

REPORTS OF THE COUNCIL ON MEDICAL EDUCATION

The following reports, 1–6, were presented by Lynne M. Kirk, MD, Chair.

1. COUNCIL ON MEDICAL EDUCATION SUNSET REVIEW OF 2008 HOUSE POLICIES

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS REMAINDER OF REPORT FILED

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

1. As the House of Delegates adopts policies, a maximum ten-year time horizon shall exist. A policy will typically sunset after ten years unless action is taken by the House of Delegates to retain it. Any action of our AMA House that reaffirms or amends an existing policy position shall reset the sunset “clock,” making the reaffirmed or amended policy viable for another 10 years.
2. In the implementation and ongoing operation of our AMA policy sunset mechanism, the following procedures shall be followed: (a) Each year, the Speakers shall provide a list of policies that are subject to review under the policy sunset mechanism; (b) Such policies shall be assigned to the appropriate AMA Councils for review; (c) Each AMA council that has been asked to review policies shall develop and submit a report to the House of Delegates identifying policies that are scheduled to sunset; (d) For each policy under review, the reviewing council can recommend one of the following actions: (i) Retain the policy; (ii) Sunset the policy; (iii) Retain part of the policy; or (iv) Reconcile the policy with more recent and like policy; (e) For each recommendation that it makes to retain a policy in any fashion, the reviewing Council shall provide a succinct, but cogent justification; (f) The Speakers shall determine the best way for the House of Delegates to handle the sunset reports.
3. Nothing in this policy shall prohibit a report to the HOD or resolution to sunset a policy earlier than its 10-year horizon if it is no longer relevant, has been superseded by a more current policy, or has been accomplished.
4. The AMA Councils and the House of Delegates should conform to the following guidelines for sunset: (a) when a policy is no longer relevant or necessary; (b) when a policy or directive has been accomplished; or (c) when the policy or directive is part of an established AMA practice that is transparent to the House and codified elsewhere such as the AMA Bylaws or the AMA House of Delegates Reference Manual: Procedures, Policies and Practices.
5. The most recent policy shall be deemed to supersede contradictory past AMA policies.
6. Sunset policies will be retained in the AMA historical archives.

The Council on Medical Education’s recommendations on the disposition of the 2008 House policies that were assigned to it are included in the Appendix to this report. Due to their complexity, and the need for a more thorough consolidation of policy than is available through the sunset report mechanism, the following policies will be addressed in a Council on Medical Education report(s) at the 2018 Interim Meeting:

H-200.956, “Appropriations for Increasing Number of Primary Care Physicians”

H-200.966, “Federal Financial Incentives and Medical Student Career Choice”

H-200.973, “Increasing the Availability of Primary Care Physicians”

H-200.977, “Establishing a National Priority and Appropriate Funding for Increased Training of Primary Care Physicians”

H-200.978, “Loan Repayment Programs for Primary Care Careers”

H-200.997, “Primary Care”

H-295.956, “Educational Grants for Innovative Programs in Undergraduate and Residency Training for Primary Care Careers”

H-310.979, “Resident Physician Working Hours and Supervision”

H-310.999, “Guidelines for Housestaff Contracts or Agreements”

D-305.970, “Proposed Revisions to AMA Policy on Medical Student Debt”

D-305.978, “Mechanisms to Reduce Medical Student Debt”

D-305.980, “Immediate Legislative Solutions to Medical Student Debt”

RECOMMENDATION

The Council on Medical Education recommends that the House of Delegates policies listed in the appendix to this report be acted upon in the manner indicated and the remainder of this report be filed.

APPENDIX - Recommended Actions on 2008 and Other or Related House of Delegates Policies

<i>Policy Number, Title, Policy</i>	<i>Recommended Action</i>
<i>H-200.975, “Availability, Distribution and Need for Family Physicians”</i>	
The AMA will continue to recommend specific strategies to increase the availability of primary care physicians, which may include curricular modification, financing mechanisms for medical education and research, financial aid options, and modifications of the practice environment. (Sub. Res. 306, I-92; Reaffirmed: CME Rep. 2, A-03; Modified: CME Rep. 2, I-03; Reaffirmation I-08)	Retain.
<i>H-250.991, “Support of the AMA Mission in International Medicine”</i>	
The AMA will include the International Medical Graduates Section as a resource for international medical initiatives. (Res. 608, A-98; Reaffirmed: CLRPD Rep. 1, A-08)	Retain; still relevant.
<i>H-255.980, “USMLE Scores not Sole Criteria for Residency Selection”</i>	
Our AMA (1) urges that the United States Medical Licensing Examination (USMLE) scores not be used as the sole criteria for selecting interns and residents; (2) recommends that residency programs consider all of the candidates’ attributes and qualifications during the selection process; and (3) reaffirms policy that residency appointments should be made solely on the basis of the individual applicants merit and qualifications. Citation: Res. 143, A-90; Appended Res. 303, I-98; Modified and Reaffirmed: CME Rep. 2, A-08; Modified: Speakers Rep. 01, A-17	Retain; still relevant.
<i>H-275.937, “Patient/Physician Relationship and Medical Licensing Boards”</i>	
(1) Our AMA encourages all state medical societies to advocate for inclusion of the following policy in their state medical licensing board regulations: Without regard to whether an act or failure to act is entirely determined by a physician, or is the result of a contractual or other relationship with a health care entity, the relationship between a physician and a patient must be based on trust and must be considered inviolable. Included among the elements of such a relationship of trust are: (a) Open and honest communication between the physician and the patient, including disclosure of all information necessary for the patient to be an informed participant in his or her care.(b)- Commitment of the physician to be an advocate for the patient and for what is best for the patient, without regard to the physician’s personal interests. (c) Provision by the physician of that care which is necessary and appropriate for the condition of the patient and neither	Retain; still relevant, with the editorial change shown below: (4) Our AMA encourages all state medical societies to advocate for inclusion of the following policy in their state medical licensing board regulations: (1) . . .

<p>more nor less.(d)- Avoidance of any conflict of interest or inappropriate relationships outside of the therapeutic relationship.</p> <p>(2) The relationship between a physician and a patient is fundamental and is not to be constrained or adversely affected by any considerations other than what is best for the patient. The existence of other considerations, including financial or contractual concerns, is and must be secondary to the fundamental relationship.</p> <p>(3) Any act or failure by a physician that violates the trust upon which the relationship is based may place the physician at risk of being found in violation of the Medical Practice Act.</p> <p>(4) The following statement reflects the policy of the (name of state) Board of Medical Examiners regarding the physicians it licenses.</p> <p>(5) A (name of state) physician has both medical-legal and ethical obligations to his or her patients. These are well established in both law and professional tradition. Some models of medical practice may result in an inappropriate restriction of the physician's ability to practice quality medicine. This may create negative consequences for the public. It is incumbent that physicians take those actions they consider necessary to assure that medical practice models do not adversely affect the care that they render to their patients. (BOT Rep. 30, I-98; Reaffirmed: CME Rep. 2, A-08)</p>	
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H-275.938, "USMLE Part III and Licensure"

Our AMA will lobby the Federation of State Medical Boards to discourage states from linking mandatory application for licensure with application to take the USMLE Part III. (Res. 325, A-98; Reaffirmed: CME Rep. 2, A-08)	Retain, still relevant, with the following editorial changes: Our AMA will lobby <u>advocate to</u> the Federation of State Medical Boards to discourage states from linking mandatory application for licensure with application to take the USMLE Part III <u>Step 3</u> .
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H-275.957, "Changing the Grading Policy for Medical Licensure Examinations"

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)	<p>Sunset; superseded by H-255.980, "USMLE Scores not Sole Criteria for Residency Selection," as follows:</p> <p>Our AMA (1) urges that the United States Medical Licensing Examination (USMLE) scores not be used as the sole criteria for selecting interns and residents; (2) recommends that residency programs consider all of the candidates' attributes and qualifications during the selection process; and (3) reaffirms policy that residency appointments should be made solely on the basis of the individual applicants merit and qualifications."</p>
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H-275.968, "Recredentialing of Physicians"

The AMA vigorously opposes any state or other government agency plan for mandated recredentialing of physicians for the purpose of relicensure or reregistration. (Res. 201, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CME Rep. 2, A-08)	Retain through incorporation into H-275.978, "Medical Licensure," as follows: (23) <u>vigorously opposes any state or other government agency plan for mandated recredentialing of physicians for the purpose of relicensure or reregistration.</u>
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H-275.972, "Annual Report of Disciplinary Actions from the Federation of State Medical Boards"

The AMA supports the Federation of State Medical Boards' efforts to assure that organizations that use the Federation's copyrighted disciplinary data secure permission to do so and accompany their publications with an explanation that comparison between states based on those data alone is misleading to the public and does a disservice to the work of the state medical boards. (Sub.	<p>Retain through incorporation into H-275.978, "Medical Licensure," to read as follows:</p> <p>(24) <u>supports the Federation of State Medical Boards' efforts to assure that organizations that use the Federation's copyrighted disciplinary data secure permission to do so and accompany their publications with an explanation that</u></p>
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Res. 126, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CME Rep. 2, A-08)	<u>comparison between states based on those data alone is misleading to the public and does a disservice to the work of the state medical boards.</u>
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H-275.978, "Medical Licensure"

<p>The AMA: (1) urges directors of accredited residency training programs to certify the clinical competence of graduates of foreign medical schools after completion of the first year of residency training; however, program directors must not provide certification until they are satisfied that the resident is clinically competent;</p> <p>(2) encourages licensing boards to require a certificate of competence for full and unrestricted licensure;</p> <p>(3) urges licensing boards to review the details of application for initial licensure to assure that procedures are not unnecessarily cumbersome and that inappropriate information is not required. Accurate identification of documents and applicants is critical. It is recommended that boards continue to work cooperatively with the Federation of State Medical Boards to these ends;</p> <p>(4) will continue to provide information to licensing boards and other health organizations in an effort to prevent the use of fraudulent credentials for entry to medical practice;</p> <p>(5) urges those licensing boards that have not done so to develop regulations permitting the issuance of special purpose licenses. It is recommended that these regulations permit special purpose licensure with the minimum of educational requirements consistent with protecting the health, safety and welfare of the public;</p> <p>(6) urges licensing boards, specialty boards, hospitals and their medical staffs, and other organizations that evaluate physician competence to inquire only into conditions which impair a physician's current ability to practice medicine. (BOT Rep. I-93-13; CME Rep. 10 - I-94);</p> <p>(7) urges licensing boards to maintain strict confidentiality of reported information;</p> <p>(8) urges that the evaluation of information collected by licensing boards be undertaken only by persons experienced in medical licensure and competent to make judgments about physician competence. It is recommended that decisions concerning medical competence and discipline be made with the participation of physician members of the board;</p> <p>(9) recommends that if confidential information is improperly released by a licensing board about a physician, the board take appropriate and immediate steps to correct any adverse consequences to the physician;</p> <p>(10) urges all physicians to participate in continuing medical education as a professional obligation;</p> <p>(11) urges licensing boards not to require mandatory reporting of continuing medical education as part of the process of reregistering the license to practice medicine;</p> <p>(12) opposes the use of written cognitive examinations of medical knowledge at the time of reregistration except when there is reason to believe that a physician's knowledge of medicine is deficient;</p> <p>(13) supports working with the Federation of State Medical Boards to develop mechanisms to evaluate the competence of physicians who do not have hospital privileges and who are not subject to peer review;</p> <p>(14) believes that licensing laws should relate only to requirements for admission to the practice of medicine and to assuring the continuing competence of physicians, and</p>	<p>Revise to incorporate the following relevant policies that are being appended to this policy:</p> <p>H-275.968, "Recredentialing of Physicians"</p> <p>H-275.972, "Annual Report of Disciplinary Actions from the Federation of State Medical Boards."</p> <p>The AMA: (1) urges directors of accredited residency training programs to certify the clinical competence of graduates of foreign medical schools after completion of the first year of residency training; however, program directors must not provide certification until they are satisfied that the resident is clinically competent;</p> <p>(2) encourages licensing boards to require a certificate of competence for full and unrestricted licensure;</p> <p>(3) urges licensing boards to review the details of application for initial licensure to assure that procedures are not unnecessarily cumbersome and that inappropriate information is not required. Accurate identification of documents and applicants is critical. It is recommended that boards continue to work cooperatively with the Federation of State Medical Boards to these ends;</p> <p>(4) will continue to provide information to licensing boards and other health organizations in an effort to prevent the use of fraudulent credentials for entry to medical practice;</p> <p>(5) urges those licensing boards that have not done so to develop regulations permitting the issuance of special purpose licenses. It is recommended that these regulations permit special purpose licensure with the minimum of educational requirements consistent with protecting the health, safety and welfare of the public;</p> <p>(6) urges licensing boards, specialty boards, hospitals and their medical staffs, and other organizations that evaluate physician competence to inquire only into conditions which impair a physician's current ability to practice medicine. (BOT Rep. I-93-13; CME Rep. 10 - I-94);</p> <p>(7) urges licensing boards to maintain strict confidentiality of reported information;</p> <p>(8) urges that the evaluation of information collected by licensing boards be undertaken only by persons experienced in medical licensure and competent to make judgments about physician competence. It is recommended that decisions concerning medical competence and discipline be made with the participation of physician members of the board;</p> <p>(9) recommends that if confidential information is improperly released by a licensing board about a physician, the board take appropriate and immediate steps to correct any adverse consequences to the physician;</p> <p>(10) urges all physicians to participate in continuing medical education as a professional obligation;</p> <p>(11) urges licensing boards not to require mandatory reporting of continuing medical education as part of the process of reregistering the license to practice medicine;</p> <p>(12) opposes the use of written cognitive examinations of medical knowledge at the time of reregistration except when there is reason to believe that a physician's knowledge of medicine is deficient;</p> <p>(13) supports working with the Federation of State Medical Boards to develop mechanisms to evaluate the competence</p>
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<p>opposes efforts to achieve a variety of socioeconomic objectives through medical licensure regulation;</p> <p>(15) urges licensing jurisdictions to pass laws and adopt regulations facilitating the movement of licensed physicians between licensing jurisdictions; licensing jurisdictions should limit physician movement only for reasons related to protecting the health, safety and welfare of the public;</p> <p>(16) encourages the Federation of State Medical Boards and the individual medical licensing boards to continue to pursue the development of uniformity in the acceptance of examination scores on the Federation Licensing Examination and in other requirements for endorsement of medical licenses;</p> <p>(17) urges licensing boards not to place time limits on the acceptability of National Board certification or on scores on the United State Medical Licensing Examination for endorsement of licenses;</p> <p>(18) urges licensing boards to base endorsement on an assessment of physician competence and not on passing a written examination of cognitive ability, except in those instances when information collected by a licensing board indicates need for such an examination;</p> <p>(19) urges licensing boards to accept an initial license provided by another board to a graduate of a US medical school as proof of completion of acceptable medical education;</p> <p>(20) urges that documentation of graduation from a foreign medical school be maintained by boards providing an initial license, and that the documentation be provided on request to other licensing boards for review in connection with an application for licensure by endorsement;</p> <p>(21) urges licensing boards to consider the completion of specialty training and evidence of competent and honorable practice of medicine in reviewing applications for licensure by endorsement; and</p> <p>(22) encourages national specialty boards to reconsider their practice of decertifying physicians who are capable of competently practicing medicine with a limited license. (CME Rep. A, A-87 Modified: Sunset Report, I-97; Reaffirmation A-04; Reaffirmed: CME Rep. 3, A-10; Reaffirmation I-10; Reaffirmed: CME Rep. 6, A-12 Appended: Res. 305, A-13 Reaffirmed: BOT Rep. 3, I-14)</p>	<p>of physicians who do not have hospital privileges and who are not subject to peer review;</p> <p>(14) believes that licensing laws should relate only to requirements for admission to the practice of medicine and to assuring the continuing competence of physicians, and opposes efforts to achieve a variety of socioeconomic objectives through medical licensure regulation;</p> <p>(15) urges licensing jurisdictions to pass laws and adopt regulations facilitating the movement of licensed physicians between licensing jurisdictions; licensing jurisdictions should limit physician movement only for reasons related to protecting the health, safety and welfare of the public;</p> <p>(16) encourages the Federation of State Medical Boards and the individual medical licensing boards to continue to pursue the development of uniformity in the acceptance of examination scores on the Federation Licensing Examination and in other requirements for endorsement of medical licenses;</p> <p>(17) urges licensing boards not to place time limits on the acceptability of National Board certification or on scores on the United State Medical Licensing Examination for endorsement of licenses;</p> <p>(18) urges licensing boards to base endorsement on an assessment of physician competence and not on passing a written examination of cognitive ability, except in those instances when information collected by a licensing board indicates need for such an examination;</p> <p>(19) urges licensing boards to accept an initial license provided by another board to a graduate of a US medical school as proof of completion of acceptable medical education;</p> <p>(20) urges that documentation of graduation from a foreign medical school be maintained by boards providing an initial license, and that the documentation be provided on request to other licensing boards for review in connection with an application for licensure by endorsement;</p> <p>(21) urges licensing boards to consider the completion of specialty training and evidence of competent and honorable practice of medicine in reviewing applications for licensure by endorsement; and</p> <p>(22) encourages national specialty boards to reconsider their practice of decertifying physicians who are capable of competently practicing medicine with a limited license; and</p> <p>(23) vigorously opposes any state or other government agency plan for mandated recredentialing of physicians for the purpose of relicensure or reregistration; and</p> <p>(24) supports the Federation of State Medical Boards' efforts to assure that organizations that use the Federation's copyrighted disciplinary data secure permission to do so and accompany their publications with an explanation that comparison between states based on those data alone is misleading to the public and does a disservice to the work of the state medical boards.</p>

H-275.981, "Education in the Professional Discipline Process"

<p>The AMA (1) urges all state medical associations to recommend that each medical school in its state invite members of the state agency in charge of professional medical conduct to lecture on the topic of professional discipline; and (2) urges each state medical association to recommend that each hospital in its state with a training program invite a member of the state agency in charge of professional medical conduct to disseminate to its</p>	<p>Retain; still relevant.</p>
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housestaff information on the workings of the professional discipline agency. (Res. 8, I-86; Reaffirmed: Sunset Report, I-98; Reaffirmed: CME Rep. 2, A-08)	
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H-295.869, "Student Loan Empowerment"

	<p>Retain through incorporation into D-305.993, "Medical School Financing, Tuition, and Student Debt," to read as follows:</p> <ol style="list-style-type: none"> 1. The Board of Trustees of our AMA will pursue the introduction of member benefits to help medical students, resident physicians, and young physicians manage and reduce their debt burden. This should include consideration of the feasibility of a developing web-based information on financial planning/debt management; introducing a loan consolidation program, automatic bill collection and, loan repayment programs, and a rotating loan program; and creating an AMA scholarship program funded through philanthropy. The AMA also should collect and disseminate information on available opportunities for medical students and resident physicians to obtain financial aid for emergency and other purposes. 2. Our AMA will vigorously advocate for ongoing, adequate funding for federal and state programs that provide scholarship or loan repayment funds in return for service, including funding in return for practice in underserved areas, participation in the military, and participation in academic medicine or clinical research. Obtaining adequate support for the National Health Service Corps and similar programs, tied to the demand for participation in the programs, should be a focus for AMA advocacy efforts. 3. Our AMA will collect and disseminate information on successful strategies used by medical schools to cap or reduce tuition. 4. Our AMA will encourage medical schools to provide yearly financial planning/debt management counseling to medical students.
Our AMA supports a requirement that medical schools inform students of all government loan opportunities along with private loans, and requires disclosure of reasons that preferred lenders were chosen. (Res. 307, A-08)	<p><u>5. Our AMA supports a requirement that medical schools inform students of all government loan opportunities and requires disclosure of reasons that preferred lenders were chosen.</u></p>
	<p>56. Our AMA will urge the Accreditation Council for Graduate Medical Education (ACGME) to revise its Institutional Requirements to include a requirement that financial planning/debt management counseling be provided for resident physicians.</p> <p>67. Our AMA will work with other organizations, including the Association of American Medical Colleges, residency program directors groups, and members of the Federation, to develop and disseminate standardized information, for example, computer-based modules, on financial planning/debt management for use by medical students, resident physicians, and young physicians.</p> <p>78. Our AMA will work with other concerned organizations to promote legislation and regulations with the aims of increasing loan deferment through the period of residency, promoting the expansion of subsidized loan programs, eliminating taxes on aid from service-based programs, and restoring tax deductibility of interest on educational loans.</p> <p>89. Our AMA will advocate against putting a monetary cap on federal loan forgiveness programs.</p>

	<p>9<u>10</u>. Our AMA will: (a) advocate for maintaining a variety of student loan repayment options to fit the diverse needs of graduates; (b) work with the United States Department of Education to ensure that any cap on loan forgiveness under the Public Service Loan Forgiveness program be at least equal to the principal amount borrowed; and (c) ask the United States Department of Education to include all terms of Public Service Loan Forgiveness in the contractual obligations of the Master Promissory Note.</p> <p>10<u>11</u>. Our AMA encourages 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.</p> <p>11<u>12</u>. Our AMA will advocate that the profit status of a physician's training institution not be a factor for PSLF eligibility.</p> <p>12<u>13</u>. Our AMA encourages medical school financial advisors to counsel wise borrowing by medical students, in the event that the PSLF program is eliminated or severely curtailed.</p> <p>13<u>14</u>. Our AMA encourages medical school financial advisors to promote to medical students service-based loan repayment options, and other federal and military programs, as an attractive alternative to the PSLF in terms of financial prospects as well as providing the opportunity to provide care in medically underserved areas.</p> <p>14<u>15</u>. Our AMA will strongly advocate that the terms of the PSLF that existed at the time of the agreement remain unchanged for any program participant in the event of any future restrictive changes.</p>
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H-295.892, "Potential Implications of Attending Non-LCME/AOA Accredited Medical Education Programs"

Our AMA encourages efforts to educate all prospective medical students about the potential implications of attending any non-Liaison Committee on Medical Education/American Osteopathic Association accredited medical education program. (Res. 322, I-98; Reaffirmed: CME Rep. 2, A-08)	Sunset; superseded by D-295.309, "Promoting and Reaffirming Domestic Medical School Clerkship Education," which reads in part: "4. AMA policy is that U.S. citizens should have access to factual information on the requirements for licensure and for reciprocity in the various U.S. medical licensing jurisdictions, prerequisites for entry into graduate medical education programs, and other relevant factors that should be considered before deciding to undertake the study of medicine in schools not accredited by the LCME or COCA."
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H-295.893, "Voting Rights for AMA-MSS NBME Representatives"

Our AMA will: (1) petition the National Board of Medical Examiners (NBME) to add AMA student representation to the National Board, the governing and voting body of the NBME; and (2) work with the NBME to ensure that the AMA-MSS, through its Governing Council, is given appropriate advance notice of any major upcoming votes. (Res. 323, I-98; Reaffirmed: CME Rep. 2, A-08; Reaffirmed: CME Rep. 10, A-08)	Sunset; no longer relevant, as this has been accomplished.
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H-295.894, "Medical Education on Sleep and Sleep Disorders"

Our AMA supports diagnosis and management of sleep and sleep disorders as an essential and integral component of medical education. (Res. 310, I-98; Reaffirmed: CME Rep. 2, A-08)	Retain; still relevant.
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H-295.896, "Conscience Clause: Final Report"

<p>Principles to guide exemption of medical students from activities based on conscience include the following:</p> <p>(1) Medical schools should address the various types of conflicts that could arise between a physician's individual conscience and patient wishes or health care institution policies as part of regular curricular discussions of ethical and professional issues.</p> <p>(2) Medical schools should have mechanisms in place that permit students to be excused from activities that violate the students' religious or ethical beliefs. Schools should define and regularly review what general types of activities a student may exempt as a matter of conscience, and what curricular alternatives are required for students who exempt each type of activity.</p> <p>(3) Prospective students should be informed prior to matriculation of the school's policies related to exemption from activities based on conscience.</p> <p>(4) There should be formal written policies that govern the granting of an exemption, including the procedures to obtain an exemption and the mechanism to deal with matters of conscience that are not covered in formal policies.</p> <p>(5) Policies related to exemption based on conscience should be applied consistently.</p> <p>(6) Students should be required to learn the basic content or principles underlying procedures or activities that they exempt. Any exceptions to this principle should be explicitly described by the school.</p> <p>(7) Patient care should not be compromised in permitting students to be excused from participating in a given activity. (CME Rep. 9, I-98; Reaffirmed: CEJA Rep. 11, A-08)</p>	Retain; still relevant.
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H-295.902, "Alternative Medicine"

