of these; and

Whereas, 37% of the SMBs that participated in the study stated that they have the ability to sanction physicians on the basis of information revealed about the presence of a psychiatric condition, rather than on the basis of impairment; and

Whereas, 37% of the SMBs that participated in the study also stated that they deal differently with physicians receiving psychiatric care versus medical care; and

Whereas, Often applications only require disclosure of physical health conditions only if it is likely to cause impairment; and

Whereas, Our AMA policy H-275.970 currently "encourages state licensing boards to require that, if an applicant has had psychiatric treatment, the physician who has provided the treatment submit to the board an official statement that the applicant’s current state of health does not interfere with his or her ability to practice medicine," but does not specify whether or not the applicant is actively impaired; and

Whereas, AMA Ethical Opinion E-9.3.1 on professional rights and responsibilities states that a physician is impaired when physical or mental health “reaches the point of interfering with a physician’s ability to engage safely in professional activities”; and

Whereas, AMA Policy H-275.945 encourages the American Board of Medical Specialties and the Federation of State Medical Boards to provide the rationale behind inquiries on personal information, such as mental health; and

Whereas, Physicians may be less likely to seek treatment for mental health impairment for fear of sanctions or repercussions from regulatory bodies; therefore be it

RESOLVED, That our American Medical Association encourage state medical boards to consider physical and mental conditions similarly (New HOD Policy); and be it further

References:
RESOLVED, That our AMA encourage state medical boards to recognize that the presence of a mental health condition does not equate with an impaired ability to practice medicine (New HOD Policy); and be it further

RESOLVED, That our AMA amend Policy H-275.970, “Licensure Confidentiality,” by addition and deletion to read as follows:

H-275.970, Licensure Confidentiality
The AMA (1) encourages specialty boards, hospitals, and other organizations involved in credentialing, as well as state licensing boards, to take all necessary steps to assure the confidentiality of information contained on application forms for credentials; (2) encourages boards to include in application forms only requests for information that can reasonably be related to medical practice; (3) encourages state licensing boards to exclude from license application forms information that refers to psychoanalysis, counseling, or psychotherapy required or undertaken as part of medical training; (4) encourages state medical societies and specialty societies to join with the AMA in efforts to change statutes and regulations to provide needed confidentiality for information collected by licensing boards; and (5) encourages state licensing boards to require disclosure of physical or mental health history by physician health programs or providers only if they believe the illness of the physician they are treating is likely to impair the physician's practice of medicine or presents a public health danger, that, if an applicant has had psychiatric treatment, the physician who has provided the treatment submit to the board an official statement that the applicant's current state of health does not interfere with his or her ability to practice medicine. (Modify Current HOD Policy); and be it further

RESOLVED, That our AMA encourage state medical societies to advocate that state medical boards not sanction physicians based solely on the presence of a psychiatric disease, irrespective of treatment or behavior. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 02/20/17

RELEVANT AMA POLICY

Mental Health Services for Medical Students and Resident and Fellow Physicians H-345.973
Our AMA promotes the availability of timely, confidential, accessible, and affordable medical and mental health services for medical students and resident and fellow physicians, to include needed diagnostic, preventive, and therapeutic services. Information on where and how to access these services should be readily available at all education/training sites, and these services should be provided at sites in reasonable proximity to the sites where the education/training takes place. (Res. 915, I-15; Revised: CME Rep. 01, I-16)

Access to Mental Health Services H-345.981
Our AMA advocates the following steps to remove barriers that keep Americans from seeking and obtaining treatment for mental illness:
(1) reducing the stigma of mental illness by dispelling myths and providing accurate knowledge to ensure a more informed public;
(2) improving public awareness of effective treatment for mental illness;
(3) ensuring the supply of psychiatrists and other well trained mental health professionals, especially in rural areas and those serving children and adolescents;
(4) tailoring diagnosis and treatment of mental illness to age, gender, race, culture and other characteristics that shape a person’s identity;
(5) facilitating entry into treatment by first-line contacts recognizing mental illness, and making proper referrals and/or to addressing problems effectively themselves; and
Reaffirmed: BOT action in response to referred for decision Res. 402, A-12; Reaffirmed in lieu of Res. 804, I-13; Reaffirmed in lieu of Res. 808, I-14)

**Physician Health and Wellness E 9.3.1**

To preserve the quality of their performance, physicians have a responsibility to maintain their health and wellness, construed broadly as preventing or treating acute or chronic diseases, including mental illness, disabilities, and occupational stress. When health or wellness is compromised, so may the safety and effectiveness of the medical care provided. When failing physical or mental health reaches the point of interfering with a physician’s ability to engage safely in professional activities, the physician is said to be impaired.

In addition to maintaining healthy lifestyle habits, every physician should have a personal physician whose objectivity is not compromised. Physicians whose health or wellness is compromised should take measures to mitigate the problem, seek appropriate help as necessary, and engage in an honest self-assessment of their ability to continue practicing.

Those physicians caring for colleagues should not disclose without the physician-patient’s consent any aspects of their medical care, except as required by law, by ethical and professional obligation (Opinion E-9.031), or when essential to protect patients from harm. Under such circumstances, only the minimum amount of information required by law or to preserve patient safety should be disclosed.

The medical profession has an obligation to ensure that its members are able to provide safe and effective care. This obligation is discharged by:

- promoting health and wellness among physicians;
- supporting peers in identifying physicians in need of help;
- intervening promptly when the health or wellness of a colleague appears to have become compromised, including the offer of encouragement, coverage or referral to a physician health program;
- establishing physician health programs that provide a supportive environment to maintain and restore health and wellness;
- establishing mechanisms to assure that impaired physicians promptly cease practice;
- assisting recovered colleagues when they resume patient care;
- reporting impaired physicians who continue to practice, despite reasonable offers of assistance, to appropriate bodies as required by law and/or ethical obligations. This may entail reporting to the licensing authority. (I, II)


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

The AMA will: (1) encourage the Federation of State Medical Boards and its constituent members to develop uniform definitions and nomenclature for use in licensing and disciplinary proceedings to better facilitate the sharing of information; (2) seek clarification of the application of the Americans with Disabilities Act to the actions of medical licensing and medical specialty boards; and (3) until the applicability and scope of the Americans with Disabilities Act are clarified, will encourage the American Board of Medical Specialties and the Federation of State Medical Boards and their constituent members to advise physicians of the rationale behind inquiries on mental illness, substance abuse or physical disabilities in materials used in the licensure, reregistration, and certification processes when such questions are asked. (BOT Rep. 1, I-933; CME Rep. 10 - I-94; Reaffirmed: CME Rep. 2, A-04; Reaffirmed: CME Rep. 2, A-14)

**Licensure Confidentiality H-275.970**

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

Whereas, Continuing medical education (CME) is an integral part of the practice of medicine, and CME is a requirement for licensure; and

Whereas, Many medical societies use complimentary CME for their members as a membership benefit; and

Whereas, The charge to provide CME as dictated by the ACCME has risen dramatically in the last four years, more than doubling in cost, and the medical societies have no option but to pass through the increased costs that are being charged for CME accreditation; and

Whereas, The complexity and difficulty in completing the CME process continues to increase, and component medical societies may not be able to continue to offer CME to their members; therefore be it

RESOLVED, That our American Medical Association do a comprehensive review of the continuing medical education (CME) process on a national level, with the goal of decreasing costs and simplifying the process of providing CME. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 04/25/17

The topic of this resolution is currently under study by the Council on Medical Education.

RELEVANT AMA POLICY

**Opposition to Increased CME Provider Fees D-300.980**

1. 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 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 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. 2. 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."
AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 303
(A-17)

Introduced by: Medical Student Section

Subject: Addressing Medical Student Mental Health Through Data Collection and Screening

Referred to: Reference Committee C
(Kenneth M. Certa, MD, Chair)

Whereas, Physicians suffer high rates of mental illness, especially depression, throughout their training and career, with up to 400 physicians committing suicide each year;1,2,3 and

Whereas, Studies report medical students and residents are at high risk for depression and suicidal thinking due to various factors associated with training including decreased sleep, relocation causing less social support, and feelings of isolation;1 and

Whereas, A large multi-institutional study indicated that about 10% of medical students experience suicidal ideation during medical school, and 50% experience burnout;4 and

Whereas, Barriers such as limited time to seek help, concerns regarding confidentiality, negative stigma associated with use of mental health services, lack of institutional and peer support, fear of repercussions related to licensure applications, and fear of documentation on academic record have prevented medical students from seeking help;5,6 and

Whereas, There is a dearth of data on medical student suicide in the United States;7 and

Whereas, Australia successfully conducted a National Mental Health Survey of Doctors and Medical Students to better understand issues associated with the mental health of this population and increase awareness across the medical profession and broader community of these issues;8 and

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7 Rubin R. Recent suicides highlight need to address depression in medical students and residents. JAMA 2014;312(17):1725–1727.
8 Haikerwal M. National Mental Health Survey Of Doctors and Medical Students. beyondblue; 2013:78–104.
Whereas, The University of California, San Diego School of Medicine has successfully installed a program aimed at reducing suicides, beginning with gathering data on suicides and suicide risk factors within its ranks;\textsuperscript{9,10} 

Whereas, Anonymously screening medical students for depression and suicidal ideations can promote awareness on the prevalence of mental health issues in medical students;\textsuperscript{9,10} and 

Whereas, Collection of information on medical student depression and/or suicide can aid in the identification and development of more effective interventions to address these issues;\textsuperscript{10} and 

Whereas, Screening programs with the goal of identifying depression and/or suicide can help to de-stigmatize help-seeking and offer an avenue for initiating needed counseling and mental health treatment;\textsuperscript{9,10} and 

Whereas, Existing AMA policy encourages the development of methods to address mental health among medical students and supports making these methods available to students at the earliest possible point in medical education (H-295.999); therefore be it 

RESOLVED, That our American Medical Association encourage study of medical student mental health, including but not limited to rates and risk factors of depression and suicide (New HOD Policy); and be it further 

RESOLVED, That our AMA encourage medical schools to confidentially gather and release information regarding reporting rates of depression/suicide on an opt-out basis from its students. (New HOD Policy) 

Fiscal Note: Minimal – less than $1,000 

Received: 04/28/17 

**RELEVANT AMA POLICY:** 
Depression and Physician Licensure D-275.974 
Increasing Detection of Mental Illness and Encouraging Education D-345.994 
Educating Physicians About Physician Health Programs D-405.990 
Self-Incriminating Questions on Applications for Licensure and Specialty Boards H-275.945 
Medical Student Support Groups H-295.999 
Expansion of Student Health Services H-295.872 
Mental Health Services for Medical Students and Resident and Fellow Physicians H-345.973
Whereas, Programs authorized under Title IV of the Higher Education Act are the major source of federal student aid and include Federal Family Education Loans, Direct Loans, and Federal Perkins Loans;¹ and

Whereas, In order for a foreign medical school to be eligible for Title IV funding, no more than 40% of its enrollees and graduates may be United States citizens or permanent residents, and at least 75% of its students and graduates who took examinations administered by the Educational Commission for Foreign Medical Graduates must have received a passing score in the preceding year;² and

Whereas, Five foreign medical programs, (American University of the Caribbean School of Medicine, Ross University School of Medicine, St. George’s School of Medicine, Saba University School of Medicine, and Universidad Iberoamericana) are exempt from Title IV funding requirements regarding the citizenship and examination pass rates of their students because they were grandfathered under a clause of 20 U.S.C. §1002;²,³ and

Whereas, Subclauses 1002(a)(2)(A)(i)(II)(aa & bb) of 20 U.S.C. §1002 specify that an American student attending a foreign medical institution is eligible for federal student loans if the institution “has or had a clinical training program approved by a State as of Jan. 1992”, and “continues to operate that program that is approved by the State”;³ and

Reference Committee C  
(Kenneth M. Certa, MD, Chair)
 Whereas, In the 2011-2012 year, students at three of the exempted schools accepted a total of about $470 million in U.S. government loans; and 

 Whereas, The mean Title IV loan debt incurred by U.S. students who completed medical school in 2015 was $274,985 for American University of the Caribbean School of Medicine, $252,320 for Ross University School of Medicine, and $242,261 for St. George’s School of Medicine; and 

 Whereas, The bipartisan, bicameral Foreign Medical School Accountability Fairness Act was proposed to eliminate the grandfather provisions that currently exempt these foreign medical schools from the requirements of 20 U.S.C. §1002(a)(2) (A)(i)(I), to “establish consistent eligibility requirements for graduate medical schools operating outside of the United States and Canada in order to increase accountability and protect American students and taxpayer dollars”; and 

 Whereas, The Foreign Medical School Accountability Fairness Act had support from many medical organizations, including the Associated Medical Schools of New York, the American Osteopathic Association, the American Association of Colleges of Osteopathic Medicine, and the medical school deans of more than 60 U.S. medical schools; therefore be it 

 RESOLVED, That our American Medical Association support the application of the existing requirements for foreign medical schools seeking Title IV Funding to those schools which are currently exempt from these requirements, thus creating equal standards for all foreign medical schools seeking Title IV Funding. (New HOD Policy)

 Fiscal note: Minimal – less than $1,000

 Received: 04/28/17

 RELEVANT AMA POLICY:

 Graduates of Foreign Health Professional Schools H-255.985
 AMA Principles on International Medical Graduates H-255.988
 Foreign Medical Graduates H-255.998

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Whereas, A 2015 study by the Pew Research Center estimates 40.4 million Americans are 1 caregivers to adults 65 years old or older and 23% of these caregivers are between the ages of 2 45 and 64; and

Whereas, A 2015 study by the AARP Public Policy Institute estimates 34.2 million Americans 3 have provided unpaid care to an adult age 50 years or older in the prior 12 months; and 4

Whereas, Sixty percent (60%) of caregivers are women; and 5

Whereas, Higher rates of depression and anxiety in women may be associated with gender- 6 based roles, stressors, and negative life experiences and events; and 7

Whereas, The 2015 AARP study notes that caregivers spend on average 24.4 hours per week 8 providing unpaid in-home care and 1 in 4 caregivers provide 41 or more hours of care each 9 week; and 10

Whereas, The 2015 AARP study notes the majority of caregivers (58%) provide high or medium 11 burden care [involving activities of daily living (ADL) or instrumental activities of daily living 12 (IADL) situations]2; and 13

Whereas, The 2015 AARP study further notes 57% of caregivers assist with “medical/nursing” 14 tasks such as injections, tube feedings, and catheter and colostomy care2; and 15

Whereas, The 2015 AARP study suggests roughly half (47%) of caregivers report moderate to 16 high physical strain, 63% of caregivers report high to moderate stress, and 38% report high to 17 moderate financial strain2; and 18

Whereas, “Caregiver burnout” is defined as a state of physical, emotional, and/or mental 19 exhaustion that can creative negative and unconcerned caregiver attitudes which can occur 20 when caregivers feel unsupported, confused, out of control, or required to meet unreasonable 21 demands3,4,5; and 22

Whereas, “Caregiver burnout” can create symptoms of stress and depression in the caregiver 23 and negatively affect both the caregiver and the care recipient5; therefore be it 24

RESOLVED, That our American Medical Association encourage partner organizations to 25 develop resources to better prepare caregivers in performing medical/nursing tasks (New HOD 26 Policy); and be it further
RESOLVED, That our AMA create an online educational module to promote physician understanding of caregiver burnout and develop strategies to support caregivers and their patients. (Directive to Take Action)

Fiscal Note: Estimate cost between $15,000 - $25,000 to implement resolution.

