

REPORTS OF THE COUNCIL ON MEDICAL EDUCATION

The following reports, 1–8, were presented by Carol Berkowitz, MD, Chair:

1. COMPETENCY OF SENIOR PHYSICIANS

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: REFERRED

American Medical Association (AMA) Policy D-275.956, “Assuring Safe and Effective Care for Patients by Senior/Late Career Physicians,” directs our AMA to: “1) 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) 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.”

The first report on this topic, Council on Medical Education Report 5-A-15, “Assuring Safe and Effective Care for Patients by Senior/Late Career Physicians,” recommended that a work group be convened to further study the topic of assessing the competency of senior/late career physicians. 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 to provide direction and serve as a reference for the development of guidelines for screening and assessing senior/late career physicians.

BACKGROUND: SCOPE OF THE ISSUE

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

Evidence supports findings that physical health and some cognitive abilities decline with aging.³ Research shows that cognitive dysfunction is more prevalent among older adults, although aging does not necessarily result in cognitive impairment.⁴ The effect of age on any individual physician’s competence can be highly variable, and aging is just one of several factors that may impact performance.^{2,5} Other factors may influence clinical performance, i.e., practice setting, lack of board certification, high clinical volume, certain specialty practices, etc.^{6,7} Fatigue, stress, burnout, and health issues unrelated to aging are also risk factors that can affect clinical performance.⁷ Performance also may be broadly determined by characteristics ranging from intelligence to personality.³ However, some attributes relevant to the practice of medicine—such as wisdom, resilience, compassion, and tolerance of stress—may actually increase as a function of aging.^{5,8-11}

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

Knowing when to give up practice remains an important decision for most doctors and a critically difficult decision for some.¹⁴ For this reason, physicians with decades of experience and contributions to medicine and to their patients, as they experience health changes that may or may not allow continued clinical practice, deserve the same sensitivity and respect afforded their patients.¹⁵ Shifting away from procedural work, allocating more time with individual

patients, using memory aids, and seeking input from professional colleagues might help physicians successfully adjust to the cognitive changes that accompany aging.^{5,14}

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

WORK GROUP MEETINGS

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

March 16, 2016 Work Group Meeting

The work group meeting, held March 16, 2016, brought together 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. Work group participants concurred that this first meeting raised important issues related to the rationale for developing guidelines to screen and assess the competence and practice performance of senior physicians, which are challenging for a number of reasons. Discussion centered around the evidence and factors related to competency and aging physicians, existing and needed policies, screening and assessment approaches, and legal requirements and challenges. Although current evidence and preliminary research pointed toward the need for developing guidelines, most work group participants felt that additional information/data should be gathered on aging physicians' competence and practice performance. In addition, the participants felt that a set of guiding principles should be developed to reflect the values and beliefs underlying any guidelines that may be developed for screening and assessing senior/late career physicians.

July 19, 2016 Work Group Conference Call

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

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

December 15, 2017 Work Group Conference Call

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

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

Survey Results Related to Screening and Assessing Senior Physicians

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

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

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

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

Highlights from the Literature Review

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

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

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

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

In Canada, the aging medical workforce presents a challenge for medical regulatory authorities charged with protecting the public from unsafe practice. Adler and Constantinou note that normal aging is associated with some cognitive decline as part of the aging process, but physicians, who are highly educated individuals with advanced degrees may be less at risk.¹⁴

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

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

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

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

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

Careful planning, innovative thinking, and the incorporation of new patterns of medical practice are all part of this complex transition of timing into retirement in the United States.^{23,34} A literature review that looked at retirement ages for doctors in different countries found that there is no mandatory retirement age for doctors in most countries.³⁵ Anecdotal reports published in the *British Medical Journal* suggest that retirement has never been easy and is getting harder for some physicians because requirements for reappraisal and other barriers are discouraging some from considering part-time work after retirement.³⁶⁻³⁷ In Canada, Ireland, and India, the retirement age (65) is limited to public sectors only, but older physicians can continue to practice in the private sector.³⁵ In Russia and China, the mandated retirement age is 60 for men and 55 for women.³⁵

Studies show that doctors can mitigate the impact of cognitive decline by ceasing procedural work, allocating more time to each patient, using memory aids, seeking advice from trusted colleagues, and seeking second opinions.¹⁴ Peisah, et al. (Australia) proposed a range of secondary and primary prevention measures for dealing with the problem

of the older impaired doctor; these included educating the medical community, encouraging early notification, and facilitating career planning and timely retirement of older doctors.²⁶ Racine (Canada) suggested that physicians retire before health or competency issues arise.³⁸ Lee (Canada) suggested that older practicing physicians consider slowing down in aspects of practice that require rapid cognitive processing and listen carefully to the concerns of colleagues, patients, friends, and family.³⁹ The University of Toronto, Department of Surgery, has developed Guidelines for Late Career Transitions that require each full-time faculty surgeon to undergo an annual assessment of academic and surgical activity and productivity. As surgeons age, the University creates individual plans for a decrease in on-call surgical responsibilities and encourages late-career surgeons to engage in greater levels of teaching, research, and administration.⁴⁰

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

Since 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,⁵ the work group concurred that it was important to investigate the current screening practices and policies of state medical and osteopathic boards, medical societies, large U.S. health systems, and remediation programs. Some of the more significant findings are summarized below.

All physicians must meet state licensure requirements to practice medicine in the United States. In addition, some hospitals and medical systems have initiated age-based screening,¹²⁻¹³ 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.

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

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

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

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

PROPOSED GUIDING PRINCIPLES

The Council on Medical Education proposes a set of guiding principles as a basis for developing guidelines for the screening and assessment of 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.

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

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

systems should provide easily accessible screening assessments for their employed senior physicians. Similar procedures and screening mechanisms should be available to senior physicians who are not employed by hospitals and health care systems.

AMA POLICY

The AMA has policy in which it urges members of the profession to discover and rehabilitate if possible, or exclude if necessary, the physicians whose practices are incompetent, and to fulfill their responsibility to the public and to their profession by reporting to the appropriate authority those physicians who, by being impaired, are in need of help or whose practices are incompetent (H-275.998). AMA policy urges licensing boards, specialty boards, hospitals and their medical staffs, and other organizations that evaluate physician competence to inquire only into conditions that impair a physician's current ability to practice medicine (H-275.978[6]). AMA policy also reaffirms that it is the professional responsibility of every physician to participate in voluntary quality assurance, peer review, and CME activities (H-300.973 and H-275.996). These and other related policies are attached (see Appendix).

SUMMARY AND RECOMMENDATIONS

The Council on Medical Education concurs that physicians should be allowed to remain in practice as long as patient safety is not endangered, and they are providing appropriate and effective treatment. However, data and anecdotal information support the development of guidelines for the screening and assessment of senior/late career physicians. The variations around cognitive skills as physicians age, as well as the changing demographics of the physician workforce, are also key factors contributing to this need. 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. The guiding principles outlined in this report provide direction and serve as a reference for setting priorities and standards for further action.

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

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

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

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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)

2. REVIEW OF AMA EDUCATIONAL OFFERINGS

Informational report; no reference committee hearing.

HOUSE ACTION: FILED

INTRODUCTION

The Council on Medical Education has been gratified to observe our American Medical Association's (AMA) committed investment in and focus on the development and provision of high-quality educational resources and initiatives for physicians and physicians in training, and is pleased to be able to highlight these to members of the House of Delegates (HOD).

THE EARLY YEARS: THE AMA'S COUNCIL ON MEDICAL EDUCATION

Our AMA's commitment to medical education dates to the founding of the Association in 1847, when one of its first acts was to appoint a body known as the Committee on Medical Education. The Committee on Medical Education was transformed into the Council on Medical Education in 1904; an addition to AMA bylaws in that year noted that:

The functions of the Council on Medical Education shall be:

- To make an annual report to the House of Delegates on the existing conditions of medical education in the United States.
- To make suggestions as to the means and methods by which the American Medical Association may best influence favorably medical education.
- To act as the agent of the American Medical Association (under instructions from the House of Delegates) in its efforts to elevate medical education.¹

In 1905, the Council published its first set of educational standards for medical schools, recommending (1) that medical schools require preliminary education sufficient to enable the candidate to enter a recognized university; (2) a 5-year medical course; and (3) a sixth year as an intern in the hospital.²

In 1906, the Council, tasked with rating U.S. medical schools, surveyed 160 schools regarding the performance of graduates on state licensure examinations. Schools were graded as acceptable, doubtful, or non-acceptable based on a set of ten defined qualifications. Only 82 schools received an "acceptable" rating. This led to the Council's 1909 partnership with the Carnegie Foundation on a new study of medical schools; the results of this study were published in 1910 in the Flexner Report.³

In the intervening years, our AMA, through the Council on Medical Education and other groups, has been involved in the establishment of many of the leading U.S. medical education organizations that exist today and with the development of multiple educational innovations. These organizations and innovations are summarized in Appendix A.

EXPANDING OUR AMA'S EDUCATION DEVELOPMENT AND DELIVERY CAPABILITIES

Our AMA has recently dedicated additional resources and staff to its educational initiatives, and as a result, numerous innovations are being developed.

Content

In-house instructional design capabilities have been enhanced, and measures have been taken to ensure educational content incorporates learning trends that engage adult learners. Additionally, our AMA has developed a library of templated eLearning interactions, which can be leveraged across the organization in content development efforts. A robust quality rubric has been implemented to guide the planning, development, and evaluation of education. The

rubric helps to ensure that education is well-designed and likely to result in achieving the desired learning outcomes. Finally, the assessment creation process has been improved to better evaluate mastery of learning objectives.

Platform

Our AMA plans to launch a unified education delivery platform known as the AMA Ed Hub™. The AMA Ed Hub™ will bring together our AMA's diverse educational offerings under a unified umbrella, including [JN Learning™](#); the [GME Competency Education Program](#) (GCEP); e-learning modules that support our AMA's *Health Systems Science* (HSS) textbook; interactive micro-learning modules based on our AMA's modernized [Code of Medical Ethics](#); the [STEPS Forward™](#) practice transformation series; and curricula related to pain management, firearm safety, and other topics.

The platform will blend innovations in content, technology, and user experience to deliver increasingly more personalized and compelling virtual learning experiences to meet individual needs and preferences. Additionally, it will feature trusted education in engaging and multi-dimensional formats to satisfy a variety of preferences (audio, interactive, journal, and video). The platform is designed to facilitate easy discovery of relevant education. All content is standardized, tagged, and enriched in a way that allows our AMA to actively engage learners by offering content across many channels, sites, apps, and products.

OUR AMA'S EDUCATIONAL INITIATIVES AND RESOURCES

Our AMA is also proactively seeking cooperation between business units to mine additional educational content, more effectively leverage subject matter expertise across products, and expand target audiences. For example, authors of the HSS textbook have extended their contributions beyond medical school to residency by contributing to the development of GME Competency Education Program educational modules. Also, education regarding physician burnout has been repackaged to focus on burnout at the resident physician level.

Accelerating Change in Medical Education Consortium innovations

Our AMA's [Accelerating Change in Medical Education](#) initiative, launched in 2013, has fostered a culture of medical education advancement, leading to the development and scaling of innovations at the undergraduate medical education level across the country. After awarding initial grants to 11 U.S. medical schools, the AMA convened these schools to form the Accelerating Change in Medical Education Consortium—an unprecedented collective that facilitated the development and communication of groundbreaking ideas and projects. The AMA awarded grants to an additional 21 schools in 2016. Today, almost one-fifth of all U.S. allopathic and osteopathic medical schools are represented in the 32-member consortium, which is delivering revolutionary educational experiences to approximately 19,000 medical students—students who one day will provide care to a potential 33 million patients annually.

A summary of innovations resulting from the Consortium can be found in Appendix B. Additionally, a comprehensive, annotated bibliography of publications based on the work of the Consortium has been published and is available for review.⁴

Innovative Educational Formats in the JAMA Network

The JN Listen™ app provides learners with convenient access to engaging podcasts based on peer-reviewed articles published in *JAMA*. Learners can listen to content they select and earn CME, all via the mobile app.

STEPS Forward™

The AMA STEPS Forward™ practice transformation series is an online educational product designed to offer innovative strategies that assist physicians in the new health care environment. Leveraging findings from an AMA-RAND study,⁵ the online modules provide clinicians and practice managers with the data, tools, education, and certification needed to be successful in a value-based payment environment. Learners can take courses about patient care, workflow and process, and professional well-being, among other topics. All STEPS Forward™ modules are Centers for Medicare & Medicaid Services-approved Clinical Practice Improvement Activities; by completing these modules, physicians can demonstrate compliance with Merit-Based Incentive Payment System requirements.

