AMA AMERICAN MEDICAL ASSOCIATION | MEMBERSHIP MOVES MEDICINE™

AMA Academic Physicians Section (APS)
2019 Interim Meeting
Manchester Grand Hyatt, San Diego
November 15-16

AMA House of Delegates
2019 Interim Meeting
November 16-19

Table of Contents

For the best user experience, please download a copy of this handbook to your personal device

Elections

- Election for APS Governing Council at-large member
- Nominations for 2020-2021 APS Governing Council members

Educational materials

- Session descriptions
- Educational session faculty
- Other AMA meeting educational programming

About the APS

- Governing Council
- Members
- Membership form
- APS 2019 Annual Meeting highlights
- APS 2019 Annual Meeting recommendations on House of Delegates' items
- Future meeting dates
- Internal Operating Procedures
- Contact information

AMA AMERICAN MEDICAL ASSOCIATION | MEMBERSHIP MOVES MEDICINE™

AMA Academic Physicians Section and Governing Council

2019 Interim Meeting
Manchester Grand Hyatt, San Diego, California
November 14-19, 2019

THURSDAY, NOV. 14		LOCATION
3:45 – 5 p.m.	**Council on Medical Education meeting with sections' leadership** ***(invitation only)*** Cynda Ann Johnson, MD; J. Manuel de la Rosa, MD; Kenneth B. Simons, MD; Alma B. Littles, MD	**Balboa**
8 – 9 p.m.	**Informal APS reception/networking opportunity** ***(cash bar)*** Join your fellow academic physicians to network and socialize	**Brew30**

FRIDAY, NOV. 15		LOCATION
7:30 – 11:30 a.m.	**APS Governing Council meeting** ***(invitation only; breakfast available at 7 a.m.; lunch at 11:30 a.m.)***	**Nautical**
1 – 4:15 p.m.	**APS business meeting, first session**	**Harbor G**
1 p.m.	**APS meeting welcome and introductions** Jose Manuel de la Rosa, MD, MSc	
1:15 p.m.	**Accelerating Change in Medical Education update** Khanh-Van T. Le-Bucklin, MD; Susan Skochelak, MD, MPH	
1:45 p.m.	**"The Power and Promise of Project ECHO to Enhance Patient Care through Empowered Learner Communities" *** Ron Stock, MD; Lisa Ayoub-Rodriguez, MD; Jose Manuel de la Rosa, MD, MSc	
2:45 p.m.	**Networking break**	
3 p.m.	**"Recruiting, Retaining, 'Retraining,' and Rewarding Community Physicians" *** *(cosponsored by the Senior Physicians Section)* Alma Littles, MD; Cynda Ann Johnson, MD, MBA; Jose Manuel de la Rosa, MD, MSc	
4 p.m.	**Open discussion, new business, and organizational updates**	
4:15 p.m.	**Closing remarks and adjournment (first session)** Jose Manuel de la Rosa, MD, MSc	
4:30 p.m.	**AMA Research Symposium** ***(APS members are invited to serve as judges)***	**Grand Hall C-D**
7 p.m.	**APS Governing Council and Council on Medical Education dinner** ***(invitation only)***	**Gaslamp Fish House**

* The American Medical Association is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

The AMA designates this live activity for a maximum of 1.0 *AMA PRA Category 1 Credit*™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

To claim *AMA PRA Category 1 Credit*™ for eligible AMA education activities, enter the activity code and complete the evaluation at amaedhub.com/pages/ama-interim-meeting-2019. Deadline to claim CME credit is December 31.

SATURDAY, NOV. 16		LOCATION
7 – 8 a.m.	**BOT Chair Breakfast with AMA Sections Leadership** ***(invitation only)*** J. Manuel de la Rosa, MD; Gary Gaddis, MD	**Grand Hall C**
8 a.m. – 12 p.m.	**APS business meeting, second session** ***(breakfast served)***	**Grand Hall D**
8 a.m.	**APS meeting welcome and introductions** Jose Manuel de la Rosa, MD, MSc	
8:05 a.m.	**Election of APS Governing Council at-large member** Hal B. Jenson, MD, MBA	
8:10 a.m.	**APS debate/voting on AMA House of Delegates' business items** Kenneth B. Simons, MD	
9:15 a.m.	**Opportunities for service on national medical education organizations** Liana Puscas, MD	
9:30 a.m.	**Networking break**	
9:45 a.m.	**"Update on ABMS Continuing Board Certification" *** *(cosponsored by the Council on Medical Education and Young Physicians Section)* Richard Hawkins, MD; Cynda Ann Johnson, MD, MBA; Cynthia A. Jumper, MD, MPH; Christie Morgan, MD; Jose Manuel de la Rosa, MD, MSc	
11 a.m.	**Joint meeting of the APS and Academic Medicine Caucus** Peter Carmel, MD, and Darlyne Menscer, MD	
11:45 a.m.	**Closing remarks and adjournment of APS meeting** Jose Manuel de la Rosa, MD, MSc	
12 to 1:30 p.m.	**"The Impact of Vision and Hearing Loss in the Senior Population"** ***(Senior Physicians Section educational session; buffet lunch served at 11:30 a.m.)***	**Harbor B**
2 p.m.	**AMA House of Delegates (HOD) opening**	**Seaport Ballroom**