(1) AMA policy states that courses offered by medical schools on alternative medicine should present the scientific view of unconventional theories, treatments, and practice as well as the potential therapeutic utility, safety, and efficacy of these modalities. (2) Our AMA will work with members of the Federation to convey physicians' and patients' concerns and questions about alternative care to the NIH Office of Alternative Medicine and work with them and other appropriate bodies to address those concerns and questions. (CSA Rep. 12, A-97; Appended by Res. 525, A-98; Reaffirmed: CSAPH Rep. 2, A-08)	Retain; still relevant.
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H-295.972, "Education Regarding Prescribing Controlled Substances"

The AMA (1) encourages physicians, hospital medical staff organizations, resident physicians, and medical students to participate in education programs to ensure proper prescribing and dispensing of controlled substances; and (2) encourages regulatory agencies, state medical societies, and state medical boards to recognize the value of participation in such educational programs as an alternative to imposing disciplinary sanctions on well-intentioned physicians. (Sub. Res. 76, I-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CME Rep. 2, A-08)	Retain; still relevant.
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H-295.993, "Inclusion of Medical Students and Residents in Medical Society Impaired Physician Programs"

<p>Our AMA: (1) recognizes the need for (a) appropriate mechanisms to include medical students and resident physicians in existing medical society impaired physician programs; and (b) these programs to include activities to prevent impairment; and (2) encourages medical school administration and students to work together to develop creative ways to inform students concerning available medical school impairment treatment programs and that schools ensure that these services are provided confidentially. (Sub. Res. 84, I-82; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmed and appended: CME Rep. 4, I-98; Reaffirmed: CME Rep. 2, A-08)</p>	<p>Retain, but incorporate following amendments by addition and deletion:</p> <p>Our AMA: (1) recognizes the need for (a) appropriate mechanisms to include medical students and resident physicians in <u>the monitoring and advocacy services of state existing medical society impaired physician health</u> programs; and (b) these <u>wellness and other</u> programs to include activities to prevent impairment <u>and burnout</u>; and (2) encourages medical school administration and students to work together to develop creative ways to inform students concerning available <u>student assistance programs</u> and other related services medical school impairment treatment programs and that schools ensure that these services are provided confidentially.</p>
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H-295.999, "Medical Student Support Groups"

	<p>Retain through incorporation into H-295.858, "Access to Confidential Health Services for Medical Students and Physicians," as follows:</p> <p>1. Our AMA will ask the Liaison Committee on Medical Education, Commission on Osteopathic College Accreditation, American Osteopathic Association, and Accreditation Council for Graduate Medical Education to encourage medical schools and residency/fellowship programs, respectively, to:</p> <p>A. Provide or facilitate the immediate availability of urgent and emergent access to low-cost, confidential health care, including mental health and substance use disorder counseling services, that: (1) include appropriate follow-up; (2) are outside the trainees' grading and evaluation pathways; and (3) are available (based on patient preference and need for assurance of confidentiality) in reasonable proximity to the education/training site, at an external site, or through telemedicine or other virtual, online means;</p> <p>B. Ensure that residency/fellowship programs are abiding by all duty hour restrictions, as these regulations exist in part to ensure the mental and physical health of trainees;</p> <p>C. Encourage and promote routine health screening among medical students and resident/fellow physicians, and consider designating some segment of already-allocated personal time off (if necessary, during scheduled work hours) specifically for routine health screening and preventive services, including physical, mental, and dental care; and</p> <p>D. Remind trainees and practicing physicians to avail themselves of any needed resources, both within and external to their institution, to provide for their mental and physical health and well-being, as a component of their professional obligation to ensure their own fitness for duty and the need to prioritize patient safety and quality of care by ensuring appropriate self-care, not working when sick, and following generally accepted guidelines for a healthy lifestyle.</p> <p>2. Our AMA will urge state medical boards to refrain from asking applicants about past history of mental health or substance use disorder diagnosis or treatment, and only focus on current impairment by mental illness or addiction, and to accept "safe haven" <input type="checkbox"/> non-reporting for physicians seeking licensure or relicensure who are undergoing treatment for mental health or addiction issues, to help</p>
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	<p>ensure confidentiality of such treatment for the individual physician while providing assurance of patient safety.</p> <p>3. Our AMA encourages medical schools to create mental health and substance abuse awareness and suicide prevention screening programs that would:</p> <p>A. be available to all medical students on an opt-out basis;</p> <p>B. ensure anonymity, confidentiality, and protection from administrative action;</p> <p>C. provide proactive intervention for identified at-risk students by mental health and addiction professionals; and</p> <p>D. inform students and faculty about personal mental health, substance use and addiction, and other risk factors that may contribute to suicidal ideation.</p> <p>4. Our AMA: (a) encourages state medical boards to consider physical and mental conditions similarly; (b) encourages state medical boards to recognize that the presence of a mental health condition does not necessarily equate with an impaired ability to practice medicine; and (c) encourages 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.</p> <p>5. Our AMA: (a) encourages study of medical student mental health, including but not limited to rates and risk factors of depression and suicide; (b) encourages medical schools to confidentially gather and release information regarding reporting rates of depression/suicide on an opt-out basis from its students; and (c) will work with other interested parties to encourage research into identifying and addressing modifiable risk factors for burnout, depression and suicide across the continuum of medical education.</p>
<p>1) Our AMA encourages the development of alternative methods for dealing with the problems of student-physician mental health among medical schools, such as: (a) introduction to the concepts of physician impairment at orientation; (b) ongoing support groups, consisting of students and house staff in various stages of their education; (c) journal clubs; (d) fraternities; (e) support of the concepts of physical and mental well-being by heads of departments, as well as other faculty members; and/or (f) the opportunity for interested students and house staff to work with students who are having difficulty.</p> <p>(2) Our AMA supports making these alternatives available to students at the earliest possible point in their medical education. (Res. 164, A-79; Reaffirmed: CLRPD Rep. B, I-89; Reaffirmed: CME Rep. 4, I-98; Reaffirmed: CME Rep. 2, A-08)</p>	<p><u>6) Our AMA encourages the development of alternative methods for dealing with the problems of student-physician mental health among medical schools, such as: (a) introduction to the concepts of physician impairment at orientation; (b) ongoing support groups, consisting of students and house staff in various stages of their education; (c) journal clubs; (d) fraternities; (e) support of the concepts of physical and mental well-being by heads of departments, as well as other faculty members; and/or (f) the opportunity for interested students and house staff to work with students who are having difficulty. Our AMA supports making these alternatives available to students at the earliest possible point in their medical education.</u></p>

H-305.938, "Use of Social Security Numbers in Student Loan Accounts"

Our AMA will work with student loan servicers and other associated agencies to end the use of Social Security Numbers as account numbers. (Res. 302, I-98; Reaffirmed: CME Rep. 2, A-08)	Retain; still relevant.
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H-310.935, "The Educational and Work Environment of Resident Physicians"

AMA policy is that there should be resident organizations in place at institutions that sponsor graduate medical education programs to facilitate the ability of residents to negotiate about issues related to their working environment. (CME Rep. 11, A-98; Reaffirmed: CME Rep. 2, A-08)	Retain; although the Accreditation Council for Graduate Medical Education has related policy in its Institutional Requirements, the AMA needs to have policy that addresses the need for residents to be able to negotiate on issues related to their working conditions.
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H-310.967, "Resident Training in Varied Settings"

<p>Our AMA reaffirms the inclusion of ambulatory care settings and the participation of community hospitals in graduate medical education. (CME Rep. A, A-90; Reaffirmed: Sunset Report, I-00; Reaffirmation I-08)</p>	<p>Sunset; superseded by H-310.929, "Principles for Graduate Medical Education," which reads in part: "(14) GRADUATE MEDICAL EDUCATION IN THE AMBULATORY SETTING. Graduate medical education programs must provide educational experiences to residents in the broadest possible range of educational sites, so that residents are trained in the same types of sites in which they may practice after completing GME. It should include experiences in a variety of ambulatory settings, in addition to the traditional inpatient experience. The amount and types of ambulatory training is a function of the given specialty."</p> <p>Also reflected in H-305.929, "Proposed Revisions to AMA Policy on the Financing of Medical Education Programs," which reads in part: "H. Funding for graduate medical education should support the training of resident physicians in both hospital and non-hospital (ambulatory) settings. Federal and state funding formulas must take into account the resources, including volunteer faculty time and practice expenses, needed for training residents in all specialties in non-hospital, ambulatory settings. Funding for GME should be allocated to the sites where teaching occurs."</p> <p>Also reflected in H-295.949, "Encouraging Community Based Medical Education," which reads: "Our AMA recognizes and acknowledges the vital role of practicing physicians in community hospitals in medical student and resident teaching."</p> <p>Also reflected in The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education D-305.967 (26), which reads: "Our AMA encourages insurance payers and foundations to enter into partnerships with state and local agencies as well as academic medical centers and community hospitals seeking to expand GME."</p>
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H-310.973, "Primary Care Residencies in Community Hospitals"

<p>Our AMA advocates that the Accreditation Council for Graduate Medical Education support primary care residency programs, including community hospital based programs. (Sub. Res. 27, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmation I-08)</p>	<p>Retain; still relevant.</p>
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H-315.982, "CMS Documentation Guidelines for Teaching Physicians"

<p>The AMA will work with the CMS to: (1) reduce the redundant and burdensome documentation for teaching physicians; (2) accept documentation by the physician team under the supervision of a teaching physician if it collectively meets all CMS documentation requirements; and (3) accept a statement of the teaching physician's level of participation in patient care as sufficient or adequate documentation. (Res. 861, A-98; Reaffirmed: CME Rep. 2, A-08)</p>	<p>Retain; still relevant.</p>
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H-350.979, "Increase the Representation of Minority and Economically Disadvantaged Populations in the Medical Profession"

<p>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</p>	<p>Retain; still relevant.</p>
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<p>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.</p> <p>(2) Encouraging all medical schools to reaffirm the goal of increasing representation of underrepresented minorities in their student bodies and faculties.</p> <p>(3) Urging medical school admission committees to consider minority representation as one factor in reaching their decisions.</p> <p>(4) Increasing the supply of minority health professionals.</p> <p>(5) Continuing its efforts to increase the proportion of minorities in medical schools and medical school faculty.</p> <p>(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.</p> <p>(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.</p> <p>(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)</p>	
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H-360.981, "State Legislative Response to NBME Practice of Using USMLE Step 3 Physician Licensing Exam Questions for Doctors of Nursing Practice Certification"

	<p>Retain through incorporation into H-35.972, "Need to Expose and Counter Nurse Doctoral Programs (NDP) Misrepresentation," as follows:</p> <p>1. It is the policy of our AMA that institutions offering advanced education in the healing arts and professions shall fully and accurately inform applicants and students of the educational programs and degrees offered by an institution and the limitations, if any, on the scope of practice under applicable state law for which the program prepares the student. 2. Our AMA disapproves of questions developed for the United States Medical Licensing Examination (USMLE) being used for purposes other than the assessment of physicians-in-training and physicians. 3. Our AMA, with the Council of Medical Specialty Societies, and members of the Federation, will continue to work with the National Board of Medical Examiners (NBME) to assure that accurate information continues to be presented in communications about the use of USMLE questions in the Doctor of Nursing Practice (DNP) examination. 4. Our AMA, through its representatives to the NBME, will continue to provide feedback as plans for the restructuring of the USMLE are developed and implemented. 5. Our AMA will request the NBME to emphasize in future publications that the DNP certification examination is not for the purposes of licensure of nurses. 6. Our AMA will continue to monitor the use of questions developed for the USMLE and COMLEX by any group for purposes other than the assessment of physicians-in-training and physicians;</p>
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AMA policy is that the integrity of the physician (MD/DO) licensure process, through appropriate examination, be maintained so that no person is misled that the training of allied health professionals through their programs or certification is equivalent to the education, skills and training of physicians (MDs/DOs). (Res. 212, I-08)	<u>7. Our AMA policy is that the integrity of the physician (MD/DO) licensure process, through appropriate examination, be maintained so that no person is misled that the training of allied health professionals through their programs or certification is equivalent to the education, skills and training of physicians (MDs/DOs).</u> (Res. 211, A-06 Appended: CME Rep. 10, A-10 Modified: CCB/CLRPD Rep. 2, A-14)
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H-360.982, "Leadership for Patient Safety: Reducing the Hospital Registered Nurse Shortage at the Bedside"

<p>Our AMA supports:</p> <ol style="list-style-type: none"> 1. increased physician awareness of their role in solving the RN shortage at the bedside and the importance of physicians' participation in efforts to relieve the shortage; 2. increased awareness of opportunities for physician leadership and participation in efforts to solve the RN shortage at the bedside; 3. physician efforts to identify those models and strategies that are most applicable to their communities and hospitals and, additionally, will produce the best results; and 4. national efforts to increase funding for bedside nursing education. (BOT Rep. 27, A-08) 	<p>Sunset; still relevant, but superseded by D-360.998, "The Growing Nursing Shortage in the United States," which reads:</p> <p>"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;</p> <p>(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;</p> <p>(3) encourages hospitals and other health care facilities to collect and analyze data on the relationship between staffing levels, nursing interventions, and patient outcomes, and to use this data in the quality assurance process;</p> <p>(4) will work with nursing, hospital, and other appropriate organizations to enhance the recruitment and retention of qualified individuals to the nursing and other allied health professions;</p> <p>(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."</p>
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H-360.984, "Nursing Shortage"

Our AMA supports proposals to increase basic nursing education opportunities, workforce incentives and similar efforts to increase the supply of registered nurses. (Res. 313, A-02 Reaffirmed: CME Rep. 2, A-12)	<p>Sunset; superseded by D-360.998, "The Growing Nursing Shortage in the United States."</p> <p>In particular, "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...."</p>
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H-360.999, "Nursing Education"

The AMA urges that a constructive attitude be assumed by the medical profession at all levels in an attempt to aid those closely concerned with nursing education, to increase the facilities for those training programs, and to aid in recruiting personnel into the training programs. (BOT Rep. D, A-59; Reaffirmed: CLRPD Rep. C, A-88; Reaffirmed: CLRPD Rep. 1, I-98; Reaffirmed: CME Rep. 2, A-08)	<p>Sunset; superseded by D-360.998, "The Growing Nursing Shortage in the United States." In particular, "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;</p> <p>(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...."</p>
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	<p>(4) will work with nursing, hospital, and other appropriate organizations to enhance the recruitment and retention of qualified individuals to the nursing and other allied health professions;</p> <p>(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.”</p>
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H-450.987, “Education of Physicians in Utilization and Quality Review Matters”

<p>The AMA (1) commends medical schools that provide instruction in quality assurance and utilization review; (2) advocates making available model curriculum information to medical schools wishing to undertake such instruction; (3) reaffirms its support for the provision in the ACGME Program Requirements which requires that residents participate in patient care review activities; and (4) supports and encourages accredited sponsors which currently provide continuing medical education on the subject of quality assurance and utilization review or those which may be interested in developing educational activities for this purpose. (CME Rep. D, A-88; Reaffirmed: Sunset Report, I-98; Modified and Reaffirmed: CME Rep. 2, A-08)</p>	<p>Sunset; superseded by H-450.994 (5), “Quality Assurance in Health Care,” which reads: “Educational programs on quality assurance issues for health care professionals should be expanded through the inclusion of such material in health professions education programs, in preceptorships, in clinical graduate training and in continuing education programs.”</p>
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D-200.985, “Strategies for Enhancing Diversity in the Physician Workforce”

<p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p>	<p>Retain in part; rescind Item 5, as having been fulfilled by Council on Medical Education Report 5-A-18, “Study of Declining Native American Medical Student Enrollment.”</p>
<p>5. Our AMA will 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.</p>	<p>5. Our AMA will 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.</p>

<p>6. Our AMA will develop an internal education program for its members on the issues and possibilities involved in creating a diverse physician population.</p> <p>7. Our AMA will provide on-line educational materials for its membership that address diversity issues in patient care including, but not limited to, culture, religion, race and ethnicity.</p> <p>8. Our AMA will create and support programs that introduce elementary through high school students, especially those from groups that are underrepresented in medicine (URM), to healthcare careers.</p> <p>9. Our AMA will 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.</p> <p>10. Our AMA will recommend that medical school admissions committees use holistic assessments of admission applicants that take into account the diversity of preparation and the variety of talents that applicants bring to their education.</p> <p>11. Our AMA will advocate for the tracking and reporting to interested stakeholders of demographic information pertaining to URM status collected from Electronic Residency Application Service (ERAS) applications through the National Resident Matching Program (NRMP).</p> <p>12. Our AMA will continue the research, advocacy, collaborative partnerships and other work that was initiated by the Commission to End Health Care Disparities. (CME Rep. 1, I-06 Reaffirmation I-10 Reaffirmation A-13 Modified: CCB/CLRPD Rep. 2, A-14 Reaffirmation: A-16 Appended: Res. 313, A-17 Appended: Res. 314, A-17)</p>	<p>65. Our AMA will develop an internal education program for its members on the issues and possibilities involved in creating a diverse physician population.</p> <p>76. Our AMA will provide on-line educational materials for its membership that address diversity issues in patient care including, but not limited to, culture, religion, race and ethnicity.</p> <p>87. Our AMA will create and support programs that introduce elementary through high school students, especially those from groups that are underrepresented in medicine (URM), to healthcare careers.</p> <p>98. Our AMA will 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.</p> <p>109. Our AMA will recommend that medical school admissions committees use holistic assessments of admission applicants that take into account the diversity of preparation and the variety of talents that applicants bring to their education.</p> <p>110. Our AMA will advocate for the tracking and reporting to interested stakeholders of demographic information pertaining to URM status collected from Electronic Residency Application Service (ERAS) applications through the National Resident Matching Program (NRMP).</p> <p>121. Our AMA will continue the research, advocacy, collaborative partnerships and other work that was initiated by the Commission to End Health Care Disparities.</p>
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D-255.980, "Impact of Immigration Barriers on the Nation's Health"

<p>1. Our American Medical Association (AMA) recognizes the valuable contributions and affirms 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.</p> <p>2. Our AMA will 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.</p> <p>3. Our AMA will oppose policies that would broadly deny issuance of legal visas to persons based on their country of origin and/or religion.</p> <p>4. Our AMA will advocate for the immediate reinstatement of premium processing of H-1B visas for physicians and trainees to prevent any negative impact on patient care.</p> <p>5. Our AMA will advocate for the timely processing of visas for all physicians, including residents, fellows, and physicians in independent practice.</p> <p>6. Our AMA will work with other stakeholders to study the current impact of immigration reform efforts on residency and fellowship programs, physician supply, and timely access of patients to health care throughout the U.S.</p>	<p>Retain in part; rescind Item 7, as having been fulfilled by Council on Medical Education Report 3-I-17, "Impact of Immigration Barriers on the Nation's Health."</p>
<p>7. Our AMA will update the House of Delegates by the 2017 Interim Meeting on the impact of immigration barriers on the physician workforce. (Alt. Res. 308, A-17)</p>	<p>7. Our AMA will update the House of Delegates by the 2017 Interim Meeting on the impact of immigration barriers on the physician workforce.</p>

D-255.983, "Observerships for International Medical Graduates"

Our AMA will, through its relevant Sections, work with internal and external groups to develop guidelines for observership programs for International Medical Graduates (IMGs) who have received certification by the Educational Commission for Foreign Medical Graduates, including the following: (a) development of a set of educational objectives and a model curriculum outline; and (b) identification of educational/informational materials to address the objectives; and (c) creation of informational materials related to legal, organizational, and operational issues related to program implementation. (CME Rep. 12, A-08)	Sunset; this has been accomplished; see https://www.ama-assn.org/life-career/establish-observership-international-medical-graduates .
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D-275.999, "Board Certification and Discrimination"

Our AMA will collect information from members discriminated against solely because of lack of American Board of Medical Specialties or equivalent American Osteopathic Board certification (Res. 314, I-98; Reaffirmed: CME Report 2, A-08)	<p>Sunset; the action called for in this policy was addressed in Council on Medical Education Report 2-A-17, "Update on Maintenance of Certification and Osteopathic Continuous Certification (Resolution 315-A-16)," which was adopted in lieu of Resolution 315-A-16, "Maintenance of Certification (MOC) and Licensure (MOL) vs. Board Certification, CME and Life-Long Commitment to Learning." Resolve 2 of Resolution 315-A-16 asked that our AMA "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 Interim 2016."</p> <p>In response, the report noted: "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."</p> <p>The principles behind this policy are also reflected in H-275.924 (15), "Maintenance of Certification": "15. The MOC program should not be a mandated requirement for licensure, credentialing, recertification, privileging, reimbursement, network participation, employment, or insurance panel participation."</p>
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D-295.933, "Transparency In Medical Schools' Utilization of Funds From Tuition and Fee Increases"

Our AMA encourages the development of policies by Liaison Committee on Medical Education- and American Osteopathic Association-accredited medical schools that ensure information on the use of funds from tuition and fee increases is disclosed in a standardized format and in a timely manner to prospective and current medical students. (Sub. Res. 310, A-08)	Sunset. Schools are required to report to the LCME their actual tuition revenues, actual dollars accrued, and the percentage of total institutional revenues resulting from tuition. The complexity of medical school structure and expenditures as well as the diversity of medical school funding sources renders tracking of actual tuition dollars impossible. The LCME does monitor the percentage of
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	total revenues from tuition dollars and expects that tuition revenues are less than 50 percent of total revenues. The LCME also monitors trends in tuition revenues, both actual dollars and the percentage of total revenues. The AOA Commission on Osteopathic College Accreditation monitors similar data among its accredited schools.
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D-295.936, "Educational Implications of the Medical Home Model"

<p>Our AMA:</p> <p>(1) encourages the integration of medical education into Patient-Centered Medical Home (PC-MH) demonstration projects;</p> <p>(2) will ask the Liaison Committee on Medical Education and the Accreditation Council for Graduate Medical Education to review their accreditation standards so as not to impede education in and about the PC-MH model; and</p> <p>(3) will advocate for funding from all sources for medical schools and residency training programs to provide medical education in the context of PC-MH models. (CME Rep. 4, A-08; Modified: Speakers Rep., I-15)</p>	<p>Sunset; superseded by D-200.979, "Barriers to Primary Care as a Medical School Choice," which reads in part: "6. Our AMA will work with the Accreditation Council for Graduate Medical Education (ACGME) to develop an accreditation environment and novel pathways that promote innovations in training that use progressive, community-based models of integrated care focused on quality and outcomes such as the patient-centered medical home and the chronic care model. 7. Our AMA will advocate for public (federal and state) and private payers to develop enhanced funding and related incentives from all sources to provide graduate medical education for resident physicians and fellows in progressive, community-based models of integrated care focused on quality and outcomes such as the patient-centered medical home and the chronic care model in order to enhance primary care as a career choice. 8. Our AMA will advocate for public (federal and state) and private payers to develop enhanced funding and related incentives from all sources to provide undergraduate medical education for students in progressive, community-based models of integrated care focused on quality and outcomes such as the patient-centered medical home and the chronic care model in order to enhance primary care as a career choice. 9. Our AMA will advocate for public (federal and state) and private payers to develop physician reimbursement systems to promote primary care and specialty practices in progressive, community-based models of integrated care focused on quality and outcomes such as the patient-centered medical home and the chronic care model consistent with current AMA Policies H-160.918 and H-160.919."</p> <p>In addition, related to D-295.936(2), LCME standards already allow for clinical educational scenarios that include assignment of medical students to patients' homes and longitudinal experiences that emphasize continuity of patient care.</p>
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D-295.938, "Increasing Medical School Class Sizes"

Our AMA supports increasing the number of medical students, provided that such expansion would not jeopardize the quality of medical education. (Res. 309, A-08)	Retain; still relevant.
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D-295.939, "Independent Regulation of Physician Licensing Exams"