Recently, each of the 48 available modules' learning objectives and assessments were revised to ensure that learner expectations and outcomes are aligned. Content is currently being converted to a standardized format for multichannel publication.

GME Competency Education Program

The AMA GME Competency Education Program (GCEP) comprises a series of online educational modules designed to complement teaching in patient settings and didactic curricula in residency and fellowship programs. The program helps residents and their institutions meet core competency requirements. In 2018, GCEP was selected as a Gold winner in the 2018 Digital Health Awards, which recognizes high-quality digital health resources for health professionals.

Over the past year, the 33-module GCEP library has been upgraded to add animation, case vignettes, and mock simulations to help residents visualize how the content is applicable to their daily practice. The final eight modules are currently being enhanced, including content on quality improvement practices, promoting medication adherence, navigating a lawsuit, and creating an effective and respectful learning environment, among other topics. Personalized instruction has been incorporated, as well as guided learning using relatable mentor characters.

Health Systems Science

In addition to basic and clinical sciences, recognition is growing that physicians also need to know HSS, understanding how care is delivered, how patients receive that care, and how systems function to improve health. By the end of 2018, the AMA plans to have completed six e-learning modules for medical students that complement the HSS textbook, with the goal of providing a cohesive introduction to HSS. While the initial target audience is medical students, faculty development components will be included. Eventually, a parallel learning strategy for faculty and residents is also envisioned. Current modules in development include systems thinking, patient safety, and population health.

Ethics

In 2017, our AMA adopted the modernized *Code of Medical Ethics*,⁶ and new, interactive micro-learning modules have been created around key *Code* opinions. In 2018, the AMA has been developing new modules on privacy and confidentiality, surrogates, and physicians as leaders.

Health Equity

To support the work stemming from our AMA's newly adopted policy related to health equity,⁷ a new module has been launched titled *Collecting Patient Data: Improving Health Equity in Your Practice*.

The AMA Physician's Recognition Award and Credit System

The AMA Physician's Recognition Award (PRA), established by the HOD in December 1968 and celebrating its 50th anniversary in 2018, recognizes physicians who, by participating in CME activities, have demonstrated their commitment to staying current with advances in medicine. The AMA PRA credit system was developed to describe CME activities with sufficient educational value that could be counted towards the requirements to obtain the PRA. AMA PRA credit is the most widely accepted CME credit used by physicians of all specialties to document CME participation for licensing boards, certification boards, hospital credentialing committees, insurance groups, and other organizations.

The AMA PRA credit system has continued to respond to the needs of physicians and to changes in the practice of medicine. Recognizing that physicians learn in different ways and that a variety of educational formats should be recognized for credit, the Council on Medical Education has approved new educational formats for *AMA PRA Category 1 Credit*TM over the years in addition to the original formats of live certified activities and enduring materials. Subsequently approved formats include Journal-Based CME (1998), Manuscript Review (2003), Test Item Writing (2003), Performance Improvement CME (2004), and Internet Point-of-Care (2005). Most recently, in 2017, the Council on Medical Education approved a format of "Other" for those activities that meet core requirements but do not fall within one of the already existing formats.

The AMA PRA credit system also operates beyond U.S. borders. In 1990, the HOD adopted a Council on Medical Education report to establish a process for qualified international conferences to offer *AMA PRA Category 1 Credit™* to attendees. The International Conference Recognition Program continues to this day, and international opportunities to earn *AMA PRA Category 1 Credit™* have expanded to include activities covered by agreements between the AMA and the credit systems of other regions and nations. Three agreements currently exist, with the European Union of Medical Specialists, the Royal College of Physicians and Surgeons of Canada, and the Qatar Council for Healthcare Practitioners.

Section/Council Educational Sessions

Since 2014, AMA sections and/or councils have produced approximately 120 educational sessions at the Annual and Interim meetings (15 sessions per meeting, on average), in addition to various other activities provided throughout the years. Nationally renowned experts, including many AMA members, have educated on important and timely topics, such as physician burnout, the opioid epidemic, firearm safety, value-based care, physician leadership, and innovation.

Collaboration with External Organizations

Our AMA continues to work to lessen the administrative burden for physicians by simplifying and streamlining the automatic tracking and reporting of credit to support certification and licensure needs. Currently, our AMA partners with the ACCME and ABIM to report completed JAMA Network CME activities on behalf of physicians certified by the ABIM. The AMA will extend these reporting capabilities to include all AMA educational activities and additional ABMS member boards in 2019. Finally, a pilot is being planned with the ACCME and Board of Medical Examiners in Tennessee to report completed activities on behalf of physicians licensed in Tennessee.

Our AMA has also been approved as an ABMS Multi-Specialty Portfolio Program sponsor and has developed CME programs that are eligible for continuing certification (MOC Part IV) credit.

Future Innovations

Additional planned innovations will focus on educational features and apps that offer innovation in the education space. Currently, our AMA is:

- Leveraging augmented intelligence to power learning experiences;
- Taking new approaches to documenting meaningful involvement in performance improvement; and
- Considering different types of assessment, which could expand the content for which credit can be offered.

Finally, our AMA is also exploring the potential of the AMA Ed Hub™ platform to be of service to other educational providers.

SUMMARY

For 150 years, our AMA has demonstrated a commitment to developing and supporting advancements in medical education, both autonomously and in partnership with others. From the Council on Medical Education's contributions to the Flexner Report, to the groundbreaking Accelerating Change in Medical Education Consortium, to newly enhanced e-learning content design and delivery, our AMA is well positioned to lead medical education innovations into the next century.

APPENDIX A: THE AMA'S INFLUENCE IN ESTABLISHING MANY LEADING U.S. MEDICAL EDUCATION ORGANIZATIONS AND DEVELOPING EDUCATIONAL INNOVATIONS

- 1847 The American Medical Association is organized and the Committee on Medical Education is formed.
- 1904 The AMA transforms the Committee on Medical Education into the Council on Medical Education (Council).
- 1905 The Council publishes its first set of educational standards for medical schools.
- 1906 The Council performs its first inspection of medical schools.
- 1910 The Council's partnership with the Carnegie Foundation leads to the publication of the Flexner Report.
- 1912 The Council fields its first survey of hospitals for the training of interns.

- 1919 The Council establishes the “Essentials” for approved Internships.
- 1920 The Council organizes 15 committees to study and “recommend what preparation was deemed essential to secure expertness in each of the specialties”; these committees represent the forerunners of today’s boards.
- 1927 The Council begins approval of residency programs in hospitals.
- 1928 The Council establishes “Essentials” for registered hospitals and for approved residencies and fellowships.
- 1934 The Council approves examining boards for the certification of specialists and establishes standards for the formation of American boards in the specialties.
- 1939 The Council, with the American Board of Internal Medicine (ABIM) and American College of Physicians (ACP), forms the Conference Committee on Graduate Training in Internal Medicine, later to become the Residency Review Committee for Internal Medicine; other specialty boards soon request their own committees.
- 1942 At the request of the Council, the AMA Board of Trustees and the Association of American Medical Colleges (AAMC) form the Liaison Committee on Medical Education (LCME).
- 1948 The Council and the Advisory Board for Medical Specialties establish the Liaison Committee for Specialty Boards.
- 1950 The Council establishes the Conference Committee on Graduate Training in Surgery.
- 1954 With representation from the Council, the AAMC, the American Hospital Association (AHA), and the Federation of State Medical Boards (FSMB), an Internship Review Committee is established to review the reports of surveys of intern training programs made by members of the Council’s field staff.
- 1955 Based on work performed by the Council, the “Publication of Postgraduate Medical Education in the United States: A Report of the Survey of Postgraduate Medical Education Carried Out by the Council on Medical Education and Hospitals” is published.
- 1957 A guide on postgraduate medical education (continuing medical education) is issued.
- 1957 With the AHA, AAMC, and FSMB, the Council sponsors the organization of the Educational Commission for Foreign Medical Graduates (ECFMG).
- 1962 The AMA completes the first accreditation survey of continuing medical education (CME) sponsors; the lists of accredited sponsors are published in JAMA.
- 1967 The Advisory Committee on Continuing Medical Education, of the AMA House of Delegates, develops a nationwide accreditation system for CME providers.
- 1968 The AMA establishes the AMA Physician’s Recognition Award (PRA) to recognize physicians who earn at least an average of 50 credits per year from educational activities that meet AMA standards and the AMA PRA CME credit system.
- 1970 The Advisory Board for Medical Specialties is reorganized as the American Board of Medical Specialties (ABMS).
- 1971 The Council establishes the Liaison Committee on Graduate Medical Education, which later becomes the Accreditation Council for Graduate Medical Education (ACGME).
- 1977 The Council establishes the Liaison Committee on Continuing Medical Education (LCCME).
- 1981 The AMA, with the AAMC, AHA, FSMB, ABMS, Association for Hospital Medical Education, and Council of Medical Specialty Societies, creates the Accreditation Council for Continuing Medical Education (ACCME) as successor to the LCCME for the accreditation of CME sponsors.
- 1982 CME Report B, Recommendations for “Future Directions for Medical Education,” is adopted by the AMA House of Delegates.
- 1987 CME Report C, “Resident Working Hours and Supervision,” is adopted by the AMA House of Delegates.
- 1991 The AMA’s Fellowship and Residency Electronic Interactive Data Access (FREIDA) System is established.
- 1996 The Council on Medical Education approves AMA PRA Category 1 Credit™ for reading journal articles.
- 1996 AMA FREIDA becomes AMA FREIDA Online®.
- 2000 The Council approves its first international agreement for the conversion of CME credits, providing physicians the opportunity to receive AMA PRA Category 1 Credit™ for attending European Union of Medical Specialists educational activities certified for credit. Other agreements would follow.
- 2002 CME Report 9, “Resident Physician Working Conditions,” is adopted by the AMA House of Delegates.
- 2003 The Council on Medical Education approves AMA PRA Category 1 Credit™ for test item writing and manuscript review learning formats.
- 2004 The Council on Medical Education approves AMA PRA Category 1 Credit™ for Performance Improvement CME (PI CME) learning format.

- 2005 The Council on Medical Education approves AMA PRA Category 1 Credit™ for Internet Point of Care learning format.
- 2005 The AMA embarks on its Initiative to Transform Medical Education (ITME).
- 2006 The Alliance for CME awards the AMA the Frances M. Maitland PACME Award for “significant contribution to the field of CME and the future of the profession.”
- 2006 The AMA trademarks the phrase AMA PRA Category 1 Credit™.
- 2006 Phase 2 of ITME begins, resulting in recommendations for change across the continuum to address identified gaps in medical education.
- 2007 Phase 3 of ITME begins with a working conference on Optimizing the Medical Education Learning Environment.
- 2008 Phase 3 of ITME continues with a conference in collaboration with the American Academy of Pediatrics on Physician Reentry into Practice.
- 2009 The AMA and Association of American Medical Colleges hold ITME Conference on Increasing Attention to Behavioral Competencies in the Admissions Process.
- 2010 The AMA and AAMC co-sponsor an invitational conference, “New Horizons in Medical Education: A Second Century of Achievement.”
- 2011 The AMA Innovative Strategies for Transforming the Education of Physicians (ISTEP) research collaborative begins the second stage of its study of the medical education learning environment.
- 2012 The AMA announces a new strategic plan to focus on Accelerating Change in Medical Education as one of its three main focus areas.
- 2012 The AMA and AAMC sign a formal agreement that outlines their joint, ongoing commitment to supporting the medical education accreditation process.
- 2013 The AMA announces grant funding for medical school innovations and awards \$11 million to 11 medical schools nationwide as part of its Accelerating Change in Medical Education initiative.
- 2013 The AMA PRA recognizes teaching students and residents as an AMA PRA Category 1 Credit™ activity.
- 2013 The AMA launches its Save GME grassroots campaign (saveGME.org) to urge Congress to preserve GME funding and lift the federal cap on residency slots.
- 2014 The AMA is among the four signers of a formal agreement between the LCME and the Committee on Accreditation of Canadian Medical Schools (CACMS) to ensure medical school graduates in both the United States and Canada meet their respective countries’ standards and are prepared for the next phase of their medical training.
- 2014 The Council on Medical Education convenes a conference with the ABMS and its member boards to discuss ways to improve Maintenance of Certification and make the process more meaningful for physicians.
- 2015 The AMA awards grants to an additional 21 medical schools as a part of the Accelerating Change in Medical Education Consortium, further expanding this community of learning.
- 2018 The Council on Medical Education co-convenes a second conference with the ABMS and its member boards to discuss the future of continuing certification.

