

Online Member Forum Summary Report

Reference Committee C

2018 Interim Meeting

November 5, 2018



Tue, 10/09/2018 - 12:07

#1

Carla Frenzel

Competency of Senior Physicians

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 available to all interested parties the Assessment of Senior/Late Career Physicians Guiding Principles:

- a) Evidence-based: The development of guidelines for assessing and screening senior/late career physicians is based on evidence of the importance of cognitive changes associated with aging that are relevant to physician performance. Current research suggests that physician competency and practice performance decline with increasing years in practice. However, research also suggests that the effect of age on an individual physician's competency can be highly variable, and wide variations are seen in cognitive performance with aging.
- b) Ethical: Guidelines should be based on the principles of medical ethics. Self-regulation is an important aspect of medical professionalism. Physicians should be involved in the development of guidelines/standards for monitoring and assessing both their own and their colleagues' competency.
- c) Relevant: Guidelines, procedures, or methods of assessment should be relevant to physician practices to inform judgments and provide feedback regarding physicians' ability to perform the tasks specifically required in their practice environment.
- d) Accountable: The ethical obligation of the profession to the health of the public and patient safety should be the primary driver for establishing guidelines and informing decision making about physician screening and assessment results.
- e) Fair and equitable: The goal of screening and assessment is to optimize physician competency and performance through education, remediation, and modifications to physicians' practice environment or scope. Unless public health or patient safety is directly threatened, physicians should retain the right to modify their practice environment to allow them to continue to provide safe and effective care. When public health or patient safety is directly threatened, removal from practice is one potential outcome.
- f) Transparent: Guidelines, procedures or methods of screening and assessment should be transparent to all parties, including the public. Physicians should be aware of the specific methods used, performance expectations and standards against which performance will be judged, and the possible outcomes of the screening or assessment.
- g) Supportive: Education and/or remediation practices that result from screening and /or assessment procedures should be supportive of physician wellness, ongoing, and proactive.
- h) Cost conscious: Procedures and screening mechanisms that are distinctly different from "for cause" assessments should not result in undue cost or burden to senior physicians providing patient care. Hospitals and health care systems should provide easily accessible screening assessments for their employed senior physicians. Similar procedures and screening mechanisms should be available to senior physicians who are not employed by hospitals and health care systems.

2. That our AMA encourage the Federation of State Medical Boards, Council of Medical Specialty Societies, and other interested organizations to develop educational materials on the effects of age on physician practice for senior/late career physicians.

3. That Policy D-275.956, "Assuring Safe and Effective Care for Patients by Senior/Late Career Physicians," be rescinded, as having been fulfilled by this report.

Resolution:

1

Wed, 10/24/2018 - 15:55

Jim Rohack

RE: Competency of Senior Physicians

My conflict is that I am not a member of the AMA Senior Physican Section but in August 2019, I will automatically become a member.

These are reasonable guidelines but I am concern with the last sentence of e. It notes that "removal from practice is one outcome" but does not note any other outcomes. As a former chair of Credentials and By-laws Committees, if a physican (regardless of age) exhibits behaviors that are immediate threat to patient safety, then immediate supension of privileges is required by Joint Commission and CMS Standards. It would seem best to use same phrases to be clear rather that create a question of having different standards or unclear outcome options for the senior vs non-senior physician.

thank you.

Opinion Type:

My post is my personal opinion

Sat, 10/27/2018 - 18:03

DAVID WELSH

RE: Competency of Senior Physicians

I support this report. I appreciate Dr Rohack's comments. This is an area of interest of mine. I laud the Senior Physician's Section for bringing it up. This is an area of interest and concern for surgeons. The ACS has been working on this issue. The ACS Governors' Competency and Health work group has been working on this. I helped chair this group in the past. The current chair is Dr Reid Adams. I thank the CME for their hard work.

Opinion Type:

My post is my personal opinion



Published on *American Medical Association* (<https://www.ama-assn.org>)

Home > Developing Physician-Led Public Health/Population Health Capacity in Rural Communities

Thu, 10/11/2018 - 13:40

#1

Carla Frenzel

Developing Physician-Led Public Health/Population Health Capacity in Rural Communities

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

That Policy D-295.311, "Developing Physician Led Public Health / Population Health Capacity in Rural Communities," be rescinded, as having been fulfilled by this report. (Rescind HOD Policy)

That our American Medical Association (AMA) reaffirm the following policies:

D-295.327, "Integrating Content Related to Public Health and Preventive Medicine Across the Medical Education Continuum"

D-305.964, "Support for the Epidemic Intelligence Service (EIS) Program and Preventive Medicine Residency Expansion"

D-305.974, "Funding for Preventive Medicine Residencies"

H-425.982, "Training in the Principles of Population-Based Medicine"

D-440.951, "One-Year Public Health Training Options for all Specialties"

H-440.954, "Revitalization of Local Public Health Units for the Nation"

H-440.888, "Public Health Leadership"

H-440.969, "Meeting Public Health Care Needs Through Health Professions Education" (Reaffirm HOD Policy)

That our AMA encourage the Association of American Medical Colleges (AAMC), American Association of Colleges of Osteopathic Medicine (AACOM), and Accreditation Council for Graduate Medical Education (ACGME) to highlight public/population health leadership learning opportunities to all learners, but especially to women and those who are underrepresented in medicine. (Directive to Take Action)

That our AMA encourage public health leadership programs to evaluate the effectiveness of various leadership interventions. (Directive to Take Action)

Resolution:

3

Sun, 11/04/2018 - 20:53

DAVID WELSH

RE: Developing Physician-Led Public Health/Population Health Cap

As a County Health officer working in a Rural setting, i support this resolution.

Opinion Type:

My post is my personal opinion

Sun, 11/04/2018 - 20:55

DAVID WELSH

RE: Developing Physician-Led Public Health/Population Health Cap

Support this report.

Opinion Type:

My post is my personal opinion

Sun, 11/04/2018 - 21:14

Sanjay Menghani

RE: Developing Physician-Led Public Health/Population Health Cap

Sanjay Menghani, Alternate Delegate from Arizona, speaking on behalf of the Medical Student Section in SUPPORT of the Council on Medical Education Report 3. The MSS supports increasing opportunities for medical students to engage in clinical experiences located in rural communities. We especially would like to applaud the third recommendation, which encourages the AAMC, AACOM, and ACGME to highlight learning opportunities in rural and public health. We commend the Council on highlighting current opportunities at specific medical schools, opportunities during GME, and beyond. Thank you for your consideration.