Our AMA will: (1) continue to work with the National Board of Medical Examiners to ensure that the AMA is given appropriate advance notice of any major potential changes in the examination system in support of Policy H-295.893, "Voting Rights for AMA-MSS NBME Representatives;" (2) continue to collaborate with the organizations who create, validate, monitor, and administer the United States Medical Licensing Examination; (3) continue to promote and disseminate the rules governing	<p>Retain in part, with the deletion shown below, as H-295.893, "Voting Rights for AMA-MSS NBME Representatives," has been accomplished and is being sunset through this report.</p> <p>Our AMA will: (1) continue to work with the National Board of Medical Examiners to ensure that the AMA is given appropriate advance notice of any major potential changes in the examination system in support of Policy H-295.893, "Voting Rights for AMA-MSS NBME Representatives;" (2)</p>
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USMLE in its publications; (4) continue its dialog with and be supportive of the process of the Committee to Evaluate the USMLE Program (CEUP); and (5) work with American Osteopathic Association and National Board of Osteopathic Medical Examiners to stay apprised of any major potential changes in the Comprehensive Osteopathic Medical Licensing Examination (COMLEX). (CME Rep. 10, A-08)	continue to collaborate with the organizations that create, validate, monitor, and administer the United States Medical Licensing Examination; (3) continue to promote and disseminate the rules governing USMLE in its publications; (4) continue its dialog with and be supportive of the process of the Committee to Evaluate the USMLE Program (CEUP); and (5) work with American Osteopathic Association and National Board of Osteopathic Medical Examiners to stay apprised of any major potential changes in the Comprehensive Osteopathic Medical Licensing Examination (COMLEX). (CME Rep. 10, A-08)
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D-295.999, "Extending Impaired Physician Programs to Medical Students"

Our AMA will inform students of the variety of options available for treatment of impairment, including medical school and state medical society programs. (CME Rep. 4, I-98; Reaffirmed: CME Report 2, A-08)	Sunset; superseded by H-295.863, "Impairment Prevention and Treatment in the Training Years," which reads: "Our AMA: (1) reaffirms the importance of preventing and treating psychiatric illness, alcoholism and substance abuse in medical students, residents and fellows; (2) strongly encourages medical schools and teaching hospitals to develop and maintain impairment prevention and treatment programs with confidential services for medical students, residents and fellows; (3) urges medical schools, hospitals with graduate medical education programs, and state and county medical societies to initiate active liaison with local impaired physician committees in order to more effectively diagnose and treat medical student and resident substance abuse; (4) advocates (a) further study (and continued monitoring of other studies) concerning the problem of substance abuse among students, residents, and faculty in U.S. medical schools, and (b) development of model policy and programmatic guidelines which might assist in the establishment of programs for medical students, residents and faculty and which could significantly impact this problem and potentially reduce the risk of future impairment among physicians." (CCB/CLRPD Rep. 3, A-14)
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D-300.983, "Financial Conflicts in CME"

Our AMA will continue to monitor the implementation of the Accreditation Council for Continuing Medical Education 2004 Standards for Commercial Support and report to the House of Delegates any major evidence that these requirements are or are not effective in ensuring the independence of or adversely impact the availability of continuing medical education. (CME Rep. 13, A-08)	Sunset, no longer relevant. The ACCME Standards for Commercial Support have been in place since 2004, and have been adopted by many organizations and societies in the United States and elsewhere in the world. Monitoring is no longer necessary.
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D-305.964, "Support for the Epidemic Intelligence Service (EIS) Program and Preventive Medicine Residency Expansion"

Our AMA will work to support increased federal funding for training of public health physicians through the Epidemic Intelligence Service program and work to support increased federal funding for preventive medicine residency training programs. (Res. 301, A-08)	Retain; still relevant.
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D-305.998, "Impact of the Balanced Budget Act of 1997 on Graduate Medical Education Funding in Non-Hospital Settings"

Our AMA will continue to advocate for additional funds from the federal government and other third party payers for GME programs that take place in non-hospital settings. (BOT Rep. 5, I-98; Reaffirmed: CME Report 2, A-08)	Sunset; superseded by D-305.967, "The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education," which reads in part: "7. Our AMA will actively explore additional sources of GME funding and their potential impact on the quality of residency training and on patient care. 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
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	<p>private sources) to fund both the direct and indirect costs of GME.”</p> <p>Also reflected in H-305.929, “Proposed Revisions to AMA Policy on the Financing of Medical Education Programs,” which reads in part: “H. Funding for graduate medical education should support the training of resident physicians in both hospital and non-hospital (ambulatory) settings. Federal and state funding formulas must take into account the resources, including volunteer faculty time and practice expenses, needed for training residents in all specialties in non-hospital, ambulatory settings. Funding for GME should be allocated to the sites where teaching occurs.”</p> <p>Also reflected in H-310.929, “Principles for Graduate Medical Education,” which reads in part: “(14) GRADUATE MEDICAL EDUCATION IN THE AMBULATORY SETTING. Graduate medical education programs must provide educational experiences to residents in the broadest possible range of educational sites, so that residents are trained in the same types of sites in which they may practice after completing GME. It should include experiences in a variety of ambulatory settings, in addition to the traditional inpatient experience. The amount and types of ambulatory training is a function of the given specialty.”</p>
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D-310.962, “Evaluation of Increasing Resident Review Committee Requirements”

Our AMA will work with and monitor the Accreditation Council for Graduate Medical Education and American Osteopathic Association in studying residency/fellowship documentation requirements for program accreditation and the impact of these documentation requirements on program directors and residents with recommendations for improvement. (Res. 315, A-08)	Retain; still relevant.
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D-360.994, “State Legislative Response to NBME Practice of Using USMLE Step 3 Physician Licensing Exam Questions for Doctors of Nursing Practice Certification”

Our AMA, through its Council on Legislation, will work expeditiously to develop and circulate to all state medical and national medical specialty societies, model state legislation that would prohibit the National Board of Medical Examiners from using the past, present or future content of its United States Medical Licensing Examination Step 3 exam, and National Board of Osteopathic Medical Examiners from using the past, present or future content of its COMLEX Step 3 Exam in the certification processes for non-physician providers. (Res. 212, I-08)	Sunset.
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2. UPDATE ON MAINTENANCE OF CERTIFICATION AND OSTEOPATHIC CONTINUOUS CERTIFICATION (RESOLUTIONS 316-A-17 AND 318-A-17)

Reference committee hearing: see report of Reference Committee C.

**HOUSE ACTION: RECOMMENDATIONS ADOPTED
IN LIEU OF RESOLUTIONS 316-A-17 AND 318-A-17
REMAINDER OF REPORT FILED
*See Policy D-275.954***

Resolution 316-A-17, “Action Steps Regarding Maintenance of Certification,” Resolves 4 and 5, introduced by Florida, Pennsylvania, Georgia, California, New York, Arizona, Texas, American College of Radiation Oncology, and American Society of Interventional Pain Physicians and referred by the American Medical Association (AMA) House of Delegates (HOD), asks the AMA to:

- 4) 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; and
- 5) 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.

Resolution 318-A-17, “Oppose Direct to Consumer Advertising of the ABMS MOC Product,” introduced by Michigan and also referred by the HOD, asks the AMA to:

- 1) 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; and
- 2) 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.

Policy D-275.954 (1), “Maintenance of Certification and Osteopathic Continuous Certification,” asks that the AMA 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 HOD regarding the MOC and OCC processes.

BACKGROUND

Reference Committee C heard mixed testimony on Resolution 316-A-17. There was overwhelming support for the first and second resolves, which are consistent with existing HOD policy that 1) affirms that lifelong learning is a fundamental obligation of the profession, and 2) recognizes that lifelong learning for a physician is best achieved by ongoing participation in a program of high quality continuing medical education (CME) appropriate to that physician’s medical practice as determined by the relevant specialty society.

However, in accordance with existing policy, the AMA has already developed model state legislation intended to prohibit hospitals, health care insurers, and state boards of medicine and osteopathic medicine from requiring participation in MOC processes as a condition of credentialing, privileging, insurance panel participation, licensure, or licensure renewal. This model bill is on file with the AMA Advocacy Resource Center, which will assist any interested state medical associations in pursuing legislation that is consistent with AMA policy. The AMA has also focused on educating state medical associations about activity around the country, as well as on the risks and benefits of legislating the use of MOC. During the testimony, it was noted that enacted and defeated state legislation related to the use of MOC is complex and its potential impact on professional self-regulation is unknown. It was therefore recommended that the fourth and fifth resolves be referred for study with a report back to the HOD on the current status of such legislation.

The reference committee also heard mixed testimony related to Resolution 318-A-17. Although the AMA opposes direct-to-consumer marketing of drugs and devices, it was noted that this resolution focuses on a different kind of communication. It was also noted that the American Board of Medical Specialties (ABMS) is making a statement to inform the public about the certification status of physicians. There is no precedent in AMA policy that supports this issue, and the AMA has no purview over how the ABMS communicates information about its certification process. It was therefore recommended that this resolution be referred for further study.

MAINTENANCE OF CERTIFICATION (MOC): AN UPDATE

The AMA Council on Medical Education and the AMA HOD have carried out extensive and sustained work in developing policy on MOC and OCC (Appendix A), including working with the ABMS and the American Osteopathic Association (AOA) to provide physician feedback to improve the MOC processes, informing our members about progress on MOC and OCC through annual reports to the House, and developing strategies to address the concerns about the MOC and OCC processes raised by physicians. The Council has prepared reports covering MOC and OCC for the past nine years.¹⁻⁹ During the last year, Council members, AMA Trustees, and AMA staff have participated in the following meetings with the ABMS and its member boards:

- ABMS Board of Directors Meeting (2/27/2018 - 3/1/2018)
- American Board of Anesthesiology/ABMS Maintenance of Certification Research Summit (9/24-25/2017)
- ABMS 2017 Conference and Forum on Organizational Quality Improvement (9/26-29/2017)
- ABMS Committee on Continuing Certification (11/15-16/2017)
- ABMS Meeting with Medical Societies to address physician concerns about MOC (12/4/2017)
- Council of Medical Specialty Societies (CMSS) National Specialties and ABMS Medical Boards Annual Dyad Meeting (12/5/2017)
- Planning Committee for the Continuing Board Certification: Vision for the Future Initiative (12/6/2017)
- Commission for the Continuing Board Certification: Vision for the Future Initiative (3/19-20/2018)
- AMA Council on Medical Education and the ABMS Jointly Sponsored Conference on Continuing Board Certification (3/26/2018)

Council on Medical Education members, AMA trustees, and AMA staff are planning additional dialogue on this topic with stakeholders throughout 2018.

“Maintenance of Certification” to be modernized and renamed “Continuing Board Certification”

In 2017, the ABMS Board adopted a new name, “Continuing Board Certification,” for its MOC Program, but some member boards still refer to the program as MOC. The ABMS and its 24 member boards also launched a major initiative to modernize continuing board certification (visioninitiative.org/). A planning committee was formed to establish the “Continuing Board Certification: Vision for the Future” Commission, which includes representatives from the ABMS, Accreditation Council for Continuing Medical Education (ACCME), Accreditation Council for Graduate Medical Education (ACGME), Coalition for Physician Accountability, CMSS, and AMA Council on Medical Education, as well as public members. The Commission has been designed to engage physicians, the public, users of the credential, and other stakeholders in a collaborative process.

The planning committee identified the construct and membership of a 27-member Commission, and a member of the Council on Medical Education was selected to serve on the Commission. The planning committee also identified key questions for consideration by the Commission and will oversee a national opinion survey.

The Commission is in turn gathering information, holding hearings, addressing key questions, and making recommendations for the future continuing board certification process. During the course of its work, the Commission will generate several briefing documents for community consideration and feedback. The purposes of these documents are to present information about current and proposed practices, test concepts and ideas, and continue to engage the broader community in this process. The Commission will communicate with the broader community about the concepts and ideas and will engage in a series of discussions with stakeholders about different aspects of continuing board certification. This process is intended to facilitate the Commission's building an achievable, sustainable model. In addition, portions of the Commission meetings will be open to guests; guests will be able to hear testimony, presentations, and discussions. The Commission will also meet in closed sessions.

On March 26, 2018, the AMA Council on Medical Education, ABMS, and ABMS member boards jointly convened a conference that included additional stakeholders (i.e., specialty societies, state medical societies, ACCME, American Hospital Association, Association for Hospital Medical Education, Association of American Medical Colleges, CMSS, and the Federation of State Medical Boards) to determine how continuing certification can meet the needs of diverse stakeholders and to develop recommendations that will be sent to the Commission for their consideration on behalf of the attendees. During the conference, several ABMS member boards shared the results of surveys to obtain feedback from physicians regarding MOC and discussed some of their recently implemented changes. In order to develop recommendations for the Commission, the conference focused on the roles of the boards and specialty and medical societies to determine how assessment, learning, and improvement in practice can be relevant, meaningful, and integrated with the way physicians practice. A white paper summarizing the conference and final recommendations is being considered by the Council at the suggestion of the attendees. The Commission is expected to release a draft report for public comment in November 2018. A final report will be sent to the ABMS in February 2019.

Report from the ABMS Committee on Continuing Certification

The Committee on Continuing Certification (3C) is charged with reviewing existing MOC programs to ensure the ABMS member boards meet the 2015 Standards for the Program for MOC, which evaluates the effectiveness of different approaches to MOC and identifies innovations to share among the boards.

In 2017, 3C reviewed the Professionalism and Professional Standing (Part I) component of the member boards' Programs for MOC, seeking to understand the boards' current processes for assessing professionalism and responding to potential lapses. Additionally, the member boards have been sharing information with 3C about pilot projects undertaken to enhance the experience and value of their MOC programs for their diplomates.

Report from the ABMS meeting with medical societies to address physician concerns about MOC

On December 4, 2017, staff from the ABMS held a meeting with members of the CMSS, the Specialty Society CEO Consortium (S2C2), state medical societies, and other stakeholders, including a member of the Council on Medical Education, to discuss the MOC programs of its member boards. The meeting focused on the critical issues and concerns physicians have raised about MOC, what the ABMS member boards are doing to resolve these concerns, and how these organizations can work together to create a future continuing board certification program that is relevant and valuable to stakeholders, board certified physicians, and the patients they serve.

State medical and specialty societies voiced their members' concerns about the complexity, relevance to practice, and the time and indirect cost burden associated with MOC programs. They also noted that physician frustration with MOC programs has led to legislative initiatives in many states that would prevent hospitals from requiring physicians to recertify. The state medical society leaders and their members expressed a desire to have ongoing input into the development of the continuing certification programs, a commitment to action and transparency from the member boards, and improved communication. In addition, they requested more consistency across the boards' continuing board certification programs in order to establish best practices across specialties that also indicate the programs' impact in improving patient care. All attendees agreed on the need to jointly develop solutions to avoid a decline in the value of board certification and the erosion of public trust in the ability of the profession to self-regulate.

The following “Statement of Shared Purpose” was agreed to by those present:

ABMS certifying boards and national medical specialty societies will collaborate to resolve differences in the process of on-going certification and to fulfill the principles of professional self-regulation, achieving appropriate standardization, and assuring that on-going certification is relevant to the practices of physicians without undue burden.

Furthermore, the boards and societies, and their organizations (ABMS and CMSS), will undertake necessary changes in a timely manner, and will commit to ongoing communication with state medical associations to solicit their input.

On December 5, 2017, leaders from the CMSS membership, ABMS, ABMS member boards, and additional guests met to discuss innovative approaches for continuous medical education. The ABMS member boards discussed 170 innovations they are working on to address continuous learning for physicians. Many of the innovations included input from various outside stakeholders and focused on greater consistency amongst the member boards. The innovations included alternatives to the high-stakes examinations with a focus on longitudinal learning for physicians in their relevant practice areas. Many of the member boards outlined current (or planned) learning modules that would be seamless for physicians, and they provided a gap analysis. There was also discussion by some member boards about reducing the exam fees and the need for the member boards to be more “customer friendly” when dealing with their diplomates. The member boards are interested in bidirectional communication going forward.

Update on new innovative CME models

The AMA and the ACCME have been collaborating on a strategy to more closely align the two organizations’ requirements, simplify the system, and eliminate any barriers that would constrain innovation in educational development and the delivery of CME.¹⁰ Both organizations want to ensure the education community has the permission to provide more CME options to physicians that integrate new technology and are adaptable to their learning style, accessible, and relevant. A proposal that was developed with various groups (including staff, volunteers, and the leadership from accredited organizations and state medical societies) about how to simplify the system to better support the evolution of CME was adopted by the AMA and ACCME and went into effect in September 2017.

The ABMS and its member boards are also collaborating with academic medical centers, specialty societies, and other continuing professional development/continuing medical education (CPD/CME) stakeholders to help board certified physicians find quality certified CME activities linked to components of the ABMS Program for MOC.

ABMS Continuing Certification Directory

The ABMS “Continuing Certification Directory,” formerly called the “MOC Directory” (continuingcertification.org) continues to offer physicians access to a comprehensive, centralized, web-based repository of CME activities that have been approved for MOC credit by ABMS member boards. During the past two years, the directory has increased its inventory and now indexes 600-plus activities from more than 60 CME providers to help diplomates from across the specialties meet MOC requirements for Lifelong Learning and Self-Assessment (Part II) and Improvement in Medical Practice (Part IV).

The following types of activities are currently included in the directory: internet enduring activities, journal CME, internet point of care, live activities, and performance improvement CME. All CME activities are qualified to award credit(s) from one or more of the CME credit systems: *AMA PRA Category 1 Credit™*, AAFP Prescribed Credit, ACOG Cognates, and AOA Category 1-A.

The directory includes a wide variety of activities addressing emerging issues such as physician well-being and safe opioid prescribing initiatives as well as a full suite of AMA STEPS Forward™ Practice Improvement Strategies. STEPS Forward offers more than 40 online modules, plus resources, case studies, and other content around patient care, work flow process, leading change, professional well-being, technology, and finance. The ABMS has invited the CPD/CME communities to submit for inclusion in the directory any certified CME activities that support the development of high-functioning physicians. For example, the most recent call for activities (abms.org/news-events/abms-call-for-physician-well-being-cme-activities/) focuses on improving physician well-being.

The ACCME continues to collaborate with the American Board of Internal Medicine (ABIM), American Board of Anesthesiology (ABA), and American Board of Pediatrics (ABP); allows accredited CME providers to identify CME activities that also meet the MOC requirements for each of the member boards (ABIM, ABA, and ABP); and facilitates reporting of learner data from the accredited provider to the relevant member board (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 Part II requirements. This simplifies a physician's search for approved activities (cmefinder.org/). CME providers are using 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 transmits JAMA Network data to the ACCME for ABIM and is considering expansion to additional boards in the future.

Elimination of the secure, high-stakes examination for assessing knowledge and cognitive skills in MOC

Twenty-one ABMS member boards (87.5%) have moved away from the secure, high-stakes exam, and more than two thirds of the boards (71%) have launched, or will soon be launching, assessment pilots that combine adult learning principles with state-of-the-art technology, enabling delivery of assessments that promote learning and are less stressful (Table). A number of them are combining the longitudinal assessment approach with CertLink™, a technology platform developed by the ABMS to support its boards in delivering more frequent, practice-relevant, and user-friendly competence assessments to physicians (abms.org/initiatives/certlink-platform-and-pilot-programs/). The platform provides the technology to enable the boards to create assessments focused on practice-relevant content; offers convenient access on desktop, tablet, or smartphone (depending on the board's program); provides immediate, focused feedback and guidance to resources for further study; and provides a personal dashboard that displays areas of strength and weakness. The member boards that are developing CertLink™ pilot programs include the American Board of Colon and Rectal Surgery (ABCRS), American Board of Dermatology (ABD), American Board of Medical Genetics and Genomics (ABMGG), American Board of Nuclear Medicine (ABNM), American Board of Otolaryngology (ABOto), American Board of Pathology (ABPath), and American Board of Physical Medicine and Rehabilitation (ABPMR).

Other ABMS member boards that have been piloting new innovative assessment approaches have received positive feedback on their pilots. For example, the ABA surveyed its physicians in December 2016 to collect their feedback on year one of the redesigned Maintenance of Certification in Anesthesiology Program® (known as MOCA 2.0®). Nearly 75 percent of the physicians who responded reported that the MOCA Minute® pilot served them well as an assessment tool. Additionally, nearly 62 percent of survey respondents rated the experience better or much better than their experience with the traditional MOCA exam. Furthermore, physicians who participated in the 2014 and 2015 MOCA Minute pilot outperformed non-participants on the MOCA Exam, according to a study published in the November 2016 issue of *Anesthesiology*.¹¹ In January 2017, the ABA expanded its longitudinal assessment program to include diplomates maintaining subspecialty certificates.

In January 2017, the ABP launched a pilot of its proposed longitudinal assessment approach called Maintenance of Certification Assessment for Pediatrics (MOCA-Peds) (abp.org/mocapeds). Nearly all 5,000 diplomates—approximately 98 percent of those eligible—enrolled in the 2017 MOCA-Peds pilot. At the end of each quarter, the ABP surveyed pilot participants about their experiences. Highlights from the first two surveys showed that 92 percent of participants had a satisfactory experience with the information technology platform, and nearly 80 percent agreed or strongly agreed that the MOCA-Peds questions were relevant to general pediatrics.¹² Based on this feedback, the ABP plans to replace the 10-year secure exam with MOCA-Peds beginning in 2019.

In 2018, the ABIM began offering a new two-year assessment option to provide physicians more choice, relevance, and convenience in meeting the assessment requirement of its MOC program. These “Knowledge Check-Ins” will allow diplomates to take shorter assessments in a location of their choice. The ABIM will first pilot the Knowledge Check-In for physicians certified in internal medicine or nephrology. The shorter assessments will become available to other specialties in 2019 and 2020 as an additional option along with the traditional 10-year MOC exam.

Several member boards are considering or have integrated journal article-based core questions into their assessments. The American Board of Obstetrics and Gynecology (ABOG) launched its MOC Pilot Program

(abog.org/new/abog_mocimp.aspx) in 2016; more than 2,000 physicians opted to participate. In a survey of pilot participants conducted in 2017, 93 percent of the 1,268 respondents affirmed that the journal article assignments—a core element of the pilot—are beneficial to their clinical practice. Additionally, 87 percent of respondents agreed that if the ABOG fully adopts the pilot, it will make MOC more valuable to clinical practice, and 89 percent agreed that it will make MOC more relevant to clinical practice.¹³ The ABOG studied the pilot results through 2017 and will decide whether to permanently adopt the changes to its MOC program in 2018.

Preliminary analysis from the American Board of Ophthalmology's (ABO) new Quarterly Questions™ program (diplomatedigest.com/single-post/2018/02/06/Article-Based-Learning-and-Assessment-in-Quarterly-Questions), launched in 2017, has been extremely favorable, earning the support of ABO diplomates as an approach to learning and assessment. Nearly 20 percent of ABO's active diplomate population participated in the program's optional pilot year, with 94 percent reporting that the article-based questions were useful for learning new, relevant information. Eighty-five percent of participants said the information they learned while completing the activity would help them provide better care to their patients in the future, and 99 percent said they would recommend the program to a colleague.

Other member board efforts include more diplomate input into exam blueprints; modularization of exam content that allows for tailoring of assessments to reflect physicians' actual areas of practice; access during the exam to resources similar to those used at the point of care; remote proctoring to permit diplomates to be assessed at home or in the office; and performance feedback mechanisms. All boards will also provide multiple opportunities for physicians to retake the exam. These program enhancements will significantly reduce the cost diplomates incur to participate in MOC by reducing the need to take time off or travel to a testing center for the assessment; ensure that the assessment is practice relevant; emphasize the role of assessment for learning; assure opportunities for remediation of knowledge gaps; and reduce the stress associated with a high-stakes test environment.

Progress with improving MOC Part IV, Improvement in Medical Practice

The ABMS member boards have broadened the range of acceptable activities that meet the Improvement in Medical Practice (IMP) requirements, including those offered at the physician's institution and/or individual practices, in order to address physician concerns about the relevance, cost, and burden associated with fulfilling the IMP requirements. In addition to improving alignment between national value-based reporting requirements and continuing certification programs, the boards are implementing a number of activities related to registries, systems-based practice, and practice audits.