APPENDIX B: SUMMARY OF CONSORTIUM INNOVATIONS IN MEDICAL EDUCATION⁸

INNOVATION FOCUS	SUMMARY	PUBLICATIONS AND OUTCOMES
Developing flexible, competency-based pathways	<p>Medical education at all levels is shifting away from emphasizing time spent in lectures and classrooms and toward establishing that the necessary knowledge and skills have been acquired. Medical schools are incorporating milestones and entrustable professional activities (EPAs) into the curriculum to determine the best path for students to follow in order to move to the next level of training.</p> <p>These flexible, competency-based pathways create physicians who are comfortable assessing their abilities and addressing any deficiencies throughout their careers.</p>	<p>Generalizing Competency Assessment Scores Across and Within Clerkships⁹</p> <p>Finding a Path to Entrustment in Undergraduate Medical Education¹⁰</p> <p>Constructing a Shared Mental Model for Faculty Development in CEPAER¹¹</p>
Teaching new content in Health Systems Science	To fully serve patients, physicians must know more than biomedical and clinical sciences. The new discipline of health systems science includes understanding how to improve health care quality,	<i>Health Systems Science</i> ¹²

	<p>increase value, enhance patient safety, deliver population-based care, and work collaboratively in teams.</p> <p>Physicians need to learn how to advocate for their patients and communities and understand the socio-ecological determinants of health, health care policy, and health care economics.</p>	<p>Investigate the Barriers to Integrating Health Systems Science in Medical Education¹³</p> <p>Science of Health Care Delivery Milestones for Undergraduate Medical Education¹⁴</p>
Working with health care delivery systems in novel ways	<p>Consortium schools are creating new learning experiences embedded within health care systems.</p> <p>Training students to be patient navigators, to plan and execute quality improvement projects, and to perform important functions that benefit patient-centered teams serve dual purposes. Students learn about health care delivery by working in authentic settings and are able to contribute to improving the health of patients in meaningful ways.</p>	<p>How Can Medical Students Add Value? Identifying Roles, Barriers, and Strategies to Advance the Value of Undergraduate Medical Education to Patient Care and the Health System.¹⁵</p> <p>Socially Accountable Medical Education: An Innovative Approach at Florida International University Herbert Wertheim College of Medicine¹⁶</p> <p>Value-Added Clinical Systems Learning Roles for Medical Students That Transform Education and Health: A Guide for Building Partnerships Between Medical Schools and Health Systems¹⁷</p>
Making technology work for learning	<p>Consortium schools are adapting technology in new ways to solve key problems and advance physician training. They are teaching the use of EHRs, management of patient panels to improve health outcomes, and interpretation of big data.</p> <p>In addition, schools are applying learning technology to manage individualized, flexible progress by assessing student competencies along their medical education journey. New tools are being used to compile assessment data that will allow for easier self-assessment by students and review with faculty coaches.</p>	<p>Regenstrief EHR Clinical Learning Platform¹⁸</p> <p>Barriers to Medical Students' Electronic Health Record Access Can Impede Their Preparedness for Practice.¹⁹</p> <p>NYU Langone Health: Healthcare by the Numbers: Populations, Systems, and Clinically Integrated Data²⁰</p>
Envisioning the master adaptive learner	<p>Physicians need to rapidly access and interpret continuously evolving information and to understand how the use of new data supports the delivery of the best patient care.</p> <p>One of the aims of the consortium is to assist physicians in becoming master adaptive learners—expert, self-directed, self-regulated and lifelong workplace learners.</p>	<p>Fostering the Development of Master Adaptive Learners: A Conceptual Model to Guide Skill Acquisition in Medical Education.²¹</p> <p>Mission Control: The Gamification of Medical Learning²²</p>
Shaping tomorrow's leaders	<p>Future physicians will need to do more than deliver high-quality care. To be effective in the health care system of tomorrow, they will need to possess the ability to lead teams and participate in positive change. Consortium schools are integrating leadership and teamwork training into curricula that will prepare today's medical students to become future leaders.</p>	<p>Shifting the Curve: Fostering Academic Success in a Diverse Student Body²³</p> <p>Medical Student Perceptions of the Learning Environment: Learning Communities Are Associated With a More Positive Learning Environment in a Multi-Institutional Medical School Study²⁴</p>
Universal outcomes		<p>Coaching Handbook²⁵</p> <p>Curricular Transformation: The Case Against Global Change²⁶</p> <p>Why Not Wait? Eight Institutions Share Their Experiences Moving United States Medical Licensing Examination Step 1 After Core Clinical Clerkships.²⁷</p>

		Turn Med Ed on its Head: Medical Education Innovation Challenge. ²⁸
Creating an online community	Participants in this online community are discussing developments and innovations in medical education, including the work emerging from the AMA's Accelerating Change in Medical Education Consortium, as part of the AMA's work to create the medical schools of the future. Webinars educate and connect participants and help spread innovations nationally.	Implementing a Teaching EHR as a Clinical Learning Platform ²⁹ Transforming Education: Leading Innovations in Health Professions Education ³⁰ Using Big Data to Teach Population Health ³¹ Health Systems Science: The Third Pillar of Medical Education ³² Interprofessional Education: Using Technology to Teach Team-Based Care ³³ To Medical Student Wellness and Beyond: Creating a Healthy Culture for All ³⁴ Leadership Training: Developing the Next Generation of Physician Leaders Portfolios and Dashboards: Leveraging Data for Student Success

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3. DEVELOPING PHYSICIAN-LED PUBLIC HEALTH / POPULATION HEALTH CAPACITY IN RURAL COMMUNITIES

Reference committee hearing: see report of Reference Committee C.

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

See Policy H-440.888

INTRODUCTION

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. Previous reports on this topic include Council on Medical Education Report 11-A-09, “Integrating Content Related to Public Health and Preventive Medicine Across the Medical Education Continuum”; Council on Medical Education Report 8-A-08, “One-Year Public Health Training Options for All Specialties”; and Council on Medical Education Report 12-A-07, “One-Year Public Health Training Options for All Specialties.”

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 HOD.

BACKGROUND

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

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

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

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

CME Report 11-A-09, “Integrating Content Related to Public Health and Preventive Medicine Across the Medical Education Continuum,” identified ways in which medical students are educated in public health and reported on strategies for integrating public health-related content across the medical education continuum. The report further recommends that our AMA encourage 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; and that our AMA encourage 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.

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

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

DISCUSSION

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

American Board of Preventive Medicine

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

- **Residency Pathway**
The ABPM Residency Pathway is open to all individuals “who have completed an Accreditation Council for Graduate Medical Education (ACGME)-accredited residency of not less than two years, in the specialty area for which certification is being sought.”¹⁰ Participation in the pathway requires a supervised year of postgraduate clinical training, including at least 10 months of direct patient care; completion of an ACGME-accredited residency training program accredited in the specialty area for which certification is being pursued; successful completion of an MPH or equivalent graduate degree; and demonstration of current practice if more than 24 months have passed since completion of residency training (unless otherwise engaged in specialty or subspecialty training).
- **Complementary Pathway**
The ABPM Complementary Pathway, meant to engage mid-career physicians seeking to change their specialty practice, requires two years of supervised postgraduate clinical training in an ACGME-accredited training program; a year of ACGME-accredited residency training in the specialty area in which certification is sought; postgraduate level coursework in epidemiology, biostatistics, health services administration, environmental health sciences, and social and behavioral health sciences; and proof of current practice (unless in training) for two of the last five years.
- **Special Pathway**
The ABPM Special Pathway allows ABPM diplomates with current certification in Aerospace Medicine, Occupational Medicine, or Public Health and General Preventive Medicine to pursue certification in another ABPM primary specialty. (Diplomates with current subspecialty certification in Addiction Medicine, Clinical Informatics, Medical Toxicology, and Undersea and Hyperbaric Medicine are not eligible for this pathway.) In addition to ABPM specialty certification, candidates must also be able to demonstrate they have been practicing (or training) for two of the last five years in the specialty/subspecialty area in which they are seeking additional certification.
- **Alternative Pathway**
The ABPM Alternative Pathway is only applicable to those individuals who graduated from medical school prior to January 1, 1984, and who do not qualify for certification through one of the three previously described pathways. In addition to the graduation year requirement, candidates must have completed a year of supervised

postgraduate training in an ACGME-accredited GME program, including at least 10 months of direct patient care; postgraduate level coursework in epidemiology, health services administration, environmental health sciences, and social and behavioral health sciences; and demonstration of practice for at least two of the last five years. For this category, the required, demonstrated number of years in practice is dependent on ABMS member board certification status; completion of residency training in the specialty area in which certification is sought; and possession of an MPH degree or equivalent.

American College of Physicians

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

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

Efforts of the Accelerating Change in Medical Education Consortium

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

- The partnership between A.T. Still University’s School of Osteopathic Medicine in Arizona and the National Association of Community Health Centers embeds second-, third-, and fourth-year medical students in rural health centers. Additionally, second-year students participate in a year-long course in epidemiology, biostatistics, and preventive medicine, during which they work with community stakeholders and health centers to identify and address local issues of community concern.
- The Brody School of Medicine at East Carolina University integrates a population health component into its comprehensive longitudinal core curriculum.
- Case Western Reserve University School of Medicine incorporates a patient navigator model into its curriculum, and medical student navigators learn to use and create registries for population health management in specific population groups.
- The curriculum at Dell Medical School at the University of Texas at Austin is built around instruction in leadership, which is incorporated into all four years of education. During the third year, students can choose to focus on specific areas of study, including population health.
- Upon joining the consortium, Florida International University Herbert Wertheim College of Medicine enhanced its “Green Family Foundation Neighborhood Health Education Learning Program” (NeighborhoodHELP™), which provides a longitudinal, interprofessional community-based experience for medical students and partnerships with local hospitals.
- The blended learning curriculum at the Mayo Clinic School of Medicine focuses on six content domains, one of which is population-centered care. Students can also pursue an additional 12 credits to receive a master’s degree in health care delivery science, which includes instruction in population and preventive health. Further, Mayo has created milestones for students related to population health in alignment with ACGME competencies.
- The New York University School of Medicine’s Health Care by the Numbers curriculum uses very large de-identified datasets to train students to improve the health of populations.
- Ohio University Heritage College of Osteopathic Medicine integrates population health into its continuous, longitudinal curriculum.
- The University of Connecticut School of Medicine’s MDelta curriculum has been specifically designed so that all students can achieve a certificate in public health, with a specific focus on disparities and the social determinants of health. Additionally, the school has incorporated the Regenstrief EHR Clinical Learning Platform into the MDelta curriculum. This platform includes large numbers of de-identified patient records, allowing students to research population health issues.

- The University of Nebraska Medical Center College of Medicine, through its focus on interprofessional education, has established official partnerships with its colleges of nursing, public health, pharmacy, dentistry, and allied health professions.
- The University of North Dakota School of Medicine and Health Sciences incorporates training in the use of telemedicine to connect remote patients and providers at multiple locations to address rural health care needs. Simulation training mimics common cases seen in rural settings.
- Medical students at the University of Texas Rio Grande Valley School of Medicine learn onsite in unincorporated *colonias* along the U.S./Mexico border, allowing incorporation of oral histories into the medical record. Students also have the opportunity to shadow community health workers, or *promotoras*, as part of a curriculum that simulates the process necessary to convince legislators to fund similar interventions.
- In Vanderbilt University School of Medicine's longitudinal, four-year Foundations of Health Care Delivery course, third- and fourth-year medical students complete self-directed modules in a number of topic areas, including advanced population health and public health.
- The Warren Alpert Medical School of Brown University offers nine courses in its Master of Science degree in population medicine, covering social determinants of health, disparities, instruction in population medicine research, leadership, and epidemiology. Some of these courses are required for all students, even if not pursuing the master's degree. Students are also required to prepare a thesis on population medicine.

