Reference Committee C

CME Report(s)

02 Healthcare Finance in the Medical School Curriculum

03 Standardization of Medical Licensing Time Limits Across States

04 Board Certification Changes Impact Access to Addiction Medicine Specialists

06 Veterans Health Administration Funding of Graduate Medical Education

Resolution(s)

301 Engaging Stakeholders for Establishment of a Two-Interval, or Pass/Fail, Grading System of Non-Clinical Curriculum in U.S. Medical Schools

302 Strengthening Standards for LGBTQ Medical Education

303 Investigation of Existing Application Barriers for Osteopathic Medical Students Applying for Away Rotations

304 Issues with the Match, The National Residency Matching Program (NRMP)

305 Ensuring Access to Safe and Quality Care for our Veterans

306 Financial Burden of USMLE Step 2 CS on Medical Students

307 Implementation of Financial Education Curriculum for Medical Students and Physicians in Training

308 Study Expediting Entry of Qualified IMG Physicians to US Medical Practice

* *Contained in Handbook Addendum*

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 2-I-19

Subject: Healthcare Finance in the Medical School Curriculum (Resolution 307-A-18)

Presented by: Jacqueline A. Bello, MD, Chair

Referred to: Reference Committee C

INTRODUCTION

Resolution 307-A-18, "Healthcare Finance in the Medical School Curriculum," introduced by the Missouri Delegation and referred by the American Medical Association (AMA) House of Delegates (HOD), asks that the AMA "study the extent to which medical schools and residency programs are teaching topics of healthcare finance and medical economics" and "make a formal suggestion to the Liaison Committee on Medical Education encouraging the addition of a new Element, 7.10, under Standard 7, 'Curricular Content,' that would specifically address the role of healthcare finance and medical economics in undergraduate medical education."

During the 2018 Annual Meeting, Reference Committee C heard mixed testimony on this item. It was noted that health care finance is already being taught in some medical schools, but an overall understanding of the breadth, depth, and frequency of these offerings is unknown. Furthermore, concern was expressed that the second Resolve implied a curricular mandate in an already distended medical education curriculum. The reference committee believed that additional study was warranted; the HOD agreed, and this item was referred. This report addresses that referral.

BACKGROUND AND DATA

The United States spends more on health care than any other nation in the world, with health care expenditures at 17.9 percent of gross domestic product in 2017, and national health care spending is projected to increase at a rate of 5.5 percent per year for the next 10 years under current law. Multiple factors contribute to the high cost of health care in the United States, including costs for labor and goods, pharmaceutical costs, administrative costs.[1,2,3] Numerous studies have found that while cost of care in the U.S. is often double that of other industrialized countries, outcome measures are essentially the same. In recognition of this concern, reducing cost of care is one of the Triple Aims of the Institute for Health Care Improvement and one of the three core aims of health care reform. [4]

The medical education system has been shown to favorably impact cost of care by medical school graduates who have had cost, financing, and medical economics topics integrated into their respective program curricula. Chen et al.[5] found that the spending pattern of the training location was positively associated with care expenditures when the residents entered practice, implying that interventions in training may have the potential to reduce health care spending after completion of training. Phillips et al.[6] similarly found that family physician and general internist spending was influenced by location of training in low, average, or high-cost locations, and concluded, "The 'imprint' of training spending patterns on physicians is strong and enduring, without discernible

© 2019 American Medical Association. All rights reserved.

quality effects…" Stammen et al.[7] in a published systematic review on the effectiveness of medical education on high-value, cost-conscious care, reached the following conclusion:

> … learning by practicing physicians, resident physicians, and medical students is promoted by combining specific knowledge transmission, reflective practice, and a supportive environment. These factors should be considered when educational interventions are being developed.

Curriculum content in health care financing is currently required by the accrediting body for allopathic medical schools in the United States, the Liaison Committee on Medical Education (LCME). The LCME's accreditation *Standard 7: Curricular Content* requires that "the medical school curriculum provides content of sufficient breadth and depth to prepare medical students for entry into any residency program and for the subsequent contemporary practice of medicine." This requirement is expressed through *Element 7.1: Biomedical, Behavioral, and Social Sciences* by ensuring that "the medical curriculum includes content from biomedical, behavioral, and socioeconomic sciences to support medical students' mastery of contemporary scientific knowledge and concepts and the methods fundamental to applying them to the health of individuals and populations."[8] As part of their accreditation documents, schools are asked to document where in the curriculum health care financing is taught (preclinical or clinical phases), but schools are not asked to comment on the content or quantity of the subject matter. The quality of instruction and educational materials is not evaluated. No inquiries are made regarding medical economics.[9]

Unrelated to the accreditation process, each year the LCME requests that schools complete a voluntary survey, the LCME Annual Medical School Questionnaire Part II. The questionnaire includes queries on where in the curriculum certain topics are taught. Data relevant to this report from academic years 2013-14 through 2017-18 are provided in the tables below.

Health Care Financing*/Cost of Care#					
Survey year	Total number of schools surveyed	Location in curriculum			
		Required Course	Elective	Pre-clerkship	Clerkships
2017-18*	147	131	63	120	89
2016-17#	145	140	72	128	97
2015-16#	142	137	67	120	125
2014-15*	141	140	61	127	112
2014-15#	141	139	84	120	112
2013-14*	140	133	64	120	108
2013-14#	140	129	53	112	103

* Survey item was "health care financing"
# Survey question was "cost of care"
2013-14 and 2014-15 surveys included both terms

Medical Socioeconomics*/Medical Economics#					
Survey year	Total number of schools surveyed	Location in curriculum			
		Required Course	Elective	Pre-clerkship	Clerkships
2017-18*	147	143	79	141	117
2017-18#	147	135	85	132	105
2016-17*	145	136	84	129	105
2016-17#	145	141	77	136	112
2015-16#	142	132	71	123	107

2015-16*	142	138	72	131	110
2014-15*	141	137	96	128	116
2013-14*	140	133	60	125	106

* Survey item was "medical socioeconomics"
# Survey question was "medical economics"
2015-16, 2016-17, and 2017-18 surveys included both terms

1 For 2016-17 and 2017-18, schools were also asked where in the curriculum the specific topics were
2 covered to prepare students for entry into residency training.

Health system content (e.g., health care financing, billing, coding)					
Survey year	Total number of schools surveyed	Location in curriculum			
		4th year transition to residency course	Required sub-internship	Required 3rd year clinical clerkship	Intersession
2017-18	147	67	42	80	42
2016-17	145	82	51	93	52

3 The accreditation standards of the Commission on Accreditation of Osteopathic Colleges (COCA)
4 do not explicitly state a requirement for curriculum related to medical economics or health care
5 financing.[10]
6
7 The Accreditation Council for Graduate Medical Education common program requirements
8 IV.B.1.f).(1).(f) and (g) require residents to demonstrate competence in "incorporating
9 considerations of value, cost awareness, delivery and payment…" and "understanding health care
10 finances and its impact on individual patients' health decisions." [11] A limited review of specialty-
11 specific milestones, the mechanism by which residents are assessed for achievement of
12 competency, revealed that family medicine, internal medicine, emergency medicine, and diagnostic
13 radiology have milestones that assess residents' competency in delivering cost-conscious care,
14 cost-effective care, or consideration of health care costs.[12]
15
16 CURRENT INITIATIVES
17
18 Despite the UME and GME requirements noted above, there has been a growing realization of the
19 need for additional training in health systems, including health care financing and medical
20 economics during UME. To address this concern, the concept of health systems science (HSS) has
21 recently taken hold as a "third pillar" of medical education[13] (basic science and clinical science
22 being the traditional two pillars). In recognition of the need to change the medical education system
23 to train physicians in HSS, the AMA funded the Accelerating Change in Medical Education
24 initiative, with the goal of enhancing medical school curricula to better train future physicians in
25 the competencies needed to provide high quality care in health systems. HSS curriculum, which
26 includes medical economics content, is a focus of the initiative. A tangible outcome from the
27 consortium was the publication of the first HSS textbook.[14] The initial 11-school consortium has
28 grown to 37 schools. The AMA also supports a learning module, "Health Care Delivery Systems -
29 AMA Health Systems Science Learning Series," through the AMA Ed Hub.[15] In addition, through
30 its GME Competency Education Program (GCEP), the AMA offers a series of online educational
31 modules designed to complement teachings in residency and fellowship programs, with a library of
32 more than 30 individualized courses designed for self-paced learning. One content area of the

module is how payment models affect patient care and costs. A study of consortium schools found that health care economics and value-based care are core domains of their HSS curricula.[16]

The inclusion of UME curricular content on HSS in general, and health care financing specifically, has been advanced by the inclusion of these topics on standardized examinations. The United States Medical Licensing Examination (USMLE) Content Outline website lists health care economics, health care financing, high value/cost-conscious care, and relevant subtopics as content areas across all USMLE examinations.[17] A case-based review book on HSS has been developed by the ACE consortium as a review tool on HSS topics covered on the USMLE examinations.[18] The review book includes a chapter of cases and questions on health care economics.[19] To further support HSS assessment at the UME level, a pilot subject examination in HSS has been developed by a consortium of medical schools in collaboration with the National Board of Medical Examiners.[20]

RELEVANT AMA POLICY

H-295.924, "Future Directions for Socioeconomic Education" (Modified and reaffirmed 2017)

> The AMA: (1) asks medical schools and residencies to encourage that basic content related to the structure and financing of the current health care system, including the organization of health care delivery, modes of practice, practice settings, cost effective use of diagnostic and treatment services, practice management, risk management, and utilization review/quality assurance, is included in the curriculum; (2) asks medical schools to ensure that content related to the environment and economics of medical practice in fee-for-service, managed care and other financing systems is presented in didactic sessions and reinforced during clinical experiences, in both inpatient and ambulatory care settings, at educationally appropriate times during undergraduate and graduate medical education; and (3) will encourage representatives to the Liaison Committee on Medical Education (LCME) to ensure that survey teams pay close attention during the accreditation process to the degree to which "socioeconomic" subjects are covered in the medical curriculum.

D-295.321, "Health Care Economics Education" (Modified and reaffirmed 2015)

> Our AMA, along with the Association of American Medical Colleges, Accreditation Council for Graduate Medical Education, and other entities, will work to encourage education in health care economics during the continuum of a physician's professional life, starting in undergraduate medical education, graduate medical education and continuing medical education.

H-295.977, "Socioeconomic Education for Medical Students" (Modified 2010)

> 1. The AMA favors (a) continued monitoring of U.S. medical school curricula and (b) providing encouragement and assistance to medical school administrators to include or maintain material on health care economics in medical school curricula.
> 2. Our AMA will advocate that the medical school curriculum include an optional course on coding and billing structure, RBRVS, RUC, CPT and ICD-9.

H-295.864, "Systems-Based Practice Education for Medical Students and Resident/Fellow Physicians" (Modified and reaffirmed 2017)

> Our AMA: (1) supports the availability of educational resources and elective rotations for medical students and resident/fellow physicians on all aspects of systems-based practice, to improve awareness of and responsiveness to the larger context and system of health care and to aid in developing our next generation of physician leaders; (2) encourages development of model guidelines and curricular goals for elective courses and rotations and fellowships in systems-based practice, to be used by state and specialty societies, and explore developing an educational module on this topic as part of its Introduction to the Practice of Medicine (IPM) product; and (3) will request that undergraduate and graduate medical education accrediting bodies consider incorporation into their requirements for systems-based practice education such topics as health care policy and patient care advocacy; insurance, especially pertaining to policy coverage, claim processes, reimbursement, basic private insurance packages, Medicare, and Medicaid; the physician's role in obtaining affordable care for patients; cost awareness and risk benefit analysis in patient care; inter-professional teamwork in a physician-led team to enhance patient safety and improve patient care quality; and identification of system errors and implementation of potential systems solutions for enhanced patient safety and improved patient outcomes.

SUMMARY AND RECOMMENDATIONS

The academic literature suggests that education and role-modeling have an effect on the cost-effectiveness of care provided by graduates of programs that emphasize cost considerations in education of physicians. Curriculum content on health care financing/medical economics is required by the accrediting bodies for allopathic medical schools and GME programs. With few exceptions, allopathic medical schools report the inclusion of the topics of health care financing, health care costs, medical socioeconomics, and medical economics in their respective curricula. Several of the larger GME specialty milestones require cost considerations in the training curricula. The exact content and amount of curricular time devoted to these topics at individual schools and GME programs is unknown. The AMA provides online educational resources on HSS topics, including the effect of payment models on health outcomes and cost of care, and the AMA-supported Accelerating Change in Medical Education initiative includes medical economics in the focus area of HSS. USMLE Step exams include questions on health care economics, and a subject exam focusing on HSS has been developed. The AMA has existing policy encouraging medical schools and residency programs to include health care finance and medical economics in their respective curricula while avoiding curricular mandates.

Related to Resolution 307-A-18, its first directive (that the AMA "study the extent to which medical schools and residency programs are teaching topics of healthcare finance and medical economics") has been addressed through this report.

The resolution also asks that the AMA "make a formal suggestion to the Liaison Committee on Medical Education encouraging the addition of a new Element, 7.10, under Standard 7, 'Curricular Content,' that would specifically address the role of healthcare finance and medical economics in undergraduate medical education." To address this aspect, amendments to Policy H-295.924, "Future Directions for Socioeconomic Education," are proposed below. The rationale for each edit is as follows:

- GME programs, not medical schools, are responsible for graduate medical education. Most GME programs are not under the direct authority of medical schools. Adding "and

residencies" to item 2 of this policy clarifies the responsibility and authority for oversight of graduate medical education and curricular content.

- Historically, the AMA has refrained from curricular mandates, especially mandates with this degree of specificity. Similarly, the LCME has been disinclined to accept recommendations with curricular mandates. Eliminating the phrase "in didactic sessions and reinforced during clinical experiences, in both inpatient and ambulatory care settings" allows for more flexibility to medical schools and residency programs in implementation of this curricular content.

- The AMA does not have "representatives" on the LCME. Some LCME members are nominated by the AMA for consideration as professional members of the LCME, but, if elected by the LCME, they do not represent the AMA. Their fiduciary responsibility while serving as a member of the LCME is to the LCME. DOE regulations require separation of the accrediting agency from direct sponsor influence.

The Council on Medical Education therefore recommends that the following recommendation be adopted in lieu of Resolution 307-A-18 and the remainder of the report be filed.

1. That our American Medical Association (AMA) amend Policy H-295.924, "Future Directions for Socioeconomic Education," by addition and deletion to read as follows:

"The AMA: (1) asks medical schools and residencies to encourage that basic content related to the structure and financing of the current health care system, including the organization of health care delivery, modes of practice, practice settings, cost effective use of diagnostic and treatment services, practice management, risk management, and utilization review/quality assurance, is included in the curriculum; (2) asks medical schools and residencies to ensure that content related to the environment and economics of medical practice in fee-for-service, managed care and other financing systems is presented ~~in didactic sessions and reinforced during clinical experiences, in both inpatient and ambulatory care settings,~~ at educationally appropriate times during undergraduate and graduate medical education; and (3) will encourage ~~representatives to~~ the Liaison Committee on Medical Education (LCME) to ensure that survey teams pay close attention during the accreditation process to the degree to which 'socioeconomic' subjects are covered in the medical curriculum." (Modify Current HOD Policy)

Fiscal note: $500.

REFERENCES

1. Garber AM, Skinner J. Is American Health Care Uniquely Inefficient? J. Econ Perspect 2008 Sept 1, 22(4) 27-50.

2. CMS.gov NHE Fact Sheet. https://www.cms.gov/research-statistics-data-and-systems/statistics- trends-and-reports/nationalhealthexpenddata/nhe-fact-sheet.html (Accessed May 29, 2019)

3. Papanicolas I, Woske LR, Jha AK. Health Care Spending in the United States and Other High-Income Countries. JAMA. 2018 Mar 13;319(10):1024-1039. doi: 10.1001/jama.2018.1150.