Opinion Type:

My post reflects the opinion of my delegation or section

Signature Name:

Sanjay Menghani

Delegation section or society:

AMA-MSS



Thu, 10/11/2018 - 13:41

#1

Carla Frenzel

Reconciliation of AMA Policy on Primary Care Workforce

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) adopt as policy "Principles of and Actions to Address Primary Care Workforce" the language shown in column 1 in Appendix A to this report. (New HOD Policy)

1. That our AMA rescind the following policies, as shown in Appendix C:

1. D-200.979, "Barriers to Primary Care as a Medical School Choice"
2. D-200.994, "Appropriations for Increasing Number of Primary Care Physicians"
3. H-200.956, "Appropriations for Increasing Number of Primary Care Physicians"
4. H-200.966, "Federal Financial Incentives and Medical Student Career Choice"
5. H-200.973, "Increasing the Availability of Primary Care Physicians"
6. H-200.975, "Availability, Distribution and Need for Family Physicians"
7. H-200.977, "Establishing a National Priority and Appropriate Funding for Increased Training of Primary Care Physicians"
8. H-200.978, "Loan Repayment Programs for Primary Care Careers"
9. H-200.982, "Significant Problem of Access to Health Care in Rural and Urban Underserved Areas"
10. H-200.997, "Primary Care"
11. H-295.956, "Educational Grants for Innovative Programs in Undergraduate and Residency Training for Primary Care Careers"
12. H-300.957, "Promoting Primary Care Services Through Continuing Medical Education"
13. H-310.973, "Primary Care Residencies in Community Hospitals" (Rescind HOD Policy)

1. That H-200.972, "Primary Care Physicians in the Inner City," be amended by addition and deletion, and a title change, to read as follows:

"Primary Care Physicians in Underserved Areas"

Our AMA should pursue the following plan to improve the recruitment and retention of physicians in the inner-city underserved areas:

- (1) Encourage the creation and pilot-testing of school-based, ~~church-faith-based~~, and community-based urban/rural "family Hh ealth clinics, with an emphasis on health education, prevention, primary care, and prenatal care.
- (2) Encourage the affiliation of these family health clinics with ~~urban-local~~ medical schools and teaching hospitals.
- (3) ~~Promote medical student rotations through the various inner-city neighborhood family health clinics, with financial assistance to the clinics to compensate their teaching efforts.~~
- (4) ~~Encourage medical schools and teaching hospitals to integrate third- and fourth-year undergraduate medical education and residency training into these teams.~~
- (53) Advocate for the implementation of AMA policy that supports extension of the rural health clinic concept to urban areas with appropriate federal agencies.

- (6) — Study the concept of having medical schools with active outreach programs in the inner city offer additional training to physicians from nonprimary care specialties who are interested in achieving specific primary care competencies.
- (7) — Consider expanding opportunities for practicing physicians in other specialties to gain specific primary care competencies through short-term preceptorships or postgraduate fellowships offered by departments of family practice, internal medicine, pediatrics, etc. These may be developed so that they are part-time, thereby allowing physicians enrolling in these programs to practice concurrently.
- (84) Encourage the AMA Senior Physicians Services Group Section to consider the use involvement of retired physicians in underserved urban settings of retired physicians, with appropriate mechanisms to ensure their competence.
- (95) Urge urban hospitals and medical societies to develop opportunities for physicians to work part-time to staff urban health clinics that help meet the needs of underserved patient populations.
- (106) Encourage the AMA and state medical associations to incorporate into state and federal health system reform legislative relief or immunity from professional liability for senior, part-time, or other physicians who serve the inner-city poor help meet the needs of underserved patient populations.
- (11) — Urge medical schools to seek out those students whose profiles indicate a likelihood of practicing in underserved urban areas, while establishing strict guidelines to preclude discrimination.
- (12) — Encourage medical school outreach activities into secondary schools, colleges, and universities to stimulate students with these profiles to apply to medical school.
- (13) — Encourage medical schools to continue to change their curriculum to put more emphasis on primary care.
- (14) — Urge state medical associations to support the development of methods to improve physician compensation for serving this population, such as Medicaid case management programs in their respective states.
- (157) Urge urban hospitals and medical centers to seek out the use of available military health care resources and personnel, which can be used to fill gaps in urban care help meet the needs of underserved patient populations.
- (16) — Urge CMS to explore the use of video and computer capabilities to improve access to and support for urban primary care practices in underserved settings.
- (17) — Urge urban hospitals, medical centers, state medical associations, and specialty societies to consider the expanded use of mobile health care capabilities.
- (18) — Continue to urge measures to enhance payment for primary care in the inner city. (Modify Current HOD Policy)

Resolution:

4

Sun, 11/04/2018 - 21:39

Nathan Carpenter

RE: Reconciliation of AMA Policy on Primary Care Workforce

Tanya Singh, medical student from Florida, speaking on behalf of the Medical Student Section in SUPPORT of the Council on Medical Education Report 4. We thank the Council for their work in consolidating AMA policy regarding the primary care workforce. We found that the proposed changes in Appendix A preserve the intent of the original resolutions and we continue to support efforts to expose medical students to primary care early in medical education. Thank you for your consideration.

Opinion Type:

My post reflects the opinion of my delegation or section

Signature Name:

Tanya Singh

Delegation section or society:
Medical Student Section



Published on American Medical Association (<https://www.ama-assn.org>)

Home > Reconciliation of AMA Policy on Medical Student Debt

Wed, 10/24/2018 - 09:43

#1

Roger Brown



Reconciliation of AMA Policy on Medical Student Debt

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) adopt as policy "Principles of and Actions to Address Medical Education Costs and Student Debt" the language shown in column 1 of Appendix A of this report.
2. That our AMA rescind the following policies, as shown in Appendix C:
 1. D-305.956, "AMA Participation in Reducing Medical Student Debt"
 2. D-305.957, "Update on Financial Aid Programs"
 3. D-305.962, "Tax Deductibility of Student Loan Payments"
 4. D-305.966, "Reinstatement of Economic Hardship Loan Deferment"
 5. D-30970, "Proposed Revisions to AMA Policy on Medical Student Debt"
 6. D-305.975, "Long-Term Solutions to Medical Student Debt"
 7. D-305.977, "Deductibility of Medical Student Loan Interest"
 8. D-305.978, "Mechanisms to Reduce Medical Student Debt"
 9. D-305.979, "State and Local Advocacy on Medical Student Debt"
 10. D-305.980, "Immediate Legislative Solutions to Medical Student Debt"
 11. D-305.981, "Financing Federal Consolidation Loans"
 12. D-305.993, "Medical School Financing, Tuition, and Student Debt"
 13. D-405.986, "Student Loans and Medicare / Medicaid Participation"
 14. H-305.926, "Supporting Legislation to Create Student Loan Savings Accounts"
 15. H-305.928, "Proposed Revisions to AMA Policy on Medical Student Debt"
 16. H-305.932, "State and Local Advocacy on Medical Student Debt"
 17. H-305.948, "Direct Loan Consolidation Program"
 18. H-305.954, "Repayment of Medical School Loans"
 19. H-305.965, "Student Loans"
 20. H-305.980, "Student Loan Repayment Grace Period"
 21. H-305.991, "Repayment of Educational Loans"

Sun, 11/04/2018 - 16:39

Nathan Carpenter

RE: Reconciliation of AMA Policy on Medical Student Debt

Nathan Carpenter, Alternate Delegate from Wisconsin speaking on behalf of the Medical Student Section in SUPPORT of the Council on Medical Education Report 5. Medical student debt is a constant concern for nearly all medical students and has been shown to influence specialty choice. The AMA has done, and is continuing to do, great work on this issue. As the authors of multiple policies that are being reconciled in this report, we believe the Council has done a great job in condensing present policy to be more concise while reflecting the same comprehensiveness. We thank our resident, fellow, and physician counterparts for their continuous support and advocacy on this issue and we thank the Reference Committee for their work as well.