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

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

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

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

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

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

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

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

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

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

National Public Health Organizations

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

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

Additional AMA Resources

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

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

PROMOTING PUBLIC HEALTH LEADERSHIP

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

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

Leadership Roles for Women

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

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

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

RELEVANT AMA POLICY

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

SUMMARY AND RECOMMENDATIONS

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

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

1. That Policy D-295.311, "Developing Physician Led Public Health / Population Health Capacity in Rural Communities," be rescinded, as having been fulfilled by this report.
2. That our American Medical Association (AMA) reaffirm the following policies:
D-295.327, "Integrating Content Related to Public Health and Preventive Medicine Across the Medical

Education Continuum”

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

D-305.974, “Funding for Preventive Medicine Residencies”

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

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

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

H-440.888, “Public Health Leadership”

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

3. That our AMA encourage the Association of American Medical Colleges (AAMC), American Association of Colleges of Osteopathic Medicine (AACOM), and Accreditation Council for Graduate Medical Education (ACGME) to highlight public/population health leadership learning opportunities to all learners, but especially encourage dissemination to women physician groups and other groups typically underrepresented in medicine.
4. That our AMA encourage public health leadership programs to evaluate the effectiveness of various leadership interventions.

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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.

4. RECONCILIATION OF AMA POLICY ON PRIMARY CARE WORKFORCE

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS REMAINDER OF REPORT FILED

See Policies H-200.949 and H-200.972

INTRODUCTION

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

POLICIES INCLUDED IN THIS REPORT

The following AMA policies are addressed in this report:

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

SUMMARY AND RECOMMENDATIONS

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

The new policy being proposed in Recommendation 1, below, incorporates relevant portions of the 13 existing policies that are recommended for rescission in Recommendation 2. Appendices A and B show a worksheet version and a

clean text version, respectively, of the policy that is being proposed for adoption. Appendix C lists the 13 existing policies that are proposed for rescission.

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

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

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

Primary Care Physicians in Underserved Areas

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

- (1) Encourage the creation and pilot-testing of school-based, ~~church-faith-based~~, and community-based urban/rural "family H~~e~~alth clinics, with an emphasis on health education, prevention, primary care, and prenatal care.
- (2) Encourage the affiliation of these family health clinics with ~~urban~~-local medical schools and teaching hospitals.
- ~~(3) Promote medical student rotations through the various inner city neighborhood family health clinics, with financial assistance to the clinics to compensate their teaching efforts.~~
- ~~(4) Encourage medical schools and teaching hospitals to integrate third and fourth year undergraduate medical education and residency training into these teams.~~
- (~~5~~3) Advocate for the implementation of AMA policy that supports extension of the rural health clinic concept to urban areas with appropriate federal agencies.

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

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
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.	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
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	(new)

Proposed language for adoption	Original language
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:	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
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;	(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
b) Curriculum changes throughout the medical education continuum;	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. H-200.977
c) Expanded financial aid and debt relief options;	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
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	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
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.	(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
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.	(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
	(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
	(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
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) Medical schools should provide career counseling related to the choice of a primary care specialty. 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: ... b. utilization of primary care physicians in the roles of 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	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

Proposed language for adoption	Original language
include funded preceptorships or summer work/study opportunities.	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 <u>all primary care specialties</u> 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.	<p>(4) Medical schools with an explicit commitment to primary care should structure the curriculum to support this objective. H-200.973</p> <p>(13) Encourage medical schools to continue to change their curriculum to put more emphasis on primary care. H-200.972</p> <p>(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</p>
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.	<p>(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</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: ... c. educational 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>(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</p>

Proposed language for adoption	Original language
	<p>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 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</p>
<p>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.</p>	<p>(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</p> <p>(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</p>
<p>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).</p>	<p>(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</p> <p>Our AMA advocates that the Accreditation Council for Graduate Medical Education support primary care residency programs, including community hospital based programs. H-310.973</p> <p>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</p>
<p>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.</p>	<p>(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</p>
<p>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.</p>	<p>(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</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>

Proposed language for adoption	Original language
	<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 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.</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 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</p>
<p>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.</p>	<p>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</p>
<p>19. There should be educational support systems for primary care physicians, especially those practicing in underserved areas.</p>	<p>(11) There should be educational support systems for primary care physicians, especially those practicing in underserved areas. H-200.973</p>
<p>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.</p>	<p>(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</p>
<p>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.</p>	<p>(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</p>
<p>22. Accredited continuing medical education providers should promote and establish continuing medical education courses in performing, prescribing, interpreting and reinforcing primary care services.</p>	<p>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</p>
<p>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.</p>	<p>(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</p> <p>(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</p>

Proposed language for adoption	Original language
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

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

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

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

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

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

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

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

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

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

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

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

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

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

5. RECONCILIATION OF AMA POLICY ON MEDICAL STUDENT DEBT

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: RECOMMENDATIONS ADOPTED REMAINDER OF REPORT FILED

See Policy H-305.925

INTRODUCTION AND METHODS

The goal of this report is to review, reconcile, and consolidate existing American Medical Association (AMA) policy on medical student debt, eliminate duplication, and ensure that current policies are coherent and relevant. For each policy recommendation, a succinct but cogent justification is provided to support the proposed action. If a contradiction in policies was discovered, the most recent policy was deemed to supersede past AMA policies, and the language of each proposed policy was then edited so that it would be coherent and easily understood, without altering its meaning or intent.

Policies Included in this Report

The following AMA policies are addressed in this report:

1. D-305.956, "AMA Participation in Reducing Medical Student Debt"
2. D-305.957, "Update on Financial Aid Programs"
3. D-305.962, "Tax Deductibility of Student Loan Payments"
4. D-305.966, "Reinstatement of Economic Hardship Loan Deferment"

5. D-305.970, "Proposed Revisions to AMA Policy on Medical Student Debt"
6. D-305.975, "Long-Term Solutions to Medical Student Debt"
7. D-305.977, "Deductibility of Medical Student Loan Interest"
8. D-305.978, "Mechanisms to Reduce Medical Student Debt"
9. D-305.979, "State and Local Advocacy on Medical Student Debt"
10. D-305.980, "Immediate Legislative Solutions to Medical Student Debt"
11. D-305.981, "Financing Federal Consolidation Loans"
12. D-305.993, "Medical School Financing, Tuition, and Student Debt"
13. D-405.986, "Student Loans and Medicare / Medicaid Participation"
14. H-305.926, "Supporting Legislation to Create Student Loan Savings Accounts"
15. H-305.928, "Proposed Revisions to AMA Policy on Medical Student Debt"
16. H-305.932, "State and Local Advocacy on Medical Student Debt"
17. H-305.948, "Direct Loan Consolidation Program"
18. H-305.954, "Repayment of Medical School Loans"
19. H-305.965, "Student Loans"
20. H-305.980, "Student Loan Repayment Grace Period"
21. H-305.991, "Repayment of Educational Loans"

SUMMARY AND RECOMMENDATIONS

This report encompasses a review of current AMA policies on medical student debt to ensure such policy is consistent, accurate and up-to-date. The new policy being proposed in recommendation 1, below (shown in Appendix A), incorporates relevant portions of the 21 existing policies that are recommended for rescission in recommendation 2. Appendix B shows a clean text version of the policy that is being proposed for adoption. Appendix C lists all 21 policies that are proposed for rescission. The (relatively few) segments of policy that are not being retained in the proposed new policy are listed in Appendix D.

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

1. That our American Medical Association (AMA) adopt as policy "Principles of and Actions to Address Medical Education Costs and Student Debt" the language shown in column 1 of Appendix A of this report.
2. That our AMA rescind the following policies, as shown in Appendix C:
 1. D-305.956, "AMA Participation in Reducing Medical Student Debt"
 2. D-305.957, "Update on Financial Aid Programs"
 3. D-305.962, "Tax Deductibility of Student Loan Payments"
 4. D-305.966, "Reinstatement of Economic Hardship Loan Deferment"
 5. D-305.970, "Proposed Revisions to AMA Policy on Medical Student Debt"
 6. D-305.975, "Long-Term Solutions to Medical Student Debt"
 7. D-305.977, "Deductibility of Medical Student Loan Interest"
 8. D-305.978, "Mechanisms to Reduce Medical Student Debt"
 9. D-305.979, "State and Local Advocacy on Medical Student Debt"
 10. D-305.980, "Immediate Legislative Solutions to Medical Student Debt"
 11. D-305.981, "Financing Federal Consolidation Loans"
 12. D-305.993, "Medical School Financing, Tuition, and Student Debt"
 13. D-405.986, "Student Loans and Medicare / Medicaid Participation"
 14. H-305.926, "Supporting Legislation to Create Student Loan Savings Accounts"
 15. H-305.928, "Proposed Revisions to AMA Policy on Medical Student Debt"
 16. H-305.932, "State and Local Advocacy on Medical Student Debt"
 17. H-305.948, "Direct Loan Consolidation Program"
 18. H-305.954, "Repayment of Medical School Loans"
 19. H-305.965, "Student Loans"
 20. H-305.980, "Student Loan Repayment Grace Period"
 21. H-305.991, "Repayment of Educational Loans"

APPENDIX A - Proposed AMA Policy: “Principles of and Actions to Address Medical Education Costs and Student Debt”
(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
The costs of medical education should never be a barrier to pursuit of a career in medicine nor to the decision to practice in a given specialty.	3. Financial aid opportunities, including scholarship and loan repayment programs, should be available so that individuals are not denied an opportunity to pursue medical education because of financial constraints. H-305.928
	4. A sufficient breadth of financial aid opportunities should be available so that student specialty choice is not constrained based on the need for financial assistance. H-305.928
To help address this issue, our American Medical Association (AMA) will:	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: D-305.970
1. Collaborate with members of the Federation and the medical education community, and with other interested organizations, to address the cost of medical education and medical student debt through public- and private-sector advocacy.	1. Our AMA will make reducing medical student debt a high priority for legislative and other action and will collaborate with other organizations to study how costs to students of medical education can be reduced. H-305.928
2. Vigorously advocate for and support expansion of and adequate funding for federal scholarship and loan repayment programs—such as those from the National Health Service Corps, Indian Health Service, Armed Forces, and Department of Veterans Affairs, and for comparable programs from states and the private sector—to promote practice in underserved areas, the military, and academic medicine or clinical research.	(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. D-305.970
	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. D-305.993
	5. Our AMA supports the creation of new and the expansion of existing medical education financial assistance programs from the federal government, the states, and the private sector. H-305.928
3. Encourage the expansion of National Institutes of Health programs that provide loan repayment in exchange for a commitment to conduct targeted research.	(b) Encourage the expansion of National Institutes of Health programs that provide loan repayment in exchange for a commitment to conduct targeted research. D-305.970
4. Advocate for increased funding for the National Health Service Corps Loan Repayment Program to assure adequate funding of primary care within the National Health Service Corps, as well as to permit: (a) inclusion of all medical specialties in need, and (b) service in clinical settings that care for the underserved but are not necessarily located in health professions shortage areas.	(2) advocate for increased funding for the National Health Service Corps Loan Repayment Program to assure adequate funding of primary care within the National Health Service Corps, as well as to permit: (a) inclusion of all medical specialties in need, and (b) service in clinical settings that care for the underserved but are not necessarily located in health professions shortage areas; D-305.975
5. Encourage the National Health Service Corps to have repayment policies that are consistent with other federal loan forgiveness programs, thereby decreasing the amount of loans in default and increasing the number of physicians practicing in underserved areas.	(5) encourage the National Health Services Corps to have repayment policies that are consistent with other federal loan forgiveness programs, thereby decreasing the amount of loans in default and increasing the number of physicians practicing in underserved areas. D-305.975
6. Work to reinstate the economic hardship deferment qualification criterion known as the “20/220 pathway,” and support alternate mechanisms that better address the financial needs of trainees with educational debt.	Our AMA will actively work to reinstate the economic hardship deferment qualification criterion known as the “20/220 pathway,” and support alternate mechanisms that better address the financial needs of post-graduate trainees with educational debt. D-305.966