SUNDAY, NOV. 17		LOCATION
7:30 a.m.	**APS preparation for Reference Committee testimony** ***(optional)***	**Cove**
8 a.m.	**AMA HOD second opening**	**Seaport Ballroom**
8:30 a.m. – 12 p.m.	**AMA HOD reference committee hearings**	**(Refer to AMA agenda)**
1:30 – 5 p.m.	**Educational and ancillary sessions**	**(Refer to AMA agenda)**

MONDAY, NOV. 18		LOCATION
8 – 11 a.m.	**Educational and ancillary sessions**	**(Refer to AMA agenda)**
9:30 – 11 a.m.	**Academic Medicine Caucus**	**Cortez Hill C**
2 – 6 p.m.	**AMA HOD business session**	**Seaport Ballroom**

TUESDAY, NOV. 19		LOCATION
9 a.m. – 12 p.m.	**AMA HOD business session**	**Seaport Ballroom**

* The American Medical Association is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

The AMA designates this live activity for a maximum of 1.25 *AMA PRA Category 1 Credits*™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

To claim *AMA PRA Category 1 Credit*™ for eligible AMA education activities, enter the activity code and complete the evaluation at amaedhub.com/pages/ama-interim-meeting-2019. Deadline to claim CME credit is December 31.

AMA
AMERICAN MEDICAL ASSOCIATION

Professional.

Ethical.

Welcoming.

Safe.

This is what we expect of our members and guests at AMA-sponsored events.

All attendees are expected to exhibit respectful, professional and collegial behavior consistent with the Code of Conduct passed by the AMA House of Delegates.

We take claims of harassment and conflicts of interest seriously. Visit **ama-assn.org/codeofconduct** to learn more. Violations of the Code of Conduct may be reported as follows:

- Conduct liaison assigned to the meeting
- AMA Office of General Counsel
- AMA speaker or vice speaker
- Our third-party hotline at (800) 398-1496 or online at lighthouse-services.com/ama (which includes an anonymous reporting option)

AMA AMERICAN MEDICAL ASSOCIATION | MEMBERSHIP MOVES MEDICINE™

Message from the APS chair

Thank you for registering for the Academic Physicians Section (APS) meeting, Friday, November 15 and Saturday, November 16 in San Diego. We are very pleased you have included our section in your plans. A few notes on the meeting:

- **Badges** are available at the AMA meeting registration desk.
- All APS meetings will be held at the **Manchester Grand Hyatt**.
- Please join us on Thursday, November 14 at 8 p.m. in the Brew30 bar for an informal **APS reception** (cash bar), to meet old friends and make new ones.
- Please **sign in** at the Section's registration table on Friday and Saturday.
- **Elections**—To be credentialed as a voting member of the APS, current membership in the AMA will be verified.
- All AMA-member physicians with an interest in medical education are welcome to **join the APS**. Please see our staff to learn more.
- All academic physicians and AMA delegates interested in medical education are invited to attend the **Academic Medicine Caucus**, from 9:30 to 11 a.m. on Monday in Cortez Hill 2. (The caucus will also meet on Saturday at 11 a.m. as part of the APS business meeting.)
- Mentor future physicians by serving as a judge during the **AMA Research Symposium** on Friday, from 4:30 to 6 p.m.
- During the APS business meeting on Saturday, from 8:10 to 9:15 a.m., APS members will **review and vote** on I-19 resolutions and reports.
- Section members are also encouraged to **testify at Reference Committee hearings** to help present the views of the APS. Attend our pre-RefComm meeting on Sunday, November 17 at 7:30 a.m. in the Cove Room.
- Want to learn more about the **AMA policy-making process?** View this **video**.
- Check out "**Academic Physicians Section Five-Year Review**," a report from the Council on Long Range Planning and Development.

