

Reference Committee C

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REPORT 1 OF THE COUNCIL ON MEDICAL EDUCATION (I-18)
Competency of Senior Physicians
(Reference Committee C)

EXECUTIVE SUMMARY

Older physicians remain an essential part of the physician workforce as they continue to practice into their 70s and 80s. Although some studies of physicians have shown decreasing practice performance with increasing years in medical practice, the effect of age on any individual physician's competence can be highly variable. The call for increased accountability by the public has led regulators and policymakers to consider implementing some form of age-based competency screening to assure safe and effective practice. In addition, some hospitals and medical systems have initiated age-based screening, but there is no national standard. Older physicians are not required to pass a health assessment or an assessment of competency or quality performance in their area or scope of practice. It is critical that physicians take the lead in developing standards for monitoring and assessing their personal competency and that of fellow physicians to head off a call for nationally implemented mandatory retirement ages or imposition of guidelines by others that are not evidenced based.

The Council on Medical Education studied this issue and prepared its first report on this topic in 2015. American Medical Association (AMA) Policy D-275.956, "Assuring Safe and Effective Care for Patients by Senior/Late Career Physicians," was adopted and the Council, in collaboration with the Senior Physicians Section, identified organizations to work together to develop preliminary guidelines for screening and assessing the competency of the senior/late career physician. The AMA Work Group on Assessment of Senior/Late Career Physicians included key stakeholders that represented physicians, medical specialty societies, accrediting and certifying organizations, hospitals and other health care institutions, and patients' advocates as well as content experts who research physician competence and administer assessment programs.

The work group concurred that it was important to investigate the current screening practices and policies of the state medical and osteopathic boards, medical societies, large U.S. health systems, and remediation programs as well as to collect data and review the current literature to learn more about age and risk factors associated with the assessment of senior/late career physicians in the United States and internationally. This report summarizes the activities of the work group and additional research findings on this topic.

This report also outlines a set of guiding principles developed by the Council with extensive feedback from members of the work group as well as from other content experts who research physician competence and administer assessment programs. The guiding principles provide direction and serve as a reference for the development of guidelines for screening and assessing senior/late career physicians. The underlying assumption is that guidelines must be based on evidence and on the principles of medical ethics. Furthermore, guidelines should be relevant, supportive, fair, equitable, and transparent, and not result in undue cost or burden to senior physicians. The primary driver for the establishment of guidelines should be to fulfill the ethical obligation of the profession to the health of the public and patient safety.

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 1-I-18

Subject: Competency of Senior Physicians

Presented by: Carol Berkowitz, MD, Chair

Referred to: Reference Committee C
(Peter C. Amadio, MD, Chair)

1 American Medical Association (AMA) Policy D-275.956, “Assuring Safe and Effective Care for
2 Patients by Senior/Late Career Physicians,” directs our AMA to: “1) identify organizations that
3 should participate in the development of guidelines and methods of screening and assessment to
4 assure that senior/late career physicians remain able to provide safe and effective care for patients;
5 and 2) convene organizations identified by the AMA to work together to develop preliminary
6 guidelines for assessment of the senior/late career physician and develop a research agenda that
7 could guide those interested in this field and serve as the basis for guidelines more grounded in
8 research findings.”
9

10 The first report on this topic, Council on Medical Education Report 5-A-15, “Assuring Safe and
11 Effective Care for Patients by Senior/Late Career Physicians,” recommended that a work group be
12 convened to further study the topic of assessing the competency of senior/late career physicians.
13 This report summarizes the activities of the work group and additional research findings on this
14 topic. This report also outlines a set of guiding principles to provide direction and serve as a
15 reference for the development of guidelines for screening and assessing senior/late career
16 physicians.
17

18 BACKGROUND: SCOPE OF THE ISSUE

19

20 Older physicians remain an essential part of the physician workforce. The total number of
21 physicians 65 years and older has increased greatly from 50,993 in 1975 to 300,752 in 2017.¹
22 Physicians 65 and older currently represent 26.6 percent of all physicians in the United States.¹
23 Within this age group, two-fifths (40.6 percent) are actively engaged in patient care, while half
24 (52.7 percent) are listed as inactive in the AMA Physician Masterfile.¹ Many physicians are
25 hesitant to retire and may continue to practice into their 70s and 80s due to professional
26 satisfaction, increased life expectancy, and concerns regarding financial security.²
27

28 Evidence supports findings that physical health and some cognitive abilities decline with aging.³
29 Research shows that cognitive dysfunction is more prevalent among older adults, although aging
30 does not necessarily result in cognitive impairment.⁴ The effect of age on any individual
31 physician’s competence can be highly variable, and aging is just one of several factors that may
32 impact performance.^{2,5} Other factors may influence clinical performance, i.e., practice setting, lack
33 of board certification, high clinical volume, certain specialty practices, etc.^{6,7} Fatigue, stress,
34 burnout, and health issues unrelated to aging are also risk factors that can affect clinical
35 performance.⁷ Performance also may be broadly determined by characteristics ranging from
36 intelligence to personality.³ However, some attributes relevant to the practice of medicine—such as

1 wisdom, resilience, compassion, and tolerance of stress—may actually increase as a function of
2 aging.^{5,8-11}

3
4 Although age alone may not be associated with reduced competence, the variation around cognitive
5 abilities as physicians age suggests that the issue cannot be ignored. There are a limited number of
6 valid tools for measuring competence/performance, but these tools are primarily used when a
7 physician is “referred for cause.” In addition, physicians’ practices vary throughout the United
8 States and from specialty to specialty. A few hospitals have introduced mandatory age-based
9 evaluations, but there is no national standard.¹²⁻¹³ Furthermore, there is cultural resistance to
10 externally imposed assessment approaches and concern about discriminatory regulatory policies
11 and procedures.

12
13 Knowing when to give up practice remains an important decision for most doctors and a critically
14 difficult decision for some.¹⁴ For this reason, physicians with decades of experience and
15 contributions to medicine and to their patients, as they experience health changes that may or may
16 not allow continued clinical practice, deserve the same sensitivity and respect afforded their
17 patients.¹⁵ Shifting away from procedural work, allocating more time with individual patients,
18 using memory aids, and seeking input from professional colleagues might help physicians
19 successfully adjust to the cognitive changes that accompany aging.^{5,14}

20
21 It is in physicians’ best interest to proactively address issues related to aging in order to maintain
22 professional self-regulation. Self-regulation is an important aspect of medical professionalism, and
23 helping colleagues recognize their declining skills is an important part of self-regulation.¹⁶
24 Furthermore, contemporary methods of self-regulation (e.g., clinical performance measurement;
25 continuing professional development requirements, including novel performance improvement
26 continuing medical education programs; and new and evolving maintenance of certification
27 programs) have been created by the profession to meet shared obligations for quality assurance and
28 patient safety.

29 30 WORK GROUP MEETINGS

31
32 To fulfill the directive of Policy D-275.956, the Council on Medical Education, in collaboration
33 with the Senior Physicians Section, identified organizations to participate in a joint effort to
34 develop preliminary guidelines for screening and assessing the senior/late career physician. As
35 summarized below, one work group meeting and two conference calls were convened to develop a
36 research agenda that could guide those interested in this field and serve as the basis for guidelines
37 supported by research findings.

38 39 *March 16, 2016 Work Group Meeting*

40
41 The work group meeting, held March 16, 2016, brought together key stakeholders that represented
42 physicians, medical specialty societies, accrediting and certifying organizations, hospitals and other
43 health care institutions, and patients’ advocates as well as content experts who research physician
44 competence and administer assessment programs. Work group participants concurred that this first
45 meeting raised important issues related to the rationale for developing guidelines to screen and
46 assess the competence and practice performance of senior physicians, which are challenging for a
47 number of reasons. Discussion centered around the evidence and factors related to competency and
48 aging physicians, existing and needed policies, screening and assessment approaches, and legal
49 requirements and challenges. Although current evidence and preliminary research pointed toward
50 the need for developing guidelines, most work group participants felt that additional
51 information/data should be gathered on aging physicians’ competence and practice performance. In

1 addition, the participants felt that a set of guiding principles should be developed to reflect the
2 values and beliefs underlying any guidelines that may be developed for screening and assessing
3 senior/late career physicians.

4
5 *July 19, 2016 Work Group Conference Call*

6
7 The purpose of this conference call was to convene a smaller group of participants to develop
8 guiding principles to support the subsequent development of guidelines to screen and assess
9 senior/late career physicians. During the call, the conversation focused upon the thresholds at
10 which screening/assessment should be required. Although physicians of all ages can be assessed
11 “for cause,” the group discussed whether age alone is a sufficient cause for some kind of
12 monitoring beyond what is typical for all physicians. Other factors discussed included the influence
13 of practice setting and medical specialty, as well as the metrics and standards for different settings
14 that would have to be developed to determine at “what age” and “how do you test,” etc. The need
15 for surveillance, associated risk factors, and the ability to take appropriate steps, if needed, were
16 also discussed. It was noted that there is a need to be able to fairly and equitably identify physicians
17 who may need help while assuring patient safety. It was also noted that very few hospitals have
18 specific age guidelines, and that there was evidence that the number of disciplinary actions increase
19 at ages 65 and 70. The cost of and who will pay for screening/assessments were also discussed.

20
21 The group felt that more information and data were needed before the guiding principles could be
22 finalized and agreed to reconvene after gathering more information and studying evidence-based
23 data from the United States and other countries related to age and risk factors.

24
25 *December 15, 2017 Work Group Conference Call*

26
27 The purpose of this conference call was to reconvene the same smaller group of participants to
28 review the literature and data that had been gathered, and to finalize guiding principles to support
29 the subsequent development of guidelines to screen and assess senior/late career physicians.
30 Background information to help guide the development of the guiding principles included:

- 31
- 32 1. Results from a survey of members of the Federation of State Medical Boards (FSMB),
33 Council of Medical Specialty Societies (CMSS), and International Association of Medical
34 Regulatory Authorities (IAMRA) regarding the screening and assessment of senior
35 physicians.
 - 36 2. A literature review of available data related to senior physician screening and assessment,
37 focusing on international work in this area.
 - 38 3. Data from large health systems regarding their screening and assessment policies and
39 procedures.
- 40
41
42

43 Survey Results Related to Screening and Assessing Senior Physicians

44
45 To support the development of guiding principles, data were gathered through surveys of
46 professional associations (CMSS), state medical boards (FSMB), and international regulatory
47 authorities (IAMRA). The goal was to learn if these organizations had processes in place to screen
48 and assess senior physicians for clinical or cognitive competence, and if not, whether they had
49 thought about developing such screening and assessment processes.

1 The survey data showed that most respondents were not screening or assessing senior physicians. A
2 slightly larger number of respondents have thought about this, but those numbers were still fairly
3 small.

4
5 Most respondents did not have clinical or cognitive screening/competence assessment policies in
6 place. In addition, most did not know (42, or 46.7 percent) or were unsure (26, or 28.9 percent)
7 whether other organizations had age-based screening in place. Regarding whether age-based
8 screening should be included within physician wellness programs, 28 (32.9 percent) said yes, while
9 nine (10.6 percent) said no, and 48 (56.5 percent) were unsure.

10
11 Respondents were asked if their organizations/boards offered educational resources regarding the
12 effects of age on physician practice; eight (9.2 percent) said yes, 72 (82.8 percent) said no, and
13 seven (8.0 percent) were unsure. The survey also asked organizations if they were interested in
14 having resources that promoted physician awareness of screening aging physicians in practice.
15 Very few groups offered these types of resources, but 100 percent (11) of IAMRA respondents,
16 60.8 percent (31) of FSMB respondents, and 25 percent (3) of CMSS respondents were interested
17 in offering them.

18 19 Highlights from the Literature Review

20
21 A review of current literature focusing on age and risk factors associated with the assessment of
22 senior/late career physicians in the United States and internationally is summarized below.

23
24 Peer-reviewed studies recently published focus on institutional policies related to cognitive
25 assessment of senior physicians. Dellinger et al. concluded that as physicians age, a required
26 cognitive evaluation combined with a confidential, anonymous feedback evaluation by peers and
27 coworkers regarding wellness and competence would be beneficial both to physicians and their
28 patients.¹⁷ The authors also recommended that large professional organizations identify a range of
29 acceptable policies to address the aging physician, while leaving institutions the flexibility to
30 customize the approach.¹⁷ Institutions such as Cooper University Health Care in Camden, New
31 Jersey, are developing late career practitioner policies that include cognitive assessment with peer
32 review and medical assessment to assure the hospital and physicians that competency is intact and
33 that physicians can continue to practice with confidence.¹⁸

34
35 Studies related to professionalism, self-reporting, and peer review indicate that these methods are
36 not always reliable.^{16, 19-20} Since early “red flags” of cognitive impairment may include prescription
37 errors, billing mistakes, irrational business decisions, skill deficits, patient complaints, office staff
38 observations, unsatisfactory peer review, patient injuries, or lawsuits, Soonsawat et al. encouraged
39 improved reporting of impaired physicians by patients, peers, and office staff.² LoboPrabhu et al.
40 suggested that either age-related screening for cognitive impairment should be initiated, or rigorous
41 evaluation after lapses in standard of care should be the norm regardless of age.²¹

42
43 Any screening process needs to achieve a balance between protecting patients from harm due to
44 substandard practice while at the same time ensuring fairness to physicians and avoiding any
45 unnecessary reductions in workforce.³ A recent study of U.S. senior surgeons showed that a steady
46 proportion of surgeons, even in the oldest age group (>65), are still active in new surgical
47 innovations and challenging cases.²² Individual and institutional considerations require a dialogue
48 among the interested parties to optimize the benefits while minimizing the risks for both.²³⁻²⁴

49
50 In Canada, the aging medical workforce presents a challenge for medical regulatory authorities
51 charged with protecting the public from unsafe practice. Adler and Constantinou note that normal

1 aging is associated with some cognitive decline as part of the aging process, but physicians, who
2 are highly educated individuals with advanced degrees may be less at risk.¹⁴

3
4 A review of the aging psychiatric workforce in Australia showed how specific cognitive and other
5 skills required for the practice of psychiatry vary from those applied by procedural specialists.²⁵
6 The Australian medical boards are responsible for protecting the public from unsafe medical
7 practice. There is some uniformity in the way that Australian regulatory bodies deal with
8 impairment that supports the dual goals of protecting the public and rehabilitating the physician.²⁶
9 However, there are no agreed upon guidelines to help medical boards decide what level of
10 cognitive impairment in a physician may put the public at risk.¹⁴ In Australia, the primary approach
11 to dealing with older physicians (age 55 and older) is individualized and multi-levelled, beginning
12 with assessment, followed by rehabilitation where appropriate; secondary measures proposed for
13 older impaired physicians include early notification and facilitating career planning and timely
14 retirement.²⁶

15
16 It is the responsibility of licensing bodies in New Zealand, Canada, and the United Kingdom to use
17 reasonable methods to determine whether performance remains acceptable.²⁷ However, high
18 performance by all physicians throughout their careers cannot be fully ensured.

19
20 A better understanding of physician aging and cognition can inform more effective approaches to
21 continuous professional development and lifelong learning in medicine—a critical need in a global
22 economy, where changing technology can quickly render knowledge and skills obsolete.⁴ The
23 development of recertification programs, such as maintenance of certification (MOC) by the
24 member boards of the American Board of Medical Specialties, provides an opportunity to study the
25 knowledge base across the professional lifespan of physicians.²⁸⁻²⁹ For example, a recent study of
26 initial certification and MOC examinees in the subspecialty of forensic psychiatry using a common
27 item test question bank compared the two examinee groups' performance and demonstrated that
28 performance for those younger than 50 was similar to those 60 and older, and that diplomates
29 recertifying for the second time outperformed those doing so for the first time.³⁰

30
31 The Royal Australasian College of Surgeons developed strategies to support senior surgeons over
32 65 years of age (expected to be about 25 percent of surgeons by 2050) and a position statement that
33 provides clear guidelines to aging surgeons, with a focus on continuing professional
34 development.³¹⁻³² An assessment of the competence of practicing physicians in New Zealand,
35 Canada, and the United Kingdom showed that “maintenance of professional standards” by
36 continuing education did not identify the poorly performing physician; rather, assessment of
37 clinical performance was needed.²⁷ The most common approach to assessment may be
38 responsive—following a complaint—or periodic, either for all physicians or for an identified high-
39 risk group. However, a single, valid, reliable, and practical screening tool is not available.²⁷

40
41 A literature review conducted in Europe to explore the effects of aging on surgeons' performance
42 and to identify current practical methods for transitioning surgeons out of practice at the
43 appropriate time and age, suggested that competence should be assessed at an individual level,
44 focusing on functional ability over chronological age; this may inform retirement policies for
45 surgeons, which differ worldwide.²² Research conducted in Canada suggested that some
46 interventions (external support, deliberate practice, and education and testing) might prove
47 successful in remediating older physicians, who should be tested more thoroughly.³³

48
49 Careful planning, innovative thinking, and the incorporation of new patterns of medical practice are
50 all part of this complex transition of timing into retirement in the United States.^{23,34} A literature
51 review that looked at retirement ages for doctors in different countries found that there is no

1 mandatory retirement age for doctors in most countries.³⁵ Anecdotal reports published in the *British*
2 *Medical Journal* suggest that retirement has never been easy and is getting harder for some
3 physicians because requirements for reappraisal and other barriers are discouraging some from
4 considering part-time work after retirement.³⁶⁻³⁷ In Canada, Ireland, and India, the retirement age
5 (65) is limited to public sectors only, but older physicians can continue to practice in the private
6 sector.³⁵ In Russia and China, the mandated retirement age is 60 for men and 55 for women.³⁵

7
8 Studies show that doctors can mitigate the impact of cognitive decline by ceasing procedural work,
9 allocating more time to each patient, using memory aids, seeking advice from trusted colleagues,
10 and seeking second opinions.¹⁴ Peisah, et al. (Australia) proposed a range of secondary and primary
11 prevention measures for dealing with the problem of the older impaired doctor; these included
12 educating the medical community, encouraging early notification, and facilitating career planning
13 and timely retirement of older doctors.²⁶ Racine (Canada) suggested that physicians retire before
14 health or competency issues arise.³⁸ Lee (Canada) suggested that older practicing physicians
15 consider slowing down in aspects of practice that require rapid cognitive processing and listen
16 carefully to the concerns of colleagues, patients, friends, and family.³⁹ The University of Toronto,
17 Department of Surgery, has developed Guidelines for Late Career Transitions that require each
18 full-time faculty surgeon to undergo an annual assessment of academic and surgical activity and
19 productivity. As surgeons age, the University creates individual plans for a decrease in on-call
20 surgical responsibilities and encourages late-career surgeons to engage in greater levels of teaching,
21 research, and administration.⁴⁰

22 23 How Some U.S. Organizations Are Addressing the Screening and Assessment of Competency of 24 Senior Physicians

25
26 Since the call for increased accountability by the public has led regulators and policymakers to
27 consider implementing some form of age-based competency screening to assure safe and effective
28 practice,⁵ the work group concurred that it was important to investigate the current screening
29 practices and policies of state medical and osteopathic boards, medical societies, large U.S. health
30 systems, and remediation programs. Some of the more significant findings are summarized below.

31
32 All physicians must meet state licensure requirements to practice medicine in the United States. In
33 addition, some hospitals and medical systems have initiated age-based screening,¹²⁻¹³ but there is no
34 national standard. Older physicians are not required to pass a health assessment or an assessment of
35 competency or quality performance in their area or scope of practice.

36
37 The American College of Surgeons (ACS) explored the challenges of assessing aging surgeons.
38 Recognizing that the average age of the practicing surgeon is rising and approximately one-third of
39 all practicing surgeons are 55 and older, the ACS was concerned that advanced age may influence
40 competency and occupational performance. In January 2016, the ACS Board of Governors'
41 Physician Competency and Health Workgroup published a statement that emphasized the
42 importance of high-quality and safe surgical care.³⁹ The statement recognized that surgeons are not
43 immune to age-related decline in physical and cognitive skills and stressed the importance of a
44 healthy lifestyle. The ACS recommended that, starting at ages 65 to 70, surgeons undergo a
45 voluntary and confidential baseline physician examination and visual testing for overall health
46 assessment, with regular reevaluation thereafter. In addition, the ACS encouraged surgeons to
47 voluntarily assess their neurocognitive function using confidential online tools and asserted a
48 professional obligation to disclose any concerning findings, as well as inclusion of peer review
49 reports in the re-credentialing process.⁴¹

1 The American College of Obstetricians and Gynecologists (ACOG) recommends that when
2 evaluating an aging physician, focus should be placed on the physician’s quality of care provided
3 to patients.⁴² ACOG’s recommendations regarding the later-career obstetrician–gynecologist also
4 state that: 1) it is important to establish systems-based competency assessments to monitor and
5 address physicians’ health and the effect age has on performance and outcomes; 2) workplace
6 adaptations should be adopted to help obstetrician–gynecologists transition and age well in their
7 practice and throughout their careers; and 3) to avoid the potential for legal challenges, hospitals
8 should address the provisions of the Age Discrimination in Employment Act, making sure that
9 assessments are equitably applied to all physicians, regardless of age.⁴²

10
11 At Kaiser Permanente, within its Permanente Medical Group, physicians are classified as “in
12 partnership” or “incorporated.” In a region where a partnership exists, such as Southern California,
13 the mandatory retirement age as a partner is at the end of the calendar year when one turns 65.
14 Southern California Permanente Medical Group has approximately 3,000 partners, of which 300
15 retire each year at full retirement age. In the incorporated regions, there is no mandatory retirement
16 for clinicians. In the partnership regions, retired physicians (partners emeritus) may apply for
17 employment at age 66, but they are not guaranteed employment. If granted employment, these
18 physicians see a dramatic decrease in remuneration, and they are usually not required to have a
19 patient panel. Rehiring is at the discretion of the medical director and the budget. Therefore, a
20 limited number of opportunities are available. Approximately 10 percent of these physicians apply
21 for rehiring, and approximately 15 to 20 percent of those are rehired. They are usually limited to no
22 more than 20 hours per week performing either clinical or administrative work. As a result, very
23 few Permanente physicians work until age 70 or older.

24
25 The University of California, San Diego, Physician Assessment and Clinical Education (PACE)
26 Program is the largest assessment and remediation program for health care professionals in the
27 country. Recently, PACE conducted a pilot screening project to assess physicians. Thirty volunteer
28 physicians, aged 50 to 83, were recruited to participate in the screening regimen. Preliminary data
29 analysis showed that a number of senior physicians performed less than optimally (seven of 30
30 participants). However, when age-based capacity was reviewed (i.e., did those individuals between
31 50 to 59 or those between 60 to 69 years old perform better than those age 70 and older), the results
32 were not statistically significant. The pilot study did have sufficient power to reach significance.
33 However, the trend of the data was that older physicians did perform less optimally. It was also
34 noted that 75 percent of the physicians who didn’t perform well on the MicroCog (a computerized
35 assessment that detects early signs of cognitive impairment) were still working in a clinical
36 capacity. The study did not include enough participants to provide a breakdown on specialties.

37 38 PROPOSED GUIDING PRINCIPLES

39
40 The Council on Medical Education proposes a set of guiding principles as a basis for developing
41 guidelines for the screening and assessment of senior/late career physicians. The underlying
42 assumption is that guidelines must be based on evidence and on the principles of medical ethics.
43 Furthermore, guidelines should be relevant, supportive, fair, equitable, and transparent, and not
44 result in undue cost or burden to senior physicians. The primary driver for the establishment of
45 guidelines should be to fulfill the ethical obligation of the profession to the health of the public and
46 patient safety.

47
48 The Council developed the following eight guiding principles with extensive feedback from
49 members of the AMA Work Group on Assessment of Senior/Late Career Physicians as well as
50 feedback from other content experts who research physician competence and administer screening
51 and assessment programs.

- 1 1. *Evidence-based:* The development of guidelines for assessing and screening senior/late
2 career physicians is based on evidence of the importance of cognitive changes associated
3 with aging that are relevant to physician performance. Current research suggests that
4 physician competency and practice performance decline with increasing years in practice.
5 However, research also suggests that the effect of age on an individual physician's
6 competency can be highly variable, and wide variations are seen in cognitive performance
7 with aging.
8
- 9 2. *Ethical:* Guidelines should be based on the principles of medical ethics. Self-regulation is
10 an important aspect of medical professionalism. Physicians should be involved in the
11 development of guidelines/standards for monitoring and assessing both their own and their
12 colleagues' competency.
13
- 14 3. *Relevant:* Guidelines, procedures, or methods of assessment should be relevant to
15 physician practices to inform judgments and provide feedback regarding physicians' ability
16 to perform the tasks specifically required in their practice environment.
17
- 18 4. *Accountable:* The ethical obligation of the profession to the health of the public and patient
19 safety should be the primary driver for establishing guidelines and informing decision
20 making about physician screening and assessment results.
21
- 22 5. *Fair and equitable:* The goal of screening and assessment is to optimize physician
23 competency and performance through education, remediation, and modifications to
24 physicians' practice environment or scope. Unless public health or patient safety is directly
25 threatened, physicians should retain the right to modify their practice environment to allow
26 them to continue to provide safe and effective care. When public health or patient safety is
27 directly threatened, removal from practice is one potential outcome.
28
- 29 6. *Transparent:* Guidelines, procedures, or methods of screening and assessment should be
30 transparent to all parties, including the public. Physicians should be aware of the specific
31 methods used, performance expectations and standards against which performance will be
32 judged, and the possible outcomes of the screening or assessment.
33
- 34 7. *Supportive:* Education and/or remediation practices that result from screening and /or
35 assessment procedures should be supportive of physician wellness, ongoing, and proactive.
36
- 37 8. *Cost conscious:* Procedures and screening mechanisms that are distinctly different from
38 "for cause" assessments should not result in undue cost or burden to senior physicians
39 providing patient care. Hospitals and health care systems should provide easily accessible
40 screening assessments for their employed senior physicians. Similar procedures and
41 screening mechanisms should be available to senior physicians who are not employed by
42 hospitals and health care systems.
43

44 AMA POLICY

45
46 The AMA has policy in which it urges members of the profession to discover and rehabilitate if
47 possible, or exclude if necessary, the physicians whose practices are incompetent, and to fulfill
48 their responsibility to the public and to their profession by reporting to the appropriate authority
49 those physicians who, by being impaired, are in need of help or whose practices are incompetent
50 (H-275.998). AMA policy urges licensing boards, specialty boards, hospitals and their medical
51 staffs, and other organizations that evaluate physician competence to inquire only into conditions

1 that impair a physician's current ability to practice medicine (H-275.978[6]). AMA policy also
2 reaffirms that it is the professional responsibility of every physician to participate in voluntary
3 quality assurance, peer review, and CME activities (H-300.973 and H-275.996). These and other
4 related policies are attached (see Appendix).

5
6 SUMMARY AND RECOMMENDATIONS

7
8 The Council on Medical Education concurs that physicians should be allowed to remain in practice
9 as long as patient safety is not endangered, and they are providing appropriate and effective
10 treatment. However, data and anecdotal information support the development of guidelines for the
11 screening and assessment of senior/late career physicians. The variations around cognitive skills as
12 physicians age, as well as the changing demographics of the physician workforce, are also key
13 factors contributing to this need. It is critical that physicians take the lead in developing standards
14 for monitoring and assessing their personal competency and that of fellow physicians to head off a
15 call for nationally implemented mandatory retirement ages or imposition of guidelines by others.
16 The guiding principles outlined in this report provide direction and serve as a reference for setting
17 priorities and standards for further action.

18
19 The Council on Medical Education therefore recommends that the following recommendations be
20 adopted and that the remainder of the report be filed.

- 21
22 1. That our American Medical Association (AMA) make available to all interested parties the
23 Assessment of Senior/Late Career Physicians Guiding Principles:
24
- 25 a) Evidence-based: The development of guidelines for assessing and screening senior/late
26 career physicians is based on evidence of the importance of cognitive changes associated
27 with aging that are relevant to physician performance. Current research suggests that
28 physician competency and practice performance decline with increasing years in practice.
29 However, research also suggests that the effect of age on an individual physician's
30 competency can be highly variable, and wide variations are seen in cognitive performance
31 with aging.
 - 32 b) Ethical: Guidelines should be based on the principles of medical ethics. Self-regulation is
33 an important aspect of medical professionalism. Physicians should be involved in the
34 development of guidelines/standards for monitoring and assessing both their own and their
35 colleagues' competency.
 - 36 c) Relevant: Guidelines, procedures, or methods of assessment should be relevant to
37 physician practices to inform judgments and provide feedback regarding physicians' ability
38 to perform the tasks specifically required in their practice environment.
 - 39 d) Accountable: The ethical obligation of the profession to the health of the public and patient
40 safety should be the primary driver for establishing guidelines and informing decision
41 making about physician screening and assessment results.
 - 42 e) Fair and equitable: The goal of screening and assessment is to optimize physician
43 competency and performance through education, remediation, and modifications to
44 physicians' practice environment or scope. Unless public health or patient safety is directly
45 threatened, physicians should retain the right to modify their practice environment to allow
46 them to continue to provide safe and effective care. When public health or patient safety is
47 directly threatened, removal from practice is one potential outcome.
 - 48 f) Transparent: Guidelines, procedures or methods of screening and assessment should be
49 transparent to all parties, including the public. Physicians should be aware of the specific
50 methods used, performance expectations and standards against which performance will be
51 judged, and the possible outcomes of the screening or assessment.