Proposed language for adoption	Original language
7. Advocate for federal legislation to support the creation of student loan savings accounts that allow for pre-tax dollars to be used to pay for student loans.	Our AMA will advocate for federal legislation to support the creation of student loan savings accounts that allow for pre-tax dollars to be used to pay for student loans. H-305.926
8. Work with other concerned organizations to advocate for legislation and regulation that would result in favorable terms and conditions for borrowing and for loan repayment, and would permit 100% tax deductibility of interest on student loans and elimination of taxes on aid from service-based programs.	8. Our AMA will work with other concerned organizations to promote legislation and regulations with the aims of ...eliminating taxes on aid from service-based programs, and restoring tax deductibility of interest on educational loans. D-305.993
	(d) Ensure that the Higher Education Act and other legislation allow interest from medical student loans to be fully tax deductible. D-305.970
	Our AMA will draft legislation allowing 100% tax deductibility of student loan interest. D-305.962
	Our AMA will work toward 100% tax deductibility of medical student loan interest on federal and state income tax returns. D-305.977
	7. Our AMA supports legislation and regulation that would result in favorable terms and conditions for borrowing and for loan repayment, and would permit the full deductibility of interest on student loans. H-305.928
9. 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).	(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). D-305.970
10. Support stable funding for medical education programs to limit excessive tuition increases, and collect and disseminate information on medical school programs that cap medical education debt, including the types of debt management education that are provided.	(g) Support stable funding for medical education programs to limit excessive tuition increases. D-305.970
	(4) collect and disseminate information on medical school programs that cap medical education debt, including the types of debt management education that are provided; and D-305.975
11. Work with state medical societies to advocate for the creation of either tuition caps or, if caps are not feasible, pre-defined tuition increases, so that medical students will be aware of their tuition and fee costs for the total period of their enrollment.	(3) work with state medical societies to advocate for the creation of either tuition caps or, if caps are not feasible, pre-defined tuition increases, so that medical students will be aware of their tuition and fee costs for the total period of their enrollment; D-305.975
12. Encourage medical schools to (a) Study the costs and benefits associated with non-traditional instructional formats (such as online and distance learning, and combined baccalaureate/MD or DO programs) to determine if cost savings to medical schools and to medical students could be realized without jeopardizing the quality of medical education;	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. D-305.970
	(b) Engage in fundraising activities to increase the availability of scholarship support, with the support of the Federation, medical schools, and state and specialty medical societies, and develop or enhance financial aid opportunities for medical students, such as self-managed, low-interest loan programs;
	(3) encourage members of the Federation to develop or enhance financial aid opportunities for medical students; D-305.978
	(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 D-305.978
	Our AMA will: (1) encourage medical schools and state medical societies to consider the creation of self-managed, low-interest loan programs for medical students, and collect and disseminate information on such programs; D-305.975

Proposed language for adoption	Original language
	(2) urge state medical societies to actively solicit funds (either directly or through their Foundations) for the establishment and expansion of medical student scholarships, and that our AMA develop a set of guidelines and suggestions to assist states in carrying out such initiatives. D-305.979
(c) Cooperate with postsecondary institutions to establish collaborative debt counseling for entering first-year medical students;	(3) encourages medical schools to cooperate with undergraduate institutions to establish collaborative debt counseling for entering first-year medical students. H-305.932
(d) Allow for flexible scheduling for medical students who encounter financial difficulties that can be remedied only by employment, and consider creating opportunities for paid employment for medical students;	8. Medical students should not be forced to jeopardize their education by the need to seek employment. Any decision on the part of the medical student to seek employment should take into account his/her academic situation. Medical schools should have policies and procedures in place that allow for flexible scheduling in the case that medical students encounter financial difficulties that can be remedied only by employment. Medical schools should consider creating opportunities for paid employment for medical students. H-305.928
(e) Counsel individual medical student borrowers on the status of their indebtedness and payment schedules prior to their graduation;	(3) encourages medical school financial aid officers to counsel individual medical student borrowers on the status of their indebtedness and payment schedules prior to their graduation. H-305.991
(f) Inform students of all government loan opportunities and disclose the reasons that preferred lenders were chosen;	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. D-305.993
(g) Ensure that all medical student fees are earmarked for specific and well-defined purposes, and avoid charging any overly broad and ill-defined fees, such as but not limited to professional fees;	Our AMA: (1) opposes the charging of broad and ill-defined student fees by medical schools, such as but not limited to professional fees, encouraging in their place fees that are earmarked for specific and well-defined purposes; H-305.932
(h) Use their collective purchasing power to obtain discounts for their students on necessary medical equipment, textbooks, and other educational supplies;	(2) encourages medical schools to use their collective purchasing power to obtain discounts for their students on necessary medical equipment, textbooks, and other educational supplies; and H-305.932
(i) Work to ensure stable funding, to eliminate the need for increases in tuition and fees to compensate for unanticipated decreases in other sources of revenue; mid-year and retroactive tuition increases should be opposed.	2. Our AMA supports stable funding for medical schools to eliminate the need for increases in tuition and fees to compensate for unanticipated decreases in other sources of revenue and should oppose mid-year and retroactive tuition increases. H-305.928
13. Support and encourage state medical societies to support further expansion of state loan repayment programs, particularly those that encompass physicians in non-primary care specialties.	Our AMA will: (1) support and encourage our state medical societies to support further expansion of state loan repayment programs, and in particular expansion of those programs to cover physicians in non-primary care specialties; and D-305.979
14. Take an active advocacy role during reauthorization of the Higher Education Act and similar legislation, to achieve the following goals:	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: D-305.978
	Our AMA will: (1) endorse and actively lobby for the Reauthorization of the Higher Education Act, including: D-305.980
(a) Eliminating the single holder rule;	(1) (a) eliminating the single holder rule, D-305.978
	(1) (a) Elimination of the "single-holder" rule; D-305.980
(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) 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-305.970
	(1) (b) making the availability of loan deferment more flexible, including broadening the definition of economic hardship and

Proposed language for adoption	Original language
	expanding the period for loan deferment to include the entire length of residency and fellowship training, D-305.978
	(1) (d) Broadening of the definition of economic hardship as used to determine eligibility for student loan deferment; D-305.980
	(1) (c) Expansion of the deferment period for loan repayment to cover the entire duration of residency and fellowship; D-305.980
	Our AMA: (1) reaffirms its support of legislation that would defer the repayment of loans for education until the completion of residency training; and H-305.965
	(2) will lobby for deferment of medical student loans for the full initial residency period. H-305.965
	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.... D-305.993
(c) Retaining the option of loan forbearance for residents ineligible for loan deferment;	(1) (c) retaining the option of loan forbearance for residents ineligible for loan deferment, D-305.978
	(1) (e) Retention of the option of loan forbearance for residents who are ineligible for student loan deferment; D-305.980
(d) Including, explicitly, dependent care expenses in the definition of the “cost of attendance”;	(1) (d) including, explicitly, dependent care expenses in the definition of the “cost of attendance,” D-305.978
	(1) (f) Inclusion of dependent care expenses in the definition of “cost of attendance”; and D-305.980
(e) Including room and board expenses in the definition of tax-exempt scholarship income;	(1) (e) including room and board expenses in the definition of tax-exempt scholarship income, D-305.978
	(2) (c) Include room and board expenses in the definition of tax-exempt scholarship income; D-305.980
(f) Continuing the federal Direct Loan Consolidation program, including the ability to “lock in” a fixed interest rate, and giving consideration to grace periods in renewals of federal loan programs;	(1) (f) continuing the loan consolidation program, including the ability to “lock in” a fixed interest rate, and D-305.978
	The AMA supports the Individual Education Account/Direct Loan Consolidation Program. H-305.948
	(1) (b) Continuation of the consolidation loan program and a consolidator’s ability to lock in a fixed interest rate; D-305.980
	The AMA supports giving consideration to grace periods in renewals of federal loan programs and attempting to secure the most favorable repayment terms. H-305.980
(g) Adding the ability to refinance Federal Consolidation Loans;	(1) (g) adding the ability to refinance Federal Consolidation Loans; D-305.978
	Our AMA will: (1) support the refinancing of Federal Consolidation Loans; and D-305.981
	Our AMA will: (2) actively advocate for modification of pending and future legislation which that provides the opportunity to refinance Federal Consolidation Loans. D-305.981
(h) Eliminating the cap on the student loan interest deduction;	(2) (a) Eliminate the cap on the student loan interest deduction; D-305.980
(i) Increasing the income limits for taking the interest deduction;	(2) (b) Increase the income limits for taking the interest deduction; D-305.980
(j) Making permanent the education tax incentives that our AMA successfully lobbied for as part of Economic Growth and Tax Relief Reconciliation Act of 2001;	(2) (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. D-305.980
(k) Ensuring that loan repayment programs do not place greater burdens upon married couples than for similarly situated couples who are cohabitating;	11. Our AMA opposes any stipulations in loan repayment programs that place greater burdens upon married couples than for similarly-situated couples who are cohabitating. H-305.928
(l) Increasing efforts to collect overdue debts from the present medical student loan programs in a manner	(2) urges increased efforts to collect overdue debts from the present medical student loan programs in a manner that would

Proposed language for adoption	Original language
that would not interfere with the provision of future loan funds to medical students.	not interfere with the provision of future loan funds to medical students; and H-305.991
15. 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.	(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; D-305.978
16. Continue to study medical education financing, so as to identify long-term strategies to mitigate the debt burden of medical students, and monitor the short-and long-term impact of the economic environment on the availability of institutional and external sources of financial aid for medical students, as well as on choice of specialty and practice location.	(6) continue to study medical education financing, so as to identify long-term strategies to mitigate the debt burden of medical students. D-305.978 (b) continue to monitor the short-and long-term impact of the economic environment on the availability of institutional and external sources of financial aid for medical students, as well as on choice of specialty and practice location. D-305.957
17. Collect and disseminate information on successful strategies used by medical schools to cap or reduce tuition.	3. Our AMA will collect and disseminate information on successful strategies used by medical schools to cap or reduce tuition. D-305.993
18. Continue to monitor the availability of and encourage medical schools and residency/fellowship programs to (a) provide financial aid opportunities and financial planning/debt management counseling to medical students and resident/fellow physicians; (b) work with key stakeholders to develop and disseminate standardized information on these topics for use by medical students, resident/fellow physicians, and young physicians; and (c) share innovative approaches with the medical education community.	4. Our AMA will encourage medical schools to provide yearly financial planning/debt management counseling to medical students. D-305.993 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. D-305.993 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. D-305.993 6. Medical schools should have programs in place to assist students to limit their debt. This includes making scholarship support available, counseling students about financial aid availability, and providing comprehensive debt management/financial planning counseling. H-305.928 (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; D-305.978
19. Seek federal legislation or rule changes that would stop Medicare and Medicaid decertification of physicians due to unpaid student loan debt. The AMA believes that it is improper for physicians not to repay their educational loans, but assistance should be available to those physicians who are experiencing hardship in meeting their obligations.	Our AMA will seek federal legislation or rule changes that would stop Medicare and Medicaid decertification of physicians due to unpaid student loan debt. D-405.986 The AMA (1) believes that it is improper for any physician not to repay his or her educational loans; H-305.991 9. Financial obligations, such as repayment of loans, and service obligations made in exchange for financial assistance, should be fulfilled. There should be mechanisms to assist physicians who are experiencing hardship in meeting these obligations. H-305.928
20. Related to the Public Service Loan Forgiveness (PSLF) Program, our AMA supports increased medical student and physician benefits the program, and will:	10. Our AMA supports the expansion and increase of medical student and physician benefits under Public Service Loan Forgiveness. H-305.928
(a) Advocate that all resident/fellow physicians have access to PSLF during their training years;	Our AMA will: (a) through the advocacy process, explore the possibility of assuring that all resident physicians and fellows have access to the Public Service Loan Forgiveness Program for the time they are in residency and fellowship training; and D-305.957
(b) Advocate against a monetary cap on PSLF and other federal loan forgiveness programs;	9. Our AMA will advocate against putting a monetary cap on federal loan forgiveness programs. D-305.993

Proposed language for adoption	Original language
(c) Work with the United States Department of Education to ensure that any cap on loan forgiveness under PSLF be at least equal to the principal amount borrowed;	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. D-305.993
(d) Ask the United States Department of Education to include all terms of PSLF in the contractual obligations of the Master Promissory Note;	
(e) Encourage the Accreditation Council for Graduate Medical Education (ACGME) to require residency/fellowship programs to include within the terms, conditions, and benefits of program appointment information on the PSLF program qualifying status of the employer;	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. D-305.993
(f) Advocate that the profit status of a physician’s training institution not be a factor for PSLF eligibility;	12. Our AMA will advocate that the profit status of a physician’s training institution not be a factor for PSLF eligibility. D-305.993
(g) Encourage medical school financial advisors to counsel wise borrowing by medical students, in the event that the PSLF program is eliminated or severely curtailed;	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. D-305.993
(h) Encourage medical school financial advisors to increase medical student engagement in 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;	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. D-305.993
(i) 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.	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. D-305.993

Appendix B - Proposed AMA Policy: “Principles of and Actions to Address Medical Education Costs and Student Debt” (Text Version)

The costs of medical education should never be a barrier to the pursuit of a career in medicine nor to the decision to practice in a given specialty.