Opinion Type:

My post reflects the opinion of my delegation or section

Signature Name:

Nathan Carpenter

Delegation section or society:

Medical Student Section



Published on *American Medical Association* (<https://www.ama-assn.org>)

Home > Reconciliation of AMA Policy on Resident/Fellow Contracts and Duty Hours

Thu, 10/11/2018 - 13:43

#1

Carla Frenzel

Reconciliation of AMA Policy on Resident/Fellow Contracts and Duty Hours

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

That our American Medical Association (AMA) adopt the proposed revisions shown in Appendix A, column 1, for the following three policies:

H-310.907, "AMA Duty Hours Policy" (with revised title: "Resident/Fellow Clinical and Educational Work Hours")

H-310.912, "Residents and Fellows' Bill of Rights"

H-310.929, "Principles for Graduate Medical Education" (Modify Current HOD Policy)

That our AMA rescind the following seven policies, as shown in Appendix C, and incorporate relevant portions of four of these policies into existing AMA policy:

D-310.987, "Impact of ACGME Resident Duty Hour Limits on Physician Well-Being and Patient Safety"

H-310.922, "Determining Residents' Salaries"

H-310.932, "Annual Contracts for Continuing Residents"

H-310.947, "Revision of the 'General Requirements' of the Essentials of Accredited Residency Programs"

H-310.979, "Resident Physician Working Hours and Supervision"

H-310.988, "Adequate Resident Compensation"

H-310.999, "Guidelines for Housestaff Contracts or Agreements"

Resolution:

6

Sun, 11/04/2018 - 18:13

Kylie Abeson

RE: Reconciliation of AMA Policy on Resident/Fellow Contracts and

Kylie Abeson, medical student from California, speaking on behalf of the Medical Student Section in SUPPORT of the Council on Medical Education Report 6. The MSS appreciates the consolidation and reconciliation of existing AMA policy regarding resident/fellow contracts and duty hours. We also support efforts to align AMA policy with the 2017 ACGME standards for clinical and educational work hours.

While we found the majority of the report preserved the intent of existing policy, the MSS does have concerns over the replacement of “maternity and paternity leave” with “family and medical leave” in H-310.912 , “Residents and Fellows’ Bill of Rights.” Because the Family and Medical Leave Act (FMLA) requires 12 months of work before an individual is eligible, we are concerned that PGY-1 residents will not qualify for leave under this law, potentially leaving a gap in policy. We suggest additional language to ensure that PGY-1 residents are afforded the same benefits as all other residents. We would like to thank the Reference Committee in their work on this issue.

Opinion Type:

My post reflects the opinion of my delegation or section

Signature Name:

Kylie Abeson

Delegation section or society:

Medical Student Section



Published on *American Medical Association* (<https://www.ama-assn.org>)

Home > Prevention of Physician and Medical Student Suicide

Fri, 09/28/2018 - 11:29

#1

Carla Frenzel

Prevention of Physician and Medical Student Suicide

RESOLVED, That our AMA request that the Liaison Committee on Medical Education and the Accreditation Council for Graduate Medical Education collect data on medical student, resident and fellow suicides to identify patterns that could predict such events.

Resolution:
951

Sat, 10/27/2018 - 18:21

DAVID WELSH

RE: Prevention of Physician and Medical Student Suicide

Support. This problem has to be handled better.

Opinion Type:
My post is my personal opinion

Mon, 10/29/2018 - 10:22

JOHN ROBERTS

RE: Prevention of Physician and Medical Student Suicide

The topic of this resolution is currently under study of the Council of Medical Education and more studies are coming out in the literature. Perhaps this should be referred until we see what the Council comes up with in its report. The Council usually does an excellent and thorough job with anything it takes on.

Opinion Type:
My post is my personal opinion

Sun, 11/04/2018 - 16:45

Paige anderson

RE: Prevention of Physician and Medical Student Suicide

Paige Anderson, Alternate Delegate from Ohio, speaking on behalf of the Medical Student Section in SUPPORT of Resolution 951.

Physician and medical student suicides do not happen in isolation, but are related to work stress and burnout that many people in the medical field unfortunately face. This is a critical issue that our AMA has been instrumental in addressing. However, there are still additional steps that need to be taken to combat this complex and vitally important problem.

By not only studying the risk factors, but also the patterns in behavior, performance, and other elements that may precede and help predict physician and medical student suicide, the AMA and other stakeholders, such as the LCME and ACGME, can take more steps to implement policy within medical education and practice that can help support and identify people at risk of suicide before it is too late.

Our MSS supports the need for continued study and intervention to help prevent physician and medical student suicide and believe this resolution accomplishes this. We believe that this resolution is a needed step to further act on current AMA policy regarding physician and medical student suicide. Thank you for your consideration.

Opinion Type:

My post reflects the opinion of my delegation or section

Signature Name:

Paige Anderson

Delegation section or society:

Medical Student Section



Published on American Medical Association (<https://www.ama-assn.org>)

Home > IMG Section Member Representation on Committees/Task Forces/Councils

Tue, 10/02/2018 - 13:14

#1

Carla Frenzel

IMG Section Member Representation on Committees/Task Forces/Councils

RESOLVED, That the American Medical Association ask the Educational Commission for Foreign Medical Graduates (ECFMG) to increase the number of international medical graduates (IMGs) proportionate to the percentage of IMGs serving in the U.S. on their councils, committees, and/or task forces.

Resolution:
952

Mon, 10/29/2018 - 23:37

CAROL BERKOWITZ

RE: IMG Section Member Representation on Committees/Task Forces/

My name is Carol Berkowitz, MD. I am a member of the AMA Council on Medical Education and am providing this testimony on behalf of the Council. I have no conflicts of interest to report. Members of the Council on Medical Education serve in voluntary capacities on boards and committees of numerous academic organizations, including the ABMS, ACGME, ACCME, LCME, NBME and others. I do not serve on the ECFMG.

*The Council on Medical Education recommends that Resolution 952 **be adopted**. Increasing IMG representation in the ECFMG leadership is a reasonable request that will help ensure that the ECFMG continues to be an effective organization.*

Opinion Type:
My post reflects the opinion of my delegation or section
Signature Name:
CAROL BERKOWITZ
Delegation section or society:
Council on Medical Education



Published on *American Medical Association* (<https://www.ama-assn.org>)

Home > Support for the Income-Driven Repayment Plans

Tue, 10/02/2018 - 13:15

#1

Carla Frenzel

Support for the Income-Driven Repayment Plans

RESOLVED, That our American Medical Association advocate for continued funding of programs including Income-Driven Repayment plans for the benefit of reducing medical student loan burden.

Resolution:
953

Sun, 10/28/2018 - 20:23

Rohit Abraham

RE: Support for the Income-Driven Repayment Plans

My name is Rohit Abraham. I am a member of the AMA Council on Medical Education and am providing this testimony on behalf of the Council. I have no conflicts of interest to report. Members of the Council on Medical Education serve in voluntary capacities on boards and committees of numerous academic organizations, including the ABMS, ACGME, ACCME, LCME, NBME and others.

The Council on Medical Education recommends that Resolution 953 be adopted for the following reasons. Current AMA policy supports maintenance and expansion both of state and federal programs that minimize the impact of student loan debt on the pursuit of a career in medicine. As such, income-driven repayment plans are critical programs that enable a diverse range of students the ability to specialize in their desired discipline within the profession's workforce.

Opinion Type:
My post reflects the opinion of my delegation or section

Signature Name:

Rohit Abraham

Delegation section or society:

Council on Medical Education

Sun, 11/04/2018 - 17:05

Allison Linehan

RE: Support for the Income-Driven Repayment Plans

Allison Linehan, medical student from Wisconsin, speaking on behalf of the Medical Student Section in SUPPORT of Resolution 953. The U.S. Department of Education crafted the Income-Driven Repayment (IDR) plans to reduce the burden of student loan

debt, but these programs were not adequately budgeted for, leading to proposed budget cuts to IDR programs and the Public Service Loan Forgiveness program. Our AMA has expended significant efforts to reduce the burden of student loan debt but has not directly addressed IDR plans. IDR plans relieve the burden of medical student loan debt by setting loan payments as a percentage of the new physician's income. Payments become more manageable with the repayment period extended from the standard 10 years to up to 25 years and the remaining balance can be forgiven at the end of that period.