- We are anticipating three excellent **APS educational sessions** on Friday and Saturday, with continuing medical education credit available (click the links below):

  The Power and Promise of Project ECHO to Enhance Patient Care through Empowered Learner Communities [1]
  Friday, 1:45 to 2:45 p.m.

  Recruiting, Retaining, "Retraining," and Rewarding Community Physicians [1]
  Friday, 3 to 4 p.m.

  Update on ABMS Continuing Board Certification [2]
  Saturday, 9:45 to 11 a.m.

- **Attend the next Section meeting**—June 5-6, 2020, in Chicago. See all future meeting dates.

Please feel free to contact us with any questions. Welcome to the APS meeting!

Best Regards,

Jose Manuel de la Rosa, MD
Chair, AMA Academic Physicians Section
Vice President for Outreach and Community
Engagement and Professor of Pediatrics
Texas Tech University Health Sciences Center Paul L.
Foster School of Medicine (El Paso, Texas)
jmanuel.delarosa@ttuhsc.edu

AMA AMERICAN MEDICAL ASSOCIATION | MEMBERSHIP MOVES MEDICINE™

Meeting Logistics

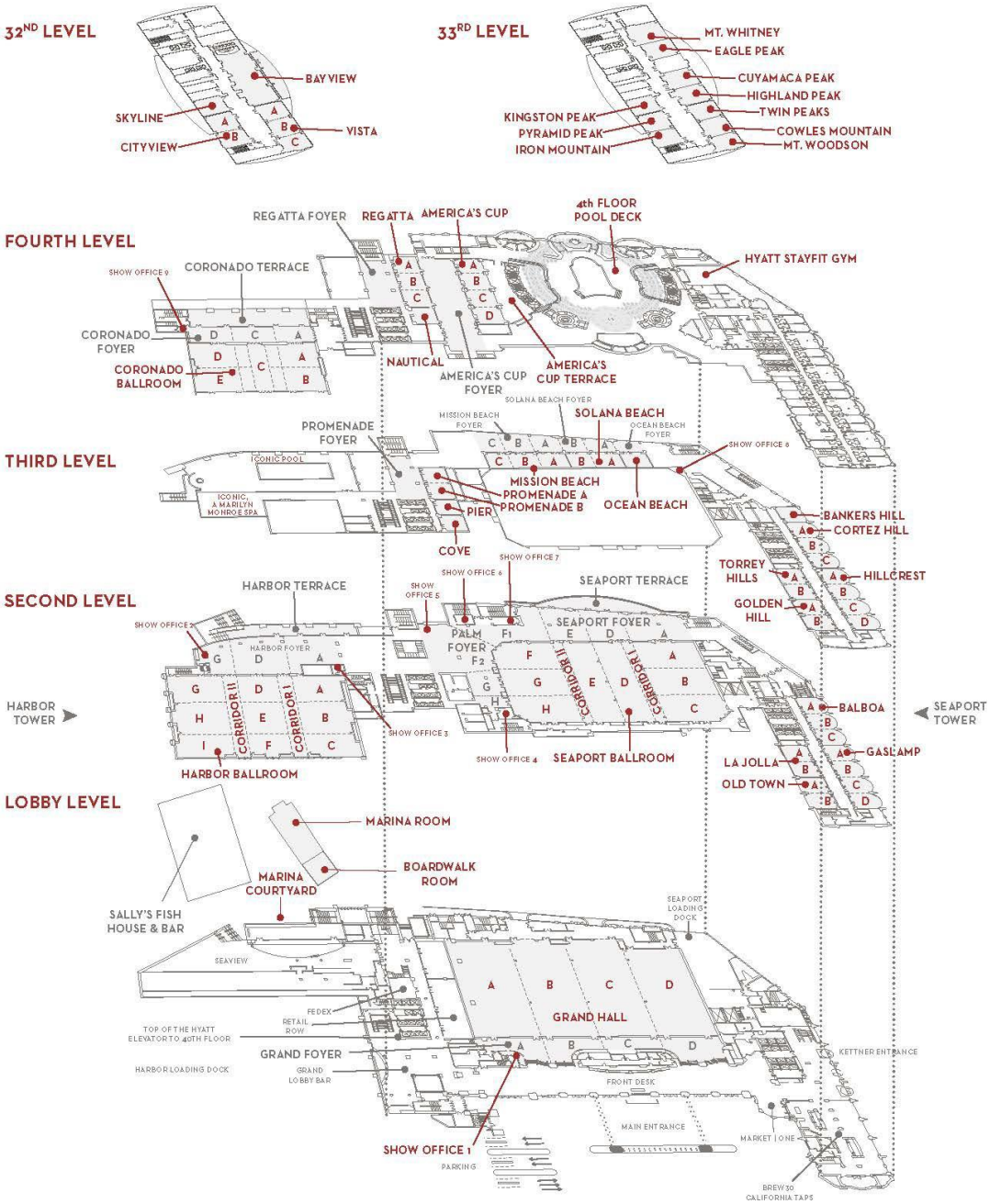
Wi-Fi: 2019INTERIM Password: 2019INTERIM
Manchester Grand Hyatt hotel map Marriott Marquis hotel map
Meeting app information