Received: 04/27/17

RELEVANT AMA POLICY:
Physicians and Family Caregivers - A Model for Partnership H-210.986
Our AMA (1) encourages residency review committees and residency program directors to consider physician needs for training in evaluation of caregivers. Emphasis at both the undergraduate and graduate level is needed on the development of the physician's interpersonal skills to better facilitate assessment and management of caregiver stress and burden; (2) supports health policies that facilitate and encourage home health care. Current regulatory and financing mechanisms favor institutionalization, often penalizing families attempting to provide lower cost, higher quality-of-life care; (3) reaffirms support for reimbursement for physician time spent in education and counseling of caregivers and/or home care personnel involved in patient care; and (4) supports research that identifies the types of education and support services that most effectively enhance the activities and reduce the burdens of caregivers. Further research is also needed on the role of physicians and others in supporting the family caregiver. (CSA Rep. I, I-91 Reaffirmed: Sunset Report, I-01 Reaffirmed: CSAPH Rep. 1, A-11)

Physicians and Family Caregivers: Shared Responsibility H-210.980
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 Reaffirmed: CME Rep. 2, A-12)

References:
Introduced by: International Medical Graduates Section
Subject: U.S. International Medical Graduates in Physician Workforce
Referred to: Reference Committee C
(Kenneth M. Certa, MD, Chair)

Whereas, There are hundreds of U.S. citizens that attend offshore medical schools each year; and

Whereas, In 2017 53% of U.S. IMGs matched and 46.1% of U.S. IMGs did not match in the National Residency Matching program;¹ and

Whereas, It is estimated that medical students spend over $800,000 to graduate from medical school, which includes lost opportunities costs;²,³ and

Whereas, It is estimated that half of those medical students may not match into a residency program;³ and

Whereas, Concerns have been raised about the quality of medical education, clinical rotations, and their accreditation requirements; and

Whereas, The challenges of U.S. IMGs impact the quality of health care provided to citizens in the U.S.; and

Whereas, 56.7% of U.S. IMGs choose a primary care specialty and fill in the gaps in the physician workforce;⁴ therefore, be it

RESOLVED, That the American Medical Association work with the Educational Commission on Foreign Medical Graduates (ECFMG) to study the personal and financial consequences of ECFMG-certified U.S. IMGs who do not match in the National Residency Matching Program (NRMP) and are therefore unable to get a residency or practice medicine. (Directive to Take Action)

Fiscal Note: Not yet determined

Received: 04/28/17

References
¹²National Residency Matching Program; http://www.nrmp.org
²³American Association of Medical Colleges; http://www.aamc.org.
RELEVANT AMA POLICY

Foreign Medical Graduates H-255.987
1. Our AMA supports continued efforts to protect the rights and privileges of all physicians duly licensed in the US regardless of ethnic or educational background and opposes any legislative efforts to discriminate against duly licensed physicians on the basis of ethnic or educational background.
2. Our AMA will: (a) continuously study challenges and issues pertinent to IMGs as they affect our country's health care system and our physician workforce; and (b) lobby members of the US Congress to fund studies through appropriate agencies, such as the Department of Health and Human Services, to examine issues and experiences of IMGs and make recommendations for improvements.


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

Whereas, Current training curriculums for physicians are designed to ensure the development of clinical skills necessary to become competent practitioners, yet there is no clearly defined process to encourage and sustain business and practice management skills essential to successful practice across the continuum of medical school, residency, fellowship and independent practice; and

Whereas, Appropriate business skills and knowledge in conjunction with effective leadership are vital to creation and maintenance of an optimal environment for providing high-quality patient care; and

Whereas, Physicians who acquire insufficient understanding and knowledge of business and practice management skills within the clinical, operational and financial spheres of practice may face greater challenges in navigating the ever-changing United States healthcare environment and in maintaining high standards of care while minimizing healthcare disparities; therefore be it

RESOLVED, That our American Medical Association encourage the Liaison Committee for Medical Education (LCME), the Accreditation Council for Graduate Medical Education (ACGME), Association of American Medical Colleges (AAMC) and other entities responsible for medical education to advocate for and support the creation of a more standardized process and approach for training and education in business and practice management skills for medical practitioners across the continuum of medical school, residency, fellowship and independent practice (Directive to Take Action); and be it further

RESOLVED, That our AMA encourage LCME, ACGME, AAMC and other entities responsible for the education of future physicians, to provide educational resources and programs on business administration and practice management in their medical education curriculum. (Directive to Take Action)

Fiscal Note: Minimal – less than $1,000

Received: 04/28/17
References:

RELEVANT AMA POLICY

AMA Mission and Vision G-625.010
Mission: To promote the art and science of medicine and the betterment of public health.
Core Values: (1) Leadership; (2) Excellence; and (3) Integrity and Ethical Behavior.
Vision: To be an essential part of the professional life of every physician.

AMA Sponsored Leadership Training for Hospital Medical Staff Officers and Committee Chairs H-225.972
It is the policy of the AMA (1) to offer, both regionally and locally, extensive training and skill development for emerging medical staff leaders to assure that they can effectively perform the duties and responsibilities associated with medical staff self-governance; and (2) that training and skill development programs for medical staff leaders be as financially self-supporting as feasible.

See also:
Management and Leadership for Physicians D-295.316
Initiative to Transform Medical Education: Strategies for Medical Education Reform H-295.871
Physician Employment Trends and Principles H-225.947
Physicians’ Ability to Negotiate and Undergo Practice Consolidation H-383.988
Practice Options and Skills Curriculum for Residents H-310.953
Physician Managers H-405.990
AMERICAN MEDICAL ASSOCIATION HOUSE OF DElegates

Resolution: 308
(A-17)

Introduced by: American College of Cardiology
American Society of Echocardiography
Heart Rhythm Society
Society of Cardiovascular Angiography and Interventions

Subject: Immigration Reform Impacts on International Medical Graduate Training and Patient Access

Referred to: Reference Committee C
(Kenneth M. Certa, MD, Chair)

Whereas, AAMC’s most recent data show that 30% of all US cardiologists are international medical graduates; and

Whereas, 43% of current cardiac electrophysiology fellows are international medical graduates; and

Whereas, A significant portion of residency training spots are filled by international medical graduates; and

Whereas, Many underserved patients are cared for by international medical graduates who obtain a Fast Track H-1B Visa after residency via the Conrad 30 J-1 visa waiver program; and

Whereas, 10500 physicians were employed by H-1B visas nationwide, with many more trainees receiving J visas¹; and

Whereas, Recent proposed changes to visa issuances, visa acceptances, have had impact on trainees and their program directors’ planning; and

Whereas, Recent proposed changes to the H-1B program will impact residency slots, and patients’ access to timely medical care; and

Whereas, Existing AMA policy D-255.991, Visa Complications for IMGs in GME states that, Our AMA will: (A) work with the ECFMG to minimize delays in the visa process for International Medical Graduates applying for visas to enter the US for postgraduate medical training and/or medical practice; (B) promote regular communication between the Department of Homeland Security and AMA IMG representatives to address and discuss existing and evolving issues related to the immigration and registration process required for International Medical Graduates; and (C) work through the appropriate channels to assist residency program directors, as a group or individually, to establish effective contacts with the State Department and the Department of Homeland Security, in order to prioritize and expedite the necessary procedures for qualified residency applicants to reduce the uncertainty associated with considering a non-citizen or permanent resident IMG for a residency position; therefore be it

RESOLVED, That our American Medical Association advocate for the timely processing of visas for physicians to fill residency and fellowship training spots (New HOD Policy); and be it further
RESOLVED, That our AMA study the current impact of immigration reform efforts on residency and fellowship training programs, physician supply, and timely access of patients to healthcare throughout the US (Directive to Take Action); and be it further

RESOLVED, That our AMA report back to the House of Delegates by the 2017 Interim Meeting such study findings, including appropriate proposals to advocate on behalf of international medical graduate physicians and their patients. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 05/01/17

1 Kahn PA, Gardin TM. Distribution of Physicians With H-1B Visas By State and Sponsoring Employer. JAMA. Published online April 17, 2017. doi:10.1001/jama.2017.4877

RELEVANT AMA POLICY

Visa Complications for IMGs in GME D-255.991
1. Our AMA will: (A) work with the ECFMG to minimize delays in the visa process for International Medical Graduates applying for visas to enter the US for postgraduate medical training and/or medical practice; (B) promote regular communication between the Department of Homeland Security and AMA IMG representatives to address and discuss existing and evolving issues related to the immigration and registration process required for International Medical Graduates; and (C) work through the appropriate channels to assist residency program directors, as a group or individually, to establish effective contacts with the State Department and the Department of Homeland Security, in order to prioritize and expedite the necessary procedures for qualified residency applicants to reduce the uncertainty associated with considering a non-citizen or permanent resident IMG for a residency position.

2. Our AMA International Medical Graduates Section will continue to monitor any H-1B visa denials as they relate to IMGs? inability to complete accredited GME programs.

3. Our AMA will study, in collaboration with the Educational Commission on Foreign Medical Graduates and the Accreditation Council for Graduate Medical Education, the frequency of such J-1 Visa reentry denials and its impact on patient care and residency training.

4. Our AMA will, in collaboration with other stakeholders, advocate for unfettered travel for IMGs for the duration of their legal stay in the US in order to complete their residency or fellowship training to prevent disruption of patient care.

Whereas, Our AMA “endorses the concept of a single examination for medical licensure” (AMA Policy H-275.962); and

Whereas, In 2014, our AMA asked “the appropriate stakeholders to track USMLE Step 1 Exam timing and subsequently publish aggregate data to determine the significance of advanced clinical experience on Step 1 Exam performance” (D-275.958); and

Whereas, At least eleven United States medical schools now allow or instruct their students to take the USMLE Step 1 exam following one or more clinical clerkships;¹⁻¹² and

Whereas, Students at some medical schools using accelerated preclinical foundational science curriculum models are taking the USMLE Step 1 and Step 2 Clinical Knowledge examinations in close proximity; and

Whereas, Our AMA has asked the ACGME that its “General Requirements state clearly that residency program directors must not use NBME or USMLE ranked passing scores as a screening criterion for residency selection” (H-275.953), and the AMA “urges that USMLE scores not be used as the sole criteria for selecting interns and residents” (H-255.980); and

Whereas, The primary purpose of the USMLE exam is initial medical licensure and primary users of scores are state licensing boards, but secondary users of numerical scores include residency programs (for applicant assessment) and medical schools;\textsuperscript{13,14} and

Whereas, In the 2014 NRMP Program Director (PD) Survey, 94\% of program directors among all specialties (n=1793) cited USMLE Step 1 scores as a factor in selecting applicants for interviews, and 80\% (n=1799) cited Step 1 scores as a factor in ranking applicants;\textsuperscript{15} and

Whereas, According to the 2016 AAMC Residency PD Survey, 75\% of responding PDs “use filters or minimum thresholds when selecting applicants to interview (e.g., USMLE Step 1 scores, state residency; n = 1,453)”\textsuperscript{16} and

Whereas, The 2014 NRMP Residency PD Survey reports Step 1 numerical scores below which PDs do not generally interview applicants (e.g., all specialties combined inter-quartile range (IQR) = 200-220 [n=989], plastic surgery IQR 221-239 [n=21]);\textsuperscript{15} and

Whereas, While numerical USMLE scores are perceived as an objective way to screen applicants for interviews, “reliance on such scores may be having negative consequences on curricular innovation and student well-being” according to the deans of the Icahn School of Medicine at Mount Sinai;\textsuperscript{17} and

Whereas, Though the data is mixed, several studies have shown that Step 1 scores are poorly predictive of success in graduate medical education programs;\textsuperscript{18,19,20} and

Whereas, According to a 2011 research synthesis published in Academic Medicine, ”using USMLE Step 1 and 2 scores for postgraduate residency selection decisions is neither structured, coherent, nor evidence based,” and “the scores are not associated with measures of clinical skill acquisition among advanced medical students, residents, and…fellows”;\textsuperscript{20} and

Whereas, The comprehensive review by the Committee to Evaluate the USMLE Program completed in 2008 did not provide a recommendation on score reporting, because “it believed that the implications of its other recommendations, in terms of design and structure, need to be further defined before USMLE would be in a position to consider this reporting issue”,\textsuperscript{13} therefore be it

RESOLVED, That our American Medical Association work with the appropriate stakeholders to investigate the advantages, disadvantages, and practicality of combining the USMLE Step 1 and Step 2 CK exams into a single licensure exam measuring both foundational science and clinical knowledge competencies (Directive to Take Action); and be it further

\textsuperscript{17} Gliatto P, Leitman IM, Muller D. Scylla and Charybdis: The MCAT, USMLE, and Degrees of Freedom in Undergraduate Medical Education. Acad Med 2016 [Epub ahead of print].
RESOLVED, That our AMA work with the appropriate stakeholders to study alternate means of scoring USMLE exams. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Date Received: 05/02/17

RELEVANT AMA POLICY:

Proposed Single Examination for Licensure H-275.962 – Our AMA: (1) endorses the concept of a single examination for medical licensure; (2) urges the NBME and the FSMB to place responsibility for developing Steps I and II of the new single examination for licensure with the faculty of U.S. medical schools working through the NBME; (3) continues its vigorous support of the LCME and its accreditation of medical schools and supports monitoring the impact of a single examination on the effectiveness of the LCME; (4) urges the NBME and the FSMB to establish a high standard for passing the examination; and (5) strongly recommends and supports actively pursuing efforts to assure that the standard for passing be criterion-based; that is, that passing the examination indicate a degree of knowledge acceptable for practicing medicine. CME Rep. B, I-89; Reaffirmed: Sunset Report, A-00; Modified: CME Rep. 2, A-10; Reaffirmed: BOT Rep. 3, I-14

The Grading Policy for Medical Licensure Examinations H-275.953 – 1) The AMA's representatives to the ACGME are instructed to promote the principle that selection of residents should be based on a broad variety of evaluative criteria, and to propose that the ACGME General Requirements state clearly that residency program directors must not use NBME or USMLE ranked passing scores as a screening criterion for residency selection. (2) The AMA adopts the following policy on NBME or USMLE examination scoring: (a) Students receive "pass/fail" scores as soon as they are available. (If students fail the examinations, they may request their numerical scores immediately.) (b) Numerical scores are reported to the state licensing authorities upon request by the applicant for licensure. At this time, the applicant may request a copy of his or her numerical scores. (c) Scores are reported in pass/fail format for each student to the medical school. The school also receives a frequency distribution of numerical scores for the aggregate of their students. CME Rep. G, I-90; Reaffirmed by Res. 310, A-98; Reaffirmed: CME Rep. 3, A-04; Reaffirmed: CME Rep. 2, A-14

Foreign Medical Graduate Examination in Medical Sciences Scores not Sole Criteria for Residency Selection H-255.980 – The AMA (1) urges that the United States Medical Licensing Examination (USMLE) scores not be used as the sole criteria for selecting interns and residents; and (2) recommends that residency programs consider all of the candidates' attributes and qualifications during the selection process. (3) Our AMA re-affirms policy that residency appointments should be made solely on the basis of the individual applicant's merit and qualifications. Res. 143, A-90; Appended Res. 303, I-98; Modified and Reaffirmed: CME Rep. 2, A-08

Changing the Grading Policy for Medical Licensure Examinations H-275.957 – Our AMA is concerned about the potential for inappropriate use of numerical scores of licensing examinations, particularly as a significant criterion in appointment to residency training programs. Past studies show some residency programs inappropriately use USMLE examination scores in screening their applicants. Our AMA supports the development of mechanisms to ensure confidentiality of the results of licensure exams, and that these results are used only in an appropriate fashion. BOT Rep. GGG, A-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CME Rep. 2, A-10

USMLE Step 1 Timing D-275.958 – Our AMA will ask the appropriate stakeholders to track United States Medical Licensing Examination (USMLE) Step 1 Exam timing and subsequently publish aggregate data to determine the significance of advanced clinical experience on Step 1 Exam performance. (Res. 911, I-14)

See also:
Independent Regulation of Physician Licensing Exams D-295.939
Discouraging the Use of Licensing Exams for Internal Promotion in Medical Schools H-275.958
Reevaluation of Residency Selection Process H-310.982
Whereas, 47% of medical students, 46% of residents, and 38% of full time faculty are women;¹
and

Whereas, Exclusively breastfeeding is recommended for the first six months of life followed by
continued breastfeeding with appropriate foods for up to two;²,³ and

Whereas, Pumping is recommended every three to four hours during the time that the mother
and infant are apart;⁴ and

Whereas, Prolonging the interval between pumping and/or feeding results in engorgement of
the breasts, which can be very painful and distract the examinee from performing appropriately
on the examination; and

Whereas, Wisconsin State Statute Sec. 253.165 states that “A mother may breastfeed in any
private or public location where the mother and child are authorized to be. In such a location, no
person may prohibit a mother from breastfeeding her child, direct a mother to cover her child or
breast while breastfeeding, or otherwise restrict a mother from breastfeeding;”⁵ and

Whereas, Infants that are bottle fed over breast-fed have higher chances of infectious morbidity.
This includes increased risk of otitis media, hospitalization due to lower respiratory infection,
gastroenteritis, diarrhea, necrotizing enterocolitis, obesity, type II diabetes, and infant mortality;⁶
and

Whereas, The Massachusetts Supreme Judicial Court Case Currier vs National Board of
Medical Examiners ruled that Currier was to be provided with adequate breast pumping
conditions, including a private room with an outlet and an additional 60 minutes of break time,
during her licensing exam;⁷ therefore be it

RESOLVED, That our American Medical Association encourage that the accommodation of
breastfeeding individuals in all medical licensing exams in all specialties be allowed if the
individual can provide a note from their physician (New HOD Policy); and be it further

RESOLVED, That our AMA encourage that accommodations include necessary time per exam
day in addition to the standard pool of scheduled break time found in the specific exam as well
as access to a private, non-bathroom location on the testing center site with an electrical outlet
for individuals to breast pump. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000
Received: 05/02/17
References:
7 Sophie C. Currier vs National Board of Medical Examiners, No. 07-J-434 (Mass. 2007).

RELEVANT AMA POLICY

Support for Breastfeeding H-245.982
1. Our AMA: (a) recognizes that breastfeeding is the optimal form of nutrition for most infants; (b) endorses the 2012 policy statement of American Academy of Pediatrics on Breastfeeding and the use of Human Milk, which delineates various ways in which physicians and hospitals can promote, protect, and support breastfeeding practices; (c) supports working with other interested organizations in actively seeking to promote increased breastfeeding by Supplemental Nutrition Program for Women, Infants, and Children (WIC Program) recipients, without reduction in other benefits; (d) supports the availability and appropriate use of breast pumps as a cost-effective tool to promote breast feeding; and (e) encourages public facilities to provide designated areas for breastfeeding and breast pumping; mothers nursing babies should not be singled out and discouraged from nursing their infants in public places.
2. Our AMA: (a) promotes education on breastfeeding in undergraduate, graduate, and continuing medical education curricula; (b) encourages all medical schools and graduate medical education programs to support all residents, medical students and faculty who provide breast milk for their infants, including appropriate time and facilities to express and store breast milk during the working day; (c) encourages the education of patients during prenatal care on the benefits of breastfeeding; (d) supports breastfeeding in the health care system by encouraging hospitals to provide written breastfeeding policy that is communicated to health care staff; (e) encourages hospitals to train staff in the skills needed to implement written breastfeeding policy, to educate pregnant women about the benefits and management of breastfeeding, to attempt early initiation of breastfeeding, to practice “rooming-in,” to educate mothers on how to breastfeed and maintain lactation, and to foster breastfeeding support groups and services; (f) supports curtailing formula promotional practices by encouraging perinatal care providers and hospitals to ensure that physicians or other appropriately trained medical personnel authorize distribution of infant formula as a medical sample only after appropriate infant feeding education, to specifically include education of parents about the medical benefits of breastfeeding and encouragement of its practice, and education of parents about formula and bottle-feeding options; and (g) supports the concept that the parent's decision to use infant formula, as well as the choice of which formula, should be preceded by consultation with a physician.
3. Our AMA: (a) supports the implementation of the WHO/UNICEF Ten Steps to Successful Breastfeeding at all birthing facilities; (b) endorses implementation of the Joint Commission Perinatal Care Core Measures Set for Exclusive Breast Milk Feeding for all maternity care facilities in the US as measures of breastfeeding initiation, exclusivity and continuation which should be continuously tracked by the nation, and social and demographic disparities should be addressed and eliminated; (c) recommends exclusive breastfeeding for about six months, followed by continued breastfeeding as complementary food are introduced, with continuation of breastfeeding for 1 year or longer as mutually desired by mother and infant; (d) recommends the adoption of employer programs which support breastfeeding mothers so that they may safely and privately express breast milk at work or take time to feed their infants; and (e) encourages employers in all fields of healthcare to serve as role models to improve the public health by supporting mothers providing breast milk to their infants beyond the postpartum period.
4. Our AMA supports the evaluation and grading of primary care interventions to support breastfeeding, as developed by the United States Preventive Services Task Force (USPSTF).

Burdensome Paperwork for Breast Pumps H-185.928
Our AMA will vigorously oppose unnecessary and burdensome paperwork which presents barriers to lactation support, such as prescriptions to support physiologic functions; and further, to ensure that The Joint Commission and Healthy People 2020 breastfeeding goals are met. (Res. 825, I-15)
AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 311
(A-17)

Introduced by: Wisconsin

Subject: Support of International Medical Students and Graduates

Referred to: Reference Committee C
(Kenneth M. Certa, MD, Chair)

Whereas, International medical graduates (IMGs) comprise 26% of physicians in practice and 24% of residents in specialty programs;¹ and

Whereas, IMGs receive certification from the Education Commission for Foreign Medical Graduates in order to qualify for U.S. medical education admission;² and

Whereas, In addition to certification from the Education Commission for Foreign Medical Graduates, IMGs must also abide by state-specific requirements published by the Federation of State Medical Boards to qualify for U.S. residency programs;³ and

Whereas, According to the Association of American Medical Colleges (AAMC), out of the total 88,304 students who are enrolled in medical schools for the 2016-2017 academic year, 1,375 of those students are non-U.S. citizens or are non-permanent U.S. residents;³ and

Whereas, For most minority subgroups, the number of students enrolled in medical schools continually falls short of what the expected number of students would be based upon the demographics of the population surrounding the schools, showing a lack of diversity in medical students;⁴ and

Whereas, The AAMC believes that diversity in healthcare is a critical driver on the path to ensure equitable healthcare for all because minority students choose to serve underserved populations more so than students from other backgrounds;⁵ and

Whereas, Foreign-born physicians will help increase the cultural competency of hospitals and clinics through better communication with non-English speaking patients in addition to being more sensitive to culturally-based medical decisions, which can improve patient satisfaction and positively affect patient outcomes;⁶ and

Whereas, The care provided to patients by IMGs is equal to that of U.S. medical school graduates. When comparing IMGs to U.S. graduates, there is no statistical significance between patient mortality and the length of hospital stay for patients being treated for congestive heart failure and acute myocardial infarction;⁷ and

Whereas, It is estimated that there will be a physician shortage of 125,000 by 2025, and that primary care will experience the largest decline;⁸ and

Whereas, IMGs are more likely to practice in primary care shortage areas outside metropolitan statistical areas (67.8%) than U.S. medical graduates (39.8%);⁹ and

Whereas, Many IMGs entered the U.S. on temporary visas that allowed them residence permitting that they work in an underserved area for three years following residency;⁸ and
Whereas, The Conrad visa program for non-U.S. citizen international medical graduates has

directed almost 10,000 physicians into practice in rural and underserved communities across
the U.S., including in Wisconsin communities;9 and

Whereas, The number of IMGs on these visas declined by 47% as use of less-restrictive
temporary specialized worker visas increased and the decreasing number of IMGs has
decreased access to care in underserved areas;10 and

Whereas, The federal government, through presidential executive order on January 27, 2017,
issued an order banning nationals of seven countries from entering the United States for at least
the following 90 days and has also called for a review into suspending the Visa Interview Waiver
Program, which allows travelers from 38 countries to renew travel authorizations without an in-
person interview;11 and

Whereas, This executive order has created hardships for international medical graduates with
temporary or permanent visas who need to travel outside of the U.S. and has prevented the
return of travelling international medical graduates to the U.S. to continue residency/fellowship
training, and thus negatively impacted the ability of healthcare systems to provide patient care
without any identified safety risk to the U.S. public;12 and

Whereas, The Association of American Medical Colleges (AAMC) has reported that 260 IMGs
have applied for U.S. medical residency from the seven nations impacted by the order’s 90-day
ban and that uncertainty regarding this order is impacting the selection and ranking of these
IMGs into the match;13 and

Whereas, Many physician professional organizations including the American College of
Physicians14 and the American Academy of Family Physicians,15 and the AAMC9 have decried
the executive order’s impact on and offered support for IMGs and prospective medical students;
therefore be it

RESOLVED, That our American Medical Association recognize the unique contributions and
affirm our support of international medical students and international medical graduates and
their participation in U.S. medical schools, residency and fellowship training programs and in the
practice of medicine (New HOD Policy); and be it further

RESOLVED, That our AMA oppose changes to immigration policies for international and
foreign-born medical graduates and students that use country of origin to restrict visa
procurement and ability to travel outside of the U.S. and return with a visa. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Received: 05/02/17

References:
2 Residency Application Requirements for International Medical Graduates. American Academy of Family Physicians.
4 Smith, Mark M. et al. 15 May 2015. Diversity of United States medical students by region compared to US census data. US
5 Kirch M.D., Darell. 2014. Reflections on Diversity and Inclusion in Academic Medicine: Commemorating Dr. Herbert W. Nickens’
Legacy. Association of American Medical Colleges.
Our AMA supports:

1. Current U.S. visa and immigration requirements applicable to foreign national physicians who are graduates of medical schools other than those in the United States and Canada.

2. Current regulations governing the issuance of exchange visitor visas to foreign national IMGs, including the requirements for successful completion of the USMLE.

3. The AMA reaffirms its policy that the U.S. and Canada medical schools be accredited by a nongovernmental accrediting body.

4. Cooperation in the collection and analysis of information on medical schools in nations other than the U.S. and Canada.

5. Continued cooperation with the ECFMG and other appropriate organizations to disseminate information to prospective and current students in foreign medical schools. An AMA member, who is an IMG, should be appointed regularly as one of the AMA's representatives to the ECFMG Board of Trustees.

6. The core clinical curriculum of a foreign medical school should be provided by that school; U.S. hospitals should not provide substitute core clinical experience for students attending a foreign medical school.

7. Working with the Accreditation Council for Graduate Medical Education (ACGME) and the Federation of State Medical Boards (FSMB) to assure that institutions offering accredited residencies, residency program directors, and U.S. licensing authorities do not deviate from established standards when evaluating graduates of foreign medical schools.

8. In cooperation with the ACGME and the FSMB, supports only those modifications in established graduate medical education or licensing standards designed to enhance the quality of medical education and patient care.