- 1 g) Supportive: Education and/or remediation practices that result from screening and /or
2 assessment procedures should be supportive of physician wellness, ongoing, and proactive.
- 3 h) Cost conscious: Procedures and screening mechanisms that are distinctly different from
4 “for cause” assessments should not result in undue cost or burden to senior physicians
5 providing patient care. Hospitals and health care systems should provide easily accessible
6 screening assessments for their employed senior physicians. Similar procedures and
7 screening mechanisms should be available to senior physicians who are not employed by
8 hospitals and health care systems. (New HOD Policy)
9
- 10 2. That our AMA encourage the Federation of State Medical Boards, Council of Medical
11 Specialty Societies, and other interested organizations to develop educational materials on the
12 effects of age on physician practice for senior/late career physicians. (Directive to Take Action)
13
- 14 3. That Policy D-275.956, “Assuring Safe and Effective Care for Patients by Senior/Late Career
15 Physicians,” be rescinded, as having been fulfilled by this report. (Rescind HOD Policy)

Fiscal note: \$1,000

APPENDIX: AMA POLICIES

D-275.956, "Assuring Safe and Effective Care for Patients by Senior/Late Career Physicians"

Our American Medical Association: (1) will identify organizations that should participate in the development of guidelines and methods of screening and assessment to assure that senior/late career physicians remain able to provide safe and effective care for patients; and (2) will convene organizations identified by the AMA to work together to develop preliminary guidelines for assessment of the senior/late career physician and develop a research agenda that could guide those interested in this field and serve as the basis for guidelines more grounded in research findings. (CME Rep. 5, A-15)

H-275.936, "Mechanisms to Measure Physician Competency"

Our AMA: (1) continues to work with the American Board of Medical Specialties and other relevant organizations to explore alternative evidence-based methods of determining ongoing clinical competency; (2) reviews and proposes improvements for assuring continued physician competence, including but not limited to performance indicators, board certification and recertification, professional experience, continuing medical education, and teaching experience; and (3) opposes the development and/or use of "Medical Competency Examination" and establishment of oversight boards for current state medical boards as proposed in the fall 1998 Report on Professional Licensure of the Pew Health Professions Commission, as an additional measure of physician competency. (Res. 320, I-98 Amended: Res. 817, A-99 Reaffirmed: CME Rep. 7, A-02 Reaffirmed: CME Rep. 7, A-07 Reaffirmed: CME Rep. 16, A-09 Reaffirmed in lieu of Res. 313, A-12 Modified: Res. 309, I-16)

H-275.996, "Physician Competence"

Our AMA: (1) urges the American Board of Medical Specialties and its constituent boards to reconsider their positions regarding recertification as a mandatory requirement rather than as a voluntarily sought and achieved validation of excellence; (2) urges the Federation of State Medical Boards and its constituent state boards to reconsider and reverse their position urging and accepting specialty board certification as evidence of continuing competence for the purpose of re-registration of licensure; and (3) favors continued efforts to improve voluntary continuing medical education programs, to maintain the peer review process within the profession, and to develop better techniques for establishing the necessary patient care data base. (CME Rep. J, A-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CME Rep. 7, A-02; Reaffirmed: CME Rep. 7, A-07; Reaffirmed: CME Rep. 16, A-09; Reaffirmed in lieu of Res. 302, A-10; Reaffirmed in lieu of Res. 320, A-14)

H-275.998, "Physician Competence"

Our AMA urges: (1) The members of the profession of medicine to discover and rehabilitate if possible, or to exclude if necessary, the physicians whose practices are incompetent. (2) All physicians to fulfill their responsibility to the public and to their profession by reporting to the appropriate authority those physicians who, by being impaired, need help, or whose practices are incompetent. (3) The appropriate committees or boards of the medical staffs of hospitals which have the responsibility to do so, to restrict or remove the privileges of physicians whose practices are known to be incompetent, or whose capabilities are impaired, and to restore such physicians to limited or full privileges as appropriate when corrective or rehabilitative measures have been successful. (4) State governments to provide to their state medical licensing boards resources

adequate to the proper discharge of their responsibilities and duties in the recognition and maintenance of competent practitioners of medicine. (5) State medical licensing boards to discipline physicians whose practices have been found to be incompetent. (6) State medical licensing boards to report all disciplinary actions promptly to the Federation of State Medical Boards and to the AMA Physician Masterfile. (Failure to do so simply allows the incompetent or impaired physician to migrate to another state, even after disciplinary action has been taken against him, and to continue to practice in a different jurisdiction but with the same hazards to the public.) (CME Rep. G, A-79; Reaffirmed: CLRPD Rep. B, I-89; Reaffirmed: Sunset Report, A-00; Reaffirmation I-03; Reaffirmed: CME Rep. 2, A-13)

H-275.978, "Medical Licensure"

The AMA: (1) urges directors of accredited residency training programs to certify the clinical competence of graduates of foreign medical schools after completion of the first year of residency training; however, program directors must not provide certification until they are satisfied that the resident is clinically competent;

(2) encourages licensing boards to require a certificate of competence for full and unrestricted licensure;

(3) urges licensing boards to review the details of application for initial licensure to assure that procedures are not unnecessarily cumbersome and that inappropriate information is not required. Accurate identification of documents and applicants is critical. It is recommended that boards continue to work cooperatively with the Federation of State Medical Boards to these ends;

(4) will continue to provide information to licensing boards and other health organizations in an effort to prevent the use of fraudulent credentials for entry to medical practice;

(5) urges those licensing boards that have not done so to develop regulations permitting the issuance of special purpose licenses. It is recommended that these regulations permit special purpose licensure with the minimum of educational requirements consistent with protecting the health, safety and welfare of the public;

(6) urges licensing boards, specialty boards, hospitals and their medical staffs, and other organizations that evaluate physician competence to inquire only into conditions which impair a physician's current ability to practice medicine. (BOT Rep. I-93-13; CME Rep. 10 - I-94);

(7) urges licensing boards to maintain strict confidentiality of reported information;

(8) urges that the evaluation of information collected by licensing boards be undertaken only by persons experienced in medical licensure and competent to make judgments about physician competence. It is recommended that decisions concerning medical competence and discipline be made with the participation of physician members of the board;

(9) recommends that if confidential information is improperly released by a licensing board about a physician, the board take appropriate and immediate steps to correct any adverse consequences to the physician;

(10) urges all physicians to participate in continuing medical education as a professional obligation;

(11) urges licensing boards not to require mandatory reporting of continuing medical education as part of the process of reregistering the license to practice medicine;

(12) opposes the use of written cognitive examinations of medical knowledge at the time of reregistration except when there is reason to believe that a physician's knowledge of medicine is deficient;

(13) supports working with the Federation of State Medical Boards to develop mechanisms to evaluate the competence of physicians who do not have hospital privileges and who are not subject to peer review;

(14) believes that licensing laws should relate only to requirements for admission to the practice of medicine and to assuring the continuing competence of physicians, and opposes efforts to achieve a variety of socioeconomic objectives through medical licensure regulation;

(15) urges licensing jurisdictions to pass laws and adopt regulations facilitating the movement of licensed physicians between licensing jurisdictions; licensing jurisdictions should limit physician movement only for reasons related to protecting the health, safety and welfare of the public;

(16) encourages the Federation of State Medical Boards and the individual medical licensing boards to continue to pursue the development of uniformity in the acceptance of examination scores on the Federation Licensing Examination and in other requirements for endorsement of medical licenses;

(17) urges licensing boards not to place time limits on the acceptability of National Board certification or on scores on the United State Medical Licensing Examination for endorsement of licenses;

(18) urges licensing boards to base endorsement on an assessment of physician competence and not on passing a written examination of cognitive ability, except in those instances when information collected by a licensing board indicates need for such an examination;

(19) urges licensing boards to accept an initial license provided by another board to a graduate of a US medical school as proof of completion of acceptable medical education;

(20) urges that documentation of graduation from a foreign medical school be maintained by boards providing an initial license, and that the documentation be provided on request to other licensing boards for review in connection with an application for licensure by endorsement;

(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

(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)

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REPORT 3 OF THE COUNCIL ON MEDICAL EDUCATION (I-18)
Developing Physician-Led Public Health/Population Health Capacity in Rural Communities
(Reference Committee C)

EXECUTIVE SUMMARY

American Medical Association (AMA) Policy D-295.311, “Developing Physician Led Public Health/Population Health Capacity in Rural Communities,” asks that our AMA, with the participation of the appropriate educational and certifying entities, study innovative approaches that could be developed and/or implemented to support interested physicians as they seek qualifications and credentials in preventive medicine/public health to strengthen public health leadership, especially in rural communities.

Our country’s need for public health and preventive medicine investments continues to grow, spurred by many factors (e.g., the closing of rural hospitals, lack of access to urban health care, maintaining the viability of safety-net hospitals, the opioid crisis, increasing prevalence of lifestyle diseases, etc.), and resource deficiencies have been documented in both rural and urban communities. It is well documented that investments in preventive medicine and public health are cost effective and save lives. Therefore, support for physicians seeking qualifications and credentials in these areas is desirable.

A wide range of organizations, both physician- and non-physician focused, offers education and resources regarding this important topic. Rural training tracks and programs are available at the UME, GME, and postgraduate level, and multiple national public/population health organizations offer strategies and solutions to individuals and entities seeking to improve their public health knowledge and gain new skills. The AMA also offers resources that help physicians expand their knowledge base in population/public health, including STEPSforward™ modules and the Health Systems Science textbook, which focuses on providing a fundamental understanding of how health care is delivered, how health care professionals work together to deliver that care, and how the health system can improve patient care and health care delivery. Programs are also available to address the multiple complex issues related to the advancement of women’s health and fulfilling women’s potential for leadership in education, research, and clinical practice.

This report focuses on existing and planned educational interventions that are intended to help physicians and medical students develop professional skills and qualifications related to preventive, public, population, and rural health. The report: 1) outlines previous Council on Medical Education reports related to this topic; 2) summarizes relevant available resources; and 3) makes recommendations to the House of Delegates.

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 3-I-18

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

Presented by: Carol Berkowitz, MD, Chair

Referred to: Reference Committee C
(Peter C. Amadio, MD, Chair)

1 INTRODUCTION

2
3 American Medical Association (AMA) Policy D-295.311, “Developing Physician Led Public
4 Health/Population Health Capacity in Rural Communities,” asks that our AMA, with the
5 participation of the appropriate educational and certifying entities, study innovative approaches that
6 could be developed and/or implemented to support interested physicians as they seek qualifications
7 and credentials in preventive medicine/public health to strengthen public health leadership,
8 especially in rural communities. Previous reports on this topic include Council on Medical
9 Education Report 11-A-09, “Integrating Content Related to Public Health and Preventive Medicine
10 Across the Medical Education Continuum”; Council on Medical Education Report 8-A-08, “One-
11 Year Public Health Training Options for All Specialties”; and Council on Medical Education
12 Report 12-A-07, “One-Year Public Health Training Options for All Specialties.”

13
14 This report focuses on existing and planned educational interventions that are intended to help
15 physicians and medical students develop professional skills and qualifications related to preventive,
16 public, population, and rural health. The report: 1) outlines previous Council on Medical Education
17 reports related to this topic; 2) summarizes relevant available resources; and 3) makes
18 recommendations to the HOD.

19 20 BACKGROUND

21
22 Our country’s need for public health and preventive medicine investments continues to grow,
23 spurred by a number of factors (e.g., the closing of rural hospitals, lack of access to urban health
24 care, maintaining the viability of safety-net hospitals, the opioid crisis, and the increasing
25 prevalence of lifestyle diseases), and resource deficiencies have been documented in both rural and
26 urban communities.^{1,2,3,4} The Affordable Care Act (ACA) reduced the number of uninsured
27 persons due to Medicaid expansion, health insurance marketplaces, the employer mandate to
28 provide health insurance, and a provision permitting young adults to remain on a parent’s health
29 insurance plan until 26 years of age. However, an estimated 27 million U.S. citizens remain
30 uninsured.⁵ Inpatient, emergency, and ambulatory services for this population, as well as for
31 millions of other patients, particularly Medicaid beneficiaries, continue to rely on safety-net health
32 systems that provide health care regardless of the patient’s ability to pay. Although a few programs,
33 such as Emergency Medicaid, provide some payment for lifesaving treatments and limited recovery
34 services, longer-term care, such as psychiatric care, is also disproportionately delivered by safety-
35 net health systems.⁵

1 In 2017, Congress eliminated the individual mandate penalty for not having health insurance
2 (effective 2019);⁴ this will have the greatest effect on safety net hospitals that are already in poor
3 financial condition, especially those in rural and suburban areas. Without the mandate, more people
4 are likely to forgo insurance and, if they later need care, will seek that care from safety-net health
5 systems. Since the total demand for uncompensated care in a health care market does not change,
6 evidence suggests that there is nearly complete spillover of uncompensated care to neighboring
7 hospitals.⁵

8
9 It is well documented that investments in preventive medicine and public health are cost effective
10 and save lives.^{6,7,8,9} Therefore, support for physicians seeking qualifications and credentials in these
11 areas is desirable.

12
13 The AMA Council on Medical Education (CME) has addressed related topics on several previous
14 occasions.

15
16 CME Report 11-A-09, “Integrating Content Related to Public Health and Preventive Medicine
17 Across the Medical Education Continuum,” identified ways in which medical students are educated
18 in public health and reported on strategies for integrating public health-related content across the
19 medical education continuum. The report further recommends that our AMA encourage medical
20 schools, schools of public health, graduate medical education programs, and key stakeholder
21 organizations to develop and implement longitudinal educational experiences in public health for
22 medical students in the pre-clinical and clinical years and to provide both didactic and practice-
23 based experiences in public health for residents in all specialties including public health and
24 preventive medicine; and that our AMA encourage the Liaison Committee on Medical Education
25 and the Accreditation Council for Graduate Medical Education to examine their standards to assure
26 that public health-related content and skills are included and integrated as appropriate in the
27 curriculum.

28
29 CME Reports 8-A-08 and 12-A-07, both titled “One-Year Public Health Training Options for All
30 Specialties,” concluded that a strong public health infrastructure is necessary to further
31 advancements that have been made in public health as well as to combat existing and future threats
32 to the nation’s health. Further, these reports noted that concern over the nation’s ability to produce
33 the number of well-trained public health physicians needed to address these public health needs has
34 been growing, and that there is clear need for a cadre of physicians prepared for public health
35 practice.

36
37 CME Report 4-A-10, “Educational Strategies to Promote Physician Practice in Underserved
38 Areas,” does not specifically address public or population health. However, it does link the
39 importance of exposure to rural training experiences to eventual rural practice.

40 41 DISCUSSION

42
43 A wide range of organizations, both physician- and non-physician-focused, offers education and
44 resources regarding this important topic.

45 46 *American Board of Preventive Medicine*

47
48 The American Board of Preventive Medicine (ABPM) offers four pathways to achieve board
49 certification in Public Health and General Preventive Medicine.

- 1 • Residency Pathway
2 The ABPM Residency Pathway is open to all individuals “who have completed an
3 Accreditation Council for Graduate Medical Education (ACGME)-accredited residency of
4 not less than two years, in the specialty area for which certification is being sought.”¹⁰
5 Participation in the pathway requires a supervised year of postgraduate clinical training,
6 including at least 10 months of direct patient care; completion of an ACGME-accredited
7 residency training program accredited in the specialty area for which certification is being
8 pursued; successful completion of an MPH or equivalent graduate degree; and
9 demonstration of current practice if more than 24 months have passed since completion of
10 residency training (unless otherwise engaged in specialty or subspecialty training).
11
- 12 • Complementary Pathway
13 The ABPM Complementary Pathway, meant to engage mid-career physicians seeking to
14 change their specialty practice, requires two years of supervised postgraduate clinical
15 training in an ACGME-accredited training program; a year of ACGME-accredited
16 residency training in the specialty area in which certification is sought; postgraduate level
17 coursework in epidemiology, biostatistics, health services administration, environmental
18 health sciences, and social and behavioral health sciences; and proof of current practice
19 (unless in training) for two of the last five years.
20
- 21 • Special Pathway
22 The ABPM Special Pathway allows ABPM diplomates with current certification in
23 Aerospace Medicine, Occupational Medicine, or Public Health and General Preventive
24 Medicine to pursue certification in another ABPM primary specialty. (Diplomates with
25 current subspecialty certification in Addiction Medicine, Clinical Informatics, Medical
26 Toxicology, and Undersea and Hyperbaric Medicine are not eligible for this pathway.) In
27 addition to ABPM specialty certification, candidates must also be able to demonstrate they
28 have been practicing (or training) for two of the last five years in the specialty/subspecialty
29 area in which they are seeking additional certification.
30
- 31 • Alternative Pathway
32 The ABPM Alternative Pathway is only applicable to those individuals who graduated
33 from medical school prior to January 1, 1984, and who do not qualify for certification
34 through one of the three previously described pathways. In addition to the graduation year
35 requirement, candidates must have completed a year of supervised postgraduate training in
36 an ACGME-accredited GME program, including at least 10 months of direct patient care;
37 postgraduate level coursework in epidemiology, health services administration,
38 environmental health sciences, and social and behavioral health sciences; and
39 demonstration of practice for at least two of the last five years. For this category, the
40 required, demonstrated number of years in practice is dependent on ABMS member board
41 certification status; completion of residency training in the specialty area in which
42 certification is sought; and possession of an MPH degree or equivalent.
43

44 *American College of Physicians*

45
46 The American College of Physicians (ACP) sponsors an ACP Leadership Academy, which
47 provides leadership training and resources.¹¹ The Academy offers an 18-month certificate program
48 in conjunction with the American Association for Physician Leadership, including a combination
49 of formal training (through webinar or live coursework), group discussions, and a capstone project.
50 The Leadership Academy also offers free webinars,¹² several of which (population health,
51 leadership principles for women in medicine) are directly related to this report.

1 Recently, the ACP released a position paper noting that, “The American College of Physicians
2 recommends that social determinants of health and the underlying individual, community, and
3 systemic issues related to health inequities be integrated into medical education at all levels.”¹³ The
4 paper also reviews particular health challenges associated with rural locations.

5
6 *Efforts of the Accelerating Change in Medical Education Consortium*
7

8 Many Accelerating Change in Medical Education Consortium members have been working to
9 address population, public, and rural health education at the UME level.¹⁴

- 10
11 • The partnership between A.T. Still University’s School of Osteopathic Medicine in
12 Arizona and the National Association of Community Health Centers embeds second-,
13 third-, and fourth-year medical students in rural health centers. Additionally, second-year
14 students participate in a year-long course in epidemiology, biostatistics, and preventive
15 medicine, during which they work with community stakeholders and health centers to
16 identify and address local issues of community concern.
- 17 • The Brody School of Medicine at East Carolina University integrates a population health
18 component into its comprehensive longitudinal core curriculum.
- 19 • Case Western Reserve University School of Medicine incorporates a patient navigator
20 model into its curriculum, and medical student navigators learn to use and create registries
21 for population health management in specific population groups.
- 22 • The curriculum at Dell Medical School at the University of Texas at Austin is built around
23 instruction in leadership, which is incorporated into all four years of education. During the
24 third year, students can choose to focus on specific areas of study, including population
25 health.
- 26 • Upon joining the consortium, Florida International University Herbert Wertheim College
27 of Medicine enhanced its “Green Family Foundation Neighborhood Health Education
28 Learning Program” (NeighborhoodHELP™), which provides a longitudinal,
29 interprofessional community-based experience for medical students and partnerships with
30 local hospitals.
- 31 • The blended learning curriculum at the Mayo Clinic School of Medicine focuses on six
32 content domains, one of which is population-centered care. Students can also pursue an
33 additional 12 credits to receive a master’s degree in health care delivery science, which
34 includes instruction in population and preventive health. Further, Mayo has created
35 milestones for students related to population health in alignment with ACGME
36 competencies.
- 37 • The New York University School of Medicine’s Health Care by the Numbers curriculum
38 uses very large de-identified datasets to train students to improve the health of populations.
- 39 • Ohio University Heritage College of Osteopathic Medicine integrates population health
40 into its continuous, longitudinal curriculum.
- 41 • The University of Connecticut School of Medicine’s MDelta curriculum has been
42 specifically designed so that all students can achieve a certificate in public health, with a
43 specific focus on disparities and the social determinants of health. Additionally, the school
44 has incorporated the Regenstrief EHR Clinical Learning Platform into the MDelta
45 curriculum. This platform includes large numbers of de-identified patient records, allowing
46 students to research population health issues.
- 47 • The University of Nebraska Medical Center College of Medicine, through its focus on
48 interprofessional education, has established official partnerships with its colleges of
49 nursing, public health, pharmacy, dentistry, and allied health professions.
- 50 • The University of North Dakota School of Medicine and Health Sciences incorporates
51 training in the use of telemedicine to connect remote patients and providers at multiple

- 1 locations to address rural health care needs. Simulation training mimics common cases
2 seen in rural settings.
- 3 • Medical students at the University of Texas Rio Grande Valley School of Medicine learn
4 onsite in unincorporated *colonias* along the U.S./Mexico border, allowing incorporation of
5 oral histories into the medical record. Students also have the opportunity to shadow
6 community health workers, or *promotoras*, as part of a curriculum that simulates the
7 process necessary to convince legislators to fund similar interventions.
 - 8 • In Vanderbilt University School of Medicine's longitudinal, four-year Foundations of
9 Health Care Delivery course, third- and fourth-year medical students complete self-
10 directed modules in a number of topic areas, including advanced population health and
11 public health.
 - 12 • The Warren Alpert Medical School of Brown University offers nine courses in its Master
13 of Science degree in population medicine, covering social determinants of health,
14 disparities, instruction in population medicine research, leadership, and epidemiology.
15 Some of these courses are required for all students, even if not pursuing the master's
16 degree. Students are also required to prepare a thesis on population medicine.

17

18 *Combined UME, GME, and Postgraduate Educational Programs and Rural and Public/Population* 19 *Health Training Tracks*

20

21 The topic of public/population health recently has been the focus of increased attention and study
22 for physician learners,^{15, 16} and a number of public health training opportunities are available to
23 learners beginning at the UME level. According to the Association of American Medical Colleges
24 (AAMC), 87 MD-MPH programs are currently offered at institutions spanning 37 states and the
25 District of Columbia.¹⁷ The American Association of Colleges of Osteopathic Medicine (AACOM)
26 also maintains a list of dual degree programs. As of June 2018, 17 institutions offered combined
27 DO-MPH degrees.¹⁸

28

29 In addition to MD- or DO-MPH programs, some medical schools offer specific experiences in rural
30 training. For example, the Rural Opportunities in Medical Education (ROME) program at the
31 University of North Dakota School of Medicine is available to third-year students and involves a
32 multi-month, interdisciplinary assignment to a rural primary care setting.¹⁹ Likewise, the
33 Wisconsin Academy for Rural Medicine (WARM) is a training program intended to address rural
34 physician shortages and ultimately improve the health of rural Wisconsin.²⁰ Of WARM graduates,
35 91 percent practice in Wisconsin, and 52 percent practice primary care medicine. Similar to the
36 ROME program, the Rural Physician Associate Program (RPAP) offered by the University of
37 Minnesota Medical School provides third-year medical students a hands-on opportunity to live and
38 train in rural communities.²¹

39

40 Due to limited access to health care in some regions of West Virginia, the Rural Health Partners
41 Scholarship Program is collaborating with third-year medical students who are interested in
42 matching into a Charleston Area Medical Center (CAMC) Residency Program.²² Scholarship
43 recipients receive mentoring during their fourth year of medical school in preparation for the
44 residency program; experience a one-month rural health rotation at one of the participating rural
45 sites; complete a required research project; and then receive a \$10,000 scholarship when they
46 successfully graduate from medical school and match into one of the participating CAMC
47 residency programs. The candidates must be medical students at West Virginia University,
48 Marshall University, or West Virginia School of Osteopathic Medicine. The educational base and
49 residency enable students to develop clinical and leadership experiences uniquely targeted for rural
50 and underserved areas.²⁰ (The "All-in Policy" for waivers from the National Resident Matching
51 Program is currently under review. Certain CAMC departments such as family medicine may

1 pursue and be awarded such a match waiver. Applicants will be notified of waiver status as that
2 information becomes available.)²⁰

3
4 At the GME level, the ACGME Common Program Requirements include expectations that issues
5 related to public health be included in the educational program for all specialties. Among the
6 ACGME's six competencies, Systems-Based Practice is especially relevant to the integration of
7 public health. This competency states that "Residents must demonstrate an awareness of and
8 responsiveness to the larger context and system of health care, including the social determinants of
9 health, as well as the ability to call effectively on other resources to provide optimal health care."
10 This includes "advocating for quality patient care and optimal patient care systems...incorporating
11 considerations of value, cost awareness, delivery and payment, and risk-benefit analysis in patient
12 and/or population-based care as appropriate," and "understanding health care finances and its
13 impact on individual patients' health decisions."²³

14
15 Several individual specialties also incorporate training in public health-related matters.
16 Accreditation requirements for pediatrics, for example, require structured activities designed to
17 prepare pediatric residents to be effective advocates for the health of children in the community.
18 Additionally, many family medicine residencies teach community-oriented primary care, which
19 integrates public health principles into primary care practice.

20
21 Combined residency programs also are available for trainees interested in pursuing experience in
22 public/population health. Of the 73 currently accredited residency training programs in preventive
23 medicine,²⁴ three are combined family medicine/preventive medicine programs, and six are
24 combined internal medicine/preventive medicine programs.²⁵ Furthermore, of the 11,300 ACGME-
25 accredited programs in all specialties, 357 indicated that they offer a separate rural track.²⁶

26
27 For example, Texas Tech University has established a rural health residency training program in
28 family medicine at four sites (Andrews, Fort Stockton, Sweetwater, and Alpine). The program
29 began as a 1115 waiver project/grant of \$3 million and has been successful enough that each of the
30 hospitals involved is now contributing funding to support the program. The program requires
31 residents to complete a one-year core program and then two years of training at a rural site in West
32 Texas. The goal is to place physicians in the region who will stay and provide care to the residents
33 of these locations. Texas currently has the largest number of at-risk hospitals of any state in the
34 nation (75).²⁷

35
36 For medical school graduates, public/population health training opportunities exist beyond
37 combined residency training programs. The AAMC curates a list of public health pathways.²⁸
38 Currently, the website identifies 57 public health fellowship, faculty development, and continuing
39 education opportunities.

40
41 At the postgraduate level, the Centers for Disease Control and Prevention (CDC), through its
42 Epidemic Intelligence Service (EIS) Program, offers two-year, postgraduate programs that train
43 physicians (and others) in infectious disease investigation, thereby preparing them to respond to
44 public health threats both domestically and internationally. In 2017, 71 EIS officers were trained
45 through this program, 65 of whom were U.S. citizens or permanent residents.²⁹

46 47 *National Public Health Organizations*

48
49 Multiple national public/population health organizations currently offer strategies and solutions to
50 individuals and entities seeking to improve their public health knowledge and gain new skills.

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- The American Association of Public Health Physicians (AAPHP), founded to provide a voice to physician directors of state and local health departments at the national level, offers publicly available educational resources, ranging from ethics in public health, food safety, fracking, and gun violence/racism prevention.³⁰
 - In addition to a collection of reports, educational webinars, and policy statements on a broad range of public health topics, the American Public Health Association offers a substantial number of internships (not limited to physicians-in-training or physicians) in topics ranging from environmental health, government relations, injury and violence prevention, and public health policy, as well as a Public Health Fellowship in Government. This fellowship places future public health leaders into positions as staff members for elected officials in Congress.³¹
 - The National Association of County and City Health Officials (NACCHO) offers a publicly available “toolbox” focusing on public health tools created by and for members of the public health community. Tools range from emergency preparedness and vector control to public engagement and injury and violence prevention. NACCHO also offers a library of best practices related to chronic disease management intended to help local health departments stay current in both knowledge and interventions.³² Furthermore, NACCHO University is an online learning hub where public health professionals can access training and develop competencies.³³ Finally, NACCHO Consulting works with local public health departments on research and evaluation projects, performance improvement, workforce development, and public health topics.³⁴
 - The CDC has compiled a resource list “for health professional students, educators, and health professionals to learn more about issues affecting individuals at a population level, to become more familiar with other population health issues, to integrate public health into existing curricula, and for increased collaboration with public health.”³⁵ This list comprises collaborative efforts, competencies, curricula, training opportunities, and peer-reviewed publications, among other resources.
 - The Public Health Leadership Forum, funded by the Robert Wood Johnson Foundation, seeks to engage public health leaders and stakeholders in efforts that promote transformation in the field of public health.³⁶ The Forum has worked on a number of impactful projects, including the development of a set of foundational public health services for public health departments and the visioning of the future of high-functioning public health departments.
 - The Association of State and Territorial Health Officials (ASTHO) has developed a list of educational tools and resources that support cooperation between public health and primary care organizations.³⁷ ASTHO also provides resources to state and territorial health officials regarding proven and cost-effective population health improvement approaches.³⁸
 - The National Network of Public Health Institutes serves as the national coordinating center for ten regional public health training centers and 40 additional local sites to “offer high-quality training, tools, and resources for thousands of professionals engaged in the critical work of advancing public health practice and improving population health,”³⁹ and serves as facilitator of the Public Health Learning Network. These training centers and affiliate sites focus on building skills in change management, communication, diversity/inclusion, information/analytics, leadership, policy engagement, problem solving, resource

1 management, and systems thinking on a wide range of topics in communities across the
2 United States.

- 3
- 4 • In conjunction with other organizations, the Council of State and Territorial
5 Epidemiologists currently sponsors four fellowships in applied epidemiology, public health
6 informatics, health systems integration, and informatics (training in place).⁴⁰ Fellowship
7 recipients commit to two years of on-the job training onsite at a state or local health
8 agency, in step with recommendations from the National Academy of Medicine (NAM)
9 that “State and large local health departments, in conjunction with medical schools and
10 schools of public health, expand postresidency fellowships in public health that emphasize
11 transition into governmental public health practice.”⁴¹
 - 12
 - 13 • Also supportive of this NAM recommendation are fellowships sponsored by the
14 Association of Schools and Programs of Public Health (ASPPH). ASPPH notes that more
15 than 2,200 “ASPPH Fellows and Interns have been placed at state/local health departments
16 and federal agency offices across the U.S., and in 26 countries worldwide where U.S.
17 agencies are assisting Ministries of Health.”⁴²

18

19 *Additional AMA Resources*

20

21 The AMA’s STEPS Forward™ library includes a module on Project ECHO™, which is
22 specifically designed to help coordinate care across rural areas in need of certain specialty care.⁴³
23 Additionally, the AMA published a STEPS Forward™ module on social determinants of health in
24 September 2018.⁴⁴

25

26 Further, the AMA’s groundbreaking work in the discipline of health systems science (HSS) has
27 highlighted the importance of teaching physician learners how to advocate for their patients and
28 communities and understand the socioecological determinants of health, health care policy, and
29 health care economics. The AMA’s HSS textbook⁴⁵ is the first text that focuses on providing a
30 fundamental understanding of how health care is delivered, how health care professionals work
31 together to deliver that care, and how the health system can improve patient care and health care
32 delivery. Along with the basic and clinical sciences, HSS is rapidly becoming a crucial “third
33 pillar” of medical science, requiring a practical, standardized curriculum with an emphasis on
34 understanding the role of human factors, systems engineering, leadership, and patient improvement
35 strategies that will help transform the future of health care and ensure greater patient safety. As of
36 the writing of this report, the AMA’s HSS textbook is in use by 32 medical schools across the
37 country, and a second edition is scheduled to be released at the end of 2019.