Registries

The ABMS member boards are increasingly incorporating the use of patient registries into their continuing certification process. Registries target quality concerns and provide physicians with meaningful, actionable information that helps align their MOC activities with federal and state quality incentive programs. While many member boards have been providing physicians the opportunity to earn MOC credit for participating in externally developed patient registries, some boards are designing performance improvement initiatives supported by registry data. Many of the member boards also recognize participation in registries developed by their professional societies as satisfying their IMP requirements.

- In 2017, the ABO began piloting a program that enables ophthalmologists to create customized quality improvement (QI) projects using the data supplied through the American Academy of Ophthalmology's IRIS® Registry. After numerous improvement projects were successfully completed, ABO transitioned the pilot into a permanent program in October 2017. Ophthalmologists can use the monthly reports to identify areas for improvement, set specific goals for each measure, outline the steps (changes in care delivery processes) to achieve these goals, and evaluate their success by analyzing subsequent monthly performance reports. Ophthalmologists receive MOC credit for approved, completed projects.
- The ABOto has partnered with the American Academy of Otolaryngology-Head and Neck Surgery for the past two years to develop a qualified clinical data registry, Reg-ent. This registry is able to extract data from an otolaryngologist's electronic health records (EHRs) for multiple purposes, including reporting quality measures for Merit-based Incentive Payment System (MIPS) as payment shifts to performance under the Quality Payment Program. The ABOto will be able to extract data from Reg-ent to provide feedback to board certified

otolaryngologists and document improvement, thereby meeting MOC requirements without requiring data entry by the physicians.

- More than 3,000 physicians are using the American Board of Family Medicine (ABFM) PRIME Registry, which extracts patient data from the practice EHR and converts it into actionable measures that are presented in an easy to use dashboard. The PRIME Registry is a qualified clinical data registry that is approved to propose measures to the Centers for Medicare & Medicaid Services (CMS). The ABFM's PRIME Registry offers tools that simplify and automate reporting for MIPS and CMS's Comprehensive Primary Care Plus or CPC+, and enables physicians to use their measures data to create and implement a QI plan in their practice to simplify continuous certification and align it with MIPS reporting requirements. The ABFM is also developing a new tool, the Population Health & Assessment Engine, to integrate social determinants of health data with clinical data in the registry to help physicians understand the impact of social determinants on individual patients and the populations they serve and to improve intervention and care.

Interoperability between clinical data registries and EHRs continues to be a priority for specialty society registry hosts. CMSS published the *Registry Primer* to serve as background and a resource guide on clinical registry development and implementation (<https://cmss.org/732-2/>). CMSS member societies are also exploring a Clinical Data Registry Collaborative, which is planning a pilot project to identify and match patient-centric data elements from two or more data registries in their current hosting environment. CMSS plans to engage with the National Quality Registry Network and the National Quality Forum, which are exploring similar interoperability challenges.

Systems-based practice

The ABMS member boards are aligning MOC activities with other organizations' 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. 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 [PDSA] 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 ABMS member boards have developed online practice assessment protocols that allow physicians to assess patient care using evidence-based quality indicators. Other initiatives include:

- Free tools to complete an IMP project, including a simplified and flexible template to document small improvements, educational videos, infographics, and enhanced web pages.
- Partnering with specialty societies to design quality and performance improvement activities for diplomates with a population-based clinical focus.
- 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.
- 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 process.

ABMS Multi-Specialty Portfolio Program

The ABMS Multi-Specialty Portfolio Program (Portfolio Program™) offers health care organizations a way to support physician involvement in their institution's quality and performance improvement initiatives by offering credit for the IMP component of the ABMS Program for MOC (mocportfolioprogram.org). Originally designed as a service for large hospital institutions, the Portfolio Program is extending its reach to physicians whose practices are not primarily in institutions. This includes non-hospital organizations such as academic medical centers, integrated delivery systems,

interstate collaboratives, specialty societies, and state medical societies. Recent additions among the 93 current sponsors include the American College of Cardiology, American Hospital Association, and American College of Obstetricians and Gynecologists.

More than 2,600 types of QI projects have been approved by the Portfolio Program, focusing on such areas as advanced care planning, cancer screening, cardiovascular disease prevention, depression, immunizations, obesity, patient-physician communication, transitions of care, and patient-safety related topics including sepsis and central line infection reduction. Many of these projects have had a profound impact on patient care and outcomes. For example, during the past two years, Portfolio Program initiatives at the Children's Hospital of Philadelphia have been responsible for inpatient hospital days for oncology patients with fever and neutropenia decreasing by more than 35 percent, preventable readmissions for neurology patients decreasing by approximately 80 percent, and rates of urinary catheterization for febrile infants decreasing by 65 percent. Additionally, rates of pneumococcal immunization among patients with chronic kidney disease have increased by 79 percent, and the application of evidence-based practices to evaluate and manage children with attention deficit disorder and hyperactivity has increased by 50 percent. There have been nearly 19,700 instances of physicians receiving MOC IMP credit through participation in the program. Twenty ABMS member boards participate in the program.

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

The Council on Medical Education has continued to review published literature and emerging data as part of its ongoing efforts to critically review MOC and OCC issues. Although there is still frustration with the MOC process and its cost,¹⁴ many improvements have been made to the MOC Program, such as making the process more efficient, convenient, and cost-effective, and less burdensome. In addition, important peer-reviewed studies published during the last year demonstrate the benefits of participating in a continuous certification program. These studies are summarized below.

Many of the ABMS member boards have been enhancing the MOC Part III examinations to ensure the exam is practice-relevant. A study by Gray et al. analyzed whether the ABIM MOC exams from 2010-2013 reflected practice conditions during either office visits or hospital stays for each of 186 condition categories within internal medicine. The study showed that the majority of exam questions generally reflected what occurs in practice, with 69 percent of the questions on these exams harmonizing with conditions in practice.¹⁵ A study by Lipner et al., involving 825 physicians initially certified by the ABIM or who took the ABIM MOC exam in 2012 to 2015, compared the results of a closed book exam to an open book exam that allowed the use of electronic resources typically used at the point of care. The study showed that inclusion of an electronic resource with time constraints did not adversely affect test performance and did not change the specific skill or factor targeted by the exam.¹⁶

One study looked at the benefits derived from taking the MOC Part III examination. More than 2,500 emergency physicians who took the American Board of Emergency Medicine (ABEM) ConCert high-stakes examination in 2015 participated in a voluntary post-examination survey in 2015. When asked about the benefits of preparing for the exam and maintaining ABEM certification, the majority of emergency physicians (more than 90 percent) reported they either gained medical knowledge or reinforced knowledge they already had, making them better clinicians. Most of them also found career benefits to remaining ABEM certified, including greater employment choices, higher financial compensation, and higher esteem from other physicians.¹⁷

A number of recently published studies evaluate the effectiveness and value of IMP activities (MOC Part IV).

- A study conducted by the University of Michigan Health System Adolescent Health Initiative evaluated whether a MOC Part IV project could improve the delivery of confidential care to minor adolescent patients seen in outpatient primary care practices. This study showed that this Part IV project was an effective way to change physician practice and improve the delivery of confidential care to minor adolescents seen for wellness visits. The study also showed that another major benefit was that it served as the primary mechanism to get physicians in non-adolescent specialties engaged in improving care for adolescents. In addition, participation broadly increased participating primary care physicians' knowledge of best practices in adolescent care, which may lead to wider improvements for adolescents in the practice as a whole.¹⁸
- A study of pediatric gastroenterologists who participated in a MOC Part IV activity showed significant improvements in clinical care documentation and processes as well as improvements in patient outcomes for

various endoscopic procedures. In addition, parents had a much greater understanding of the informed consent process. An analysis of data taken from web-based MOC QI modules also showed significant practice variation across several processes and demonstrated how the web-based MOC activities improved them.¹⁹

- In a study that examined whether organization-developed MOC performance improvement modules (PIMs), such as the PIMs created by the ABP, improve the quality of pediatric care, the PIMs were linked to better care for children. Pediatricians improved care for attention-deficit/hyperactivity disorder, asthma, and influenza. Hand hygiene also improved.²⁰
- A study of hypertension Performance in Practice Modules completed by family physicians from July 2006 through 2013 showed that these physicians significantly improved the quality of care for patients with hypertension, including improving blood pressure control and diet and exercise counseling, after completing the activity.²¹
- A study undertaken at Nationwide Children's Hospital evaluated the effectiveness of integrating QI training within the institution by developing a course called "Quality Improvement Essentials" in 2012. The results of surveys were positive, indicating increased and maintained QI competency among staff. Approximately 40 percent of the physicians who participated in the course converted their course project to receive MOC Part IV credit.²²
- A study by Jennings, et al., evaluated a QI project in a community emergency department (ED) aimed at decreasing the use of head computed tomography (CT) scans in children. The study showed that pediatricians who participated in the MOC activity reduced the use of unnecessary head CT scans for children with head injuries in the ED. In addition, coaching and mentoring from a regional hospital participating in the MOC Portfolio Program (Seattle Children's Hospital) had a significant effect on the successful QI effort at the community setting.²³
- Shaw et al. described how pediatric physicians' increased participation in MOC Part IV QI activities at the Children's Hospital of Philadelphia is improving patient care (e.g., asthma management, patient flow, and cardiac arrest outcomes).²⁴

Recently published articles describe improvements made to the continuing certification process.

- One article describes how the American Board of Allergy and Immunology's (ABAI) Part III continuous assessment program will replace the ABAI's 10-year high-stakes examination beginning in 2018. This process will be an open-book and web-based program that will focus on adult learning theory methods to reduce the cost and burden on diplomates.²⁵
- Two articles discuss how improvements being made to the MOC process make continuing certification more meaningful and acceptable to physicians. The ABIM and ABP have worked closely with their specialty societies to increase the number of CME programs that count for MOC. In addition, the ABIM and ABP have tested and evaluated new assessment models to replace the 10-year high-stakes examinations.^{26, 27}
- An article by Juul et al. highlights the development of geriatric psychiatry subspecialty certification. The article focuses on how the American Board of Psychiatry and Neurology (ABPN) is attempting to meet the need for more geriatric psychiatrists by strategically developing a flexible approach to MOC that includes options for taking combined examinations which cover their diplomates' specialty and/or subspecialty. Other ABPN MOC requirements are the same as those for recertification in general psychiatry only or in a single subspecialty.²⁸
- An article by Carlos et al. provides an overview of how the American Thoracic Society developed a core curriculum focusing on adult pulmonary, critical care, and sleep medicine and pediatric pulmonary medicine that can be integrated into the MOC programs offered by the ABIM and ABP. The guiding principles outlined in this article may aid other societies that are considering launching similar initiatives to meet the needs of their members.²⁹

- An article by McMillan et al. addresses the importance of focusing on behavioral and mental health in pediatric resident training and the efforts being made by the ACGME and ABP to improve this area of need. This article also identifies how MOC will be used to try to improve learning.³⁰

Three articles describe quality measurement that is being used in clinical care improvement, regulation, accreditation, public reporting, surveillance, and MOC. A 2015 quality metrics (QUALMET) survey assessed the commonalities and variability of selected quality and productivity indicators, including MOC participation, currently used by 112 U.S. academic radiology departments. MOC participation was found to be varied and a requirement of employment for nearly half of the survey respondents. The study suggests that MOC is currently the best metric to evaluate whether a radiologist has up-to-date knowledge and is familiar with quality and safety practices.³¹ A policy statement published by the American Academy of Pediatrics recommended that national policymakers “harmonize and align measures used in national/state reporting programs, including payment programs, such as state Medicaid and private payers, accreditation bodies, regulatory agencies, and MOC programs to reduce reporting burden on physicians.”³² An article by Price and Lang presents a QI model for the clinical practice of allergy and immunology that can be used by physicians to develop and implement practice-based QI activities that improve processes and outcomes of care for patients.³³

Recent articles also evaluate self-regulation, professionalism, and perceptions about MOC. A review of retrospective cohort studies between MOC and clinical processes or outcomes, published from 2007 to 2016, shows that although methodological challenges remain, a rapidly growing body of literature provides evidence that MOC is associated with better care or has been an incentive for physicians to collaborate in systematically improving patient care and outcomes.³⁴ A review article summarizes the challenges of teaching and assessing professionalism in radiology, how professionalism is part of MOC and the American Board of Radiology’s competency assessment, and how a greater understanding of professionalism as part of competency assessment is needed.³⁵ A study conducted by the Seattle Children’s Hospital showed that, of 123 physicians who participated in a MOC project and completed a survey, 97 percent of the survey respondents view Part IV favorably. Participation was associated with modest improvements in perceptions of QI engagement and attitude, application of QI methods, and patient care.³⁶

More than 60 sessions at the ABMS annual QI Forum held during the 2017 ABMS Conference (abmsconference.com/2017/session-descriptions) focused on continuing certification, initial certification, health policy research, patient safety, and improvement in medical practice. Posters presented by Portfolio Program sponsors and other health care researchers underscored best practices and research in continuing certification and QI activities (abmsconference.com/2017/poster-session). One example highlighted a program at the University of Michigan Health System in which more than 40 QI projects are available for physician participation, including improving the rate of foot exams for adult diabetic patients, reducing the number of non-medically indicated planned deliveries, and improving the clinical management of overweight and obese pediatric patients.

Stakeholders from the fields of medical education and assessment also met to develop a collaborative research agenda and strategy to study learning and assessment throughout a physician’s career during the 2017 ABA/ABMS Research Summit entitled, “Improving Health and Healthcare Systems: Defining a Research Agenda for Learning and Assessment across the Continuum of a Physician’s Career” (abmsconference.com/2017/session-descriptions/).

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.

OSTEOPATHIC CONTINUOUS CERTIFICATION (OCC): AN UPDATE

The American Osteopathic Association Bureau of Osteopathic Specialists (AOA-BOS) 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 and subspecialties. As of December 2016, over 29,000 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 18 specialty certifying member boards of the AOA-BOS.³⁷ 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, District of Columbia, or U.S. territories, 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.

Although osteopathic physicians who hold non-time-limited (non-expiring) certificates are not required to participate in OCC, there are requirements to maintain active certification status: 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.

In July 2016, the AOA House of Delegates approved a resolution calling for the AOA to study and evaluate all components of OCC. 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 drafted resolutions based on the Task Force's recommendations and submitted these to the AOA Board of Trustees for approval at its February 2017 meeting. The resolutions were approved by the AOA Board of Trustees and the individual boards are now working on implementation plans for the updated OCC components.

STATE LEGISLATION RELATED TO THE USE OF MOC

MOC is intended to be a career-long process of learning, assessment, and performance improvement that is meant to demonstrate physicians' proficiency within a chosen discipline, but is separate from and not required for state medical licensure. 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, AMA policy discourages such mandates. The AMA has adopted the following related policies:

- Policy H-275.924, "Maintenance of Certification," (15) states, "The MOC program should not be a mandated requirement for licensure, credentialing, recredentialing, privileging, reimbursement, network participation, employment, or insurance panel participation."

- Policy D-275.954, “Maintenance of Certification and Osteopathic Continuous Certification,” (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.”

Some states are proposing or have enacted legislation that prohibits the use of MOC as a criterion for licensure, privileging, employment, reimbursement, and/or insurance panel participation. Nine states (Arizona, Georgia, Kentucky, Maryland, Maine, Missouri, Oklahoma, Tennessee, and Texas) have enacted laws addressing MOC requirements. With the exception of Texas, where the enacted legislation has implications for hospitals’ and health plans’ use of MOC, the laws passed to date prohibit the use of MOC for initial and renewal licensure decisions. At the time of filing, 18 state legislatures (Alaska, Florida, Iowa, Indiana, Maryland, Massachusetts, Michigan, Missouri, New Hampshire, New York, Ohio, Oklahoma, Rhode Island, South Carolina, Tennessee, Utah, Washington, and Wisconsin) were actively considering MOC-related legislation.

The AMA Council on Legislation has developed, and the AMA Board of Trustees has 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.

DIRECT-TO-CONSUMER ADVERTISING OF THE ABMS MOC PRODUCT

Society relies on members of the medical profession to establish standards for entering the profession and to assure that they are maintaining competence throughout their careers.³⁸ Patients expect that their physician’s certification reflects ongoing education and practice improvement. Board certification makes a public statement about a physician’s capabilities to provide quality care in his or her chosen specialty. Patients, families, and others have a right to know a physician’s certification status, and they should also be able to access this information through multiple channels and in formats that are easily understood.

Although the AMA opposes direct-to-consumer marketing of drugs and devices, Resolution 318-A-17 focuses on a different aspect of marketing. Health professionals, both physicians and non-physicians alike, are generally allowed to advertise to the public their training, education, experience, and expertise. Twenty states have enacted legislation prohibiting deceptive or misleading advertising, communication, or other deceptive or misleading conduct concerning health professionals’ skills, education, training, professional competence, or licensure.

Some physicians may advertise that they are board certified or board eligible. The AMA opposes any action, regardless of intent, that appears likely to confuse the public about the unique credentials of ABMS- or AOA-BOS-board certified physicians in any medical specialty, or takes advantage of the prestige of any medical specialty for purposes contrary to the public good and safety (H-275.926 (1), “Medical Specialty Board Certification Standards”). Similarly, the AMA’s “Truth in Advertising” campaign highlights the need to improve transparency, clarity, and reliability for the patient and public. Through this campaign, the AMA developed materials including a model bill, the “Health Care Professional Transparency Act,” which includes a drafting note with sample language for use by state and specialty societies that wish to pursue legislation governing advertising about physician certification status (ama-assn.org/truth-advertising). The campaign provides medical societies with tools and resources to develop and advocate for legislation to help ensure that patients are promptly and clearly informed of the training and qualifications of their health care practitioner.

SUMMARY AND RECOMMENDATIONS

The Council on Medical Education is committed to ensuring that MOC and OCC support physicians’ ongoing learning and practice improvement and serve to assure 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

has continued to monitor the development of MOC and OCC and work with the ABMS, ABMS member boards, AOA, and the state and specialty medical societies to identify and suggest improvements to the MOC and OCC programs. Since the AMA will continue to work with these organizations and key stakeholders and a council member will be closely involved in the ABMS Commission and in the development of the Commission's recommendations for the future continuing board certification process, a study with the goal of establishing a program that will certify physicians is not warranted at this time.

The Council on Medical Education therefore recommends that the following recommendations be adopted in lieu of Resolutions 316-A-17 and 318-A-17 and the remainder of the report be filed.

1. That our American Medical Association (AMA) continue to work with the medical societies and the American Board of Medical Specialties (ABMS) member boards that have not yet moved to a process to improve the Part III secure, high-stakes examination to encourage them to do so.
2. That our AMA, through its Council on Medical Education, continue to be actively engaged in following the work of the ABMS Continuing Board Certification: Vision for the Future Commission.

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

American Board of:	Current Examination Format	New Models/Innovations
Allergy and Immunology (ABAI) 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: <ul style="list-style-type: none"> • A 10-year program with two five-year cycles. • Diplomates take exam where and when it is convenient. • Open-book exam with a total of approximately 80 questions per year. • Mostly article-based with some core questions during each six-month cycle. Diplomates are 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 six

American Board of:	Current Examination Format	New Models/Innovations
		<p>months. Articles can be printed or downloaded for review.</p> <ul style="list-style-type: none"> • Questions can be answered for each article independently. Diplomate feedback on each question will be required. • Opportunity to drop the two lowest six-month cycle scores during each five-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.
Anesthesiology (ABA) theaba.org	<ol style="list-style-type: none"> 1) MOCA 2.0 introduced in 2014 to provide a tool for ongoing low-stakes assessment and provide more extensive, question-specific feedback. Also provides focused content that could be reviewed periodically to refresh knowledge and document cognitive expertise. 2) Piloting MOCA Minute™—a longitudinal assessment tool that requires diplomates to answer 30 questions per calendar quarter, or 120 per year, in lieu of taking a 10-year exam. <p><i>All diplomates with time-limited certification that expired on or before Dec. 31, 2015 and diplomates whose subspecialty certificates expired on or before December 31, 2016, must complete the traditional MOCA® requirements before they can register for MOCA 2.0®.</i></p>	<p>Analysis of the pilot data is underway to determine whether participants accessed the links to additional resources, learned the material, and improved performance in the content knowledge areas represented in the MOCA Minute Pilot.</p>
Colon and Rectal Surgery (ABCRS) ¹ abcrs.org	<p>Computer-based secure exam administered at a proctored test center once a year (in May). Diplomates must pass the exam once every 10 years.</p>	<ul style="list-style-type: none"> • Exploring ways to modify the exam experience to provide a more consistent evaluation process and to replace the exam as it presently is administered. The ABCRS is developing a CertLink™-based longitudinal assessment pilot to evaluate assessment methods to provide immediate, personalized feedback as an alternative to the high-stakes exam. • The first diplomates enrolled are those sitting for the ABCRS certifying exam in September 2017. These diplomates start CertLink™ MOC in the Spring of 2018. Other diplomates will be able to enroll shortly thereafter.
Dermatology (ABD) ¹ abderm.org	<ul style="list-style-type: none"> • 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. • Test preparation material available six months before the exam at no cost. 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 to assess diagnostic skills, and can then choose among 50-item subspecialty modules. 	<ul style="list-style-type: none"> • The ABD successfully completed trials employing remote proctoring technology to monitor exam administration in the diplomates' homes or offices. • The ABD is developing a CertLink™-based longitudinal assessment pilot to explore and evaluate assessment methods to provide immediate, personalized feedback as an alternative to the high-stakes exam.
Emergency Medicine (ABEM) abem.org	<p>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.</p>	<p>The 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</p>

American Board of:	Current Examination Format	New Models/Innovations
		an every-10-year exam. The alternative assessment method would have to show that its learning and assessment advantage is better than the current ABEM exam.
Family Medicine (ABFM) theabfm.org	<ul style="list-style-type: none"> 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. Improving relevance of recertification exam by using national study of care content in family medicine practices. Providing feedback to residents and practicing physicians about the “anatomy” of the exam and their particular knowledge gaps. Effort has resulted in significant improvement in passing rates and improved feedback regarding relevance. 	Changes to the ABFM exam are not being considered at this time.
Internal Medicine (ABIM) abim.org	<ul style="list-style-type: none"> Computer-based secure exam administered at a proctored test center. Diplomates must pass the exam once every 10 years. Introduced grace period for physicians to retry assessments for additional study and preparation if initially unsuccessful. 	<p>In 2018, the ABIM plans to offer two assessment options:</p> <ol style="list-style-type: none"> 1) Certified physicians (Internal Medicine and Nephrology with more specialties to roll out in 2019 and 2020) will be eligible to take the Knowledge Check-In, a new two-year open-book (access to <i>UpToDate</i>®) assessment with immediate performance feedback. Assessments can be taken at the physician’s home or office, or at a computer testing facility instead of taking the long-form exam every 10 years at a testing facility. 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 open-book access (to <i>UpToDate</i>®) that physicians requested. <p><i>ABIM is also working with specialty societies to explore the development of collaborative pathways through which physicians can maintain board certification.</i></p>
Medical Genetics and Genomics ¹ (ABMGG) abmgg.org	Computer-based secure exam administered at a proctored test center once a year (August). Diplomates must pass the exam once every 10 years.	Developing a CertLink™-based longitudinal assessment pilot to explore and evaluate assessment methods to provide immediate, personalized feedback as an alternative to the high-stakes exam.
Neurological Surgery (ABNS) abns.org	<ul style="list-style-type: none"> The 10-year secure exam can be taken from any computer, i.e., in the diplomate’s office or home. Access to reference materials is not restricted; it is an open book exam. On applying to take the exam, 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. 	<p>In 2018, an adaptive MOC cognitive learning tool will be available:</p> <ul style="list-style-type: none"> The tool will consist of updated knowledge that has evolved since the diplomate’s last certification, and the tool will be shorter, relevant, and more focused than the prior exam. The open book knowledge-based 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.