9. The AMA continues to support the activities of the ECFMG related to verification of education credentials and testing of IMGs.

10. That special consideration be given to the limited number of IMGs who are refugees from foreign governments that refuse to provide pertinent information usually required to establish eligibility for residency training or licensure.

11. That accreditation standards enhance the quality of patient care and medical education and not be used for purposes of regulating physician manpower.

12. That AMA representatives to the ACGME, residency review committees and to the ECFMG should support AMA policy opposing discrimination. Medical school admissions officers and directors of residency programs should select applicants on the basis of merit, without considering status as an IMG or an ethnic name as a negative factor.

13. The requirement that all medical school graduates complete at least one year of graduate medical education in an accredited U.S. program in order to qualify for full and unrestricted licensure.

14. Publicizing existing policy concerning the granting of staff and clinical privileges in hospitals and other health facilities.

15. The participation of all physicians, including graduates of foreign as well as U.S. and Canadian medical schools, in organized medicine. The AMA offers encouragement and assistance to state, county, and specialty medical societies in fostering greater membership among IMGs and their participation in leadership positions at all levels of organized medicine, including AMA committees and councils and state boards of medicine, by providing guidelines and non-financial incentives, such as recognition for outstanding achievements by either individuals or organizations in promoting leadership among IMGs.

### RELEVANTAMA POLICY

AMA Principles on International Medical Graduates H-255.988

Our AMA supports:

1. Current U.S. visa and immigration requirements applicable to foreign national physicians who are graduates of medical schools other than those in the United States and Canada.

2. Current regulations governing the issuance of exchange visitor visas to foreign national IMGs, including the requirements for successful completion of the USMLE.

3. The AMA reaffirms its policy that the U.S. and Canada medical schools be accredited by a nongovernmental accrediting body.

4. Cooperation in the collection and analysis of information on medical schools in nations other than the U.S. and Canada.

5. Continued cooperation with the ECFMG and other appropriate organizations to disseminate information to prospective and current students in foreign medical schools. An AMA member, who is an IMG, should be appointed regularly as one of the AMA's representatives to the ECFMG Board of Trustees.

6. The core clinical curriculum of a foreign medical school should be provided by that school; U.S. hospitals should not provide substitute core clinical experience for students attending a foreign medical school.

7. Working with the Accreditation Council for Graduate Medical Education (ACGME) and the Federation of State Medical Boards (FSMB) to assure that institutions offering accredited residencies, residency program directors, and U.S. licensing authorities do not deviate from established standards when evaluating graduates of foreign medical schools.

8. In cooperation with the ACGME and the FSMB, supports only those modifications in established graduate medical education or licensing standards designed to enhance the quality of medical education and patient care.

9. The AMA continues to support the activities of the ECFMG related to verification of education credentials and testing of IMGs.

10. That special consideration be given to the limited number of IMGs who are refugees from foreign governments that refuse to provide pertinent information usually required to establish eligibility for residency training or licensure.

11. That accreditation standards enhance the quality of patient care and medical education and not be used for purposes of regulating physician manpower.

12. That AMA representatives to the ACGME, residency review committees and to the ECFMG should support AMA policy opposing discrimination. Medical school admissions officers and directors of residency programs should select applicants on the basis of merit, without considering status as an IMG or an ethnic name as a negative factor.

13. The requirement that all medical school graduates complete at least one year of graduate medical education in an accredited U.S. program in order to qualify for full and unrestricted licensure.

14. Publicizing existing policy concerning the granting of staff and clinical privileges in hospitals and other health facilities.

15. The participation of all physicians, including graduates of foreign as well as U.S. and Canadian medical schools, in organized medicine. The AMA offers encouragement and assistance to state, county, and specialty medical societies in fostering greater membership among IMGs and their participation in leadership positions at all levels of organized medicine, including AMA committees and councils and state boards of medicine, by providing guidelines and non-financial incentives, such as recognition for outstanding achievements by either individuals or organizations in promoting leadership among IMGs.
16. Support studying the feasibility of conducting peer-to-peer membership recruitment efforts aimed at IMGs who are not AMA members.

17. AMA membership outreach to IMGs, to include a) using its existing publications to highlight policies and activities of interest to IMGs, stressing the common concerns of all physicians; b) publicizing its many relevant resources to all physicians, especially to nonmember IMGs; c) identifying and publicizing AMA resources to respond to inquiries from IMGs; and d) expansion of its efforts to prepare and disseminate information about requirements for admission to accredited residency programs, the availability of positions, and the problems of becoming licensed and entering full and unrestricted medical practice in the U.S. that face IMGs. This information should be addressed to college students, high school and college advisors, and students in foreign medical schools.

18. Recognition of the common aims and goals of all physicians, particularly those practicing in the U.S., and support for including all physicians who are permanent residents of the U.S. in the mainstream of American medicine.

19. Its leadership role to promote the international exchange of medical knowledge as well as cultural understanding between the U.S. and other nations.

20. Institutions that sponsor exchange visitor programs in medical education, clinical medicine and public health to tailor programs for the individual visiting scholar that will meet the needs of the scholar, the institution, and the nation to which he will return.

21. Informing foreign national IMGs that the availability of training and practice opportunities in the U.S. is limited by the availability of fiscal and human resources to maintain the quality of medical education and patient care in the U.S., and that those IMGs who plan to return to their country of origin have the opportunity to obtain GME in the United States.

22. U.S. medical schools offering admission with advanced standing, within the capabilities determined by each institution, to international medical students who satisfy the requirements of the institution for matriculation.

23. Providing U.S. students who are considering attendance at an international medical school with information enabling them to assess the difficulties and consequences associated with matriculation in a foreign medical school.

24. The Federation of State Medical Boards, its member boards, and the ECFMG in their willingness to adjust their administrative procedures in processing IMG applications so that original documents do not have to be recertified in home countries when physicians apply for licenses in a second state.

See also:

Employment of Non-Certified IMGs H-255.970
Foreign Medical Graduates H-255.998
Visa Complications for IMGs in GME D-255.991
Conrad 30 - J-1 Visa Waivers D-255.985
Enhancing the Cultural Competence of Physicians H-295.897
Whereas, On January 27, 2017, President Trump signed Executive Order 13769, which banned citizens/nationals of seven Middle Eastern countries from entering the United States; and

Whereas, The aforementioned executive order prevented many of our colleagues from returning to the United States to practice; and

Whereas, The order was issued in the middle of residency application season after most interviews were complete, ruining the chances of many international medical graduates from entering residencies and fellowships for the foreseeable future and potentially resulting in unfilled residency spots which will decrease the quality of care for our patients; and

Whereas, According to studies performed by the Association of American Medical Colleges (AAMC) there is currently a shortage of physicians in America, which will likely be worsened if fewer IMGs are allowed to immigrate to the USA; and

Whereas, Several other medical societies including the American College of Physicians and AAMC have come out in opposition to Executive Order 13769; and

Whereas, On March 6, 2017, President Trump rescinded Executive Order 13769, and replaced it with Executive Order 13780, which still bans the issuance of new visas for citizens/nationals of six Middle Eastern countries; therefore be it

RESOLVED, That our American Medical Association oppose laws and regulations that would broadly deny entry or re-entry to the United States of persons who currently have legal visas, including permanent resident status (green card) and student visas, based on their country of origin and/or religion (New HOD Policy); and be it further

RESOLVED, That our AMA oppose policies that would broadly deny issuance of legal visas to persons based on their country of origin and/or religion. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Received: 05/01/17
Whereas, The total number of US medical school matriculates has increased by 27% between
2002 and 2016 (4,537 more students), Native American medical school matriculates declined
from 156 in 2002 to 142 in 2016;¹ and

Whereas, The AMA House of Delegates has 552 delegates and 552 alternate delegates, or
1104 people, which is 8 times more than Native American medical student matriculates this
year; and

Whereas, A 2016 Government Accounting Office reported cited that the Indian Health Service
has a 20% vacancy rate for physicians, which is contributing to critical wait times;² and

Whereas, AMA policy supports increasing diversity in the physician workforce, including “broad-
based efforts that involve partners within and beyond the medical profession and medical
education community” (D-200.985); and

RESOLVED, That our American Medical Association partner with key stakeholders (including
but not limited to the Association of American Medical Colleges, Association of American Indian
Physicians, Association of Native American Medical Students, We Are Healers, and the Indian
Health Service) to study and report back by July 2018 on why enrollment in medical school for
Native Americans is declining in spite of an overall substantial increase in medical school
enrollment, and lastly to propose remedies to solve the problems identified in the AMA study.

(Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 05/03/17

References:
RELEVANT AMA POLICY

Strategies for Enhancing Diversity in the Physician Workforce D-200.985

1. Our AMA, independently and in collaboration with other groups such as the Association of American Medical Colleges (AAMC), will actively work and advocate for funding at the federal and state levels and in the private sector to support the following: a. Pipeline programs to prepare and motivate members of underrepresented groups to enter medical school; b. Diversity or minority affairs offices at medical schools; c. Financial aid programs for students from groups that are underrepresented in medicine; and d. Financial support programs to recruit and develop faculty members from underrepresented groups. 2. Our AMA will work to obtain full restoration and protection of federal Title VII funding, and similar state funding programs, for the Centers of Excellence Program, Health Careers Opportunity Program, Area Health Education Centers, and other programs that support physician training, recruitment, and retention in geographically-underserved areas. 3. Our AMA will take a leadership role in efforts to enhance diversity in the physician workforce, including engaging in broad-based efforts that involve partners within and beyond the medical profession and medical education community. 4. Our AMA will encourage the Liaison Committee on Medical Education to assure that medical schools demonstrate compliance with its requirements for a diverse student body and faculty. CME Rep. 1, I-06 Reaffirmation I-10 Reaffirmation A-13 Modified: CCB/CLRDPD Rep. 2, A-14 Reaffirmation: A-16
Whereas, Our AMA Minority Affairs Section (MAS) membership is composed of physicians and medical students dedicated to addressing the issues and concerns of underrepresented minority (URM) physicians and improving the health of minority populations¹; and 
  Whereas, AMA-MAS provides a national forum for advocacy on minority health issues and professional concerns of minority physicians and medical students²; and 
  Whereas, There are health benefits of having physicians from diverse backgrounds³; and 
  Whereas, The Association of American Medical Colleges reports that U.S. physician workforce diversity remains constant with prior years with approximately 8.9 percent of physicians identifying as black or African-American, American Indian or Alaska Native, and Hispanic or Latino, which is not consistent with the nation’s demographic shift⁴; therefore be it 

RESOLVED, That our American Medical Association develop an internal education program for its members on the issues and possibilities involved in creating a diverse physician population (Directive to Take Action); and be it further 

RESOLVED, That our AMA provide on-line educational materials for its membership that address cultural, racial and religious issues in patient care (Directive to Take Action); and 

RESOLVED, That our AMA create and support programs that introduce elementary through high school students, especially those from under-represented minority groups, to healthcare careers (Directive to Take Action); and be it further 

RESOLVED, That our AMA create and support pipeline programs and encourage support services for URM college students that will support them as they move through college, medical school and residency programs (Directive to Take Action); and be it further 

RESOLVED, That our AMA recommend that medical school admissions committees use holistic evaluation of admission applicants, taking into account the diversity of preparation and the variety of talents that applicants bring to their education (New HOD Policy); and be it further 

RESOLVED, That our AMA advocate for the tracking and reporting to interested stakeholders of demographic information pertaining to race and ethnicity collected from Electronic Residency Application Service (ERAS) applications through the National Residency Matching Program (NRMP) (New HOD Policy); and be it further
RESOLVED, That our AMA continue the research, advocacy, collaborative partnerships and other work that was initiated by the Commission to End Health Care Disparities. 3 (Directive to Take Action)

2. Ibid.

Fiscal Note: Not yet determined

Received: 05/03/17

RELEVANT AMA POLICY

Strategies for Enhancing Diversity in the Physician Workforce D-200.985
1. Our AMA, independently and in collaboration with other groups such as the Association of American Medical Colleges (AAMC), will actively work and advocate for funding at the federal and state levels and in the private sector to support the following: a. Pipeline programs to prepare and motivate members of underrepresented groups to enter medical school; b. Diversity or minority affairs offices at medical schools; c. Financial aid programs for students from groups that are underrepresented in medicine; and d. Financial support programs to recruit and develop faculty members from underrepresented groups. 2. Our AMA will work to obtain full restoration and protection of federal Title VII funding, and similar state funding programs, for the Centers of Excellence Program, Health Careers Opportunity Program, Area Health Education Centers, and other programs that support physician training, recruitment, and retention in geographically-underserved areas. 3. Our AMA will take a leadership role in efforts to enhance diversity in the physician workforce, including engaging in broad-based efforts that involve partners within and beyond the medical profession and medical education community. 4. Our AMA will encourage the Liaison Committee on Medical Education to assure that medical schools demonstrate compliance with its requirements for a diverse student body and faculty. CME Rep. 1, I-06 Reaffirmation I-10 Reaffirmation A-13 Modified: CCB/CLRPD Rep. 2, A-14 Reaffirmation: A-16

Increase the Representation of Minority and Economically Disadvantaged Populations in the Medical Profession H-350.979
Our AMA supports increasing the representation of minorities in the physician population by: (1) Supporting efforts to increase the applicant pool of qualified minority students by: (a) Encouraging state and local governments to make quality elementary and secondary education opportunities available to all; (b) Urging medical schools to strengthen or initiate programs that offer special premedical and precollegiate experiences to underrepresented minority students; (c) Urging medical schools and other health training institutions to develop new and innovative measures to recruit underrepresented minority students, and (d) Supporting legislation that provides targeted financial aid to financially disadvantaged students at both the collegiate and medical school levels. (2) Encouraging all medical schools to reaffirm the goal of increasing representation of underrepresented minorities in their student bodies and faculties. (3) Urging medical school admission committees to consider minority representation as one factor in reaching their decisions. (4) Increasing the supply of minority health professionals. (5) Continuing its efforts to increase the proportion of minorities in medical schools and medical school faculty. (6) Facilitating communication between medical school admission committees and premedical counselors concerning the relative importance of requirements, including grade point average and Medical College Aptitude Test scores. (7) Continuing to urge for state legislation that will provide funds for medical education both directly to medical schools and indirectly through financial support to students. (8) Continuing to provide strong support for federal legislation that provides financial assistance for able students whose financial need is such that otherwise they would be unable to attend medical school. CLRPD Rep. 3, I-98 Reaffirmed: CLRPD Rep. 1, A-08
Whereas, One in six children aged 3 through 17 years have one or more Developmental Disabilities (DD). DD’s are a group of conditions due to an impairment in physical, learning, language, or behavior areas and include intellectual disability, autism spectrum disorder, hearing loss, cerebral palsy, learning disability, ADHD, vision impairment, and other developmental delays. These conditions occur among all racial, ethnic, and socioeconomic groups and become manifest during the early developmental period, typically impact day-to-day functioning, and usually last throughout a person’s lifetime; and