For the best user experience, please download a copy of this handbook to your personal device

Manchester Grand Hyatt

FLOOR PLAN

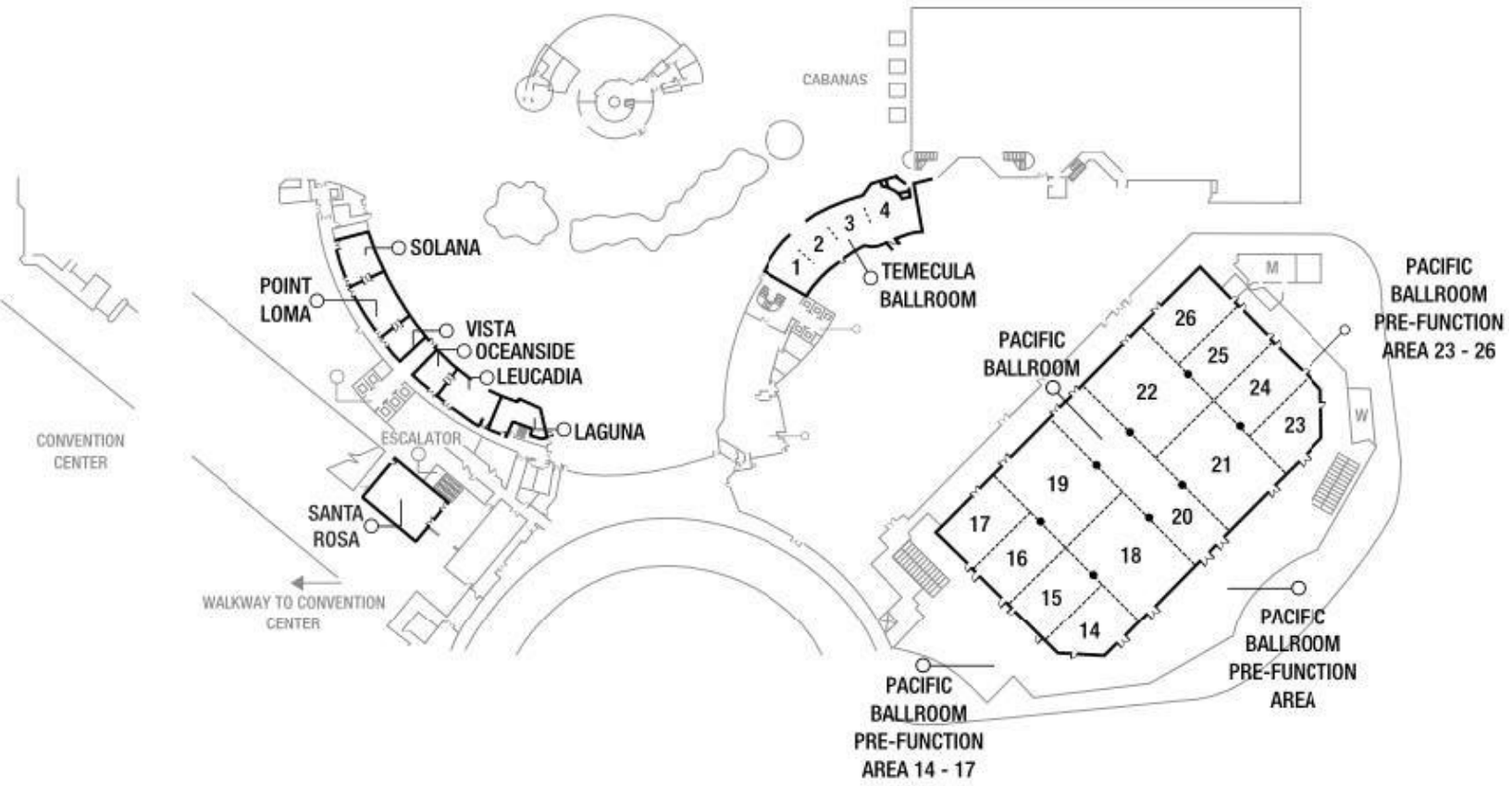
All Floors



For the best user experience, please download a copy of this handbook to your personal device