4. Davis MM, Tobin-Tyler E, Schwartz MD. Health Care Policy and Economics. In Skochelak SE, Hawkins RE, Lawson LE, Starr SR, Borkan JM, and Gonzalo JD, eds. *Health System Science*. Elsevier Philadelphia 2017.

5. Chen C, Petterson S, Phillips R, Bazemore A, Mullan F. Spending patterns in region of residency training and subsequent expenditures for care provided by practicing physicians for Medicare beneficiaries. JAMA. 2014 Dec 10;312(22):2385-93. doi: 10.1001/jama.2014.15973.

6. Phillips RL Jr, Petterson SM, Bazemore AW, Wingrove P, Puffer JC. The Effects of Training Institution Practice Costs, Quality, and Other Characteristics on Future Practice. Ann Fam Med. 2017 Mar;15(2):140-148. doi: 10.1370/afm.2044.

7. Stammen LA, Stalmeijer RE, Paternotte E, et al. 2015. Training Physicians to Provide High-Value, Cost-Conscious Care: A Systematic Review. JAMA. 2015 Dec 8;314(22):2384-400. doi: 10.1001/jama.2015.16353.

8. Functions and Structure of a Medical School. March 2018 ed. Published by the Liaison Committee on Medical Education. Available at www.LCME.org.

9. Guide to the Institutional Self-study for Full Accreditation. April 2019 ed. Published by the Liaison Committee on Medical Education. Available at http://lcme.org/publications/.

10. Commission on Osteopathic College Accreditation Standards. July 2019 ed. Published by the Commission on Osteopathic College Accreditation. Available at https://osteopathic.org/accreditation/standards/.

11. ACGME Common Program Requirements (Residency). 2018 ed. Available at https://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/CPRResidency2019.pdf.

12. Accreditation Council for Graduate Medical Education: Milestones. Available at https://www.acgme.org/Specialties/Milestones/pfcatid/16Julie/Specialties

13. Gonzalo JD, Skochelak SE. Wolpaw DR. Health Systems Science in Medical Education. In Skochelak SE, Hawkins RE, Lawson LE, Starr SR, Borkan JM, and Gonzalo JD, eds. *Health System Science*. Elsevier Philadelphia, 2017.

14. Skochelak SE, Hawkins RE, Lawson LE, Starr SR, Borkan JM, and Gonzalo JD, eds. *Health Systems Science,* Elsevier; Philadelphia 2017.

15. Health Care Delivery Systems - AMA Health Systems Science Learning Series https://edhub.ama-assn.org/health-systems-science/interactive/17498797.

16. Gonzalo JD, Dekhtyar M, Starr SR, Borkan J, Brunett P *et al*. Health systems science curricula in undergraduate medical education: identifying and defining a potential curricular framework. Academic Medicine 2017; 92(1): 123-31.

17. USMLE Content Outline. https://www.usmle.org/pdfs/usmlecontentoutline.pdf. (Accessed June 5, 2019).

18. Ehrenfeld JM, Gonzalo JD eds. *Health Systems Science Review*. Elsevier; Philadelphia, 2020.

19. Okanlawon T, Shah TR. Health care policy and economics. In Ehrenfeld JM, Gonzalo JD, eds. Health Systems Science Review. Elsevier; Philadelphia, 2020.

20. Dekhtyar M, Ross LP, D'Angelo J, Guernsey J, Hauer KE, et al. Validity of the health systems science examination: relationship between examinee performance and the time of training. Medical Quality. Accepted for publication 2019.

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 3-I-19

Subject: Standardization of Medical Licensing Time Limits Across States (Resolution 305-A-18)

Presented by: Jacqueline A. Bello, MD, Chair

Referred to: Reference Committee C

---

1 INTRODUCTION
2
3 Resolution 305-A-18, introduced by the American Medical Association Medical Student Section
4 (AMA-MSS), asked that our AMA:
5
6 Amend Policy H-275.978, "Medical Licensure," by addition to read as follows
7
8 The AMA… (23) urges the state medical and osteopathic licensing boards which maintain a
9 time limit on complete licensing examination sequences to adopt a time limit of no less than 10
10 years for completion of a licensing examination sequence for either USMLE or COMLEX.
11
12 Testimony before Reference Committee C at the 2018 Annual Meeting was in favor of referring this
13 complex item for further study. Some states have no time limit for completion of the licensing
14 examination sequence; some set a time limit of seven years; and some cap eligibility at 10 years (to
15 accommodate the longer timeline for dual-degree individuals, e.g., those seeking to hold MD and
16 PhD credentials). Testimony was heard concerning the perception that physicians who have
17 academic troubles will take longer to complete the sequence, such that the time limit becomes a
18 mechanism through which to ensure patient safety by eliminating these individuals from the practice
19 of medicine. This belief, however, does not take into account the legitimate health or personal issues
20 that may affect a given physician's ability to complete all exams within a prescribed timeframe, or
21 the challenges faced by those pursuing dual degrees. Testimony in favor of a time limit was that this
22 would ensure that examinees are being assessed based on their current medical knowledge.
23 Accordingly, the AMA House of Delegates referred this item, to ensure a comprehensive, holistic
24 review and study of all the relevant factors and consideration of potential unintended consequences,
25 with the involvement of all relevant stakeholders, such as the Federation of State Medical Boards
26 (FSMB) and the 70 state medical and osteopathic regulatory boards it represents.
27
28 BACKGROUND
29
30 State medical boards are entrusted to protect the public from unprofessional, unlawful or
31 incompetent physician behavior. To ensure that physicians practicing in a state or jurisdiction are
32 minimally competent to provide patient care, physicians under the board's purview are required to
33 complete either the United States Medical Licensing Examination (USMLE), for allopathic medical
34 school graduates, or the Comprehensive Osteopathic Medical Licensing Examination (COMLEX-
35 USA), if a graduate of an osteopathic medical college. Passage of the USMLE or the COMLEX-
36 USA is necessary to be eligible for a full and unrestricted license to practice medicine. Both the
37 USMLE and COMLEX-USA are composed of a series of exams. Most students studying medicine

© 2019 American Medical Association. All rights reserved.

in the U.S. take the first three exams while in medical school; the final exam is typically taken while the physician is in residency training.

Current U.S. Licensing Completion Requirements

States may have different requirements as to the number of attempts to pass the exams, as well as different limits that cap the length of time for completion. Furthermore, many states allow for more time if the physician is pursuing a dual-degree (e.g., MD-PhD), and may also waive the time limit in the event of extenuating circumstances. Although many states have similar requirements, there is no universal standard, and there is great variability between MD and DO boards within states (for USMLE and COMLEX-USA, respectively) and between states. Table 1 presents data from the FSMB on the 66 licensing boards in the states, District of Columbia, and Puerto Rico. Some states' responses regarding extenuating circumstances are omitted due to lack of clarity.[1]

Table 1.
U.S. medical boards' USMLE or COMLEX-USA completion time limits

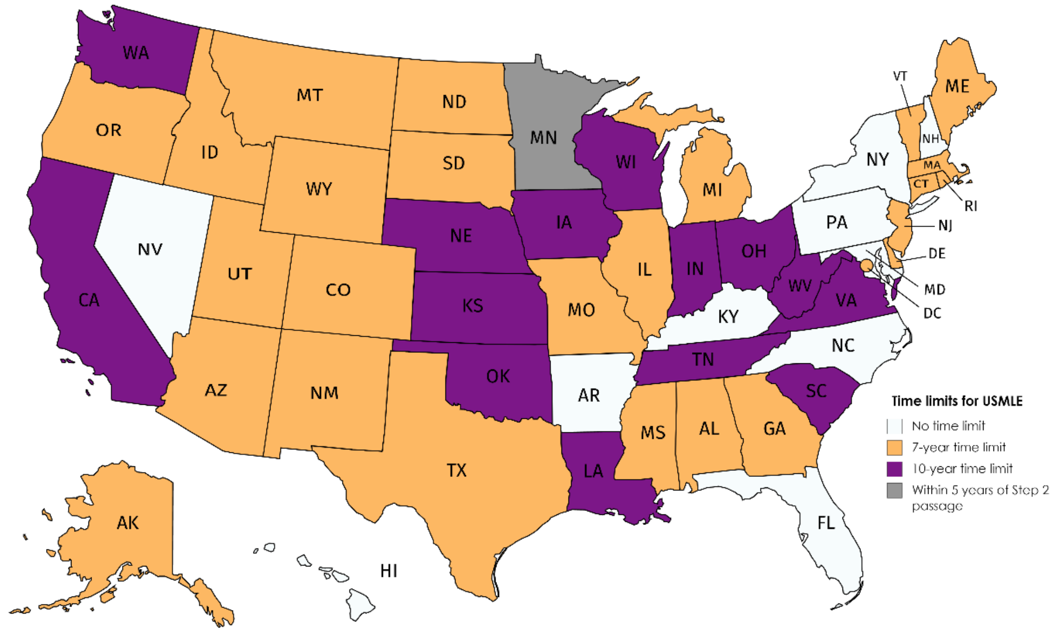
	No limit	7 years	8 years	9 years	10 years	12 years
USMLE	10	28			13	
COMLEX-USA	22	14			8	
MD/DO-PhD/dual degree	4		1	1	14	1

Although 23 of reporting boards with a time limit for completion will waive the limit depending on extenuating circumstances, 12 will not; these 12 have the time limits as shown in Table 2.

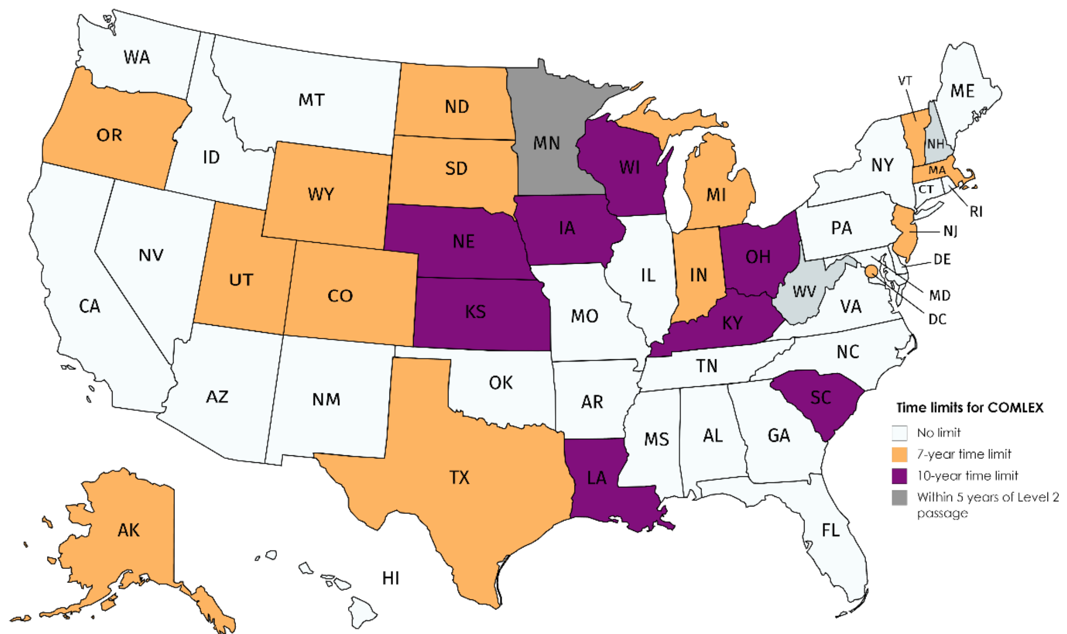
Table 2.
USMLE or COMLEX-USA completion and dual-degree time limits of U.S. medical boards that do not waive time limits

Number of boards	USMLE/COMLEX-USA limit	Dual-degree limit
6	7 years	—
2	10 years	—
1	7 years	8 years
1	7 years	10 years
1	10 years	10 years
1	10 years	12 years

The two maps present time limits for USMLE and COMLEX-USA completion. Although some contiguous states have identical requirements, many do not. For example, four of the five states bordering New York—which has no time limit for completion of USMLE—require completion within seven years.



Created with mapchart.net ©



Created with mapchart.net ©

Data from the National Board of Medical Examiners (NBME), the organization that administers the USMLE, suggests that most physicians pass the three steps of the USMLE within seven years of starting the process (91 percent); 99 percent complete the USMLE within 10 years. These data are for U.S. medical school graduates of schools accredited by the Liaison Committee on Medical Education (LCME) and do not include graduates of foreign medical schools or graduates of osteopathic medical schools.[2] Similarly, the National Board of Osteopathic Medical Examiners (NBOME), which administers the COMLEX-USA, has found the average time from the initial attempt of the Level 1 examination to completion of COMLEX-USA with passage of Level 3 to be 2.81 years. In addition, less than 0.2% of candidates who passed Level 3 between 2015 and 2019 took longer than seven years.[3]

In a study examining the performance of over 40,000 Step 3 examinees, Feinberg et al. reported that 55 percent of examinees took the Step 3 exam within six to 18 months of starting residency, 93 percent tested within 36 months of training, and 99 percent had tested within 60 months of starting training.[4]

Patient Safety and Workforce Issues

The purpose of passing the USMLE and the COMLEX-USA is to ensure the public that a physician has met a standard of medical knowledge and clinical skills to provide safe and effective patient care. There have been studies examining the association between USMLE performance and 1) demographic characteristics of physicians[5] and 2) academic performance, remediation, and referral to a competency committee while in medical school,[6,7] among other studies. Much is unknown, however, about USMLE/COMLEX-USA performance and state medical licensure. In a study that found an association between physicians' unprofessional behavior noted during medical school and subsequent disciplinary actions by state medical licensing boards, there was no statistical association with Step 1 score and subsequent disciplinary action.[8] A study by Cuddy et al. that included Step 1, Step 2 CK scores, and state medical licensure data on over 164,000 physicians found that higher Step 2 CK scores were associated with a decreased chance of disciplinary action.[9]

Actions taken by state medical licensure boards are, by default, taken against physicians who have completed the medical licensure process. As Cuddy et al. point out: "Physicians who fail the USMLE are unable to obtain a license to practice medicine in the United States, thus precluding the possibility of establishing whether or not physicians who have met USMLE standards provide better patient care than those who have failed to meet these standards."[9] It is not known if physicians who do not become licensed as a result of not completing the licensure process within the time required, or ever, would pose a risk to patient safety—linkages have been made between poor performance on exams and academic performance in medical school and state disciplinary actions. It can be assumed that *failing* the exams is an indicator of compromised physician competency.

Physician-scientists, or physicians who pursue PhDs as well as clinical training, are an important workforce in biomedical research; however, they likely take longer to become licensed, an accommodation recognized by 21 state licensing boards. Typically, around 550 physicians graduate each year with an MD-PhD, taking approximately eight years to receive both degrees.[10]

When considering time-limit exceptions for completing the USMLE sequence in the case of dual-degree physicians, the NBME recommends state licensing boards waive the time limit for candidates meeting the following requirements:

- The candidate has obtained both degrees from an institution or program accredited by the LCME and a regional university accrediting body.

- The PhD should reflect an area of study which ensures the candidate a continuous involvement with medicine and/or issues related, or applicable to, medicine.