38

39 **PROMOTING PUBLIC HEALTH LEADERSHIP**

40

41 A review of the medical education literature finds recommendations for strategies to improve the
42 development of public health leadership capacity across the medical education continuum. Such
43 strategies include instituting specific public health leadership curricula;⁴⁶ looking at how public
44 health leadership is currently defined;⁴⁷ focusing on the specific skills and talents public health
45 leaders require;⁴⁸ and considering the risks and benefits of engaging non-clinician celebrity
46 diplomacy.⁴⁹

47

48 Additional studies focus more specifically on the limits of public health leadership programs.
49 Grimm et al. note that the number of public health leadership programs has declined since 2012
50 and consequently proposed a framework for greater uniformity in leadership development and
51 evaluation.⁵⁰ Others note that evaluation of public health leadership interventions is often lacking.⁵¹

1 *Leadership Roles for Women*

2
3 Although their numbers in leadership roles are increasing, women remain underrepresented in the
4 top echelons of health care leadership, and gender differences exist in the types of leadership roles
5 women do attain.⁵² The Department of Health and Human Services Office on Women’s Health,
6 through its National Center of Excellence initiative, has encouraged the institutions participating in
7 the initiative to address the multiple complex issues that are impeding the advancement of women
8 in education, research, and clinical practice and are preventing the realization of women
9 physicians’ full potential for leadership.⁵³

10
11 Considering the many ways that sex and gender influence disease presentation and patient
12 management, there have been various studies and initiatives to improve the integration of these
13 topics into medical education. A growing network of medical and academic institutions,
14 professional organizations, government agencies, and individuals who share a vision of women’s
15 health and sex- and gender-specific medicine are developing materials for medical education and
16 clinical practice. The Laura W. Bush Institute for Women’s Health and the Texas Tech University
17 Medical Center Women’s Health Committee have developed a website that provides resources on
18 sex- and gender-specific health and continuing medical education programs. The Sex and Gender
19 Women’s Health Collaborative maintains a digital resource library of sex- and gender-specific
20 materials. The Office of Research on Women’s Health website offers a series of courses for
21 researchers, clinicians, and students to provide a foundation for sex and gender accountability in
22 medical research and treatment. Articles that present a case for the inclusion of sex- and gender-
23 focused content into medical education curricula are summarized in a [bibliography](#) that was
24 recently developed for the AMA Council on Medical Education website.

25
26 Programs are also available to educate women on the practices needed to enhance their leadership
27 skills and effectiveness. One example is the Emerging Women Executives in Health Care Program,
28 offered through the Harvard T.H. Chan School of Public Health.⁵⁴

29
30 RELEVANT AMA POLICY

31
32 The AMA has extensive policy related to this topic; these policies are listed in the Appendix.

33
34 SUMMARY AND RECOMMENDATIONS

35
36 Leadership in public and population health remains an important topic deserving of continued
37 interest within the community of medicine. In addition to the ongoing focus on available training
38 opportunities related to public/population health leadership for physicians and medical students,
39 attention should be directed to the future composition of the country’s public health leaders. A
40 recent study found that 73 percent of deans of schools of public health were male, and 70 percent
41 received their terminal degree more than 35 years ago; 64 percent of state health directors received
42 their terminal degree more than 25 years ago; and 26 percent of state health directors hold no
43 terminal degree.¹⁴ There is no evidence to suggest that these individuals are anything other than
44 effective, dedicated leaders who are passionate about promoting public/population health in their
45 communities and throughout the country. However, these statistics should perhaps spark a
46 discussion within the medical community regarding how individuals are currently encouraged and
47 incentivized to enter public health leadership positions, and how to ensure that current
48 public/population health leaders are actively engaging in relevant lifelong learning.

49
50 The Council on Medical Education therefore recommends that the following recommendations be
51 adopted and the remainder of the report be filed:

- 1 1. That Policy D-295.311, “Developing Physician Led Public Health / Population Health
2 Capacity in Rural Communities,” be rescinded, as having been fulfilled by this report.
3 (Rescind HOD Policy)
4
- 5 2. That our American Medical Association (AMA) reaffirm the following policies:
6 D-295.327, “Integrating Content Related to Public Health and Preventive Medicine Across
7 the Medical Education Continuum”
8 D-305.964, “Support for the Epidemic Intelligence Service (EIS) Program and Preventive
9 Medicine Residency Expansion”
10 D-305.974, “Funding for Preventive Medicine Residencies”
11 H-425.982, “Training in the Principles of Population-Based Medicine”
12 D-440.951, “One-Year Public Health Training Options for all Specialties”
13 H-440.954, “Revitalization of Local Public Health Units for the Nation”
14 H-440.888, “Public Health Leadership”
15 H-440.969, “Meeting Public Health Care Needs Through Health Professions Education”
16 (Reaffirm HOD Policy)
17
- 18 3. That our AMA encourage the Association of American Medical Colleges (AAMC),
19 American Association of Colleges of Osteopathic Medicine (AACOM), and Accreditation
20 Council for Graduate Medical Education (ACGME) to highlight public/population health
21 leadership learning opportunities to all learners, but especially to women and those who are
22 underrepresented in medicine. (Directive to Take Action)
23
- 24 4. That our AMA encourage public health leadership programs to evaluate the effectiveness
25 of various leadership interventions. (Directive to Take Action)

Fiscal Note: \$1,000.

APPENDIX: RELEVANT AMA POLICY

8.11, “Health Promotion and Preventive Care”

Medicine and public health share an ethical foundation stemming from the essential and direct role that health plays in human flourishing. While a physician’s role tends to focus on diagnosing and treating illness once it occurs, physicians also have a professional commitment to prevent disease and promote health and well-being for their patients and the community.

The clinical encounter provides an opportunity for the physician to engage the patient in the process of health promotion. Effective elements of this process may include educating and motivating patients regarding healthy lifestyle, helping patients by assessing their needs, preferences, and readiness for change and recommending appropriate preventive care measures. Implementing effective health promotion practices is consistent with physicians’ duties to patients and also with their responsibilities as stewards of health care resources.

While primary care physicians are typically the patient’s main source for health promotion and disease prevention, specialists can play an important role, particularly when the specialist has a close or long-standing relationship with the patient or when recommended action is particularly relevant for the condition that the specialist is treating. Additionally, while all physicians must balance a commitment to individual patients with the health of the public, physicians who work solely or primarily in a public health capacity should uphold accepted standards of medical professionalism by implementing policies that appropriately balance individual liberties with the social goals of public health policies.

Health promotion should be a collaborative, patient-centered process that promotes trust and recognizes patients’ self-directed roles and responsibilities in maintaining health. In keeping with their professional commitment to the health of patients and the public, physicians should:

- (a) Keep current with preventive care guidelines that apply to their patients and ensure that the interventions they recommend are well supported by the best available evidence.
- (b) Educate patients about relevant modifiable risk factors.
- (c) Recommend and encourage patients to have appropriate vaccinations and screenings.
- (d) Encourage an open dialogue regarding circumstances that may make it difficult to manage chronic conditions or maintain a healthy lifestyle, such as transportation, work and home environments, and social support systems.
- (e) Collaborate with the patient to develop recommendations that are most likely to be effective.
- (f) When appropriate, delegate health promotion activities to other professionals or other resources available in the community who can help counsel and educate patients.
- (g) Consider the health of the community when treating their own patients and identify and notify public health authorities if and when they notice patterns in patient health that may indicate a health risk for others.
- (h) Recognize that modeling health behaviors can help patients make changes in their own lives.

Collectively, physicians should:

- (i) Promote training in health promotion and disease prevention during medical school, residency and in continuing medical education.
- (j) Advocate for healthier schools, workplaces and communities.
- (k) Create or promote healthier work and training environments for physicians.
- (l) Advocate for community resources designed to promote health and provide access to preventive services.
- (m) Support research to improve the evidence for disease prevention and health promotion.

H-225.949, “Medical Staff and Hospital Engagement of Community Physicians”

2. Our AMA encourages medical staffs and hospitals to engage community physicians, as appropriate, in medical staff and hospital activities, which may include but need not be limited to: (a) medical staff duties and leadership; (b) hospital governance; (c) population health management initiatives; (d) transitions of care initiatives; and (e) educational and other professional and collegial events.

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

1. Our AMA encourages medical schools, schools of public health, graduate medical education programs, and key stakeholder organizations to develop and implement longitudinal educational experiences in public health for medical students in the pre-clinical and clinical years and to provide both didactic and practice-based experiences in public health for residents in all specialties including public health and preventive medicine.
2. Our AMA encourages the Liaison Committee on Medical Education and the Accreditation Council for Graduate Medical Education to examine their standards to assure that public health-related content and skills are included and integrated as appropriate in the curriculum.
3. Our AMA actively encourages the development of innovative models to integrate public health content across undergraduate, graduate, and continuing medical education.
4. Our AMA, through the Initiative to Transform Medical Education (ITME), will work to share effective models of integrated public health content.
5. Our AMA supports legislative efforts to fund preventive medicine and public health training programs for graduate medical residents.
6. Our AMA will urge the Centers for Medicare and Medicaid Services to include resident education in public health graduate medical education funding in the Medicare Program and encourage other public and private funding for graduate medical education in prevention and public health for all specialties

H-295.868, “Education in Disaster Medicine and Public Health Preparedness During Medical School and Residency Training”

1. Our AMA recommends that formal education and training in disaster medicine and public health preparedness be incorporated into the curriculum at all medical schools and residency programs.
2. Our AMA encourages medical schools and residency programs to utilize multiple methods, including simulation, disaster drills, interprofessional team-based learning, and other interactive formats for teaching disaster medicine and public health preparedness.
3. Our AMA encourages public and private funders to support the development and implementation of education and training opportunities in disaster medicine and public health preparedness for medical students and resident physicians.
4. Our AMA supports the National Disaster Life Support (NDLS) Program Office’s work to revise and enhance the NDLS courses and supporting course materials, in both didactic and electronic formats, for use in medical schools and residency programs.
5. Our AMA encourages involvement of the National Disaster Life Support Education Consortium’s adoption of training and education standards and guidelines established by the newly created Federal Education and Training Interagency Group (FETIG).
6. Our AMA will continue to work with other specialties and stakeholders to coordinate and encourage provision of disaster preparedness education and training in medical schools and in graduate and continuing medical education.

7. Our AMA encourages all medical specialties, in collaboration with the National Disaster Life Support Educational Consortium (NDLSEC), to develop interdisciplinary and inter-professional training venues and curricula, including essential elements for national disaster preparedness for use by medical schools and residency programs to prepare physicians and other health professionals to respond in coordinated teams using the tools available to effectively manage disasters and public health emergencies.
8. Our AMA encourages medical schools and residency programs to use community-based disaster training and drills as appropriate to the region and community they serve as opportunities for medical students and residents to develop team skills outside the usual venues of teaching hospitals, ambulatory clinics, and physician offices.
9. Our AMA will make medical students and residents aware of the context (including relevant legal issues) in which they could serve with appropriate training, credentialing, and supervision during a national disaster or emergency, e.g., non-governmental organizations, American Red Cross, Medical Reserve Corps, and other entities that could provide requisite supervision.
10. Our AMA will work with the Federation of State Medical Boards to encourage state licensing authorities to include medical students and residents who are properly trained and credentialed to be able to participate under appropriate supervision in a national disaster or emergency.
11. Our AMA encourages physicians, residents, and medical students to participate in disaster response activities through organized groups, such as the Medical Response Corps and American Red Cross, and not as spontaneous volunteers.
12. Our AMA encourages teaching hospitals to develop and maintain a relocation plan to ensure that educational activities for faculty, medical students, and residents can be continued in times of national disaster and emergency.

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.

D-305.974, "Funding for Preventive Medicine Residencies"

Our AMA will work with the American College of Preventive Medicine, other preventive medicine specialty societies, and other allied partners, to formally support legislative efforts to fund preventive medicine training programs.

D-385.963, "Health Care Reform Physician Payment Models"

8. Our AMA recommends that state and local medical societies encourage the new Accountable Care Organizations (ACOs) to work with the state health officer and local health officials as they develop the electronic medical records and medical data reporting systems to assure that data needed by Public Health to protect the community against disease are available.
9. Our AMA recommends that ACO leadership, in concert with the state and local directors of public health, work to assure that health risk reduction remains a primary goal of both clinical practice and the efforts of public health.
10. Our AMA encourages state and local medical societies to invite ACO and health department leadership to report annually on the population health status improvement, community health problems, recent successes and continuing problems relating to health risk reduction, and measures of health care quality in the state.

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

The AMA will continue to monitor and support the progress made by medical and public health organizations in championing disease prevention and health promotion; and will support efforts to bring schools of medicine and public health back into a closer relationship.

H-425.984, "Clinical Preventive Services"

Implications for Adolescent, Adult, and Geriatric Medicine: (1) Prevention should be a philosophy that is espoused and practiced as early as possible in undergraduate medical schools, residency training, and continuing medical education, with heightened emphasis on the theory, value, and implementation of both clinical preventive services and population-based preventive medicine. (2) Practicing physicians should become familiar with authoritative clinical preventive services guidelines and routinely implement them as appropriate to the age, gender, and individual risk/environmental factors applicable to the patients in the practice at every opportunity, including episodic/acute care visits. (3) Where appropriate, clinical preventive services recommendations should be based on outcomes-based research and effectiveness data. Federal and private funding should be increased for further investigations into outcomes, application, and public policy aspects of clinical preventive services.

H-425.986, "Challenges in Preventive Medicine"

It is the policy of the AMA that (1) physicians should become familiar with and increase their utilization of clinical preventive services protocols; (2) individual physicians as well as organized medicine at all levels should increase communication and cooperation with and support of public health agencies. Physician leadership in advocating for a strong public health infrastructure is particularly important; (3) physicians should promote and offer to serve on local and state advisory boards; and (4) in concert with other groups, physicians should study local community needs, define appropriate public health objectives, and work toward achieving public health goals for the community.

H-425.993, "Health Promotion and Disease Prevention"

The AMA (1) reaffirms its current policy pertaining to the health hazards of tobacco, alcohol, accidental injuries, unhealthy lifestyles, and all forms of preventable illness; (2) advocates intensified leadership to promote better health through prevention; (3) believes that preventable illness is a major deterrent to good health and accounts for a major portion of our country's total health care expenditures; (4) actively supports appropriate scientific, educational and legislative activities that have as their goals: (a) prevention of smoking and its associated health hazards; (b) avoidance of alcohol abuse, particularly that which leads to accidental injury and death; (c) reduction of death and injury from vehicular and other accidents; and (d) encouragement of healthful lifestyles and personal living habits; and (5) strongly emphasizes the important opportunity for savings in health care expenditures through prevention.

H-440.888, "Public Health Leadership"

Our AMA: (1) urges that appropriately trained and experienced licensed physicians (MDs or DOs) be employed by state and local health departments to be the responsible leader when patient care decisions are made, whether for individuals in the STD or TB Clinics or for the community at large when an epidemic is to be managed; and

(2) defines public health leadership and decision-making that promotes health and prevents disease in the community as the practice of medicine, requiring a licensed practitioner with all the skills, training, experience and knowledge of a public health trained physician.

H-440.892, "Bolstering Public Health Preparedness"

Our AMA supports: (1) the concept that enhancement of surveillance, response, and leadership capabilities of state and local public health agencies be specifically targeted as among our nation's highest priorities; and (2) in principle, the funding of research into the determinants of quality performance by public health agencies, including but not limited to the roles of Boards of Health and how they can most effectively help meet community needs for public health leadership, public health programming, and response to public health emergencies.

H-440.912, "Federal Block Grants and Public Health"

- (1) Our AMA should collaborate with national public health organizations to explore ways in which public health and clinical medicine can become better integrated; such efforts may include the development of a common core of knowledge for public health and medical professionals, as well as educational vehicles to disseminate this information.
 - (2) Our AMA urges Congress and responsible federal agencies to: (a) establish set-asides or stable funding to states and localities for essential public health programs and services, (b) provide for flexibility in funding but ensure that states and localities are held accountable for the appropriate use of the funds; and (c) involve national medical and public health organizations in deliberations on proposed changes in funding of public health programs.
 - (3) Our AMA will work with and through state and county medical societies to: (a) improve understanding of public health, including the distinction between publicly funded medical care and public health; (b) determine the roles and responsibilities of private physicians in public health, particularly in the delivery of personal medical care to underserved populations; (c) advocate for essential public health programs and services; (d) monitor legislative proposals that affect the nation's public health system; (e) monitor the growing influence of managed care organizations and other third party payers and assess the roles and responsibilities of these organizations for providing preventive services in communities; and (f) effectively communicate with practicing physicians and the general public about important public health issues.
 - (4) Our AMA urges state and county medical societies to: (a) establish more collegial relationships with public health agencies and increase interactions between private practice and public health physicians to develop mutual support of public health and clinical medicine; and (b) monitor and, to the extent possible, participate in state deliberations to ensure that block grant funds are used appropriately for health-related programs.
 - (5) Our AMA urges physicians and medical societies to establish community partnerships comprised of concerned citizens, community groups, managed care organizations, hospitals, and public health agencies to: (a) assess the health status of their communities and determine the scope and quality of population- and personal-based health services in their respective regions; and (b) develop performance objectives that reflect the public health needs of their states and communities.
6. Our AMA: (a) supports the continuation of the Preventive Health and Health Services Block Grant, or the securing of adequate alternative funding, in order to assure preservation of many critical public health programs for chronic disease prevention and health promotion in California and nationwide, and to maintain training of the public health physician workforce; and (b) will communicate support of the continuation of the Preventive Health and Health Services Block Grant, or the securing of adequate alternative funding, to the US Congress.

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

1. Our AMA encourages additional funding for public health training for more physicians. 2. Our AMA, in conjunction with other appropriate organizations, supports the work of relevant groups to initiate the development of specific physician competencies for physicians engaged in public health practice. 3. Our AMA will inform medical students and physicians of existing opportunities for physician training in preparation for public health practice.

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

The AMA (1) reaffirms its support of state and local health departments; (2) recommends that health departments be directed by well qualified public health trained physicians; and (3) urges federal, state and local governments to study public health and preventive services, and urges the allocation of necessary resources to maintain these services at a high level of quality.

H-440.960, "The IOM Report (The Future of Public Health) and Public Health"

Our AMA

(1) encourages medical societies to establish liaison committees through which physicians in private practice and officials in public health can explore issues and mutual concerns involving public health activities and private practice;

(2) seeks increased dialogue, interchange, and cooperation among national organizations representing public health professionals and those representing physicians in private practice or academic medicine;

(3) actively supports promoting and contributing to increased attention to public health issues in its programs in medical science and education;

(4) continues to support the providing of medical care to poor and indigent persons through the private sector and the financing of this care through an improved Medicaid program;

(5) encourages public health agencies, as the IOM report suggests, to focus on assessment of problems, assurance of healthy living conditions, policy development, and activities such as those mentioned in the "Model Standards";

(6) encourages physicians and others interested in public health programs to apply the messages and injunctions of the IOM report as these fit their own situations and communities; and

(7) encourages physicians in private practice and those in public health to work cooperatively, striving to ensure better health for each person and an improved community as enjoined in the Principles of Medical Ethics.

H-440.969, "Meeting Public Health Care Needs Through Health Professions Education"

(1) Faculties of programs of health professions education should be responsive to the expectations of the public in regard to the practice of health professions. Faculties should consider the variety of practice circumstances in which new professionals will practice. Faculties should add curriculum segments to ensure that graduates are cognizant of the services that various health care professionals and alternative delivery systems provide. Because of the dominant role of public bodies in setting the standards for practice, courses on health policy are appropriate for health professions education. Additionally, governing boards of programs of education for the health professions, as well as the boards of the institutions in which these programs are frequently located, should ensure that programs respond to changing societal needs. Health professions educators should be involved in the education of the public regarding health matters. Programs of health professions education should continue to provide care to patients regardless of the patient's ability

to pay and they should continue to cooperate in programs designed to provide health practitioners in medically underserved areas.

(2) Faculty and administrators of health professions education programs should participate in efforts to establish public policy in regard to health professions education. Educators from the health professions should collaborate with health providers and practitioners in efforts to guide the development of public policy on health care and health professions education.

H-450.933, "Clinical Data Registries"

1. Our AMA encourages multi-stakeholder efforts to develop and fund clinical data registries for the purpose of facilitating quality improvements and research that result in better health care, improved population health, and lower costs.

D-478.974, "Quality Improvement in Clinical / Population Health Information Systems"

Our American Medical Association will invite other expert physician associations into the AMA consortium to further the quality improvement of electronic health records and population health as discussed in the consortium letter of January 21, 2015 to the National Coordinator of Health Information Technology.

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REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 4-I-18

Subject: Reconciliation of AMA Policy on Primary Care Workforce

Presented by: Carol Berkowitz, MD, Chair

Referred to: Reference Committee C
(Peter C. Amadio, MD, Chair)

1 INTRODUCTION

2

3 The goal of this report is to review, reconcile, and consolidate existing American Medical
4 Association (AMA) policy on primary care workforce, eliminate duplication, and ensure that
5 current policies are coherent and relevant. For each policy recommendation, a succinct but cogent
6 justification is provided to support the proposed action. The most recent policy was deemed to
7 supersede contradictory past AMA policies, and the language of each proposed policy was edited
8 so that it is coherent and easily understood, without altering its meaning or intent.

9

10 POLICIES INCLUDED IN THIS REPORT

11

12 The following AMA policies are addressed in this report:

13

- 14 1. D-200.979, "Barriers to Primary Care as a Medical School Choice"
- 15 2. D-200.994, "Appropriations for Increasing Number of Primary Care Physicians"
- 16 3. H-200.956, "Appropriations for Increasing Number of Primary Care Physicians"
- 17 4. H-200.966, "Federal Financial Incentives and Medical Student Career Choice"
- 18 5. H-200.972, "Primary Care Physicians in the Inner City"
- 19 6. H-200.973, "Increasing the Availability of Primary Care Physicians"
- 20 7. H-200.975, "Availability, Distribution and Need for Family Physicians"
- 21 8. H-200.977, "Establishing a National Priority and Appropriate Funding for Increased
22 Training of Primary Care Physicians"
- 23 9. H-200.978, "Loan Repayment Programs for Primary Care Careers"
- 24 10. H-200.982, "Significant Problem of Access to Health Care in Rural and Urban
25 Underserved Areas"
- 26 11. H-200.997, "Primary Care"
- 27 12. H-295.956, "Educational Grants for Innovative Programs in Undergraduate and Residency
28 Training for Primary Care Careers"
- 29 13. H-300.957, "Promoting Primary Care Services Through Continuing Medical Education"
- 30 14. H-310.973, "Primary Care Residencies in Community Hospitals"

31

32 SUMMARY AND RECOMMENDATIONS

33

34 This report encompasses a review of current AMA policies on primary care workforce to ensure
35 such policy is consistent, accurate and up-to-date.

1 The new policy being proposed in recommendation 1, below, incorporates relevant portions of the
2 13 existing policies that are recommended for rescission in recommendation 2. Appendices A and
3 B show a worksheet version and a clean text version, respectively, of the policy that is being
4 proposed for adoption. Appendix C lists the 13 existing policies that are proposed for rescission.

5
6 Policy H-200.972, "Primary Care Physicians in the Inner City," contained elements that were not
7 germane to the newly proposed policies. Accordingly, this policy is recommended for revision, as
8 shown below, with the deleted portions to be reflected in the proposed policy. In addition, the
9 policy's content and title have been expanded to reflect rural as well as urban populations of
10 underserved patients.

11
12 The Council on Medical Education therefore recommends that the following recommendations be
13 adopted and that the remainder of the report be filed:

- 14
15 1. That our American Medical Association (AMA) adopt as policy "Principles of and Actions
16 to Address Primary Care Workforce" the language shown in column 1 in Appendix A to
17 this report. (New HOD Policy)
- 18
19 2. That our AMA rescind the following policies, as shown in Appendix C:
20
21 1. D-200.979, "Barriers to Primary Care as a Medical School Choice"
22 2. D-200.994, "Appropriations for Increasing Number of Primary Care Physicians"
23 3. H-200.956, "Appropriations for Increasing Number of Primary Care Physicians"
24 4. H-200.966, "Federal Financial Incentives and Medical Student Career Choice"
25 5. H-200.973, "Increasing the Availability of Primary Care Physicians"
26 6. H-200.975, "Availability, Distribution and Need for Family Physicians"
27 7. H-200.977, "Establishing a National Priority and Appropriate Funding for Increased
28 Training of Primary Care Physicians"
29 8. H-200.978, "Loan Repayment Programs for Primary Care Careers"
30 9. H-200.982, "Significant Problem of Access to Health Care in Rural and Urban
31 Underserved Areas"
32 10. H-200.997, "Primary Care"
33 11. H-295.956, "Educational Grants for Innovative Programs in Undergraduate and
34 Residency Training for Primary Care Careers"
35 12. H-300.957, "Promoting Primary Care Services Through Continuing Medical
36 Education"
37 13. H-310.973, "Primary Care Residencies in Community Hospitals" (Rescind HOD
38 Policy)
- 39
40 3. That H-200.972, "Primary Care Physicians in the Inner City," be amended by addition and
41 deletion, and a title change, to read as follows:

42
43 "Primary Care Physicians in Underserved Areas"

44
45 Our AMA should pursue the following plan to improve the recruitment and retention of
46 physicians in ~~the inner city~~ underserved areas:

- 47
48 (1) Encourage the creation and pilot-testing of school-based, ~~church~~ faith-based, and
49 community-based urban/rural "family H~~e~~alth clinics, with an emphasis on health
50 education, prevention, primary care, and prenatal care.

- 1 (2) Encourage the affiliation of these family health clinics with ~~urban~~local medical
2 schools and teaching hospitals.
3
- 4 ~~(3) Promote medical student rotations through the various inner-city neighborhood~~
5 ~~family health clinics, with financial assistance to the clinics to compensate their~~
6 ~~teaching efforts.~~
7
- 8 ~~(4) Encourage medical schools and teaching hospitals to integrate third- and fourth-~~
9 ~~year undergraduate medical education and residency training into these teams.~~
10
- 11 ~~(5)~~ Advocate for the implementation of AMA policy that supports extension of the
12 rural health clinic concept to urban areas with appropriate federal agencies.
13
- 14 ~~(6) Study the concept of having medical schools with active outreach programs in the~~
15 ~~inner city offer additional training to physicians from nonprimary care specialties~~
16 ~~who are interested in achieving specific primary care competencies.~~
- 17 ~~(7) Consider expanding opportunities for practicing physicians in other specialties to~~
18 ~~gain specific primary care competencies through short-term preceptorships or~~
19 ~~postgraduate fellowships offered by departments of family practice, internal~~
20 ~~medicine, pediatrics, etc. These may be developed so that they are part-time,~~
21 ~~thereby allowing physicians enrolling in these programs to practice concurrently.~~
22
- 23 ~~(8)~~ Encourage the AMA Senior Physicians Services Group Section to consider the use
24 involvement of retired physicians in underserved ~~urban~~ settings ~~of retired~~
25 ~~physicians~~, with appropriate mechanisms to ensure their competence.
26
- 27 ~~(9)~~ Urge ~~urban~~ hospitals and medical societies to develop opportunities for physicians
28 to work part-time to staff ~~urban~~ health clinics that help meet the needs of
29 underserved patient populations.
30
- 31 ~~(10)~~ Encourage the AMA and state medical associations to incorporate into state and
32 federal health system reform legislative relief or immunity from professional
33 liability for senior, part-time, or other physicians who ~~serve the inner-city poor~~help
34 meet the needs of underserved patient populations.
35
- 36 ~~(11) Urge medical schools to seek out those students whose profiles indicate a~~
37 ~~likelihood of practicing in underserved urban areas, while establishing strict~~
38 ~~guidelines to preclude discrimination.~~
39
- 40 ~~(12) Encourage medical school outreach activities into secondary schools, colleges, and~~
41 ~~universities to stimulate students with these profiles to apply to medical school.~~
42
- 43 ~~(13) Encourage medical schools to continue to change their curriculum to put more~~
44 ~~emphasis on primary care.~~
45
- 46 ~~(14) Urge state medical associations to support the development of methods to improve~~
47 ~~physician compensation for serving this population, such as Medicaid case~~
48 ~~management programs in their respective states.~~

- 1 (157) Urge ~~urban~~ hospitals and medical centers to seek out the use of available military
2 health care resources and personnel, which can be used to ~~fill gaps in urban~~
3 ~~care~~ help meet the needs of underserved patient populations.
4
5 (16) ~~Urge CMS to explore the use of video and computer capabilities to improve access~~
6 ~~to and support for urban primary care practices in underserved settings.~~
7
8 (17) ~~Urge urban hospitals, medical centers, state medical associations, and specialty~~
9 ~~societies to consider the expanded use of mobile health care capabilities.~~
10
11 (18) ~~Continue to urge measures to enhance payment for primary care in the inner city.~~
12 (Modify Current HOD Policy)

Fiscal note: \$1,000.