AMA AMERICAN MEDICAL ASSOCIATION | MEMBERSHIP MOVES MEDICINE™

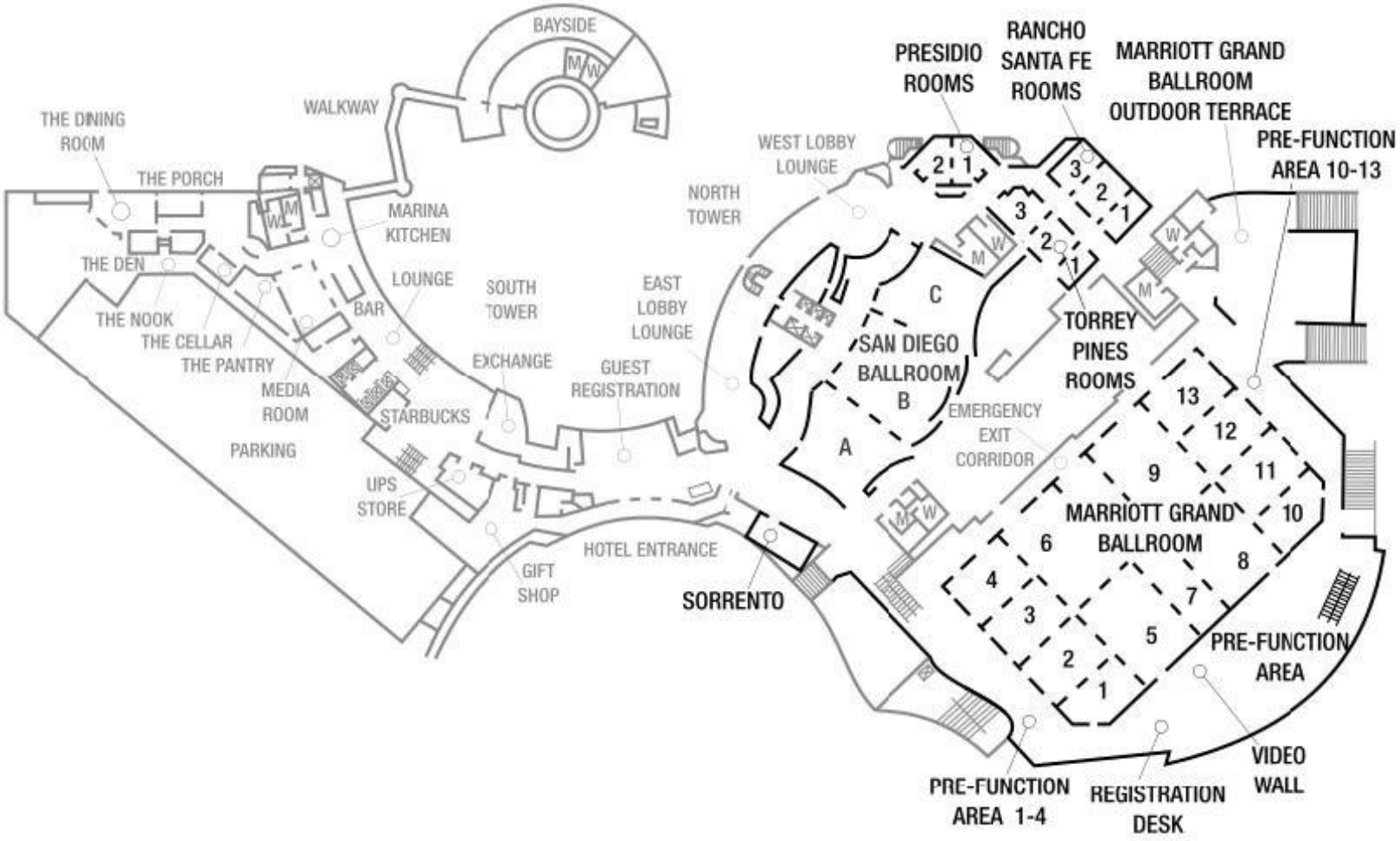
Marriott Marquis
Level One



For the best user experience, please download a copy of this handbook to your personal device