Whereas, Individuals with DD are living well into adult life, with approximately 5 million of the US population living with a DD and about one in ten US families directly affected by a person living with a DD and the great majority of individuals with DD across the age span receive their health care in integrated community and primary care settings rather than specialized centers; and

Whereas, Numerous areas of disparity in both health and health care access have been identified for this population, such as:

- vision and hearing impairments, as well as common dental disease, often undiagnosed;
- incomplete immunizations;
- prevalence of obesity and cardiac disorders;
- respiratory disorders as a common cause of death;
- sexuality-related health concerns;
- frequency of musculoskeletal disorders, as well as endocrine disorders;
- needs for screening for cancer; and
- prevalence of co-morbid behavioral conditions and psychiatric/psychotic disorders; and

Whereas, The vast majority of medical students and residents do not receive training specific to the care of people living with DD; therefore be it

RESOLVED, That our American Medical Association reaffirm AMA Policies H-90.968, “Medical Care of Persons with Developmental Disabilities,” and H-90.969, “Early Intervention for Individuals with Developmental Delay” (Reaffirm HOD Policy); and be it further

RESOLVED, That our AMA recognize the importance of managing the health of children and adults with developmental disabilities as a part of overall patient care for the entire community (New HOD Policy); and be it further
RESOLVED, That our AMA support efforts to educate physicians on health management of children and adults with developmental disabilities, as well as the consequences of poor health management on mental and physical health for people with developmental disabilities (New HOD Policy); and be it further

RESOLVED, That our AMA encourage allopathic and osteopathic medical schools to develop and implement curriculum on the care and treatment of people with developmental disabilities (New HOD Policy); and be it further

RESOLVED, That our AMA encourage graduate medical education programs to develop and implement curriculum on providing appropriate and comprehensive health care to people with developmental disabilities (New HOD Policy); and be it further

RESOLVED, That our AMA encourage continuing medical education providers to develop and implement continuing education programs that focus on the care and treatment of people with developmental disabilities. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Received: 05/03/17

References:

Medical Care of Persons with Developmental Disabilities H-90.968
1. Our AMA encourages: (A) clinicians to learn and appreciate variable presentations of complex functioning profiles in all persons with developmental disabilities; (B) medical schools and graduate medical education programs to acknowledge the benefits of education on how aspects in the social model of disability (e.g. ableism) can impact the physical and mental health of persons with Developmental Disabilities; (C) medical schools and graduate medical education programs to acknowledge the benefits of teaching about the nuances of uneven skill sets, often found in the functioning profiles of persons with developmental disabilities, to improve quality in clinical care; (D) the education of physicians on how to provide and/or advocate for quality, developmentally appropriate medical, social and living supports for patients with developmental disabilities so as to improve health outcomes; (E) medical schools and residency programs to encourage faculty and trainees to appreciate the opportunities for exploring diagnostic and therapeutic challenges while also accruing significant personal rewards when delivering care with professionalism to persons with profound developmental disabilities and multiple co-morbid medical conditions in any setting; (F) medical schools and graduate medical education programs to establish and encourage enrollment in elective rotations for medical students and residents at health care facilities specializing in care for the developmentally disabled; and (G) cooperation among physicians, health & human services professionals, and a wide variety of adults with developmental disabilities to implement priorities and quality improvements for the care of persons with developmental disabilities.
2. Our AMA seeks: (A) legislation to increase the funds available for training physicians in the care of individuals with intellectual disabilities/developmentally disabled individuals, and to increase the reimbursement for the health care of these individuals; and (B) insurance industry and government reimbursement that reflects the true cost of health care of individuals with intellectual disabilities/developmentally disabled individuals.

3. Our AMA entreats health care professionals, parents and others participating in decision-making to be guided by the following principles: (A) All people with developmental disabilities, regardless of the degree of their disability, should have access to appropriate and affordable medical and dental care throughout their lives; and (B) An individual's medical condition and welfare must be the basis of any medical decision. Our AMA advocates for the highest quality medical care for persons with profound developmental disabilities; encourages support for health care facilities whose primary mission is to meet the health care needs of persons with profound developmental disabilities; and informs physicians that when they are presented with an opportunity to care for patients with profound developmental disabilities, that there are resources available to them.

4. Our AMA will continue to work with medical schools and their accrediting/licensing bodies to encourage disability related competencies/objectives in medical school curricula so that medical professionals are able to effectively communicate with patients and colleagues with disabilities, and are able to provide the most clinically competent and compassionate care for patients with disabilities.


**Early Intervention for Individuals with Developmental Delay H-90.969**

(1) Our AMA will continue to work with appropriate medical specialty societies to educate and enable physicians to identify children with developmental delay, autism and other developmental disabilities, and to urge physicians to assist parents in obtaining access to appropriate individualized early intervention services. (2) Our AMA supports a simplified process across appropriate government agencies to designate individuals with intellectual disabilities as a medically underserved population.

CCB/CLRPD Rep. 3, A-14
Whereas, The AMA has established Policy D-275.954 which asks the American Board of Medical Specialties (ABMS) to ensure that all ABMS member boards provide full transparency related to the costs of preparing, administering, scoring, and reporting maintenance of certification (MOC) and certifying examinations, and this policy also calls on the AMA to continue to monitor the evolution of MOC, continue its active engagement in discussions regarding their implementation, encourage specialty boards to investigate and/or establish alternative approaches for MOC and prepare a yearly report to the AMA HOD regarding the MOC process; and

Whereas, Hospitals, health care insurers, and at least one state board for medical licensure are using participation in ABMS sponsored MOC programs featuring interval, high stakes examinations as a condition for credentialing including for physicians previously “grandfathered in” with “permanent specialty boards”; and

Whereas, The ABMS response to the AMA request for improvements in the MOC process to work toward the elimination of lifelong interval, high stakes testing in favor of lifelong learning featuring high quality continuing medical education course work as determined by the physician’s specialty society in review of that physicians established medical practice was inadequate and unsatisfactory; therefore be it

RESOLVED, That our American Medical Association affirm that lifelong learning is a fundamental obligation of our profession (Directive to Take Action); and be it further

RESOLVED, That our AMA recognize that lifelong learning for a medical physician is best achieved by ongoing participation in a program of high quality continuing medical education (CME) course appropriate to that physician’s medical practice as determined by the relevant specialty society (Directive to Take Action); and be it further

RESOLVED, That our AMA develop model state legislation that would bar hospitals, health care insurers, and the state medical licensing board from using non-participation in the ABMS sponsored MOC process using lifelong, interval, high stakes testing as a exclusionary criteria for credentialing (Directive to Take Action); and be it further
RESOLVED, That our AMA join with state medical associations and specialty societies in directly lobbying state medical licensing boards, hospital associations, and health care insurers to adopt policy supporting the use of satisfactory demonstration of lifelong learning with high quality CME as specified by a physician’s specialty society for credentialing and bar these entities from using the ABMS sponsored MOC process using lifelong interval high stakes testing for credentialing (Directive to Take Action); and be it further

RESOLVED, That our AMA partner with state medical associations and specialty societies to undertake a study with the goal of establishing a program that will certify physicians as satisfying the requirements for continuation of their specialty certification by successful demonstration of lifelong learning utilizing high quality CME appropriate for that physician’s medical practice as determined by their specialty society with a target start date of 2020 or before, with report back biannually to the HOD and AMA members. (Directive to Take Action)

Fiscal Note: Not yet determined

Received: 05/03/17

The topic of this resolution is currently under study by the Council on Medical Education.

RELEVANT AMA POLICY

Maintenance of Certification and Osteopathic Continuous Certification D-275.954
Our AMA will:
1. Continue to monitor the evolution of Maintenance of Certification (MOC) and Osteopathic Continuous Certification (OCC), continue its active engagement in discussions regarding their implementation, encourage specialty boards to investigate and/or establish alternative approaches for MOC, and prepare a yearly report to the House of Delegates regarding the MOC and OCC process.
2. Continue to review, through its Council on Medical Education, published literature and emerging data as part of the Council's ongoing efforts to critically review MOC and OCC issues.
3. Continue to monitor the progress by the American Board of Medical Specialties (ABMS) and its member boards on implementation of MOC, and encourage the ABMS to report its research findings on the issues surrounding certification and MOC on a periodic basis.
4. Encourage the ABMS and its member boards to continue to explore other ways to measure the ability of physicians to access and apply knowledge to care for patients, and to continue to examine the evidence supporting the value of specialty board certification and MOC.
5. Work with the ABMS to streamline and improve the Cognitive Expertise (Part III) component of MOC, including the exploration of alternative formats, in ways that effectively evaluate acquisition of new knowledge while reducing or eliminating the burden of a high-stakes examination.
6. Work with interested parties to ensure that MOC uses more than one pathway to assess accurately the competence of practicing physicians, to monitor for exam relevance and to ensure that MOC does not lead to unintended economic hardship such as hospital de-credentialing of practicing physicians.
7. Recommend that the ABMS not introduce additional assessment modalities that have not been validated to show improvement in physician performance and/or patient safety.
8. Work with the ABMS to eliminate practice performance assessment modules, as currently written, from MOC requirements.
9. Encourage the ABMS to ensure that all ABMS member boards provide full transparency related to the costs of preparing, administering, scoring and reporting MOC and certifying examinations.
10. Encourage the ABMS to ensure that MOC and certifying examinations do not result in substantial financial gain to ABMS member boards, and advocate that the ABMS develop fiduciary standards for its member boards that are consistent with this principle.

11. Work with the ABMS to lessen the burden of MOC on physicians with multiple board certifications, particularly to ensure that MOC is specifically relevant to the physician's current practice.

12. Work with key stakeholders to (a) support ongoing ABMS member board efforts to allow multiple and diverse physician educational and quality improvement activities to qualify for MOC; (b) support ABMS member board activities in facilitating the use of MOC quality improvement activities to count for other accountability requirements or programs, such as pay for quality/performance or PQRS reimbursement; (c) encourage ABMS member boards to enhance the consistency of quality improvement programs across all boards; and (d) work with specialty societies and ABMS member boards to develop tools and services that help physicians meet MOC requirements.

13. Work with the ABMS and its member boards to collect data on why physicians choose to maintain or discontinue their board certification.

14. Work with the ABMS to study whether MOC is an important factor in a physician's decision to retire and to determine its impact on the US physician workforce.

15. Encourage the ABMS to use data from MOC to track whether physicians are maintaining certification and share this data with the AMA.

16. Encourage AMA members to be proactive in shaping MOC and OCC by seeking leadership positions on the ABMS member boards, American Osteopathic Association (AOA) specialty certifying boards, and MOC Committees.

17. Continue to monitor the actions of professional societies regarding recommendations for modification of MOC.

18. Encourage medical specialty societies' leadership to work with the ABMS, and its member boards, to identify those specialty organizations that have developed an appropriate and relevant MOC process for its members.

19. Continue to work with the ABMS to ensure that physicians are clearly informed of the MOC requirements for their specific board and the timelines for accomplishing those requirements.

20. Encourage the ABMS and its member boards to develop a system to actively alert physicians of the due dates of the multi-stage requirements of continuous professional development and performance in practice, thereby assisting them with maintaining their board certification.

21. Recommend to the ABMS that all physician members of those boards governing the MOC process be required to participate in MOC.

22. Continue to participate in the National Alliance for Physician Competence forums.

23. Encourage the PCPI Foundation, the ABMS, and the Council of Medical Specialty Societies to work together toward utilizing Consortium performance measures in Part IV of MOC.

24. Continue to assist physicians in practice performance improvement.

25. Encourage all specialty societies to grant certified CME credit for activities that they offer to fulfill requirements of their respective specialty board's MOC and associated processes.

26. Support the American College of Physicians as well as other professional societies in their efforts to work with the American Board of Internal Medicine (ABIM) to improve the MOC program.

27. Oppose those maintenance of certification programs administered by the specialty boards of the ABMS, or of any other similar physician certifying organization, which do not appropriately adhere to the principles codified as AMA Policy on Maintenance of Certification.

28. Examine the activities that medical specialty organizations have underway to review alternative pathways for board recertification; and determine if there is a need to establish criteria and construct a tool to evaluate if alternative methods for board recertification are equivalent to established pathways.
29. Ask the ABMS to encourage its member boards to review their maintenance of certification policies regarding the requirements for maintaining underlying primary or initial specialty board certification in addition to subspecialty board certification, if they have not yet done so, to allow physicians the option to focus on maintenance of certification activities relevant to their practice.

30. Call for the immediate end of any mandatory, secured recertifying examination by the ABMS or other certifying organizations as part of the recertification process for all those specialties that still require a secure, high-stakes recertification examination.

31. Support a recertification process based on high quality, appropriate Continuing Medical Education (CME) material directed by the AMA recognized specialty societies covering the physician's practice area, in cooperation with other willing stakeholders, that would be completed on a regular basis as determined by the individual medical specialty, to ensure lifelong learning.

32. Continue to work with the ABMS to encourage the development by and the sharing between specialty boards of alternative ways to assess medical knowledge other than by a secure high stakes exam.

33. Continue to support the requirement of CME and ongoing, quality assessments of physicians, where such CME is proven to be cost-effective and shown by evidence to improve quality of care for patients.