- A candidate seeking an exception to the seven-year rule should be required to present a verifiable and rational explanation for the fact that he or she was unable to meet the seven-year limit. These explanations will vary, and each licensing jurisdiction will need to decide on its own which explanation justifies an exception. Students who pursue both degrees should understand that while many states' regulations provide specific exceptions to the seven-year rule for dual-degree candidates, others do not. Students pursuing a dual degree are advised to check the state-specific requirements for licensure listed by the FSMB.[11]

The NBME has had discussions with its Advisory Committee for Medical School Programs concerning dual-degree candidates and their potential need for more time to complete the licensure sequence than some states may permit. Within those discussions, however, the committee was not able to identify a qualified dual-degree candidate who was denied state licensure based on exceeding a state time-limited rule for passing USMLE.[2]

What is not known is how many physicians are delayed in completing the USMLE or COMLEX-USA sequence due to life circumstances, including taking a leave of absence to care for a family member or for other personal situations. Physicians who do not become licensed can pursue careers in health-related fields but will not be able to practice medicine. At a time when physician workforce shortages are predicted, lack of state licensure resulting solely from circumstances that did not permit a physician to complete the USMLE or COMLEX-USA sequence within a given time limit seems improvident.

Advantages to Nationwide Uniformity

Medical licensing boards vary greatly in their regulations concerning the number of times physicians can take the different Step or Level exams, the length of time to complete the sequence for single- or dual-degree physicians, and whether exceptions can be made for qualifying extenuating circumstances. States that are contiguous can have very different requirements. Yet, once a physician is licensed in one jurisdiction, and is in good standing, another licensing board is not likely to weigh the length of time the physician required to complete the exam sequence in the initial location against the physician if he or she is seeking a license to practice in a new state. Without data suggesting qualitative differences in the competency of physicians who become licensed in seven versus 10 years, or even longer, there may be few valid arguments for time limits except as an external source for motivation to complete the task—although the ability to independently practice medicine should be the most compelling motivation.

RELEVANT AMA POLICY

The appendix shows relevant AMA policy, including H-275.955, "Physician Licensure Legislation" and D-275.994, "Facilitating Credentialing for State Licensure."

SUMMARY AND RECOMMENDATIONS

There is geographic mobility among physicians, particularly soon after completing residency or in pursuing a fellowship, and crossing state lines is likely. Ensuring uniformity in the time requirement in which to become fully licensed would remove one regulatory burden for young physicians when mapping out their career and future practice location. Furthermore, an acknowledgement of, and accommodation for, the many life events that can affect the ability to study for and take the required

exams may potentially allow for greater diversity among the physician workforce. Lastly, providing the extra time that dual-degree physicians need in order to complete both degrees and become fully licensed will ensure that this vital workforce is fully integrated into both research and clinical realms.

The Council on Medical Education therefore recommends that the following recommendations be adopted in lieu of Resolution 305-A-18 and the remainder of this report be filed:

1. That our American Medical Association (AMA) urge the state medical and osteopathic boards that maintain a time limit for completing licensing examination sequences for either USMLE or COMLEX to adopt a time limit of no less than 10 years for completion of the licensing exams to allow sufficient time for individuals who are pursuing combined degrees (e.g, MD/PhD). (New HOD Policy)

2. That our AMA urge that state medical and osteopathic licensing boards with time limits for completing the licensing examination sequence provide for exceptions that may involve personal health/family circumstances. (New HOD Policy)

3. That our AMA encourage uniformity in the time limit for completing the licensing examination sequence across states, allowing for improved inter-state mobility for physicians. (New HOD Policy)

Fiscal note: $1,000.

APPENDIX: RELEVANT AMA POLICY

H-275.955, "Physician Licensure Legislation"

Our AMA reaffirms earlier policy urging licensing jurisdictions to adopt laws and rules facilitating the movement of physicians between states, to move toward uniformity in requirements for the endorsement of licenses to practice medicine, and to base endorsement of medical licenses on an assessment of competence rather than on passing a written examination of cognitive knowledge.

D-275.994, "Facilitating Credentialing for State Licensure"

Our AMA: (1) encourages the Federation of State Medical Boards to urge its Portability Committee to complete its work on developing mechanisms for greater reciprocity between state licensing jurisdictions as soon as possible; (2) will work with the Federation of State Medical Boards (FSMB) and the Association of State Medical Board Executive Directors to encourage the increased standardization of credentials requirements for licensure, and to increase the number of reciprocal relationships among all licensing jurisdictions; (3) encourages the Federation of State Medical Boards and its licensing jurisdictions to widely disseminate information about the Federation's Credentials Verification Service, especially when physicians apply for a new medical license; and (4) supports the FSMB Interstate Compact for Medical Licensure and will work with interested medical associations, the FSMB and other interested stakeholders to ensure expeditious adoption by the states of the Interstate Compact for Medical Licensure and creation of the Interstate Medical Licensure Compact Commission.

REFERENCES

[1] U.S. Medical Regulatory Trends and Actions 2018. Federation of State Medical Boards: 2018.

[2] Michael Barone, MD, National Board of Medical Examiners. Personal communication, August 7, 2019.

[3] Joseph Flamini, MBA, National Board of Osteopathic Medical Examiners. Personal communication, August 13, 2019.

[4] Feinberg RA, Swygert KA, Halst SA, Dillon GF, Murray CT. The impact of postgraduate training on USMLE® Step 3® and its computer-based case simulation component. *J Gen Intern Med* 27(1):65-70 2011.

[5] Rubright JD, Jodoin M, Barone MA. Examining demographics, prior academic performance, and United States Medical Licensing Examination scores. *Acad Med*. 2019;94:364–370. doi: 10.1097/ACM.0000000000002366

[6] Dong T, Swygert KA, Durning SJ, Saguil A, Zahn CM, DeZeeKJ, Gilliland WR, Cruess DF, Balog EK, Servey JT, Welling DR, Ritter M, Goldenberg MN, Ramsay LB, Artino AR. Is poor performance on NBME clinical subject examinations associated with a failing score on the USMLE Step 3 examination? *Acad Med*. 2014;89:762–766. doi: 10.1097/ACM.0000000000000222

[7] Hemann BA, Durning SJ, Kelly WF, Dong T, Pangaro LN, Hemmer PA. The Association of students requiring remediation in the internal medicine clerkship with poor performance during internship. *Military Medicine*. 2015; 180, April Supplement. doi: 10.7205/MILMED-D-14-00567

[8] Papadakis MA, Teherani A, Banach MA, Knettler TR, Rattner SL, Stern DT, Veloski JJ, Hodgson CS. Disciplinary action by Medical Boards and prior behavior in medical school. *N Engl J Med* 2005; 353:2673-2682. DOI: 10.1056/NEJMsa052596

[9] Cuddy MM, Young A, Gelman A, Swanson DB, Johnson DA, Dillon GF, Clauser BE. Exploring the relationships between USMLE performance and disciplinary action in practice: a validity study of score inferences from a licensure examination. Acad Med 92(12) 2017. doi: 10.1097/ACM.0000000000001747

[10] Harding CV, Akabas MH, Andersen OS. History and outcomes of 50 years of physician–scientist training in medical scientist training programs. *Acad Med*. 2017;92:1390–1398. doi: 10.1097/ACM.0000000000001779

[11] USMLE. https://www.usmle.org/frequently-asked-questions/#general. Accessed August 6, 2019

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 4-I-19

Subject: Board Certification Changes Impact Access to Addiction Medicine Specialists (Resolution 314-A-18)

Presented by: Jacqueline A. Bello, MD, Chair

Referred to: Reference Committee C

Resolution 314-A-18, "Board Certification Changes Impact Access to Addiction Medicine Specialists," introduced by the Michigan Delegation and referred by the American Medical Association (AMA) House of Delegates (HOD), asks:

> That our American Medical Association work with the American Board of Addiction Medicine (ABAM) and American Board of Medical Specialties (ABMS) to accept ABAM board certification as equivalent to any other ABMS-recognized Member Board specialty as a requirement to enroll in the transitional maintenance of certification program and to qualify for the ABMS Addiction Medicine board certification examination.

This resolution was referred due to mixed testimony about the new requirements for ABMS subspecialty board certification in addiction medicine and concerns centered around the equivalency of ABAM and ABMS board certifications. Although a number of physicians have held ABAM certification, they do not meet the requirements for ABMS subspecialty certification in addiction medicine if they do not hold current ABMS certification in a primary specialty. Although specialty board certification is not required to practice medicine, it may be needed to meet the credentialing requirements of hospitals.

This report calls attention to the urgent need to train physicians in addiction medicine, provides background information on the process for obtaining subspecialty board certification in addiction medicine, and provides an update on the time-limited pathway for subspecialty certification in addiction medicine for ABAM diplomates.

BACKGROUND

More than 20 million Americans need treatment for substance use disorder, and 2 million Americans have an opioid use disorder.[1-2] However, only 3,500 U.S. physicians (approximately) are trained in addiction medicine to meet this need.[2] Although medical schools and teaching hospitals are actively working to address the crisis in their communities, more physicians need to be trained in addiction medicine to address this public health challenge.

Since 2008, the ABAM, a non-ABMS member board, has offered certification and recertification in addiction medicine. ABAM certification is valid as long as ABAM diplomates maintain enrollment in the ABAM Maintenance of Certification program.[3] In October 2015, the new subspecialty of addiction medicine, sponsored by the American Board of Preventive Medicine (ABPM), was recognized by the ABMS.[4] In June 2016, fellowship training in addiction medicine was approved by the Accreditation Council for Graduate Medical Education (ACGME).

© 2019 American Medical Association. All rights reserved.

In 2017, the ABPM began offering physicians the opportunity to become certified in the subspecialty of addiction medicine, and physicians certified by any of the ABMS member boards have been eligible to apply. During the first five years (2017-2021) the addiction medicine examination is given, individuals may become qualified by the Practice Pathway (through which physicians can meet eligibility requirements for certification in addiction medicine without completing an addiction medicine fellowship). In order to meet the requirements for ABPM subspecialty certification in addiction medicine, physicians who do not hold ABAM certification must also hold a current ABMS certification in any primary specialty to meet the requirements for ABPM subspecialty certification in addiction medicine.

ABPM PATHWAYS AVAILABLE TO ACHIEVE SUBSPECIALTY CERTIFICATION IN ADDICTION MEDICINE

There are multiple pathways to achieve subspecialty certification in addiction medicine through the ABPM, as described below.[5]

Practice Pathway

- Time in Practice
  Applicants must submit documentation of a minimum of 1,920 hours in which they were engaged in the practice of addiction medicine at the subspecialty level; this minimum of 1,920 hours must have occurred over at least 24 of the previous 60 months prior to application. The minimum of 24 months of practice time need not be continuous; however, all practice time must have occurred in the five-year period preceding June 30 of the application year. Practice must consist of broad-based professional activity with significant addiction medicine responsibility. Applicants must also demonstrate a minimum of 25 percent (or 480 hours) as direct patient care. Addiction medicine practice outside of direct patient care, such as research, administration, and teaching activities, may count for a combined maximum of 75 percent (or 1,440 hours). Only 25 percent (480 hours) of general practice can count towards the required hours for the Practice Pathway, and the remaining 75 percent must be specific addiction medicine practice. Fellowship activity that is less than 12 months in duration or non-ACGME accredited may be applied toward the practice activity requirement. The actual training must be described for any fellowship activity.

  Documentation of addiction medicine teaching, research, and administration activities, as well as clinical care or prevention of, or treatment of, individuals who are at risk for or have a substance use disorder may be considered.

- Non-accredited fellowship training
  Credit for completion of training in a non-ACGME-accredited fellowship program may be substituted for the Time in Practice hour requirements of the Practice Pathway. To qualify, the applicant must have successfully completed a non-ACGME-accredited addiction medicine fellowship of at least 12 months that is acceptable to the ABPM. The fellowship training curriculum as well as a description of the actual training experience must also be submitted to the ABPM for its review and consideration.

  Fellowship training of less than 12 months in a non-ACGME accredited program may be applied towards the Time in Practice hour requirements of the Practice Pathway.

ABAM Diplomate Pathway (available through 2021)

Applicants holding certification by ABAM must meet the medical licensure and ABPM certification requirements to be considered for the addiction medicine subspecialty examination. Documentation of current ABAM diplomate status may be submitted in place of practice time documentation and required attestation of clinical competence. (ABAM diplomates are required to maintain certification through ABAM's Transitional Continuous Certification [TraCC] Program. Diplomates who passed ABAM's certifying exam in 2015 or who recertified by passing ABAM's recertifying exam in 2015 may be qualified to expedite the certification process with the ABPM.)

ABAM diplomates certified, or recertified, in 2015 must submit formal application through the ABAM diplomate pathway and be accepted by the ABPM. Only then may their ABPM certifying exam be waived and certification conferred following usual procedures, with an effective date of January 1 of the year following the ABPM's approval of the formal application.

The Addiction Medicine ABAM Diplomate Pathway will expire in 2021. Beginning in 2022, all applicants for ABPM certification in addiction medicine must successfully complete an ACGME-accredited addiction medicine fellowship program.

ACGME-accredited Fellowship Pathway

Applicants must successfully complete a minimum of 12 months in an ACGME-accredited addiction medicine fellowship program. If the program is longer than 12 months, the physician must successfully complete all years of training for which the program is accredited in order to meet the eligibility criteria for certification in addiction medicine.

THE ABMS COMMITTEE ON CERTIFICATION (COCERT) APPROVED SPECIFIC, TIME-LIMITED PATHWAY FOR SUBSPECIALTY CERTIFICATION IN ADDICTION MEDICINE FOR ABAM DIPLOMATES

In 2018, the ABPM, in collaboration with the American Society of Addiction Medicine, submitted a request to ABMS to expand the eligibility requirements for the ABPM's Addiction Medicine subspecialty.[6] The ABPM's request was limited in time to include a period beginning on January 1, 2019 and ending at the conclusion of the 2021 exam cycle on December 31, 2021. In March 2019, the ABMS Committee on Certification (COCERT) approved the ABPM's request to expand eligibility to include physicians certified by ABAM, current with the ABAM's TraCC Program, and who previously possessed underlying primary certification from an ABMS member board but allowed that certification to lapse because addiction medicine became the primary area of the physician's practice.

The proposed expansion excluded physicians who never obtained primary ABMS member board certification, who lost ABMS member board certification as a result of a disciplinary action, or who may have surrendered a medical license in lieu of or otherwise to avoid the possibility of disciplinary action.

DIPLOMATES CERTIFIED BY THE ABPM IN ADDICTION MEDICINE NO LONGER REQUIRED TO MAINTAIN PRIMARY CERTIFICATION TO RECERTIFY IN ADDICTION MEDICINE

Previously, the ABMS approved ABPM's request that diplomates certified by the ABPM in addiction medicine will no longer be required to maintain primary ABMS member board

certification in order to recertify. With this policy change, diplomates certified by the ABPM in addiction medicine may recertify their ABPM subspecialty certificate in addiction medicine without the need to maintain primary ABMS member board certification.

RELEVANT AMA POLICY

It is the policy of the AMA to encourage all physicians, particularly those in primary care fields, to undertake education in treatment of substance use disorder. The AMA also supports the new ABMS-approved multispecialty subspecialty of addiction medicine, which offers certification to qualified physicians who are diplomates of any of the 24 ABMS member boards and the ABPM certification examination in addiction medicine. AMA policies related to addiction medicine and specialty board certification are shown in the Appendix.