American Board of:	Current Examination Format	New Models/Innovations
		<ul style="list-style-type: none"> Immediate feedback to each question and references with links and/or articles will be provided.
Nuclear Medicine ¹ (ABNM) abnm.org	Computer-based secure exam administered at a proctored test center once a year (October). Diplomates must pass the exam once every 10 years.	Developing a CertLink™-based longitudinal assessment pilot to explore and evaluate assessment methods to provide immediate, personalized feedback as an alternative to the high-stakes exam.
Obstetrics and Gynecology (ABOG) abog.org	The secure, external assessment is offered in the last year of each ABOG diplomate's six-year cycle in a modular test format, and they are allowed to choose two selections that are the most relevant to their current practice.	Studying the results of a pilot program launched in 2016 and 2017 to integrate the self-assessment and external assessment MOC requirements which allowed diplomates to continuously demonstrate their knowledge of the specialty. The pilot allowed 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 five years of the self-assessment program.
Ophthalmology (ABO) abop.org	<ul style="list-style-type: none"> Quarterly Questions™ replacing DOCK (high-stakes, 10-year) exam with longitudinal assessment program. Will deliver 50 questions (40 knowledge based and 10 article based) remotely at home or office through computer, tablet or mobile apps. The questions should not require preparation in advance, but a content outline for the multiple choice questions will be available. Users will receive instant feedback and recommendations for resources related to gaps in knowledge. Key ophthalmic journal articles with questions focused on the application of this information to patient care are provided. The journal portion will require reading five articles from a list of 30 options. 	In 2019, Quarterly Questions™ will replace the DOCK Examination for all diplomates.
Orthopaedic Surgery (ABOS) abos.org	<ul style="list-style-type: none"> 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. Diplomates without subspecialty certifications are allowed to take practice-profiled exams in orthopaedic sports medicine and surgery of the hand. General orthopaedic questions were eliminated from the practice-profiled exams so diplomates are only tested in areas relevant to their practice. Detailed blueprints are being produced for all exams to provide additional information for candidates to prepare for and complete the exams. Eight different practice-profiled exams offered to allow assessment in the diplomate's practice area. 	Piloting a virtual practice evaluation to evaluate diplomates on their own cases without requiring travel. Diplomates must submit medical records on 12 selected cases similar to an oral exam with the exam performed in a virtual platform.
Otolaryngology ¹ (ABOto) aboto.org	Computer-based secure modular exam administered at a proctored test center. Diplomates must pass the exam once every 10 years.	Developing a CertLink™-based longitudinal assessment pilot to explore and evaluate assessment methods to provide immediate, personalized feedback as an alternative to the high-stakes exam.
Pathology ¹ (ABPath) abpath.org	<ul style="list-style-type: none"> Computer-based secure modular exam administered at the ABP Exam Center in Tampa, Florida twice a year (March and August). 	Participating in the ABMS Longitudinal Assessment pilot utilizing the CertLink™ platform. ¹

American Board of:	Current Examination Format	New Models/Innovations
	<ul style="list-style-type: none"> Remote computer exams can be taken anytime 24/7 that the physician chooses during the assigned two-week period (spring and fall) from their home or office. Physicians are allowed to choose from more than 90 modules, covering numerous practice areas for a practice-relevant assessment. <p><i>Diplomates must pass the exam once every 10 years.</i></p>	
Pediatrics (ABP) abp.org	<ol style="list-style-type: none"> Computer-based secure exam administered at a proctored test center. Diplomates must pass the exam once every 10 years. Piloting Maintenance of Certification Assessment for Pediatrics (MOCA-Peds), a new testing platform with shorter and more frequent assessments that include: <ul style="list-style-type: none"> A series of questions released through mobile devices or a web browser at regular intervals. Twenty multiple choice questions that are available quarterly and may be answered anytime during the quarter. Immediate feedback and references. Resources (i.e., internet, books) that can be used when taking the exam. Allows for questions to be tailored to the pediatrician's practice profile. Physicians will provide feedback on individual questions so the exam can be continuously improved. 	In 2019, MOCA-Peds will roll out to all certified pediatricians in subsequent years. Those who wish to continue taking the exam once every five years in a secure testing facility will still be able to do so.
Physical Medicine and Rehabilitation (ABPMR) ¹ abpmr.org	<ul style="list-style-type: none"> Computer-based secure exam administered at a proctored test center. Diplomates must pass the exam once every 10 years. Releasing MOC 100, a set of free practice questions pulled directly from the ABPMR exam question banks to help physicians prepare for the exam. Working with the specialty society to produce clinical updates that integrate with the longitudinal assessment tool. 	Developing a CertLink™-based longitudinal assessment pilot to explore and evaluate assessment methods to provide immediate, personalized feedback as an alternative to the high-stakes exam.
Plastic Surgery (ABPS) abplasticsurgery.org	<ul style="list-style-type: none"> Computer-based secure exam administered at a proctored test center once a year (October). Diplomates must pass the exam once every 10 years. Modular exam to ensure relevance to practice. Offers an MOC Study Guide with multiple choice question items derived from the same sources used for the exam. 	Piloting online delivery of MOC exam in place of centralized in-person testing center to reduce costs and time away from practice. Diplomates will be given immediate feedback on answers and offered an opportunity to respond again. If successful, this pilot may replace the high-stakes exam.
Preventive Medicine (ABPM) theabpm.org	<p>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).</p> <p><i>In 2016, new multispecialty subspecialty of Addiction Medicine was established. In 2017, Addiction Medicine subspecialty certification exam was administered to diplomates of any of the 24 ABMS member boards who meet the eligibility requirements.</i></p>	Changes to the ABPM exam are not being considered at this time.
Psychiatry and Neurology (ABPN) abpn.com	<ul style="list-style-type: none"> Computer-based secure exam administered at a proctored test center. Diplomates must pass the exam once every 10 years. 	Implementing a Part III pilot program to allow physicians who read lifelong learning articles and demonstrate learning by high performance on the questions accompanying the article, to

American Board of:	Current Examination Format	New Models/Innovations
	<ul style="list-style-type: none"> Developing MOC exams with committees of clinically active diplomates to ensure relevance to practice. Enabling diplomates with multiple certificates to take all of their MOC exams at once and for a reduced fee. Grace period so that diplomates can retake the exam. 	earn exemption from the 10-year MOC high-stakes exam.
Radiology (ABR) theabr.org	Computer-based secure modular exam administered at a proctored test center. Diplomates must pass the exam once every 10 years.	<p>Developing a pilot that may replace the current 10-year traditional exam, with an Online Longitudinal Assessment (OLA) model that will be piloted and include modern and more relevant adult learning concepts to provide psychometrically valid sampling of the diplomate's knowledge.</p> <ul style="list-style-type: none"> 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. Those who answer questions incorrectly will receive future questions on the same topic to gauge whether they have learned the material.
Surgery (ABS) absurgery.org	<ul style="list-style-type: none"> Computer-based secure exam administered at a proctored test center. Diplomates must pass the exam once every 10 years. Transparent exam content, with outlines, available on the ABS website and regularly updated. Coordinating with the American College of Surgeons and other organizations to ensure available study materials align with exam content. 	In 2018, the ABS will begin offering shorter, more frequent, open-book, modular, lower-stakes assessments required every two years in place of the high-stakes exam. The new assessment is being introduced for general surgery, with other ABS specialties launching over the next few years. For 2018, diplomates will select from four practice-related areas: general surgery, abdomen, alimentary tract, or breast. More areas are planned for the future based on feedback from diplomates and surgical societies. Diplomates will take the assessment through their own computer at a time and place of their choosing within the assessment window, be provided with immediate feedback, and have two opportunities to answer a question correctly.
Thoracic Surgery (ABTS) abts.org	<ul style="list-style-type: none"> Remote, secure, computer-based exams can be taken any time 24/7 that the physician chooses during the assigned two-month period (September-October) from their home or office. Diplomates must pass the exam once every 10 years. Modular exam, based on specialty, and presented in a self-assessment format with critiques and resources made available to diplomates. 	The ABTS developed a web-based self-assessment tool (SESATS) that includes all exam material, instant access to questions, critiques, abstracts and references.
Urology (ABU) abu.org	<ul style="list-style-type: none"> Computer-based secure exam administered at a proctored test center once a year (October). 	

American Board of:	Current Examination Format	New Models/Innovations
	<p>Diplomates must pass the exam once every 10 years.</p> <ul style="list-style-type: none"> Clinical management emphasized on the exam. Questions are derived from the American Urological Association (AUA) Self-Assessment Study Program booklets from the past five years, AUA Guidelines, and AUA Updates. Diplomates required to take the 40-question core module on general urology, and choose one of four 35-question content specific modules. ABU provides increased feedback to reinforce areas of knowledge deficiency. 	
<p>*The information in this table is sourced from ABMS member board websites and is current as of March 27, 2018.</p> <p>1. Seven ABMS member boards are utilizing CertLink™, an ABMS web-based platform that leverages smart mobile technology to support the design, delivery, and evaluation of longitudinal assessment pilots, some of which launched in 2017. More information is available at: abms.org/news-events/american-board-of-medical-specialties-announces-development-of-new-web-based-platform/ (accessed 1-8-18).</p>		

APPENDIX - Current AMA Policies Related to MOC and OCC

H-275.924, "Maintenance of Certification"

AMA Principles on Maintenance of Certification (MOC)

- Changes in specialty-board certification requirements for MOC programs should be longitudinally stable in structure, although flexible in content.
- 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.
- 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.
- 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).
- 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.
- 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.
- 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.
- 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.
- 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 Credit™, American Academy of Family Physicians Prescribed, American College of Obstetricians and Gynecologists, and/or American Osteopathic Association Category 1A)."
- 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.
- 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.
- 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.
- The MOC process should be evaluated periodically to measure physician satisfaction, knowledge uptake and intent to maintain or change practice.
- MOC should be used as a tool for continuous improvement.
- The MOC program should not be a mandated requirement for licensure, credentialing, recredentialing, privileging, reimbursement, network participation, employment, or insurance panel participation.
- 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 be reflective of and consistent with the cost of development and administration of the MOC components, ensure a fair fee structure, and not present a barrier 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.
 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.
 27. Our AMA will continue to work with the national medical specialty societies to advocate for the physicians of America to receive value in the services they purchase for Maintenance of Certification from their specialty boards. Value in MOC should include cost effectiveness with full financial transparency, respect for physicians time and their patient care commitments, alignment of MOC requirements with other regulator and payer requirements, and adherence to an evidence basis for both MOC content and processes.
- (CME Rep. 16, A-09 Reaffirmed: CME Rep. 11, A-12 Reaffirmed: CME Rep. 10, A-12 Reaffirmed in lieu of Res. 313, A-12 Reaffirmed: CME Rep. 4, A-13 Reaffirmed in lieu of Res. 919, I-13 Appended: Sub. Res. 920, I-14 Reaffirmed: CME Rep. 2, A-15 Appended: Res. 314, A-15 Modified: CME Rep. 2, I-15 Reaffirmation A-16 Reaffirmed: Res. 309, A-16 Modified: Res. 307, I-16 Reaffirmed: BOT Rep. 05, I-16 Appended: Res. 319, A-17 Reaffirmed in lieu of: Res. 322, A-17 Modified: Res. 953, I-17)

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. 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.
 29. 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.
 30. 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.
 31. 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.
 32. 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.
 33. 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.
 34. Increase its efforts to work with the insurance industry to ensure that maintenance of certification does not become a requirement for insurance panel participation.
 35. Advocate that physicians who participate in programs related to quality improvement and/or patient safety receive credit for MOC Part IV.
- (CME Rep. 2, I-15 Appended: Res. 911, I-15 Appended: Res. 309, A-16 Appended: CME Rep. 02, A-16 Appended: Res. 307, I-16 Appended: Res. 310, I-16 Modified: CME Rep. 02, A-17 Reaffirmed: Res. 316, A-17 Reaffirmed in lieu of: Res. 322, A-17)

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.

(Res. 318, A-07 Reaffirmation A-11 Modified: CME Rep. 2, I-15)

3. EXPANDING UME WITHOUT CONCURRENT GME EXPANSION

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS REMAINDER OF REPORT FILED

See Policy D-305.967

INTRODUCTION

American Medical Association (AMA) Policy D-305.967 (31), “The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education,” directs our AMA to “study the effect of medical school expansion that occurs without corresponding graduate medical education expansion.” This report is in response to this directive.

This portion of the policy was appended through Resolution 320-A-16, “Expanding GME Concurrently with UME,” which was introduced by the Resident and Fellow Section at the 2016 Annual Meeting of the AMA House of Delegates (HOD). Testimony before Reference Committee C during the HOD meeting was overwhelmingly in favor of Resolution 320-A-16. Multiple individuals noted that the number of new medical schools and enrollment in existing institutions have expanded substantially of late, without a corresponding increase in the number of entry-level graduate medical education (GME) positions. Concern was voiced that the number of U.S. seniors successfully completing their undergraduate medical education (UME) at either allopathic or osteopathic medical schools likely will approach or surpass the total number of available U.S. GME positions within the next one to two decades. It was further acknowledged that the Accreditation Council for Graduate Medical Education (ACGME) is examining this important issue, with discussions that consider mitigating barriers to establishing training programs in specialties and locations that are underserved. Some testimony requested the addition of a second resolve to ask the AMA to advocate for expansion in resident and fellowship positions in proportion to expansions in medical school student populations and the health needs of the populace. Other testimony proposed limiting the number of U.S. medical school graduates (USMGs) per year. Additional discussion referenced the need for a national workforce plan that appropriately addresses specialty and geographic shortages. Testimony in opposition to the addition of the proposed second resolve focused on concerns that advocating for U.S. medical schools to limit class sizes could be construed as restraint of trade. Both the Liaison Committee on Medical Education (LCME) and the Commission on Osteopathic College Accreditation (COCA) have the authority to set standards for schools, but they must approve any school that meets those standards; they cannot arbitrarily prohibit the establishment of new schools. While medical schools may have a moral obligation to consider the issue of the narrowing gap between the number of USMGs and the number of residency positions, it is not a legal obligation.

This report: 1) provides an update on recent numbers of medical students, graduates, and residency positions; 2) summarizes recent residency applicant behavior and results in terms of matching into residency programs; 3) describes recent state and medical school efforts to expand GME positions; 4) describes the AMA’s national SaveGME campaign; and 5) concludes with a discussion concerning a changing GME environment, recommendations to help allay student concern about matching, and potential policy changes for medical schools to consider.

BACKGROUND

Concerns regarding the number of GME positions available to medical school graduates, known as post-graduate year 1 (PGY1) positions, have been increasing over the past several years.

In 2006, the Association of American Medical Colleges (AAMC) issued a call for expanding the number of medical school graduates, due to data suggesting an imminent physician shortage. The AAMC recommended a 30 percent increase (over 2002–2003 levels) in first-year medical school enrollment in LCME-accredited schools by the 2015–2016 academic year. Using the baseline of the 2002–2003 first-year enrollment (16,488 students), a 30 percent increase corresponds to an increase of 4,946 students. The AAMC forecast in 2017 that the 30 percent goal would be attained by 2017–2018 and exceeded in future years.¹ Osteopathic medical schools, which are accredited by COCA, also have grown in number and in the number of enrollees and graduates.² The number of LCME- and COCA-accredited schools, first year enrollment, and corresponding allopathic and osteopathic graduates is presented in Table 1, at the end of this report.

The rate of growth in the number of USMGs currently is greater than the rate of growth in PGY1 positions. Analysis of existing data and projections suggests there is still substantial room for placement of USMGs into GME, with an excess of 4,500 positions relative to graduates, as shown in the Figure at the end of this report.^{3,4}

One analysis found that 99% of U.S. MD graduates ultimately do find careers in medicine.⁵ The percent of U.S. MDs matching into PGY1 positions through the National Resident Matching Program (NRMP) has been consistently at 94% since at least 2008; only 500 to 600 U.S. MD graduates do not find a position through the NRMP's Supplemental Offer and Acceptance Program (SOAP), which assists in placing unmatched applicants into unfilled positions.⁶ Other, infrequent opportunities exist post-SOAP for students to find positions in unfilled programs. Nonetheless, medical students continue to experience anxiety over the possibility of graduating from medical school without a training position, a necessary requirement for a clinical career in medicine.

Although there are more PGY1 positions than USMGs, it is important to consider that other physicians also are vying for these training opportunities. Approximately half of international medical school graduates (IMGs), either U.S. citizens (US IMGs) or foreign nationals (non-US IMGs) participating in the NRMP, successfully match. A much smaller proportion find positions through SOAP.

There are a number of reasons why USMGs do not match into PGY1 positions; the Council on Medical Education has written several recent reports on this topic (CME 3-A-16, "Addressing the Increasing Number of Unmatched Medical Students," and CME 5-A-17, "Options for Unmatched Medical Students"). One contributing factor is that not all positions are equally desirable to every applicant because of specialty and practice location preferences. For example, an average overall growth rate of two percent does not necessarily mean that there are enough positions in dermatology for all the applicants who wish to train in dermatology or wish to train in dermatology in the state of Georgia. The apprehension born of the perception of fewer available positions, often misreported in the popular press,⁷ is coupled with a sense of increasing competitiveness, which may be caused in part by the increase in the number of DOs participating in the NRMP (in the 2013 Match, DOs made up 7.9 percent of matched applicants, versus 10.6 percent in 2017). The number of osteopathic students choosing to match into allopathic programs via the NRMP was increasing even before the transition to the Single Accreditation System, through which the ACGME will accredit both allopathic and osteopathic programs. This increase will continue during the transition of osteopathic program positions into the NRMP, which will be completed in July 2020.

One of the unintended consequences of this perceived bottleneck is that residency applicants have increased their number of program applications in an attempt to improve the likelihood of receiving an invitation to interview and eventually secure a residency. Table 2, at the end of this report, provides the average number of program applications per applicant through the Electronic Residency Application Service (ERAS) and the average number of applications received by programs. An NRMP analysis of U.S. MD seniors participating in the 2017 Match in the 20 largest specialties found that MD seniors who ultimately successfully matched applied to a median number of 35 programs, resulting in a median number of 16 offered interviews. MD seniors who ultimately did not match applied to a median number of 54 programs, resulting in a median number of six offered interviews.⁸ Data from the 2013 Match shows comparable numbers: successfully matched MD seniors applied to a median number of 29 programs, yielding 15 interview offers. Unmatched MD seniors applied to a median number of 50 programs, yielding seven interview offers.⁹ These data suggest that simply applying to more programs does not necessarily result in more interview opportunities. In addition, analyses by the AAMC provide information on the point of diminishing returns in the number of applications sent by U.S. MD applicants, by USMLE Step 1 score and specialty.¹⁰

STATE AND MEDICAL SCHOOL EFFORTS

Recently, some individual schools, medical systems, and states have begun to address the discrepancy between rapidly expanding UME enrollment and GME expansion, often in tandem with efforts to meet the health care needs of local populations.

Texas

In 2017, the Texas state legislature passed Bill 1066, “Requirement to Plan GME Needs in Conjunction with Medical School Planning,” which requires that all new public allopathic and osteopathic medical schools in the state provide to the Texas Higher Education Coordinating Board an assessment of the adequacy of the projected number of first-year residency positions that may be available for graduates of the new medical school. If a shortage is projected, the medical school will be required to submit a plan to increase the number of PGY1 positions in the state to reasonably accommodate the number of graduates from all MD and DO medical school programs in Texas and “provide adequate opportunity for those graduates to remain in the state for the clinical portion of their education.” Submission of the assessment, and, if necessary, the plan to increase PGY1 positions, is a prerequisite for the board’s approval of the medical school.¹¹

Not only does this bill serve Texas’s needs by ensuring UME expansion within the state is coupled with GME expansion, allowing newly graduated physicians the opportunity to remain in Texas for their training, but it also establishes a legislative strategy to assure UME expansion is coupled with corresponding GME expansion so that the newly admitted medical students have the theoretical opportunity to complete GME training in the state. It does not, however, address the expansion of already existing medical schools. The law also does not affect future planned private medical schools. In addition, although the plan must specify that there will be adequate PGY1 positions in the state, the proposed medical school itself is not required to sponsor the GME programs. The plan regards total state numbers, not type of program or location, and is not specific to an institution. If the state’s total number of existing residency positions is expected to meet the needs of the total number of medical school graduates, the medical school does not have to submit a plan for developing additional GME positions.

The Texas Medical Association (TMA) is working to address a loophole in the current law. New medical schools are required to submit a GME plan to demonstrate the projected availability of training positions for the total number of students in the inaugural class. Most schools, however, start with a relatively small number in the inaugural class, with plans to expand the class size after achieving full accreditation status. The result is that the full GME needs of their students are neither identified nor planned for from the beginning. The TMA will likely consider a proposed amendment that would stipulate that medical schools must submit a plan to meet the GME needs for the school’s planned target class-size.

Kaiser Permanente

Kaiser Permanente, a large, integrated, population-based health care delivery system in the Western U.S., has been one of the largest private contributors to GME funding through its integrated residency programs. Kaiser currently hosts residency positions in five regions (Northern and Southern California, the Pacific Northwest, Colorado, and Hawaii). These collective programs support 900 full-time equivalents of residents in over 30 specialties. Residents in the Kaiser Permanente system are hosted primarily through Kaiser itself (600 residents), but affiliate programs also send residents to train within the Kaiser system for some duration of time. In total, 3,000 individuals per year rotate through the Kaiser system for training.¹² Kaiser has been very successful in retaining trainees following completion of residency training, with one-third to one-half of trainees staying and practicing in the Kaiser system. Savings on physician recruitment are then used to support Kaiser’s resident complement.¹³

Following its success in establishing diverse and sustainable residency training positions, Kaiser is building a medical school in Southern California. The inaugural class of 2019 is expected to have 48 students, with a full complement of 192 enrolled by 2022. Initial plans for student education include early exposure to patients and integration into the robust network of clinical opportunities available within the Kaiser system.¹⁴

Local assistance

Creating a new GME program from scratch is a daunting process, but more information has become available about the process. Consultants with GME experience are available to assist. One institution recently published a plan for starting a new residency program, with step-by-step guidelines.¹⁵ The state of Indiana has worked with at least two consultant groups to develop its plan to expand GME.¹⁶

SAVEGME CAMPAIGN

The AMA has long advocated for both the preservation of GME funding and additional monies to support future physician workforce needs, as noted in, for example, Council on Medical Education Report 5-A-16, “Accountability and Transparency in Graduate Medical Education Funding.” The SaveGME website (savegme.org), originally oriented toward medical students and physicians, was revamped with a public-facing aspect in 2017. The revitalized website was then shared across social media platforms and various advocacy groups including the Patients Action Network and the Physicians Grassroots Network. This campaign emphasized the value of residents to patient care, including the provision of 40 percent of charity care nationwide as well as the importance of residency programs to innovations in health care delivery and patient safety initiatives. The new website includes videos, statistics, demographics, and other material to support the SaveGME campaign. From March through October 2017, there were 78,827 visits to the SaveGME.org website and 1,816,821 video views. Social media platforms proved useful in spreading the message, with over 12.5 million impressions on Facebook and Twitter. Over 2,300 letters were sent via the site to legislators by 720 individuals, representing a 16-fold increase compared to the year prior in communication to legislators.¹⁷

CURRENT AMA POLICY

Currently, the AMA has several policies or directives that concern the lack of appropriate growth in GME positions; these are listed in the Appendix.

SUMMARY

Without expansion in the number of PGY1 positions available to recently minted medical school graduates, eventually the number of USMGs seeking positions will exceed what is available. Lacking this expansion, some potential applicants likely will seek training elsewhere. Non-US IMGs, a group that long has trained in the U.S. and greatly added to the U.S. physician workforce in numbers and diversity, as well as specialty and geographic focus, may choose to train in other countries where there are more opportunities and fewer immigration barriers (CME Report 3-I-17, “Impact of Immigration Barriers on the Nation’s Health”). The reduction in the size of one applicant pool likely will prolong the period during which there is increasing competition for positions, but still more available positions than USMGs. Despite this temporary reprieve, medical students perceive increasing competition and suffer anxiety engendered by the risk of graduating with substantial educational debt but without a residency position. Medical schools should increase their efforts to guide students concerning educational debt, specialty choice, and potential career paths, in order to better prepare students entering a physician workforce that may have constraints in its capacity to grow. In this context, and in anticipation of this country’s future health care needs, efforts to expand UME without thoughtful provision of GME opportunities is careless at best and negligent at worst.