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

35. Increase its efforts to work with the insurance industry to ensure that maintenance of certification does not become a requirement for insurance panel participation.
Whereas, The recent Immigration Executive Order temporarily banning immigration from six countries has created chaos, fear and uncertainty among physicians and their patients; and

Whereas, This threatens the free exchange of medical ideas, experience and perspectives; and

Whereas, International Medical Graduates have a crucial impact on internal medicine, making up more than 50 percent of the residency slots in 2016, filling gaps through care provided to underserved residents and veterans and serving as faculty in top internal medicine programs across the US; and

Whereas, Twenty-four percent of all practicing physicians in the US in 2015 were international medical graduates; and

Whereas, Restrictions on immigration for physicians would adversely affect patient care in the US for years to come; and

Whereas, Over the past 50 years, the US biomedical research enterprise has benefited greatly from the ideas, creativity, ingenuity and drive of international medical graduates and other non-US nationals engaged in biomedical research; and

Whereas, An immigration policy that blocks the best and brightest from coming to work and train in the United States and blocks our trainees, physicians and faculty from traveling to other countries is a step backward that will harm our patients, our colleagues, and America’s position as a world leader in health care and innovation; therefore be it

RESOLVED, That our American Medical Association lobby the US Congress and other appropriate US government officials to exempt physicians from any current or future ban or suspension impacting immigration or the issuance of a J1 Visa or H1-B Visa. (Directive to Take Action)

The topic of this resolution is currently under study by the Council on Medical Education.

Fiscal Note: Modest – between $1,000 - $5,000

Received: 05/11/17
RELEVANT AMA POLICY

Visa Complications for IMGs in GME D-255.991
1. Our AMA will: (A) work with the ECFMG to minimize delays in the visa process for International Medical Graduates applying for visas to enter the US for postgraduate medical training and/or medical practice; (B) promote regular communication between the Department of Homeland Security and AMA IMG representatives to address and discuss existing and evolving issues related to the immigration and registration process required for International Medical Graduates; and (C) work through the appropriate channels to assist residency program directors, as a group or individually, to establish effective contacts with the State Department and the Department of Homeland Security, in order to prioritize and expedite the necessary procedures for qualified residency applicants to reduce the uncertainty associated with considering a non-citizen or permanent resident IMG for a residency position.
2. Our AMA International Medical Graduates Section will continue to monitor any H-1B visa denials as they relate to IMGs’ inability to complete accredited GME programs.
3. Our AMA will study, in collaboration with the Educational Commission on Foreign Medical Graduates and the Accreditation Council for Graduate Medical Education, the frequency of such J-1 Visa reentry denials and its impact on patient care and residency training.
4. Our AMA will, in collaboration with other stakeholders, advocate for unfettered travel for IMGs for the duration of their legal stay in the US in order to complete their residency or fellowship training to prevent disruption of patient care.

Conrad 30 - J-1 Visa Waivers D-255.985
1. Our AMA will: (A) lobby for the reauthorization of the Conrad 30 J-1 Visa Waiver Program; (B) advocate that the J-1 Visa waiver slots be increased from 30 to 50 per state; (C) advocate for expansion of the J-1 Visa Waiver Program to allow IMGs to serve on the faculty of medical schools and residency programs in geographic areas or specialties with workforce shortages; (D) publish on its website J-1 visa waiver (Conrad 30) statistics and information provided by state Conrad 30 administrators along with a frequently asked questions (FAQs) document about the Conrad 30 program; (E) advocate for solutions to expand the J-1 Visa Waiver Program to increase the overall number of waiver positions in the US in order to increase the number of IMGs who are willing to work in underserved areas to alleviate the physician workforce shortage; (F) work with the Educational Commission for Foreign Medical Graduates and other stakeholders to facilitate better communication and information sharing among Conrad 30 administrators, IMGs, US Citizenship and Immigration Services and the State Department; and (G) continue to communicate with the Conrad 30 administrators and IMGs members to share information and best practices in order to fully utilize and expand the Conrad 30 program.
2. Our AMA will continue to monitor legislation and provide support for improvements to the J-1 Visa Waiver program.
3. Our AMA will continue to promote its educational or other relevant resources to IMGs participating or considering participating in J-1 Visa waiver programs.
4. As a benefit of membership, our AMA will provide advice and information on Federation and other resources (but not legal opinions or representation), as appropriate to IMGs in matters pertaining to work-related abuses.
5. Our AMA encourages IMGs to consult with their state medical society and consider requesting that their state society ask for assistance by the AMA Litigation Center, if it meets the Litigation Center's established case selection criteria.

Whereas, There are no studies linking physician’s participation in the American Board of Medical Specialties (ABMS) Maintenance of Certification (MOC) product with a positive effect on the quality or cost of care; and

Whereas, Advertising medical products and processes directly to patients bypasses the critical filter of physicians who can help patients decipher complicated medical concepts; and

Whereas, There is no regulatory proof required for these direct-to-consumer advertising campaigns, making it difficult to refute these claims in the marketplace of ideas; and

Whereas, Existing AMA Policy H-105.988 opposes direct-to-consumer advertising of prescription drugs and implantable devices for the ethical concerns of misleading information and corporate interference with the doctor-patient relationship; and

Whereas, The American Board of Medical Specialties has launched a direct-to-consumer campaign at certificationmatters.org; and

Whereas, Subspecialty boards such as the American Board of Pediatrics are following suit with mycertifiedpediatrician.org; and

Whereas, These advertising campaigns contain misleading information linking quality care to the board certification product; and

Whereas, These advertising campaigns direct patients and families to search misleading databases that eliminate the names of physicians who have passed multiple board exams over decades, but choose not to participate in MOC; and

Whereas, These campaigns do not mention alternate certification boards where a physician may be certified; and

Whereas, These direct-to-consumer campaigns with misleading and incomplete information have potential to harm the physician-patient trust and relationship; therefore be it

RESOLVED, That our American Medical Association oppose direct-to-consumer marketing of the American Board of Medical Specialties Maintenance of Certification (MOC) product in the form of print media, social media, apps, and websites that specifically target patients and their families including but not limited to the promotion of false or misleading claims linking MOC participation with improved patient health outcomes and experiences where limited evidence exists (Directive to Take Action); and be it further
RESOLVED, That our AMA amend existing AMA Policy D-275.954, “Maintenance of Certification and Osteopathic Continuous Certification” by addition as follows:

36. Direct the ABMS to ensure that any publicly accessible information pertaining to maintenance of certification (MOC) available on ABMS and ABMS Member Boards’ websites or via promotional materials includes only statistically validated, evidence based, data linking MOC to patient health outcomes. (Modify Current HOD Policy)

Fiscal Note: Not yet determined

Received: 05/11/17

RELEVANT AMA POLICY

Maintenance of Certification H-275.924
AMA Principles on Maintenance of Certification (MOC)
1. Changes in specialty-board certification requirements for MOC programs should be longitudinally stable in structure, although flexible in content.
2. Implementation of changes in MOC must be reasonable and take into consideration the time needed to develop the proper MOC structures as well as to educate physician diplomates about the requirements for participation.
3. Any changes to the MOC process for a given medical specialty board should occur no more frequently than the intervals used by that specialty board for MOC.
4. Any changes in the MOC process should not result in significantly increased cost or burden to physician participants (such as systems that mandate continuous documentation or require annual milestones).
5. MOC requirements should not reduce the capacity of the overall physician workforce. It is important to retain a structure of MOC programs that permits physicians to complete modules with temporal flexibility, compatible with their practice responsibilities.
6. Patient satisfaction programs such as The Consumer Assessment of Healthcare Providers and Systems (CAHPS) patient survey are neither appropriate nor effective survey tools to assess physician competence in many specialties.
7. Careful consideration should be given to the importance of retaining flexibility in pathways for MOC for physicians with careers that combine clinical patient care with significant leadership, administrative, research and teaching responsibilities.
8. Legal ramifications must be examined, and conflicts resolved, prior to data collection and/or displaying any information collected in the process of MOC. Specifically, careful consideration must be given to the types and format of physician-specific data to be publicly released in conjunction with MOC participation.
9. Our AMA affirms the current language regarding continuing medical education (CME): "Each Member Board will document that diplomates are meeting the CME and Self-Assessment requirements for MOC Part II. The content of CME and self-assessment programs receiving credit for MOC will be relevant to advances within the diplomate’s scope of practice, and free of commercial bias and direct support from pharmaceutical and device industries. Each diplomate will be required to complete CME credits (AMA PRA Category 1 CreditTM, American Academy of Family Physicians Prescribed, American College of Obstetricians and Gynecologists, and/or American Osteopathic Association Category 1A)."
10. In relation to MOC Part II, our AMA continues to support and promote the AMA Physician’s Recognition Award (PRA) Credit system as one of the three major credit systems that comprise the foundation for continuing medical education in the U.S., including the Performance Improvement CME (PICME) format; and continues to develop relationships and agreements that may lead to standards accepted by all U.S. licensing boards, specialty boards, hospital credentialing bodies and other entities requiring evidence of physician CME.
11. MOC is but one component to promote patient safety and quality. Health care is a team effort, and changes to MOC should not create an unrealistic expectation that lapses in patient safety are primarily failures of individual physicians.
12. MOC should be based on evidence and designed to identify performance gaps and unmet needs, providing direction and guidance for improvement in physician performance and delivery of care.
13. The MOC process should be evaluated periodically to measure physician satisfaction, knowledge uptake and intent to maintain or change practice.
14. MOC should be used as a tool for continuous improvement.
15. The MOC program should not be a mandated requirement for licensure, credentialing, recredentialing, privileging, reimbursement, network participation, employment, or insurance panel participation.

16. Actively practicing physicians should be well-represented on specialty boards developing MOC.

17. Our AMA will include early career physicians when nominating individuals to the Boards of Directors for ABMS member boards.

18. MOC activities and measurement should be relevant to clinical practice.

19. The MOC process should not be cost prohibitive or present barriers to patient care.

20. Any assessment should be used to guide physicians’ self-directed study.

21. Specific content-based feedback after any assessment tests should be provided to physicians in a timely manner.

22. There should be multiple options for how an assessment could be structured to accommodate different learning styles.

23. Physicians with lifetime board certification should not be required to seek recertification.

24. No qualifiers or restrictions should be placed on diplomates with lifetime board certification recognized by the ABMS related to their participation in MOC.

25. Members of our House of Delegates are encouraged to increase their awareness of and participation in the proposed changes to physician self-regulation through their specialty organizations and other professional membership groups.


**Maintenance of Certification and Osteopathic Continuous Certification D-275.954**

Our AMA will:

1. Continue to monitor the evolution of Maintenance of Certification (MOC) and Osteopathic Continuous Certification (OCC), continue its active engagement in discussions regarding their implementation, encourage specialty boards to investigate and/or establish alternative approaches for MOC, and prepare a yearly report to the House of Delegates regarding the MOC and OCC process.

2. Continue to review, through its Council on Medical Education, published literature and emerging data as part of the Council's ongoing efforts to critically review MOC and OCC issues.

3. Continue to monitor the progress by the American Board of Medical Specialties (ABMS) and its member boards on implementation of MOC, and encourage the ABMS to report its research findings on the issues surrounding certification and MOC on a periodic basis.

4. Encourage the ABMS and its member boards to continue to explore other ways to measure the ability of physicians to access and apply knowledge to care for patients, and to continue to examine the evidence supporting the value of specialty board certification and MOC.

5. Work with the ABMS to streamline and improve the Cognitive Expertise (Part III) component of MOC, including the exploration of alternative formats, in ways that effectively evaluate acquisition of new knowledge while reducing or eliminating the burden of a high-stakes examination.

6. Work with interested parties to ensure that MOC uses more than one pathway to assess accurately the competence of practicing physicians, to monitor for exam relevance and to ensure that MOC does not lead to unintended economic hardship such as hospital de-credentialing of practicing physicians.

7. Recommend that the ABMS not introduce additional assessment modalities that have not been validated to show improvement in physician performance and/or patient safety.

8. Work with the ABMS to eliminate practice performance assessment modules, as currently written, from MOC requirements.

9. Encourage the ABMS to ensure that all ABMS member boards provide full transparency related to the costs of preparing, administering, scoring and reporting MOC and certifying examinations.

10. Encourage the ABMS to ensure that MOC and certifying examinations do not result in substantial financial gain to ABMS member boards, and advocate that the ABMS develop fiduciary standards for its member boards that are consistent with this principle.

11. Work with the ABMS to lessen the burden of MOC on physicians with multiple board certifications, particularly to ensure that MOC is specifically relevant to the physician's current practice.