AMA AMERICAN MEDICAL ASSOCIATION | MEMBERSHIP MOVES MEDICINE™

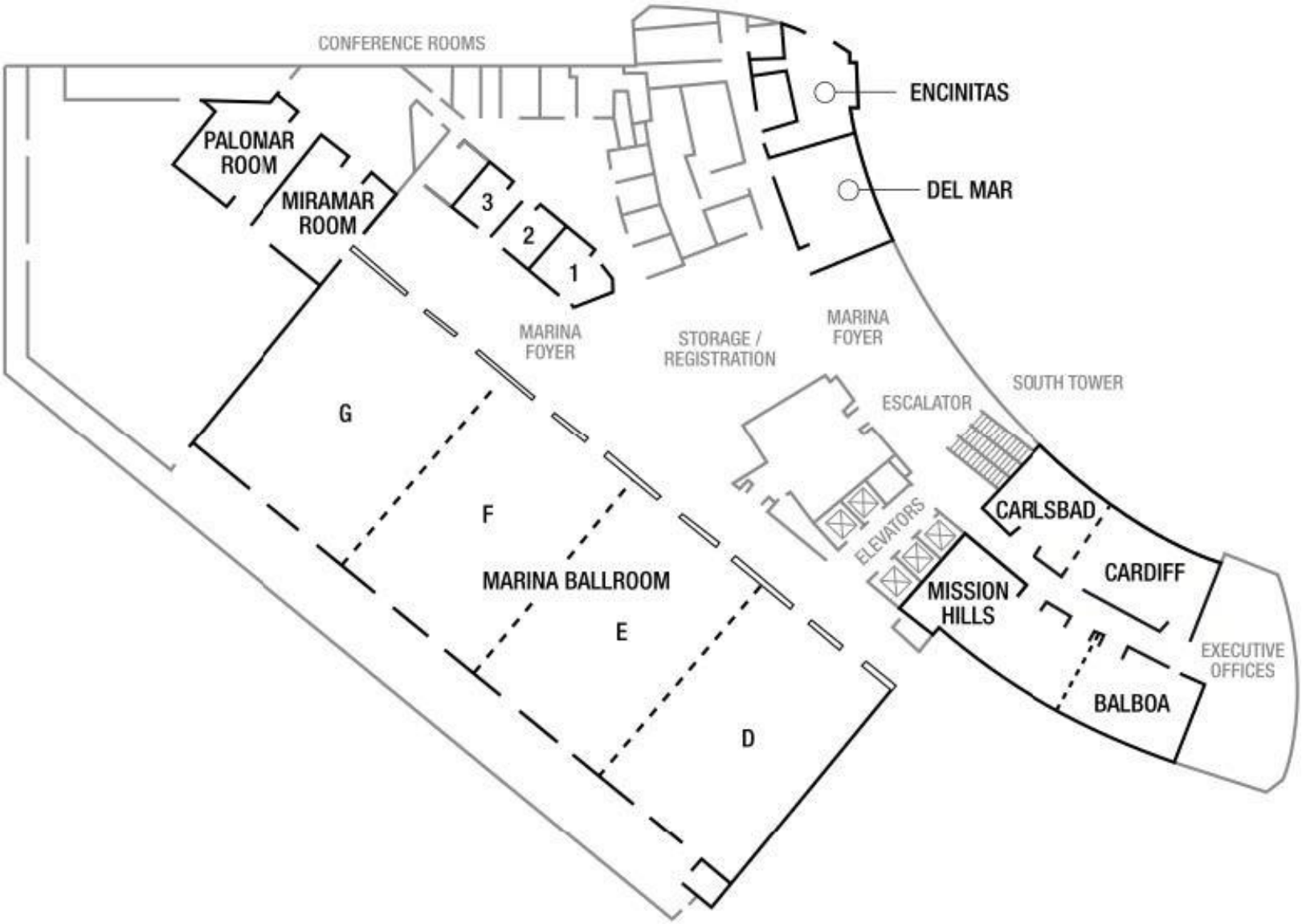
Marriott Marquis
Lobby Level



For the best user experience, please download a copy of this handbook to your personal device