DISCUSSION

There is a significant shortage of qualified addiction physicians in the United States, and physicians from a variety of disciplines (e.g., internal medicine, family medicine, pediatrics) are needed.[7] Expanding the ABPM pathway will assist in growing the addiction medicine workforce at a time when the treatment of opioid addiction is a national public health crisis and there is a spectrum of medical problems associated with substance use disorders.[7]

The ABPM pathway runs through an examination and not through any “deeming” or general recognition of equivalency of any board outside the ABMS member board community. Thus, individuals will be required to demonstrate to the ABPM that they possess the “knowledge, clinical skills, and professionalism” to practice safely in the discipline of addiction medicine in order to be granted a certificate from this ABMS member board. Physicians who choose to become certified in the new subspecialty may qualify to take the addiction medicine exam by meeting time-in-practice and other eligibility requirements, but will not be required to complete specialized fellowship training at this time. However, in 2022 the ABPM will require physicians to complete an ACGME-accredited program. The ACGME has accredited 62 twelve-month addiction medicine fellowship programs, with plans to increase the number of programs to 125.[8] Education in addiction medicine is also becoming a viable choice for medical students and residents.[9]

The American Osteopathic Association (AOA) has also created a mechanism to allow osteopathic physicians (DOs) with an active primary AOA board certification and ABAM certification to be granted AOA subspecialty certification in addiction medicine.[10] Osteopathic physicians will be required to maintain such certification through the AOA’s addiction medicine osteopathic continuous certification process.[10]

SUMMARY AND RECOMMENDATIONS

The Council on Medical Education has been committed to working with the ABMS and the ABPM to ensure that all qualified physicians are offered pathways to obtain ABMS-approved certification in the new ABPM subspecialty of addiction medicine in order to improve access to care for patients with substance use disorder.

The Council on Medical Education therefore recommends that the following recommendations be adopted in lieu of Resolution 314-A-18 and the remainder of the report be filed.

1. That our American Medical Association (AMA) recognize the American Board of Preventive Medicine (ABPM) for developing and providing pathways for all qualified physicians to obtain ABMS-approved certification in the new ABPM subspecialty of addiction medicine, in order to improve access to care for patients with substance use disorder. (Directive to Take Action)

2. That our AMA rescind Policy H-300.962 (3) "Recognition of Those Who Practice Addiction Medicine," since the ABPM certification examination in addiction medicine is now offered. (Rescind HOD Policy)

Fiscal Note: $500.

APPENDIX

H-300.962, "Recognition of Those Who Practice Addiction Medicine"

1. It is the policy of the AMA to: (a) encourage all physicians, particularly those in primary care fields, to undertake education in treatment of substance abuse; (b) direct its representatives to appropriate Residency Review Committees (RRCs) to ask the committees on which they serve to consider requiring instruction in the recognition and management of substance abuse. Those RRCs that already require such instruction should consider greater emphasis for this subject. (c) encourage treatment of substance abuse as a subject for continuing medical education; and (d) affirm that many physicians in fields other than psychiatry have graduate education and experience appropriate for the treatment of substance abuse, and for utilization review, and for other evaluation of such treatment, and should be entitled to compensation.
2. Our AMA commends the American Board of Preventive Medicine (ABPM) for its successful application to the American Board of Medical Specialties (ABMS) to establish the new ABMS-approved multispecialty subspecialty of addiction medicine, which will be able to offer certification to qualified physicians who are diplomates of any of the 24 ABMS member boards.
3. Our AMA encourages the ABPM to offer the first ABMS-approved certification examination in addiction medicine expeditiously in order to improve access to care to treat addiction.

(CME Rep. I-93-5 Reaffirmed: CME Rep. 10, I-98 Reaffirmed: CME Rep. 11, A-07 Appended: Res. 314, A-16)

Policy H-275.924 (15), "Continuing Board Certification"

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

H-275.926, "Medical Specialty Board Certification Standards"

Our AMA:

1. Opposes any action, regardless of intent, that appears likely to confuse the public about the unique credentials of American Board of Medical Specialties (ABMS) or American Osteopathic Association Bureau of Osteopathic Specialists (AOA-BOS) board certified physicians in any medical specialty, or take advantage of the prestige of any medical specialty for purposes contrary to the public good and safety.
2. Continues to work with other medical organizations to educate the profession and the public about the ABMS and AOA-BOS board certification process. It is AMA policy that when the equivalency of board certification must be determined, accepted standards, such as those adopted by state medical boards or the Essentials for Approval of Examining Boards in Medical Specialties, be utilized for that determination.
3. Opposes discrimination against physicians based solely on lack of ABMS or equivalent AOA-BOS board certification, or where board certification is one of the criteria considered for purposes of measuring quality of care, determining eligibility to contract with managed care entities, eligibility to receive hospital staff or other clinical privileges, ascertaining competence to practice medicine, or for other purposes. Our AMA also opposes discrimination that may occur against physicians involved in the board certification process, including those who are in a clinical practice period for the specified minimum period of time that must be completed prior to taking the board certifying examination.
4. Advocates for nomenclature to better distinguish those physicians who are in the board certification pathway from those who are not.
5. Encourages member boards of the ABMS to adopt measures aimed at mitigating the financial burden on residents related to specialty board fees and fee procedures, including shorter preregistration periods, lower fees and easier payment terms.

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

D-120.985, "Education and Awareness of Opioid Pain Management Treatments, Including Responsible Use of Methadone"

1. Our AMA will incorporate into its web site a directory consolidating available information on the safe and effective use of opioid analgesics in clinical practice.
2. Our AMA, in collaboration with Federation partners, will collate and disseminate available educational and training resources on the use of methadone for pain management.
3. Our AMA will work in conjunction with the Association of American Medical Colleges, American Osteopathic Association, Commission on Osteopathic College Accreditation, Accreditation Council for

Graduate Medical Education, and other interested professional organizations to develop opioid education resources for medical students, physicians in training, and practicing physicians.
(Sub. Res. 508, A-03 Reaffirmed: CSAPH Rep. 1, A-13 Appended: Res. 515, A-14 Reaffirmed: BOT Rep. 14, A-15 Appended: Res. 311, A-18 Reaffirmation: A-19)

H-310.906, "Improving Residency Training in the Treatment of Opioid Dependence"
Our AMA: (1) encourages the expansion of residency and fellowship training opportunities to provide clinical experience in the treatment of opioid use disorders, under the supervision of an appropriately trained physician; and (2) supports additional funding to overcome the financial barriers that exist for trainees seeking clinical experience in the treatment of opioid use disorders.

REFERENCES

1. Bose J, Hedden SL, Lipari RN, P E. Key Substance Use and Mental Health Indictors in the United States: Results from the 2015 National Survey on Drug Use and Health. Department of Health and Human Services. Available at: https://www.samhsa.gov/data/sites/default/files/NSDUH-FFR1-2015/NSDUH-FFR1-2015/NSDUH-FFR1-2015.htm (Accessed July 26, 2019)
2. Sokol RJ, Kunz K. Training Future Physicians to Address Opioid Crisis. AAMC News. September 19, 2017. Available at: https://news.aamc.org/patient-care/article/training-future-physicians-address-opioid-crisis/ (Accessed July 26, 2019)
3. Diplomate Paths to ABMS ADM Certification. March 7, 2017. Available at: https://www.abam.net/wp-content/uploads/2015/02/ABAM-Diplomate-Paths-to-ABMS-ADM-Certification-March-7_2017.pdf (Accessed July 26, 2019)
4. ABMS Officially Recognizes Addiction Medicine as a Subspecialty. American Board of Medical Specialties. Available at: https://www.abms.org/news-events/abms-officially-recognizes-addiction-medicine-as-a-subspecialty/ (Accessed July 26, 2019)
5. Addiction Medicine: Pathway Requirements. Available at: https://www.theabpm.org/become-certified/subspecialties/addiction-medicine/ (Accessed July 26, 2019)
6. The American Board of Preventive Medicine (ABPM) has obtained approval from The American Board of Medical Specialties' (ABMS) to expand eligibility requirements for physicians seeking to become board certified in Addiction Medicine. American Board of Preventive Medicine. Available at: https://www.theabpm.org/2019/03/25/the-american-board-of-preventive-medicine-abpm-has-obtained-approval-from-the-american-board-of-medical-specialties-abms-to-expand-eligibility-requirements-for-physicians-seeking-to-becom/ (Accessed July 26, 2019)
7. Wood E, Samet JH, Volkow ND. Physician Education in Addiction Medicine. JAMA. 2013;310(16):1673-1674.
8. Juman R. An Absolute Game-Changer: Addiction as an Officially Recognized Subspecialty. The Fix. Available at: https://www.thefix.com/absolute-game-changer-addiction (Accessed July 26, 2019)
9. Accredited Fellowships: Addiction Medicine Fellowships. American College of Academic Addiction Medicine. Available at: https://www.acaam.org/accreditedfellowships/ (Accessed July 26, 2019)
10. Follow-up: AOA Board Certification in Addiction Medicine. The American Osteopathic Academy of Addiction Medicine. April 24, 2017. Available at: https://aoaam.org/general-news/6271752 (Accessed July 26, 2019)

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 6-I-19

Subject: Veterans Health Administration Funding of Graduate Medical Education (Resolution 954-I-18)

Presented by: Jacqueline A. Bello, MD, Chair

Referred to: Reference Committee C

INTRODUCTION

Resolution 954-I-18, introduced by the American Academy of Dermatology, American Society for Dermatologic Surgery Association, and American Society of Dermatopathology, asked that our American Medical Association (AMA):

1. Continue to support the mission of the Department of Veterans Affairs Office of Academic Affiliations for expansion of graduate medical education (GME) residency positions;

2. Collaborate with appropriate stakeholder organizations to advocate for preservation of Veterans Health Administration (VHA) funding for GME and support its efforts to expand GME residency positions in the federal budget and appropriations process; and

3. Oppose service obligations linked to VHA GME residency or fellowship positions, particularly for resident physicians rotating through the VA for only a portion of their GME training.

The AMA House of Delegates adopted Resolves 1 and 2; these were appended to Policy D-510.990, "Fixing the VA Physician Shortage with Physicians." Resolve 3, which was referred, is the topic of this report.

Testimony before the reference committee on this resolution was mixed. The AMA has long been an advocate for preservation and expansion of GME funding to mitigate projected physician shortages and ensure that positions are available for medical school graduates applying to residency programs. Currently, there are no residency completion service obligations for Veterans Administration (VA) residency programs. Furthermore, it was noted that all funding for residency/fellowship positions, whether from private, VA, and/or Centers for Medicare & Medicaid Services (CMS) sources, carries with it the expectation that residents/fellows perform service for patients during their years in the training program. In addition, the VA sponsors very few residency programs; most residents who train in a VA facility do so as part of their training, with other sites and institutions responsible for components of the residency or fellowship. Due to the complicated rules at institutions that sponsor residency programs related to full funding for a resident full-time employee, it was recommended that Resolve 3 be referred for further study.

© 2019 American Medical Association. All rights reserved.

BACKGROUND

The Department of Veterans Affairs (VA) has long supported the training of health care professionals as part of its mission. With very few exceptions, the VA does not sponsor and operate its own GME programs, but instead partners with teaching hospitals to provide rotations in VA medical facilities, sharing the costs of faculty and residents when residents are training in VA facilities. When a resident is training at a VA facility, that resident is not counted as part of the Medicare GME cap for the sponsoring institution (and so is not paid via Medicare). This allows the sponsoring institution to train additional residents above its Medicare cap. Over 43,000 residents and fellows rotate through roughly 11,000 VA-funded full-time-equivalent residency positions in VA medical facilities each year; while rotating through the VA, residents remain employees of the sponsoring institution and are not employees of the VA, nor are they subject to service obligations upon completion of the rotation or training program.[1] Approximately one third of the entire GME workforce per year receives training in VA facilities and provides care to veterans.[2]

VA GME Expansion

The Veterans Access, Choice, and Accountability Act (VACAA) of 2014 included a requirement that the VA expand the number of residents and fellows it trains by up to 1,500 positions by 2024, in selected specialties and/or geographic areas, as well as specialties designated as critical need specialties located within health professional shortage areas (as defined by the Health Resources and Services Administration), having a shortage of physicians, rural locations, or in a program/area where there are significant delays in veteran access to care.[3] After five rounds, the VA has approved 1,055 positions, from 2015 through 2019 (443.2 in primary care, 229.1 in mental health, and 383.0 in critical need specialties).[4]

Subsequent legislation introduced in 2017, but not passed, also increased the number of GME positions funded by the VA by 1,500, but required a service obligation post-GME equal to the number of years of residency stipend and benefit support.[5,6]

The VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018 builds upon VACAA in that one of its aims is to increase GME in rural locations, an area in which VACAA has had limited success.[4] The MISSION Act will enable the VA to place at least 100 residents (through positions created by VACAA) in "covered" federal facilities, that may not be on a traditional VA campus. Indian Health Service facilities, Federally Qualified Health Centers, Department of Defense medical centers, or other underserved VA areas are included as sites for potential GME expansion. The MISSION Act also provides the VA authority to assist in the development costs of starting new GME programs in VA-designated underserved areas. Finally, the MISSION Act includes provisions to enable the VA to recruit physicians and dentists into rural and underserved areas through two scholarship opportunities and a loan repayment program. The Health Professions Scholarship Program (HPSP) will offer scholarships to medical and dental students in exchange for VA service, with a repayment period of 18 months per year of support. Upon completion of training, the participants will be assigned by the VA to areas experiencing a critical need in the specialty of training. The number of scholarships to be funded will be based on VA-determined provider shortages.[7]

A second scholarship opportunity provides four years of tuition, fees and stipend support to two veterans at nine medical schools:

- Charles R. Drew University of Medicine and Science (California)
- Howard University College of Medicine (District of Columbia)

- Morehouse School of Medicine (Georgia)
- Wright State University Boonshoft School of Medicine (Ohio)
- University of South Carolina School of Medicine
- East Tennessee State University James H. Quillen College of Medicine
- Meharry Medical College (Tennessee)
- Texas A&M Health Science Center College of Medicine
- Joan C. Edwards School of Medicine at Marshall University (West Virginia)

After completion of residency or fellowship, the recipient of the scholarship is required to practice in a VA facility for four years.[7]

The Specialty Education Loan Repayment program offers $40,000 in loan repayment to residents (who have at least two or more years left of training) in exchange for 12 months' service post-GME in a VA medical center or site, with a maximum of $160,000 loan repayment. Preferences will be given to veterans, residents training in rural areas or in the Indian Health Services, or in sites in underserved areas. Rather than an assignment by the VA, recipients in the loan repayment program can select from a list of approved sites the location of the VA site for their service obligation.[7]

To date, the Specialty Education Loan Repayment program has been enacted. The scholarship opportunity for recently separated military veterans attending selected medical schools will be offered to the medical school class of 2020, as a trial, with hope of its continuation. The language for the HPSP scholarship opportunity is currently in development and not yet published for public comment. It is anticipated that the GME expansion in "covered" facilities, as well as the creation of new GME programs in Indian Health Service (IHS) and tribal facilities, will not be underway until at least 2022.[8]

RELEVANT AMA POLICY

D-510.990, "Fixing the VA Physician Shortage with Physicians"

Our AMA will: (1) work with the VA to enhance its loan forgiveness efforts to further incentivize physician recruiting and retention and improve patient access in the Veterans Administration facilities; (2) Call for an immediate change in the Public Service Loan Forgiveness Program to allow physicians to receive immediate loan forgiveness when they practice in a Veterans Administration facility; (3) Work with the Veterans Administration to minimize the administrative burdens that discourage or prevent non-VA physicians without compensation (WOCs) from volunteering their time to care for veterans; (4) (a) continue to support the mission of the Department of Veterans Affairs Office of Academic Affiliations for expansion of graduate medical education (GME) residency positions; and (b) collaborate with appropriate stakeholder organizations to advocate for preservation of Veterans Health Administration funding for GME and support its efforts to expand GME residency positions in the federal budget and appropriations process.

SUMMARY AND RECOMMENDATIONS

The health care system of the VA is the largest system in the U.S. Not only does the VA provide training opportunities for over 43,000 residents and fellows, it also has collaborative agreements with 178 allopathic and osteopathic medical schools, providing educational opportunities for nearly 25,000 medical students and other health professions trainees[7] (who are not subject to service obligations upon completion of the rotation or training program). As such, the importance and value of the VA to the nation's health care workforce cannot be overstated.