12. Work with key stakeholders to (a) support ongoing ABMS member board efforts to allow multiple and diverse physician educational and quality improvement activities to qualify for MOC; (b) support ABMS member board activities in facilitating the use of MOC quality improvement activities to count for other accountability requirements or programs, such as pay for quality/performance or PQRS reimbursement; (c) encourage ABMS member boards to enhance the consistency of quality improvement programs across all boards; and (d) work with specialty societies and ABMS member boards to develop tools and services that help physicians meet MOC requirements.
13. Work with the ABMS and its member boards to collect data on why physicians choose to maintain or discontinue their board certification.
14. Work with the ABMS to study whether MOC is an important factor in a physician's decision to retire and to determine its impact on the US physician workforce.
15. Encourage the ABMS to use data from MOC to track whether physicians are maintaining certification and share this data with the AMA.
16. Encourage AMA members to be proactive in shaping MOC and OCC by seeking leadership positions on the ABMS member boards, American Osteopathic Association (AOA) specialty certifying boards, and MOC Committees.
17. Continue to monitor the actions of professional societies regarding recommendations for modification of MOC.
18. Encourage medical specialty societies' leadership to work with the ABMS, and its member boards, to identify those specialty organizations that have developed an appropriate and relevant MOC process for its members.
19. Continue to work with the ABMS to ensure that physicians are clearly informed of the MOC requirements for their specific board and the timelines for accomplishing those requirements.
20. Encourage the ABMS and its member boards to develop a system to actively alert physicians of the due dates of the multi-stage requirements of continuous professional development and performance in practice, thereby assisting them with maintaining their board certification.
21. Recommend to the ABMS that all physician members of those boards governing the MOC process be required to participate in MOC.
22. Continue to participate in the National Alliance for Physician Competence forums.
23. Encourage the PCPI Foundation, the ABMS, and the Council of Medical Specialty Societies to work together toward utilizing Consortium performance measures in Part IV of MOC.
24. Continue to assist physicians in practice performance improvement.
25. Encourage all specialty societies to grant certified CME credit for activities that they offer to fulfill requirements of their respective specialty board's MOC and associated processes.
26. Support the American College of Physicians as well as other professional societies in their efforts to work with the American Board of Internal Medicine (ABIM) to improve the MOC program.
27. Oppose those maintenance of certification programs administered by the specialty boards of the ABMS, or of any other similar physician certifying organization, which do not appropriately adhere to the principles codified as AMA Policy on Maintenance of Certification.
28. Examine the activities that medical specialty organizations have underway to review alternative pathways for board recertification; and determine if there is a need to establish criteria and construct a tool to evaluate if alternative methods for board recertification are equivalent to established pathways.
29. Ask the ABMS to encourage its member boards to review their maintenance of certification policies regarding the requirements for maintaining underlying primary or initial specialty board certification in addition to subspecialty board certification, if they have not yet done so, to allow physicians the option to focus on maintenance of certification activities relevant to their practice.
30. Call for the immediate end of any mandatory, secured recertifying examination by the ABMS or other certifying organizations as part of the recertification process for all those specialties that still require a secure, high-stakes recertification examination.
31. Support a recertification process based on high quality, appropriate Continuing Medical Education (CME) material directed by the AMA recognized specialty societies covering the physician's practice area, in cooperation with other willing stakeholders, that would be completed on a regular basis as determined by the individual medical specialty, to ensure lifelong learning.
32. Continue to work with the ABMS to encourage the development by and the sharing between specialty boards of alternative ways to assess medical knowledge other than by a secure high stakes exam.
33. Continue to support the requirement of CME and ongoing, quality assessments of physicians, where such CME is proven to be cost-effective and shown by evidence to improve quality of care for patients.
34. Through legislative, regulatory, or collaborative efforts, will work with interested state medical societies and other interested parties by creating model state legislation and model medical staff bylaws while advocating that Maintenance of Certification not be a requirement for: (a) medical staff membership, privileging, credentialing, or recredentialing; (b) insurance panel participation; or (c) state medical licensure.
35. Increase its efforts to work with the insurance industry to ensure that maintenance of certification does not become a requirement for insurance panel participation.

Whereas, Initial American Board of Medical Specialties (ABMS) board certification is a credential of great accomplishment for many physicians; and

Whereas, Initial ABMS board certification is all that is required of time-unlimited or "grandfathered" physicians; and

Whereas, Existing AMA Policy H-275.924, “Maintenance of Certification,” protects the status of "grandfathered" physicians, stating “No qualifiers or restrictions should be placed on diplomates with lifetime board certification recognized by the ABMS related to their participation in MOC;” and

Whereas, The names of grandfathered physicians are available when verifying certification status on ABMS credentialing websites, indicating the date of initial certification, regardless of their participation in Maintenance of Certification (MOC); and

Whereas, Similar protections for physicians holding time-limited certificates do not exist; and

Whereas, The ABMS and ABMS member boards erase the name of time-limited physicians when they choose not to participate in any of the four parts of MOC, regardless of how many times the physician has passed his or her board examinations; and

Whereas, Under this punitive system that erases the name of time-limited physicians, the only way for the public to verify initial certification is via formal inquiry and a fee; and

Whereas, This punitive system causes great harm to time-limited diplomates during professional physician credentialing, when initial certification is not readily available; and

Whereas, This punitive system causes great harm to time-limited diplomates in terms of patient trust under the current direct-to-consumer advertising campaigns directing patients and families to “verify if your doctor is board certified,” when patients and families are not able to access initial board certification status of time-limited diplomates; therefore be it
RESOLVED, That our American Medical Association amend the AMA Principles of Maintenance of Certification (MOC), AMA Policy H-275.924, “Maintenance of Certification,” by addition as follows:

26. The initial certification status of time-limited diplomates shall be listed and publicly available on all American Board of Medical Specialties (ABMS) and ABMS Member Boards’ websites and physician certification databases. The names and initial certification status of time-limited diplomates shall not be removed from ABMS and ABMS Member Boards’ websites or physician certification databases even if the diplomate chooses not to participate in MOC. (Modify Current HOD Policy)

Fiscal Note: Minimal – less than $1,000

Received: 05/11/17

RELEVANT AMA POLICY

Maintenance of Certification H-275.924
AMA Principles on Maintenance of Certification (MOC)
1. Changes in specialty-board certification requirements for MOC programs should be longitudinally stable in structure, although flexible in content.
2. Implementation of changes in MOC must be reasonable and take into consideration the time needed to develop the proper MOC structures as well as to educate physician diplomates about the requirements for participation.
3. Any changes to the MOC process for a given medical specialty board should occur no more frequently than the intervals used by that specialty board for MOC.
4. Any changes in the MOC process should not result in significantly increased cost or burden to physician participants (such as systems that mandate continuous documentation or require annual milestones).
5. MOC requirements should not reduce the capacity of the overall physician workforce. It is important to retain a structure of MOC programs that permits physicians to complete modules with temporal flexibility, compatible with their practice responsibilities.
6. Patient satisfaction programs such as The Consumer Assessment of Healthcare Providers and Systems (CAHPS) patient survey are neither appropriate nor effective survey tools to assess physician competence in many specialties.
7. Careful consideration should be given to the importance of retaining flexibility in pathways for MOC for physicians with careers that combine clinical patient care with significant leadership, administrative, research and teaching responsibilities.
8. Legal ramifications must be examined, and conflicts resolved, prior to data collection and/or displaying any information collected in the process of MOC. Specifically, careful consideration must be given to the types and format of physician-specific data to be publicly released in conjunction with MOC participation.
9. Our AMA affirms the current language regarding continuing medical education (CME): "Each Member Board will document that diplomates are meeting the CME and Self-Assessment requirements for MOC Part II. The content of CME and self-assessment programs receiving credit for MOC will be relevant to advances within the diplomate's scope of practice, and free of commercial bias and direct support from pharmaceutical and device industries. Each diplomat will be required to complete CME credits (AMA PRA Category 1 CreditTM, American Academy of Family Physicians Prescribed, American College of Obstetricians and Gynecologists, and/or American Osteopathic Association Category 1A)."
10. In relation to MOC Part II, our AMA continues to support and promote the AMA Physician’s Recognition Award (PRA) Credit system as one of the three major credit systems that comprise
the foundation for continuing medical education in the U.S., including the Performance Improvement CME (PICME) format; and continues to develop relationships and agreements that may lead to standards accepted by all U.S. licensing boards, specialty boards, hospital credentialing bodies and other entities requiring evidence of physician CME.

11. MOC is but one component to promote patient safety and quality. Health care is a team effort, and changes to MOC should not create an unrealistic expectation that lapses in patient safety are primarily failures of individual physicians.

12. MOC should be based on evidence and designed to identify performance gaps and unmet needs, providing direction and guidance for improvement in physician performance and delivery of care.

13. The MOC process should be evaluated periodically to measure physician satisfaction, knowledge uptake and intent to maintain or change practice.

14. MOC should be used as a tool for continuous improvement.

15. The MOC program should not be a mandated requirement for licensure, credentialing, recredentialing, privileging, reimbursement, network participation, employment, or insurance panel participation.

16. Actively practicing physicians should be well-represented on specialty boards developing MOC.

17. Our AMA will include early career physicians when nominating individuals to the Boards of Directors for ABMS member boards.

18. MOC activities and measurement should be relevant to clinical practice.

19. The MOC process should not be cost prohibitive or present barriers to patient care.

20. Any assessment should be used to guide physicians’ self-directed study.

21. Specific content-based feedback after any assessment tests should be provided to physicians in a timely manner.

22. There should be multiple options for how an assessment could be structured to accommodate different learning styles.

23. Physicians with lifetime board certification should not be required to seek recertification.

24. No qualifiers or restrictions should be placed on diplomates with lifetime board certification recognized by the ABMS related to their participation in MOC.

25. Members of our House of Delegates are encouraged to increase their awareness of and participation in the proposed changes to physician self-regulation through their specialty organizations and other professional membership groups.

Resolved: Standardized patients are used throughout medical education to assess competency in communication, quality of care delivery, and for accreditation of residency programs, and teacher evaluation.

Whereas, Medical students develop clinical, communication, and interpersonal skills through clinical scenarios with standardized patients of varied cultural and socioeconomic backgrounds.

Whereas, The US Census Bureau’s 2014 National Projections state that the US is predicted to become more racially and ethnically diverse in the coming years, with the non-Hispanic White population comprising less than 50 percent by 2044.

Whereas, Culture is defined as a pattern of integrated beliefs, values, behaviors, social practices of a group, including but not limited to groups characterized by race, ethnicity, gender, sexual orientation, religion, disability, etc.

Whereas, The Association of American Medical Colleges defined cultural competency as “a set of congruent behaviors, knowledge, attitudes, and policies that come together in a system, organization, or among professionals that enables effective work in cross-cultural situations.”

Whereas, Cultural competency training is intended to help health care professionals avoid stereotyping, be aware of normative cultural values that can affect informed consent, and adapt more readily to cultural differences.

Whereas, A systematic review of 34 studies have shown that cultural competency training improved the cultural knowledge, perspective, and skills of health professionals, with beneficial impacts on patient satisfaction; according to one study, families in the emergency room setting were two to three times more likely to report feeling comfortable with and respected by their physician.

Whereas, Cultural competency training in medical education, as it is taught in the US, Canada, and the United Kingdom, is largely limited to incorporation in lectures, case studies, and mostly optional workshops.

Whereas, Without application of cultural competency-related knowledge and skills in patient encounters during the pre-clinical years of medical school, students are more likely to perceive such training as more theoretical than useful.
Whereas, Pilot programs in schools such as Wake Forest School of Medicine (WFSM) have shown that cultural competency can be built through immersion, allowing medical students to learn the health challenges of diverse populations through activities like community-based service learning, simulations, role-play, and demonstrations; afterwards, medical students in the WFSM pilot program reported up to two times more improvement in their knowledge, skills, and attitude with interacting with patients of different backgrounds; and

Whereas, Of those that participated in cultural competence programs in a community setting, medical students at the University of California-San Diego School of Medicine felt more prepared for their third-year clinical clerkships and beyond; and

Whereas, The standardized patient population that includes those with a diverse spectrum of intellectual and/or physical disabilities will better equip medical students to meet the unique medical needs of this patient population; and

Whereas, The American Medical Association supports efforts to continually integrate medical training with education regarding health disparities, social determinants, and cultural competencies, so that student doctors are well prepared to serve high quality and patient-centered care to all their future patients; and

Whereas, The Liaison Committee on Medical Education recognizes the necessity for cultural competence training in medical education and states, under Standard 7.6, that medical curriculum should provide opportunities for medical students to not only learn but also “appropriately address cultural biases in themselves and others, and in the process of health care delivery”; therefore be it

RESOLVED, That our American Medical Association amend existing AMA Policy H-295.897, “Enhancing the Cultural Competence of Physicians” by addition as follows:

7. Our AMA supports initiatives for medical schools to incorporate diversity in their Standardized Patient programs as a means of combining knowledge of health disparities and practice of cultural competence with clinical skills. (Modify Current HOD Policy)

Fiscal Note: Minimal – less than $1,000

Received: 05/11/17

RELEVANT AMA POLICY

Enhancing the Cultural Competence of Physicians H-295.897
1. Our AMA continues to inform medical schools and residency program directors about activities and resources related to assisting physicians in providing culturally competent care to patients throughout their life span and encourage them to include the topic of culturally effective health care in their curricula.
2. Our AMA continues research into the need for and effectiveness of training in cultural competence, using existing mechanisms such as the annual medical education surveys and focus groups at regularly scheduled meetings.
3. Our AMA will form an expert national advisory panel (including representation from the AMA Minority Affairs Consortium and International Medical Graduate Section) to consult on all areas related to enhancing the cultural competence of physicians, including developing a list of
resources on cultural competencies for physicians and maintaining it and related resources in an electronic database.

4. Our AMA will assist physicians in obtaining information about and/or training in culturally effective health care through development of an annotated resource database on the AMA home page, with information also available through postal distribution on diskette and/or CD-ROM.

5. Our AMA will seek external funding to develop a five-year program for promoting cultural competence in and through the education of physicians, including a critical review and comprehensive plan for action, in collaboration with the AMA Consortium on Minority Affairs and the medical associations that participate in the consortium (National Medical Association, National Hispanic Medical Association, and Association of American Indian Physicians,) the American Medical Women's Association, the American Public Health Association, the American Academy of Pediatrics, and other appropriate groups. The goal of the program would be to restructure the continuum of medical education and staff and faculty development programs to deliberately emphasize cultural competence as part of professional practice.

6. Our AMA encourages training opportunities for students and residents, as members of the physician-led team, to learn cultural competency from community health


11 Beagan BL. Teaching social and cultural awareness to medical students:"It's all very nice to talk about it in theory, but ultimately it makes no difference". Academic Medicine. 2003 Jun 1. 78(6): 605-14.


14 Sopoaga F, Zahari T, Koka J, Covello S. Training a medical workforce to meet the needs of diverse minority communities. BMC Medical Education. 2017. 17, 19.


20 LCME® Functions and Structure of a Medical School Standards for Accreditation of Medical Education Programs Leading to the MD Degree. N.p.: Liaison Committee on Medical Education (LCME), Mar. 2016.
Whereas, We are facing a looming shortage of physicians in this country, and international medical graduates provide access to physician care for thousands of people in rural and underserved communities; and

Whereas, The H-1B visa and the J-1 visa are the principal means by which international medical graduates train and/or work in the U.S.; and

Whereas, The H-1B visa program supports graduate medical education training for international medical graduates; and

Whereas, The H-1B visa requires an employer-employee relationship, and individuals granted H-1B visas are admitted for a period of up to three years, with an extension possible for up to six years; and

Whereas, The H-1B visa has an annual cap of 65,000 visas each fiscal year, with exemptions to the cap existing for (1) workers who are petitioned for or employed at an institution of higher education or its affiliated or related nonprofit entities or a nonprofit research organization, or a government research organization, and (2) the first 20,000 petitions filed on behalf of beneficiaries with a U.S. master’s degree or higher; and

Whereas, The Trump Administration stopped H-1B visa "premium processing" beginning April 3, 2017 for up to six months, a mechanism that cuts wait times for H-1B visas from a few months to as little as 15 days; and

Whereas, Many international medical graduates who are finishing their training in the U.S. and looking for positions in rural or urban underserved areas currently do not have the expedited premium processing option available to them, causing uncertainty with respect to their status in the U.S.; therefore be it

RESOLVED, That our American Medical Association urge the Trump Administration to immediately reinstate premium processing of H-1B visas for physicians to prevent any negative impact on patient care in underserved communities. (Directive to Take Action)

The topic of this resolution is currently under study by the Council on Medical Education.