APPENDIX A: PROPOSED AMA POLICY: “PRINCIPLES OF AND ACTIONS TO ADDRESS PRIMARY CARE WORKFORCE” (WORKSHEET VERSION)

Note: The left column shows the proposed language for adoption ; the right column shows the original language that is being modified and its policy number, if any.

Proposed language for adoption	Original language
<p>1. Our patients require a sufficient, well-trained supply of primary care physicians—family physicians, general internists, general pediatricians, and obstetricians/gynecologists—to meet the nation’s current and projected demand for health care services.</p>	<p>The AMA believes that there should be a sufficient supply of primary care physicians - family physicians, general internists, general pediatricians, and obstetricians/gynecologists. In order to achieve this objective: H-200.997</p>
<p>2. To help accomplish this critical goal, our American Medical Association (AMA) will work with a variety of key stakeholders, to include federal and state legislators and regulatory bodies; national and state specialty societies and medical associations, including those representing primary care fields; and accreditation, certification, licensing, and regulatory bodies from across the continuum of medical education (undergraduate, graduate, and continuing medical education).</p>	<p>(new)</p>
<p>3. Through its work with these stakeholders, our AMA will encourage development and dissemination of innovative models to recruit medical students interested in primary care, train primary care physicians, and enhance both the perception and the reality of primary care practice, to encompass the following components:</p> <ul style="list-style-type: none"> a) Changes to medical school admissions and recruitment of medical students to primary care specialties, including counseling of medical students as they develop their career plans; b) Curriculum changes throughout the medical education continuum; c) Expanded financial aid and debt relief options; d) Financial and logistical support for primary care practice, including 	<p>4. Our AMA will collaborate with appropriate organizations to support the development of innovative models to recruit medical students interested in primary care, to train primary care physicians, and to enhance the image of primary care practice. D-200.979</p> <p>(3) It is the policy of the AMA, with representatives of primary care specialty groups and the academic community, to develop recommendations for adequate reimbursement of primary care physicians and improved recruitment of medical school graduates into primary care specialties. H-200.997</p> <p>It is the policy of the AMA, with representatives of primary care specialty groups and the academic community, to develop recommendations for adequate reimbursement of primary care physicians, improved recruitment of medical school graduates and training a sufficient number of</p>

Proposed language for adoption	Original language
<p>adequate reimbursement, and enhancements to the practice environment to ensure professional satisfaction and practice sustainability; and</p> <p>e) Support for research and advocacy related to primary care.</p>	<p>primary care physicians to meet projected national needs. H-200.977</p> <p>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. H-200.975</p> <p>2. Our AMA will collaborate with appropriate organizations in urging medical schools to develop policies and to allocate appropriate resources to activities and programs that encourage students to select primary care specialties, including: a. admissions policies ...D-200.979</p>
<p>4. Admissions and recruitment: The medical school admissions process should reflect the specific institution’s mission. Those schools with missions that include primary care should consider those predictor variables among applicants that are associated with choice of these specialties.</p>	<p>(2) The admission process should be sensitive to the institution’s mission. Those schools with missions that include primary care should consider those predictor variables known to be associated with choice of these specialties. H-200.973</p>
<p>5. Medical schools, through continued and expanded recruitment and outreach activities into secondary schools, colleges, and universities, should develop and increase the pool of applicants likely to practice primary care by seeking out those students whose profiles indicate a likelihood of practicing in primary care and underserved areas, while establishing strict guidelines to preclude discrimination.</p>	<p>(3) Through early recruitment and outreach activities, attempts should be made to increase the pool of applicants likely to practice primary care. H-200.973</p> <p>(11) Urge medical schools to seek out those students whose profiles indicate a likelihood of practicing in underserved urban areas, while establishing strict guidelines to preclude discrimination. H-200.972</p> <p>(12) Encourage medical school outreach activities into secondary schools, colleges, and universities to stimulate students with these profiles to apply to medical school. H-200.972</p>
<p>6. Career counseling and exposure to primary care: Medical schools should provide to students career counseling related to the choice of a primary care specialty, and ensure that primary care physicians are well-represented as teachers, mentors, and role models to future physicians.</p>	<p>(7) Medical schools should provide career counseling related to the choice of a primary care specialty. H-200.973</p> <p>5. Our AMA will collaborate with appropriate organizations in urging medical schools to develop policies and to allocate appropriate resources to activities and programs that encourage students to select primary care specialties, including: ... b. utilization of primary care physicians in the roles of</p>

Proposed language for adoption	Original language
	teachers, mentors, and role models.... D-200.979
7. Financial assistance programs should be created to provide students with primary care experiences in ambulatory settings, especially in underserved areas. These could include funded preceptorships or summer work/study opportunities.	Federal financial assistance programs aimed at stimulating interest in primary care should have the following characteristics: (1) Financial assistance programs should be created to provide students with primary care experiences in ambulatory settings, especially in underserved areas. These could include funded preceptorships or summer work/study opportunities. H-200.966
8. Curriculum: Voluntary efforts to develop and expand both undergraduate and graduate medical education programs to educate primary care physicians in increasing numbers should be continued, including such innovations as a three-year medical school curriculum that leads directly to primary care residency programs. The establishment of appropriate administrative units for family medicine should be encouraged.	(1) Voluntary efforts to develop and expand both undergraduate and graduate programs to educate primary care physicians in increasing numbers should be continued. The establishment of appropriate administrative units for family practice should be encouraged. H-200.997
9. Medical schools with an explicit commitment to primary care should structure the curriculum to support this objective. At the same time, all medical schools should be encouraged to continue to change their curriculum to put more emphasis on primary care.	(4) Medical schools with an explicit commitment to primary care should structure the curriculum to support this objective. H-200.973 (13) Encourage medical schools to continue to change their curriculum to put more emphasis on primary care. H-200.972 (1) Each medical school should reexamine its institutional goals and objectives, including the extent of its commitment to primary care. Those schools recognizing a commitment related to primary care should make this an explicit part of the mission, and set institutional priorities accordingly. H-200.973
10. All four years of the curriculum in every medical school should provide primary care experiences for all students, to feature increasing levels of student responsibility and use of ambulatory and community-based settings.	(5) All four years of the curriculum in every medical school should provide experiences in primary care for all students. These experiences should feature increasing levels of student responsibility and use of ambulatory and community settings. H-200.973 5. Our AMA will collaborate with appropriate organizations in urging medical schools to develop policies and to allocate appropriate resources to activities and programs that encourage students to select primary care specialties, including: ... c. educational

Proposed language for adoption	Original language
	experiences in community-based primary care settings. D-200.979
<p>11. Federal funding, without coercive terms, should be available to institutions needing financial support to expand resources for both undergraduate and graduate medical education programs designed to increase the number of primary care physicians. Our AMA will advocate for public (federal and state) and private payers to a) develop enhanced funding and related incentives from all sources to provide education for medical students and resident/fellow physicians, respectively, 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) to enhance primary care as a career choice; b) fund and foster innovative pilot programs that change the current approaches to primary care in undergraduate and graduate medical education, especially in urban and rural underserved areas; and c) evaluate these efforts for their effectiveness in increasing the number of students choosing primary care careers and helping facilitate the elimination of geographic, racial, and other health care disparities.</p>	<p>(2) Federal support, without coercive terms, should be available to institutions needing financial support for the expansion of resources for both undergraduate and graduate programs designed to increase the number of primary care physicians. H-200.997</p> <p>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. D-200.979</p> <p>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. D-200.979</p> <p>Our AMA encourages the Bureau of Health Professions to establish a series of grants for innovative pilot programs that change the current approaches to medical education at the undergraduate/graduate level in the primary care area which can be evaluated for their effectiveness in increasing the number of students choosing primary care careers. H-295.956</p> <p>2. Our AMA will encourage the Centers for Medicare & Medicaid Services, American Osteopathic Association, Accreditation Council for Graduate Medical Education, American Board of Medical Specialties and the Association of American Medical Colleges to foster the development of innovative training programs for medical students, residents and fellows in rural and</p>

Proposed language for adoption	Original language
	underserved areas so that the number of physicians increases in these underserved areas, which would facilitate the elimination of geographic, racial, and other health care disparities. H-200.982
12. Medical schools and teaching hospitals in underserved areas should promote medical student and resident/fellow physician rotations through local family health clinics for the underserved, with financial assistance to the clinics to compensate their teaching efforts.	(3) Promote medical student rotations through the various inner-city neighborhood family health clinics, with financial assistance to the clinics to compensate their teaching efforts. H-200.972 (4) Encourage medical schools and teaching hospitals to integrate third- and fourth-year undergraduate medical education and residency training into these teams. H-200.972
13. The curriculum in primary care residency programs and training sites should be consistent with the objective of training generalist physicians. Our AMA will encourage the Accreditation Council for Graduate Medical Education to (a) support primary care residency programs, including community hospital-based programs, and (b) develop an accreditation environment and novel pathways that promote innovations in graduate medical education, using progressive, community-based models of integrated care focused on quality and outcomes (such as the patient-centered medical home and the chronic care model).	(8) The curriculum in primary care residency programs and the sites used for training should be consistent with the objective of training generalist physicians. H-200.973 Our AMA advocates that the Accreditation Council for Graduate Medical Education support primary care residency programs, including community hospital based programs. H-310.973 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. D-200.979
14. The visibility of primary care faculty members should be enhanced within the medical school, and positive attitudes toward primary care among all faculty members should be encouraged.	(6) The visibility of primary care faculty members should be enhanced within the medical school and positive attitudes toward primary care among all faculty members should be encouraged. H-200.973
15. Support for practicing primary care physicians: Administrative support mechanisms should be developed to assist primary care physicians in the logistics of their practices, along with enhanced efforts to reduce administrative activities unrelated to patient care, to help ensure	(10) Administrative support mechanisms should be developed to assist primary care physicians in the logistics of their practices, and enhanced efforts to eliminate “hassle” and unnecessary paper work should be undertaken. H-200.973

Proposed language for adoption	Original language
<p>professional satisfaction and practice sustainability.</p>	
<p>16. There should be increased financial incentives for physicians practicing primary care, especially those in rural and urban underserved areas, to include scholarship or loan repayment programs, relief of professional liability burdens, and Medicaid case management programs, among others. Our AMA will advocate to state and federal legislative and regulatory bodies, among others, for development of public and/or private incentive programs, and expansion and increased funding for existing programs, to further encourage practice in underserved areas and decrease the debt load of primary care physicians. The imposition of specific outcome targets should be resisted, especially in the absence of additional support to the schools.</p>	<p>(9) There should be increased financial incentives for physicians practicing primary care. H-200.973</p> <p>1. Our AMA encourages state legislatures and the Congress of the United States to recognize this significant problem and to develop rapidly incentives to make practice in rural and urban underserved areas more attractive to primary care physicians in order to provide access to necessary medical services in these areas. H-200.982</p> <p>(18) Continue to urge measures to enhance payment for primary care in the inner city. H-200.972</p> <p>(14) Urge state medical associations to support the development of methods to improve physician compensation for serving this population, such as Medicaid case management programs in their respective states. H-200.972</p> <p>2. Our AMA supports existing programs and advocate for the introduction of new programs in the public and private sectors that decrease the debt load of physicians who choose to practice in a primary care specialty. D-200.979</p> <p>The AMA will (1) work with federal and state governments to develop incentive programs, such as loan repayment, to encourage practice in underserved areas, H-200.978</p> <p>(12) States should be encouraged to provide positive incentives--such as scholarship or loan repayment programs, relief of professional liability burdens and reduction of duplicative administrative responsibilities--to support medical students' choice of a primary care specialty. The imposition of specific outcome targets should be resisted, especially in the absence of additional support to the schools. H-200.973</p>
<p>17. Our AMA will continue to advocate, in collaboration with relevant specialty societies, for the recommendations from the AMA/Specialty Society RVS Update Committee (RUC) related to reimbursement for E&M services and</p>	<p>1. In collaboration with relevant specialty societies, our AMA will take the following actions related to reimbursement for primary care physician services: a. Continue to advocate for the recommendations from the AMA/Specialty Society RVS Update</p>

Proposed language for adoption	Original language
coverage of services related to care coordination, including patient education, counseling, team meetings and other functions; and work to ensure that private payers fully recognize the value of E&M services, incorporating the RUC-recommended increases adopted for the most current Medicare RBRVS.	Committee (RUC) related to reimbursement for E&M services and coverage of services related to care coordination, including patient education, counseling, team meetings and other functions. b. Work to assure that private payers fully recognize the value of E&M services, incorporating the RUC recommended increases adopted for the most current Medicare RBRVS. D-200.979
18. 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.	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. D-200.979
19. There should be educational support systems for primary care physicians, especially those practicing in underserved areas.	(11) There should be educational support systems for primary care physicians, especially those practicing in underserved areas. H-200.973
20. Our AMA will urge urban hospitals, medical centers, state medical associations, and specialty societies to consider the expanded use of mobile health care capabilities.	(17) Urge urban hospitals, medical centers, state medical associations, and specialty societies to consider the expanded use of mobile health care capabilities. H-200.972
21. Our AMA will encourage the Centers for Medicare & Medicaid Services to explore the use of telemedicine to improve access to and support for urban primary care practices in underserved settings.	(16) Urge CMS to explore the use of video and computer capabilities to improve access to and support for urban primary care practices in underserved settings. H-200.972
22. Accredited continuing medical education providers should promote and establish continuing medical education courses in performing, prescribing, interpreting and reinforcing primary care services.	The AMA urges accredited continuing medical education sponsors to promote and establish continuing medical education courses in performing, prescribing, interpreting and reinforcing primary care services. H-300.957
23. Practicing physicians in other specialties—particularly those practicing in underserved urban or rural areas—should be provided the opportunity to gain specific primary care competencies through short-term preceptorships or postgraduate fellowships offered by departments of family medicine, internal medicine, pediatrics, etc., at medical schools or teaching hospitals. In addition,	(7) Consider expanding opportunities for practicing physicians in other specialties to gain specific primary care competencies through short-term preceptorships or postgraduate fellowships offered by departments of family practice, internal medicine, pediatrics, etc. These may be developed so that they are part-time, thereby allowing physicians enrolling in these programs to practice concurrently. H-200.972

Proposed language for adoption	Original language
part-time training should be encouraged, to allow physicians in these programs to practice concurrently, and further research into these concepts should be encouraged.	(6) Study the concept of having medical schools with active outreach programs in the inner city offer additional training to physicians from nonprimary care specialties who are interested in achieving specific primary care competencies. H-200.972
24. Our AMA supports continued funding of Public Health Service Act, Title VII, Section 747, and encourages advocacy in this regard by AMA members and the public.	Our AMA supports continued funding of Public Health Service Act, Title VII, Section 747. H-200.956 Our AMA will encourage members to communicate with their US Senators and Representatives to support Public Health Service Act, Title VII, Section 747. D-200.994
25. Research: Analysis of state and federal financial assistance programs should be undertaken, to determine if these programs are having the desired workforce effects, particularly for students from disadvantaged groups and those that are underrepresented in medicine, and to gauge the impact of these programs on elimination of geographic, racial, and other health care disparities. Additional research should identify the factors that deter students and physicians from choosing and remaining in primary care disciplines. Further, our AMA should continue to monitor trends in the choice of a primary care specialty and the availability of primary care graduate medical education positions. The results of these and related research endeavors should support and further refine AMA policy to enhance primary care as a career choice.	Federal financial assistance programs aimed at stimulating interest in primary care should have the following characteristics:... (2) There should be an analysis of outcome data for federal financial assistance programs, to determine if they are having the desired effects and a study of the impact of these programs on disadvantaged and underrepresented groups of students. H-200.966 (2) engage in research to identify all factors which deter students and physicians from choosing and remaining in primary care disciplines H-200.978 3. Our AMA will continue to monitor trends in the choice of a primary care specialty and the availability of primary care graduate medical education positions. D-200.979 and (3) use this information to support and implement AMA policy to enhance primary care as a career choice. H-200.978

APPENDIX B: PROPOSED AMA POLICY: “PRINCIPLES OF AND ACTIONS TO ADDRESS PRIMARY CARE WORKFORCE” (TEXT VERSION)

1. Our patients require a sufficient, well-trained supply of primary care physicians—family physicians, general internists, general pediatricians, and obstetricians/gynecologists—to meet the nation’s current and projected demand for health care services.
2. To help accomplish this critical goal, our American Medical Association (AMA) will work with a variety of key stakeholders, to include federal and state legislators and regulatory bodies; national and state specialty societies and medical associations, including those representing primary care fields; and accreditation, certification, licensing, and regulatory bodies from across the continuum of medical education (undergraduate, graduate, and continuing medical education).
3. Through its work with these stakeholders, our AMA will encourage development and dissemination of innovative models to recruit medical students interested in primary care, train primary care physicians, and enhance both the perception and the reality of primary care practice, to encompass the following components:
 - a) Changes to medical school admissions and recruitment of medical students to primary care specialties, including counseling of medical students as they develop their career plans;
 - b) Curriculum changes throughout the medical education continuum;
 - c) Expanded financial aid and debt relief options;
 - d) Financial and logistical support for primary care practice, including adequate reimbursement, and enhancements to the practice environment to ensure professional satisfaction and practice sustainability; and
 - e) Support for research and advocacy related to primary care.
4. **Admissions and recruitment:** The medical school admissions process should reflect the specific institution’s mission. Those schools with missions that include primary care should consider those predictor variables among applicants that are associated with choice of these specialties.
5. Medical schools, through continued and expanded recruitment and outreach activities into secondary schools, colleges, and universities, should develop and increase the pool of applicants likely to practice primary care by seeking out those students whose profiles indicate a likelihood of practicing in primary care and underserved areas, while establishing strict guidelines to preclude discrimination.
6. **Career counseling and exposure to primary care:** Medical schools should provide to students career counseling related to the choice of a primary care specialty, and ensure that primary care physicians are well-represented as teachers, mentors, and role models to future physicians.
7. Financial assistance programs should be created to provide students with primary care experiences in ambulatory settings, especially in underserved areas. These could include funded preceptorships or summer work/study opportunities.
8. **Curriculum:** Voluntary efforts to develop and expand both undergraduate and graduate medical education programs to educate primary care physicians in increasing numbers should be continued, including such innovations as a three-year medical school curriculum that leads

directly to primary care residency programs. The establishment of appropriate administrative units for family medicine should be encouraged.

9. Medical schools with an explicit commitment to primary care should structure the curriculum to support this objective. At the same time, all medical schools should be encouraged to continue to change their curriculum to put more emphasis on primary care.
10. All four years of the curriculum in every medical school should provide primary care experiences for all students, to feature increasing levels of student responsibility and use of ambulatory and community-based settings.
11. Federal funding, without coercive terms, should be available to institutions needing financial support to expand resources for both undergraduate and graduate medical education programs designed to increase the number of primary care physicians. Our AMA will advocate for public (federal and state) and private payers to a) develop enhanced funding and related incentives from all sources to provide education for medical students and resident/fellow physicians, respectively, 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) to enhance primary care as a career choice; b) fund and foster innovative pilot programs that change the current approaches to primary care in undergraduate and graduate medical education, especially in urban and rural underserved areas; and c) evaluate these efforts for their effectiveness in increasing the number of students choosing primary care careers and helping facilitate the elimination of geographic, racial, and other health care disparities.
12. Medical schools and teaching hospitals in underserved areas should promote medical student and resident/fellow physician rotations through local family health clinics for the underserved, with financial assistance to the clinics to compensate their teaching efforts.
13. The curriculum in primary care residency programs and training sites should be consistent with the objective of training generalist physicians. Our AMA will encourage the Accreditation Council for Graduate Medical Education to (a) support primary care residency programs, including community hospital-based programs, and (b) develop an accreditation environment and novel pathways that promote innovations in graduate medical education, using progressive, community-based models of integrated care focused on quality and outcomes (such as the patient-centered medical home and the chronic care model).
14. The visibility of primary care faculty members should be enhanced within the medical school, and positive attitudes toward primary care among all faculty members should be encouraged.
15. **Support for practicing primary care physicians:** Administrative support mechanisms should be developed to assist primary care physicians in the logistics of their practices, along with enhanced efforts to reduce administrative activities unrelated to patient care, to help ensure professional satisfaction and practice sustainability.
16. There should be increased financial incentives for physicians practicing primary care, especially those in rural and urban underserved areas, to include scholarship or loan repayment programs, relief of professional liability burdens, and Medicaid case management programs, among others. Our AMA will advocate to state and federal legislative and regulatory bodies, among others, for development of public and/or private incentive programs, and expansion and increased funding for existing programs, to further encourage practice in underserved areas and

decrease the debt load of primary care physicians. The imposition of specific outcome targets should be resisted, especially in the absence of additional support to the schools.

17. Our AMA will continue to advocate, in collaboration with relevant specialty societies, for the recommendations from the AMA/Specialty Society RVS Update Committee (RUC) related to reimbursement for E&M services and coverage of services related to care coordination, including patient education, counseling, team meetings and other functions; and work to ensure that private payers fully recognize the value of E&M services, incorporating the RUC-recommended increases adopted for the most current Medicare RBRVS.
18. 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.
19. There should be educational support systems for primary care physicians, especially those practicing in underserved areas.
20. Our AMA will urge urban hospitals, medical centers, state medical associations, and specialty societies to consider the expanded use of mobile health care capabilities.
21. Our AMA will encourage the Centers for Medicare & Medicaid Services to explore the use of telemedicine to improve access to and support for urban primary care practices in underserved settings.
22. Accredited continuing medical education providers should promote and establish continuing medical education courses in performing, prescribing, interpreting and reinforcing primary care services.
23. Practicing physicians in other specialties—particularly those practicing in underserved urban or rural areas—should be provided the opportunity to gain specific primary care competencies through short-term preceptorships or postgraduate fellowships offered by departments of family medicine, internal medicine, pediatrics, etc., at medical schools or teaching hospitals. In addition, part-time training should be encouraged, to allow physicians in these programs to practice concurrently, and further research into these concepts should be encouraged.
24. Our AMA supports continued funding of Public Health Service Act, Title VII, Section 747, and encourages advocacy in this regard by AMA members and the public.
25. **Research:** Analysis of state and federal financial assistance programs should be undertaken, to determine if these programs are having the desired workforce effects, particularly for students from disadvantaged groups and those that are underrepresented in medicine, and to gauge the impact of these programs on elimination of geographic, racial, and other health care disparities. Additional research should identify the factors that deter students and physicians from choosing and remaining in primary care disciplines. Further, our AMA should continue to monitor trends in the choice of a primary care specialty and the availability of primary care graduate medical education positions. The results of these and related research endeavors should support and further refine AMA policy to enhance primary care as a career choice.

APPENDIX C: AMA POLICIES AND DIRECTIVES PROPOSED FOR RESCISSION

1. *D-200.979, "Barriers to Primary Care as a Medical School Choice"*

1. In collaboration with relevant specialty societies, our AMA will take the following actions related to reimbursement for primary care physician services: a. Continue to advocate for the recommendations from the AMA/Specialty Society RVS Update Committee (RUC) related to reimbursement for E&M services and coverage of services related to care coordination, including patient education, counseling, team meetings and other functions. b. Work to assure that private payers fully recognize the value of E&M services, incorporating the RUC recommended increases adopted for the most current Medicare RBRVS.

2. Our AMA supports existing programs and advocate for the introduction of new programs in the public and private sectors that decrease the debt load of physicians who choose to practice in a primary care specialty.

3. Our AMA will continue to monitor trends in the choice of a primary care specialty and the availability of primary care graduate medical education positions.

4. Our AMA will collaborate with appropriate organizations to support the development of innovative models to recruit medical students interested in primary care, to train primary care physicians, and to enhance the image of primary care practice.

5. Our AMA will collaborate with appropriate organizations in urging medical schools to develop policies and to allocate appropriate resources to activities and programs that encourage students to select primary care specialties, including: a. admissions policies b. utilization of primary care physicians in the roles of teachers, mentors, and role models, and c. educational experiences in community-based primary care settings.

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.

CME Rep. 3, I-08; Appended: CME Rep. 8, A-10; Modified: CCB/CLRPD Rep. 2, A-14

2. *D-200.994, "Appropriations for Increasing Number of Primary Care Physicians"*

Our AMA will encourage members to communicate with their US Senators and Representatives to support Public Health Service Act, Title VII, Section 747.

Res. 814, I-03; Reaffirmed: BOT Rep. 28, A-13

3. *H-200.956, "Appropriations for Increasing Number of Primary Care Physicians"*

Our AMA supports continued funding of Public Health Service Act, Title VII, Section 747. Res. 814, I-03; Reaffirmation I-08

4. *H-200.966, "Federal Financial Incentives and Medical Student Career Choice"*

To further expand policy the AMA has adopted the following:

Federal financial assistance programs aimed at stimulating interest in primary care should have the following characteristics:

(1) Financial assistance programs should be created to provide students with primary care experiences in ambulatory settings, especially in underserved areas. These could include funded preceptorships or summer work/study opportunities.

(2) There should be an analysis of outcome data for federal financial assistance programs, to determine if they are having the desired effects and a study of the impact of these programs on disadvantaged and underrepresented groups of students.

CME Rep. 6, A-94; Reaffirmed: CME Rep. 2, A-05; Modified: CME Rep. 13, A-06; Reaffirmation I-08

5. *H-200.973, "Increasing the Availability of Primary Care Physicians"*

It is the policy of the AMA that:

(1) Each medical school should reexamine its institutional goals and objectives, including the extent of its commitment to primary care. Those schools recognizing a commitment related to primary care should make this an explicit part of the mission, and set institutional priorities accordingly.

(2) The admission process should be sensitive to the institution's mission. Those schools with missions that include primary care should consider those predictor variables known to be associated with choice of these specialties.

(3) Through early recruitment and outreach activities, attempts should be made to increase the pool of applicants likely to practice primary care.

(4) Medical schools with an explicit commitment to primary care should structure the curriculum to support this objective.

(5) All four years of the curriculum in every medical school should provide experiences in primary care for all students. These experiences should feature increasing levels of student responsibility and use of ambulatory and community settings.

(6) The visibility of primary care faculty members should be enhanced within the medical school and positive attitudes toward primary care among all faculty members should be encouraged.

(7) Medical schools should provide career counseling related to the choice of a primary care specialty.

(8) The curriculum in primary care residency programs and the sites used for training should be consistent with the objective of training generalist physicians.

(9) There should be increased financial incentives for physicians practicing primary care.

(10) Administrative support mechanisms should be developed to assist primary care physicians in the logistics of their practices, and enhanced efforts to eliminate "hassle" and unnecessary paper work should be undertaken.

(11) There should be educational support systems for primary care physicians, especially those practicing in underserved areas.

(12) States should be encouraged to provide positive incentives--such as scholarship or loan repayment programs, relief of professional liability burdens and reduction of duplicative administrative responsibilities--to support medical students' choice of a primary care specialty. The

imposition of specific outcome targets should be resisted, especially in the absence of additional support to the schools.

CME Rep. N, A-93; Reaffirmed: CME Rep. 2, A-03; Modified: CME Rep. 13, A-06; Reaffirmed: CME Rep. 1, I-08; Reaffirmation I-08

6. *H-200.975, "Availability, Distribution and Need for Family Physicians"*

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

7. *H-200.977, "Establishing a National Priority and Appropriate Funding for Increased Training of Primary Care Physicians"*

It is the policy of the AMA, with representatives of primary care specialty groups and the academic community, to develop recommendations for adequate reimbursement of primary care physicians, improved recruitment of medical school graduates and training a sufficient number of primary care physicians to meet projected national needs.

Res. 306, I-91; Reaffirmed: BOT Rep. GG, I-92; Reaffirmed: CME Rep. 2, A-03; Reaffirmation I-08

8. *H-200.978, "Loan Repayment Programs for Primary Care Careers"*

The AMA will (1) work with federal and state governments to develop incentive programs, such as loan repayment, to encourage practice in underserved areas, (2) engage in research to identify all factors which deter students and physicians from choosing and remaining in primary care disciplines and (3) use this information to support and implement AMA policy to enhance primary care as a career choice.

BOT Rep. EEE, A-91; Reaffirmed: BOT Rep. GG, I-92; Reaffirmed: CME Rep. 2, A-03; Reaffirmation I-06; Reaffirmed: CME Rep. 1, I-08

9. *H-200.982, "Significant Problem of Access to Health Care in Rural and Urban Underserved Areas"*

1. Our AMA encourages state legislatures and the Congress of the United States to recognize this significant problem and to develop rapidly incentives to make practice in rural and urban underserved areas more attractive to primary care physicians in order to provide access to necessary medical services in these areas.

2. Our AMA will encourage the Centers for Medicare & Medicaid Services, American Osteopathic Association, Accreditation Council for Graduate Medical Education, American Board of Medical Specialties and the Association of American Medical Colleges to foster the development of innovative training programs for medical students, residents and fellows in rural and underserved areas so that the number of physicians increases in these underserved areas, which would facilitate the elimination of geographic, racial, and other health care disparities.

Sub. Res. 35, I-90; Reaffirmed: BOT Rep. GG, I-92; Reaffirmation A-01; Modified: CME Rep. 2, I-03; Appended: Res. 320, A-10

10. H-200.997, "Primary Care"

The AMA believes that there should be a sufficient supply of primary care physicians - family physicians, general internists, general pediatricians, and obstetricians/gynecologists. In order to achieve this objective:

(1) Voluntary efforts to develop and expand both undergraduate and graduate programs to educate primary care physicians in increasing numbers should be continued. The establishment of appropriate administrative units for family practice should be encouraged.

(2) Federal support, without coercive terms, should be available to institutions needing financial support for the expansion of resources for both undergraduate and graduate programs designed to increase the number of primary care physicians.

(3) It is the policy of the AMA, with representatives of primary care specialty groups and the academic community, to develop recommendations for adequate reimbursement of primary care physicians and improved recruitment of medical school graduates into primary care specialties.