While other sources of financing for more GME positions have been limited, the VA's ability to expand may reduce the effects of a forecasted physician shortage. Recently passed legislation that enables the VA to expand opportunities for physician training within the VA, and to provide financial assistance to eligible physicians who will then repay that assistance through service obligation to VA and other underserved populations, will further one of the statutory missions of the VA, which is to assist in the training of health professionals for its own needs and those of the nation.

The Council on Medical Education therefore recommends that the following recommendations be adopted in lieu of Resolution 954-I-18 and the remainder of this report be filed:

1. That our AMA support postgraduate medical education service obligations through any program where the expectation for service is explicitly delineated in the contract with the trainee. (New HOD Policy)

2. That our American Medical Association (AMA) oppose the blanket imposition of service obligations through any program where physician trainees rotate through the facility as one of many sites for their training. (New HOD Policy)

Fiscal note: $500.

REFERENCES

[1] Heisler EJ, Mendez BHP, Mitchell A, Panangala SV, Villagrana MA. 2018. *Federal Support for Graduate Medical Education: An Overview.* (CRS Report No. R44376) Retrieved from Congressional Research Service website: https://crsreports.congress.gov/product/pdf/R/R44376. Accessed July 3, 2019.

[2] Brotherton SE, Etzel, SI. Graduate Medical Education, 2017-2018. *JAMA* 2018; 320(10): 1051-1070.

[3] Department of Veterans Affairs. VA Physician Resident Positions Grant for Graduate Medical Education (GME) Enhancement under the Veterans Access, Choice, and Accountability Act (VACAA) of 2014 [PL 113-146].
https://www.va.gov/OAA/docs/Request_for_Proposals_VACAA_Physician_Resident_Positions_Grant_for_Graduate_Medical_Education_GME_Round_6.pdf. Accessed July 3, 2019.

[4] Bope ET, Albanese AP. Advisory Committee on Training in Primary Care Medicine & Dentistry (ACTPCMD)-2018 VACAA & VA MISSIONS ACT Update.
https://www.hrsa.gov/sites/default/files/hrsa/advisory-committees/primarycare-dentist/meetings/20180910/presentation-veterans-affairs-update-sept2018.pdf. Accessed July 5, 2019.

[5] Caring For Our Veterans Act of 2017 https://www.congress.gov/115/bills/s2193/BILLS-115s2193pcs.pdf. Accessed July 5, 2019.

[6] Veterans Community Care and Access Act of 2017 https://www.congress.gov/115/bills/s2184/BILLS-115s2184is.pdf. Accessed July 5, 2019.

[7] Albanese AP, Bope ET, Sanders KM, Bowman M. The VA MISSION Act of 2018: A potential game changer for rural GME expansion and veteran health care. *Journal of Rural Health* 2019 doi: 10.1111/jrh.12360.

[8] Anthony Albanese, MD, VA Office of Academic Affiliations (OAA). Personal communication, July 11, 2019.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 301
(I-19)

Introduced by: Medical Student Section

Subject: Engaging Stakeholders for Establishment of a Two-Interval, or Pass/Fail, Grading System of Non-Clinical Curriculum in U.S. Medical Schools

Referred to: Reference Committee C

---

1 Whereas, Students in two-interval, or pass/fail, grading systems have better mental well-being
2 compared to students in multi-tiered grading systems, including experiencing less emotional
3 exhaustion, fewer feelings of depersonalization, less consideration for dropping out of school,
4 decreased perceived stress, and greater satisfaction with their medical education and personal
5 lives[1,2,3,4]; and
6
7 Whereas, Students in a pass/fail grading system experienced increased group cohesion,
8 collaboration, and cooperation compared to students in a multi-tiered grading system[4,5]; and
9
10 Whereas, Students in a pass/fail grading system had more time to devote to extracurricular
11 activities, student organizations, and volunteer/service activities compared to students in a
12 multi-tiered grading system[6]; and
13
14 Whereas, Multiple medical schools that changed to a pass/fail grading system did not have a
15 statistical difference in United States Medical Licensing Examination (USMLE) Step 1 scores
16 and USMLE Step 2 scores[3,4,6,7,8]; and
17
18 Whereas, Even though there is no study on osteopathic schools with two-interval grading
19 systems and Comprehensive Osteopathic Medical Licensing Examination of the United States
20 (COMLEX-USA) Level 1 Scores, the previous literature suggests that COMLEX-USA Level 1
21 scores will not be affected, since the correlation between COMLEX-USA Level 1 and USMLE
22 Step 1 scores is statistically significant[9]; and
23
24 Whereas, Non-clinical, or preclinical, grades were ranked 12th out of 14 academic criteria when
25 selecting for residency according to the 2006 National Program Director Survey, and as of 2016,
26 residency program directors are no longer surveyed to rank the importance of preclinical
27 grades[10]; and
28
29 Whereas, There is a growing trend for allopathic and osteopathic medical schools to adopt a
30 pass/fail grading system for preclinical courses, from 87 to 108 allopathic schools from 2013 to
31 2017, and 21 to 27 osteopathic schools from 2012 to 2016[11,12,13]; and
32
33 Whereas, U.S. medical students want a pass/fail grading system; in 2011, pass/fail was the
34 most requested form of preclinical grading, as exhibited by the responses of 52 medical schools
35 to the American Association of Medical Colleges (AAMC) Organization of Student
36 Representatives (OSR) Preclinical Grading Questionnaire[14]; and

Whereas, Existing AMA policy recognizes that burnout, defined as emotional exhaustion, depersonalization, and a reduced sense of personal accomplishment or effectiveness, is a problem among residents, and fellows, and medical students (H-295.866); and

Whereas, Existing AMA policy acknowledges the importance of physician health and the need for ongoing education of all physicians and medical students regarding physician health and wellness (H-405.961); and

Whereas, Existing AMA policy acknowledges the benefits of a pass/fail grading system in medical colleges and universities in the United States for the non-clinical curriculum (H-295.866); and

Whereas, AMA policy could use stronger wording in support of pass/fail grading systems; and

Whereas, Existing AMA policy states that AMA will encourage the Accreditation Council for Graduate Medical Education (ACGME) and the AAMC to address the recognition, treatment, and prevention of burnout among residents, fellows, and medical students (H-295.866); and

Whereas, The Liaison Committee on Medical Education (LCME) currently does not take a position on a pass/fail grading system for preclinical courses; and

Whereas, Existing AMA policy insufficiently addresses the importance of pass/fail grading systems, as there remain medical schools that have multi-tiered grading systems[5]; therefore be it

RESOLVED, That our American Medical Association amend Policy H-295.866 by addition and deletion to read as follows:

> **Supporting Two-Interval Grading Systems for Medical Education, H-295.866**
> Our AMA will work with stakeholders to encourage the establishment of ~~acknowledges the benefits of~~ a two-interval grading system in medical colleges and universities in the United States for the non-clinical curriculum. (Modify Current HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 08/28/19

References:

1. Wasson L.T., Cusmano A., Meli L., et al. Association Between Learning Environment Interventions and Medical Student Well-being: A Systematic Review. JAMA. 2016;316(21):2237–2252. doi:10.1001/jama.2016.17573
2. Reed D.A., et al. Relationship of pass/fail grading and curriculum structure with well-being among preclinical medical students: a multi-institutional study. Acad Med. 2011;86:1367–1373.
3. Bloodgood, R. A., et al. A change to pass/fail grading in the first two years at one medical school results in improved psychological well-being. Acad Med. 2009; 84(5): 655-662. doi:10.1097/ACM.0b013e31819f6d78
4. Rohe D.E., et al. The benefits of pass-fail grading on stress, mood, and group cohesion in medical students. Mayo Clin Proc. 2006;81:1443–1448.
5. Robins L. S., et al. The effect of pass/fail grading and weekly quizzes on first-year students' performances and satisfaction. Acad Med. 1995;70(4):327–329.
6. White, C. B., & Fantone, J. C. Pass-fail grading: laying the foundation for self-regulated learning. Adv Health Sci Educ Theory Pract. 2010; 15(4): 469-477. doi:10.1007/s10459-009-9211-1
7. Ange, B., et al. Differences in medical students' academic performance between a pass/fail and tiered grading system. South Med J. 2018; 111(11): 683-687. doi:10.14423/smj.0000000000000884
8. McDuff S.G., et al. Evaluating a grading change at UCSD school of medicine: pass/fail grading is associated with decreased performance on preclinical exams but unchanged performance on USMLE step 1 scores BMC Med Educ. 2014;14:127. doi:10.1186/1472-6920-14-127
9. Jeanne M. Sandella, John R. Gimpel, Larissa L. Smith, and John R. Boulet. The Use of COMLEX-USA and USMLE for Residency Applicant Selection. Journal of Graduate Medical Education: July 2016, Vol. 8, No. 3, pp. 358-363.

10. Association of American Medical Colleges. Results of the 2018 NRMP: Program Director Survey. Available at: (https://www.nrmp.org/wp-content/uploads/2018/07/NRMP-2018-Program-Director-Survey-for-WWW.pdf). Accessed March 21, 2019.
11. Association of American Medical Colleges. Number of Medical Schools Using Selected Grading Systems in Pre-Clerkship Courses (Excluding Physical Diagnosis/Clinical Skills); Available at: (https://www.aamc.org/initiatives/cir/406418/11.html) Accessed March 21, 2019.
12. American Association of Colleges of Osteopathic Medicine. 2012-13 Osteopathic Medical College Student Performance Evaluation Methods: Basic Science & Other Preclerkship Courses. Available at: (https://www.aacom.org/docs/default-source/data-and-trends/2012-13-COM-StPerfEvalMethod.pdf?sfvrsn=ec416197_10) Accessed March 21, 2019.
13. American Association of Colleges of Osteopathic Medicine. 2016-17 Osteopathic Medical College Student Performance Evaluation Methods: Basic Science and other Preclerkship Courses. Available at: (https://www.aacom.org/docs/default-source/data-and-trends/2016-17-osteopathic-medical-college-student-performance-evaluation-methods.pdf?sfvrsn=b5232c97_10) Accessed March 21, 2019.
14. Association of American Medical Colleges. OSR Preclinical Grading Questionnaire Results. May 2011. Available at: (https://www.aamc.org/download/185190/data/preclinical_grading.pdf) Access March 21, 2019.

RELEVANT AMA POLICY

Supporting Two-Interval Grading Systems for Medical Education H-295.866
Our AMA acknowledges the benefits of a two-interval grading system in medical colleges and universities in the United States for the non-clinical curriculum.

Physician and Medical Student Burnout D-310.968
1. Our AMA recognizes that burnout, defined as emotional exhaustion, depersonalization, and a reduced sense of personal accomplishment or effectiveness, is a problem among residents, fellows, and medical students.
2. Our AMA will work with other interested groups to regularly inform the appropriate designated institutional officials, program directors, resident physicians, and attending faculty about resident, fellow, and medical student burnout (including recognition, treatment, and prevention of burnout) through appropriate media outlets.
3. Our AMA will encourage partnerships and collaborations with accrediting bodies (e.g., the Accreditation Council for Graduate Medical Education and the Liaison Committee on Medical Education) and other major medical organizations to address the recognition, treatment, and prevention of burnout among residents, fellows, and medical students and faculty.
4. Our AMA will encourage further studies and disseminate the results of studies on physician and medical student burnout to the medical education and physician community.
5. Our AMA will continue to monitor this issue and track its progress, including publication of peer-reviewed research and changes in accreditation requirements.
6. Our AMA encourages the utilization of mindfulness education as an effective intervention to address the problem of medical student and physician burnout.
7. Our AMA will encourage medical staffs and/or organizational leadership to anonymously survey physicians to identify local factors that may lead to physician demoralization.
8. Our AMA will continue to offer burnout assessment resources and develop guidance to help organizations and medical staffs implement organizational strategies that will help reduce the sources of physician demoralization and promote overall medical staff well-being.
9. Our AMA will continue to: (a) address the institutional causes of physician demoralization and burnout, such as the burden of documentation requirements, inefficient work flows and regulatory oversight; and (b) develop and promote mechanisms by which physicians in all practices settings can reduce the risk and effects of demoralization and burnout, including implementing targeted practice transformation interventions, validated assessment tools and promoting a culture of well-being.
Citation: CME Rep. 8, A-07; Modified: Res. 919, I-11; Modified: BOT Rep. 15, A-19

Physician Health Programs H-405.961
1. Our AMA affirms the importance of physician health and the need for ongoing education of all physicians and medical students regarding physician health and wellness.
2. Our AMA encourages state medical societies to collaborate with the state medical boards to: (a) develop strategies to destigmatize physician burnout; and (b) encourage physicians to participate in the state's physician health program without fear of loss of license or employment. Citation: CSAPH Rep. 2, A-11; Reaffirmed in lieu of Res. 412, A-12; Reaffirmed: BOT action in response to referred for decision Res. 403, A-12; Modified: BOT Rep. 15, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 302
(I-19)

Introduced by: Medical Student Section

Subject: Strengthening Standards for LGBTQ Medical Education

Referred to: Reference Committee C

---

1 Whereas, Approximately 8 million adults in the United States identify as lesbian, gay, or
2 bisexual, and 700,000 U.S. adults identify as transgender[1]; and
3
4 Whereas, Individuals with disorders/differences of sex development (DSD) have "congenital
5 conditions in which development of chromosomal, gonadal, or anatomic sex is atypical," as
6 defined by the 2006 Consensus Statement[2]; and
7
8 Whereas, Individuals with DSD comprise approximately 1% of the population and are at
9 increased risk of cancer, infertility, psychosocial distress, and other issues[2]; and
10
11 Whereas, Research has shown significant disparities between sexual and gender minorities and
12 the general public, with poorer health outcomes in areas including: 1) modifiable risk factors for
13 cardiovascular disease such as mental distress, obesity, hypertension, and average blood
14 glucose levels[3]; 2) risk of mortality from breast cancer[4]; 3) substance use disorders, including
15 use of tobacco and electronic nicotine vapor devices[5]; 4) sexually transmitted infections such as
16 human immunodeficiency virus and syphilis[6]; and 5) mental health disorders, including suicidal
17 behavior[7]; and
18
19 Whereas, The Association of American Medical Colleges recommends comprehensive
20 coverage of the specific health care needs of lesbian, gay, bisexual, transgender, and queer
21 (LGBTQ) patients in medical school curricula[8] but these recommendations are not reflected in
22 Liaison Committee for Medical Education (LCME) or American Osteopathic Association (AOA)
23 accreditation requirements for medical schools, nor are they reflected in the Accreditation
24 Council for Graduate Medical Education (ACGME) accreditation requirements for medical
25 residency programs; and
26
27 Whereas, A survey of American and Canadian medical school deans found that medical
28 schools allocate five hours of instruction to LGBTQ health care on average[9]; and
29
30 Whereas, Most medical students rate their LGBTQ curriculum as "fair" or worse but feel more
31 prepared and comfortable caring for LGBTQ patients after additional LGBTQ-focused medical
32 education[10]; and
33
34 Whereas, LGBTQ medical education has been demonstrated to improve knowledge, behavior,
35 and beliefs regarding this patient population among medical students[11-13]; and
36
37 Whereas, Pursuant to existing AMA policy H-160.991, our AMA believes in educating
38 physicians on the current state of research in and knowledge of LGBTQ health; and

Whereas, Numerous health disparities and unique risk factors experienced by LGBTQ people are not limited to children and adolescents[3-7]; and

Whereas, The screening, diagnosis, and treatment of conditions affecting LGBTQ patients are not fully encompassed by a cultural competency curriculum; therefore be it

RESOLVED, That our American Medical Association amend policy H-295.878, "Eliminating Health Disparities - Promoting Awareness and Education of Lesbian, Gay, Bisexual, Transgender and Queer (LGBTQ) Health Issues in Medical Education," by addition and deletion to read as follows:

> **Eliminating Health Disparities – Promoting Awareness and Education of Lesbian, Gay, Bisexual, Transgender and Queer (LGBTQ) Health Issues, H-295.878**
> Our AMA: (1) supports the right of medical students and residents to form groups and meet on-site to further their medical education or enhance patient care without regard to their gender, gender identity, sexual orientation, race, religion, disability, ethnic origin, national origin or age; (2) supports students and residents who wish to conduct on-site educational seminars and workshops on health issues in Lesbian, Gay, Bisexual, Transgender and Queer communities; and (3) encourages the Liaison Committee on Medical Education (LCME), the American Osteopathic Association (AOA), and the Accreditation Council for Graduate Medical Education (ACGME) to include Lesbian, Gay, Bisexual, Transgender and Queer health issues in the basic science, clinical care, and cultural competency ~~curriculum~~ curricula for both undergraduate and graduate medical education; and (4) encourages the Liaison Committee on Medical Education (LCME), American Osteopathic Association (AOA), and Accreditation Council for Graduate Medical Education (ACGME) to periodically reassess the current status of curricula for medical student and residency education addressing the needs of ~~pediatric and adolescent~~ Lesbian, Gay, Bisexual, Transgender and Queer patients. (Modify Current HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 08/28/19

References:

1. Gates GJ. How many people are lesbian, gay, bisexual, or transgender? Williams Institute. 2011. https://williamsinstitute.law.ucla.edu/wp-content/uploads/Gates-How-Many-People-LGBT-Apr-2011.pdf. Accessed June 25, 2018.
2. Adam M, Vilain E. Emerging issues in disorders/differences of sex development (DSD). American Journal of Medical Genetics Part C: Seminars in Medical Genetics. 2017;175(2):249-252. doi:10.1002/ajmg.c.31564
3. Caceres B, Brody A, Halkitis P, Dorsen C, Yu G, Chyun D. Sexual Orientation Differences in Modifiable Risk Factors for Cardiovascular Disease and Cardiovascular Disease Diagnoses in Men. LGBT Health. 2018;5(5):284-294. doi:10.1089/lgbt.2017.0220
4. Cochran S, Mays V. Risk of Breast Cancer Mortality Among Women Cohabiting with Same Sex Partners: Findings from the National Health Interview Survey, 1997–2003. J Womens Health. 2012;21(5):528-533. doi:10.1089/jwh.2011.3134
5. Dai H. Tobacco Product Use Among Lesbian, Gay, and Bisexual Adolescents. Pediatrics. 2017;139(4):e20163276. doi:10.1542/peds.2016-3276
6. Mustanski B, Van Wagenen A, Birkett M, Eyster S, Corliss H. Identifying Sexual Orientation Health Disparities in Adolescents: Analysis of Pooled Data From the Youth Risk Behavior Survey, 2005 and 2007. Am J Public Health. 2014;104(2):211-217. doi:10.2105/ajph.2013.301748
7. Sutter M, Perrin P. Discrimination, mental health, and suicidal ideation among LGBTQ people of color. J Couns Psychol. 2016;63(1):98-105. doi:10.1037/cou0000126
8. Association of American Medical Colleges. Joint AAMC-GSA and AAMC-OSR recommendations regarding institutional programs and educational activities to address the needs of gay, lesbian, bisexual and transgender (GLBT) students and patients. Washington, DC: Association of American Medical Colleges, 2007. Available at: http://www.aamc.org/download/157460/data/institutional_programs_and_educational_activities_to_address_th.pdf. Accessed February 23, 2019.
9. Obedin-Maliver J, Goldsmith ES, Stewart L, White W, Tran E, Brenman S, et al. Lesbian, gay, bisexual, and transgender-related content in undergraduate medical education. Journal of the American Medical Association 2011;306:971–7.

10. White W, Brenman S, Paradis E, Goldsmith E, Lunn M, Obedin-Maliver J et al. Lesbian, Gay, Bisexual, and Transgender Patient Care: Medical Students' Preparedness and Comfort. Teaching and Learning in Medicine. 2015;27(3):254-263.
11. Kelley L, Chou CL, Dibble SL, Robertson PA. A critical intervention in lesbian, gay, bisexual, and transgender health: Knowledge and attitude outcomes among second-year medical students. Teaching and Learning in Medicine 2008;20:248–53.
12. Sanchez NF, Rabatin J, Sanchez JP, Hubbard S, Kalet A. Medical students' ability to care for lesbian, gay, bisexual, and transgendered patients. Family Medicine 2006;38:21–7.
13. Safer JD, Pearce EN. A simple curriculum content change increased medical student comfort with transgender medicine. Endocrine Practice 2013;19:633–7.

RELEVANT AMA POLICY

Eliminating Health Disparities - Promoting Awareness and Education of Lesbian, Gay, Bisexual, Transgender and Queer (LGBTQ) Health Issues in Medical Education H-295.878
Our AMA: (1) supports the right of medical students and residents to form groups and meet on-site to further their medical education or enhance patient care without regard to their gender, gender identity, sexual orientation, race, religion, disability, ethnic origin, national origin or age; (2) supports students and residents who wish to conduct on-site educational seminars and workshops on health issues in Lesbian, Gay, Bisexual, Transgender and Queer communities; and (3) encourages the Liaison Committee on Medical Education (LCME), the American Osteopathic Association (AOA), and the Accreditation Council for Graduate Medical Education (ACGME) to include LGBTQ health issues in the cultural competency curriculum for both undergraduate and graduate medical education; and (4) encourages the LCME, AOA, and ACGME to assess the current status of curricula for medical student and residency education addressing the needs of pediatric and adolescent LGBTQ patients.
Citation: Res. 323, A-05; Modified in lieu of Res. 906, I-10; Reaffirmation A-11; Reaffirmation A-12; Reaffirmation A-16; Modified: Res. 16, A-18

Health Care Needs of Lesbian, Gay, Bisexual and Transgender Populations H-160.991
1. Our AMA: (a) believes that the physician's nonjudgmental recognition of patients' sexual orientations, sexual behaviors, and gender identities enhances the ability to render optimal patient care in health as well as in illness. In the case of lesbian, gay, bisexual, transgender, queer/questioning, and other (LGBTQ) patients, this recognition is especially important to address the specific health care needs of people who are or may be LGBTQ; (b) is committed to taking a leadership role in: (i) educating physicians on the current state of research in and knowledge of LGBTQ Health and the need to elicit relevant gender and sexuality information from our patients; these efforts should start in medical school, but must also be a part of continuing medical education; (ii) educating physicians to recognize the physical and psychological needs of LGBTQ patients; (iii) encouraging the development of educational programs in LGBTQ Health; (iv) encouraging physicians to seek out local or national experts in the health care needs of LGBTQ people so that all physicians will achieve a better understanding of the medical needs of these populations; and (v) working with LGBTQ communities to offer physicians the opportunity to better understand the medical needs of LGBTQ patients; and (c) opposes, the use of "reparative" or "conversion" therapy for sexual orientation or gender identity.
2. Our AMA will collaborate with our partner organizations to educate physicians regarding: (i) the need for sexual and gender minority individuals to undergo regular cancer and sexually transmitted infection screenings based on anatomy due to their comparable or elevated risk for these conditions; and (ii) the need for comprehensive screening for sexually transmitted diseases in men who have sex with men; (iii) appropriate safe sex techniques to avoid the risk for sexually transmitted diseases; and (iv) that individuals who identify as a sexual and/or gender minority (lesbian, gay, bisexual, transgender, queer/questioning individuals) experience intimate partner violence, and how sexual and gender minorities present with intimate partner violence differs from their cisgender, heterosexual peers and may have unique complicating factors.
3. Our AMA will continue to work alongside our partner organizations, including GLMA, to increase physician competency on LGBTQ health issues.
4. Our AMA will continue to explore opportunities to collaborate with other organizations, focusing on issues of mutual concern in order to provide the most comprehensive and up-to-date education and information to enable the provision of high quality and culturally competent care to LGBTQ people.
Citation: CSA Rep. C, I-81; Reaffirmed: CLRPD Rep. F, I-91; CSA Rep. 8 - I-94; Appended: Res. 506, A-00; Modified and Reaffirmed: Res. 501, A-07; Modified: CSAPH Rep. 9, A-08; Reaffirmation A-12; Modified: Res. 08, A-16; Modified: Res. 903, I-17; Modified: Res. 904, I-17; Res. 16, A-18; Reaffirmed: CSAPH Rep. 01, I-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 303
(I-19)

Introduced by: Medical Student Section

Subject: Investigation of Existing Application Barriers for Osteopathic Medical Students Applying for Away Rotations

Referred to: Reference Committee C

---

1 Whereas, By June 30, 2020, all U.S. osteopathic and allopathic residencies will be accredited
2 under a single graduate medical education (GME) system that is managed under a single
3 National Resident Matching Program (NRMP)[1]; and
4
5 Whereas, The Accreditation Council for Graduate Medical Education (ACGME) states that the
6 benefits of the single GME accreditation system include offering all U.S. medical graduates a
7 uniform education pathway, increasing collaboration among the medical education community,
8 providing consistency across all residency and fellowship programs, reducing costs and
9 increasing opportunities for osteopathic graduate medical education[1]; and
10
11 Whereas, Undergraduate medical education will continue to be accredited by the two separate
12 accreditation bodies of the Liaison Committee of Medical Education (LCME) for allopathic
13 schools and the Commission on Osteopathic College Accreditation (COCA) for osteopathic
14 schools[2,3]; and
15
16 Whereas, The Executive Summary of the Agreement among ACGME, American Osteopathic
17 Association (AOA), and American Association of Colleges of Osteopathic Medicine (AACOM)
18 specifically outlines that graduates of osteopathic medical schools will be eligible for all
19 ACGME-accredited programs[4]; and
20
21 Whereas, Both osteopathic and allopathic physicians practice medicine across all specialties, in
22 all 50 US states and are licensed under the same state licensing boards, as well as have
23 completed similar undergraduate paths, medical school, clinical rotations and a residency
24 program[5]; and
25
26 Whereas, Elective visiting clinical rotations -- also known as 'Sub-Internships' or 'Away
27 Rotations' -- are beneficial to fourth year medical students by providing additional clinical
28 experiences in varying specialties, often at their residencies of interest, promoting networking
29 opportunities, and allowing students to obtain letters of recommendations to submit with their
30 residency program application[6]; and
31
32 Whereas, The majority of U.S. medical schools offering visiting medical student clinical rotations
33 participate in the Visiting Student Application Services program (VSAS), serviced by the
34 Association of American Medical Colleges (AAMC), which enables students to browse and
35 apply to electives offered by host institutions[7]; and
36
37 Whereas, The AAMC strives "to assure that all medical students possess equal freedom and
38 opportunity to pursue the career directions of their choice"[8]; and

1 Whereas, Despite AMA policy Equal Fees for Osteopathic and Allopathic Medical Students
2 H-295.876 that states: “Our AMA, in collaboration with the American Osteopathic Association,
3 discourages discrimination against medical students by institutions and programs based on
4 osteopathic or allopathic training. Our AMA encourages equitable fees for allopathic and
5 osteopathic medical students in access to clinical electives, while respecting the rights of
6 individual allopathic and osteopathic medical schools to set their own policies related to visiting
7 students,” other programs participating in VSAS have differing rotation fees between allopathic
8 and osteopathic medical students[13, 25, 29]; and
9
10 Whereas, Despite having such policy in place, osteopathic medical students continue to face
11 financial barriers in applying for away rotations[25,29] and
12
13 Whereas, An osteopathic student upon finding such language while searching for potential
14 rotation sites, would likely be deterred from pursuing the away rotation and thus would not
15 possess equal freedom of opportunity to pursue their desired career direction; and
16
17 Whereas, In our primary research, including contacting aforementioned programs, we were not
18 able to determine a cause for the discrepancies between accepting osteopathic students for
19 away rotations at specific programs; therefore be it
20
21 RESOLVED, That our American Medical Association work with relevant stakeholders to explore
22 reasons behind application barriers that result in discrimination against osteopathic medical
23 students when applying to elective visiting clinical rotations, and generate a report with the
24 findings by the 2020 Interim Meeting. (Directive to Take Action)

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

Received: 08/28/19

References:
1. Single GME Accreditation System. (2019). Retrieved March 28, 2019, from https://www.acgme.org/What-We-Do/Accreditation/Single-GME-Accreditation-System/Benefits-of-Single-GME
2. American Association of Medical Colleges. (2019). Liaison Committee on Medical Education. Retrieved March 29, 2019, from https://www.aamc.org/members/osr/committees/48814/reports_lcme.html
3. American Osteopathic Association. (2019). Commission on Osteopathic College Accreditation. Retrieved March 29, 2019, from https://osteopathic.org/accreditation/
4. Accreditation Council for Graduate Medical Education (ACGME). (2014, September 26). Executive Summary of the Agreement among ACGME, AOA, and AACOM. Retrieved March 27, 2019, from https://www.acgme.org/Portals/0/PDFs/Nasca-Community/Executive_Summary_of_the_Agreement_between_ACGME_and_AOA.pdf
5. American Academy of Osteopathy. Osteopathic Medical Education. Retrieved April 21, 2019 from https://www.academyofosteopathy.org/osteopathic-medical-education
6. The National Resident Matching Program. Results of the 2018 NRMP Program Director Survey. (2019). Retrieved March 29, 2019, from xf
7. AAMC Visiting Student Learning Opportunities. (2019). Retrieved March 29, 2019, from https://students-residents.aamc.org/attending-medical-school/article/visiting-student-learning-opportunities/
8. AAMC Mission, Goals, and Priorities. (2019). Retrieved March 28, 2019, from https://www.aamc.org/members/osr/about/77852/mission_goals_priorities.html
9. Tufts University School of Medicine. Visiting Student Program. (2019). Retrieved March 28, 2019, from http://medicine.tufts.edu/Student-Services-and-Campus-Life/Registrar/Visiting-Student-ProgramUniversity of Iowa Health Care Carver College of Medicine. Visiting Student Information and Application. (2019). Retrieved September 14, 2019, from https://medicine.uiowa.edu/md/student-support/visiting-student-information-and-application.
10. University of Miami - Miller School of Medicine. (2019). Visiting Students. Retrieved March 27, 2019, from http://www.mededu.miami.edu/visiting-students1.
11. University of New Mexico School of Medicine. (2019, February 6). Ortho audition rotation [Letter to Jacob Mushaben, OMS-III].
12. University of Washington in St Louis. Visiting Students. Visiting Students | MD Program. https://md.wustl.edu/academics/visiting-students/. Accessed April 22, 2019.
13. University of Utah School of Medicine. (2019). Overview - Visiting Students. https://medicine.utah.edu/students/current-students/visiting-students/. Accessed March 27, 2019
14. Albert Einstein College of Medicine. (2019). Registrar’s Office - Visiting Medical Students. Retrieved March 27, 2019, from https://www.einstein.yu.edu/education/student-affairs/registrar/visiting-students/.