To help address this issue, our American Medical Association (AMA) will:

1. Collaborate with members of the Federation and the medical education community, and with other interested organizations, to address the cost of medical education and medical student debt through public- and private-sector advocacy.
2. Vigorously advocate for and support expansion of and adequate funding for federal scholarship and loan repayment programs—such as those from the National Health Service Corps, Indian Health Service, Armed Forces, and Department of Veterans Affairs, and for comparable programs from states and the private sector—to promote practice in underserved areas, the military, and academic medicine or clinical research.
3. Encourage the expansion of National Institutes of Health programs that provide loan repayment in exchange for a commitment to conduct targeted research.
4. Advocate for increased funding for the National Health Service Corps Loan Repayment Program to assure adequate funding of primary care within the National Health Service Corps, as well as to permit: (a) inclusion of all medical specialties in need, and (b) service in clinical settings that care for the underserved but are not necessarily located in health professions shortage areas.

5. Encourage the National Health Service Corps to have repayment policies that are consistent with other federal loan forgiveness programs, thereby decreasing the amount of loans in default and increasing the number of physicians practicing in underserved areas.
6. Work to reinstate the economic hardship deferment qualification criterion known as the “20/220 pathway,” and support alternate mechanisms that better address the financial needs of trainees with educational debt.
7. Advocate for federal legislation to support the creation of student loan savings accounts that allow for pre-tax dollars to be used to pay for student loans.
8. Work with other concerned organizations to advocate for legislation and regulation that would result in favorable terms and conditions for borrowing and for loan repayment, and would permit 100% tax deductibility of interest on student loans and elimination of taxes on aid from service-based programs.
9. 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).
10. Support stable funding for medical education programs to limit excessive tuition increases, and collect and disseminate information on medical school programs that cap medical education debt, including the types of debt management education that are provided.
11. Work with state medical societies to advocate for the creation of either tuition caps or, if caps are not feasible, pre-defined tuition increases, so that medical students will be aware of their tuition and fee costs for the total period of their enrollment.
12. Encourage medical schools to
 - (a) Study the costs and benefits associated with non-traditional instructional formats (such as online and distance learning, and combined baccalaureate/MD or DO programs) to determine if cost savings to medical schools and to medical students could be realized without jeopardizing the quality of medical education;
 - (b) Engage in fundraising activities to increase the availability of scholarship support, with the support of the Federation, medical schools, and state and specialty medical societies, and develop or enhance financial aid opportunities for medical students, such as self-managed, low-interest loan programs;
 - (c) Cooperate with postsecondary institutions to establish collaborative debt counseling for entering first-year medical students;
 - (d) Allow for flexible scheduling for medical students who encounter financial difficulties that can be remedied only by employment, and consider creating opportunities for paid employment for medical students;
 - (e) Counsel individual medical student borrowers on the status of their indebtedness and payment schedules prior to their graduation;
 - (f) Inform students of all government loan opportunities and disclose the reasons that preferred lenders were chosen;
 - (g) Ensure that all medical student fees are earmarked for specific and well-defined purposes, and avoid charging any overly broad and ill-defined fees, such as but not limited to professional fees;
 - (h) Use their collective purchasing power to obtain discounts for their students on necessary medical equipment, textbooks, and other educational supplies;
 - (i) Work to ensure stable funding, to eliminate the need for increases in tuition and fees to compensate for unanticipated decreases in other sources of revenue; mid-year and retroactive tuition increases should be opposed.
13. Support and encourage state medical societies to support further expansion of state loan repayment programs, particularly those that encompass physicians in non-primary care specialties.
14. Take an active advocacy role during reauthorization of the Higher Education Act and similar 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 federal Direct Loan Consolidation program, including the ability to “lock in” a fixed interest rate, and giving consideration to grace periods in renewals of federal loan programs;
 - (g) Adding the ability to refinance Federal Consolidation Loans;
 - (h) Eliminating the cap on the student loan interest deduction;
 - (i) Increasing the income limits for taking the interest deduction;
 - (j) Making permanent the education tax incentives that our AMA successfully lobbied for as part of Economic Growth and Tax Relief Reconciliation Act of 2001;
 - (k) Ensuring that loan repayment programs do not place greater burdens upon married couples than for similarly situated couples who are cohabitating;
 - (l) Increasing efforts to collect overdue debts from the present medical student loan programs in a manner that would not interfere with the provision of future loan funds to medical students.
15. 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.
 16. Continue to study medical education financing, so as to identify long-term strategies to mitigate the debt burden of medical students, and monitor the short-and long-term impact of the economic environment on the availability of institutional and external sources of financial aid for medical students, as well as on choice of specialty and practice location.
 17. Collect and disseminate information on successful strategies used by medical schools to cap or reduce tuition.
 18. Continue to monitor the availability of and encourage medical schools and residency/fellowship programs to (a) provide financial aid opportunities and financial planning/debt management counseling to medical students and resident/fellow physicians; (b) work with key stakeholders to develop and disseminate standardized information on these topics for use by medical students, resident/fellow physicians, and young physicians; and (c) share innovative approaches with the medical education community.
 19. Seek federal legislation or rule changes that would stop Medicare and Medicaid decertification of physicians due to unpaid student loan debt. The AMA believes that it is improper for physicians not to repay their educational loans, but assistance should be available to those physicians who are experiencing hardship in meeting their obligations.
 20. Related to the Public Service Loan Forgiveness (PSLF) Program, our AMA supports increased medical student and physician benefits the program, and will:
 - (a) Advocate that all resident/fellow physicians have access to PSLF during their training years;
 - (b) Advocate against a monetary cap on PSLF and other federal loan forgiveness programs;
 - (c) Work with the United States Department of Education to ensure that any cap on loan forgiveness under PSLF be at least equal to the principal amount borrowed;
 - (d) Ask the United States Department of Education to include all terms of PSLF in the contractual obligations of the Master Promissory Note;
 - (e) Encourage the Accreditation Council for Graduate Medical Education (ACGME) to require residency/fellowship programs to include within the terms, conditions, and benefits of program appointment information on the PSLF program qualifying status of the employer;
 - (f) Advocate that the profit status of a physician’s training institution not be a factor for PSLF eligibility;
 - (g) Encourage medical school financial advisors to counsel wise borrowing by medical students, in the event that the PSLF program is eliminated or severely curtailed;

- (h) Encourage medical school financial advisors to increase medical student engagement in 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;
- (i) 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.

APPENDIX C - AMA Policies Proposed for Rescission

D-305.956, "AMA Participation in Reducing Medical Student Debt"

Our AMA will explore the feasibility of the development of an affinity program in which student, resident and fellow members of our AMA could obtain new educational loans and consolidate existing loans from one or more national banks or other financial intermediaries. Membership in our AMA would be required during the life of the loan (typically 10 years or more following medical school). Such activities or program would neither result in our AMA becoming subject to regulation as a financial institution nor impair our AMA's ability to continue to be treated as a not-for-profit entity.

Res. 609, A-14; Modified: Speakers Rep., I-15

D-305.957, "Update on Financial Aid Programs"

Our AMA will: (a) through the advocacy process, explore the possibility of assuring that all resident physicians and fellows have access to the Public Service Loan Forgiveness Program for the time they are in residency and fellowship training; and (b) continue to monitor the short- and long-term impact of the economic environment on the availability of institutional and external sources of financial aid for medical students, as well as on choice of specialty and practice location.

CME Rep. 1, I-10

D-305.962, "Tax Deductibility of Student Loan Payments"

Our AMA will draft legislation allowing 100% tax deductibility of student loan interest.

Res. 232, A-09; Reaffirmed in lieu of Res. 225, I-12

D-305.966, "Reinstatement of Economic Hardship Loan Deferral"

Our AMA will actively work to reinstate the economic hardship deferral qualification criterion known as the "20/20 pathway," and support alternate mechanisms that better address the financial needs of post-graduate trainees with educational debt.

Res. 930, I-07; Reaffirmed: BOT Rep. 22, A-17

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

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 deferral 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-305.975, "Long-Term Solutions to Medical Student Debt"

Our AMA will:

(1) encourage medical schools and state medical societies to consider the creation of self-managed, low-interest loan programs for medical students, and collect and disseminate information on such programs;

(2) advocate for increased funding for the National Health Service Corps Loan Repayment Program to assure adequate funding of primary care within the National Health Service Corps, as well as to permit: (a) inclusion of all medical specialties in need, and (b) service in clinical settings that care for the underserved but are not necessarily located in health professions shortage areas;

- (3) work with state medical societies to advocate for the creation of either tuition caps or, if caps are not feasible, pre-defined tuition increases, so that medical students will be aware of their tuition and fee costs for the total period of their enrollment;
- (4) collect and disseminate information on medical school programs that cap medical education debt, including the types of debt management education that are provided; and
- (5) encourage the National Health Services Corps to have repayment policies that are consistent with other federal loan forgiveness programs, thereby decreasing the amount of loans in default and increasing the number of physicians practicing in underserved areas.

CME Rep. 3, I-04; Reaffirmation I-06; Appended: Res. 321, A-12; Reaffirmation A-13; Modified: CCB/CLRPD Rep. 2, A-14; Reaffirmation I-14

D-305.977, “Deductibility of Medical Student Loan Interest”

Our AMA will work toward 100% tax deductibility of medical student loan interest on federal and state income tax returns.
Res. 705, I-04; Reaffirmed: CME Rep. 2, A-14

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-305.979, “State and Local Advocacy on Medical Student Debt”

Our AMA will: (1) support and encourage our state medical societies to support further expansion of state loan repayment programs, and in particular expansion of those programs to cover physicians in non-primary care specialties; and
(2) urge state medical societies to actively solicit funds (either directly or through their Foundations) for the establishment and expansion of medical student scholarships, and that our AMA develop a set of guidelines and suggestions to assist states in carrying out such initiatives.

Res. 847, I-03; Reaffirmation A-13; Modified: CME Rep. 2, A-13

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-305.981, "Financing Federal Consolidation Loans"

Our AMA will: (1) support the refinancing of Federal Consolidation Loans; and (2) actively advocate for modification of pending and future legislation which that provides the opportunity to refinance Federal Consolidation Loans.

Res. 849, I-03; Reaffirmed: BOT Rep. 28, A-13

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

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.

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.

D-405.986, "Student Loans and Medicare / Medicaid Participation"

Our AMA will seek federal legislation or rule changes that would stop Medicare and Medicaid decertification of physicians due to unpaid student loan debt.

Res. 203, I-12

H-305.926, "Supporting Legislation to Create Student Loan Savings Accounts"

Our AMA will advocate for federal legislation to support the creation of student loan savings accounts that allow for pre-tax dollars to be used to pay for student loans.

Res. 202, A-16

H-305.928, "Proposed Revisions to AMA Policy on Medical Student Debt"

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

2. Our AMA supports stable funding for medical schools to eliminate the need for increases in tuition and fees to compensate for unanticipated decreases in other sources of revenue and should oppose mid-year and retroactive tuition increases.