CME Rep. C, I-79; Reaffirmed: CLRPD Rep. B, I-89; Reaffirmed: BOT Rep. GG, I-92;
Reaffirmed: CME Rep. 2, A-03; Modified: CME Rep. 2, I-03; Reaffirmation I-08

11. H-295.956, "Educational Grants for Innovative Programs in Undergraduate and Residency Training for Primary Care Careers"

Our AMA encourages the Bureau of Health Professions to establish a series of grants for innovative pilot programs that change the current approaches to medical education at the undergraduate/graduate level in the primary care area which can be evaluated for their effectiveness in increasing the number of students choosing primary care careers.

Res. 173, I-90; Reaffirmed: Sunset Report, I-00; Modified: CME Rep. 2, A-10

12. H-300.957, "Promoting Primary Care Services Through Continuing Medical Education"

The AMA urges accredited continuing medical education sponsors to promote and establish continuing medical education courses in performing, prescribing, interpreting and reinforcing primary care services.

Res. 311, A-94; Reaffirmed: CME Rep. 2, A-04; Reaffirmed: CME Rep. 2, A-14

13. H-310.973, "Primary Care Residencies in Community Hospitals"

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

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 6-I-18

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

Presented by: Carol Berkowitz, MD, Chair

Referred to: Reference Committee C
(Peter C. Amadio, MD, Chair)

1 INTRODUCTION

2

3 The goal of this report is to review, reconcile, and consolidate existing American Medical
4 Association (AMA) policy on resident/fellow contracts and duty hours, eliminate duplication, and
5 ensure that current policies are coherent and relevant. For each policy recommendation, a succinct
6 but cogent justification is provided to support the proposed action. The most recent policy was
7 deemed to supersede contradictory past AMA policies, and the language of each proposed policy
8 was edited so that it is coherent and easily understood, without altering its meaning or intent.

9

10 POLICIES INCLUDED IN THIS REPORT

11

12 The following AMA policies are addressed in this report:

13

- 14 1. D-310.987, "Impact of ACGME Resident Duty Hour Limits on Physician Well-Being and
15 Patient Safety"
- 16 2. H-310.907, "AMA Duty Hours Policy"
- 17 3. H-310.912, "Residents and Fellows' Bill of Rights"
- 18 4. H-310.922, "Determining Residents' Salaries"
- 19 5. H-310.929, "Principles for Graduate Medical Education"
- 20 6. H-310.932, "Annual Contracts for Continuing Residents"
- 21 7. H-310.947, "Revision of the 'General Requirements' of the Essentials of Accredited
22 Residency Programs"
- 23 8. H-310.979, "Resident Physician Working Hours and Supervision"
- 24 9. H-310.988, "Adequate Resident Compensation"
- 25 10. H-310.999, "Guidelines for Housestaff Contracts or Agreements"

26

27 SUMMARY AND RECOMMENDATIONS

28

29 This report encompasses a review of current AMA policies on resident/fellow contracts and duty
30 hours to ensure such policy is consistent, accurate, and up-to-date. Three of the 10 policies being
31 addressed in this report are recommended for revision, as shown in Appendix A, with a clean text
32 version shown in Appendix B:

33

- 34 • H-310.907, "AMA Duty Hours Policy"
- 35 • H-310.912, "Residents and Fellows' Bill of Rights"
- 36 • H-310.929, "Principles for Graduate Medical Education"

1 Appendix C lists the seven remaining policies that are proposed for rescission. Relevant aspects of
2 the following four of these seven policies are recommended for a) incorporation into the three
3 policies above and b) rescission:

- 4
- 5 • D-310.987, “Impact of ACGME Resident Duty Hour Limits on Physician Well-Being and
- 6 Patient Safety”
- 7 • H-310.922, “Determining Residents’ Salaries”
- 8 • H-310.947, “Revision of the ‘General Requirements’ of the Essentials of Accredited
- 9 Residency Programs”
- 10 • H-310.979, “Resident Physician Working Hours and Supervision”
- 11

12 The remaining three policies being treated in this report are recommended for rescission and are
13 not being retained in the three revised policies, as they are superseded by or already reflected in
14 existing AMA policy:

- 15
- 16 • H-310.932, “Annual Contracts for Continuing Residents”
- 17 • H-310.988, “Adequate Resident Compensation”
- 18 • H-310.999, “Guidelines for Housestaff Contracts or Agreements”
- 19

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

- 22
- 23 1. That our American Medical Association (AMA) adopt the proposed revisions shown in
- 24 Appendix A, column 1, for the following three policies:
- 25

- 26 1) H-310.907, “AMA Duty Hours Policy” (with revised title: “Resident/Fellow
- 27 Clinical and Educational Work Hours”)
- 28 2) H-310.912, “Residents and Fellows’ Bill of Rights”
- 29 3) H-310.929, “Principles for Graduate Medical Education”
- 30 (Modify Current HOD Policy)
- 31

- 32 2. That our AMA rescind the following seven policies, as shown in Appendix C, and
- 33 incorporate relevant portions of four of these policies into existing AMA policy:
- 34

- 35 1) D-310.987, “Impact of ACGME Resident Duty Hour Limits on Physician Well-
- 36 Being and Patient Safety”
- 37 2) H-310.922, “Determining Residents’ Salaries”
- 38 3) H-310.932, “Annual Contracts for Continuing Residents”
- 39 4) H-310.947, “Revision of the ‘General Requirements’ of the Essentials of
- 40 Accredited Residency Programs”
- 41 5) H-310.979, “Resident Physician Working Hours and Supervision”
- 42 6) H-310.988, “Adequate Resident Compensation”
- 43 7) H-310.999, “Guidelines for Housestaff Contracts or Agreements”
- 44 (Rescind HOD Policy)

Fiscal note: \$1,000.

APPENDIX A: PROPOSED REVISIONS TO THREE AMA POLICIES RELATED TO RESIDENT/FELLOW CONTRACTS AND DUTY HOURS (WORKSHEET VERSION)

Note: The right column shows the original language; the left column shows the recommended action and any edits to the original language.

H-310.907, “AMA duty hours policy”

Proposed language for adoption	Original language
<p><i>Note: Revise title of policy and aspects of policy as noted below, to reflect 2018 terminology from the Accreditation Council for Graduate Medical Education (ACGME), with “duty hours” replaced by “clinical and educational work hours.”</i></p>	
<p>Policy Title: AMA duty hours policy <u>Resident/Fellow Clinical and Educational Work Hours</u></p>	<p>Policy Title: AMA duty hours policy</p>
<p>Our AMA adopts the following Principles of Resident/Fellow Duty Hours <u>Clinical and Educational Work Hours</u>, Patient Safety, and Quality of Physician Training:”</p>	<p>Our AMA adopts the following Principles of Resident/Fellow Duty Hours, Patient Safety, and Quality of Physician Training:</p>
<p>1. Our AMA reaffirms supports of the 2003 <u>2017</u> Accreditation Council for Graduate Medical Education (ACGME) duty hour standards <u>for clinical and educational work hours</u> (previously referred to as “duty hours”).</p>	<p>1. Our AMA reaffirms support of the 2003 Accreditation Council for Graduate Medical Education (ACGME) duty hour standards. <i>(Note: The 2003 standards have been superseded by the 2017 standards.)</i></p>
<p>2. Our AMA will continue to monitor the enforcement and impact of duty <u>clinical and educational work</u> hour standards, in the context of the larger issues of patient safety and the optimal learning environment for residents.</p>	<p>2. Our AMA will continue to monitor the enforcement and impact of duty hour standards, in the context of the larger issues of patient safety and the optimal learning environment for residents.</p>
<p>3. Our AMA encourages publication and supports dissemination of studies in peer-reviewed publications and educational sessions about all aspects of duty <u>clinical and educational work</u> hours, to include such topics as extended work shifts, handoffs, in-house call and at-home call, level of supervision by attending physicians, workload and growing service demands, moonlighting, protected sleep periods, sleep deprivation and fatigue, patient safety, medical error, continuity of care, resident well-being and burnout, development of professionalism, resident learning outcomes, and <u>preparation for independent practice</u>.</p>	<p>3. Our AMA encourages publication and supports dissemination of studies in peer-reviewed publications and educational sessions about all aspects of duty hours, to include such topics as extended work shifts, handoffs, in-house call and at-home call, level of supervision by attending physicians, workload and growing service demands, moonlighting, protected sleep periods, sleep deprivation and fatigue, patient safety, medical error, continuity of care, resident well-being and burnout, development of professionalism, resident learning outcomes, and preparation for independent practice.</p>
<p>4. Our AMA endorses the study of innovative models of duty <u>clinical and educational work</u> hour requirements and, pending the outcomes of</p>	<p>4. Our AMA endorses the study of innovative models of duty hour requirements and, pending the outcomes of ongoing and future research,</p>

Proposed language for adoption	Original language
ongoing and future research, should consider the evolution of specialty- and rotation-specific duty hours requirements that are evidence-based and will optimize patient safety and competency-based learning opportunities.	should consider the evolution of specialty- and rotation-specific duty hours requirements that are evidence-based and will optimize patient safety and competency-based learning opportunities.
5. Our AMA encourages the ACGME to:	<i>(unchanged)</i>
a) Decrease the barriers to reporting of both duty clinical and educational work hour violations and resident intimidation.	a) Decrease the barriers to reporting of both duty hour violations and resident intimidation.
b) Ensure that readily accessible, timely and accurate information about duty clinical and educational work hours is not constrained by the cycle of ACGME survey visits.	b) Ensure that readily accessible, timely and accurate information about duty hours is not constrained by the cycle of ACGME survey visits.
c) Use, where possible, recommendations from respective specialty societies and evidence-based approaches to any future revision or introduction of resident-duty clinical and educational work hour rules.	c) Use, where possible, recommendations from respective specialty societies and evidence-based approaches to any future revision or introduction of resident duty hour rules.
d) Broadly disseminate aggregate data from the annual ACGME survey on the educational environment of resident physicians, encompassing all aspects of duty clinical and educational work hours.	d) Broadly disseminate aggregate data from the annual ACGME survey on the educational environment of resident physicians, encompassing all aspects of duty hours.
6. Our AMA recognizes the ACGME for its work in ensuring an appropriate balance between resident education and patient safety, and encourages the ACGME to continue to:	<i>(unchanged)</i>
a) Offer incentives to programs/institutions to ensure compliance with duty clinical and educational work hour standards.	a) Offer incentives to programs/institutions to ensure compliance with duty hour standards.
b) Ensure that site visits include meetings with peer-selected or randomly selected residents and that residents who are not interviewed during site visits have the opportunity to provide information directly to the site visitor.	<i>(unchanged)</i>
c) Collect data on at-home call from both program directors and resident/fellow physicians; release these aggregate data annually; and develop standards to ensure that appropriate education and supervision are maintained, whether the setting is in-house or at-home.	<i>(unchanged)</i>
d) Ensure that resident/fellow physicians receive education on sleep deprivation and fatigue.	<i>(unchanged)</i>
7. Our AMA supports the following statements related to duty clinical and educational work hours:	7. Our AMA supports the following statements related to duty hours:
a) Resident physician Total <u>duty clinical and educational work</u> hours must not exceed 80	a) Resident physician total duty hours must not exceed 80 hours per week, averaged over a four-

Proposed language for adoption	Original language
<p>hours per week, averaged over a four-week period (Note: “Total <u>duty clinical and educational work</u> hours” includes providing direct patient care or supervised patient care that contributes to meeting educational goals; participating in formal educational activities; providing administrative and patient care services of limited or no educational value; and time needed to transfer the care of patients).</p>	<p>week period (Note: “Total duty hours” includes providing direct patient care or supervised patient care that contributes to meeting educational goals; participating in formal educational activities; providing administrative and patient care services of limited or no educational value; and time needed to transfer the care of patients).</p>
<p>b) Scheduled on-call assignments should not exceed 24 hours. Residents may remain on-duty for an additional 4 hours to complete the transfer of care, patient follow-up, and education; however, residents may not be assigned new patients, cross-coverage of other providers’ patients, or continuity clinic during that time.</p>	<p><i>(unchanged)</i></p>
<p>c) Time spent in the hospital by residents on at-home call must count towards the 80-hour maximum weekly hour limit, and on-call frequency must not exceed every third night averaged over four weeks. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one-day-in-seven free of duty, when averaged over four weeks.</p>	<p><i>(unchanged)</i></p>
<p>d) At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident.</p>	<p><i>(unchanged)</i></p>
<p>e) Residents are permitted to return to the hospital while on at-home call to care for new or established patients. Each episode of this type of care, while it must be included in the 80-hour weekly maximum, will not initiate a new “off-duty period.”</p>	<p><i>(unchanged)</i></p>
<p>f) Given the different education and patient care needs of the various specialties and changes in resident responsibility as training progresses, <u>duty clinical and educational work</u> hour requirements should allow for flexibility for different disciplines and different training levels to ensure appropriate resident education and patient safety; for example, allowing exceptions for certain disciplines, as appropriate, to the 16-hour shift limit for first-year residents, or allowing a limited increase to the total number of <u>duty clinical and educational work</u> hours when need is demonstrated.</p>	<p>f) Given the different education and patient care needs of the various specialties and changes in resident responsibility as training progresses, duty hour requirements should allow for flexibility for different disciplines and different training levels to ensure appropriate resident education and patient safety; for example, allowing exceptions for certain disciplines, as appropriate, to the 16-hour shift limit for first-year residents, or allowing a limited increase to the total number of duty hours when need is demonstrated.</p>

Proposed language for adoption	Original language
g) Resident physicians should be ensured a sufficient duty-free interval prior to returning to duty.	<i>(unchanged)</i>
h) Duty <u>Clinical and educational work</u> hour limits must not adversely impact resident physician participation in organized educational activities. Formal educational activities must be scheduled and available within total duty <u>clinical and educational work</u> hour limits for all resident physicians.	h) Duty hour limits must not adversely impact resident physician participation in organized educational activities. Formal educational activities must be scheduled and available within total duty hour limits for all resident physicians.
i) Scheduled time providing patient care services of limited or no educational value should be minimized.	<i>(unchanged)</i>
j) Accurate, honest, and complete reporting of resident duty <u>clinical and educational work</u> hours is an essential element of medical professionalism and ethics.	j) Accurate, honest, and complete reporting of resident duty hours is an essential element of medical professionalism and ethics.
k) The medical profession maintains the right and responsibility for self-regulation (one of the key tenets of professionalism) through the ACGME and its purview over graduate medical education, and categorically rejects involvement by the Centers for Medicare & Medicaid Services, The Joint Commission, Occupational Safety and Health Administration, and any other federal or state government bodies in the monitoring and enforcement of duty <u>clinical and educational work</u> hour regulations, and opposes any regulatory or legislative proposals to limit the duty work hours of practicing physicians.	k) The medical profession maintains the right and responsibility for self-regulation (one of the key tenets of professionalism) through the ACGME and its purview over graduate medical education, and categorically rejects involvement by the Centers for Medicare & Medicaid Services, The Joint Commission, Occupational Safety and Health Administration, and any other federal or state government bodies in the monitoring and enforcement of duty hour regulations, and opposes any regulatory or legislative proposals to limit the duty hours of practicing physicians.
l) Increased financial assistance for residents/fellows, such as subsidized child care, loan deferment, debt forgiveness, and tax credits, may help mitigate the need for moonlighting. At the same time, resident/fellow physicians in good standing with their programs should be afforded the opportunity for internal and external moonlighting that complies with ACGME policy.	<i>(unchanged)</i>
m) Program directors should establish guidelines for scheduled work outside of the residency program, such as moonlighting, and must approve and monitor that work such that it does not interfere with the ability of the resident to achieve the goals and objectives of the educational program.	<i>(unchanged)</i>
n) The costs of duty <u>clinical and educational work</u> hour limits should be borne by all health	n) The costs of duty hour limits should be borne by all health care payers.

Proposed language for adoption	Original language
care payers. <u>Individual resident compensation and benefits must not be compromised or decreased as a result of changes in the graduate medical education system.</u>	(j) Individual resident compensation and benefits must not be compromised or decreased as a result of these recommended changes in the graduate medical education system. H-310.979
o) The general public should be made aware of the many contributions of resident/fellow physicians to high-quality patient care and the importance of trainees' realizing their limits (under proper supervision) so that they will be able to competently and independently practice under real-world medical situations.	<i>(unchanged)</i>
8. Our AMA is in full support of the collaborative partnership between allopathic and osteopathic professional and accrediting bodies in developing a unified system of residency/fellowship accreditation for all residents and fellows, with the overall goal of ensuring patient safety.	<i>(unchanged)</i>
<u>9. Our AMA will actively participate in ongoing efforts to monitor the impact of clinical and educational work hour limitations to ensure that patient safety and physician well-being are not jeopardized by excessive demands on post-residency physicians.</u>	Our American Medical Association will actively participate in ongoing efforts to monitor the impact of resident duty hour limitations to ensure that patient safety and physician well-being are not jeopardized by excessive demands on post-residency physicians. D-310.987
CME Rep. 5, A-14	

H-310.912, “Residents and Fellows’ Bill of Rights”

Proposed language for adoption	Original language
<p>1. Our AMA continues to advocate for improvements in the ACGME Institutional and Common Program Requirements that support AMA policies as follows: a) adequate financial support for and guaranteed leave to attend professional meetings; b) submission of training verification information to requesting agencies within 30 days of the request; c) adequate compensation with consideration to local cost-of-living factors and years of training, and to include the orientation period; d) health insurance benefits to include dental and vision services; e) paid leave for all purposes (family, educational, vacation, sick) to be no less than six weeks per year; and f) stronger due process guidelines.</p>	<p><i>(unchanged)</i></p>
<p>2. Our AMA encourages the ACGME to ensure access to educational programs and curricula as necessary to facilitate a deeper understanding by resident physicians of the US health care system and to increase their communication skills.</p>	<p><i>(unchanged)</i></p>
<p>3. Our AMA regularly communicates to residency and fellowship programs and other GME stakeholders through various publication methods (e.g., the AMA GME e-letter) this Residents and Fellow Physicians’ Bill of Rights.</p>	<p>3. Our AMA regularly communicates to residency and fellowship programs and other GME stakeholders through various publication methods (e.g., the AMA GME e-letter) this Residents and Fellows’ Bill of Rights.</p>
<p>4. Our AMA: a) will promote residency and fellowship training programs to evaluate their own institution’s process for repayment and develop a leaner approach. This includes disbursement of funds by direct deposit as opposed to a paper check and an online system of applying for funds; b) encourages a system of expedited repayment for purchases of \$200 or less (or an equivalent institutional threshold), for example through payment directly from their residency and fellowship programs (in contrast to following traditional workflow for reimbursement); and c) encourages training programs to develop a budget and strategy for planned expenses versus unplanned expenses, where planned expenses should be estimated using historical data, and should include trainee reimbursements for items such as educational materials, attendance at conferences, and entertaining applicants. Payment in advance or</p>	<p><i>(unchanged)</i></p>

Proposed language for adoption	Original language
within one month of document submission is strongly recommended.	
5. Our AMA encourages teaching institutions to explore benefits to residents and fellows that will reduce personal cost of living expenditures, such as allowances for housing, childcare, and transportation.	<i>(unchanged)</i>
6. Our AMA adopts the following ‘Residents and Fellows’ Bill of Rights’ as applicable to all resident and fellow physicians in ACGME-accredited training programs:	<i>(unchanged)</i>
RESIDENTS AND FELLOW PHYSICIANSs’ BILL OF RIGHTS	RESIDENTS AND FELLOWS’ BILL OF RIGHTS
Residents and fellows have a right to:	<i>(unchanged)</i>
A. An education that fosters professional development, takes priority over service, and leads to independent practice.	<i>(unchanged)</i>
With regard to education, residents and fellows should expect: (1) A graduate medical education experience that facilitates their professional and ethical development, to include regularly scheduled didactics for which they are released from clinical duties. Service obligations should not interfere with educational opportunities and clinical education should be given priority over service obligations; (2) Faculty who devote sufficient time to the educational program to fulfill their teaching and supervisory responsibilities; (3) Adequate clerical and clinical support services that minimize the extraneous, time-consuming work that draws attention from patient care issues and offers no educational value; (4) 24-hour per day access to information resources to educate themselves further about appropriate patient care; and (5) Resources that will allow them to pursue scholarly activities to include financial support and education leave to attend professional meetings.	<i>(unchanged)</i>
B. Appropriate supervision by qualified faculty with progressive resident responsibility toward independent practice.	<i>(unchanged)</i>
With regard to supervision, residents and fellows should expect supervision by physicians and non-physicians who are adequately qualified and which allows them to assume progressive responsibility appropriate to their level of education, competence, and experience.	With regard to supervision, residents and fellows should expect supervision by physicians and non-physicians who are adequately qualified and which allows them to assume progressive responsibility appropriate to their level of education, competence, and experience.

Proposed language for adoption	Original language
<p><u>It is neither feasible nor desirable to develop universally applicable and precise requirements for supervision of residents.</u></p>	<p>(i) Is neither feasible nor desirable to develop universally applicable and precise requirements for supervision of residents. As stated in the ACGME Common Program Requirements (VI.B) “the program must ensure that qualified faculty provide appropriate supervision of residents in patient care activities.” H-310.979</p>
<p>C. Regular and timely feedback and evaluation based on valid assessments of resident performance.</p>	<p><i>(unchanged)</i></p>
<p>With regard to evaluation and assessment processes, residents and fellows should expect: (1) Timely and substantive evaluations during each rotation in which their competence is objectively assessed by faculty who have directly supervised their work; (2) To evaluate the faculty and the program confidentially and in writing at least once annually and expect that the training program will address deficiencies revealed by these evaluations in a timely fashion; (3) Access to their training file and to be made aware of the contents of their file on an annual basis; and (4) Training programs to complete primary verification/credentialing forms and recredentialing forms, apply all required signatures to the forms, and then have the forms permanently secured in their educational files at the completion of training or a period of training and, when requested by any organization involved in credentialing process, ensure the submission of those documents to the requesting organization within thirty days of the request.</p>	<p><i>(unchanged)</i></p>
<p>D. A safe and supportive workplace with appropriate facilities.</p>	<p><i>(unchanged)</i></p>
<p>With regard to the workplace, residents and fellows should have access to: (1) A safe workplace that enables them to fulfill their clinical duties and educational obligations; (2) Secure, clean, and comfortable on-call rooms and parking facilities which are secure and well-lit; (3) Opportunities to participate on committees whose actions may affect their education, patient care, workplace, or contract.</p>	<p><i>(unchanged)</i></p>
<p>E. Adequate compensation and benefits that provide for resident well-being and health.</p>	<p><i>(unchanged)</i></p>
<p>(1) With regard to contracts, residents and fellows should receive: a. Information about the</p>	<p><i>(unchanged)</i></p>

Proposed language for adoption	Original language
<p>interviewing residency or fellowship program including a copy of the currently used contract clearly outlining the conditions for (re)appointment, details of remuneration, specific responsibilities including call obligations, and a detailed protocol for handling any grievance; and b. At least four months advance notice of contract non-renewal and the reason for non-renewal.</p>	
<p>(2) With regard to compensation, residents and fellows should receive: a. Compensation for time at orientation; and b. Salaries commensurate with their level of training and experience. <u>Compensation should and that reflect cost of living differences based on geographical differences, local economic factors, such as housing, transportation, and energy costs (which affect the purchasing power of wages), and include appropriate adjustments for changes in the cost of living.</u></p>	<p>(2) With regard to compensation, residents and fellows should receive: a. Compensation for time at orientation; and b. Salaries commensurate with their level of training and experience, and that reflect cost of living differences based on geographical differences.</p> <p>Our AMA encourages teaching institutions to base residents' salaries on the resident's level of training as well as local economic factors, such as housing, transportation, and energy costs, that affect the purchasing power of wages, with appropriate adjustments for changes in cost of living.</p> <p>H-310.922</p>
<p>(3) With Regard to Benefits, Residents and Fellows <u>Must Be Fully Informed of and Should Receive:</u> a. Quality and affordable comprehensive medical, mental health, dental, and vision care <u>for residents and their families, as well as professional liability insurance and disability insurance to all residents for disabilities resulting from activities that are part of the educational program;</u> b. <u>An institutional written policy on and e</u>Education on <u>in</u> the signs of excessive fatigue, clinical depression, and substance abuse and dependence, <u>and other physician impairment issues;</u> c. Confidential access to mental health and substance abuse services; d. A guaranteed, predetermined</p>	<p>(3) With Regard to Benefits, Residents and Fellows Should Receive: a. Quality and affordable comprehensive medical, mental health, dental, and vision care; b. Education on the signs of excessive fatigue, clinical depression, and substance abuse and dependence; c. Confidential access to mental health and substance abuse services; d. A guaranteed, predetermined amount of paid vacation leave, sick leave, maternity and paternity leave and educational leave during each year in their training program the total amount of which should not be less than six weeks; and e. Leave in compliance with the Family and Medical Leave Act.</p>

Proposed language for adoption	Original language
<p>amount of paid vacation leave, sick leave, maternity and paternity family and medical leave and educational/<u>professional</u> leave during each year in their training program, the total amount of which should not be less than six weeks; and e. Leave in compliance with the Family and Medical Leave Act-; <u>and f. The conditions under which sleeping quarters, meals and laundry or their equivalent are to be provided.</u></p>	<p>The AMA supports the following principles of the ACGME Institutional Requirements: Candidates for residencies must be fully informed of benefits including financial support, vacations, professional leave, parental leave, sick leave, professional liability insurance, hospital and health insurance, disability insurance, and other insurance benefits for the residents and their family and the conditions under which living quarters, meals and laundry or their equivalent are to be provided. Institutions sponsoring graduate medical education must provide access to insurance, where available, to all residents for disabilities resulting from activities that are part of the educational program. Institutions should have a written policy and an educational program regarding physician impairment, including substance abuse. H-310.947</p>
<p>F. Duty <u>Clinical and educational work</u> hours that protect patient safety and facilitate resident well-being and education.</p>	<p>F. Duty hours that protect patient safety and facilitate resident well-being and education.</p>
<p>With regard to duty <u>clinical and educational work</u> hours, residents and fellows should experience: (1) A reasonable work schedule that is in compliance with duty <u>clinical and educational work</u> hour requirements set forth by the ACGME or other relevant accrediting body; and (2) At-home call that is not so frequent or demanding such that rest periods are significantly diminished or that duty <u>clinical and educational work</u> hour requirements are effectively circumvented. <u>Refer to AMA Policy H-310.907, "Resident/Fellow Clinical and Educational Work Hours," for more information.</u></p>	<p>With regard to duty hours, residents and fellows should experience: (1) A reasonable work schedule that is in compliance with duty-hour requirements set forth by the ACGME or other relevant accrediting body; and (2) At-home call that is not so frequent or demanding such that rest periods are significantly diminished or that duty-hour requirements are effectively circumvented.</p>
<p>G. Due process in cases of allegations of misconduct or poor performance.</p>	<p><i>(unchanged)</i></p>
<p>With regard to the complaints and appeals process, residents and fellows should have the opportunity to defend themselves against any allegations presented against them by a patient, health professional, or training program in accordance with the due process guidelines established by the AMA.</p>	<p><i>(unchanged)</i></p>
<p>H. Access to and protection by institutional and accreditation authorities when reporting violations.</p>	<p><i>(unchanged)</i></p>

Proposed language for adoption	Original language
<p>With regard to reporting violations to the ACGME, residents and fellows should: (1) Be informed by their program at the beginning of their training and again at each semi-annual review of the resources and processes available within the residency program for addressing resident concerns or complaints, including the program director, Residency Training Committee, and the designated institutional official; (2) Be able to file a formal complaint with the ACGME to address program violations of residency training requirements without fear of recrimination and with the guarantee of due process; and (3) Have the opportunity to address their concerns about the training program through confidential channels, including the ACGME concern process and/or the annual ACGME Resident Survey.</p>	<p><i>(unchanged)</i></p>
<p>CME Rep. 8, A-11 Appended: Res. 303, A-14 Reaffirmed: Res. 915, I-15 Appended: CME Rep. 04, A-16</p>	

H-310.929, “Principles for Graduate Medical Education”

Proposed language for adoption	Original language
<p>Our AMA urges the Accreditation Council for Graduate Medical Education (ACGME) to incorporate these principles in the revised “its Institutional Requirements” of the Essentials of Accredited Residencies of Graduate Medical Education, if they are not already present.</p>	<p>Our AMA urges the Accreditation Council for Graduate Medical Education to incorporate these principles in the revised “Institutional Requirements” of the Essentials of Accredited Residencies of Graduate Medical Education, if they are not already present.</p>
<p>(1) <u>PURPOSE OF GRADUATE MEDICAL EDUCATION AND ITS RELATIONSHIP TO PATIENT CARE.</u> There must be objectives for residency education in each specialty that promote the development of the knowledge, skills, attitudes, and behavior necessary to become a competent practitioner in a recognized medical specialty.</p> <p><u>Exemplary patient care is a vital component for any residency/fellowship program. Graduate medical education enhances the quality of patient care in the institution sponsoring an accredited program. Graduate medical education must never compromise the quality of patient care. Institutions sponsoring residency programs and the director of each program must assure the highest quality of care for patients and the attainment of the program’s educational objectives for the residents.</u></p>	<p>(1) <u>PURPOSE OF GRADUATE MEDICAL EDUCATION.</u> There must be objectives for residency education in each specialty that promote the development of the knowledge, skills, attitudes, and behavior necessary to become a competent practitioner in a recognized medical specialty.</p> <p>(a) Exemplary patient care is a vital component for any program of graduate medical education. Graduate medical education enhances the quality of patient care in the institution sponsoring an accredited residency program. Graduate medical education must never compromise the quality of patient care.</p> <p>(b) Institutions sponsoring residency programs and the director of each program must assure the highest quality of care for patients and the attainment of the program’s educational objectives for the residents.</p> <p>H-310.979</p>
<p>(2) <u>RELATION OF ACCREDITATION TO THE PURPOSE OF RESIDENCY TRAINING.</u> Accreditation requirements should relate to the stated purpose of a residency program and to the knowledge, skills, attitudes, and behaviors that a resident physician should have on completing residency education.</p>	<p><i>(unchanged)</i></p>
<p>(3) <u>EDUCATION IN THE BROAD FIELD OF MEDICINE.</u> GME should provide a resident physician with broad clinical experiences that address the general competencies and professionalism expected of all physicians, adding depth as well as breadth to the competencies introduced in medical school.</p>	<p><i>(unchanged)</i></p>
<p>(4) <u>SCHOLARLY ACTIVITIES FOR RESIDENTS.</u> Graduate medical education should always occur in a milieu that includes scholarship. Resident physicians should learn to appreciate the importance of scholarly activities</p>	<p><i>(unchanged)</i></p>