RECOMMENDATIONS

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

1. That Policy D-305.967 (31), “The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education,” be rescinded, as having been fulfilled by this report.
2. That our American Medical Association (AMA) 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.

3. That our AMA 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.
4. That our AMA 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 graduates' rates of placement into GME as well as GME completion.

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Table 1. Medical schools, first year enrollment, graduates, and trainees in first year positions for academic years 2012-2013 through 2017-2018

	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18
Number of allopathic medical schools†	136	140	141	142	145	147
Number of colleges of osteopathic medicine‡	26	29	29	30	36	48
MD 1 st -Year Enrollment†	20048	20583	20608	21128	21396	21338*
DO 1 st -Year Enrollment‡	5986	6636	7012	7219	7575	8113
MD Graduates†	18147	18057	18668	18820	19402¥	
DO Graduates‡	4806	4997	5323	5472	6038	
Total U.S. Graduates	22953	23054	23991	24292	25440	
Annual Graduate Growth Rate (%)		.44	4.06	1.25	4.72	
PGY1 Applicants Matched in NRMP∞	25246	25687	26252	26836	27688	29040
Residents in ACGME PGY1 Positions£	26018	26649	27122	27949	28658	
Annual ACGME PGY1 Growth Rate (%)		2.42	1.77	3.05	2.54	
Applicants Matched in NMS (Osteopathic Match)§	1891	2022	2135	2206	2162	1640
Annual Osteopathic Match Growth Rate (%)		6.93	5.59	3.32	-1.99	-24.14

† LCME database, includes schools with first year enrollment.

‡ AACOM data, includes branch campuses and remote teaching sites with first year enrollment: <http://www.aacom.org/docs/default-source/data-and-trends/AppEnrollGrad2011-2016.pdf?sfvrsn=39>. Accessed December 21, 2017; http://www.aacom.org/docs/default-source/data-and-trends/2016-17_FYEnroll_Gender_RE_COM.pdf?sfvrsn=12. Accessed December 21, 2017; https://www.aacom.org/docs/default-source/data-and-trends/2017_fall_enrollment_report.pdf. Accessed December 21, 2017.

*AAMC matriculant data: <https://www.aamc.org/download/321442/data/factstablea1.pdf> 2017-2018. Accessed February 12, 2018. 1st year enrollment data include students repeating the first year, as opposed to matriculant data.

¥ LCME database; schools estimated the number of graduates in February 2017.

∞ National Resident Matching Program, Results and Data: 2017 Main Residency Match®. National Resident Matching Program, Washington, DC. 2017, and Advance Data Tables: 2018 Main Residency Match <http://www.nrmp.org/main-residency-match-data/> Applicants match during the current academic year to become first year residents in the following academic year.

£ Brotherton SE, Etzel SI. Graduate Medical Education, 2016-2017. *JAMA*. 2017;318(23):2368–2387. doi:10.1001/jama.2017.16203

§ National Matching Service. May include those with prior training. Applicants match during the current academic year to become first year residents in the following academic year. <https://natmatch.com/aoairp/aboutstats.html>. Accessed February 13, 2018.

Table 2. Average number of applications through eras for academic years 2013-2014 through 2017-2018

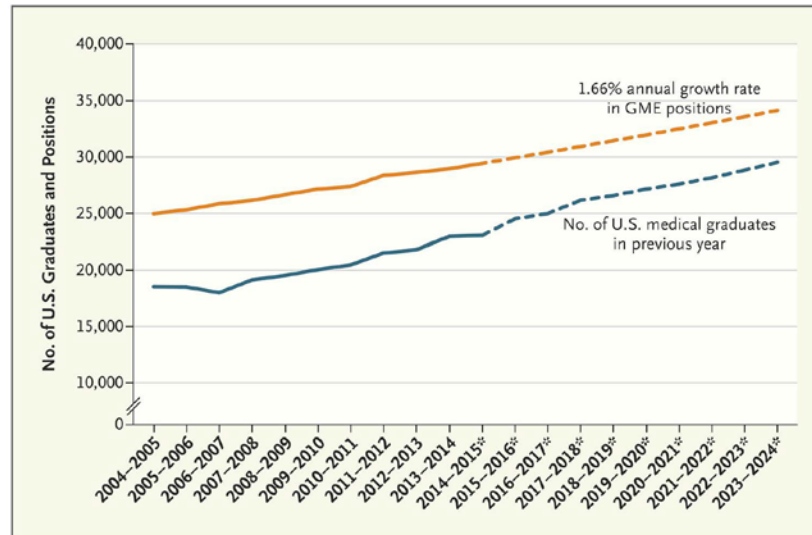
	2013-2014	2014-2015	2015-2016	2016-2017	2017-2018
Average number of applications sent by applicant*					
USMG	43.8	47.2	49.3	55.0	58.0
IMG	113.4	119.1	123.1	131.5	135.5
All applicants	74.3	78.6	80.7	87.7	90.1
Average number of applications received by program**					
USMG	285.9	306.6	327.9	367.2	386.8
IMG	576.6	601.5	606.3	654.3	639.5
All applicants	862.2	907.8	933.9	1021.1	1025.7

*<https://www.aamc.org/download/359232/data/all.pdf> Accessed August 15, 2017. USMG includes U.S. MDs and DOs, of any graduating class.

**<https://www.aamc.org/download/359236/data/all.pdf> Accessed October 13, 2017. USMG includes U.S. MDs and DOs, of any graduating class.

Figure

Actual and Projected Growth in Numbers of U.S. Medical School Graduates and Graduate Medical Education (GME) Entrants, Based on 1.66% Annual Growth in GME Positions.



Mullan F et al. *N Engl J Med* 2015;373:2397-2399.

THE NEW ENGLAND
JOURNAL OF MEDICINE

From the New England Journal of Medicine, Mullan F, Salsberg E, Weider K, Why a GME Squeeze Is Unlikely. Volume No. 373, Pages 2397-2399. Copyright 2018 Massachusetts Medical Society. Reprinted with permission from Massachusetts Medical Society.

APPENDIX - AMA Policy

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

Our AMA will: (3) 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) Strenuously advocate for increasing the number of GME positions to address the future physician workforce needs of the nation; (8) 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; (15) Encourages the ACGME to reduce barriers to rural and other underserved community experiences for graduate medical education programs that choose to provide such training, by adjusting as needed its program requirements, such as continuity requirements or limitations on time spent away from the primary residency site; (17) 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) 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; (26) Encourages insurance payers and foundations to enter into partnerships with state and local agencies as well as academic medical centers and community hospitals seeking to expand GME.

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

Our AMA will: (2) 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) 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) Actively advocate for expanded funding for entry and continued training positions in specialties and geographic regions with documented medical workforce shortages; (5) Lobby Congress to find ways to increase graduate medical education funding to accommodate the projected need for more physicians.

H-310.917, “Securing Funding for Graduate Medical Education”

Our AMA: (4) Encourages entities planning to expand or start GME programs to develop a clear statement of the benefits of their GME activities to facilitate potential funding from appropriate sources given the goals of their programs.

H-305.988, “Cost and Financing of Medical Education and Availability of First-Year Residency Positions”

Our AMA: (2) In studying the financing of medical schools, supports identification of those elements that have implications for the supply of physicians in the future.

H-465.988, “Educational Strategies for Meeting Rural Health Physician Shortage”

Our AMA: (2) Encourage medical schools to develop educationally sound primary care residencies in smaller communities with the goal of educating and recruiting more rural physicians.

H-200.954, “US Physician Shortage”

Our AMA will: (8) Continue to advocate for funding from all payers (public and private sector) to increase the number of graduate medical education positions in specialties leading to first certification; (9) Work with other groups to explore additional innovative strategies for funding graduate medical education positions, including positions tied to geographic or specialty need.

D-310.977, “National Resident Matching Program Reform”

Our AMA: (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; (15) 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 matches for medical school seniors, and reduce the number who do not match.

4. EVALUATION OF CLINICAL DOCUMENTATION TRAINING

Reference committee hearing: see report of Reference Committee C.

**HOUSE ACTION: RECOMMENDATIONS ADOPTED
REMAINDER OF REPORT FILED**

See Policy H-315.969

INTRODUCTION

American Medical Association (AMA) Policy D-295.314, “Study of Current Trends in Clinical Documentation,” directs our AMA to “study the effectiveness of current graduate and undergraduate education training processes on clinical documentation.”

This policy stemmed from Resolution 702-A-16, introduced by the Medical Student Section. Testimony before Reference Committee C during the Annual 2016 Meeting of the AMA House of Delegates highlighted the unprepared state of many medical school graduates for effective clinical note-taking, which could result in inaccurate notes and potentially negative patient outcomes. This report, which is in response to Policy D-295.314, will: 1) describe concerns about quality in clinical documentation and effects on patient care and safety, as well as reimbursement; 2) describe training and evaluation of training in incorporating the electronic health record into the physician/patient encounter in undergraduate and graduate medical education; 3) describe training and assessment of training of clinical documentation accuracy in undergraduate and graduate medical education; and 4) summarize relevant work of the Accelerating Change in Medical Education Consortium.

BACKGROUND

Concerns about clinical documentation proficiency of medical students and residents

There has been widespread concern about the quality of clinical documentation of physicians, focusing on the training provided medical students and residents. A primary concern is that many medical students lack sufficient access to their training institution’s electronic health record (EHR) system. (Note: Much of the literature uses either the term electronic medical record or electronic health record. This report will use the term EHR for both terms.)

Medical students' inconsistent access to the EHR can result in students graduating without well-developed skills, forcing first-year residents to spend time familiarizing themselves with the EHR while they are learning to care for patients for the first time without direct supervision.¹ Although the medical education community agrees that it is essential for students to become familiar with documentation and the EHR, some institutions restrict access to the EHR because of potential legal liability related to the risk of errors made by students' ability to copy and paste notes in the EHR. In addition, the Centers for Medicare & Medicaid Services (CMS) has rules regarding the use of student documentation to support billing for services which, if not followed, can add potential legal liability.

To prevent institutions from running afoul of CMS rules, the Association of American Medical Colleges has recommended that EHR systems include rigorous controls to safeguard physicians from inadvertently copy/pasting a note created by a medical student, which would have been out of compliance with CMS payment regulations. Until recently, if a student documented an evaluation and management service (E/M), the teaching physician had to verify and re-document the physical examination and the medical decision-making activities of the services. The physician could only refer to a student's documentation related to the review of system and/or past/family and/or social history.² Beginning in March 2018, CMS "allows the teaching physician to verify in the medical record any student documentation of components of E/M services, rather than re-documenting the work." As CMS notes, however, "the teaching physician must verify in the medical record all student documentation or findings, including history, physical exam and/or medical decision making. The teaching physician must personally perform (or re-perform) the physical exam and medical decision making activities of the E/M service being billed, but may verify any student documentation of them in the medical record, rather than re-documenting this work."³ While this update in policy may encourage some medical schools and clinical teaching sites to allow more medical students to access the EHR, institutions are advised, as a best practice, to "[i]nvest in provider education to create high-quality documentation with EHR tools."⁴

Students' use of copy and paste functions (CPF) in the EHR is widespread and has raised concerns about potential lapses in patient quality of care and medical ethics. Third-year medical students at one medical school were surveyed about their use of CPF in the EHR, as well as observations of other professionals using CPF. All students frequently used the EHR for documenting their patient notes. Although very few (10 percent) believed it acceptable to copy and paste from other providers' notes, 83 percent believed it acceptable to copy and paste from their own notes, 22 percent have copied from residents' notes, and 13 percent have copied from attendings' notes. Although using CPF is a common practice, 46 percent believed that notes written using CPF are less accurate than notes written without it, and 45 percent believed that CPF causes problems in patient care. Only 42 percent of students were aware of their school's policy concerning copy and paste (students are prohibited from copying others' notes, but are permitted to copy their own note from a previous day if it is altered to reflect the patient's current condition).⁵

Besides concerns about inappropriate use of CPF in the EHR by medical students, clerkship directors worry about the effect of the EHR on student-patient relationships, in that students are more engaged with the chart and computer than with the patient. In addition, students are receiving poor role modeling from faculty, as well as from the whole care team, on appropriate use of and best practices for EHRs.⁶

Similar concerns are also relevant when reviewing residents' use of the EHR. In a survey at a large integrated health system, program directors were questioned about their confidence in their first-year residents' abilities to perform 13 core entrustable professional activities (EPAs) six months into their first year of training. Overall, 62 percent of their residents were assessed. Confidence in the residents' ability to perform the activities without supervision ranged from 38 percent to 98 percent. Sixty-nine percent of first-year residents were considered to be able to perform EPA 4, "Enter and discuss orders and prescriptions," without supervision, while 98 percent were considered able to document a clinical encounter in the patient record without supervision.⁷

Although residents have been found to make fewer errors than attending physicians in the EHR, at least at the time of transition from paper to electronic documentation,⁸ other research has pointed out the need for education in clinical documentation and coding practices for residents. A retrospective chart review in 2014 of surgery residents at one institution found 28 percent of the reviewed charts had inaccuracies in one or more of the following categories: admission diagnoses, surgical diagnoses, in-hospital complications, or comorbidities. The average reimbursement of the charts with inaccuracies was \$7,849 compared to \$8,418 for the corrected versions, a 12.4 percent difference. The authors suggest that hospitals may incur significant loss in revenue due to errors in clinical documentation by residents and that educational training for surgical residents in clinical documentation and hospital-specific coding practices could prove financially advantageous.⁹

Published literature describing training in clinical documentation accuracy in the EHR and the use of the EHR and computers during the physician/patient encounter is relatively rare, especially given the concerns that clinical documentation inaccuracy and poor physician/patient interactions can affect patient care and safety.

TRAINING IN AND ASSESSMENT OF THE EHR IN THE PHYSICIAN/PATIENT ENCOUNTER

In 2012, the Alliance for Clinical Education, a consortium of clerkship directors across clinical disciplines, published guidelines for medical student documentation in the EHR.¹⁰ These guidelines note the importance of students becoming competent in EHR use prior to graduation and acknowledged that such education is infrequent. The final guideline states that medical schools should develop competencies for charting in the EHR and state how these competencies would be evaluated. The guidelines lay out opportunities for EHR training throughout the curriculum, providing a framework for institutions developing such curriculum for their students. Wald and colleagues have also outlined curriculum objectives that could be incorporated into EHR training in undergraduate medical education.¹¹

In 2014, Hersh and colleagues outlined competencies across the content of clinical informatics for medical education. These included several competencies related to EHR use, which they have begun implementing for their students at Oregon Health & Science University School of Medicine (OHSU), a member of the Accelerating Change in Medical Education Consortium.¹²

Overall, in both undergraduate and graduate medical education, there is broad support for increased education and training in the use of the EHR. Several expert groups have recommended specific objectives and competencies for such curricula. However, there are fewer reports of implementation of these curricula and assessment of their outcomes. Few studies have been conducted to examine the effectiveness of training in the use of the EHR in encounters between medical students/residents and patients. Often studies in educational environments lack the ability to control confounding factors; enroll enough participants; and include objective, third-party observers.

Assessment of training provided for medical students

OHSU has been one of the leaders in introducing medical students to the EHR as part of an objective structured clinical examination (OSCE). During the OSCE, the student interacts with a standardized patient (SP) and accesses a simulated EHR. The student's performance is evaluated by a faculty member either in the room or behind a two-way mirror. The EHR-OSCE assesses EHR skills rather than medical knowledge, which include not only what information is placed into the EHR but also the positioning of the computer/monitor throughout the examination.

The University of Texas Health Science Center at San Antonio (UTHSCSA) has adopted the OHSU EHR-OSCE. Although not designed to evaluate the effectiveness of EHR training, a paper comparing the performance of students of the two schools suggests that some differences in performance may be the result of the timing of the training. Students from UTHSCSA had better overall performance compared to OHSU students. In particular, UTHSCSA students' performance improved over the course of the year, while OHSU students' EHR skills failed to improve as the year progressed. UTHSCSA students received didactic EHR training in the weeks immediately preceding the OSCE, while OHSU students received training up to 14 months prior to the OSCE. The authors of the study suggest that this intervening period at OHSU caused EHR skills to atrophy and also increased students' exposure to negative role-modeling while observing clinicians using the EHR.¹³

Han, Waters, and Loop designed a study to measure the effectiveness of an online self-study module for medical students and other health care professionals.¹⁴ The module includes sections on education, computer placement, and provider-patient interactions in the presence of the EHR. The module emphasizes the potential of using the computer as a visual aid in patient education, along with appropriate placement of the computer to promote a positive open triadic position, and presents methods to maximize the provider-patient relationship while involving the patient in the EHR process. The researchers were able to use SP encounter videos of medical students before the introduction of the module into the second year curriculum as a pre-test and compared SP videos of students who completed the module. In addition, SP evaluations of the encounters were compared, and students were also reevaluated three months later. Students who had taken the module demonstrated better EHR communication skills compared to the pre-module students, SPs' evaluations were more positive, and three months later students had retained their skills.¹⁴

Educators at the University of Arizona College of Medicine - Phoenix assessed whether EHR ergonomics training enhances students' ability to use the EHR during SP encounters. They compared the performance of students in three

groups, all of whom took a pre-survey on computer use: 1) students who received two hours of basic EHR training and had no EHR available during SP encounters; 2) students who received the EHR training and were expected to use the EHR available during SP encounters; and 3) students who received the EHR training, were expected to use the EHR during SP encounters and received additional ergonomic training. Ergonomic assessment data were collected from students, faculty, and SPs in each session. A post-survey was administered to all students, and data were compared across all three groups to assess the impact of EHR use and ergonomic training. The results revealed a significant positive effect for the third group, in that EHR use improved with EHR ergonomic training—specifically, those who had the ergonomic training felt that they were able to use the EHR more effectively to engage with the patient, better articulate the benefits of using the EHR, better address patient concerns, more appropriately position the EHR device, and more effectively integrate the EHR into the patient encounter.¹⁵

Assessment of training provided for residents

Fogarty, Winters, and Farah developed a workshop conducted with 139 residents and faculty supervisors on the challenges and opportunities of working with the EHR in practice, covering the introduction of patient-centered behaviors and presenting videos demonstrating common behaviors and improvements. Possibly exemplifying the difficulty of conducting research into educational innovations, only 39 of the 139 participants completed both the baseline and post-intervention assessment.¹⁶

In another study, a standardized, streamlined note template was added to the EHR at a free-standing children's hospital. Comparing the notes written in the EHR with the template to notes written during the same time period a year earlier, notes using the template were statistically shorter and trainees finished their notes later in the day, although there were no differences in the total amount of time to write notes (238 vs. 225 minutes, $p=.32$). Overall, the standardized note template was well-received by residents, despite some ambivalence about EHR functionality. As another possible example of the difficulty of research in these settings, the authors point to an unexpected confounder of the study, i.e., more notes were written post-template implementation. This likely reflects an increase in the patient census and accompanying number of notes to be written without an increase in resident coverage.¹⁷

Other research looked at a family medicine residency program that developed a longitudinal primary care medical home (PCMH) case-based EHR curriculum. The EHR training was grounded in clinical cases, including a step-by-step breakdown of the PCMH clinic visit, and delivered throughout the three-year residency program; residents were scheduled for a three-hour training session each trimester, with an EHR self-assessment of six core skills taken at the end of each session. Researchers compared the self-assessments of residents who attended more training (eight or more sessions, average=nine) to those who attended fewer than eight (averaging 5.3 sessions). The results showed that low-exposed residents improved the most over time, and high-exposed residents reported overall higher post-test scores at training completion.¹⁸

In another study at a family medicine residency program, 36 residents volunteered for random assignment into either a simulation-based training program or a lecture-based training group, which covered tips on using the EHR (such as “reserve templates for documentation,” “tell your patients what you’re doing while you’re doing it,” “look at your patients,” etc.). The study included a pre-test simulation of six SPs, a post-test simulation of another six SPs, and evaluation by physician observers and by SPs. No difference was found between the two groups. Both groups had improved in their use of the EHR as evaluated by physician observers and SPs, and the residents rated themselves as more competent in the post-training phase. The authors of the study postulate that the six pre-test simulated encounters provided a major training effect for volunteers motivated to learn.¹⁹

TRAINING IN AND ASSESSMENT OF CLINICAL DOCUMENTATION ACCURACY

Assessment of training provided for medical students

Although there are studies documenting students' use of the EHR and assessing accuracy, assessment of the training provided students is lacking or at least not available in the published literature. One study did make an interesting comparison of the level of accuracy in the EHR performance of 222 third-year medical students during their internal medicine clerkships and subsequent performance on their end-of-clerkship professionalism assessments versus their end-of-year gateway OSCE clinical skills scores for communication and history taking. Overall, 31 percent of students had one error in the EHR, and 13.5 percent had two to six errors. Most errors were in structured data entry. Error rate

was correlated with poor performance as assessed at the end of clerkship. However, there was no assessment of the method by which the students learn the EHR, which was 15 online tutorials completed over 71 minutes.²⁰

One study underscores the ability of medical students to accurately use the EHR in that it describes students as credentialed trainers at one academic health center that underwent a transition from one EHR system to another. Six selected medical students went through a six-week course that included instruction on adult learning theory, change management, and conflict resolution. They were assessed through written and oral examinations with the EHR vendor and institutional training leaders. The students then trained over 1,000 providers during a two-month time period. The trainers were given extremely high marks on the post-training survey, averaging 3.93 on a 4-point Likert scale for both mastery of material and communication skills (4 being excellent, 1 being poor). The authors noted that the institution saved considerable money using in-house trainers while providing the students a valuable financial and career opportunity.²¹

Assessment of training provided for residents

Researchers at OHSU assessed the 1.5-day training on its EHR system that internal medicine residents receive at the beginning of residency. Training included instruction on real-world task completion relevant to interns' clinical practice. One month after this training, interns participated in a dedicated exercise to test their ability to perform a set of 28 defined EHR use-related competencies with the OHSU simulation version of the EHR. All interns were found to have missed at least one safety issue, and overall there was wide variation in the amount and quality of data imported to generate notes. The researchers concluded that the results highlight the inadequacies of standard EHR training in the setting of advanced EHR use for data acquisition and documentation and noted that simulation may also help inform EHR redesign by reflecting accurate use patterns.²²

An example of the difficulty of performing educational evaluation research in real-world settings is demonstrated by a study that attempted to compare the effect of two different interventions on the quality of EHR clinical documentation of internal medicine residents at two medical schools. The educational quality improvement intervention project did not improve the quality of clinical documentation. The authors noted that they were not able to combine the scores of residents at the two schools, leading to small sample sizes, and that one rater scored documentation much higher than other raters. Calibration did not occur beforehand.²³

Although another study at OHSU was designed to assess whether EHR simulation improves EHR use in an ICU by comparing residents who went through the simulation once to those who participated twice, what occurred between the two sessions may account for much of the improvement found. Specifically, after residents were given the EHR of a case study:

Participants ... presented the case to a member of the study team and were graded on the number of patient safety issues identified. After the exercise, every participant underwent an immediate, standardized debriefing session on action items missed and received suggestions to improve their skills for EHR use. Beginning with the laboratory data, participants were shown the important trends in renal function and blood counts, as well as a tutorial regarding the graphing functions available. From there, assessment and evaluation of the medication administration report was completed, with discussion of appropriate dosing of medications and finding therapeutic drug monitoring assessments. This would be followed by reviewing vital signs, beginning with the most commonly used screen to assess vitals and using two other screens that display the same information in different contexts. Participants were shown possible customizability options and graphing functions within the vital signs pages as well as specific information found only in these screens. Next, participants would review ventilator data and discuss lung protective and low tidal volume ventilation, as well as how to assess appropriateness of an individual patient's ventilator settings. Volume status and intake/output reports were then viewed and specific issues surrounding volume status in ARDS were discussed. Finally, participants were given time to ask questions, re-review any functions of the EHR, and discuss any concerns regarding participation in the simulation exercise.²⁴

Not surprisingly, given the thoroughness of the debriefing session, residents who then were presented a second case study, one to four weeks later, improved their rate of overall recognition of patient safety issues compared to the first case study (39.9 percent vs. 63.4 percent).