3. Financial aid opportunities, including scholarship and loan repayment programs, should be available so that individuals are not denied an opportunity to pursue medical education because of financial constraints.
 4. A sufficient breadth of financial aid opportunities should be available so that student specialty choice is not constrained based on the need for financial assistance.
 5. Our AMA supports the creation of new and the expansion of existing medical education financial assistance programs from the federal government, the states, and the private sector.
 6. Medical schools should have programs in place to assist students to limit their debt. This includes making scholarship support available, counseling students about financial aid availability, and providing comprehensive debt management/financial planning counseling.
 7. Our AMA supports legislation and regulation that would result in favorable terms and conditions for borrowing and for loan repayment, and would permit the full deductibility of interest on student loans.
 8. Medical students should not be forced to jeopardize their education by the need to seek employment. Any decision on the part of the medical student to seek employment should take into account his/her academic situation. Medical schools should have policies and procedures in place that allow for flexible scheduling in the case that medical students encounter financial difficulties that can be remedied only by employment. Medical schools should consider creating opportunities for paid employment for medical students.
 9. Financial obligations, such as repayment of loans, and service obligations made in exchange for financial assistance, should be fulfilled. There should be mechanisms to assist physicians who are experiencing hardship in meeting these obligations.
 10. Our AMA supports the expansion and increase of medical student and physician benefits under Public Service Loan Forgiveness.
 11. Our AMA opposes any stipulations in loan repayment programs that place greater burdens upon married couples than for similarly-situated couples who are cohabitating.
- CME Rep. 13, A-06; Reaffirmation I-06; Reaffirmation I-07; Reaffirmation I-08; Reaffirmed: CME Rep. 8, A-12; Reaffirmation A-13; Appended: Res. 304, A-13; Appended: Res. 323, A-15; Reaffirmation I-15

H-305.932, "State and Local Advocacy on Medical Student Debt"

Our AMA:

- (1) opposes the charging of broad and ill-defined student fees by medical schools, such as but not limited to professional fees, encouraging in their place fees that are earmarked for specific and well-defined purposes;
- (2) encourages medical schools to use their collective purchasing power to obtain discounts for their students on necessary medical equipment, textbooks, and other educational supplies; and
- (3) encourages medical schools to cooperate with undergraduate institutions to establish collaborative debt counseling for entering first-year medical students.

Res. 847, I-03; Reaffirmed: CME Rep. 2, A-13

H-305.948, "Direct Loan Consolidation Program"

The AMA supports the Individual Education Account/Direct Loan Consolidation Program.

Res. 312, I-95; Reaffirmed: CME Rep. 2, A-05; Reaffirmed: CME Rep. 1, A-15

H-305.954, "Repayment of Medical School Loans"

Our AMA will further develop and more aggressively publicize a low interest rate and extended payment loan program for young physician members of the AMA to assist them in retiring their educational debts.

CME Rep. O, A-93; Appended: Res. 610, I-98; Modified: CME Rep. 13, A-06; Modified: CME Rep. 01, A-16

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

H-305.980, "Student Loan Repayment Grace Period"

The AMA supports giving consideration to grace periods in renewals of federal loan programs and attempting to secure the most favorable repayment terms.

CME Rep. I, A-86; Reaffirmed: Sunset Report, I-96; Reaffirmed: CME Rep. 2, I-00; Reaffirmed: CME Rep. 2, A-10

H-305.991, "Repayment of Educational Loans"

The AMA (1) believes that it is improper for any physician not to repay his or her educational loans;

(2) urges increased efforts to collect overdue debts from the present medical student loan programs in a manner that would not interfere with the provision of future loan funds to medical students; and

(3) encourages medical school financial aid officers to counsel individual medical student borrowers on the status of their indebtedness and payment schedules prior to their graduation.

Sub. Res. 47, A-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: CME Rep. 2, A-05; Reaffirmed: CME Rep. 1, A-15

APPENDIX D - Portions of AMA Policies That Are Not Being Retained Through This Report

Language	Rationale for removal
H-305.954: Our AMA will further develop and more aggressively publicize a low interest rate and extended payment loan program for young physician members of the AMA to assist them in retiring their educational debts.	Accomplished through AMA affinity partnership programs (Credible and Laurel Roads).
H-305.980: The AMA supports giving consideration to grace periods in renewals of federal loan programs and attempting to secure the most favorable repayment terms.	The first phrase, “giving consideration to grace periods in renewals of federal loan programs,” has been integrated into the new policy. The second phrase, “attempting to secure the most favorable repayment terms,” has been accomplished through the AMA affinity partnership programs (Credible and Laurel Roads).
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.	<ul style="list-style-type: none"> • Through an AMA affinity program, AMA members can obtain discounts on refinancing student loans. https://www.ama-assn.org/content/ama-preferred-provider-offers-and-services-loans-and-financial-services • The AMA Career Planning Resource offers budget planning tools: https://www.ama-assn.org/life-career/career-planning-resource. Evaluation of the feasibility of further tools has been accomplished. • The AMA Foundation provides student scholarships, as well as the AMA Employee-funded scholarship
D-305.956: Our AMA will explore the feasibility of the development of an affinity program in which student, resident and fellow members of our AMA could obtain new educational loans and consolidate existing loans from one or more national banks or other financial intermediaries. Membership in our AMA would be required during the life of the loan (typically 10 years or more following medical school). Such activities or program would neither result in our AMA becoming subject to regulation as a financial institution nor impair our AMA's ability to continue to be treated as a not-for-profit entity.	Accomplished through AMA affinity partnership programs (Credible and Laurel Roads).

6. RECONCILIATION OF AMA POLICY ON RESIDENT/FELLOW CONTRACTS AND DUTY HOURS

Reference committee hearing: see report of Reference Committee C.

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

See Policies H-310.907, H-310.912 and H-310.929

INTRODUCTION

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

POLICIES INCLUDED IN THIS REPORT

The following AMA policies are addressed in this report:

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

2. H-310.907, "AMA Duty Hours Policy"
3. H-310.912, "Residents and Fellows' Bill of Rights"
4. H-310.922, "Determining Residents' Salaries"
5. H-310.929, "Principles for Graduate Medical Education"
6. H-310.932, "Annual Contracts for Continuing Residents"
7. H-310.947, "Revision of the 'General Requirements' of the Essentials of Accredited Residency Programs"
8. H-310.979, "Resident Physician Working Hours and Supervision"
9. H-310.988, "Adequate Resident Compensation"
10. H-310.999, "Guidelines for Housestaff Contracts or Agreements"

SUMMARY AND RECOMMENDATIONS

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

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

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

- D-310.987, "Impact of ACGME Resident Duty Hour Limits on Physician Well-Being and Patient Safety"
- H-310.922, "Determining Residents' Salaries"
- H-310.947, "Revision of the 'General Requirements' of the Essentials of Accredited Residency Programs"
- H-310.979, "Resident Physician Working Hours and Supervision"

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

- H-310.932, "Annual Contracts for Continuing Residents"
- H-310.988, "Adequate Resident Compensation"
- H-310.999, "Guidelines for Housestaff Contracts or Agreements"

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

1. That our American Medical Association (AMA) adopt the proposed revisions shown in Appendix A, column 1, for the following three policies:
 - 1) H-310.907, "AMA Duty Hours Policy" (with revised title: "Resident/Fellow Clinical and Educational Work Hours")
 - 2) H-310.912, "Residents and Fellows' Bill of Rights"
 - 3) H-310.929, "Principles for Graduate Medical Education"
2. That our AMA rescind the following seven policies, as shown in Appendix C, and incorporate relevant portions of four of these policies into existing AMA policy:
 - 1) D-310.987, "Impact of ACGME Resident Duty Hour Limits on Physician Well-Being and Patient Safety"
 - 2) H-310.922, "Determining Residents' Salaries"
 - 3) H-310.932, "Annual Contracts for Continuing Residents"
 - 4) H-310.947, "Revision of the 'General Requirements' of the Essentials of Accredited Residency Programs"
 - 5) H-310.979, "Resident Physician Working Hours and Supervision"
 - 6) H-310.988, "Adequate Resident Compensation"
 - 7) H-310.999, "Guidelines for Housestaff Contracts or Agreements"

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
<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>	
Policy Title: AMA duty hours policy <u>Resident/Fellow Clinical and Educational Work Hours</u>	Policy Title: AMA duty hours policy
Our AMA adopts the following Principles of Resident/Fellow Duty Hours Clinical and Educational Work Hours , Patient Safety, and Quality of Physician Training:”	Our AMA adopts the following Principles of Resident/Fellow Duty Hours, Patient Safety, and Quality of Physician Training:
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 (previously referred to as “duty hours”)</u> .	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>
2. Our AMA will continue to monitor the enforcement and impact of duty clinical and educational work hour standards, in the context of the larger issues of patient safety and the optimal learning environment for residents.	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.
3. Our AMA encourages publication and supports dissemination of studies in peer-reviewed publications and educational sessions about all aspects of duty 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.	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.
4. Our AMA endorses the study of innovative models of duty clinical and educational work hour requirements and, pending the outcomes of 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.	4. Our AMA endorses the study of innovative models of duty hour requirements and, pending the outcomes of 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.
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>

Proposed language for adoption	Original language
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 duty clinical and educational work hours must not exceed 80 hours per week, averaged over a four-week period (Note: “Total duty 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).	a) Resident physician total duty hours must not exceed 80 hours per week, averaged over a four-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).
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.	<i>(unchanged)</i>
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.	<i>(unchanged)</i>
d) At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident.	<i>(unchanged)</i>
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.”	<i>(unchanged)</i>
f) Given the different education and patient care needs of the various specialties and changes in resident responsibility as training progresses, duty 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, to the 16-hour shift limit for first-year residents , or allowing a limited increase to the total number of duty clinical and educational work hours when need is demonstrated.	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.
g) Resident physicians should be ensured a sufficient duty-free interval prior to returning to duty.	<i>(unchanged)</i>
h) Duty Clinical and educational work hour limits must not adversely impact resident physician participation in organized educational activities. Formal educational activities must be	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.

Proposed language for adoption	Original language
scheduled and available within total <u>duty clinical and educational work</u> 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 <u>duty clinical and educational work</u> hour limits should be borne by all health 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>	n) The costs of duty hour limits should be borne by all health care payers. (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>
9. Our AMA will actively participate in ongoing efforts to <u>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
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	<i>(unchanged)</i>

Proposed language for adoption	Original language
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.	<i>(unchanged)</i>
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.	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.
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.	<i>(unchanged)</i>
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 PHYSICIANS' 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>

Proposed language for adoption	Original language
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. <u>It is neither feasible nor desirable to develop universally applicable and precise requirements for supervision of residents.</u>	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. (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
C. Regular and timely feedback and evaluation based on valid assessments of resident performance.	<i>(unchanged)</i>
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.	<i>(unchanged)</i>
D. A safe and supportive workplace with appropriate facilities.	<i>(unchanged)</i>
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.	<i>(unchanged)</i>
E. Adequate compensation and benefits that provide for resident well-being and health.	<i>(unchanged)</i>
(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.	<i>(unchanged)</i>
(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>	(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. 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.

Proposed language for adoption	Original language
	H-310.922
(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 amount of paid vacation leave, sick leave, maternity and paternity 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; and e. Leave in compliance with the Family and Medical Leave Act-; and f. <u>The conditions under which sleeping quarters, meals and laundry or their equivalent are to be provided.</u>	(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. 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
F. Duty <u>Clinical and educational work</u> hours that protect patient safety and facilitate resident well-being and education.	F. Duty hours that protect patient safety and facilitate resident well-being and education.
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-clinical and educational work 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-clinical and educational work hour requirements are effectively circumvented. <u>Refer to AMA Policy H-310.907, "Resident/Fellow Clinical and Educational Work Hours," for more information.</u>	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.
G. Due process in cases of allegations of misconduct or poor performance.	<i>(unchanged)</i>
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.	<i>(unchanged)</i>
H. Access to and protection by institutional and accreditation authorities when reporting violations.	<i>(unchanged)</i>
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.	<i>(unchanged)</i>

Proposed language for adoption	Original language
CME Rep. 8, A-11 Appended: Res. 303, A-14 Reaffirmed: Res.	915, I-15 Appended: CME Rep. 04, A-16

H-310.929, "Principles for Graduate Medical Education"

Proposed language for adoption	Original language
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.	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.
(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. <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>	(1) PURPOSE OF GRADUATE MEDICAL EDUCATION. 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. (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. (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. H-310.979
(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.	<i>(unchanged)</i>
(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.	<i>(unchanged)</i>
(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.	<i>(unchanged)</i>
(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.	<i>(unchanged)</i>
(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	(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

Proposed language for adoption	Original language
<p>following; the initial authorization of programs, the appointment of program directors, compliance with the Essentials for Accredited Residencies in Graduate Medical Education 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.</p>	<p>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 similar organizations, to address patient care and resident work environment concerns. Institutional committees should include resident members.</p>
<p>(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.</p>	<p><i>(unchanged)</i></p>
<p>(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.</p>	<p><i>(unchanged)</i></p>
<p>(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.</p>	<p><i>(unchanged)</i></p>
<p>(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.</p>	<p><i>(unchanged)</i></p>
<p>(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</p>	<p><i>(unchanged)</i></p>

Proposed language for adoption	Original language
education and service. Resident physicians must be treated as colleagues.	
<p>(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</u>. <u>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</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>(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.</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. 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 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>(unchanged)</p>
<p>(14) GRADUATE MEDICAL EDUCATION IN THE AMBULATORY SETTING. Graduate medical education</p>	<p>(unchanged)</p>

Proposed language for adoption	Original language
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.	<i>(unchanged)</i>
CME Rep. 9, A-99 Reaffirmed: CME Rep. 2, A-09 Reaffirmed: CME Rep. 14, A-09	

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 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.
- 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 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, 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.	Still relevant, but rescind and incorporate into H-310.912 (E.3), "Residents and Fellows' Bill of Rights." 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.
CME Rep. Q, A-93 Modified: CME Rep. 2, A-03 Reaffirmed: CME Rep. 2, A-13	

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

Original language	Rationale for rescission
(1) Our AMA supports the following principles regarding the supervision of residents and the avoidance of the harmful effects of excessive fatigue and stress:	Still relevant, but rescind and incorporate relevant aspects into other policies, as noted below.
(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.	Incorporate into H-310.929 (1), "Principles for Graduate Medical Education."
(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.	
(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. (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. (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. (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.	Incorporate relevant aspects into H-310.929 (12), "Principles for Graduate Medical Education."