Our MSS has numerous policies on medical student debt including loan forgiveness, debt management, and mechanisms by which student loan debt can be reduced. Our MSS values efforts aimed at lifting the burden of medical student debt through the evaluation and development of feasible and effective loan forgiveness programs, and notes the lack of action directed at IDR plans. We believe this resolution addresses an important gap in AMA policy. Thank you for your consideration.

Opinion Type:

My post reflects the opinion of my delegation or section

Signature Name:

Allison Linehan

Delegation section or society:

Medical Student Section



Published on American Medical Association (<https://www.ama-assn.org>)

Home > VHA GME Funding

Tue, 10/02/2018 - 13:15

#1

Carla Frenzel

VHA GME Funding

RESOLVED, That our American Medical Association continue to support the mission of the Department of Veterans Affairs Office of Academic Affiliations for expansion of graduate medical education (GME) residency positions; and be it further

RESOLVED, That our AMA collaborate with appropriate stakeholder organizations to advocate for preservation of Veterans Health Administration (VHA) funding for GME and support its efforts to expand GME residency positions in the federal budget and appropriations process; and be it further

RESOLVED, That our AMA oppose service obligations linked to VHA GME residency or fellowship positions, particularly for resident physicians rotating through the VA for only a portion of their GME training.

Resolution:
954

Sat, 10/27/2018 - 18:05

DAVID WELSH

RE: VHA GME Funding

Support.

Opinion Type:
My post is my personal opinion

Sun, 10/28/2018 - 10:30

KRYSTAL TOMEI

RE: VHA GME Funding

My name is Krystal Tomei. I am a member of the AMA Council on Medical Education and am providing this testimony on behalf of the Council. I have no conflicts of interest to report. Members of the Council on Medical Education serve in voluntary capacities on boards and committees of numerous academic organizations, including the ABMS, ACGME, ACCME, LCME, NBME and others.

The Council on Medical Education recommends that Resolution 954 be adopted for the following reasons:

Our AMA has long been an advocate for both preservation and expansion of GME funding to support the projected physician shortages and ensure positions are available for medical school graduates applying to residency programs. The GME funding

from the Department of Veterans Affairs not only supports resident training but also allows for provision of critical medical care to our veterans.

Opinion Type:

My post reflects the opinion of my delegation or section

Signature Name:

KRYSTAL TOMEI

Delegation section or society:

Council on Medical Education

Mon, 10/29/2018 - 10:55
(Reply to #3)

JOHN ROBERTS

RE: VHA GME Funding

Krystal, Perhaps the Council would like to take on the review and consolidation of AMA Policy D-305.967. This thing has more appendages and accoutrements than a decorator crab. There have been more than a dozen "Appended" resolutions since 2011 and there are many redundancies. The Council did a great job this year reconciling the AMA policies on the Primary Care Workforce and Medical Student Debt!

Opinion Type:

My post is my personal opinion

Mon, 10/29/2018 - 10:11

JOHN ROBERTS

RE: VHA GME Funding

My name is John Roberts and I am a member of the Academic Physician Section and currently serve on its Governing Council. The following is my personal views/comments. I am not speaking for the Section. I have a concern regarding the 3rd resolve: "That our AMA oppose service obligations linked to VHA residency or fellowship positions....."

All funding for resident/fellowship positions, whether private, VA or CMS, carry with it the expectation that the resident/fellow will perform service to patients during the resident's or fellow's years in the training program. The authors need to clarify this resolve - are they speaking against obligating the resident/fellow to service following their training? Are the authors speaking against the use of the on-site service-time metric for dispersment of resident funding? I too find the VA "support for resident education" to be a misleading when what they actually pay for is the service the residents/fellows provide to the veterans. As an academic I think it would be ideal if the VA would say, "We consider it important that we train dermatologists that can treat our future veterans. This local VA want to train one dermatology resident. Here is the money to fund that resident. Train them the best way you know how but we want you to cover these clinics and be available for consultations." The current rules are so complicated that my institution never gets the full funding for a resident FTE. Again, I think the authors of the resolution need to make clearer the intent of the 3rd resolve.

Opinion Type:

My post is my personal opinion



Published on American Medical Association (<https://www.ama-assn.org>)

Home > Equality for COMLEX and USMLE

Tue, 10/02/2018 - 13:16

#1

Carla Frenzel

Equality for COMLEX and USMLE

RESOLVED, That our American Medical Association promote equal acceptance of the USMLE and COMLEX at all United States residency programs; and be it further

RESOLVED, That our AMA work with appropriate stakeholders including but not limited to the National Board of Medical Examiners, Association of American Medical Colleges, National Board of Osteopathic Medical Examiners, Accreditation Council for Graduate Medical Education and American Osteopathic Association to educate Residency Program Directors on how to interpret and use COMLEX scores; and be it further

RESOLVED, That our AMA work with Residency Program Directors to promote higher COMLEX utilization with residency program matches in light of the new single accreditation system.

Resolution:

955

Thu, 10/25/2018 - 19:11

Robert Goldberg

RE: Equality for COMLEX and USMLE

My name is Robert Goldberg. I am a member of the AMA Council on Medical Education and am providing this testimony on behalf of the Council. Members of the Council on Medical Education serve in voluntary capacities on boards and committees of numerous academic organizations, including the ABMS, ACGME, ACCME, LCME, NBME and others. I have no conflicts of interest to report, but as a former dean and chief academic officer of an osteopathic medical school, have intimate knowledge about this issue.

The Council on Medical Education recommends that Resolution 955 be adopted for the following reasons: the issue is timely as the single accreditation pathway and NMRP will be the primary avenue that all osteopathic medical students will participate in for residency application. In addition to the facts stated within the resolution, the COMLEX Examination is a graduation requirement for all osteopathic medical students, and the examination taken by 1 in 5 future physicians is a measurement tool that all program directors should be familiar with and accept.

Opinion Type:

My post reflects the opinion of my delegation or section

Signature Name:

Robert Goldberg

Delegation section or society:

Council on Medical Education

Aakash Sheth

RE: Equality for COMLEX and USMLE

Aakash Sheth, Delegate from New Jersey, speaking on behalf of the Medical Student Section in strong SUPPORT as sponsors of Resolution 955.

The 2020 merger of the AOA and ACGME matches under the umbrella of the ACGME is expected to yield net benefits for students, such as expanding the pool of possible residency spots for most applicants. However, one lingering issue is the status of the USMLE and COMLEX exam sequences.

US MD students take the USMLE exam sequence, and DO students take the COMLEX sequence alone or both the COMLEX and USMLE sequences. Currently, there is a large disparity between program directors' usage of the exams for residency selection criteria, with greater preference for the USMLE over the COMLEX. For example, fewer program directors currently use the COMLEX Level 1 to the same degree they use the USMLE STEP 1 for residency selection criteria. The 2016 NRMP Program Director Survey found only 77% of surveyed program directors use the COMLEX Level 1 for pass only and with a target score in mind but 99% use the USMLE STEP 1.

Beyond simply relatively lower use of the COMLEX by program directors, there also exists a potential score bias when the two tests are equated. Currently, some programs use the Slocum and Louder formula to compare students across tests. As per a 2014 study, the formula has been shown to underpredict scores of COMLEX Level 1 takers on the USMLE STEP 1 by an average of 14.16 points.

Resolution 955 addresses this inequity in a manner that is consistent with past AMA policy and within the understood purview of the AMA. The first Resolved clause calls for equal acceptance of both exams which expands upon previous AMA policy more explicitly. The third Resolved clause is a call to action for the AMA to work with program directors to promote greater acceptance of the COMLEX.