15. NYU Langone Health. (2019). Department of Medicine Elective Catalog: Advanced Medicine Sub-Internship for Visiting Students. Retrieved March 29, 2019, from https://med.nyu.edu/education/md-degree/registration-student-records/elective-catalog/department-medicine/advanced-medicine-sub-internship-visiting-students.
16. University of Maryland School of Medicine. (2019). Office of Student Affairs -- Visiting Students. Retrieved March 27, 2019, from http://www.medschool.umaryland.edu/osa/Visiting-Students/.
17. University of Virginia. Visiting Student Electives. Student Affairs. Accessed April 22, 2019.https://med.virginia.edu/student-affairs/visiting-student-electives/.
18. Creighton University School of Medicine - Omaha Campus. (n.d.). Retrieved April 21, 2019, from https://apps.aamc.org/vsas/student.html#/institution/116/?returnUrl=institution-list-view
19. Pritzker.uchicago.edu. (2019). Visiting Students | Pritzker School of Medicine | The University of Chicago. https://pritzker.uchicago.edu/page/visiting-students. Accessed 22 April 2019.
20. Visiting Students. Eastern Virginia Medical School. https://www.evms.edu/education/medical_programs/doctor_of_medicine/visiting_students/. Accessed April 21, 2019.
21. Dartmouth Geisel School of Medicine. Visiting Fourth Year Elective Program. https://geiselmed.dartmouth.edu/admin/clinical_ed/visiting/. Accessed April 21, 2019.
22. Harvard School of Medicine. Exchange Clerkship Program. https://meded.hms.harvard.edu/exchange-clerkship-program. Accessed April 21, 2019.
23. Icahn School of Medicine at Mount Sinai. Visiting Students. https://icahn.mssm.edu/education/students/registrar/electives/visiting. Accessed April 21, 2019. Is
24. Johns Hopkins School of Medicine. Visiting Medical Student Information. https://www.hopkinsmedicine.org/som/students/policies/visitors.html. Accessed April 21, 2019. el School of Medicine
25. University of Colorado. Visiting Students for Academic Year 2018-19. (2019). Retrieved March 27, 2019, from http://www.ucdenver.edu/academics/colleges/medicalschool/education/studentaffairs/extern/Pages/default.aspx
26. LSU Health New Orleans School of Medicine. Fourth year electives. Accessed April 21, 2019. https://www.medschool.lsuhsc.edu/student_affairs/electives.aspx.
27. St. Louis University. Visiting Students. . Accessed April 21, 2019. https://www.slu.edu/admission/visiting-students.php
28. University of Toledo. Checklist For Visiting Student. Accessed April 21, 2019.https://www.utoledo.edu/med/md/curriculum/pdfs/checklistforvisitingstudentsrev2013.pdf.
29. University of Florida School of Medicine. (2019). Visiting Students. Retrieved March 27, 2019, from https://osa.med.ufl.edu/catalogue/visiting-medical-student-clerkships/
30. University of Iowa Health Care Carver College of Medicine. Visiting Student Information and Application. (2019). Retrieved September 14, 2019, from https://medicine.uiowa.edu/md/student-support/visiting-student-information-and-application.

RELEVANT AMA POLICY

AMA Membership Strategy: Osteopathic Medicine G-635.053

Our AMA's membership strategy on osteopathic physicians (DOs) includes the following: Our AMA:
(1) encourages all state societies to accept DOs as members at every level of the Federation;
(2) encourages state societies with schools of osteopathic medicine to support development of Medical Student Sections at those schools; Both the MSS Governing Council and existing MSS chapters in states with osteopathic schools should assist in this effort;
(3) encourages that DO members of our AMA continue to participate in the Membership Outreach program;
(4) will provide recruiters with targeted lists of DO non-members upon request;
(5) will include DOs, as appropriate, in direct nonmember mailings; and
(6) will expand its database of information on osteopathic students and doctors.
Citation: BOT Rep. I-93-11 Consolidated: CLRPD Rep. 3, I-01 Reaffirmed: Res. 809, I-05 Reaffirmed: BOT Rep. 35, A-08 Modified: CCB/CLRPD Rep. 3, A-12

Equal Fees for Osteopathic and Allopathic Medical Students H-295.876

Our AMA, in collaboration with the American Osteopathic Association, discourages discrimination against medical students by institutions and programs based on osteopathic or allopathic training. 2. Our AMA encourages equitable fees for allopathic and osteopathic medical students in access to clinical electives, while respecting the rights of individual allopathic and osteopathic medical schools to set their own policies related to visiting students.
Citation: Res. 809, I-05 Appended: CME Rep. 6, A-07 Modified: CCB/CLRPD Rep. 2, A-14

Expanding the Visiting Students Application Service for Visiting Student Electives in the Fourth Year H-295.867

1. Our American Medical Association strongly encourages the Association of American Medical Colleges (AAMC) to expand eligibility for the Visiting Students Application Service (VSAS) to medical students from Commission on Osteopathic College Accreditation (COCA)-accredited medical schools.
2. Our AMA supports and encourages the AAMC in its efforts to increase the number of members and non-member programs in the VSAS, such as medical schools accredited by COCA and teaching institutions not affiliated with a medical school.
3. Our AMA encourages the AAMC to ensure that member institutions that previously accepted both allopathic and osteopathic applications for fourth year clerkships prior to VSAS implementation continue to have a mechanism for accepting such applications of osteopathic medical students.

Citation: Res. 910, I-09 Reaffirmed: CME Rep. 01, A-19

ACGME Residency Program Entry Requirements H-310.909

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

Citation: Res. 920, I-12

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 304
(I-19)

Introduced by: Indiana

Subject: Issues with the Match, the National Residency Matching Program (NRMP)

Referred to: Reference Committee C

---

1 Whereas, A record number of physicians applied for residency programs through the National
2 Residency Matching Program (NRMP) in 2019. The total was 44,603 with ultimately 2,718
3 withdrawing and 3,509 not fully completing the application process. Of the remainder who
4 completed the Match program, only 79.6% of 38,376 matched, with 7,826 unmatched; and
5
6 Whereas, Applicants who do not match quickly the first time go through a secondary match
7 called the SOAP (Supplemental Offer and Acceptance Program); and
8
9 Whereas, A growing discrepancy exists between the number of medical school graduates and
10 available residency slots, causing the number of applicants who do not match each year to grow
11 at a time when there is also a growing shortage of physicians, with a large number over age 60
12 who will be retiring within 10 years; and
13
14 Whereas, Medical school graduates typically incur a significant burden of academic loans
15 through their years of education that is worsened by the fees charged to go through The Match
16 process. (Costs ranging from $85 up to thousands of dollars.) The residency programs also pay
17 the NRMP for their services, which range from $370 up to many thousands of dollars. Income
18 generated by the match has become quite lucrative as the number of applicants grows from
19 year to year. The Board of the NRMP has an obligation to be good stewards of these funds and
20 to ensure that are spent wisely and frugally; and
21
22 Whereas, The SOAP gives applicants who fail to match in the first round an opportunity to find a
23 position in a second-round matching process. This year, the SOAP website crashed on the first
24 day it came online, preventing participants from entering their program of choice and the
25 programs from seeing the list of those interested in positions. While the board extended the
26 SOAP one additional day, this system failure undoubtedly affected the outcome of the
27 secondary match for some individuals in both negative and positive ways. In other words,
28 changing the procedure and process produced a different outcome than if the SOAP system
29 had not failed; and
30
31 Whereas, Failure to match initially is an extremely stressful and difficult time, as applicants try to
32 learn about residencies that have remaining slots. Applicants who do not match must scramble
33 to sort out what they will do during the next year, when they typically apply again after
34 discerning what contributed to their failure to match; and
35
36 Whereas, Failure to match for one year is serious, but the bigger tragedy is to have expended
37 resources to become a physician and yet never match. This is also a waste of taxpayer dollars,
38 since these individuals can never independently practice as physicians, and yet the state and
39 nation have invested hundreds of thousands of dollars in their education; therefore be it

RESOLVED, That our American Medical Association redouble its efforts to promote an increase in residency program positions in the U.S. (Directive to Take Action); and be it further

RESOLVED, That our AMA assign an appropriate AMA committee or committees to:

- Study the issue of why residency positions have not kept pace with the changing physician supply and investigate what novel residency programs have been successful across the country in expanding positions both traditionally and nontraditionally.

- Seek to determine what causes a failure to match and better understand what strategies are most effective in increasing the chances of a successful match, especially after a prior failure. The committee(s) would rely upon the BNRMP (Board of the National Residency Matching Program) to provide some of this information through surveys, questionnaires and other means. Valid data would be valuable to medical students who seek to improve their chances of success in The Match.

- Report back to the AMA HOD with findings and recommendations (Directive to Take Action); and be it further

RESOLVED, Because SOAP (Supplemental Offer and Acceptance Program) failed to adequately serve some physicians seeking to match this year, that our AMA support the option to allow individuals participating in one future Match at no cost (Directive to Take Action); and be it further

RESOLVED, That in order to understand the cost of The Match and identify possible savings, our AMA encourage the Board of the National Residency Matching Program to:

1. Conduct an independent and fully transparent audit of SOAP (Supplemental Offer and Acceptance Program) to identify opportunities for savings, with the goal of lowering the financial burden on medical students and new physicians

2. Actively promote success for those participating in The Match by better explaining and identifying those issues that interfere with the successful match and to offer strategies to mitigate those issues. This information can be disseminated through the program website and through services such as its “Help” and “Q&A” links, and also through the AMA. (Directive to Take Action)

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

Received: 09/27/19

RELEVANT AMA POLICY

https://policysearch.ama-assn.org/policyfinder/search/Resident%20Match%20/relevant/1.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 305
(I-19)

Introduced by: Young Physicians Section

Subject: Ensuring Access to Safe and Quality Care for our Veterans

Referred to: Reference Committee C

---

1 Whereas, Studies have identified barriers related to physicians not employed by the Veterans
2 Administration (VA) and their ability to care for veterans as patients in addressing veterans'
3 status and addressing the military associated needs of this population[1,2]; and
4
5 Whereas, Training of VA physicians require completion of educational modules for addressing
6 specific veteran needs[3-6]; and
7
8 Whereas, Recognition and treatment of these needs can be taught through the Talent
9 Management System 2.0 modules such as Veterans Health Administration Mandatory Training
10 for Trainees, Military Sexual Trauma, Traumatic Brain Injury, and Suicide Awareness Voices of
11 Education (SAVE)-Suicide[3-6]; and
12
13 Whereas, The availability of similar training resources could help physicians not employed by
14 the VA provide better care for veterans; therefore be it
15
16 RESOLVED, That our American Medical Association amend AMA Policy H-510.986, "Ensuring
17 Access to Care for our Veterans," by addition to read as follows:
18
19 Ensuring Access to <u>Safe and Quality</u> Care for our Veterans H-510.986
20 1. Our AMA encourages all physicians to participate, when needed, in the health care of
21 veterans.
22 2. Our AMA supports providing full health benefits to eligible United States Veterans to
23 ensure that they can access the Medical care they need outside the Veterans Administration
24 in a timely manner.
25 3. Our AMA will advocate strongly: a) that the President of the United States take immediate
26 action to provide timely access to health care for eligible veterans utilizing the healthcare
27 sector outside the Veterans Administration until the Veterans Administration can provide
28 health care in a timely fashion; and b) that Congress act rapidly to enact a bipartisan long
29 term solution for timely access to entitled care for eligible veterans.
30 4. Our AMA recommends that in order to expedite access, state and local medical societies
31 create a registry of doctors offering to see our veterans and that the registry be made
32 available to the veterans in their community and the local Veterans Administration.
33 5. <u>Our AMA supports access to similar clinical educational resources for all health care</u>
34 <u>professionals involved in the care of veterans as those provided by the U.S. Department of</u>
35 <u>Veterans Affairs to their employees with the goal of providing better care for all veterans.</u>
36 <u>6.</u> Our AMA will strongly advocate that the Veterans Health Administration and Congress
37 develop and implement necessary resources, protocols, and accountability to ensure the
38 Veterans Health Administration recruits, hires and retains physicians and other health care
39 professionals to deliver the safe, effective and high-quality care that our veterans have been
40 promised and are owed. (Modify Current HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 09/26/19

RELEVANT AMA POLICY:

Ensuring Access to Care for our Veterans H-510.986

1. Our AMA encourages all physicians to participate, when needed, in the health care of veterans.
2. Our AMA supports providing full health benefits to eligible United States Veterans to ensure that they can access the Medical care they need outside the Veterans Administration in a timely manner.
3. Our AMA will advocate strongly: a) that the President of the United States take immediate action to provide timely access to health care for eligible veterans utilizing the healthcare sector outside the Veterans Administration until the Veterans Administration can provide health care in a timely fashion; and b) that Congress act rapidly to enact a bipartisan long term solution for timely access to entitled care for eligible veterans.
4. Our AMA recommends that in order to expedite access, state and local medical societies create a registry of doctors offering to see our veterans and that the registry be made available to the veterans in their community and the local Veterans Administration.
5. Our AMA will strongly advocate that the Veterans Health Administration and Congress develop and implement necessary resources, protocols, and accountability to ensure the Veterans Health Administration recruits, hires and retains physicians and other health care professionals to deliver the safe, effective and high-quality care that our veterans have been promised and are owed.

Citation: Res. 231, A-14; Reaffirmation A-15; Reaffirmed: Sub. Res. 709, A-15; Modified: Res. 820, I-18

References:

1. Bonnie M Vest, Jessica A Kulak, Gregory G Homish, Caring for veterans in U.S. civilian primary care: qualitative interviews with primary care providers, *Family Practice*, cmy078, https://doi.org/10.1093/fampra/cmy078
2. Vest BM, Kulak J, Hall VM, Homish GG. Addressing Patients' Veteran Status: Primary Care Providers' Knowledge, Comfort, and Educational Needs. Fam Med. 2018;50(6):455-459. https://doi.org/10.22454/FamMed.2018.795504.
3. Training for Trainees, Military Sexual Trauma, Traumatic Brain Injury, Suicide Awareness Voices of Education (SAVE)-Suicide. U.S. Department of Veterans Affairs Talent Management System 2.0. https://www.tms.va.gov
4. Military Sexual Trauma, Traumatic Brain Injury, Suicide Awareness Voices of Education (SAVE)-Suicide. U.S. Department of Veterans Affairs Talent Management System 2.0. Available at https://www.tms.va.gov.
5. Traumatic Brain Injury, Suicide Awareness Voices of Education (SAVE)-Suicide. US Department of veterans Affairs Talent Management System 2.0. Available at https://www.tms.va.gov.
6. Suicide Awareness Voices of Education (SAVE)-Suicide. U.S. Department of Veterans Affairs Talent Management System 2.0. Available at https://www.tms.va.gov.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 306
(I-19)

Introduced by: Indiana

Subject: Financial Burden of USMLE Step 2 CS on Medical Students

Referred to: Reference Committee C

---

1 Whereas, The cost of medical education and testing is rising, with no relief in sight for medical
2 students; and
3
4 Whereas, The cost of USMLE Step 2 CS Exam will be $1,300 in 2020 and most medical
5 students will have to travel and stay near one of the five national testing centers; and
6
7 Whereas, The USMLE Step 2 CS Exam costs approximately $27.5 million annually and
8 nationally to medical students, not including travel expenses; and
9
10 Whereas, It should be noted that there is no good correlation between Board certification and
11 physician competency; and
12
13 Whereas, There are no data to support a link between the USMLE Step 2 CS Exam and
14 improved patient outcomes, and 95% of U.S. medical students pass on their first attempt;
15 therefore be it
16
17 RESOLVED, That our American Medical Association work with the Federation of State Medical
18 Boards/United States Medical Licensing Examination (USMLE) to reduce the cost of the
19 USMLE Step 2 CS exam and allow medical students to take this exam locally to defray
20 unnecessary expenses. (Directive to Take Action)

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

Received: 09/27/19

RELEVANT AMA POLICY

https://policysearch.ama-assn.org/policyfinder/detail/USMLE%20Step%202%20CS%20exam%20?uri=%2FAMADoc%2Fdirectives.xml-0-876.xml.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 307
(I-19)

Introduced by: International Medical Graduates Section

Subject: Implementation of Financial Education Curriculum for Medical Students and Physicians in Training