Proposed language for adoption	Original language
<p>and should be knowledgeable about scientific method. However, the accreditation requirements, the structure, and the content of graduate medical education should be directed toward preparing physicians to practice in a medical specialty. Individual educational opportunities beyond the residency program should be provided for resident physicians who have an interest in, and show an aptitude for, academic and research pursuits. The continued development of evidence-based medicine in the graduate medical education curriculum reinforces the integrity of the scientific method in the everyday practice of clinical medicine.</p>	
<p>(5) FACULTY SCHOLARSHIP. All residency faculty members must engage in scholarly activities and/or scientific inquiry. Suitable examples of this work must not be limited to basic biomedical research. Faculty can comply with this principle through participation in scholarly meetings, journal club, lectures, and similar academic pursuits.</p>	<p><i>(unchanged)</i></p>
<p>(6) INSTITUTIONAL RESPONSIBILITY FOR PROGRAMS. Specialty-specific GME must operate under a system of institutional governance responsible for the development and implementation of policies regarding the following; the initial authorization of programs, the appointment of program directors, compliance with the Essentials for Accredited Residencies in Graduate Medical Education <u>accreditation requirements of the ACGME</u>, the advancement of resident physicians, the disciplining of resident physicians when this is appropriate, the maintenance of permanent records, and the credentialing of resident physicians who successfully complete the program. If an institution closes or has to reduce the size of a residency program, the institution must inform the residents as soon as possible. Institutions must make every effort to allow residents already in the program to complete their education in the affected program. When this is not possible, institutions must assist residents to enroll in another program in which they can continue their education. Programs must also make arrangements, when necessary, for the disposition of program files so that future confirmation of the completion of residency education is possible. Institutions should allow</p>	<p>(6) INSTITUTIONAL RESPONSIBILITY FOR PROGRAMS. Specialty-specific GME must operate under a system of institutional governance responsible for the development and implementation of policies regarding the following; the initial authorization of programs, the appointment of program directors, compliance with the Essentials for Accredited Residencies in Graduate Medical Education, the advancement of resident physicians, the disciplining of resident physicians when this is appropriate, the maintenance of permanent records, and the credentialing of resident physicians who successfully complete the program. If an institution closes or has to reduce the size of a residency program, the institution must inform the residents as soon as possible. Institutions must make every effort to allow residents already in the program to complete their education in the affected program. When this is not possible, institutions must assist residents to enroll in another program in which they can continue their education. Programs must also make arrangements, when necessary, for the disposition of program files so that future confirmation of the completion of residency education is possible. Institutions should allow residents to form housestaff organizations, or</p>

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residents to form housestaff organizations, or similar organizations, to address patient care and resident work environment concerns. Institutional committees should include resident members.	similar organizations, to address patient care and resident work environment concerns. Institutional committees should include resident members.
(7) COMPENSATION OF RESIDENT PHYSICIANS. All residents should be compensated. Residents should receive fringe benefits, including, but not limited to, health, disability, and professional liability insurance and parental leave and should have access to other benefits offered by the institution. Residents must be informed of employment policies and fringe benefits, and their access to them. Restrictive covenants must not be required of residents or applicants for residency education.	<i>(unchanged)</i>
(8) LENGTH OF TRAINING. The usual duration of an accredited residency in a specialty should be defined in the "Program Requirements." The required minimum duration should be the same for all programs in a specialty and should be sufficient to meet the stated objectives of residency education for the specialty and to cover the course content specified in the Program Requirements. The time required for an individual resident physician's education might be modified depending on the aptitude of the resident physician and the availability of required clinical experiences.	<i>(unchanged)</i>
(9) PROVISION OF FORMAL EDUCATIONAL EXPERIENCES. Graduate medical education must include a formal educational component in addition to supervised clinical experience. This component should assist resident physicians in acquiring the knowledge and skill base required for practice in the specialty. The assignment of clinical responsibility to resident physicians must permit time for study of the basic sciences and clinical pathophysiology related to the specialty.	<i>(unchanged)</i>
(10) INNOVATION OF GRADUATE MEDICAL EDUCATION. The requirements for accreditation of residency training should encourage educational innovation and continual improvement. New topic areas such as continuous quality improvement (CQI), outcome management, informatics and	<i>(unchanged)</i>

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information systems, and population-based medicine should be included as appropriate to the specialty.	
(11) THE ENVIRONMENT OF GRADUATE MEDICAL EDUCATION. Sponsoring organizations and other GME programs must create an environment that is conducive to learning. There must be an appropriate balance between education and service. Resident physicians must be treated as colleagues.	<i>(unchanged)</i>
(12) SUPERVISION OF RESIDENT PHYSICIANS. Program directors must supervise <u>and evaluate</u> the clinical performance of resident physicians. The policies of the sponsoring institution, as enforced by the program director, <u>and specified in the ACGME Institutional Requirements and related accreditation documents,</u> must ensure that the clinical activities of each resident physician are supervised to a degree that reflects the ability of the resident physician <u>and the level of responsibility for the care of patients that may be safely delegated to the resident.</u> <u>The sponsoring institution's GME Committee must monitor programs' supervision of residents and ensure that supervision is consistent with: (A) Provision of safe and effective patient care; (B) Educational needs of residents; (C) Progressive responsibility appropriate to residents' level of education, competence, and experience; and (D) Other applicable Common and specialty/subspecialty specific Program Requirements. The program director, in cooperation with the institution, is responsible</u>	(12) SUPERVISION OF RESIDENT PHYSICIANS. Program directors must supervise the clinical performance of resident physicians. The policies of the sponsoring institution, as enforced by the program director, must ensure that the clinical activities of each resident physician are supervised to a degree that reflects the ability of the resident physician. Integral to resident supervision is the necessity for frequent evaluation of residents by faculty, with discussion between faculty and resident. It is a cardinal principle that responsibility for the treatment of each patient and the education of resident and fellow physicians lies with the physician/faculty to whom the patient is assigned and who supervises all care rendered to the patient by residents and fellows.

Proposed language for adoption	Original language
<p><u>for maintaining work schedules for each resident based on the intensity and variability of assignments in conformity with ACGME Review Committee recommendations, and in compliance with the ACGME clinical and educational work hour standards.</u> Integral to resident supervision is the necessity for frequent evaluation of residents by faculty, with discussion between faculty and resident. It is a cardinal principle that responsibility for the treatment of each patient and the education of resident and fellow physicians lies with the physician/faculty to whom the patient is assigned and who supervises all care rendered to the patient by residents and fellows. <u>Each patient’s attending physician must decide, within guidelines established by the program director, the extent to which responsibility may be delegated to the resident, and the appropriate degree of supervision of the resident’s participation in the care of the patient. The attending physician, or designate, must be available to the resident for consultation at all times.</u></p>	<p>(c) Institutional commitment to graduate medical education must be evidenced by compliance with Section III.B.4 of the ACGME Institutional Requirements, effective July 1, 2007: The sponsoring institution’s GME Committee must [m]onitor programs’ supervision of residents and ensure that supervision is consistent with: (i) Provision of safe and effective patient care; (ii) Educational needs of residents; (iii) Progressive responsibility appropriate to residents’ level of education, competence, and experience; and (iv) Other applicable Common and specialty/subspecialty specific Program Requirements.</p> <p>(d) The program director must be responsible for the evaluation of the progress of each resident and for the level of responsibility for the care of patients that may be safely delegated to the resident.</p> <p>(e) Each patient’s attending physician must decide, within guidelines established by the program director, the extent to which responsibility may be delegated to the resident, and the appropriate degree of supervision of the resident’s participation in the care of the patient. The attending physician, or designate, must be available to the resident for consultation at all times.</p> <p>(f) The program director, in cooperation with the institution, is responsible for maintaining work schedules for each resident based on the intensity and variability of assignments in conformity with Residency Review Committee (RRC) recommendations, and in compliance with the ACGME duty hour standards.</p> <p>H-310.979</p>
<p>(13) EVALUATION OF RESIDENTS AND SPECIALTY BOARD CERTIFICATION. Residency program directors and faculty are responsible for evaluating and documenting the continuing development and competency of residents, as well as the readiness of residents to enter independent clinical practice upon completion of training. Program directors should also document any deficiency or concern that could interfere with the practice of medicine and which requires remediation, treatment, or removal from training. Inherent within the concept of specialty board</p>	<p><i>(unchanged)</i></p>

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<p>certification is the necessity for the residency program to attest and affirm to the competence of the residents completing their training program and being recommended to the specialty board as candidates for examination. This attestation of competency should be accepted by specialty boards as fulfilling the educational and training requirements allowing candidates to sit for the certifying examination of each member board of the ABMS.</p>	
<p>(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><i>(unchanged)</i></p>
<p>(15) VERIFICATION OF RESIDENT PHYSICIAN EXPERIENCE. The program director must document a resident physician's specific experiences and demonstrated knowledge, skills, attitudes, and behavior, and a record must be maintained within the institution.</p>	<p><i>(unchanged)</i></p>
<p>CME Rep. 9, A-99 Reaffirmed: CME Rep. 2, A-09 Reaffirmed: CME Rep. 14, A-09</p>	

APPENDIX B: PROPOSED REVISIONS TO THREE AMA POLICIES RELATED TO RESIDENT/FELLOW CONTRACTS AND DUTY HOURS (CLEAN TEXT VERSION)

H-310.907, "Resident/Fellow Clinical and Educational Work Hours"

Our AMA adopts the following Principles of Resident/Fellow Clinical and Educational Work Hours, Patient Safety, and Quality of Physician Training:"

1. Our AMA supports the 2017 Accreditation Council for Graduate Medical Education (ACGME) standards for clinical and educational work hours (previously referred to as "duty hours").
2. Our AMA will continue to monitor the enforcement and impact of clinical and educational work hour standards, in the context of the larger issues of patient safety and the optimal learning environment for residents.
3. Our AMA encourages publication and supports dissemination of studies in peer-reviewed publications and educational sessions about all aspects of clinical and educational work hours, to include such topics as extended work shifts, handoffs, in-house call and at-home call, level of supervision by attending physicians, workload and growing service demands, moonlighting, protected sleep periods, sleep deprivation and fatigue, patient safety, medical error, continuity of care, resident well-being and burnout, development of professionalism, resident learning outcomes, and preparation for independent practice.
4. Our AMA endorses the study of innovative models of clinical and educational work hour requirements and, pending the outcomes of ongoing and future research, should consider the evolution of specialty- and rotation-specific requirements that are evidence-based and will optimize patient safety and competency-based learning opportunities.
5. Our AMA encourages the ACGME to:
 - a) Decrease the barriers to reporting of both clinical and educational work hour violations and resident intimidation.
 - b) Ensure that readily accessible, timely and accurate information about clinical and educational work hours is not constrained by the cycle of ACGME survey visits.
 - c) Use, where possible, recommendations from respective specialty societies and evidence-based approaches to any future revision or introduction of clinical and educational work hour rules.
 - d) Broadly disseminate aggregate data from the annual ACGME survey on the educational environment of resident physicians, encompassing all aspects of clinical and educational work hours.
6. Our AMA recognizes the ACGME for its work in ensuring an appropriate balance between resident education and patient safety, and encourages the ACGME to continue to:
 - a) Offer incentives to programs/institutions to ensure compliance with clinical and educational work hour standards.

- b) Ensure that site visits include meetings with peer-selected or randomly selected residents and that residents who are not interviewed during site visits have the opportunity to provide information directly to the site visitor.
 - c) Collect data on at-home call from both program directors and resident/fellow physicians; release these aggregate data annually; and develop standards to ensure that appropriate education and supervision are maintained, whether the setting is in-house or at-home.
 - d) Ensure that resident/fellow physicians receive education on sleep deprivation and fatigue.
7. Our AMA supports the following statements related to clinical and educational work hours:
- a) Total clinical and educational work hours must not exceed 80 hours per week, averaged over a four-week period (Note: “Total clinical and educational work hours” includes providing direct patient care or supervised patient care that contributes to meeting educational goals; participating in formal educational activities; providing administrative and patient care services of limited or no educational value; and time needed to transfer the care of patients).
 - b) Scheduled on-call assignments should not exceed 24 hours. Residents may remain on-duty for an additional 4 hours to complete the transfer of care, patient follow-up, and education; however, residents may not be assigned new patients, cross-coverage of other providers’ patients, or continuity clinic during that time.
 - c) Time spent in the hospital by residents on at-home call must count towards the 80-hour maximum weekly hour limit, and on-call frequency must not exceed every third night averaged over four weeks. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one-day-in-seven free of duty, when averaged over four weeks.
 - d) At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident.
 - e) Residents are permitted to return to the hospital while on at-home call to care for new or established patients. Each episode of this type of care, while it must be included in the 80-hour weekly maximum, will not initiate a new “off-duty period.”
 - f) Given the different education and patient care needs of the various specialties and changes in resident responsibility as training progresses, clinical and educational work hour requirements should allow for flexibility for different disciplines and different training levels to ensure appropriate resident education and patient safety; for example, allowing exceptions for certain disciplines, as appropriate, or allowing a limited increase to the total number of clinical and educational work hours when need is demonstrated.
 - g) Resident physicians should be ensured a sufficient duty-free interval prior to returning to duty.

- h) Clinical and educational work hour limits must not adversely impact resident physician participation in organized educational activities. Formal educational activities must be scheduled and available within total clinical and educational work hour limits for all resident physicians.
 - i) Scheduled time providing patient care services of limited or no educational value should be minimized.
 - j) Accurate, honest, and complete reporting of clinical and educational work hours is an essential element of medical professionalism and ethics.
 - k) The medical profession maintains the right and responsibility for self-regulation (one of the key tenets of professionalism) through the ACGME and its purview over graduate medical education, and categorically rejects involvement by the Centers for Medicare & Medicaid Services, The Joint Commission, Occupational Safety and Health Administration, and any other federal or state government bodies in the monitoring and enforcement of clinical and educational work hour regulations, and opposes any regulatory or legislative proposals to limit the work hours of practicing physicians.
 - l) Increased financial assistance for residents/fellows, such as subsidized child care, loan deferment, debt forgiveness, and tax credits, may help mitigate the need for moonlighting. At the same time, resident/fellow physicians in good standing with their programs should be afforded the opportunity for internal and external moonlighting that complies with ACGME policy.
 - m) Program directors should establish guidelines for scheduled work outside of the residency program, such as moonlighting, and must approve and monitor that work such that it does not interfere with the ability of the resident to achieve the goals and objectives of the educational program.
 - n) The costs of clinical and educational work hour limits should be borne by all health care payers. Individual resident compensation and benefits must not be compromised or decreased as a result of changes in the graduate medical education system.
 - o) The general public should be made aware of the many contributions of resident/fellow physicians to high-quality patient care and the importance of trainees' realizing their limits (under proper supervision) so that they will be able to competently and independently practice under real-world medical situations.
8. Our AMA is in full support of the collaborative partnership between allopathic and osteopathic professional and accrediting bodies in developing a unified system of residency/fellowship accreditation for all residents and fellows, with the overall goal of ensuring patient safety.
9. Our AMA will actively participate in ongoing efforts to monitor the impact of clinical and educational work hour limitations to ensure that patient safety and physician well-being are not jeopardized by excessive demands on post-residency physicians, including program directors and attending physicians.

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

1. Our AMA continues to advocate for improvements in the ACGME Institutional and Common Program Requirements that support AMA policies as follows: a) adequate financial support for and guaranteed leave to attend professional meetings; b) submission of training verification information to requesting agencies within 30 days of the request; c) adequate compensation with consideration to local cost-of-living factors and years of training, and to include the orientation period; d) health insurance benefits to include dental and vision services; e) paid leave for all purposes (family, educational, vacation, sick) to be no less than six weeks per year; and f) stronger due process guidelines.
2. Our AMA encourages the ACGME to ensure access to educational programs and curricula as necessary to facilitate a deeper understanding by resident physicians of the US health care system and to increase their communication skills.
3. Our AMA regularly communicates to residency and fellowship programs and other GME stakeholders this Resident/Fellows Physicians' Bill of Rights.
4. Our AMA: a) will promote residency and fellowship training programs to evaluate their own institution's process for repayment and develop a leaner approach. This includes disbursement of funds by direct deposit as opposed to a paper check and an online system of applying for funds; b) encourages a system of expedited repayment for purchases of \$200 or less (or an equivalent institutional threshold), for example through payment directly from their residency and fellowship programs (in contrast to following traditional workflow for reimbursement); and c) encourages training programs to develop a budget and strategy for planned expenses versus unplanned expenses, where planned expenses should be estimated using historical data, and should include trainee reimbursements for items such as educational materials, attendance at conferences, and entertaining applicants. Payment in advance or within one month of document submission is strongly recommended.
5. Our AMA encourages teaching institutions to explore benefits to residents and fellows that will reduce personal cost of living expenditures, such as allowances for housing, childcare, and transportation.
6. Our AMA adopts the following 'Residents and Fellows' Bill of Rights' as applicable to all resident and fellow physicians in ACGME-accredited training programs:

RESIDENT/FELLOW PHYSICIANS' BILL OF RIGHTS

Residents and fellows have a right to:

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

With regard to education, residents and fellows should expect: (1) A graduate medical education experience that facilitates their professional and ethical development, to include regularly scheduled didactics for which they are released from clinical duties. Service obligations should not interfere with educational opportunities and clinical education should be given priority over service obligations; (2) Faculty who devote sufficient time to the educational program to fulfill their teaching and supervisory responsibilities; (3) Adequate clerical and clinical support services that

minimize the extraneous, time-consuming work that draws attention from patient care issues and offers no educational value; (4) 24-hour per day access to information resources to educate themselves further about appropriate patient care; and (5) Resources that will allow them to pursue scholarly activities to include financial support and education leave to attend professional meetings.

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

With regard to supervision, residents and fellows should expect supervision by physicians and non-physicians who are adequately qualified and which allows them to assume progressive responsibility appropriate to their level of education, competence, and experience. It is neither feasible nor desirable to develop universally applicable and precise requirements for supervision of residents.

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

With regard to evaluation and assessment processes, residents and fellows should expect: (1) Timely and substantive evaluations during each rotation in which their competence is objectively assessed by faculty who have directly supervised their work; (2) To evaluate the faculty and the program confidentially and in writing at least once annually and expect that the training program will address deficiencies revealed by these evaluations in a timely fashion; (3) Access to their training file and to be made aware of the contents of their file on an annual basis; and (4) Training programs to complete primary verification/credentialing forms and recertification forms, apply all required signatures to the forms, and then have the forms permanently secured in their educational files at the completion of training or a period of training and, when requested by any organization involved in credentialing process, ensure the submission of those documents to the requesting organization within thirty days of the request.

D. A safe and supportive workplace with appropriate facilities.

With regard to the workplace, residents and fellows should have access to: (1) A safe workplace that enables them to fulfill their clinical duties and educational obligations; (2) Secure, clean, and comfortable on-call rooms and parking facilities which are secure and well-lit; (3) Opportunities to participate on committees whose actions may affect their education, patient care, workplace, or contract.

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

(1) With regard to contracts, residents and fellows should receive: a. Information about the interviewing residency or fellowship program including a copy of the currently used contract clearly outlining the conditions for (re)appointment, details of remuneration, specific responsibilities including call obligations, and a detailed protocol for handling any grievance; and b. At least four months advance notice of contract non-renewal and the reason for non-renewal.

(2) With regard to compensation, residents and fellows should receive: a. Compensation for time at orientation; and b. Salaries commensurate with their level of training and experience. Compensation should reflect cost of living differences based on local economic factors, such as housing, transportation, and energy costs (which affect the purchasing power of wages), and include appropriate adjustments for changes in the cost of living.

(3) With Regard to Benefits, Residents and Fellows Must Be Fully Informed of and Should Receive: a. Quality and affordable comprehensive medical, mental health, dental, and vision care for residents and their families, as well as professional liability insurance and disability insurance to all residents for disabilities resulting from activities that are part of the educational program; b. An institutional written policy on and education in the signs of excessive fatigue, clinical depression, substance abuse and dependence, and other physician impairment issues; c. Confidential access to mental health and substance abuse services; d. A guaranteed, predetermined amount of paid vacation leave, sick leave, family and medical leave and educational/professional leave during each year in their training program, the total amount of which should not be less than six weeks; e. Leave in compliance with the Family and Medical Leave Act; and f. The conditions under which sleeping quarters, meals and laundry or their equivalent are to be provided.

F. Clinical and educational work hours that protect patient safety and facilitate resident well-being and education.

With regard to clinical and educational work hours, residents and fellows should experience: (1) A reasonable work schedule that is in compliance with clinical and educational work hour requirements set forth by the ACGME; and (2) At-home call that is not so frequent or demanding such that rest periods are significantly diminished or that clinical and educational work hour requirements are effectively circumvented. Refer to AMA Policy H-310.907, "Resident/Fellow Clinical and Educational Work Hours," for more information.

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

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

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

With regard to reporting violations to the ACGME, residents and fellows should: (1) Be informed by their program at the beginning of their training and again at each semi-annual review of the resources and processes available within the residency program for addressing resident concerns or complaints, including the program director, Residency Training Committee, and the designated institutional official; (2) Be able to file a formal complaint with the ACGME to address program violations of residency training requirements without fear of recrimination and with the guarantee of due process; and (3) Have the opportunity to address their concerns about the training program through confidential channels, including the ACGME concern process and/or the annual ACGME Resident Survey.

H-310.929, "Principles for Graduate Medical Education"

Our AMA urges the Accreditation Council for Graduate Medical Education (ACGME) to incorporate these principles in its Institutional Requirements, if they are not already present.

(1) **PURPOSE OF GRADUATE MEDICAL EDUCATION AND ITS RELATIONSHIP TO PATIENT CARE.** There must be objectives for residency education in each specialty that promote the development of the knowledge, skills, attitudes, and behavior necessary to become a competent practitioner in a recognized medical specialty.

Exemplary patient care is a vital component for any residency/fellowship program. Graduate medical education enhances the quality of patient care in the institution sponsoring an accredited program. Graduate medical education must never compromise the quality of patient care. Institutions sponsoring residency programs and the director of each program must assure the highest quality of care for patients and the attainment of the program's educational objectives for the residents.

(2) **RELATION OF ACCREDITATION TO THE PURPOSE OF RESIDENCY TRAINING.** Accreditation requirements should relate to the stated purpose of a residency program and to the knowledge, skills, attitudes, and behaviors that a resident physician should have on completing residency education.

(3) **EDUCATION IN THE BROAD FIELD OF MEDICINE.** GME should provide a resident physician with broad clinical experiences that address the general competencies and professionalism expected of all physicians, adding depth as well as breadth to the competencies introduced in medical school.

(4) **SCHOLARLY ACTIVITIES FOR RESIDENTS.** Graduate medical education should always occur in a milieu that includes scholarship. Resident physicians should learn to appreciate the importance of scholarly activities and should be knowledgeable about scientific method. However, the accreditation requirements, the structure, and the content of graduate medical education should be directed toward preparing physicians to practice in a medical specialty. Individual educational opportunities beyond the residency program should be provided for resident physicians who have an interest in, and show an aptitude for, academic and research pursuits. The continued development of evidence-based medicine in the graduate medical education curriculum reinforces the integrity of the scientific method in the everyday practice of clinical medicine.

(5) **FACULTY SCHOLARSHIP.** All residency faculty members must engage in scholarly activities and/or scientific inquiry. Suitable examples of this work must not be limited to basic biomedical research. Faculty can comply with this principle through participation in scholarly meetings, journal club, lectures, and similar academic pursuits.

(6) **INSTITUTIONAL RESPONSIBILITY FOR PROGRAMS.** Specialty-specific GME must operate under a system of institutional governance responsible for the development and implementation of policies regarding the following; the initial authorization of programs, the appointment of program directors, compliance with the accreditation requirements of the ACGME, the advancement of resident physicians, the disciplining of resident physicians when this is appropriate, the maintenance of permanent records, and the credentialing of resident physicians who successfully complete the program. If an institution closes or has to reduce the size of a residency program, the institution must inform the residents as soon as possible. Institutions must make every effort to allow residents already in the program to complete their education in the

affected program. When this is not possible, institutions must assist residents to enroll in another program in which they can continue their education. Programs must also make arrangements, when necessary, for the disposition of program files so that future confirmation of the completion of residency education is possible. Institutions should allow residents to form housestaff organizations, or similar organizations, to address patient care and resident work environment concerns. Institutional committees should include resident members.

(7) **COMPENSATION OF RESIDENT PHYSICIANS.** All residents should be compensated. Residents should receive fringe benefits, including, but not limited to, health, disability, and professional liability insurance and parental leave and should have access to other benefits offered by the institution. Residents must be informed of employment policies and fringe benefits, and their access to them. Restrictive covenants must not be required of residents or applicants for residency education.

(8) **LENGTH OF TRAINING.** The usual duration of an accredited residency in a specialty should be defined in the "Program Requirements." The required minimum duration should be the same for all programs in a specialty and should be sufficient to meet the stated objectives of residency education for the specialty and to cover the course content specified in the Program Requirements. The time required for an individual resident physician's education might be modified depending on the aptitude of the resident physician and the availability of required clinical experiences.

(9) **PROVISION OF FORMAL EDUCATIONAL EXPERIENCES.** Graduate medical education must include a formal educational component in addition to supervised clinical experience. This component should assist resident physicians in acquiring the knowledge and skill base required for practice in the specialty. The assignment of clinical responsibility to resident physicians must permit time for study of the basic sciences and clinical pathophysiology related to the specialty.

(10) **INNOVATION OF GRADUATE MEDICAL EDUCATION.** The requirements for accreditation of residency training should encourage educational innovation and continual improvement. New topic areas such as continuous quality improvement (CQI), outcome management, informatics and information systems, and population-based medicine should be included as appropriate to the specialty.

(11) **THE ENVIRONMENT OF GRADUATE MEDICAL EDUCATION.** Sponsoring organizations and other GME programs must create an environment that is conducive to learning. There must be an appropriate balance between education and service. Resident physicians must be treated as colleagues.

(12) **SUPERVISION OF RESIDENT PHYSICIANS.** Program directors must supervise and evaluate the clinical performance of resident physicians. The policies of the sponsoring institution, as enforced by the program director, and specified in the ACGME Institutional Requirements and related accreditation documents, must ensure that the clinical activities of each resident physician are supervised to a degree that reflects the ability of the resident physician and the level of responsibility for the care of patients that may be safely delegated to the resident. The sponsoring institution's GME Committee must monitor programs' supervision of residents and ensure that supervision is consistent with: (A) Provision of safe and effective patient care; (B) Educational needs of residents; (C) Progressive responsibility appropriate to residents' level of education, competence, and experience; and (D) Other applicable Common and specialty/subspecialty specific Program Requirements. The program director, in cooperation with the institution, is responsible for maintaining work schedules for each resident based on the intensity and variability of assignments in conformity with ACGME Review Committee recommendations, and in compliance with the

ACGME clinical and educational work hour standards. Integral to resident supervision is the necessity for frequent evaluation of residents by faculty, with discussion between faculty and resident. It is a cardinal principle that responsibility for the treatment of each patient and the education of resident and fellow physicians lies with the physician/faculty to whom the patient is assigned and who supervises all care rendered to the patient by residents and fellows. Each patient's attending physician must decide, within guidelines established by the program director, the extent to which responsibility may be delegated to the resident, and the appropriate degree of supervision of the resident's participation in the care of the patient. The attending physician, or designate, must be available to the resident for consultation at all times.

(13) EVALUATION OF RESIDENTS AND SPECIALTY BOARD CERTIFICATION. Residency program directors and faculty are responsible for evaluating and documenting the continuing development and competency of residents, as well as the readiness of residents to enter independent clinical practice upon completion of training. Program directors should also document any deficiency or concern that could interfere with the practice of medicine and which requires remediation, treatment, or removal from training. Inherent within the concept of specialty board certification is the necessity for the residency program to attest and affirm to the competence of the residents completing their training program and being recommended to the specialty board as candidates for examination. This attestation of competency should be accepted by specialty boards as fulfilling the educational and training requirements allowing candidates to sit for the certifying examination of each member board of the ABMS.

(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.

(15) VERIFICATION OF RESIDENT PHYSICIAN EXPERIENCE. The program director must document a resident physician's specific experiences and demonstrated knowledge, skills, attitudes, and behavior, and a record must be maintained within the institution.

APPENDIX C: AMA POLICIES AND DIRECTIVES PROPOSED FOR RESCISSION

Note: The following seven policies are recommended for rescission. The original language is shown in the left column; the rationale for rescission is in the right column.

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

Original language	Rationale for rescission
Our American Medical Association will actively participate in ongoing efforts to monitor the impact of resident duty hour limitations to ensure that patient safety and physician well-being are not jeopardized by excessive demands on post-residency physicians.	Still relevant, but rescind and append to H-310.907 (9), “AMA duty hours policy.”
Res. 314, A-03 Reaffirmation A-12	

H-310.922, “Determining Residents’ Salaries”

Original language	Rationale for rescission
Our AMA encourages teaching institutions to base residents’ salaries on the resident’s level of training as well as local economic factors, such as housing, transportation, and energy costs, that affect the purchasing power of wages, with appropriate adjustments for changes in cost of living.	Still relevant, but rescind and incorporate into H-310.912 (E.2), “Residents and Fellows’ Bill of Rights.”
Res. 303, A-06 Modified: CME Rep. 04, A-16	

H-310.932, “Annual Contracts for Continuing Residents”

Original language	Rationale for rescission
Our AMA urges the ACGME to require resident training programs to provide their residents with notice of non-renewal of contracts no later than four months prior to the end of their contract.	Still relevant, but rescind; already reflected in H-310.912 (E), “Residents and Fellows’ Bill of Rights,” as follows: “(1) With regard to contracts, residents and fellows should receive: ... b. At least four months advance notice of contract non-renewal and the reason for non-renewal.”
Sub. Res. 310, A-99 Reaffirmed: CME Rep. 2, A-09	

H-310.947, “Revision of the ‘General Requirements’ of the Essentials of Accredited Residency Programs”

Original language	Rationale for rescission
The AMA supports the following principles of the ACGME Institutional Requirements: Candidates for residencies must be fully informed of benefits including financial support,	Still relevant, but rescind and incorporate into H-310.912 (E.3), “Residents and Fellows’ Bill of Rights.”