The second Resolved clause enumerates specific stakeholders that the AMA will work with to resolve the inequity, "including but not limited to the National Board of Medical Examiners, Association of American Medical Colleges, National Board of Osteopathic Medical Examiners, Accreditation Council for Graduate Medical Education, and American Osteopathic Association to educate Residency Program Directors on how to interpret and use COMLEX scores.". This Resolved clause encourages a multilateral concerted effort with relevant parties to work towards greater equity. We urge the AMA to take action on an issue that affects the future workforce in the fashion set by this resolution, consistent with past AMA precedent, within the purview of the AMA, and relevant towards ensuring equity in the American medical system. Thank you for your consideration.

Opinion Type:

My post reflects the opinion of my delegation or section

Signature Name:

Aakash Sheth

Delegation section or society:

MSS



Published on *American Medical Association* (<https://www.ama-assn.org>)

Home > Increasing Rural Rotations During Residency

Tue, 10/02/2018 - 13:17

#1

Carla Frenzel

Increasing Rural Rotations During Residency

RESOLVED, That our American Medical Association work with state and specialty societies, medical schools, teaching hospitals, the Accreditation Council for Graduate Medical Education (ACGME), the Centers for Medicare and Medicaid Services (CMS) and other interested stakeholders to encourage and incentivize qualified rural physicians to serve as preceptors, volunteer faculty, etc. for rural rotations in residency; and be it further

RESOLVED, That our AMA work with the ACGME, the American Board of Medical Specialties, the Federation of State Medical Boards, CMS and other interested stakeholders to lessen or remove regulations or requirements on residency training and physician practice that preclude formal educational experiences and rotations for residents in rural areas; and be it further

RESOLVED, That our AMA work with interested stakeholders to identify strategies to increase residency training opportunities in rural areas with a report back to the House of Delegates; and be it further

RESOLVED, That our AMA work with state and specialty societies and other interested stakeholders to identify appropriately qualified rural physicians who would be willing to serve as preceptors for rural rotations in residency; and be it further

RESOLVED, That our AMA work with the ACGME and other interested stakeholders to lessen the documentation requirements for off-site rural rotations during residency so that affiliated rural supervising faculty can focus on educating rotating residents; and be it further

RESOLVED, That our AMA work with interested stakeholders to study other ways to increase training in rural areas; and be it further

RESOLVED, That our AMA formulate an actionable plan of advocacy based on the results of the above study with the goal of increasing residency training in rural areas.

Resolution:

956

Sat, 10/27/2018 - 18:07

DAVID WELSH

RE: Increasing Rural Rotations During Residency

I support this resolution. IU has been working on this issue.

Opinion Type:

My post is my personal opinion

Mon, 10/29/2018 - 09:39

JOHN ROBERTS

RE: Increasing Rural Rotations During Residency

I support this resolution. I would suggest an additional resolution, or additional language in resolved #2, that asks that CMS remove language/interpretation in its regulations regarding establishing new residency programs that establishes the Per Resident Amount (PRA) for the purposes of Direct GME funding. The regulations are currently being interpreted such that the PRA is established when ANY resident rotates to the rural hospital. This is a barrier for hospitals, who later might want to establish a new residency program, to allow residents to rotate to their rural hospitals from other training programs.

Opinion Type:

My post is my personal opinion

Mon, 10/29/2018 - 11:50

JACQUELINE BELLO

RE: Increasing Rural Rotations During Residency

I am Jacqueline Bello, MD. member of the AMA Council on Medical Education, providing testimony on behalf of the Council, with no conflicts of interest to report. Members of the Council on Medical Education serve in voluntary capacities on boards and committees of numerous academic organizations, including the ABMS, ACGME, ACCME, LCME, and NBME among others.

Resolution #956, "Increasing Rural Rotations During Residency" has 7 RESOLVED clauses.

RESOLVED 1 and 4: The Council on Medical Education recommends adoption of the first RESOLVED clause, deleting "etc.", since this is nondescript and open-ended, and adoption of the fourth RESOLVED clause as it is written. Both are consistent with but go beyond two existing AMA policies: H-465.988, "Educational Strategies for Meeting Rural Health Physician Shortage" and H-200.954, "US Physician Shortage".

The first and fourth RESOLVED clauses propose that the AMA assume a more active role, to work with medical schools and teaching hospitals in addition to ACGME and CMS, to encourage and incentivize qualified rural physicians to serve as preceptors and volunteer faculty for rural rotations in residency, and for the AMA to work with state and specialty societies to identify such physicians.

RESOLVED 3 and 6: The Council recommends adoption of the third, RESOLVED clause as written, and deletion of the sixth RESOLVED clause interpreting it to be redundant to the third. The third RESOLVED suggests that the AMA work with interested stakeholders to identify strategies to increase residency training opportunities in rural areas with a report back to the House of Delegates, while the sixth RESOLVED asks the AMA to work with interested stakeholders to study other ways to increase training in rural areas. Such a study, called for by Resolution 954, I-17 resulting in AMA policy D-295.311, "Developing Physician Led Public Health/Population Health Capacity in Rural Communities" presents an opportunity for collaboration among AMA Councils.

RESOLVED 7: The Council further recommends adoption of the seventh RESOLVED clause, which asks the AMA to formulate an actionable plan of advocacy based on the results of the proposed study, with the goal of increasing residency training in rural areas. Existing AMA policy, H-200.954, "US Physician Shortage", in recommendation 7 supports AMA advocacy for funding from public and private payers for educational programs that provide experiences for medical students in rural and other underserved areas. Information from the proposed study may help broaden and strengthen AMA's advocacy effort to benefit graduate medical trainees as well.

RESOLVED 2 and 5: The second and fifth RESOLVED clauses propose that the AMA work with others to lessen or remove regulations or requirements on residency training and physician practice that preclude formal educational experiences and rotations for residents in rural areas and to lessen the documentation requirements for off-site rural rotations during residency so that affiliated rural supervising faculty can focus on educating rotating residents. The Council recommends that the second, and fifth RESOLVED clauses not be adopted for the following reasons:

It is the purview of the ACGME Review Committees, and not that of the AMA to define residency regulations or requirements. The AMA has ample policy (H-965.988) supporting funding of and research by rural health programs and addressing geographic and specialty physician shortages (H-200.954 and H-200.982, "Significant Problem of Access to Health Care in Rural and Urban Underserved Areas") and protecting physicians in particular practice settings from undue documentation burdens. AMA policy H-450-947, "Pay-for-Performance Principles and Guidelines", recently reaffirmed at A-18 states, in part, ". . . 2. Programs must neither directly nor indirectly disadvantage patients and their physicians, based on the setting where care is delivered or the location of populations served (such as inner city or rural areas)."

Opinion Type:

My post reflects the opinion of my delegation or section

Signature Name:

JACQUELINE BELLO

Delegation section or society:

Council on Medical Education



Published on American Medical Association (<https://www.ama-assn.org>)

Home > Board Certifying Bodies

Mon, 10/08/2018 - 09:29

#1

Carla Frenzel

Board Certifying Bodies

RESOLVED, That our American Medical Association conduct a study of the certifying bodies that compete with the American Board of Medical Specialties and issue a report opining on the qualifications of each such certifying body and whether each such certifying body should be added to the list of approved certifying entities in states where they are not currently approved; and be it further

RESOLVED, That our AMA develop model state legislation that would encourage competition among qualified certifying bodies and would modify board certification requirements such that maintenance of certification participation would not be a requirement for board recertification.