Referred to: Reference Committee C

---

1 Whereas, Burnout is a crisis affecting the physician community in the United States.
2 Burnout is reported to have a deleterious influence on more than half of the practicing
3 physicians[1-7], up to 70% of medical students[8,9] and up to 75% of the physicians in
4 training[5,10-15]; and
5
6 Whereas, The causes of burnout are multifactorial, but severity of burnout has been reported to
7 increase with increase in financial debt[6,14,16-18]. Financial pressures had been found to increase
8 resident burnout and negatively impact professionalism[19]. The residents with higher debt were
9 found to have lower Quality of Life (QOL), lower satisfaction with work-life balance, higher
10 emotional exhaustion and depersonalization[16]; and
11
12 Whereas, Medical students have high amounts of debt[14,20-24] contributed by a rapid increase
13 both undergraduate[25] and medical education expenses[23,26]. African American medical students
14 are reported to have more debt compared to others.[27] The high amount of student loan debt has
15 a big impact on medical student's decision to choose a higher paying specialty[28-32]. This results
16 in decreased interest in primary care specialties as the pay is low resulting in shortage of
17 primary care providers[28-30,32]. There has been many proposals and initiatives to improve the
18 crisis of medical school debt, but are not implemented widely[23,33]; and
19
20 Whereas, Debt grows significantly during the residency and fellowship period, up to 20 - 50% by
21 the end of the training[14]. Once the residents graduate, the physicians will have to pay off the
22 student loans which will take up 9-12% of their post-tax income[23], which will add a significant
23 amount of financial stress on an early career physician; and
24
25 Whereas, Physicians are found to have poor financial literacy[14,34-40]. From a survey of
26 orthopedic residents, it was reported that only 4% of the residents had a formal financial
27 education, but 85% are interested in learning[41]; and
28
29 Whereas, There have been few attempts to improve the financial literacy by implementing a
30 curriculum in personal finance during medical school and residency, but these opportunities are
31 not widely available[14,34,36,41-48]; therefore be it
32
33 RESOLVED, That our American Medical Association work with relevant stakeholders to study
34 the development of a curriculum during medical school and residency/fellowship training to
35 educate them about the financial and business aspect of medicine. (Directive to Take Action)

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

Received: 10/01/19

1. Rath KS, Huffman LB, Phillips GS, Carpenter KM, Fowler JM. Burnout and associated factors among members of the Society of Gynecologic Oncology. Am J Obstet Gynecol. 2015;213(6):824.e821-829.
2. Parola V, Coelho A, Cardoso D, Sandgren A, Apóstolo J. Prevalence of burnout in health professionals working in palliative care: a systematic review. JBI Database System Rev Implement Rep. 2017;15(7):1905-1933.
3. Shanafelt TD, Gradishar WJ, Kosty M, et al. Burnout and career satisfaction among US oncologists. J Clin Oncol. 2014;32(7):678-686.
4. Shanafelt TD, Hasan O, Dyrbye LN, et al. Changes in Burnout and Satisfaction With Work-Life Balance in Physicians and the General US Working Population Between 2011 and 2014. Mayo Clin Proc. 2015;90(12):1600-1613.
5. Lin M, Battaglioli N, Melamed M, Mott SE, Chung AS, Robinson DW. High Prevalence of Burnout Among US Emergency Medicine Residents: Results From the 2017 National Emergency Medicine Wellness Survey. Ann Emerg Med. 2019.
6. Dimou FM, Eckelbarger D, Riall TS. Surgeon Burnout: A Systematic Review. J Am Coll Surg. 2016;222(6):1230-1239.
7. Rotenstein LS, Torre M, Ramos MA, et al. Prevalence of Burnout Among Physicians: A Systematic Review. JAMA. 2018;320(11):1131-1150.
8. Mazurkiewicz R, Korenstein D, Fallar R, Ripp J. The prevalence and correlations of medical student burnout in the pre-clinical years: a cross-sectional study. Psychol Health Med. 2012;17(2):188-195.
9. Ishak W, Nikravesh R, Lederer S, Perry R, Ogunyemi D, Bernstein C. Burnout in medical students: a systematic review. Clin Teach. 2013;10(4):242-245.
10. Ramey SJ, Ahmed AA, Takita C, Wilson LD, Thomas CR, Yechieli R. Burnout Evaluation of Radiation Residents Nationwide: Results of a Survey of United States Residents. Int J Radiat Oncol Biol Phys. 2017;99(3):530-538.
11. Dahn H, McGibbon A, Bowes D. Burnout and Resiliency in Canadian Oncology Residents: A Nationwide Resident and Program Director Survey. Pract Radiat Oncol. 2019;9(1):e118-e125.
12. Rotenstein LS, Ramos MA, Torre M, et al. Prevalence of Depression, Depressive Symptoms, and Suicidal Ideation Among Medical Students: A Systematic Review and Meta-Analysis. JAMA. 2016;316(21):2214-2236.
13. West CP, Tan AD, Habermann TM, Sloan JA, Shanafelt TD. Association of resident fatigue and distress with perceived medical errors. JAMA. 2009;302(12):1294-1300.
14. Royce TJ, Davenport KT, Dahle JM. A Burnout Reduction and Wellness Strategy: Personal Financial Health for the Medical Trainee and Early Career Radiation Oncologist. Pract Radiat Oncol. 2019;9(4):231-238.
15. Dyrbye LN, Burke SE, Hardeman RR, et al. Association of Clinical Specialty With Symptoms of Burnout and Career Choice Regret Among US Resident Physicians. JAMA. 2018;320(11):1114-1130.
16. West CP, Shanafelt TD, Kolars JC. Quality of life, burnout, educational debt, and medical knowledge among internal medicine residents. Jama. 2011;306(9):952-960.
17. Sargent MC, Sotile W, Sotile MO, Rubash H, Barrack RL. Stress and coping among orthopaedic surgery residents and faculty. J Bone Joint Surg Am. 2004;86(7):1579-1586.
18. Kibbe MR, Troppmann C, Barnett CC, et al. Effect of educational debt on career and quality of life among academic surgeons. Ann Surg. 2009;249(2):342-348.
19. Mareiniss DP. Decreasing GME training stress to foster residents' professionalism. Acad Med. 2004;79(9):825-831.
20. Baum S, Saunders D. Life after debt: Results of the National Student Loan Survey selected text from the final report. Journal of Student Financial Aid. 1998;28(3):1.
21. Belasco AS, Trivette MJ, Webber KL. Advanced degrees of debt: Analyzing the patterns and determinants of graduate student borrowing. The Review of Higher Education. 2014;37(4):469-497.
22. Morrison G. Mortgaging our future--the cost of medical education. N Engl J Med. 2005;352(2):117-119.
23. Steinbrook R. Medical student debt--is there a limit? N Engl J Med. 2008;359(25):2629-2632.
24. Berliner H. US medical education. Young doctors. Health Serv J. 1997;107(5563):24-25.
25. Adashi EY, Gruppuso PA. Commentary: the unsustainable cost of undergraduate medical education: an overlooked element of U.S. health care reform. Acad Med. 2010;85(5):763-765.
26. Jolly P. Medical school tuition and young physicians' indebtedness. Health Aff (Millwood). 2005;24(2):527-535.
27. Dugger RA, El-Sayed AM, Dogra A, Messina C, Bronson R, Galea S. The color of debt: racial disparities in anticipated medical student debt in the United States. PLoS One. 2013;8(9):e74693.
28. Ebell MH. Future salary and US residency fill rate revisited. JAMA. 2008;300(10):1131-1132.
29. Grischkan J, George BP, Chaiyachati K, Friedman AB, Dorsey ER, Asch DA. Distribution of Medical Education Debt by Specialty, 2010-2016. JAMA Intern Med. 2017;177(10):1532-1535.
30. Ebell M. Choice of specialty: it's money that matters in the USA. JAMA. 1989;262(12):1630.
31. Mullan F. Some thoughts on the white-follows-green law. Health Aff (Millwood). 2002;21(1):158-159.
32. Weida NA, Phillips RL, Bazemore AW. Does graduate medical education also follow green? Arch Intern Med. 2010;170(4):389-390.
33. Weinstein L, Wolfe H. A unique solution to solve the pending medical school tuition crisis. Am J Obstet Gynecol. 2010;203(1):19.e11-13.
34. Bar-Or Y. Empowering Physicians with Financial Literacy. J Med Pract Manage. 2015;31(1):46-49.
35. Ahmad FA, White AJ, Hiller KM, Amini R, Jeffe DB. An assessment of residents' and fellows' personal finance literacy: an unmet medical education need. Int J Med Educ. 2017;8:192-204.
36. Witek M, Siglin J, Malatesta T, et al. Is financial literacy necessary for radiation oncology residents? Int J Radiat Oncol Biol Phys. 2014;90(5):986-987.
37. Liebzeit J, Behler M, Heron S, Santen S. Financial literacy for the graduating medical student. Med Educ. 2011;45(11):1145-1146.

38. Wong R, Ng P, Bonino J, Gonzaga AM, Mieczkowski AE. Financial Attitudes and Behaviors of Internal Medicine and Internal Medicine-Pediatrics Residents. J Grad Med Educ. 2018;10(6):639-645.
39. Tevis SE, Rogers AP, Carchman EH, Foley EF, Harms BA. Clinically Competent and Fiscally at Risk: Impact of Debt and Financial Parameters on the Surgical Resident. J Am Coll Surg. 2018;227(2):163-171.e167.
40. Teichman JM, Bernheim BD, Espinosa EA, et al. How do urology residents manage personal finances? Urology. 2001;57(5):866-871.
41. Jennings JD, Quinn C, Ly JA, Rehman S. Orthopaedic Surgery Resident Financial Literacy: An Assessment of Knowledge in Debt, Investment, and Retirement Savings. Am Surg. 2019;85(4):353-358.
42. Bar-Or YD, Fessler HE, Desai DA, Zakaria S. Implementation of a Comprehensive Curriculum in Personal Finance for Medical Fellows. Cureus. 2018;10(1):e2013.
43. Poppler LH, Sharma K, Buck DW, Myckatyn TM. Five Financial Pearls for Medical Students, Residents, and Young Surgeons. Plast Reconstr Surg Glob Open. 2019;7(2):e1992.
44. Shappell E, Ahn J, Ahmed N, Harris I, Park YS, Tekian A. Personal Finance Education for Residents: A Qualitative Study of Resident Perspectives. AEM Educ Train. 2018;2(3):195-203.
45. McKillip R, Ernst M, Ahn J, Tekian A, Shappell E. Toward a Resident Personal Finance Curriculum: Quantifying Resident Financial Circumstances, Needs, and Interests. Cureus. 2018;10(4):e2540.
46. Mizell JS, Berry KS, Kimbrough MK, Bentley FR, Clardy JA, Turnage RH. Money matters: a resident curriculum for financial management. J Surg Res. 2014;192(2):348-355.
47. Glaspy JN, Ma OJ, Steele MT, Hall J. Survey of emergency medicine resident debt status and financial planning preparedness. Acad Emerg Med. 2005;12(1):52-56.
48. Dhaliwal G, Chou CL. A brief educational intervention in personal finance for medical residents. J Gen Intern Med. 2007;22(3):374-377.

RELEVANT AMA POLICY

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

Our AMA:
1. believes that medical schools should further develop an information system based on common definitions to display the costs associated with undergraduate medical education;
2. in studying the financing of medical schools, supports identification of those elements that have implications for the supply of physicians in the future;
3. believes that the primary goal of medical school is to educate students to become physicians and that despite the economies necessary to survive in an era of decreased funding, teaching functions must be maintained even if other commitments need to be reduced;
4. believes that a decrease in student enrollment in medical schools may not result in proportionate reduction of expenditures by the school if quality of education is to be maintained;
5. supports continued improvement of the AMA information system on expenditures of medical students to determine which items are included, and what the ranges of costs are;
6. supports continued study of the relationship between medical student indebtedness and career choice;
7. believes medical schools should avoid counterbalancing reductions in revenues from other sources through tuition and student fee increases that compromise their ability to attract students from diverse backgrounds;
8. supports expansion of the number of affiliations with appropriate hospitals by institutions with accredited residency programs;
9. encourages for profit-hospitals to participate in medical education and training;
10. supports AMA monitoring of trends that may lead to a reduction in compensation and benefits provided to resident physicians;
11. encourages all sponsoring institutions to make financial information available to help residents manage their educational indebtedness; and
12. will advocate that resident and fellow trainees should not be financially responsible for their training.

CME Rep. A, I-83 Reaffirmed: CLRPD Rep. 1, I-93Res. 313, I-95Reaffirmed by CME Rep. 13, A-97Modified: CME Rep. 7, A-05Modified: CME Rep. 13, A-06Appended: Res. 321, A-15Reaffirmed: CME Rep. 05, A-16Modified: CME Rep. 04, A-16

Principles of and Actions to Address Medical Education Costs and Student Debt- H-305.925

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 physicians 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.

21. Advocate for continued funding of programs including Income-Driven Repayment plans for the benefit of reducing medical student load burden.
22. Formulate a task force to look at undergraduate medical education training as it relates to career choice, and develop new polices and novel approaches to prevent debt from influencing specialty and subspecialty choice.

CME Report 05, I-18 Appended: Res. 953, I-18 Reaffirmation: A-19 Appended: Res. 316, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 308
(I-19)

Introduced by: Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont

Subject: Study Expediting Entry of Qualified IMG Physicians to US Medical Practice

Referred to: Reference Committee C

---

1 Whereas, There continues to be a steady influx of immigrants from strife-torn regions of the
2 world; and
3
4 Whereas, Some of these immigrants are highly trained physicians fleeing their country because
5 of political or religious persecution; and
6
7 Whereas, In order to be able to practice in the United States these physicians often have to
8 repeat complete cycles of training including medical school, residency, and subspecialty
9 training; and
10
11 Whereas, There is projected to be a shortage of physicians[1] given the aging of the present
12 physician and general civilian populations; and
13
14 Whereas, The immigrant physician may have beneficial skills such as language proficiency; and
15
16 Whereas, It is possible to retrain immigrant physicians in 18–24 months to be able to practice
17 medicine in their host country after they have demonstrated proficiency in language, medicine,
18 and the culture of the host country as demonstrated by a program of the National Health Service
19 of Scotland[2] profiled in a recent BBC America program; and
20
21 Whereas, Immigrant physicians in Scotland who have been retrained on an accelerated path
22 and who have demonstrated proficiency in language, medicine, and Scottish culture are
23 obligated by the NHS of Scotland to practice in the NHS in specific areas of need.[3] and
24
25 Whereas, Minnesota's International Medical Graduate Assistance Program was established in
26 2015 and is the first program of its kind in the United States and may serve as a model for other
27 states; and
28
29 Whereas, The Minnesota program was created by state statute and the program has achieved
30 considerable successes, including: developing a roster of IMG physicians in the state, forming
31 grant agreements with nonprofits to provide career support to IMGs, working with residency
32 directors to carve out pathways for IMGs to demonstrate the clinical expertise required to enter
33 into residency programs, funding dedicated residency slots for IMGs, and studying the licensure

---

[1] IHS Inc. The *Complexities of Physician Supply and Demand*: Projections from *2013 to 2025*. Final Report. Prepared for the Association of American Medical Colleges. March 2015. https://www.aamc.org/download/426242/data/ihsreportdownload.pdf?cm_mmc=AAMC-_-ScientificAffairs-_-PDF-_-ihsreport. Accessed on October 25, 2017.
[2] Scottish Government. Refugee Doctors Programme, February 8, 2017. https://www.youtube.com/watch?v=mufT33JdVQQ. Accessed on October 25, 2017.
[3] Ibid.
[5] MN Dept. of Health: International Medical Graduate Assistance Program Report to the Minnesota Legislature August 1, 2018

1 changes that would be needed to facilitate full IMG integration into the Minnesota physician
2 workforce[5]; therefore be it
3
4 RESOLVED, That our American Medical Association study and make recommendations for the
5 best means for evaluating, credentialing and expediting entry of competently trained
6 international medical graduate (IMG) physicians of all specialties into medical practice in the
7 USA. (Directive to Take Action)

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

Received: 10/02/19