In another study, researchers designed an intervention bundle to improve pediatric resident progress notes written in an EHR and to establish the reliability of an audit tool used to evaluate notes (which is not typical of much of this type of research). The bundle consisted of establishing note-writing guidelines, developing a note template, and educating residents about the guidelines and using the template. The residents received classroom teaching about best practices and instruction in use of the template. Raters were trained to score notes through practice sessions during which they all scored the same note and compared findings. Overall, improvement was mixed, with reduced vital sign clutter and other visual clutter within the note, but no significant reduction in input/output clutter, lab clutter, or inclusion of the medication list.²⁵

Noting that much of clinical documentation training for medical students, residents, and practicing physicians lacks key constructs in self-efficacy, namely, vicarious learning (peer demonstration) and mastery (practice), researchers devised a study to improve clinical documentation quality that compared two different models of training.²⁶ One model, provided to internal medicine residents, used two components of self-efficacy: 1) social persuasion, e.g., emphasizing the importance of complete and accurate documentation for patient welfare and providing feedback to participants based on performance on a clinical documentation quality pretest as well as participation in the training session and 2) psychological/emotional states, e.g., discussing frustrations physicians have complying with increasing regulation, the monetary impact of incomplete or inaccurate documentation, and time management issues, as well as providing dinner as part of the training. The other model, administered to another group of residents, included two additional components of self-efficacy: 3) vicarious experience, e.g., video recordings of physicians discussing documentation, including solutions to problems, examples of good documentation shared, and experiences of documentation during the first training session (the pretest) were shared and discussed during the second session and 4) mastery experience, e.g., each participant had the opportunity to accurately and correctly document diagnoses in five problem areas from 10 sample records. This study used sophisticated data analysis and concluded that training using all four components of self-efficacy showed substantially greater positive impact on improved clinical documentation and self-efficacy compared to the two-component training. This study was not using, it appears, an EHR as part of the training, but the training model could be modified to those systems and likely is currently in use.

WORK OF THE ACCELERATING CHANGE IN MEDICAL EDUCATION CONSORTIUM

To help fill gaps in medical education and as part of its larger strategic focus to improve the nation's health, the AMA launched the "Accelerating Change in Medical Education" initiative in 2013. After awarding initial grants to 11 medical schools from across the country, the AMA brought these schools together to form the AMA Accelerating Change in Medical Education Consortium—a unique, innovative collaborative that allowed for the sharing and dissemination of groundbreaking ideas and projects. In 2016 the AMA awarded grants to another 21 schools. Today, the 32-member consortium, which represents almost one-fifth of allopathic and osteopathic medical schools, is delivering forward-thinking educational experiences to approximately 19,000 medical students—students who will provide care to a potential 33 million patients annually. As consortium members continue to implement bold ideas and demonstrate a deep commitment to creating the medical schools of the future, their solutions are being disseminated to the greater academic community. These pioneering efforts are facilitating the widespread adoption of new ideas. A number of schools in the consortium have taken the lead in finding new and inventive approaches to instructing students on the use of EHRs.

New York University School of Medicine (NYU), for example, has recently fully integrated teaching note-writing into its pre-clerkship "doctoring" course. What had initially been taught at the end of the course is now taught alongside other subjects, e.g., communication skills, cultural competency, clinical reasoning, and so forth. During the first week of school, first-year students begin writing notes with actual patients. At the end of each clerkship, clinical note-writing is now included in the OSCE. Although there has been no formal evaluation, integration of note-writing into the pre-clerkship syllabus has enhanced note-writing performance in the clerkship phase of training and on the comprehensive clinical skills exam at the end of clerkships. (Ruth Crowe, MD, PhD, assistant professor, NYU Department of Medicine, personal communication).

Recognizing that many medical students are starting residency without the experience of working effectively with EHRs, the Indiana University School of Medicine and the Regenstrief Institute (RI) developed the Regenstrief EHR Clinical Learning Platform as part of the AMA's "Accelerating Change in Medical Education" initiative. This virtual EHR was developed to ensure medical students and other health care trainees gain real-world experience using EHRs during their training. It includes over 11,000 real, pseudonymized patient records. Learners can search and access

patient data, document patient encounters, enter individual/unique actions, see actions entered across practice settings, receive alerts, place orders, and pull logs and reports.²⁷

The platform is currently in use in six medical schools/medical education programs. Schools are able to control the type of content students can access, as well as how students use the information in the platform. Some schools grade students on their ability to use the system. Although the platform was not designed to instruct students on how to write a patient note, correct documentation can be taught depending upon how a particular course adopts the platform into its curriculum. The RI team is evaluating machine learning and natural language understanding technology for the evaluation of student documentation. The first phase of this study employs supervised machine learning techniques to hopefully classify notes into good, bad, and mediocre sets. If this first phase is successful, the intent of subsequent studies will be to create automated and meaningful student documentation evaluation. (Blaine Takesue, MD, Research Scientist, Regenstrief Institute, and assistant professor of clinical informatics, Indiana University School of Medicine, personal communication)

RELEVANT AMA POLICY

Policy H-310.953, “Practice Options and Skills Curriculum for Residents,” directs our AMA to “assist medical societies and residency programs in the development of model curricula for resident physicians and those entering practice regarding practice options and management skills, including information on CPT and ICD coding.”

Policy H-315.969, “Medical Student Access to Electronic Health Records,” states that our AMA: “(1) recognizes the educational benefits of medical student access to electronic health record (EHR) systems as part of their clinical training; (2) encourages medical schools, teaching hospitals, and physicians practices used for clinical education to utilize clinical information systems that permit students to both read and enter information into the EHR, as an important part of the patient care team contributing clinically relevant information; (3) encourages research on and the dissemination of available information about ways to overcome barriers and facilitate appropriate medical student access to EHRs and advocate to the Electronic Health Record Vendors Association that all Electronic Health Record vendors incorporate appropriate medical student access to EHRs; (4) supports medical student acquisition of hands-on experience in documenting patient encounters and entering clinical orders into patients’ electronic health records (EHRs), with appropriate supervision, as was the case with paper charting; (5) (A) will research the key elements recommended for an educational Electronic Health Record (EHR) platform; and (B) based on the research—including the outcomes from the Accelerating Change in Medical Education initiatives to integrate EHR-based instruction and assessment into undergraduate medical education—determine the characteristics of an ideal software system that should be incorporated for use in clinical settings at medical schools and teaching hospitals that offer EHR educational programs; (6) encourage efforts to incorporate EHR training into undergraduate medical education, including the technical and ethical aspects of their use, under the appropriate level of supervision; and (7) will work with the Liaison Committee for Medical Education (LCME), AOA Commission on Osteopathic College Accreditation (COCA) and the Accreditation Council for Graduate Medical Education (ACGME) to encourage the nation’s medical schools and residency and fellowship training programs to teach students and trainees effective methods of utilizing electronic devices in the exam room and at the bedside to enhance rather than impede the physician-patient relationship and improve patient care.”

SUMMARY AND RECOMMENDATIONS

A review of the published literature on training in incorporating the EHR into the physician/patient encounter, and in the accuracy of clinical documentation in the EHR, reveals that few published research studies are constructed so that they can provide a useful evaluation of the results of the training. Fewer studies provide a reflection upon the value and effectiveness of the training provided. Assessments and comparisons are made and likely future revisions are planned for the training programs, but that is not shared. It is therefore difficult to provide a conclusive summary of the most effective manner in which to train medical students and residents on the EHR. Confounding and uncontrollable circumstances are always a risk in evaluation of educational programs in the “real world.” In addition, as many institutions and medical schools use their own clinical documentation systems or have modified an “off-the-shelf” system, results can be hard to generalize to other settings.

Some general observations can be made, however:

1. Any training should provide students, residents, and physicians with institutional policy regarding copy and paste functions or any other functions that have local guidelines.
2. Ergonomic training in the use and placement of a computer during the physician/patient encounter can be effective and should not be neglected.
3. Basic study methodology should always be considered: Use theory to develop hypotheses, guide the research, and organize the data analysis. Timing can affect evaluation results; without practice, newly acquired skills will atrophy. Pre-test sessions are a form of training—the more provided, the greater the risk in seeing no differences between study groups. Small sample sizes and poor training of evaluators can lead to inconclusive findings. Incentives should be designed to reduce drop out of learners for post-training assessment. Employing only one measure of evaluation is inadequate. Evaluation should include more than trainees' self-assessment; standardized patients and trained observers should also provide feedback. Expect volunteers in studies to be motivated to learn, whether in the control or intervention group. Be prepared to use post-hoc study controls, in case uncontrollable extraneous events affect results.
4. Studies utilizing simulation, OSCEs, standardized patients, one-on-one training, and a more “hands on” approach as part of the intervention generally appear to have better results. While peer instruction is important, the more opportunities trainees have to use the system themselves and receive immediate feedback, the better.
5. Publishing information on what does not work is just as helpful as providing information on what does work. Programs should use study results to “close the loop,” i.e., act on the results and make ongoing improvements.

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

1. That Policy D-295.314, “Study of Current Trends in Clinical Documentation,” be rescinded, as having been fulfilled by this report.
2. That our American Medical Association (AMA) encourage medical schools and residency programs to design clinical documentation and electronic health records (EHR) training that provides evaluative feedback regarding the value and effectiveness of the training, and, where necessary, make modifications to improve the training.
3. That our AMA encourage medical schools and residency programs to provide clinical documentation and EHR training that can be evaluated and demonstrated as useful in clinical practice.
4. That our AMA encourage medical schools and residency programs to provide EHR professional development resources for faculty to assure appropriate modeling of EHR use during physician/patient interactions.

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5. STUDY OF DECLINING NATIVE AMERICAN MEDICAL STUDENT ENROLLMENT

Informational report; no reference committee hearing.

HOUSE ACTION: FILED

American Medical Association (AMA) Policy D-200.985 (5), “Strategies for Enhancing Diversity in the Physician Workforce,” reads as follows:

5. Our AMA will 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.

This section of the policy was appended through Resolution 313-A-17, “Study of Declining Native American Medical Student Enrollment,” which was introduced by the AMA Minority Affairs Section at the 2017 Annual Meeting of the AMA House of Delegates (HOD).

Testimony before Reference Committee C during the meeting reflected limited but supportive testimony on this item focused on the need for increased diversity of the physician workforce to support access to patient care among underserved populations. It was noted that existing AMA policy on diversity dovetails with the intent of this resolution, and that the decline in the number of Native Americans entering medical school is worrisome and may hold future negative ramifications for access to care. Accordingly, Reference Committee C recommended adoption of Resolution 313 to the HOD, and the HOD accepted this recommendation. This report is in response to this policy.

BACKGROUND

The concern regarding Native American student enrollment and the Native American physician workforce is supported by Native American population health outcomes data, Native American health care accessibility data, student enrollment data, workforce data, and the quest for a culturally diverse and culturally competent physician workforce able to meet the health care needs of people from all ethnic backgrounds. The estimated 5.2 million American Indians and Alaska Natives (AI/ANs) living in the U.S. have long experienced lower health status when compared with other Americans. Between 1999 and 2014, premature mortality rates increased for AI/AN populations, while decreasing for blacks, Hispanics, Asians, and Pacific Islanders during the same period. The rates are particularly high for young adult AI/AN individuals. Lack of access to health care and mental health resources is believed to be a causative factor.¹ Lower life expectancy and a disproportionate disease burden exist for a variety of reasons, including inadequate education, lack of economic development and investment, disproportionate poverty, discrimination in the delivery of health services, and cultural differences. These are broad quality of life issues rooted in economic adversity and poor social conditions. Diseases of the heart, malignant neoplasm, unintentional injuries, and diabetes are leading causes of AI/AN deaths (2008-2010). AI/AN individuals born today have a life expectancy 4.4 years shorter than the U.S. population as a whole² and seven years shorter than non-Hispanic whites.³ In a 2016 U.S. Government Accountability Office report to Congress, difficulties in filling health care provider vacancies and long wait times for primary care appointments were noted to be contributing factors to the health care disparities facing AI/ANs.⁴ A survey by the Harvard School of Public Health found that 23% of AI/ANs surveyed experienced discrimination when seeking health care, and 15% avoided seeking healthcare for themselves or their family because of concern that they would be discriminated against.⁵

The Indian Health Service (IHS), an agency within the U.S. Department of Health and Human Services, states there is “ample opportunity—and pressing need—for physicians practicing a wide range of specializations.” The IHS website lists numerous job openings across multiple medical specialties and geographic locations.⁶ Federal law requires that absolute preference be given to AI/AN applicants. Out of the total active MD workforce (approximately 850,000) in the U.S., 0.4% (3,400) are self-identified as AI/AN.⁷

In addition to the positive impact on the educational environment through, for example—(1) cultural competence in care delivery; (2) intellectual benefits; and (3) interpersonal benefits for patients, learners and faculty⁸—increasing AI/AN medical school enrollment would translate into an increase in the AI/AN physician workforce. A workforce increase of this nature could positively impact AI/AN population health and improve access to physician services. A report from the Health Resources and Services Administration on physician workforce characteristics found that minority physicians have a greater propensity to practice in physician shortage areas (although the report did not specifically address AI/AN physicians or the AI/AN population).⁹ Another review on this subject concluded that underrepresented minority health professionals have been consistently more likely to deliver health care to the underserved; this study did include AI/AN providers but did not specifically address AI/AN physicians in the findings or conclusions.¹⁰ There are few conclusive data demonstrating that increasing the number of AI/AN medical students (and ultimately AI/AN physicians) would result in increased numbers of physicians who serve AI/AN communities. A literature search uncovered only one study, published in 1989, which concluded that most AI/AN physicians, while

residing in areas with significant AI/AN populations, were primarily serving non-AI/AN patient populations.¹¹ Collecting data on AI/AN physician practice patterns has proven difficult for a number of reasons, including the organization of providers to serve AI/AN needs. The Indian Self Determination and Education Assistance Act, also known as Public Law 93-638, allows the IHS to provide funds directly to tribes for administration and delivery of health services.¹² An unintended consequence of this law has been to make collection of provider data difficult. A comprehensive study is currently underway to determine the practice setting and populations served by AI/AN physicians (personal communication with the study author, Siobhan Wescott, February 22, 2018).

When considering the available information on this topic, it is important to note that most data on AI/AN medical student enrollment and the physician workforce rely on an individual's self-identification as American Indian, Native American, or Alaska Native. There is no established definition of AI/AN. The U.S. government relies on each of the 567 recognized tribes to set the standards for inclusion as a member of the tribe and official status of AI/AN or Native American.¹³ Inconsistency in criteria for recognition of AI/AN status may result in inaccuracies and inconsistencies in data. Some data sources also allow individuals to self-identify as "multiple race/ethnicity," which may lead to underreporting of AI/AN data.

MEDICAL SCHOOL ENROLLMENT OF AI/AN STUDENTS

Among the ethnic groups traditionally considered to be underrepresented in medicine, AI/AN ethnicity is the least represented among U.S. allopathic medical students. Data from the Association of American Medical Colleges (AAMC) show that in 2016 a total of 20 schools reported at least one applicant who self-identified as AI/AN. The percentage of AI/AN applicants to these schools ranged from 0.9% to 3.8% of the total applicant pool. AAMC enrollment data for academic year 2016-17 show that 223 students, or 0.25% of the total allopathic medical school enrollees, self-identified as AI/AN. The majority of these students were enrolled in medical schools in Oklahoma (20), New Mexico (17), Minnesota (17), Texas (16), North Dakota (15), and Arizona (10). For the allopathic medical school graduating class of 2016, 31 individuals, or 0.16%, self-identified as AI/AN.¹⁴ Since 2002, the number of AI/AN applicants and matriculants to allopathic medical schools has been relatively consistent, despite the increase in the overall number of applicants and enrollees.

Data for osteopathic medical schools show that in 2016, a total of 51 applicants, or 0.3%, self-identified as AI/AN. Over the last 15 years, the number of AI/AN applicants to osteopathic schools has remained relatively constant (between 38 to 69 annually). Nine AI/AN students, or 0.1% of the total enrollee pool, matriculated into osteopathic schools in 2016. Data were not available for AI/AN enrollment in individual osteopathic medical schools in 2016, but the greatest numbers of applications were to schools located in Arizona (31), Pennsylvania (32) and Oklahoma (29).¹⁵ These data likely include students who applied to multiple programs.

Data regarding allopathic and osteopathic AI/AN applicants and enrollment are shown in the table at the end of this report. There are no data on the number of AI/AN applicants who applied to both allopathic and osteopathic programs. Of note, while both the Liaison Committee on Medical Education and the Commission on Osteopathic College Accreditation have standards requiring medical schools to achieve diversity in enrollment, the standards do not specify what groups the schools must include in their respective definitions of diversity and efforts to achieve diversity outcomes.^{16 17}

Although the absolute numbers of applicants and matriculants, albeit small, have remained relatively constant over the last 15 years, the growth in total medical school applications and enrollment has resulted in a declining percentage of AI/AN applicants and matriculating students. This has occurred despite the emphasis on increasing diversity in matriculants to medical school and the physician workforce; an acceptance rate for AI/AN (44.9%) that exceeds all other racial and ethnic groups, including whites; and increases in the applicant and matriculation rates for other groups traditionally identified as underrepresented in medicine.¹⁸ These data indicate that efforts to recruit AI/AN students to enter health professions education are inadequate.

MEDICAL SCHOOL AND HEALTH PROFESSIONS PROGRAMS TO SUPPORT AI/AN ENTRY INTO HEALTH CARE CAREERS

The relative decline in AI/AN applicants and matriculants has occurred despite focused efforts by institutions in states with large AI/AN populations. Several medical schools, alone or in collaboration with other schools, have implemented programs to encourage and support AI/AN students into the health professions.

For example, the North Dakota School of Medicine and Health Sciences has developed the Indians Into Medicine Program (INMED™), a comprehensive program designed to assist American Indian students who aspire to be health professionals and to meet the needs of tribal communities. Established in 1973, the program aims to address three major problems: 1) too few health professionals in AI communities, 2) too few AI health professionals, and 3) the substandard level of health and health care in AI communities. INMED support services include academic and personal counseling for students, assistance with financial aid applications, and summer enrichment sessions at the junior high through professional school levels. Each year, more than 100 AI students attend INMED's annual summer enrichment sessions at the junior high, high school, and medical preparatory levels. These summer programs bolster participants' math and science backgrounds and introduce them to health careers.¹⁹

The state of Oklahoma is home to two medical schools as well as a significant AI population. The University of Oklahoma supports a summer enrichment program which aims to identify and support minority students, including AI students, who aspire to enter medical school.²⁰ In 2014 the Oklahoma State University Center for Health Sciences, which houses the Oklahoma State University College of Osteopathic Medicine (OSUCOM), launched an Office for the Advancement of American Indians in Medicine and Science (OAAIMS) to recruit more American Indian high school and college students into medicine and science careers. Through mentoring and targeted programs, the initiative aims to increase the number of American Indians practicing medicine and working in the science fields. Ultimately, efforts made by the OAAIMS are intended to provide Native American students the means to be successful in these fields by offering hands-on experiences that combine Native culture, medicine, and science.²¹ Programs include a culturally-based scientific expedition experience for high school students, residential camps with simulation exercises, and a number of outreach programs on-site with tribal partnerships. These focused efforts have been effective, as OSUCOM's latest incoming class of 2017 included 17 students who self-identified as AI/AN.²²

The University of Minnesota Medical School (UMMS) founded its Duluth campus in 1972 specifically for the purpose of serving the needs of rural Minnesota and Native American communities and to be a national leader in improving health care access and outcomes in rural Minnesota and AI/AN communities. The UMMS also launched the Center for American Indian and Minority Health in 1987.²³ The purpose of the Center is to raise the health status of American Indians and Alaska Natives by: 1) recruiting and educating Native American medical students, 2) increasing awareness of American Indian health care issues, and 3) conducting research that serves the health interests of Native American communities.

Five medical schools in the southwest—the Universities of Arizona (Phoenix and Tucson), Colorado, New Mexico, and Utah—identified a collective need to increase student diversity, particularly with regard to AI/AN students. These five schools created the “4 Corners Alliance,” and, in collaboration with the Association of American Indian Physicians, invite pre-med/health American Indian students to a free two-day Pre-Admissions Workshop (PAW) annually. The PAW aims to provide students with the information and skills necessary to succeed in the medical and health professions school admission process.²⁴

Medical schools also have developed programs to address AI/AN health. For example, the University of Washington School of Medicine offers an Indian Health Pathways Certificate Program for medical students. The program's goals are to: 1) prepare both native and non-native medical students for careers in AI/AN health, 2) encourage research on AI/AN health issues, and 3) enhance curriculum on AI/AN health issues at the University of Washington School of Medicine.²⁵

On a national level, the IHS supports AI/AN entry into the health professions and opportunities to explore career paths in AI/AN health care. Scholarships are available through the IHS Scholarship program, which has awarded more than 7,000 health professions scholarships since 1978. The IHS website provides links to allow potential students to arrange IHS externships (with salary), and to coordinate AI/AN clerkship opportunities for medical students. In addition, post-graduation financial support is available through the IHS, with a loan repayment program of \$20,000 per year of commitment (maximum \$40,000) for health professions education loans, as well as a supplemental loan repayment program. The IHS also participates in the National Health Service Corps loan repayment program, with awards up to \$50,000 for a two-year commitment.²⁶

The University of Wisconsin, in collaboration with tribal organizations in Wisconsin and the Great Lakes Region, supports an outreach program, We are Healers, which aims to inspire AI youth to envision themselves as health professionals through stories of Native role models.²⁷

Two organizations specifically provide support for AI/AN students aspiring to become physicians: the Association of American Indian Physicians (AAIP) and the Association of Native American Medical Students (ANAMS). The AAIP, whose mission includes promoting education in the medical disciplines, supports workshops, summer programs, scholarship programs, internships, and fellowships aimed at increasing the number of AI/AN students entering the health professions.²⁸ The ANAMS, whose mission is to assist with the recruitment, retention, and support of AI/AN students into medicine and other health careers, provides information on a number of scholarship opportunities available to AI/AN students.²⁹

The causes of the declining percentages of applicants and matriculants are not clear, but in part may be explained by the pre-secondary education success of and college education opportunities for AI/AN students. AI/AN students have the highest high school dropout rates among all racial and ethnic groups tracked by the National Center for Educational Statistics (NCES).³⁰ Additionally, the college enrollment rate (23%) for AI/AN 18- to 24-year-olds is the lowest of all ethnic and racial groups tracked by the NCES.³¹ A recent survey of AI/ANs found that for almost half of respondents, college attendance was never discussed during adolescence and young adulthood.³ Overall, the AI/AN college graduation rate of 9.3% is well below the national average of 20.3%. The relative ineffectiveness of health professions pipeline programs for AI/AN has been described in the literature, possibly attributable to less rigor in primary and secondary education in science and mathematics.³²

RELEVANT AMA POLICY AND ACTIVITIES

A list of relevant AMA policies on this issue is shown in the appendix. These include:

- D-200.985, “Strategies for Enhancing Diversity in the Physician Workforce”
- H-350.970, “Diversity in Medical Education”
- H-350.979, “Increase the Representation of Minority and Economically Disadvantaged Populations in the Medical Profession”
- H-350.960, “Underrepresented Student Access to US Medical Schools”

Aside from policy, since 2002 the AMA has supported the Doctors Back to School™ (DBTS), designed by the AMA Minority Affairs Consortium (today the Minority Affairs Section, or MAS) to highlight the need to expand the pipeline of underrepresented minorities (i.e., black, Latino, Native American) in medicine and eliminate minority health disparities. Through DBTS, physicians and medical students return to their communities to 1) pique young minority students’ interest in medicine by introducing them to “real-life” role models and 2) raise awareness of the need for more underrepresented minorities in the physician workforce. To date, DBTS has engaged more than 100,000 underrepresented minority youth. To expand the reach of the program and number of volunteers, the MAS has developed partnerships with other AMA sections (e.g., Medical Student Section); medical societies/associations (e.g., American Society of Anesthesiologists; Association of American Medical Colleges); coalitions (e.g., Commission to End Health Care Disparities); nonprofit organizations (e.g., National Minority Quality Forum), and diversity pipeline programs in medicine (e.g., Tour for Diversity; Mentoring in Medicine).