Resolution:
957

Mon, 10/29/2018 - 18:49

LYNNE KIRK

RE: Board Certifying Bodies

My name is Lynne Kirk. I am a member of the AMA Council on Medical Education and am providing this testimony on behalf of the Council. I have no conflicts of interest to report. Members of the Council on Medical Education serve in voluntary capacities on boards and committees of numerous academic organizations, including the ABMS, ACGME, ACCME, LCME, NBME and others.

The Council on Medical Education recommends that Resolution # 957 not be adopted.

The Council on Medical Education studied the available certification processes for physicians and reported to the HOD in CME Reports 2-A-16 and 2-A-17. Both reports were adopted.

It is not clear whether every state medical board maintains a list of "approved certifying entities." More likely, only those state medical boards that regulate physician use of the term "board certified" maintain such a list. The resolution's reference to "the list" as a thing every state medical board maintains is thus potentially inaccurate.

The AMA has two model bills that are related to the first part of the second resolve. First, the AMA Right to Treat Act prohibits licensing boards, hospitals, and insurers from requiring a physician to maintain certification for licensure, license renewal, hospital staff or admitting privileges, or reimbursement. The DOJ letter referenced in Resolution 957 specifically discouraged the Maryland state legislature from following the approach of legislation like the AMA Right to Treat Act—though the model legislation itself was not named, and the DOJ is likely not aware of the AMA's model legislation.

Second, the AMA Truth in Advertising Act contains a drafting note that allows for physicians certified by American Board of Medical Specialties (ABMS)/American Osteopathic Association (AOA) and certain alternative specialty certification boards to advertise themselves as being board certified. Since this model legislation specifically allows a pathway by which non-ABMS/AOA specialty boards may demonstrate their validity, the AMA Truth in Advertising Act is consistent with the first part of the second resolve.

The second part of the second resolve is not reasonable. The ABMS, AOA (though not mentioned in the resolution, AOA maintains a continuous certification program), and both organizations' member boards are private entities whose standards are not subject to regulation by state legislatures. The approach requested by the second portion of the second resolve is thus not reasonable, and legislation to that effect would be unenforceable.

The AMA maintains robust policy on MOC, including policy related to state legislative efforts. The AMA Advocacy Resource Center supports the work of state medical associations to develop and implement legislation related to specialty certification and MOC.

Perhaps most importantly, the Vision for the Future Commission is scheduled to release its recommendations to the ABMS regarding the future of continuing certification in February 2019, and depending on the nature of those recommendations, any AMA policy adopted on this topic at I-18 may be moot or inapplicable. The Council will address the Vision Commission's recommendations fully in its scheduled annual report on this topic for A-19, in addition to any other relevant discussions and information.

Opinion Type:

My post reflects the opinion of my delegation or section

Signature Name:

LYNNE KIRK

Delegation section or society:

Council on Medical Education

Sun, 11/04/2018 - 19:36

ANN STROINK

RE: Board Certifying Bodies

My name is Ann Stroink, MD, and I am submitting testimony regarding Resolution 957 on behalf of the American Association of Neurological Surgeons (AANS) and Congress of Neurological Surgeons (CNS). This statement incorporates feedback that was solicited from the American Board of Neurological Surgeons (ABNS). We are speaking in opposition to this resolution. For the following reasons:

Role of the AMA to set certification requirements. Organized neurosurgery is skeptical that the AMA can appropriately reflect the views of the specialty of neurological surgery or neurological surgeons, as the AMA has no expertise or experience to judge what organization(s) are qualified to certify neurosurgeons. Furthermore, for the AMA to oppose Maintenance of Certification (MOC) and/or Continuous Certification(CC) efforts is protectionist and comes across as self-serving, rather than promoting a valuable process that protects the public. Additionally, as evidenced by the Department of Justice opinion on the Maryland

legislation, these type of actions and other challenging organizations — including actions by the AMA to develop model legislation that decouples Continuing Certification/MOC with board certification — will eventually invite government intervention and oversight, which would ultimately result in more tedious physician bureaucracy and regulations. Is that what the AMA and the medical profession truly wants? It is important to note that the ABNS has initiated radical and innovative enhancements to our Continuing Certification process to make it easy, educational, positive and inexpensive. Neurosurgeons know what is best for our profession and our surgeons, not the AMA or other organizations.

There is no doubt that the American Board of Medical Specialties (ABMS) remains shortsighted and has approached MOC/CC in an inappropriate manner. However, rather than fighting the MOC/CC fight in the state legislatures, it would be better for the AMA to encourage the ABMS to turn the corner to approach MOC/CC correctly, including launching a national campaign to the public promoting that the value of MOC/CC is to ensure that physicians are maintaining their clinical competencies to provide excellent patient care.

AMA encouraging competition. Organized neurosurgery is open to competition as long as the standards remain high and the requirements for certification by certifying bodies are publicly available. But any AMA model legislation must require transparency about the qualifications and standards of the alternative certifying entities. Furthermore, the ABNS also believes it is crucial that when someone claims to be "Board Certified," that that individual is required to say exactly which board by which they board they are certified. The ABNS is confident that the standards and requirements for ABNS certification can exceed that of any competition without being unreasonably expensive and overly burdensome to neurosurgeons.

Maintenance of Certification/Continuing Certification. The ABNS is vehemently opposed to eliminating MOC/CC. The true goal of board certification and MOC/CC is to advance the public good by confirming and advancing physician competency, and neurosurgery firmly believes that it is essential to assure the public that the profession is practicing safely. Staying up to date on evolving high-level scientific evidence is part of this obligation. At the same time, the ABNS recognizes that MOC/CC must be useful to the diplomate, cost-neutral, and be reasonably expected to improve public health.

Opinion Type:

My post reflects the opinion of my delegation or section

Signature Name:

ANN STROINK

Delegation section or society:

Neurosurgery delegation



Published on American Medical Association (<https://www.ama-assn.org>)

Home > National Health Service Corps Eligibility

Tue, 10/16/2018 - 14:56

#1

Carla Frenzel

National Health Service Corps Eligibility

RESOLVED, That our American Medical Association consider eligibility criteria changes for the National Health Service Corps Program to increase the pool of eligible physicians, such as allowing participation from primary care physicians providing in-patient hospitalist care in health professional shortage areas. (Directive to Take Action)

Resolution:
958

Mon, 10/29/2018 - 11:16

John Williams

RE: National Health Service Corps Eligibility

My name is John P Williams, MD. I am a member of the AMA Council on Medical Education and am providing this testimony on behalf of the Council. I [have no conflicts of interest to report. Members of the Council on Medical Education serve in voluntary capacities on boards and committees of numerous academic organizations, including the ABMS, ACGME, ACCME, LCME, NBME and others.

The Council on Medical Education recommends that: AMA Policy D-305.975 and D- 200.980 be reaffirmed in lieu of Resolution 958 for the following reasons.

Current policy allows for the AMA, in cooperation with relevant specialty medical societies, to advocate for continued federal and state support for scholarship and loan repayment programs, including the National Health Service Corps, designed to encourage physician practice in underserved areas and with underserved populations.

Further, our current policy asks for for the creation of a national repository of innovations and experiments, both successful and unsuccessful, in improving access to and distribution of physician services to government-insured patients (National Access Toolbox).

Further, the types of facilities that fall under the definition of an HPSA include: Other Facility (OFAC)—public or non-profit private medical facilities serving a population or geographic area designated as a HPSA with a shortage of health providers; and IHS and Tribal Hospitals—Federal Indian Health Service (IHS), Tribally-run hospitals that provide inpatient and outpatient medical services to members of federally recognized Tribes and Alaska Natives.