Fiscal Note: Modest – between $1,000 - $5,000

Received: 05/09/17
Whereas, The American Board of Medical Specialties (ABMS) stated goal of Maintenance of Certification (MOC) in 2000 was to "implement a model for continuous professional development that would demonstrate to their peers and the public a commitment to lifelong learning and to staying current with medical knowledge."¹; and

Whereas, There have been no well designed studies or scholarly articles that MOC has had any impact on professional development of physicians or increased confidence in physicians by the public; and

Whereas, The MOC process is costly with physicians spending approximately $2300 per physician over 10 years (varies by specialty), however, this pales in comparison to the time costs to do the MOC which is estimated at $21,000 over 10 years²; and

Whereas, MOC has not demonstrated an impact on continuous professional development or public confidence in physicians over the well-established continuing medical education system that has long existed and this low value activity is very costly; therefore be it

RESOLVED, That our American Medical Association oppose the requirement of Maintenance of Certification (MOC) as currently constituted in privileging and credentialing providers by health systems, hospitals, and payers (New HOD Policy); and be it further

RESOLVED, That our AMA call on the American Board of Medical Specialties to pursue ongoing meaningful continuing medical education as a pathway to MOC without the requirement for re-examination (Directive to Take Action); and be it further

RESOLVED, That our AMA reaffirm Policies H-275.924 and D-275.954, and report back at the 2017 Interim Meeting with an update on progress made to toward these policies. (Directive to Take Action)

RELEVANT AMA POLICY

Maintenance of Certification H-275.924
AMA Principles on Maintenance of Certification (MOC)
1. Changes in specialty-board certification requirements for MOC programs should be longitudinally stable in structure, although flexible in content.
2. Implementation of changes in MOC must be reasonable and take into consideration the time needed to develop the proper MOC structures as well as to educate physician diplomates about the requirements for participation.
3. Any changes to the MOC process for a given medical specialty board should occur no more frequently than the intervals used by that specialty board for MOC.
4. Any changes in the MOC process should not result in significantly increased cost or burden to physician participants (such as systems that mandate continuous documentation or require annual milestones).
5. MOC requirements should not reduce the capacity of the overall physician workforce. It is important to retain a structure of MOC programs that permits physicians to complete modules with temporal flexibility, compatible with their practice responsibilities.
6. Patient satisfaction programs such as The Consumer Assessment of Healthcare Providers and Systems (CAHPS) patient survey are neither appropriate nor effective survey tools to assess physician competence in many specialties.
7. Careful consideration should be given to the importance of retaining flexibility in pathways for MOC for physicians with careers that combine clinical patient care with significant leadership, administrative, research and teaching responsibilities.
8. Legal ramifications must be examined, and conflicts resolved, prior to data collection and/or displaying any information collected in the process of MOC. Specifically, careful consideration must be given to the types and format of physician-specific data to be publicly released in conjunction with MOC participation.
9. Our AMA affirms the current language regarding continuing medical education (CME): "Each Member Board will document that diplomates are meeting the CME and Self-Assessment requirements for MOC Part II. The content of CME and self-assessment programs receiving credit for MOC will be relevant to advances within the diplomate's scope of practice, and free of commercial bias and direct support from pharmaceutical and device industries. Each diplomate will be required to complete CME credits (AMA PRA Category 1 CreditTM, American Academy of Family Physicians Prescribed, American College of Obstetricians and Gynecologists, and/or American Osteopathic Association Category 1A)"
10. In relation to MOC Part II, our AMA continues to support and promote the AMA Physician's Recognition Award (PRA) Credit system as one of the three major credit systems that comprise the foundation for continuing medical education in the U.S., including the Performance Improvement CME (PICME) format; and continues to develop relationships and agreements that may lead to standards accepted by all U.S. licensing boards, specialty boards, hospital credentialing bodies and other entities requiring evidence of physician CME.
11. MOC is but one component to promote patient safety and quality. Health care is a team effort, and changes to MOC should not create an unrealistic expectation that lapses in patient safety are primarily failures of individual physicians.
12. MOC should be based on evidence and designed to identify performance gaps and unmet needs, providing direction and guidance for improvement in physician performance and delivery of care.
13. The MOC process should be evaluated periodically to measure physician satisfaction, knowledge uptake and intent to maintain or change practice.
14. MOC should be used as a tool for continuous improvement.
15. The MOC program should not be a mandated requirement for licensure, credentialing, recredentialing, privileging, reimbursement, network participation, employment, or insurance panel participation.
16. Actively practicing physicians should be well-represented on specialty boards developing MOC.
17. Our AMA will include early career physicians when nominating individuals to the Boards of Directors for ABMS member boards.
18. MOC activities and measurement should be relevant to clinical practice.
19. The MOC process should not be cost prohibitive or present barriers to patient care.
20. Any assessment should be used to guide physicians’ self-directed study.
21. Specific content-based feedback after any assessment tests should be provided to physicians in a timely manner.
22. There should be multiple options for how an assessment could be structured to accommodate different learning styles.
23. Physicians with lifetime board certification should not be required to seek recertification.
24. No qualifiers or restrictions should be placed on diplomates with lifetime board certification recognized by the ABMS related to their participation in MOC.
25. Members of our House of Delegates are encouraged to increase their awareness of and participation in the proposed changes to physician self-regulation through their specialty organizations and other professional membership groups.


Maintenance of Certification and Osteopathic Continuous Certification D-275.954

Our AMA will:
1. Continue to monitor the evolution of Maintenance of Certification (MOC) and Osteopathic Continuous Certification (OCC), continue its active engagement in discussions regarding their implementation, encourage specialty boards to investigate and/or establish alternative approaches for MOC, and prepare a yearly report to the House of Delegates regarding the MOC and OCC process.
2. Continue to review, through its Council on Medical Education, published literature and emerging data as part of the Council's ongoing efforts to critically review MOC and OCC issues.
3. Continue to monitor the progress by the American Board of Medical Specialties (ABMS) and its member boards on implementation of MOC, and encourage the ABMS to report its research findings on the issues surrounding certification and MOC on a periodic basis.
4. Encourage the ABMS and its member boards to continue to explore other ways to measure the ability of physicians to access and apply knowledge to care for patients, and to continue to examine the evidence supporting the value of specialty board certification and MOC.
5. Work with the ABMS to streamline and improve the Cognitive Expertise (Part III) component of MOC, including the exploration of alternative formats, in ways that effectively evaluate acquisition of new knowledge while reducing or eliminating the burden of a high-stakes examination.
6. Work with interested parties to ensure that MOC uses more than one pathway to assess accurately the competence of practicing physicians, to monitor for exam relevancy and to ensure that MOC does not lead to unintended economic hardship such as hospital de-credentialing of practicing physicians.
7. Recommend that the ABMS not introduce additional assessment modalities that have not been validated to show improvement in physician performance and/or patient safety.
8. Work with the ABMS to eliminate practice performance assessment modules, as currently written, from MOC requirements.
9. Encourage the ABMS to ensure that all ABMS member boards provide full transparency related to the costs of preparing, administering, scoring and reporting MOC and certifying examinations.
10. Encourage the ABMS to ensure that MOC and certifying examinations do not result in substantial financial gain to ABMS member boards, and advocate that the ABMS develop fiduciary standards for its member boards that are consistent with this principle.
11. Work with the ABMS to lessen the burden of MOC on physicians with multiple board certifications, particularly to ensure that MOC is specifically relevant to the physician's current practice.
12. Work with key stakeholders to (a) support ongoing ABMS member board efforts to allow multiple and diverse physician educational and quality improvement activities to qualify for MOC; (b) support ABMS member board activities in facilitating the use of MOC quality improvement activities to count for other accountability requirements or programs, such as pay for quality/performance or PQRS reimbursement; (c) encourage ABMS member boards to enhance the consistency of quality improvement programs across all boards; and (d) work with specialty societies and ABMS member boards to develop tools and services that help physicians meet MOC requirements.
13. Work with the ABMS and its member boards to collect data on why physicians choose to maintain or discontinue their board certification.
14. Work with the ABMS to study whether MOC is an important factor in a physician's decision to retire and to determine its impact on the US physician workforce.
15. Encourage the ABMS to use data from MOC to track whether physicians are maintaining certification and share this data with the AMA.
16. Encourage AMA members to be proactive in shaping MOC and OCC by seeking leadership positions on the ABMS member boards, American Osteopathic Association (AOA) specialty certifying boards, and MOC Committees.
17. Continue to monitor the actions of professional societies regarding recommendations for modification of MOC.
18. Encourage medical specialty societies' leadership to work with the ABMS, and its member boards, to identify those specialty organizations that have developed an appropriate and relevant MOC process for its members.
19. Continue to work with the ABMS to ensure that physicians are clearly informed of the MOC requirements for their specific board and the timelines for accomplishing those requirements.
20. Encourage the ABMS and its member boards to develop a system to actively alert physicians of the due dates of the multi-stage requirements of continuous professional development and performance in practice, thereby assisting them with maintaining their board certification.
21. Recommend to the ABMS that all physician members of those boards governing the MOC process be required to participate in MOC.
22. Continue to participate in the National Alliance for Physician Competence forums.
23. Encourage the PCPI Foundation, the ABMS, and the Council of Medical Specialty Societies to work together toward utilizing Consortium performance measures in Part IV of MOC.
24. Continue to assist physicians in practice performance improvement.
25. Encourage all specialty societies to grant certified CME credit for activities that they offer to fulfill requirements of their respective specialty board's MOC and associated processes.
26. Support the American College of Physicians as well as other professional societies in their efforts to work with the American Board of Internal Medicine (ABIM) to improve the MOC program.
27. Oppose those maintenance of certification programs administered by the specialty boards of the ABMS, or of any other similar physician certifying organization, which do not appropriately adhere to the principles codified as AMA Policy on Maintenance of Certification.
28. Examine the activities that medical specialty organizations have underway to review alternative pathways for board recertification; and determine if there is a need to establish criteria and construct a tool to evaluate if alternative methods for board recertification are equivalent to established pathways.
29. Ask the ABMS to encourage its member boards to review their maintenance of certification policies regarding the requirements for maintaining underlying primary or initial specialty board certification in addition to subspecialty board certification, if they have not yet done so, to allow physicians the option to focus on maintenance of certification activities relevant to their practice.
30. Call for the immediate end of any mandatory, secured recertifying examination by the ABMS or other certifying organizations as part of the recertification process for all those specialties that still require a secure, high-stakes recertification examination.
31. Support a recertification process based on high quality, appropriate Continuing Medical Education (CME) material directed by the AMA recognized specialty societies covering the physician's practice area, in cooperation with other willing stakeholders, that would be completed on a regular basis as determined by the individual medical specialty, to ensure lifelong learning.
32. Continue to work with the ABMS to encourage the development by and the sharing between specialty boards of alternative ways to assess medical knowledge other than by a secure high stakes exam.
33. Continue to support the requirement of CME and ongoing, quality assessments of physicians, where such CME is proven to be cost-effective and shown by evidence to improve quality of care for patients.
34. Through legislative, regulatory, or collaborative efforts, will work with interested state medical societies and other interested parties by creating model state legislation and model medical staff bylaws while advocating that Maintenance of Certification not be a requirement for: (a) medical staff membership, privileging, credentialing, or recredentialing; (b) insurance panel participation; or (c) state medical licensure.
35. Increase its efforts to work with the insurance industry to ensure that maintenance of certification does not become a requirement for insurance panel participation.

Whereas, There is a national shortage of physicians, and the Association of American Medical Colleges projects the shortage will worsen. The shortage is projected to increase to a range of 7,300 to 43,100 for primary care physicians and 33,500 to 61,800 for physicians in specialty care by 2030; and

Whereas, U.S. medical school enrollments are projected to increase by 30 percent from 2002 to 2018; and

Whereas, Medicare remains the single largest funding source for residency training in the U.S.; and

Whereas, Hospitals that begin to sponsor residency training and become recognized as eligible for Medicare graduate medical education (GME) funding have a maximum of five years to establish all residency programs before the institution’s Medicare GME funding-cap is set. These caps are permanent in most cases; and

Whereas, New medical schools must establish GME programs in all six of the core clerkships to meet accreditation requirements, and this can be challenging to accomplish in underserved and economically depressed areas within five years. In these areas, the five-year Medicare GME cap-setting deadline is not feasible and exceptions to these deadlines should be available from the Centers for Medicare and Medicaid Services to allow medical schools sufficient time to identify qualified and willing teaching partners and establish new GME programs in underserved areas; therefore be it

RESOLVED, That our American Medical Association advocate to the Centers for Medicare & Medicaid Services for flexibility beyond the current maximum of five years for the Medicare graduate medical education cap-setting deadline for new residency programs in underserved areas and/or economically depressed areas. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 05/11/17
RELEVANT AMA POLICY

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

3. Our AMA will actively seek congressional action to remove the caps on Medicare funding of GME positions for resident physicians that were imposed by the Balanced Budget Amendment of 1997 (BBA-1997).

4. Our AMA will strenuously advocate for increasing the number of GME positions to address the future physician workforce needs of the nation.


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

H(I). New funding should be available to support increases in the number of medical school and residency training positions, preferably in or adjacent to physician shortage/underserved areas and in undersupplied specialties.


Increasing Graduate Medical Education Positions as a Component to any Federal Health Care Reform Policy D-305.958

2. Our AMA will work with the Centers for Medicare and Medicaid Services to explore ways to increase graduate medical education slots to accommodate the need for more physicians in the US.

3. Our AMA will work actively and in collaboration with the Association of American Medical Colleges and other interested stakeholders to rescind funding caps for GME imposed by the Balanced Budget Act of 1997.

4. Our AMA will actively advocate for expanded funding for entry and continued training positions in specialties and geographic regions with documented medical workforce shortages.