Each year, the MAS also partners with the AMA Foundation’s Physicians of Tomorrow scholarship program to offer the Minority Scholars Award to underrepresented minority medical students, with \$10,000 awards toward their tuition expenses. Up to two students can be nominated by each medical school dean. In recent years, awards have been disbursed to 20-25 recipients annually. Since the inception of the program in 2004, 11 recipients have self-identified as Native Alaskans.

SUMMARY

Despite the current level of support, outreach, and pipeline programs as noted above, the number of AI/AN applicants/matriculants to medical schools remains quite low and essentially unchanged over the last 15 years, even as the total enrollment in U.S. medical schools has markedly increased.

Although AI/AN students who are able to succeed in pre-medical training have ample opportunity and high rates of success in gaining entry into medical schools, the current primary and secondary education infrastructure and socioeconomic factors for AI/AN students may be inadequate to promote successful entry in larger numbers into college-level education. While health professions pipeline programs to promote AI/AN entry are in place at a number of institutions, and these programs are showing success at the local level to promote medicine as a career path for

AI/AN students, they are limited in size and scope and have not been successful to date in increasing AI/AN diversity in overall medical school enrollment or the physician workforce. Future initiatives might benefit from focused efforts to improve preparation of AI/AN students for entry into post-secondary education, particularly in the areas of science and mathematics.

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Table: AI/AN Applicants and Enrollment at U.S. Allopathic and Osteopathic Medical Schools

<u>Year</u>	<u>Allopathic medical schools</u>			<u>Osteopathic medical schools</u>		
	<u>AI/AN applicants</u>	<u>AI/AN matriculants</u>	<u>Total matriculants</u>	<u>AI/AN applicants</u>	<u>AI/AN matriculants</u>	<u>Total matriculants</u>
16-17	127	54	21,025	54	21	7,575
15-16	115	55	20,627	30	20	7,219
14-15	117	53	20,343	39	26	7,012
13-14	110	43	20,055	38	30	6,636
12-13	108	52	19,517	46	32	5,986
11-12	101	46	19,230	40	27	5,788
10-11	114	55	18,665	40	32	5,428
09-10	111	51	18,390	43	23	5,227
08-09	131	66	18,036	51	39	4,950
07-08	152	67	17,759	59	34	4,528
06-07	147	70	17,880*	63	22	4,055
05-06	95	38	17,435*	59	22	3,908
04-05	107	53	17,109*	63	28	3,646
03-04	85	38	17,118*	60	18	3,308
02-03	112	56	16,488	55	26	3,079

Allopathic data extracted from data tables found on the AAMC website, unless otherwise noted.

Osteopathic data extracted from data tables found on the AACOM website.

* Data from Barzansky B, Etzel S. Medical Schools in the United States, *JAMA* annual data publications. Data are for first year enrollment, not matriculants.

APPENDIX: RELEVANT AMA POLICY

D-200.985, "Strategies for Enhancing Diversity in the Physician Workforce"

1. Our AMA, independently and in collaboration with other groups such as the Association of American Medical Colleges (AAMC), will actively work and advocate for funding at the federal and state levels and in the private sector to support the following: a. Pipeline programs to prepare and motivate members of underrepresented groups to enter medical school; b. Diversity or minority affairs offices at medical schools; c. Financial aid programs for students from groups that are underrepresented in medicine; and d. Financial support programs to recruit and develop faculty members from underrepresented groups.
2. Our AMA will work to obtain full restoration and protection of federal Title VII funding, and similar state funding programs, for the Centers of Excellence Program, Health Careers Opportunity Program, Area Health Education Centers, and other programs that support physician training, recruitment, and retention in geographically-underserved areas.
3. Our AMA will take a leadership role in efforts to enhance diversity in the physician workforce, including engaging in broad-based efforts that involve partners within and beyond the medical profession and medical education community.
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.
5. Our AMA will 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.
6. Our AMA will develop an internal education program for its members on the issues and possibilities involved in creating a diverse physician population.
7. Our AMA will provide on-line educational materials for its membership that address diversity issues in patient care including, but not limited to, culture, religion, race and ethnicity.
8. Our AMA will create and support programs that introduce elementary through high school students, especially those from groups that are underrepresented in medicine (URM), to healthcare careers.
9. Our AMA will 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.

10. Our AMA will recommend that medical school admissions committees use holistic assessments of admission applicants that take into account the diversity of preparation and the variety of talents that applicants bring to their education.

11. Our AMA will advocate for the tracking and reporting to interested stakeholders of demographic information pertaining to URM status collected from Electronic Residency Application Service (ERAS) applications through the National Resident Matching Program (NRMP).

12. Our AMA will continue the research, advocacy, collaborative partnerships and other work that was initiated by the Commission to End Health Care Disparities.

(CME Rep. 1, I-06 Reaffirmation I-10 Reaffirmation A-13 Modified: CCB/CLRPD Rep. 2, A-14 Reaffirmation: A-16 Appended: Res. 313, A-17 Appended: Res. 314, A-17)

H-350.970, "Diversity in Medical Education"

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

(BOT Rep. 15, A-99 Reaffirmed: CME Rep. 2, A-09 Reaffirmed in lieu of Res. 311, A-15)

H-350.979, "Increase the Representation of Minority and Economically Disadvantaged Populations in the Medical Profession"

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 pre-collegiate 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)

H-350.960, "Underrepresented Student Access to US Medical Schools"

Our AMA: (1) recommends that medical schools should consider in their planning: elements of diversity including but not limited to gender, racial, cultural and economic, reflective of the diversity of their patient population; and (2) supports the development of new and the enhancement of existing programs that will identify and prepare underrepresented students from the high-school level onward and to enroll, retain and graduate increased numbers of underrepresented students.

(Res. 908, I-08 Reaffirmed in lieu of Res. 311, A-15)

6. MENTAL HEALTH DISCLOSURES ON PHYSICIAN LICENSING APPLICATIONS (RESOLUTION 301-A-17, RESOLVE 3)

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS IN LIEU OF RESOLUTION 301-A-17, RESOLVE 3 REMAINDER OF REPORT FILED

See Policy H-275.970

Resolution 301-A-17, Resolve 3, "Mental Health Disclosures on Physician Licensing Applications," introduced by the Resident and Fellow Section and referred by the American Medical Association (AMA) House of Delegates (HOD), asks the AMA to 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.~~

At the Annual 2017 Meeting of the AMA HOD, Reference Committee C heard supportive testimony on this item from a wide variety of stakeholders, reflecting growing concern among the profession and the public related to physician and medical student depression, burnout, and suicide. The AMA has expressed strong support of physical and mental health care services for medical students and physicians. Council on Medical Education Report 1-I-16, “Access to Confidential Health Services for Medical Students and Physicians,”¹ addressed the long-standing and deeply ingrained stigma endured by physicians seeking care for physical or mental health issues, partly due to concerns of career and licensure implications. Despite several existing HOD policies that support this request, testimony reflected additional concerns related to stigma, deterred or deferred care seeking, and the belief that there is a lack of understanding of impairment vs. illness. For these reasons, the HOD recommended that Resolution 301, Resolve 3, be referred for further study.

BACKGROUND

The role of state medical and osteopathic boards and patient safety

Medical and osteopathic licensing boards are state governmental agencies responsible for granting licenses to physicians to practice in the state. The primary responsibility of the boards is to determine that physicians are maintaining and advancing their knowledge and skills and providing quality patient care. Boards are also responsible for protecting the public from the unprofessional, improper, incompetent, unlawful, fraudulent and/or deceptive practice of medicine.² The boards do so by obtaining sufficient physician information to conduct rigorous and thorough application reviews before the practice of medicine is permitted.

The current licensure application processes

State medical licensing boards have traditionally made wide-ranging inquiries into applicants’ past psychiatric histories as part of the application process.³ Although the passage of the Americans with Disabilities Act (ADA) in 1990 raised serious doubts about the legality of these inquiries, the boards have been reluctant to abandon them, even though the American Bar Association and the American Psychiatric Association (APA) have since issued statements disapproving them.^{3, 4}

Most initial and renewal medical licensure application forms include questions about mental health diagnoses or treatment, but there is substantial variation in reporting requirements among the boards.⁵ For example, while some applications inquire only about current (within the previous 12 months) impairment from a medical or mental health condition (e.g., “Do you currently have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety?”), others include questions about current or past diagnosis or treatment of a mental health condition (rather than current impairment from such a condition).⁶ Some states specifically inquire if the applicant has ever had a diagnosis of, or been treated for, bipolar disorder, schizophrenia, paranoia, or other psychotic disorder or for sexual disorders. Although state case laws have determined that specific questions about bipolar, psychotic, or sexual disorders are acceptable, professional organizations and court interpretations of the ADA recommend that the boards focus on current functional impairment instead of any history of diagnoses or treatment of illness.⁷ To support this position, there are no data showing that a broad question on a licensure application that asks about diagnosis or treatment for mental illness identifies current impairment.⁸

The APA recommends that questions about the health of applicants should inquire only about the conditions that currently impair the applicant's capacity to function as a licensee and are relevant to present practice. The APA further recommends that the boards use the following language in their application form:

Are you currently suffering from any condition that impairs your judgment or that would otherwise adversely affect your ability to practice medicine in a competent, ethical, and professional manner? (Yes/No)⁴

Interpretation and definition of “psychiatric conditions” and “impairment”

In 2011, the Federation of State Medical Boards (FSMB) adopted policy on physician impairment to provide guidance to boards for including physician health programs (PHPs) in their efforts to protect the public.⁹ The policy represented a vision for medical boards and PHPs to effectively assist impaired licensees as well as those with potentially impairing illness based on best practices.

The FSMB policy on physician impairment states:

The diagnosis of an illness does not equate with impairment. Impairment is a functional classification which exists dynamically on a continuum of severity and can change over time rather than being a static phenomenon. Illness, per se, does not constitute impairment. When functional impairment exists, it is often the result of an illness in need of treatment. Therefore, with appropriate treatment, the issue of potential impairment may be resolved while the diagnosis of illness may remain.⁹

AMA policy states:

The AMA defines physician impairment as any physical, mental, or behavioral disorder that interferes with ability to engage safely in professional activities and will address all such conditions in its Physician Health Program (Policy H-95.955, “Physician Impairment”).

The FSMB defines impairment as:

The inability of a licensee to practice medicine with reasonable skill and safety as result of:

- a) mental disorder; or
- b) physical illness or condition, including but not limited to those illnesses or conditions that would adversely affect cognitive, motor, or perceptive skills; or
- c) substance-related disorders including abuse and dependency of drugs and alcohol as further defined”⁹

The Federation of State Physician Health Programs (FSPHP) created a public policy regarding “illness vs. impairment.” The following is an excerpt from this policy:

...[S]ome regulatory agencies equate illness (i.e. addiction or depression) as synonymous with impairment. Physician illness and impairment exist on a continuum with illness typically predating impairment, often by many years. This is a critically important distinction. Illness is the existence of a disease. Impairment is a functional classification and implies the inability of the person affected by disease to perform specific activities.

Most physicians who become ill are able to function effectively even during the earlier stages of their illness due to their training and dedication. For most, this is the time of referral to a state PHP. Even if illness progresses to cause impairment, treatment usually results in remission and restoration of function. PHPs are then in a position to monitor clinical stability and continuing progress in recovery...

Medical professionals recognize it is always preferable to identify and treat illness early. There are many potential obstacles to an ill physician seeking care including: denial, aversion to the patient role, practice coverage, stigma, and fear of disciplinary action. Fear of disciplinary action and stigma are powerful disincentives to doctors referring their physician colleagues or themselves. When early referrals are not made, doctors afflicted by illness often remain without treatment until overt impairment is manifest in the workplace.⁹

There is some variability among the boards regarding how their applications request information about “psychiatric conditions (diagnosis/illness)” and “impairment.” Ideally, state and federal law should facilitate the effective interface

between boards and PHPs in their efforts to support the rehabilitation of licensees with potentially impairing illness because it adds to public protection. The FSMB encourages the boards, with input from their PHPs, to revisit their Medical Practice Acts routinely to ensure that they are kept updated in response to developments in the field.

PHPs' reporting requirements and patient confidentiality requirements

The FSMB recommends that two separate PHP tracks be established for program participants:

- Track "A" is for voluntary participants who enter the PHP without the board's mandate. These physicians should be afforded anonymity from the board as long as they do not pose a risk of harm to the public. Cases that pose a danger of harm to the public should be reported to the board with laws or regulations in place that allow that reporting.
- Track "B" physicians are mandated by the board to participate in a PHP. As such, their identities are known to the board.⁹

In addition, the FSMB recommends that PHPs employ FSPHP Guidelines ([fsphp.org/sites/default/files/pdfs/2005_fsphp_guidelines-master_0.pdf](https://www.fsphp.org/sites/default/files/pdfs/2005_fsphp_guidelines-master_0.pdf)) in selecting the providers/facilities to provide treatment for physicians with addictive and/or psychiatric illness.⁹

The Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule related to mental and behavioral health ([hhs.gov/hipaa/for-professionals/special-topics/mental-health/index.html](https://www.hhs.gov/hipaa/for-professionals/special-topics/mental-health/index.html)) provides consumers with important privacy rights and protections with respect to their health information, including important controls over how their health information is used and disclosed by health plans and health care providers. Ensuring strong privacy protections is critical to maintaining individuals' trust in their health care providers and willingness to obtain needed health care services, and these protections are especially important where very sensitive information is concerned, such as mental health information. At the same time, the Privacy Rule recognizes that circumstances arise where health information may need to be shared to ensure that the patient receives the best treatment and for other important purposes, such as for the health and safety of the patient or others.

Diagnosing depression for reimbursement can impact a physician's permanent credentials

Many physicians have expressed concern that a depression diagnosis could negatively impact their medical license.¹⁰ The consequences of reporting to a licensing board stable and easily treatable conditions such as anxiety or depression can range from a physician simply being required to submit a letter from their primary care provider that documents fitness to practice, to being asked to appear before state board examiners, or to being required to undergo (and pay for) an examination by a board-appointed physician. Other consequences can include having to provide extensive or ongoing medical records, enrolling in a PHP, paying for inpatient or intensive outpatient treatment that is possibly followed by long-term monitoring, or agreeing to practice restrictions.⁸

Physicians may be discouraged from seeking treatment for mental health conditions

Even if physicians realize that they need help, many have reported substantial and persistent concern regarding the stigma, which inhibits both treatment and disclosure of mental health conditions on licensure applications.^{8, 11} Those who disclose information about seeking mental health care have suffered delays in licensure and added scrutiny. The stigma of mental health is so pervasive that many physicians consider mental health issues to be a sign indicating that they are unable to cope with the rigor of the medical profession and that their ability to care for patients, therefore, is inferior to that of other physicians.^{12, 13} Several surveys have shown that physicians are reluctant to enter into such disclosure because they fear this could expose them to examinations, potentially inappropriate treatment and monitoring, or exclusion from employment opportunities, insurance coverage, or professional advancement.¹⁴

A 2016 survey of female physicians with a history of actual mental health diagnosis or treatment also provided insight into why this information is not routinely disclosed on licensure applications. The most common reasons listed were the beliefs that the condition did not pose any potential safety risk to patients (75 percent), was not relevant to clinical care (70 percent), and was not the business of the state medical board (63 percent).⁸ In addition, many of the survey respondents (75 percent) agreed or strongly agreed that medical board questions about whether a physician has ever had a mental health diagnosis or treatment impacts decisions about seeking treatment.⁸ The study also confirmed that more than two-thirds of physicians feel reluctant to seek out the same treatments they offer their patients for fear that

they may be judged, deemed incompetent, or have their privacy and autonomy violated because of seeking help; these beliefs crossed all age and specialty categories.⁸

A similar study of licensure applicants showed that nearly 40 percent of physicians would be reluctant to seek formal medical care for treatment of a mental health condition because of concerns about repercussions to their medical license.⁶ Although providing inaccurate information on a medical license application may result in denial or revocation, acknowledging a history of mental health treatment triggers a more in-depth inquiry by the medical board.

The lack of distinction between diagnosis and impairment further stigmatizes physicians who seek care and impedes treatment.¹⁵ As a result, the traditional role of licensing boards can frustrate efforts to promote physician wellness.¹² Thus, physicians frequently seek treatment only when their psychological distress and suboptimal performance has gained the attention of insurance companies, police, and/or review boards.¹³

FSMB WORKGROUP ON PHYSICIAN WELLNESS AND BURNOUT

To address concerns about physician wellness, physician burnout, and suicide prevention, the FSMB established the Workgroup on Physician Wellness and Burnout on behalf of the state medical and osteopathic boards in 2016. In evaluating licensing and license renewal application questions that ask about health conditions, the workgroup is confronting the barriers physicians face in seeking treatment for symptoms of burnout related to the presence and phrasing of questions about mental health, substance use, and leave from practice.

The workgroup has been seeking to identify and highlight examples of effective and appropriate language in consideration of existing FSMB policies that draw an important distinction between physician illness and impairment.⁹ The workgroup also is researching this issue to determine whether it is necessary for the boards to include on licensing applications probing questions about a physician applicant's mental health and whether the information these questions are designed to elicit in the interests of patient safety may be better obtained through means less likely to discourage the search for treatment among physician applicants.

The workgroup is in the process of finalizing its report and recommendations, and the FSMB will continue to update the public and the FSMB's partner organizations, including the AMA, of its progress.

FEDERATION OF STATE PHYSICIAN HEALTH PROGRAMS

The FSPHP's mission is to support PHPs in improving the health of medical professionals, thereby contributing to quality patient care. The FSPHP aims to:

- Achieve national and international recognition as a supporter of PHP programs;
- Promote early identification, treatment, documentation, and monitoring of ongoing recovery of physicians prior to the illness impacting the care rendered to patients; and
- Pursue consistent standards, language, and definitions among state physician health programs.

PHPs were originally developed to assist physicians suffering from alcohol or other addictions to receive treatment while being protected from losing their state medical licenses. In recent years, PHPs have also begun to intervene in other areas related to mental or physical health issues.

PHPs currently operate in 47 states and the District of Columbia; these programs function within the parameters of state regulation and legislation and provide many different levels of service to physicians in need. All state member PHPs must have compensated staff and/or a compensated medical director, and/or a voluntary committee chairperson/staff member, as well as the support of organized medicine in their state. Information about the full range of program structures and services offered by each state program is available at: fsphp.org/state-programs.

States have different reporting requirements related to impairment that have been agreed upon in their monitoring contracts with the state medical boards. Some of the programs offer a safe haven to encourage physicians to proactively seek and receive the health care services that they need, confidentially. For example, the North Carolina Physicians Health Program (NCPHP) can provide non-disciplinary and confidential assistance to ensure that the physician's identity is protected, provided that the physician's behavior has not negatively impacted patient care. The North Carolina Medical Board (NCMB) renewal question specifically states, "If you are an anonymous participant in the

NCPHP and in compliance with your contract, you do not need to list any medical conditions related to that contract.” Thus a licensee who reaches out to the NCPHP for help with depression or other mental health concerns is generally not required to disclose these concerns to the board. Physicians are allowed to remain anonymous so long as the NCPHP can establish that they are safe to practice, are not an imminent danger to the public, or have not committed sexual boundary violations.¹⁶

There are scenarios when an impaired physician is agreeable to referral to a PHP in which they may meet with safe haven or diversionary status, which does not require disclosure to a state medical board. Also, while a PHP will report a physician who meets the threshold of “public danger,” they may not re-disclose the specifics of the physician’s physical or mental health history. Due to the confidentiality requirements of the physician’s health records, more than likely the reported physician will sign consents and be required to release the necessary medical information to the licensing board directly as needed and not via the PHP.

AMA POLICIES

Policies related to questions on licensure applications

Policy H-295.858 (2), “Access to Confidential Health Services for Medical Students and Physicians,” states that “Our AMA will urge state medical boards to refrain from asking applicants about past history of mental health or substance use disorder diagnosis or treatment, and only focus on current impairment by mental illness or addiction, and to accept “safe haven” non-reporting for physicians seeking licensure or relicensure who are undergoing treatment for mental health or addiction issues, to help ensure confidentiality of such treatment for the individual physician while providing assurance of patient safety.”

Policy H-275.945, “Self-Incriminating Questions on Applications for Licensure and Specialty Boards,” directs the AMA to “(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) 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.”

Policies related to management of psychiatric disorders

Policy H-275.970, “Licensure Confidentiality,” directs the AMA “(1) to encourage 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) to encourage boards to include in application forms only requests for information that can reasonably be related to medical practice; (3) to encourage 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) to encourage 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) to encourage 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.”

Policy H-95.955, “Physician Impairment,” states that: “(1) The AMA defines physician impairment as any physical, mental or behavioral disorder that interferes with ability to engage safely in professional activities and will address all such conditions in its Physician Health Program. (2) The AMA encourages state medical society-sponsored physician health and assistance programs to take appropriate steps to address the entire range of impairment problems that affect physicians, to develop case finding mechanisms for all types of physician impairments, and to collect data on the prevalence of conditions affecting physician health. (3) The AMA encourages additional research in the area of physician impairment, particularly in the type and impact of external factors adversely affecting physicians, including workplace stress, litigation issues, and restructuring of the health care delivery systems.”

DISCUSSION

There is growing concern that the presence and phrasing of questions related to current or past impairment on licensing applications may be discouraging physicians from seeking appropriate treatment because of fear of stigmatization, public disclosure, and the effect on one's job due to licensing or credentialing concerns.³ Resident physicians experience higher rates of depression than the general public, and distressed physicians who do not seek treatment, especially for conditions such as depression, anxiety, and burnout, may ultimately have an adverse effect on public safety because they may be less likely to identify and treat similar conditions in their patients and more prone to medical errors in daily practice.^{3, 17}

The medical and osteopathic licensing boards recognize that in their responsibility to evaluate the fitness of potential licensees, a potential barrier may exist that prevents current and potential licensees from seeking help. Some state boards have taken steps to address these barriers. The Oregon Medical Board initiated a program to reduce physicians' fear of reporting treatment on licensing or hospital credentialing applications. The board participates in the Health Professionals' Services Program, which was established in July 2010 as a statewide confidential referral resource for rehabilitation and monitoring. It prioritizes the identification of impaired physicians and encourages licensees struggling with burnout, depression, or substance abuse to seek professional treatment.¹⁸ The Washington State Medical Board changed its initial medical license application in the mid-1990s to include a question that asks applicants if they have ever had a drug, alcohol, or mental health problem that is not already known to the PHP. This encouraged physicians to seek help anonymously. Currently, applicants are simply asked to disclose if they have any medical conditions that limit their ability to practice medicine.¹⁹

Some hospitals have responded to the focus on physician mental health by implementing programs to help residents and physicians improve their overall health.²⁰ The AMA, American Osteopathic Association, and the state and specialty medical associations are also positioned to help alleviate the added stress physicians may experience as they interact with their respective licensing boards. The AMA has developed the following online resources focused on improving physician wellness, preventing burnout, and increasing resilience:

- Physician Wellness: Preventing Resident and Fellow Burnout (stepsforward.org/modules/physician-wellness)
- Preventing Physician Burnout (stepsforward.org/modules/physician-burnout)
- Improving Physician Resiliency (stepsforward.org/modules/improving-physician-resilience)

SUMMARY AND RECOMMENDATIONS

The Council on Medical Education is committed to ensuring that physicians seek the care they need for burnout, anxiety, depression, and substance-related disorders without fear of punitive treatment or licensure and career restrictions. The Council therefore recommends that the following recommendations be adopted in lieu of Resolution 301-A-17, Resolve 3, and the remainder of the report be filed.

1. That our American Medical Association (AMA) amend Policy H-275.970, Part 5, "Licensure Confidentiality," by addition and deletion to read as follows:

The AMA (5) encourages state licensing boards to require disclosure of physical or mental health conditions only when a physician is suffering from any condition that currently impairs his/her judgment or that would otherwise adversely affect his/her ability to practice medicine in a competent, ethical, and professional manner, or when the physician 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.~~

2. That our AMA encourage those state medical boards that wish to retain questions about the health of applicants on medical licensing applications to use the language recommended by the Federation of State Medical Boards that reads, "Are you currently suffering from any condition for which you are not being appropriately treated that impairs your judgment or that would otherwise adversely affect your ability to practice medicine in a competent, ethical and professional manner? (Yes/No)."

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