Original language	Rationale for rescission
(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."	Rescind; already reflected in H-295.858, "Access to Confidential Health Services for Medical Students and Physicians," as follows: "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."
(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.	Rescind; already reflected in H-310.912 (A), "Residents and Fellows' Bill of Rights," as follows: "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." Also reflected in H-310.907 (7), "AMA duty hours policy," as follows: "i) Scheduled time providing patient care services of limited or no educational value should be minimized."
(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."	Incorporate into H-310.912 (B), "Residents and Fellows' Bill of Rights."
(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.	Incorporate into H-310.907 (7.n), "AMA duty hours policy."
(2) These problems should be addressed within the present system of graduate medical education, without regulation by agencies of government.	Rescind; already reflected in H-310.907 (7), "AMA duty hours policy," as follows: "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."
CME Rep. C, I-87; Modified: Sunset Report, I-97; Modified and Reaffirmed: CME Rep. 2, A-08	

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
<p>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.</p>	<p>Rescinded; 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).</p>
<p>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.</p>	
<p>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 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</p>	

<p>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 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 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</p>	

<p>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 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 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>	

7. 50TH ANNIVERSARY OF THE AMA PHYSICIANS' RECOGNITION AWARD AND CREDIT SYSTEM

Informational report; no reference committee hearing.

HOUSE ACTION: FILED

INTRODUCTION

The American Medical Association (AMA) is celebrating the 50th anniversary of the AMA Physician's Recognition Award (PRA) this year. This report regarding the AMA PRA, and the credit system that was developed to support this award, is submitted to the House of Delegates (HOD) for informational purposes.

The AMA has played a central role in the development of continuing medical education (CME) in the United States by developing the AMA PRA credit system, which codified the requirements and standards for earning *AMA PRA Category 1 Credit™* and *AMA PRA Category 2 Credit™*. The AMA PRA was established by the HOD in December 1968 to recognize physicians who, by participating in CME activities, have demonstrated their commitment to staying current with advances in medicine. The 1968 report adopted by the HOD that established the AMA PRA included the following goals:

1. To provide recognition for the many thousands of physicians who regularly participate in CME.
2. To encourage each physician to keep up-to-date and to improve knowledge and judgment by CME.

3. To provide reassurance to the public that America's physicians are maintaining their competence by regular participation in CME.
4. To emphasize the AMA's position as a leader in CME.
5. To emphasize the importance of developing more meaningful continuing education opportunities for physicians.

STATUS OF THE AMA PRA AND CREDIT SYSTEM

AMA PRA credit is the most widely accepted CME credit used by physicians of all specialties to document CME participation for licensing boards, certification boards, hospital credentialing committees, insurance groups, and other organizations. A total of 50 U.S. jurisdictions, including 45 states, four territories, and Washington, DC, currently have CME requirements for licensure of physicians; all recognize AMA PRA credit to fulfill these requirements. Many jurisdictions accept the AMA PRA certificate or an approved AMA PRA application as documentation of meeting their CME requirements.

The AMA PRA credit system has continued to respond to the needs of physicians and to changes in the practice of medicine. Recognizing that physicians learn in different ways and that a variety of educational formats should be recognized for credit, the AMA Council on Medical Education has approved new educational formats for *AMA PRA Category 1 Credit™* over the years, in addition to the original formats of live certified activities and enduring materials. Subsequently approved formats include Journal-Based CME (1998), Manuscript Review (2003), Test Item Writing (2003), Performance Improvement CME (2004), and Internet Point-of-Care (2005). Most recently, in 2017, the Council on Medical Education approved a format of "Other" for those activities that meet core requirements but do not fall within one of the already existing formats.

Previous domestic credit system innovations include the following:

1. Permitting physicians to self-claim *AMA PRA Category 2 Credit™* for educational experiences (not designated for *AMA PRA Category 1 Credit™*) that comply with the AMA definition of CME and pertinent Council on Ethical and Judicial Affairs opinions; and
2. Allowing physicians to apply directly to the AMA for *AMA PRA Category 1 Credit™* for defined activities that have been recognized as worthwhile learning experiences but are not certified for credit through an accredited CME provider. These include teaching at live CME activities that are designated for *AMA PRA Category 1 Credit™*; publishing articles in MEDLINE indexed journals; presenting a poster that is included in the published abstracts for a conference certified for *AMA PRA Category 1 Credit™*; earning medically-related advanced degrees; completing an American Board of Medical Specialties (ABMS) member board certification process (a primary ABMS member board certification/recertification or a subspecialty board certification/recertification); or successfully completing an Accreditation Council for Graduate Medical Education-accredited residency or fellowship.

The AMA PRA credit system also operates beyond U.S. borders. In 1990, the HOD adopted a Council on Medical Education report to establish a process for qualified international conferences to offer *AMA PRA Category 1 Credit™* to attendees. The International Conference Recognition Program continues to this day, and international opportunities to earn *AMA PRA Category 1 Credit™* have expanded to include activities covered by agreements between the AMA and credit systems of other regions and nations. Three agreements currently exist, with the European Union of Medical Specialists, the Royal College of Physicians and Surgeons of Canada, and the Qatar Council for Healthcare Practitioners.

Finally, the AMA has embarked upon an ongoing process with the Accreditation Council for Continuing Medical Education (ACCME) with the intent of aligning the credit and accreditation systems and simplifying the process for both physicians and CME providers. Organizations that are accredited by either the ACCME or an ACCME-recognized state medical society are given the privilege, by the AMA, of certifying activities for *AMA PRA Category 1 Credit™* and awarding that credit to physicians. That privilege may be withdrawn by the AMA if the accredited CME provider fails to bring the program and activities into compliance with AMA PRA policies, regardless of accreditation status. Recently, the AMA developed a process with the ACCME to revise requirements for accredited

CME providers. That process led to development of aligned and simplified requirements that became effective September 29, 2017. The AMA and the ACCME will continue to work together to modernize and evolve CME activities while maintaining educational quality.

CURRENT AMA POLICY

AMA policies related to this topic are listed in the Appendix.

SUMMARY

The past 50 years have seen many changes in CME, and the AMA has led many of these changes by adapting the AMA PRA and the credit system to include new concepts, introduce new ideas, and recognize the multiple ways in which physicians learn and improve. The AMA PRA credit system must continue to be responsive to the needs of physicians to ensure they are adequately recognized for their participation in certified CME activities. To achieve this goal, the Council on Medical Education recognizes the importance of its continued stewardship of this valuable process.

As the AMA celebrates the 50th anniversary of this award, the Council on Medical Education would like to draw attention to Policy H-300.959, “Physician Participation in the AMA Physician’s Recognition Award,” which states that: “(1) the AMA, state medical societies, and specialty societies in the AMA House of Delegates publicize and promote physician participation in the AMA Physician’s Recognition Award; and (2) that all physicians participate in the AMA Physician’s Recognition Award as a visible demonstration of their commitment to continuing medical education.”

APPENDIX - Relevant AMA Policy

H-275.917, “An Update on Maintenance of Licensure”

3. Our AMA will: A. Continue to support and promote the AMA Physician’s Recognition Award (PRA) Credit system as one of the three major CME credit systems that comprise the foundation for continuing medical education in the United States, including the Performance Improvement CME (PICME) format, and continue 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 as part of the process for MOL.

H-275.924, “Maintenance of Certification”

AMA Principles on Maintenance of Certification (MOC): 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 United States, 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.

H-295.926, “Support for Development of Continuing Education Programs for Primary Care Physicians in Non-Academic Settings”

The AMA: (1) supports development, where appropriate, of programs of education for medical students and faculty in non-academic settings, making use of telecommunications as needed; (2) encourages that medical schools provide faculty development programs that are designated for AMA PRA Category 1 Credit™; and (3) encourages that teaching continue to be accepted for AMA PRA Category 2 Credit™ when not designated for AMA PRA Category 1 Credit™.

H-300.955, “Restructuring of Continuing Medical Education Credits”

The AMA encourages state licensing boards with CME reporting requirements to allow AMA PRA Category 1 Credit™ and AMA PRA Category 2 Credit™ toward reregistration of the license to practice medicine; and all state licensing boards be urged to accept a current and valid AMA Physician’s Recognition Award as evidence of completion of these requirements.

H-300.959, “Physician Participation in the AMA Physician’s Recognition Award”

It is policy that: (1) the AMA, state medical societies, and specialty societies in the AMA House of Delegates publicize and promote physician participation in the AMA Physician’s Recognition Award; and (2) that all physicians participate in the AMA Physician’s Recognition Award as a visible demonstration of their commitment to continuing medical education.

H-300.974, “Unification of Continuing Education Credits”

Our AMA accepts American Academy of Family Physicians prescribed credit hours and American College of Obstetricians and Gynecologists cognate credit hours for formal learning, as equivalent to AMA PRA Category 1 Credit™.

H-300.977, “Revisions to the Physician’s Recognition Award”

Our AMA has adopted the following changes in the Physician’s Recognition Award: (1) to accept recertification by an AMA-recognized specialty board in satisfaction of requirements for a three-year PRA certificate; (2) to allow credit for international conferences when these have been approved by the AMA prior to the event; and (3) to allow credit for teaching to be reported for AMA PRA Category 2 Credit™ toward the award.

D-300.999, “Registration of Accredited CME Sponsors”

1. Our AMA will continue cooperative efforts to assure that accredited sponsors of continuing medical education adhere to AMA Physician’s Recognition Award (PRA) policy when designating AMA PRA credit. 2. Our AMA will remind all accredited CME providers of their responsibility, as stated in the AMA PRA requirements, to provide documentation to participating physicians of the credit awarded at the request of the physician.

H-480.974, “Evolving Impact of Telemedicine”

Our AMA: (7) will develop a means of providing appropriate continuing medical education credit, acceptable toward the Physician’s Recognition Award, for educational consultations using telemedicine...

8. STUDY OF MEDICAL STUDENT, RESIDENT AND PHYSICIAN SUICIDE

Informational report; no reference committee hearing.

HOUSE ACTION: FILED

American Medical Association (AMA) Policy D-345.984, “Study of Medical Student, Resident, and Physician Suicide,” states:

That our American Medical Association determine the most efficient and accurate mechanism to study the actual incidence of medical student, resident, and physician suicide, and report back at the 2018 Interim Meeting of the House of Delegates with recommendations for action.

This policy resulted from Resolution 019-A-18, which called for our AMA to conduct a study to accurately quantify the actual incidence of medical student, resident, and physician suicide. Testimony on this item was unanimously supportive during the hearing of the Reference Committee on Amendments to Constitution and Bylaws at the 2018 AMA Annual Meeting. In its report, the reference committee noted the severity of the issue of physician suicide and the significant need for attention to this problem. However, our AMA does not generally conduct independent empirical research. Therefore, the Reference Committee suggested amending Resolution 19-A-18 so that the AMA could determine the most efficient and accurate mechanism to accurately quantify the actual incidence of medical student, resident, and physician suicide. Your Reference Committee consequently recommended adoption with this amendment and a directive to report back findings at the 2018 Interim Meeting of the House of Delegates (HOD).

The AMA Council on Medical Education recognizes the salience and timeliness of this topic and agrees that appropriate resources should be dedicated to identify these mechanisms for study. However, meaningful and constructive review of this issue, and of the work done to date by other organizations, will require additional time. The Council therefore will present a report on this issue at the 2019 Annual Meeting of the HOD.