Finally, our current policy asks that our AMA advocate for increased funding for the National Health Service Corps Loan Repayment Program to assure adequate funding of primary care within the National Health Service Corps, as well as to permit: (a) inclusion of all medical specialties in need, and (b) service in clinical settings that care for the underserved but are not

necessarily located in health professions shortage areas

Thus, it seems that our current policy generally covers the specifics that are outlined in the current resolution.

Opinion Type:

My post reflects the opinion of my delegation or section

Signature Name:

John P Williams, MD

Delegation section or society:

Council on Medical Education



Published on *American Medical Association* (<https://www.ama-assn.org>)

Home > Physician and Medical Student Mental Health and Suicide

Tue, 10/16/2018 - 14:57

#1

Carla Frenzel

Physician and Medical Student Mental Health and Suicide

RESOLVED, That our American Medical Association create a new Physician and Medical Student Suicide Prevention Committee with the goal of addressing suicides and mental health disease in physicians and medical students. This committee will be charged with:

- 1) Developing novel policies to decrease physician and medical trainee stress and improve professional satisfaction.
- 2) Vociferous, repeated and widespread messaging to physicians and medical students encouraging those with mood disorders to seek help.
- 3) Working with state medical licensing boards and hospitals to help remove any stigma of mental health disease and to alleviate physician and medical student fears about the consequences of mental illness and their medical license and hospital privileges.
- 4) Establishing a 24-hour mental health hotline staffed by mental health professionals whereby a troubled physician or medical student can seek anonymous advice. Communication via the 24-hour help line should remain anonymous. This service can be directly provided by the AMA or could be arranged through a third party, although volunteer physician counselors may be an option for this 24-hour phone service. (Directive to Take Action)

Resolution:
959

Sat, 10/27/2018 - 18:24

DAVID WELSH

RE: Physician and Medical Student Mental Health and Suicide

I support the concept of the resolution. I would recommend involving "interested stakeholders": specialty societies, state associations, hospital systems, hospital association and others. The OMSS can help with constructive supportive by-laws input.

Opinion Type:
My post is my personal opinion

Mon, 10/29/2018 - 23:44

CAROL BERKOWITZ

RE: Physician and Medical Student Mental Health and Suicide

My name is Carol Berkowitz, MD. I am a member of the AMA Council on Medical Education and am providing this testimony on behalf of the Council. I have no conflicts of interest to report. Members of the Council on Medical Education serve in voluntary capacities on boards and committees of numerous academic organizations, including the ABMS, ACGME, ACCME, LCME, NBME and others. I do not serve on the ECFMG.

The issue of medical student, resident and physician mental health and suicide is the focus of a Council of Medical Education Report for Annual 2019 and this resolution could be referred to the Council to address is the pending report.

Opinion Type:

My post reflects the opinion of my delegation or section

Signature Name:

CAROL BERKOWITZ

Delegation section or society:

Council on Medical Education

Sun, 11/04/2018 - 17:02

Allison Linehan

RE: Physician and Medical Student Mental Health and Suicide

Allison Linehan, medical student from Wisconsin, speaking on behalf of the Medical Student Section in SUPPORT of Resolution 959. Physician and medical student suicide continues to be a glaring issue in the medical field. Physicians and students are reluctant to report mental health issues for fear of social ostracization or professional consequences. A Physician and Medical Student Suicide Prevention Committee could benefit medical professionals and aid in reducing medical professional and medical student suicide rates. Our MSS supports suicide prevention and mental health awareness across the medical professional spectrum and has passed multiple policies emphasizing the importance of medical student and physician mental health and well-being, which could be strengthened by the addition of a committee whose sole focus is the elimination of medical professional suicide. We would like to thank the Reference Committee for your time and consideration of this matter.

Opinion Type:

My post reflects the opinion of my delegation or section

Signature Name:

Allison Linehan

Delegation section or society:

Medical Student Section



Published on *American Medical Association* (<https://www.ama-assn.org>)

Home > Inadequate Residency Slots

Tue, 10/16/2018 - 14:58

#1

Carla Frenzel

Inadequate Residency Slots

RESOLVED, That our American Medical Association adopt policy to establish parity between the number of medical school graduates and the number of match positions and withhold support for any further increase in medical school enrollment, unless there is a corresponding increase in residency positions (New HOD Policy); and be it further

RESOLVED, That our AMA lobby the federal government for increased funding for residency spots, to investigate other sustainable models for residency position funding and to advocate for loan repayment waivers for individuals who fail to match. (Directive to Take Action)

Resolution:

960

Sat, 10/27/2018 - 18:26

DAVID WELSH

RE: Inadequate Residency Slots

I support the second resolve strongly.

Opinion Type:

My post is my personal opinion

Sun, 10/28/2018 - 21:08

LUKE SELBY

RE: Inadequate Residency Slots

My name is Luke Selby, I am a member of the AMA Council on Medical Education and am providing this testimony on behalf of the Council. I have no conflicts of interest to report. Members of the Council on Medical Education serve in voluntary capacities on boards and committees of numerous academic organizations, including the ABMS, ACGME, ACCME, LCME, NBME and others. The Council on Medical Education recommends AMA policy be reaffirmed in lieu of the first Resolve of Resolution 960 and the second Resolve deleted.

The first resolved clause is quite similar to CME Report 3-A-18 was the result of Policy D-305.967, which (in part) directed the AMA to "study the effect of medical school expansion that occurs without corresponding graduate medical education expansion" (note: that part of the policy was fulfilled through writing of the report, and was thereby rescinded). In CME 3-A-18, we

recommended a number of actions in keeping with the spirit of the proposed resolution; these actions were incorporated into Policy D-305.967, as follows:

"32. Our AMA will: (a) encourage all existing and planned allopathic and osteopathic medical schools to thoroughly research match statistics and other career placement metrics when developing career guidance plans; (b) strongly advocate for and work with legislators, private sector partnerships, and existing and planned osteopathic and allopathic medical schools to create and fund graduate medical education (GME) programs that can accommodate the equivalent number of additional medical school graduates consistent with the workforce needs of our nation; and (c) encourage the Liaison Committee on Medical Education (LCME), the Commission on Osteopathic College Accreditation (COCA), and other accrediting bodies, as part of accreditation of allopathic and osteopathic medical schools, to prospectively and retrospectively monitor medical school rates of placement into GME as well as GME completion.

The second resolved clause largely mirrors existing AMA policy with the exception of the last clause, which advocates for loan waivers for students who fail to match. For a variety of reasons, including punishing students who successfully match and rewarding schools with the tuition of their students who fail to match we are specifically opposed to this clause, and recommend its deletion.

Opinion Type:

My post reflects the opinion of my delegation or section

Signature Name:

LUKE SELBY

Delegation section or society:

Council on Medical Education

Sun, 11/04/2018 - 16:58

Madhulika (Madd...

RE: Inadequate Residency Slots

Madhulika Banerjee, medical student from Arizona, speaking on behalf of the Medical Student Section in SUPPORT of the second Resolved clause of Resolution 960. Over the past several years, the growing disparity between the number of available medical school seats versus residency program spots has resulted in a growing population of fourth year medical students who do not match. Not only does this waste a valuable population of appropriately trained physicians in a time when we have a known need for medical providers, it also increases the financial burden and stress experienced by medical students across the country, further contributing to anxiety, depression, and burnout.