<p>vacations, professional leave, parental leave, sick leave, professional liability insurance, hospital and health insurance, disability insurance, and other insurance benefits for the residents and their family and the conditions under which living quarters, meals and laundry or their equivalent are to be provided. Institutions sponsoring graduate medical education must provide access to insurance, where available, to all residents for disabilities resulting from activities that are part of the educational program. Institutions should have a written policy and an educational program regarding physician impairment, including substance abuse.</p>	<p>Note: This policy is also reflected in ACGME Institution Requirements, effective July 1, 2018, under IV.A.3., III.B.7.b), and IV.B.</p>
<p>CME Rep. Q, A-93 Modified: CME Rep. 2, A-03 Reaffirmed: CME Rep. 2, A-13</p>	

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

Original language	Rationale for rescission
<p>(1) Our AMA supports the following principles regarding the supervision of residents and the avoidance of the harmful effects of excessive fatigue and stress:</p>	<p>Still relevant, but rescind and incorporate relevant aspects into other policies, as noted below.</p>
<p>(a) Exemplary patient care is a vital component for any program of graduate medical education. Graduate medical education enhances the quality of patient care in the institution sponsoring an accredited residency program. Graduate medical education must never compromise the quality of patient care.</p>	<p>Incorporate into H-310.929 (1), “Principles for Graduate Medical Education.”</p>
<p>(b) Institutions sponsoring residency programs and the director of each program must assure the highest quality of care for patients and the attainment of the program’s educational objectives for the residents.</p>	

Original language	Rationale for rescission
<p>(c) Institutional commitment to graduate medical education must be evidenced by compliance with Section III.B.4 of the ACGME Institutional Requirements, effective July 1, 2007: The sponsoring institution's GME Committee must [m]onitor programs' supervision of residents and ensure that supervision is consistent with: (i) Provision of safe and effective patient care; (ii) Educational needs of residents; (iii) Progressive responsibility appropriate to residents' level of education, competence, and experience; and (iv) Other applicable Common and specialty/subspecialty specific Program Requirements.</p> <p>(d) The program director must be responsible for the evaluation of the progress of each resident and for the level of responsibility for the care of patients that may be safely delegated to the resident.</p> <p>(e) Each patient's attending physician must decide, within guidelines established by the program director, the extent to which responsibility may be delegated to the resident, and the appropriate degree of supervision of the resident's participation in the care of the patient. The attending physician, or designate, must be available to the resident for consultation at all times.</p> <p>(f) The program director, in cooperation with the institution, is responsible for maintaining work schedules for each resident based on the intensity and variability of assignments in conformity with Residency Review Committee (RRC) recommendations, and in compliance with the ACGME duty hour standards.</p>	<p>Incorporate relevant aspects into H-310.929 (12), "Principles for Graduate Medical Education."</p>
<p>(g) The program director, with institutional support, must assure for each resident effective counseling as stated in Section II.D.4.k of the Institutional requirements: "Counseling services: The Sponsoring Institution should facilitate residents' access to confidential counseling, medical, and psychological support services."</p>	<p>Rescind; already reflected in H-295.858, "Access to Confidential Health Services for Medical Students and Physicians," as follows:</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</p>

Original language	Rationale for rescission
	external site, or through telemedicine or other virtual, online means.”
<p>(h) As stated in the ACGME Institutional Requirements (II.F.2.a-c), “The Sponsoring Institution must provide services and develop health care delivery systems to minimize residents’ work that is extraneous to their GME programs’ educational goals and objectives.” These include patient support services, laboratory/pathology/radiology services, and medical records.</p>	<p>Rescind; already reflected in H-310.912 (A), “Residents and Fellows’ Bill of Rights,” as follows:</p> <p>“With regard to education, residents and fellows should expect: . . . (3) Adequate clerical and clinical support services that minimize the extraneous, time-consuming work that draws attention from patient care issues and offers no educational value.”</p> <p>Also reflected in H-310.907 (7), “AMA duty hours policy,” as follows:</p> <p>“i) Scheduled time providing patient care services of limited or no educational value should be minimized.”</p>
<p>(i) Is neither feasible nor desirable to develop universally applicable and precise requirements for supervision of residents. As stated in the ACGME Common Program Requirements (VI.B) “the program must ensure that qualified faculty provide appropriate supervision of residents in patient care activities.”</p>	<p>Incorporate into H-310.912 (B), “Residents and Fellows’ Bill of Rights.”</p>
<p>(j) Individual resident compensation and benefits must not be compromised or decreased as a result of these recommended changes in the graduate medical education system.</p>	<p>Incorporate into H-310.907 (7.n), “AMA duty hours policy.”</p>
<p>(2) These problems should be addressed within the present system of graduate medical education, without regulation by agencies of government.</p>	<p>Rescind; already reflected in H-310.907 (7), “AMA duty hours policy,” as follows:</p> <p>“k) The medical profession maintains the right and responsibility for self-regulation (one of the key tenets of professionalism) through the ACGME and its purview over graduate medical education, and categorically rejects involvement by the Centers for Medicare & Medicaid Services, The Joint Commission, Occupational Safety and Health Administration, and any other federal or state government bodies in the monitoring and enforcement of duty hour regulations, and opposes any regulatory or legislative proposals to limit the duty hours of practicing physicians.”</p>
<p>CME Rep. C, I-87; Modified: Sunset Report, I-97; Modified and Reaffirmed: CME Rep. 2, A-08</p>	

H-310.988, “Adequate Resident Compensation”

Original language	Rationale for rescission
The AMA believes that housestaff should receive adequate compensation by their training programs.	Still relevant, but rescind; already reflected in H-310.912 (E.2), “Residents and Fellows’ Bill of Rights,” and H-310.929 (7), “Principles for Graduate Medical Education.”
Sub. Res. 124, A-85 Reaffirmed by CLRPD Rep. 2, I-95 Reaffirmed: CME Rep. 2, A-05 Reaffirmed: CME Rep. 1, A-15	

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

Original language	Rationale for rescission
The “Essentials of Approved Residencies, “ approved by the House of Delegates in 1970, includes a section on relationships of housestaff and institutions. The following outline is intended to promote additional guidance to all parties in establishing the conditions under which house officers learn and provide services to patients.	Rescind; superseded by more recent AMA policy, including H-310.929, “Principles for Graduate Medical Education,” H-310.912, “Residents and Fellows’ Bill of Rights,” H-225.950, “AMA Principles for Physician Employment,” Code of Medical Ethics 9.2.4, “Disputes Between Medical Supervisors & Trainees,” H-225.942, “Physician and Medical Staff Member Bill of Rights,” along with the AMA Annotated Model Physician-Hospital Employment Agreement and AMA Annotated Model Physician-Group Practice Employment Agreement (see https://www.ama-assn.org/life-career/understanding-employment-contracts).
Training programs have been central to the process of graduate medical education which has produced a high level of medical competence in the United States. The American Medical Association recognizes that the integrity of these programs is a primary objective in achieving the best possible care of the patient. It is, therefore, incumbent upon members of the housestaff and the institutions in which they are being trained to be aware of the parameters and responsibilities applicable to their training programs. In the absence of such awareness, unreasonable expectations may arise to threaten the harmony between hospital and housestaff in the performance of their joint mission.	
It should be emphasized that these guidelines are not intended as a fixed formula. Guidelines that seek to cover public, voluntary and proprietary hospitals necessarily entail so many variables from training institution to training institution that no single form of contract or agreement would be universally applicable. This set of guidelines has, therefore, been developed to	

<p>cover the more significant substantive provisions of a housestaff contract or agreement.</p>	
<p>The subjects included in the Guidelines are not intended to be the only subjects important or appropriate for a contract or agreement. Moreover, the definition of the respective responsibilities, rights and obligations of the parties involved can assume various forms: individual contracts or agreements, group contracts or agreements, or as a part of the rules of government of the institution.</p>	
<p>II. Proposed Terms and Conditions A. Parties to the Contract or Agreement (1) Contracts or agreements may be formed between individuals or groups, and institutions. Such a group might be a housestaff organization. (2) The two parties to an agreement or contract may be a single institution or a group of institutions, and an individual member of the housestaff, an informal group of the housestaff, or a formally constituted group or association of the housestaff, as determined by the housestaff organization.</p>	
<p>B. General Principles (1) Contracts or agreements are legal documents and must conform to the laws, rules, and regulation to which the institutions are subject. Position, salary and all other benefits should remain in effect insofar as possible without regard to rotational assignments even when the member of the housestaff is away from the parent institution. Exceptions required by law or regulations should be clearly delineated to the house officer at the time of the appointment. Changes in the number of positions in each year of a training program should be made so as not to affect adversely persons already in, or accepted in, that program. The agreement should provide fair and equitable conditions of employment for all those performing the duties of interns, residents and fellows. When a general contract or agreement is in effect between an association and an institution, individual contracts or agreements should be consistent. (2) Adequate prior notification of either party's intent not to review the contract or agreement should be required, and the date of such notification should be included in the contract or agreement. (3) The institution and the individual members of the housestaff must accept and recognize the right of the housestaff to determine the means by which the housestaff may organize its affairs, and both</p>	

<p>parties should abide by that determination; provided that the inherent right of a member of the housestaff to contract and negotiate freely with the institution, individually or collectively, for terms and conditions of employment and training should not be denied or infringed. No contract should require or prescribe that members of the housestaff shall or shall not be members of an association or union.</p>	
<p>C. Obligation of the Housestaff (1) Members of the housestaff agree to fulfill the educational requirements of the graduate training programs, and accept the obligation to use their efforts to provide safe, effective and compassionate patient care as assigned or required under the circumstances as delineated in the ACGME “Essentials of Approved Residencies” and previously approved standards of the AMA Council on Medical Education. (2) Members of the housestaff should comply with the laws, regulations, and policies to which the institution is subject.</p>	
<p>D. Obligation of the Institution (1) The institution agrees to provide an educational program that meets the standards of the ACGME “Essentials of Approved Residencies.” (2) The institution agrees to maintain continuously its staff and its facilities in compliance with all of the standards in the ACGME “Essentials of Approved Residencies.”</p>	
<p>E. Salary for Housestaff (1) The salary to be paid and the frequency of payment should be specified. The salary schedule should be published. The basis for increments and the time of the increments should be specified. (2) In determining the salary level of a member of the housestaff, prior educational experience should be considered, and a determination made as to whether credit should be given. (3) The responsibilities of senior residents should be recognized in salary differentials.</p>	
<p>F. Hours of Work There should be recognition of the fact that long duty hours extending over an unreasonably long period of time or onerous on-call schedules are not consistent with the primary objective of education or the efficient delivery of optimal patient care. The institution should commit itself to fair scheduling of duty time for all members of</p>	

<p>the housestaff, including the provision of adequate off-duty hours.</p>	
<p>G. Off-Duty Activities The contract or agreement should provide that a member of the housestaff is free to use his off-duty hours as he sees fit, including engaging in outside employment if permitted by the terms of the original contract or agreement, so long as such activity does not interfere with his obligations to the institution or to the effectiveness of the educational program to which he has been appointed.</p>	
<p>H. Vacation and Leave The AMA encourages residency programs across the country to permit and schedule off-duty time separate from personal vacation time to enable residents to attend educational and/or organized medicine conferences. The amount of vacation, sick leave, and educational leave to which each member of the housestaff is entitled should be specified. Vacations should be expressed in terms of customary working days as defined by the institution. If vacations may be taken only at certain times of the year, this restriction should be stated. Any requirements for scheduling vacation time should also be stated. Provisions may also cover leaves for maternity, paternity, bereavement, military duty, examinations and preparations therefor, and educational conferences. Reimbursement for tuition and expenses incurred at educational conferences should be considered. The agreement should set forth any progressive increases in the amount of time allowed for vacation, sick leave, and educational leave. Educational leave should not be deducted from vacation time.</p>	
<p>I. Insurance Benefits Insurance benefits should be set forth with particularity and should be tailored to the specific needs of the housestaff. Some of the more common insurance benefit provisions are (1) hospitalization and basic medical coverage for the member of the housestaff, spouse, and minor children; (2) major medical coverage for the member of the housestaff, spouse, and minor children; and (3) group life insurance, and dismemberment and disability insurance for the member of the housestaff only. It should also be specified whether the institution will pay the full amount of premiums or only a portion of the premiums, the balance to be paid by the member of the housestaff. Co-paid benefits should be</p>	

<p>established, separately from other hospital employee benefits, as a means of maximizing benefits. In some instances, free care for the housestaff and their families at the training institutions may be provided. In lieu of insurance benefits, the contract or agreement may provide for fixed annual payments to a housestaff association for each member of the housestaff so that the housestaff association may determine and provide for insurance or other benefits for the housestaff.</p>	
<p>J. Professional Liability Insurance The contract or agreement should specify the amount of professional liability insurance that the institution will provide for each member of the housestaff together with the limits of liability applicable to such coverage. It might also be appropriate to provide in the contract or agreement that the housestaff and the institution will cooperate fully with the insurance company in the handling of any professional liability claim.</p>	
<p>K. Committee Participation Insofar as possible, the institution should agree to provide for appropriate participation by the housestaff on the various committees within the institution. This participation should be on committees concerning institutional, professional and administrative matters including grievance and disciplinary proceedings. Members should have full voting rights. Representatives of the housestaff should be selected by the members of the housestaff.</p>	
<p>L. Grievance Procedures The contract or agreement should require and publish a grievance procedure. A grievance procedure typically involves the following: (1) A definition of the term "grievance" (e.g., any dispute or controversy about the interpretation or application of the contract, any rule or regulation, or any policy or practice). (2) The timing, sequence, and end point of the grievance procedure. (3) The right to legal or other representation. (4) The right of an individual member of the housestaff or a housestaff association to initiate a grievance procedure and the obligation of the housestaff to maintain patient care during the grievance procedure. (5) A statement of the bases and procedures for the final decision on grievances (end point), and agreement of both parties to abide by the decision. (6) Should costs arise in the grievance</p>	

<p>procedure, a prior agreement as to how these costs will be apportioned between the parties.</p>	
<p>M. Disciplinary Hearings and Procedure With respect to disciplinary procedures, the provisions of Article VIII - Hearing and Appellate Review Procedure of the JCAHO Guidelines for the Formulation of Medical Staff Bylaws, Rules, and Regulations shall be applicable to the housestaff in the same manner as they are to all other members of the medical staff with the proviso that the Hearing and Appeals Committees shall contain appropriate representation of the housestaff.</p>	
<p>N. Description of the Educational Program The specific details of the operation of the educational experience should be made available to each prospective candidate. These data should include specific descriptions of training programs, including numbers of resident positions at each level of training, copies of existing housestaff contracts or agreements, approval status of programs to which candidate is applying, methods of evaluation, procedures for grievances and disciplinary action, and commitments for further training.</p>	
<p>O. Patient-Care Issues The quality of patient-care services and facilities may be specified in the contract, and could include such matters as adequate equipment, bedspace, clinical staffing, and clinical staff structuring.</p>	
<p>P. Other Provisions The agreement should provide for adequate, comfortable, safe, and sanitary facilities.</p>	
<p>The foregoing provisions are not all-inclusive. Depending upon the institution's size, resources, location, and affiliations, if any, and also depending upon the relationship between the institution and the housestaff association, other provisions may be included, such as: (1) Maintenance of existing benefits and practices not otherwise expressly covered; (2) Housing, meals, laundry, uniforms, living-out and telephone allowances; (3) Adequate office space, facilities, and supporting services for housestaff affairs; (4) Housestaff association seminars and meetings</p>	
<p>BOT Rep. H, I-74; Reaffirmed: CLRPD Rep. C, A-89; Appended: Res.323, I-97; Reaffirmation A-00; Reaffirmation A-08</p>	

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 951
(I-18)

Introduced by: Resident and Fellow Section

Subject: Prevention of Physician and Medical Student Suicide

Referred to: Reference Committee C
(Peter C. Amadio, MD, Chair)

- 1 Whereas, The rate of suicide completion among medical professionals exceeds that of the
2 combined U.S. population; and
3
4 Whereas, Suicides among physicians are perceived as isolated events¹; and
5
6 Whereas, Job stress is an independent risk factor for physician suicide²; and
7
8 Whereas, More understanding is needed about what systemic factors lead physicians to
9 suicide; and
10
11 Whereas, Current AMA policy addresses a physician's or student's responsibility to seek mental
12 health care, and encourages confidential reporting of risk factors by medical students, but does
13 not include consequences for institutions that do not work to prevent suicide; and
14
15 Whereas, Work conditions beyond resident work hours, such as bullying, can contribute to
16 suicide³; and
17
18 Whereas, Media coverage of physician suicide has increased dramatically in the past year;
19 therefore be it
20
21 RESOLVED, That our American Medical Association request that the Liaison Committee on
22 Medical Education and the Accreditation Council for Graduate Medical Education collect data on
23 medical student, resident and fellow suicides to identify patterns that could predict such events.
24 (Directive to Take Action)

Fiscal Note: Minimal - less than \$1,000.

Received: 09/27/18

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

References:

- 1 <https://www.fastcompany.com/3056015/thehiddenepidemicofdoctorsuicides>
- 2 <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3549025/#idm140038005580816aff-infotitle>
- 3 <http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0150246>

RELEVANT AMA POLICY

Access to Confidential Health Services for Medical Students and Physicians H-295.858

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:
 - 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;
 - 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;
 - 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
 - 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.
 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" 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.
 3. Our AMA encourages medical schools to create mental health and substance abuse awareness and suicide prevention screening programs that would:
 - A. be available to all medical students on an opt-out basis;
 - B. ensure anonymity, confidentiality, and protection from administrative action;
 - C. provide proactive intervention for identified at-risk students by mental health and addiction professionals; and
 - D. inform students and faculty about personal mental health, substance use and addiction, and other risk factors that may contribute to suicidal ideation.
 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.
 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.
 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.
 7. Our AMA will engage with the appropriate organizations to facilitate the development of educational resources and training related to suicide risk of patients, medical students, residents/fellows, practicing physicians, and other health care professionals, using an evidence-based multidisciplinary approach.
- Citation: CME Rep. 01, I-16; Appended: Res. 301, A-17; Appended: Res. 303, A-17; Modified: CME Rep. 01, A-18; Appended: Res. 312, A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 952
(I-18)

Introduced by: International Medical Graduates Section
Subject: IMG Section Member Representation on Committees/Task Forces/Councils
Referred to: Reference Committee C
(Peter C. Amadio, MD, Chair)

1 Whereas, The American Medical Association has a very good, long-standing relationship with
2 the Educational Commission for Foreign Medical Graduates (ECFMG); and
3
4 Whereas, The AMA has a dedicated section for international medical graduates, the AMA-IMG
5 Section; and
6
7 Whereas, The AMA has the ability to appoint regularly one representative to the ECFMG Board
8 of Trustees; and
9
10 Whereas, The ECFMG mission is to promote quality health care for the public by certifying
11 international medical graduates for entry into U.S. graduate medical education, and by
12 participating in the evaluation and certification of other physicians and health care professionals
13 nationally and internationally; and
14
15 Whereas, IMGs are the main reason of existence of the ECFMG and represent 26% of the
16 physician workforce in the U.S.; and
17
18 Whereas, IMGs are best suited to understand and decipher IMG issues; therefore be it
19
20 RESOLVED, That the American Medical Association ask the Educational Commission for
21 Foreign Medical Graduates (ECFMG) to increase the number of international medical graduates
22 (IMGs) proportionate to the percentage of IMGs serving in the U.S. on their councils,
23 committees, and/or task forces. (Directive to Take Action)

Fiscal Note: Minimal - less than \$1,000.

Received: 09/28/18

Reference:
<https://www.ecfm.org/about/leadership.html>

RELEVANT AMA POLICY

AMA Principles on International Medical Graduates H-255.988

Our AMA supports:

1. Current U.S. visa and immigration requirements applicable to foreign national physicians who are graduates of medical schools other than those in the United States and Canada.
2. Current regulations governing the issuance of exchange visitor visas to foreign national IMGs, including the requirements for successful completion of the USMLE.

3. The AMA reaffirms its policy that the U.S. and Canada medical schools be accredited by a nongovernmental accrediting body.
4. Cooperation in the collection and analysis of information on medical schools in nations other than the U.S. and Canada.
5. Continued cooperation with the ECFMG and other appropriate organizations to disseminate information to prospective and current students in foreign medical schools. An AMA member, who is an IMG, should be appointed regularly as one of the AMA's representatives to the ECFMG Board of Trustees.
6. Working with the Accreditation Council for Graduate Medical Education (ACGME) and the Federation of State Medical Boards (FSMB) to assure that institutions offering accredited residencies, residency program directors, and U.S. licensing authorities do not deviate from established standards when evaluating graduates of foreign medical schools.
7. In cooperation with the ACGME and the FSMB, supports only those modifications in established graduate medical education or licensing standards designed to enhance the quality of medical education and patient care.
8. The AMA continues to support the activities of the ECFMG related to verification of education credentials and testing of IMGs.
9. That special consideration be given to the limited number of IMGs who are refugees from foreign governments that refuse to provide pertinent information usually required to establish eligibility for residency training or licensure.
10. That accreditation standards enhance the quality of patient care and medical education and not be used for purposes of regulating physician manpower.
11. That AMA representatives to the ACGME, residency review committees and to the ECFMG should support AMA policy opposing discrimination. Medical school admissions officers and directors of residency programs should select applicants on the basis of merit, without considering status as an IMG or an ethnic name as a negative factor.
12. The requirement that all medical school graduates complete at least one year of graduate medical education in an accredited U.S. program in order to qualify for full and unrestricted licensure.
13. Publicizing existing policy concerning the granting of staff and clinical privileges in hospitals and other health facilities.
14. The participation of all physicians, including graduates of foreign as well as U.S. and Canadian medical schools, in organized medicine. The AMA offers encouragement and assistance to state, county, and specialty medical societies in fostering greater membership among IMGs and their participation in leadership positions at all levels of organized medicine, including AMA committees and councils and state boards of medicine, by providing guidelines and non-financial incentives, such as recognition for outstanding achievements by either individuals or organizations in promoting leadership among IMGs.
15. Support studying the feasibility of conducting peer-to-peer membership recruitment efforts aimed at IMGs who are not AMA members.
16. AMA membership outreach to IMGs, to include a) using its existing publications to highlight policies and activities of interest to IMGs, stressing the common concerns of all physicians; b) publicizing its many relevant resources to all physicians, especially to nonmember IMGs; c) identifying and publicizing AMA resources to respond to inquiries from IMGs; and d) expansion of its efforts to prepare and disseminate information about requirements for admission to accredited residency programs, the availability of positions, and the problems of becoming licensed and entering full and unrestricted medical practice in the U.S. that face IMGs. This information should be addressed to college students, high school and college advisors, and students in foreign medical schools.
17. Recognition of the common aims and goals of all physicians, particularly those practicing in the U.S., and support for including all physicians who are permanent residents of the U.S. in the mainstream of American medicine.

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

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

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

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

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

(BOT Rep. Z, A-86 Reaffirmed: Res. 312, I-93 Modified: CME Rep. 2, A-03 Reaffirmation I-11 Reaffirmed: CME Rep. 1, I-13 Modified: BOT Rep. 25, A-15 Modified: CME Rep. 01, A-16 Appended: Res. 304, A-17 Modified: CME Rep. 01, I-17)

Visa Complications for IMGs in GME D-255.991

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

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

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

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

(Res. 844, I-03 Reaffirmation A-09 Reaffirmation I-10 Appended: CME Rep. 10, A-11 Appended: Res. 323, A-12)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 953
(I-18)

Introduced by: Resident and Fellow Section
Subject: Support for the Income-Driven Repayment Plans
Referred to: Reference Committee C
(Peter C. Amadio, MD, Chair)

1 Whereas, Since 2009 the U.S. Department of Education created several Income-Driven
2 Repayment (IDR) plans that allow borrowers to select one of five plans for repaying their loans
3 with base payment amounts based on the borrower's income and repayment periods extended
4 from the standard ten years to up to twenty-five years with any remaining balance forgiven at the
5 end of that period (these new loans went into effect for all new loans as of July 1, 2014)¹; and
6
7 Whereas, The cost of these plans had not been adequately budgeted for by the Department of
8 Education, leading to proposed budget cuts to programs including IDR plans and the Public
9 Service Loan Forgiveness (PSLF) program¹⁻³; and
10
11 Whereas, Our AMA has made a concerted effort to reduce the burden of student loan debt, but
12 has not specifically address IDR plans and their relevance to current and future medical
13 students; therefore be it
14
15 RESOLVED, That our American Medical Association advocate for continued funding of
16 programs including Income-Driven Repayment plans for the benefit of reducing medical student
17 loan burden. (New HOD Policy)

Fiscal Note: Modest - between \$1,000 - \$5,000.

Received: 09/27/18

References:

1 <https://www.gao.gov/products/GAO-17-22>

2 https://www.washingtonpost.com/news/grade-point/wp/2017/05/17/trump-and-devos-plan-to-reshape-higher-education-finance-heres-what-it-might-mean-for-you/?utm_term=.45d5f0a6d200

3 <https://www.cnn.com/2017/05/24/trumps-budget-seeks-to-cut-one-major-benefit-of-federal-student-loans.html>

RELEVANT AMA POLICY

H-305.965 Student Loans

Our AMA: (1) reaffirms its support of legislation that would defer the repayment of loans for education until the completion of residency training; and (2) will lobby for deferment of medical student loans for the full initial residency period. (Sub. Res. 203, A-90; Appended Res. 306, I-99; Reaffirmation A-01; Reaffirmation I-06; Modified: CME Rep 01, A-16)

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

Our AMA will:

1. Collaborate, based on AMA policy, with members of the Federation and the medical education community, and with other interested organizations, to achieve the following immediate public- and private-sector advocacy goals:

- (a) Support expansion of and adequate funding for federal scholarship and loan repayment programs, such as those from the National Health Service Corps, the Indian Health Service, the Armed Forces, and the Department of Veterans Affairs, and for comparable programs at the state level.
 - (b) Encourage the expansion of National Institutes of Health programs that provide loan repayment in exchange for a commitment to conduct targeted research.
 - (c) With each reauthorization of the Higher Education Act and at every other legislative opportunity, proactively pursue loan consolidation terms that favor students and ensure that loan deferment is available for the entire duration of residency and fellowship training.
 - (d) Ensure that the Higher Education Act and other legislation allow interest from medical student loans to be fully tax deductible.
 - (e) Encourage medical schools, with the support of the Federation, to engage in fundraising activities devoted to increasing the availability of scholarship support.
 - (f) Encourage the creation of private-sector financial aid programs with favorable interest rates or service obligations (such as community- or institution-based loan repayment programs or state medical society loan programs).
 - (g) Support stable funding for medical education programs to limit excessive tuition increases.
2. Encourage medical schools to study the costs and benefits associated with non-traditional instructional formats (such as online and distance learning, combined baccalaureate/MD programs) to determine if cost savings to medical schools and to medical students could be realized without jeopardizing the quality of medical education. (CME Rep. 13, A-06; Reaffirmation I-08)

D-305.978 Mechanisms to Reduce Medical Student Debt

Our AMA will:

- (1) take an active advocacy role during the upcoming reauthorization of the Higher Education Act and other pending legislation, to achieve the following goals: (a) eliminating the single holder rule, (b) making the availability of loan deferment more flexible, including broadening the definition of economic hardship and expanding the period for loan deferment to include the entire length of residency and fellowship training, (c) retaining the option of loan forbearance for residents ineligible for loan deferment, (d) including, explicitly, dependent care expenses in the definition of the "cost of attendance," (e) including room and board expenses in the definition of tax-exempt scholarship income, (f) continuing the loan consolidation program, including the ability to "lock in" a fixed interest rate, and (g) adding the ability to refinance Federal Consolidation Loans;
- (2) continue to work with state and county medical societies to advocate for adequate levels of medical school funding and to oppose legislative or regulatory provisions that would result in significant or unplanned tuition increases;
- (3) encourage members of the Federation to develop or enhance financial aid opportunities for medical students;
- (4) continue to monitor the availability of financial aid opportunities and financial planning/debt management counseling at medical schools, and share innovative approaches with the medical education community;
- (5) continue to collect and disseminate information to assist members of the Federation (state medical societies and specialty societies) and medical schools to establish or expand financial aid programs; and
- (6) continue to study medical education financing, so as to identify long-term strategies to mitigate the debt burden of medical students. (CME Rep. 10, A-04; Reaffirmation I-08)

D-305.980 Immediate Legislative Solutions to Medical Student Debt

Our AMA will: (1) endorse and actively lobby for the Reauthorization of the Higher Education Act, including: (a) Elimination of the "single-holder" rule; (b) Continuation of the consolidation loan program and a consolidator's ability to lock in a fixed interest rate; (c) Expansion of the deferment period for loan repayment to cover the entire duration of residency and fellowship; (d) Broadening of the definition of economic hardship as used to determine eligibility for student loan deferment; (e) Retention of the option of loan forbearance for residents who are ineligible for student loan deferment; and (f) Inclusion of dependent care expenses in the definition of "cost of attendance"; and

(2) lobby for passage of legislation that would: (a) Eliminate the cap on the student loan interest deduction; (b) Increase the income limits for taking the interest deduction; (c) Include room and board expenses in the definition of tax-exempt scholarship income; and (d) Make permanent the education tax incentives that our AMA successfully lobbied for as part of Economic Growth and Tax Relief Reconciliation Act of 2001. (Res. 850, I-03; Reaffirmation I-08)

D-305.984 Reduction in Student Loan Interest Rates

1. Our AMA will actively lobby for legislation aimed at establishing an affordable student loan structure with a variable interest rate capped at no more than 5.0%.
2. Our AMA will work in collaboration with other health profession organizations to advocate for a reduction of the fixed interest rate of the Stafford student loan program and the Graduate PLUS loan program.
3. Our AMA will consider the total cost of loans including loan origination fees and benefits of federal loans such as tax deductibility or loan forgiveness when advocating for a reduction in student loan interest rates.
4. Our AMA will advocate for policies which lead to equal or less expensive loans (in terms of loan benefits, origination fees, and interest rates) for Grad-PLUS loans as this would change the status quo of high-borrowers paying higher interest rates and fees in addition to having a higher overall loan burden.
5. Our AMA will work with appropriate organizations, such as the Accreditation Council for Graduate Medical Education and the Association of American Medical Colleges, to collect data and report on student indebtedness that includes total loan costs at completion of graduate medical education training. (Res. 316, A-03; Reaffirmed: BOT Rep. 28, A-13; Appended: Res. 302, A-13; Modified and Appended: 301, A-16)

Medical School Financing, Tuition, and Student Debt D-305.993

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 developing web-based information on financial planning/debt management; introducing a loan consolidation program, automatic bill collection, 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.
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.
6. 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.
7. 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.
8. 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.
9. Our AMA will advocate against putting a monetary cap on federal loan forgiveness programs.
10. 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.
11. 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.