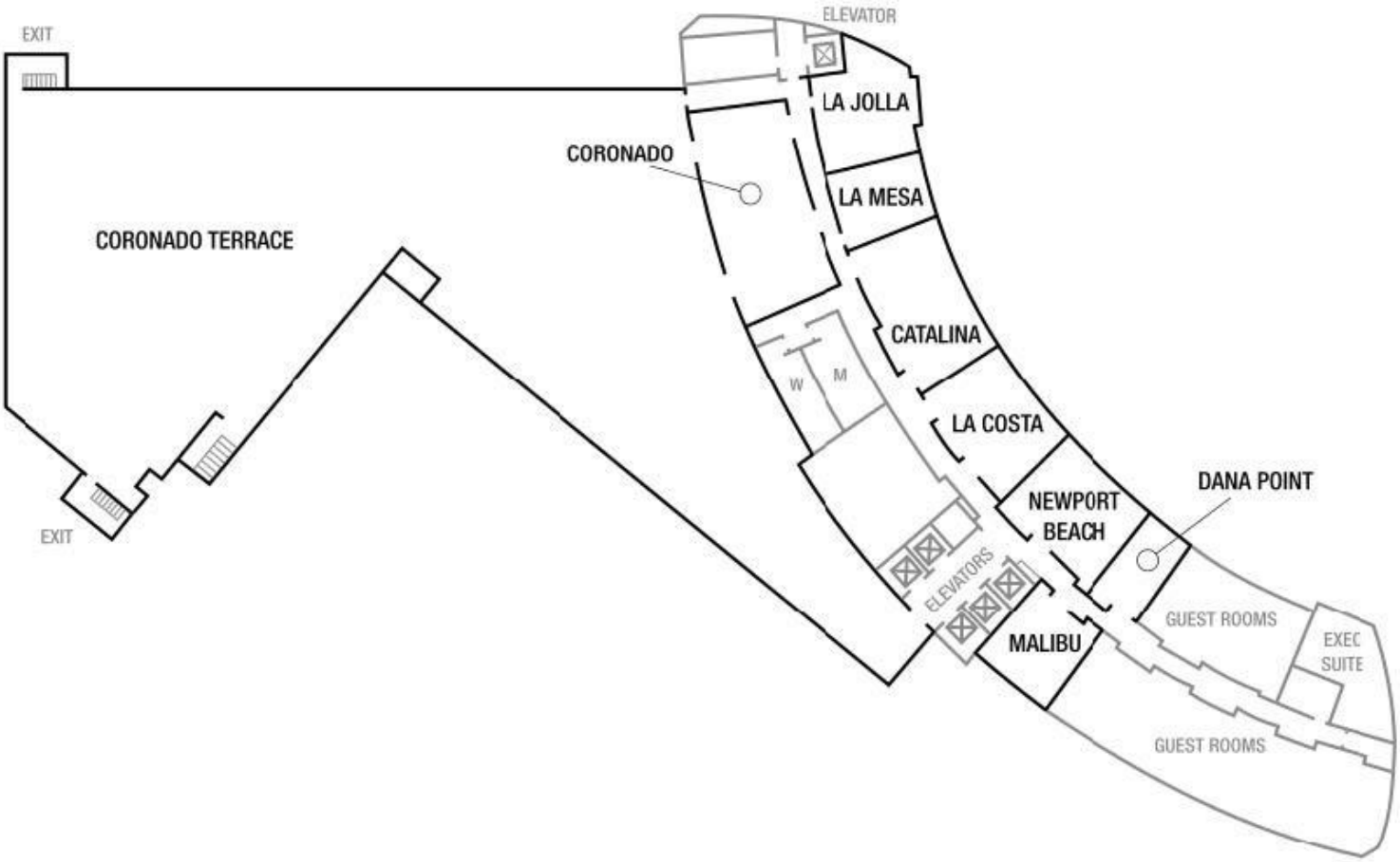
AMA AMERICAN MEDICAL ASSOCIATION | MEMBERSHIP MOVES MEDICINE™

Marriott Marquis
South Tower - Level 3



For the best user experience, please download a copy of this handbook to your personal device

Marriott Marquis
South Tower - Level 4



For the best user experience, please download a copy of this handbook to your personal device