Our MSS supports AMA policy that advocates for the stable provision of federal funds for GME positions, opposes efforts to reduce said funding, and actively explores additional sources of funding to improve the quality of existing residency training and opportunities to provide such training to qualified students. In addition to this policy, stronger action is necessary at this time to ensure the future of not only medical students as they attempt to transition into the workforce of physicians, but the future of our country's healthcare system as a whole. The second Resolved clause of Resolution 260 is in line with the SaveGME campaign and would be a strong initial step towards solving a problem that has been festering for far too long.

Thank you to the Reference Committee for your time and consideration of this matter.

Opinion Type:

My post reflects the opinion of my delegation or section

Signature Name:

Banerjee

Delegation section or society:

MSS

Sun, 11/04/2018 - 17:23
(Reply to #4)

Madhulika (Madd...

RE: Inadequate Residency Slots

Aforementioned testimony (2nd paragraph) inaccurately references Resolution 260, but should be referencing the second Resolved clause of the resolution in question (Resolution 960). Apologies for any confusion. Should read as follows:

Madhulika Banerjee, medical student from Arizona, speaking on behalf of the Medical Student Section in SUPPORT of the second Resolved clause of Resolution 960. Over the past several years, the growing disparity between the number of available medical school seats versus residency program spots has resulted in a growing population of fourth year medical students who do not match. Not only does this waste a valuable population of appropriately trained physicians in a time when we have a known need for medical providers, it also increases the financial burden and stress experienced by medical students across the country, further contributing to anxiety, depression, and burnout.

Our MSS supports AMA policy that advocates for the stable provision of federal funds for GME positions, opposes efforts to reduce said funding, and actively explores additional sources of funding to improve the quality of existing residency training and opportunities to provide such training to qualified students. In addition to this policy, stronger action is necessary at this time to ensure the future of not only medical students as they attempt to transition into the workforce of physicians, but the future of our country's healthcare system as a whole. The second Resolved clause of Resolution 960 is in line with the SaveGME campaign and would be a strong initial step towards solving a problem that has been festering for far too long.

Thank you to the Reference Committee for your time and consideration of this matter.

Opinion Type:

My post reflects the opinion of my delegation or section

Signature Name:

Madhulika (Maddy) Banerjee

Delegation section or society:

MSS



Published on *American Medical Association* (<https://www.ama-assn.org>)

Home > Protect Physician-Led Medical Education

Tue, 10/16/2018 - 14:58

#1

Carla Frenzel

Protect Physician-Led Medical Education

RESOLVED, That our American Medical Association, in their role as a member organization of the Liaison Committee on Medical Education and Accreditation Council for Graduate Medical Education, strongly advocate for the rights of medical students, residents, and fellows to be trained, supervised, and evaluated by licensed physicians (Directive to Take Action); and be it further

RESOLVED, That our AMA provide medical students, residents, and fellows a clear online resource outlining their rights, as per Liaison Committee on Medical Education and Accreditation Council for Graduate Medical Education guidelines, to physician-led education and a means to report violations without fear of retaliation. (Directive to Take Action)

Resolution:

961

Wed, 10/24/2018 - 16:06

Jim Rohack

RE: Protect Physician-Led Medical Education

I would hope that the trainee would wish the best individual to train them, regardless of terminal degree. To understand best the social determinates of health, it might be a social worker. For certain mental health issues, it might be best for a psychologist to help in the training. In the ICU, sometimes the best teacher of how to assess for bed sores and provide skin care are the nurses that have been there for many years.

I have no problems assuring that physicians are actively engaged in trainee education, but just because one has a license, does not make one automatically the best nor a good teacher. Thus, my concern with how the first Resolved is phrased.

Opinion Type:

My post is my personal opinion

Sat, 10/27/2018 - 18:13

DAVID WELSH

RE: Protect Physician-Led Medical Education

I support the concepts in the resolve. Dr Rohack makes good points. This past week I was a Moderator on a panel at the ACS Clinical Congress covering reducing Ergonomic injuries. Yvonne Saravise Phd, a physical therapy expert gave one of the best instructions on reducing Ergonomic injuries I have heard.

Opinion Type:

My post is my personal opinion

Mon, 10/29/2018 - 12:01

JACQUELINE BELLO

RE: Protect Physician-Led Medical Education

I am Jacqueline Bello, MD. member of the AMA Council on Medical Education, providing testimony on behalf of the Council, with no conflicts of interest to report. Members of the Council on Medical Education serve in voluntary capacities on boards and committees of numerous academic organizations, including the ABMS, ACGME, ACCME, LCME, and NBME among others.

Resolution #961, "Protect Physician-Led Medical Education" has two RESOLVED clauses.

RESOLVED 1

The Council on Medical Education recommends reaffirmation of existing AMA policies H-310.912, "Residents and Fellows Bill of Rights" and H-295.955, "Teacher-Learner Relationship in Medical Education" in lieu of the first RESOLVED clause, which asks the AMA to strongly advocate for the rights of medical students and fellows to be trained, supervised and evaluated by licensed physicians.

Existing AMA Policy H-310.912 supports resident and fellow rights to qualified faculty who devote sufficient time to their education, and supervision by physicians and non-physicians who are adequately qualified and which allows them to assume progressive responsibility appropriate to their level of education, competence, and experience.

It remains the purview of the ACGME to define faculty qualifications in the Core Program Requirements. Specifically, section II.B of this document allows for physician *and non-physician faculty*, and outlines strict parameters requiring sufficient numbers of faculty with strong interest in education and time allocation to supervisory and teaching responsibilities. It entrusts to the individual specialty Review Committees the role to judge acceptable qualifications beyond board certification, medical licensure, medical staff and institutional appointments. The AMA has oversight and input through representation on the ACGME board.

Existing AMA Policy H-295.955 recommends that each medical education institution have a widely disseminated policy that: (1) sets forth the expected standards of behavior of the teacher and the learner; (2) delineates procedures for dealing with breaches of that standard, including: (a) avenues for complaints, (b) procedures for investigation, (c) protection and confidentiality, (d) sanctions;

The Code of Behavior included in the policy states that the learner can expect the teacher to provide instruction, guidance, inspiration, and leadership in learning. The twelve LCME Accreditation Standards include a standard for faculty (preparation, participation, productivity and policies) and a standard covering teaching, supervision, and assessment. The AMA has oversight and input through representation on the LCME board. In addition, two LCME student members are appointed annually, one by the AMA Board of Trustees based on the recommendation of the AMA Medical Student Section (MSS) and one by the AAMC based on the recommendation of medical school deans and in consultation with the AAMC Organization of Student Representatives (OSR). The LCME pays all expenses incurred by student members related to their service on the LCME.

RESOLVED 2

The Council on Medical Education recommends that the second RESOLVED clause not be adopted. This clause asks the AMA to provide medical students, residents and fellows a clear online resource outlining their rights to physician-led education and a means to report violations without fear of retaliation. The requested online resource(s) already exist through the ACGME and LCME websites, which are freely accessible.

In its Core Requirements document, the ACGME requires confidential faculty and program evaluation by residents (sections V.B.3 and V.C.2d), resident participation on the Program Evaluation Committee (section V.C.1a) and a confidential process for reporting, investigating and addressing concerns (section VI.B.6).

The LCME document, The Role of Students in the Accreditation of Medical Education Programs in the U.S., available online, outlines mechanisms for student participation in the accreditation process, including a survey tool in Appendix D. This document also notes that information about the LCME's complaint policy can be found in the LCME Rules of Procedure publication, available from the LCME website.

Opinion Type:

My post reflects the opinion of my delegation or section

Signature Name:

JACQUELINE BELLO

Delegation section or society:

Council on Medical Education