12. Our AMA will advocate that the profit status of a physician's training institution not be a factor for PSLF eligibility.

13. 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.

14. 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.

15. 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.

Citation: CME Rep. 2, I-00; Reaffirmation I-03; Reaffirmation I-06; Reaffirmation A-13; Appended: Res. 323, A-14; Appended: Res. 324, A-15; Appended: Res. 318, A-16; Appended: CME Rep. 07, A-17;

Modified: CME Rep. 01, A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 954
(I-18)

Introduced by: American Academy of Dermatology, American Society for Dermatologic Surgery Association, American Society of Dermatopathology

Subject: VHA GME Funding

Referred to: Reference Committee C
(Peter C. Amadio, MD, Chair)

1 Whereas, The Veterans Health Administration (VHA) takes pride in providing the largest
2 education and training enterprise for graduate medical education (GME), training over 40,000
3 resident physicians annually¹; and
4
5 Whereas, Resident physicians provide care directly to veterans and expand VHA's clinical
6 capacity, allowing VHA patients to be seen more quickly¹; and
7
8 Whereas, VHA provides care in a team-based, patient centered, interprofessional work
9 environment with innovative technologies for care, which models the future of integrated health
10 care delivery¹; and
11
12 Whereas, VHA is working to expand graduate medical education in primary care, mental health,
13 and areas of physician shortages¹; and
14
15 Whereas, Increasing physician shortages nationwide are predicted in primary care and specialty
16 care, including in the VA system; and 60% of current VHA physicians received training with
17 VHA^{1,2}; and
18
19 Whereas, Our American Medical Association supports GME expansion³; and
20
21 Whereas, The ongoing funding of the VA Missions Act expanding private health care options will
22 cost billions and its funding may result in cuts to existing VHA programs⁴; therefore be it
23
24 RESOLVED, That our American Medical Association continue to support the mission of the
25 Department of Veterans Affairs Office of Academic Affiliations for expansion of graduate
26 medical education (GME) residency positions (Directive to Take Action); and be it further
27
28 RESOLVED, That our AMA collaborate with appropriate stakeholder organizations to advocate
29 for preservation of Veterans Health Administration (VHA) funding for GME and support its
30 efforts to expand GME residency positions in the federal budget and appropriations process
31 (Directive to Take Action); and be it further
32
33 RESOLVED, That our AMA oppose service obligations linked to VHA GME residency or
34 fellowship positions, particularly for resident physicians rotating through the VA for only a portion
35 of their GME training. (New HOD Policy)

Fiscal Note: Modest - between \$1,000 - \$5,000.

Received: 09/28/18

¹ VA.gov

² https://aamc-black.global.ssl.fastly.net/production/media/filer_public/85/d7/85d7b689-f417-4ef0-97fb-ecc129836829/aamc_2018_workforce_projections_update_april_11_2018.pdf

³ The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education D-305.967

⁴ <https://www.stripes.com/news/mission-act-gets-funding-under-historically-high-va-budget-agreement-1.547070>

RELEVANT AMA POLICY

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

1. Our AMA will actively collaborate with appropriate stakeholder organizations, (including Association of American Medical Colleges, American Hospital Association, state medical societies, medical specialty societies/associations) to advocate for the preservation, stability and expansion of full funding for the direct and indirect costs of graduate medical education (GME) positions from all existing sources (e.g. Medicare, Medicaid, Veterans Administration, CDC and others).
2. Our AMA will actively advocate for the stable provision of matching federal funds for state Medicaid programs that fund GME positions.
3. Our AMA will actively seek congressional action to remove the caps on Medicare funding of GME positions for resident physicians that were imposed by the Balanced Budget Amendment of 1997 (BBA-1997).
4. Our AMA will strenuously advocate for increasing the number of GME positions to address the future physician workforce needs of the nation.
5. Our AMA will oppose efforts to move federal funding of GME positions to the annual appropriations process that is subject to instability and uncertainty.
6. Our AMA will oppose regulatory and legislative efforts that reduce funding for GME from the full scope of resident educational activities that are designated by residency programs for accreditation and the board certification of their graduates (e.g. didactic teaching, community service, off-site ambulatory rotations, etc.).
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 private sources) to fund both the direct and indirect costs of GME.
9. Our AMA will work, in collaboration with other stakeholders, to improve the awareness of the general public that GME is a public good that provides essential services as part of the training process and serves as a necessary component of physician preparation to provide patient care that is safe, effective and of high quality.
10. Our AMA staff and governance will continuously monitor federal, state and private proposals for health care reform for their potential impact on the preservation, stability and expansion of full funding for the direct and indirect costs of GME.
11. Our AMA: (a) recognizes that funding for and distribution of positions for GME are in crisis in the United States and that meaningful and comprehensive reform is urgently needed; (b) will immediately work with Congress to expand medical residencies in a balanced fashion based on expected specialty needs throughout our nation to produce a geographically distributed and appropriately sized physician workforce; and to make increasing support and funding for GME programs and residencies a top priority of the AMA in its national political agenda; and (c) will continue to work closely with the Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, American Osteopathic Association, and other key stakeholders to raise awareness among policymakers and the public about the importance of expanded GME funding to meet the nation's current and anticipated medical workforce needs.
12. Our AMA will collaborate with other organizations to explore evidence-based approaches to quality and accountability in residency education to support enhanced funding of GME.
13. Our AMA will continue to strongly advocate that Congress fund additional graduate medical education (GME) positions for the most critical workforce needs, especially considering the current and worsening maldistribution of physicians.

14. Our AMA will advocate that the Centers for Medicare and Medicaid Services allow for rural and other underserved rotations in Accreditation Council for Graduate Medical Education (ACGME)-accredited residency programs, in disciplines of particular local/regional need, to occur in the offices of physicians who meet the qualifications for adjunct faculty of the residency program's sponsoring institution.
15. Our AMA 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.
16. Our AMA encourages the ACGME and the American Osteopathic Association (AOA) to continue to develop and disseminate innovative methods of training physicians efficiently that foster the skills and inclinations to practice in a health care system that rewards team-based care and social accountability.
17. Our AMA will work with interested state and national medical specialty societies and other appropriate stakeholders to share and support legislation to increase GME funding, enabling a state to accomplish one or more of the following: (a) train more physicians to meet state and regional workforce needs; (b) train physicians who will practice in physician shortage/underserved areas; or (c) train physicians in undersupplied specialties and subspecialties in the state/region.
18. Our AMA supports the ongoing efforts by states to identify and address changing physician workforce needs within the GME landscape and continue to broadly advocate for innovative pilot programs that will increase the number of positions and create enhanced accountability of GME programs for quality outcomes.
19. Our AMA will continue to work with stakeholders such as Association of American Medical Colleges (AAMC), ACGME, AOA, American Academy of Family Physicians, American College of Physicians, and other specialty organizations to analyze the changing landscape of future physician workforce needs as well as the number and variety of GME positions necessary to provide that workforce.
20. Our AMA will explore innovative funding models for incremental increases in funded residency positions related to quality of resident education and provision of patient care as evaluated by appropriate medical education organizations such as the Accreditation Council for Graduate Medical Education.
21. Our AMA will utilize its resources to share its content expertise with policymakers and the public to ensure greater awareness of the significant societal value of graduate medical education (GME) in terms of patient care, particularly for underserved and at-risk populations, as well as global health, research and education.
22. Our AMA will advocate for the appropriation of Congressional funding in support of the National Healthcare Workforce Commission, established under section 5101 of the Affordable Care Act, to provide data and healthcare workforce policy and advice to the nation and provide data that support the value of GME to the nation.
23. Our AMA supports recommendations to increase the accountability for and transparency of GME funding and continue to monitor data and peer-reviewed studies that contribute to further assess the value of GME.
24. Our AMA will explore various models of all-payer funding for GME, especially as the Institute of Medicine (now a program unit of the National Academy of Medicine) did not examine those options in its 2014 report on GME governance and financing.
25. Our AMA encourages organizations with successful existing models to publicize and share strategies, outcomes and costs.
26. 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.
27. Our AMA will develop, along with other interested stakeholders, a national campaign to educate the public on the definition and importance of graduate medical education, student debt and the state of the medical profession today and in the future.
28. Our AMA will collaborate with other stakeholder organizations to evaluate and work to establish consensus regarding the appropriate economic value of resident and fellow services.
29. Our AMA will monitor ongoing pilots and demonstration projects, and explore the feasibility of broader implementation of proposals that show promise as alternative means for funding physician education and training while providing appropriate compensation for residents and fellows.
30. Our AMA will monitor the status of the House Energy and Commerce Committee's response to public comments solicited regarding the 2014 IOM report, Graduate Medical Education That Meets the Nation's Health Needs, as well as results of ongoing studies, including that requested of the GAO, in order to formulate new advocacy strategy for GME funding, and will report back to the House of Delegates regularly on important changes in the landscape of GME funding.

31. Our AMA will advocate to the Centers for Medicare & Medicaid Services for flexibility beyond the current maximum of five years for the Medicare graduate medical education cap-setting deadline for new residency programs in underserved areas and/or economically depressed areas.

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

33. Our AMA will investigate the status of implementation of AMA Policies D-305.973, Proposed Revisions to AMA Policy on the Financing of Medical Education Programs and D-305.967, The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education and report back to the House of Delegates with proposed measures to resolve the problems of underfunding, inadequate number of residencies and geographic maldistribution of residencies.

Sub. Res. 314, A-07 Reaffirmation I-07 Reaffirmed: CME Rep. 4, I-08 Reaffirmed: Sub. Res. 314, A-09 Reaffirmed: CME Rep. 3, I-09 Reaffirmation A-11 Appended: Res. 910, I-11 Reaffirmed in lieu of Res. 303, A-12 Reaffirmed in lieu of Res. 324, A-12 Reaffirmation: I-12 Reaffirmation A-13 Appended: Res. 320, A-13 Appended: CME Rep. 5, A-13 Appended: CME Rep. 7, A-14 Appended: Res. 304, A-14 Modified: CME Rep. 9, A-15 Appended: CME Rep. 1, I-15 Appended: Res. 902, I-15 Reaffirmed: CME Rep. 3, A-16 Appended: Res. 320, A-16 Appended: CME Rep. 04, A-16 Appended: CME Rep. 05, A-16 Reaffirmation A-16 Appended: Res. 323, A-17 Appended: CME Rep. 03, A-18 Appended: Res. 319, A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 955
(I-18)

Introduced by: Medical Student Section
Subject: Equality for COMLEX and USMLE
Referred to: Reference Committee C
(Peter C. Amadio, MD, Chair)

1 Whereas, On February 26, 2014, the Accreditation Council for Graduate Medical Education
2 (ACGME), American Osteopathic Association (AOA), and American Association of Colleges of
3 Osteopathic Medicine (AACOM) announced their agreement to a Memorandum of
4 Understanding, outlining a single graduate medical education accreditation system in the United
5 States;¹ and
6
7 Whereas, “By December 31, 2017, AOA programs that are three years or longer in length were
8 required to apply to the ACGME in order to recruit residents in the 2018 AOA Match,” and the
9 AOA training programs are no longer able to accept residents if they cannot complete their
10 training by June 30, 2020;² and
11
12 Whereas, The listed benefits of the single accreditation system are to “ensure all residency and
13 fellowship applicants are eligible to enter all accredited programs in the United States, and can
14 transfer from one accredited program to another without repeating training, and without causing
15 the Sponsoring Institutions to lose Medicare funding;”³ and
16
17 Whereas, In 2017, 709 residency programs across the United States participated in the National
18 Match Service, the osteopathic version of NRMP, and as of January 2, 2018, 68% of those
19 programs have applied for the single GME accreditation system; ^{2,4-5} and
20
21 Whereas, The ACGME views the COMLEX and USMLE as equivalent licensing board exams
22 and “does not specify which licensing board exam(s) (i.e., COMLEX-USA, USMLE) applicants
23 must take to be eligible for appointment in ACGME-accredited residency programs;”⁶ and
24
25 Whereas, According to the 2016 NRMP Program Director Survey, for all specialties, only 77% of
26 program directors use COMLEX Level 1 for pass only and with a target score in mind, but 99%
27 of program directors use USMLE Step 1 for pass only and with a target score in mind;⁷ and
28
29 Whereas, According to the 2016 NRMP Program Director Survey, for all specialties, only 65% of
30 Program Directors use COMLEX Level 2 PE, but 78% of Program Directors use USMLE Step 2
31 CS scores;⁷ and
32
33 Whereas, Original research yielded much lower COMLEX score acceptance with 51.6% of
34 NRMP residency programs in Ohio, 53.3% of NRMP residency programs in Colorado, and
35 39.4% of NRMP residency programs in Utah reporting acceptance of COMLEX Step 1 scores; ⁸⁻
36 ⁹⁵ and

1 Whereas, As an examination constructed to assess the basic science knowledge of allopathic
2 medical students, the NBME-CBSE is effective at predicting performance on COMLEX-USA
3 Level 1 for osteopathic medical students, implying that the same basic science knowledge is
4 expected for DO and MD students;⁹⁶ and
5

6 Whereas, A recent study of 795 students from three osteopathic medical schools who took both
7 USMLE Step 1 and COMLEX Level 1 found that scores were statistically significant across all
8 three schools and that there was "a strong association between COMLEX Level 1 and USMLE
9 Step 1 performance";⁹⁷ and
10

11 Whereas, A formula exists to convert COMLEX Level 1 and USMLE Step 1 scores, however,
12 research has shown that attempts to derive a USMLE score from a COMLEX score using the
13 Slocum and Louder formula predicted lower scores by an average of 14.16 points (6.8%), and
14 cautioned residency program directors from using such conversion methods;⁹⁸ and
15

16 Whereas, Dr. Jon Gimpel, President of the NBOME, stated that "because of the different
17 natures of the examinations, it is not possible—or even desirable—to make a direct numerical
18 comparison between the scores of the COMLEX-USA examination series and those of the
19 USMLE. When it comes to the examinations, the NBOME encourages residency program
20 directors to consider the COMLEX-USA series as the valid and most appropriate assessment
21 tool for osteopathic medical students. Our goal is to increase program directors' understanding
22 of the COMLEX-USA examination series, including its content, development, validity, and
23 scoring";⁹⁹ and
24

25 Whereas, "The single GME accreditation system is not expected to reduce acceptance of the
26 COMLEX-USA for residency admissions, but rather to continue to grow acceptance with the
27 goal of one day achieving universal acceptance. However, it is likely – at least for a while – that
28 some ACGME programs will continue to prefer to receive a USMLE score";¹⁰⁰ and
29

30 Whereas, Equal acceptance of COMLEX and USMLE would still enable allopathic medical
31 students to enter residency programs with osteopathic recognition since "Any graduate of a
32 college of medicine accredited by the Commission on Osteopathic College Accreditation
33 (COCA), medical school within the United States or Canada accredited by the Liaison
34 Committee on Medical Education (LCME), or medical school outside of the United States or
35 Canada that meets the established eligibility criteria will be eligible to enter an ACGME-
36 accredited program, including any program with Osteopathic Recognition";³ therefore be it
37

38 RESOLVED, That our American Medical Association promote equal acceptance of the USMLE
39 and COMLEX at all United States residency programs (New HOD Policy); and be it further
40

41 RESOLVED, That our AMA work with appropriate stakeholders including but not limited to the
42 National Board of Medical Examiners, Association of American Medical Colleges, National
43 Board of Osteopathic Medical Examiners, Accreditation Council for Graduate Medical Education
44 and American Osteopathic Association to educate Residency Program Directors on how to
45 interpret and use COMLEX scores (Directive to Take Action); and be it further
46

47 RESOLVED, That our AMA work with Residency Program Directors to promote higher
48 COMLEX utilization with residency program matches in light of the new single accreditation
49 system. (Directive to Take Action)

Fiscal Note: Modest - between \$1,000 - \$5,000.

Received: 09/28/18

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RELEVANT AMA POLICY

ACGME Residency Program Entry Requirements H-310.909

Our AMA supports entry into Accreditation Council on Graduate Medical Education (ACGME) accredited residency and fellowship programs from either ACGME-accredited programs or American Osteopathic Association-accredited programs. Res 920, I-12

Potential Impact of the USMLE Step 2 CS and COMLEX-PE on Undergraduate and Graduate Medical Education D-275.981

Our AMA will: (1) continue to closely monitor the USMLE Step 2 CS and the COMLEX-USA Level 2-PE, collecting data on initial and final pass rates, delays in students starting residency training due to scheduling of examinations, economic impact on students, and the potential impact of ethnicity on passing rates; and (2) encourage residency program directors to proactively evaluate their access to resources needed to assist resident physicians who have not passed these examinations to remediate. CME Rep. 4, A-04; Modified: CME Rep. 2, A-14

Alternatives to the Federation of State Medical Boards Recommendations on Licensure H-275.934

Our AMA adopts the following principles:(1) Ideally, all medical students should successfully complete Steps 1 and 2 of the United States Medical Licensing Examination (USMLE) or Levels 1 and 2 of the Comprehensive Osteopathic Medical Licensing Examination (COMLEX USA) prior to entry into residency training. At a minimum, individuals entering residency training must have successfully completed Step 1 of the USMLE or Level 1 of COMLEX USA. There should be provision made for students who have not completed Step 2 of the USMLE or Level 2 of the COMLEX USA to do so during the first year of residency training. (2) All applicants for full and unrestricted licensure, whether graduates of U.S. medical schools or international medical graduates, must have completed one year of accredited graduate medical education (GME) in the U.S., have passed all licensing examinations (USMLE or COMLEX USA), and must be certified by their residency program director as ready to advance to the next year of GME and to obtain a full and unrestricted license to practice medicine. The candidate for licensure should have had education that provided exposure to general medical content. (3) There should be a training permit/educational license for all resident physicians who do not yet have a full and unrestricted license to practice medicine. To be eligible for an initial training permit/educational license, the resident must have completed Step 1 of the USMLE or Level 1 of COMLEX USA. (4) Residency program directors shall report only those actions to state medical licensing boards that are reported for all licensed physicians. (5) Residency program directors should receive training to ensure that they understand the process for taking disciplinary action against resident physicians, and are aware of procedures for dismissal of residents and for due process. This requirement for residency program directors should be enforced through Accreditation Council for Graduate Medical Education accreditation requirements. (6) There should be no reporting of actions against medical students to state medical licensing boards. (7) Medical schools are responsible for identifying and remediating and/or disciplining medical student unprofessional behavior, problems with substance abuse, and other behavioral problems, as well as gaps in student knowledge and skills. (8) The Dean's Letter of Evaluation should be strengthened and standardized, to serve as a better source of information to residency programs about applicants. CME Rep. 8, A-99; Reaffirmed: CME Rep. 4, I-01; Reaffirmed: CME Rep. 2, A-11; Modified: CME Rep. 2, A-12

Independent Regulation of Physician Licensing Exams D-295.939

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; (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 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).
Citation: CME Rep. 10, A-08; Modified: CME Rep. 01, A-18

Clinical Skills Assessment During Medical School D-295.988

1. Our AMA will encourage its representatives to the Liaison Committee on Medical Education (LCME) to ask the LCME to determine and disseminate to medical schools a description of what constitutes appropriate compliance with the accreditation standard that schools should "develop a system of assessment" to assure that students have acquired and can demonstrate core clinical skills.
2. Our AMA will work with the Federation of State Medical Boards, National Board of Medical Examiners, state medical societies, state medical boards, and other key stakeholders to pursue the transition from and replacement for the current United States Medical Licensing Examination (USMLE) Step 2 Clinical Skills (CS) examination and the Comprehensive Osteopathic Medical Licensing Examination (COMLEX) Level 2-Performance Examination (PE) with a requirement to pass a Liaison Committee on Medical Education-accredited or Commission on Osteopathic College Accreditation-accredited medical school-administered, clinical skills examination.
3. Our AMA will work to: (a) ensure rapid yet carefully considered changes to the current examination process to reduce costs, including travel expenses, as well as time away from educational pursuits, through immediate steps by the Federation of State Medical Boards and National Board of Medical Examiners; (b) encourage a significant and expeditious increase in the number of available testing sites; (c) allow international students and graduates to take the same examination at any available testing site; (d) engage in a transparent evaluation of basing this examination within our nation's medical schools, rather than administered by an external organization; and (e) include active participation by faculty leaders and assessment experts from U.S. medical schools, as they work to develop new and improved methods of assessing medical student competence for advancement into residency.
4. Our AMA is committed to assuring that all medical school graduates entering graduate medical education programs have demonstrated competence in clinical skills.
5. Our AMA will continue to work with appropriate stakeholders to assure the processes for assessing clinical skills are evidence-based and most efficiently use the time and financial resources of those being assessed.
6. Our AMA encourages development of a post-examination feedback system for all USMLE test-takers that would: (a) identify areas of satisfactory or better performance; (b) identify areas of suboptimal performance; and (c) give students who fail the exam insight into the areas of unsatisfactory performance on the examination.
7. Our AMA, through the Council on Medical Education, will continue to monitor relevant data and engage with stakeholders as necessary should updates to this policy become necessary. CME Rep. 7, I-99; Reaffirmed: CME Rep. 2, A-09; Appended: Alt. Res. 311, A-16; Appended: CME Rep. 09, A-17

Eliminating Questions Regarding Marital Status, Dependents, Plans for Marriage or Children, Sexual Orientation, Gender Identity, Age, Race, National Origin and Religion During the Residency and Fellowship Application Process H-310.919

Our AMA:

1. opposes questioning residency or fellowship applicants regarding marital status, dependents, plans for marriage or children, sexual orientation, gender identity, age, race, national origin, and religion;
2. will work with the Accreditation Council for Graduate Medical Education, the National Residency Matching Program, and other interested parties to eliminate questioning about or discrimination based on marital and dependent status, future plans for marriage or children, sexual orientation, age, race, national origin, and religion during the residency and fellowship application process;
3. will continue to support efforts to enhance racial and ethnic diversity in medicine. Information regarding race and ethnicity may be voluntarily provided by residency and fellowship applicants;
4. encourages the Association of American Medical Colleges (AAMC) and its Electronic Residency Application Service (ERAS) Advisory Committee to develop steps to minimize bias in the ERAS and the residency training selection process; and
5. will advocate that modifications in the ERAS Residency Application to minimize bias consider the effects these changes may have on efforts to increase diversity in residency programs.

Citation: Res. 307, A-09; Appended: Res. 955, I-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 956
(I-18)

Introduced by: Nebraska
Subject: Increasing Rural Rotations During Residency
Referred to: Reference Committee C
(Peter C. Amadio, MD, Chair)

- 1 Whereas, Residents of rural areas are generally older and sicker than their urban counterparts;
2 and
3
4 Whereas, Rural areas are facing a crisis due to physician shortages; and
5
6 Whereas, Residents and fellows are more likely to practice where they train; and
7
8 Whereas, Many residency programs offer elective rotations where residents can pursue areas
9 of interest not offered in their main residency curriculum; and
10
11 Whereas, The documentation requirements for faculty supervising residents can be substantial;
12 therefore be it
13
14 RESOLVED, That our American Medical Association work with state and specialty societies,
15 medical schools, teaching hospitals, the Accreditation Council for Graduate Medical Education
16 (ACGME), the Centers for Medicare and Medicaid Services (CMS) and other interested
17 stakeholders to encourage and incentivize qualified rural physicians to serve as preceptors,
18 volunteer faculty, etc. for rural rotations in residency (Directive to Take Action); and be it further
19
20 RESOLVED, That our AMA work with the ACGME, the American Board of Medical Specialties,
21 the Federation of State Medical Boards, CMS and other interested stakeholders to lessen or
22 remove regulations or requirements on residency training and physician practice that preclude
23 formal educational experiences and rotations for residents in rural areas (Directive to Take
24 Action); and be it further
25
26 RESOLVED, That our AMA work with interested stakeholders to identify strategies to increase
27 residency training opportunities in rural areas with a report back to the House of Delegates
28 (Directive to Take Action); and be it further
29
30 RESOLVED, That our AMA work with state and specialty societies and other interested
31 stakeholders to identify appropriately qualified rural physicians who would be willing to serve as
32 preceptors for rural rotations in residency (Directive to Take Action); and be it further
33
34 RESOLVED, That our AMA work with the ACGME and other interested stakeholders to lessen
35 the documentation requirements for off-site rural rotations during residency so that affiliated
36 rural supervising faculty can focus on educating rotating residents (Directive to Take Action);
37 and be it further

1 RESOLVED, That our AMA work with interested stakeholders to study other ways to increase
2 training in rural areas (Directive to Take Action); and be it further

3

4 RESOLVED, That our AMA formulate an actionable plan of advocacy based on the results of
5 the above study with the goal of increasing residency training in rural areas. (Directive to Take
6 Action)

Fiscal Note: Modest - between \$1,000 - \$5,000.

Received: 09/28/18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 957
(I-18)

Introduced by: Florida
Subject: Board Certifying Bodies
Referred to: Reference Committee C
(Peter C. Amadio, MD, Chair)

1 Whereas, The United States Department of Justice, Antitrust Division, set forth its views on
2 Maryland House Bill 857 in a letter dated September 10, 2018 addressed to Dan K. Morhaim,
3 M.D., a member of the Maryland House of Delegates; and
4

5 Whereas, The Division's letter focused on two questions – first, whether ABMS may harm
6 competition by imposing overly burdensome conditions on physicians who wish to maintain their
7 ABMS certification; and second, what are the policy options available to the Maryland legislature
8 if the legislature concludes that the ABMS Program for Maintenance of Certification (MOC)
9 program harms healthcare competition in Maryland; and
10

11 Whereas, The Division's letter recognized that “more entry and more competition by bona fide
12 certifying bodies may offer important benefits – including lowering the costs for physicians to be
13 certified or improving the quality of certification services – for healthcare providers, consumers,
14 and payers”; and
15

16 Whereas, The Division's letter encouraged the Maryland legislature to consider ways to facilitate
17 competition by legitimate certifying bodies, consistent with patient health and safety, and,
18 towards that end, encouraged drafters of Maryland House Bill 857 to consider ways to allow for
19 entry by additional, legitimate certifying bodies; and
20

21 Whereas, Multiple states are pursuing legislation to address issues arising from a lack of
22 competition among bona fide certifying bodies; therefore be it
23

24 RESOLVED, That our American Medical Association conduct a study of the certifying bodies
25 that compete with the American Board of Medical Specialties and issue a report opining on the
26 qualifications of each such certifying body and whether each such certifying body should be
27 added to the list of approved certifying entities in states where they are not currently approved
28 (Directive to Take Action); and be it further
29

30 RESOLVED, That our AMA develop model state legislation that would encourage competition
31 among qualified certifying bodies and would modify board certification requirements such that
32 maintenance of certification participation would not be a requirement for board recertification.
33 (Directive to Take Action)

Fiscal Note: Estimated cost to implement the resolution is \$30,000.

Received: 09/27/18

RELEVANT AMA POLICY

Maintenance of Certification H-275.924

AMA Principles on Maintenance of Certification (MOC)

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

An Update on Maintenance of Licensure D-275.957

- Our American Medical Association will:
1. Continue to monitor the evolution of Maintenance of Licensure (MOL), continue its active engagement in discussions regarding MOL implementation, and report back to the House of Delegates on this issue.
 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 MOL issues.
 3. Work with the Federation of State Medical Boards (FSMB) to study whether the principles of MOL are important factors in a physician's decision to retire or have a direct impact on the U.S. physician workforce.
 4. Work with interested state medical societies and support collaboration with state specialty medical societies and state medical boards on establishing criteria and regulations for the implementation of MOL that reflect AMA guidelines for implementation of state MOL programs and the FSMB's Guiding Principles for MOL.
 5. Explore the feasibility of developing, in collaboration with other stakeholders, AMA products and services that may help shape and support MOL for physicians.
 6. Encourage the FSMB to continue to work with state medical boards to accept physician participation in the American Board of Medical Specialties maintenance of certification (MOC) and the American Osteopathic Association Bureau of Osteopathic Specialists (AOA-BOS) osteopathic continuous certification (OCC) as meeting the requirements for MOL and to develop alternatives for physicians who are not certified/recertified, and advocate that MOC or OCC not be the only pathway to MOL for physicians.
 7. Continue to work with the FSMB to establish and assess MOL principles, with the AMA to assess the impact of MOL on the practicing physician and the FSMB to study its impact on state medical boards.
 8. Encourage rigorous evaluation of the impact on physicians of any future proposed changes to MOL processes, including cost, staffing, and time.
- Citation: (CME Rep. 3, A-15; Modified: CME Rep. 2, I-15)