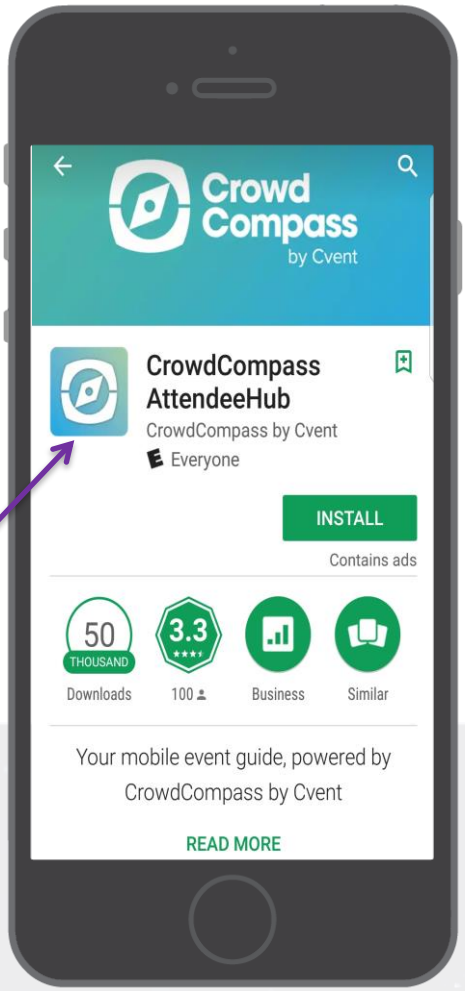
Downloading the App

Get the app

1. Go to the right store. Access the App Store on iOS devices and the Play Store on Android.

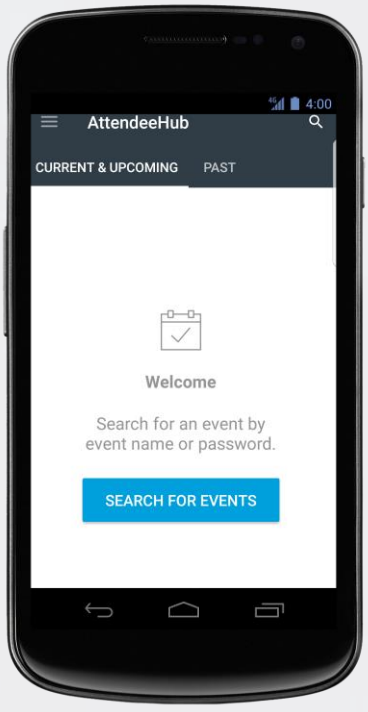
If you're using a Blackberry or Windows phone, skip these steps. **You'll need to use the web version of the app found here:**
https://event.crowdcompass.com/amainterim19

or Scan here for online version



2. Install the app. Search for CrowdCompass AttendeeHub Once you've found the app, tap either **Download** or **Install**.

After installing, a new icon will appear on the home screen.



Find your event

1. Search the AttendeeHub. Once downloaded, open the AttendeeHub app and enter
AMA 2019 Interim Meeting
2. Open your event. Tap the name of your event to open it.

AMA
AMERICAN MEDICAL ASSOCIATION

The "CrowdCompassAttendeeHub" Mobile App - FAQ

Where can I download the mobile app?

Go to the correct store for your device type. Access the App Store on iOS devices and the Play Store on Android.

Install the app. Search for CrowdCompassAttendeeHub. Once you have found the app, tap either Download or Install. After installing, a new icon will appear on your home screen.

AttendeeHub

If you're using a Blackberry or Windows phone, skip these steps. You'll need to use the web version of the app found here https://event.crowdcompass.com/amaannual2019

How do I find the Event?

Search the AttendeeHub. Once downloaded, open the AttendeeHub app and enter: AMA 2019 Annual Meeting

The app is asking me to log in. Why do I need to log-in?

Once you log in to the mobile app, you will be able to access the same schedules, bookmarks, reminders, notes, and contacts on your phone, tablet, and desktop. Below is a list of some other great things you can do after logging in:

- Take notes
- Share photos
- Rate sessions
- Join the attendee list
- Check-in
- Share contacts
- Share over social media
- Take Surveys
- Message fellow attendees

Where can I get my log-in information?

The log-in process is largely self-managed. Just follow the steps below to log in from your device:

1. **Access the Sign In page:** Tap the hamburger icon in the upper-left corner to open the side nav, then Log In.

2. **Enter your info:** You'll be prompted to enter your first and last name. Tap Next. Enter an email address, and then tap next again.

3. **Verify your account:** A verification email will be sent to your inbox. Open it and tap Verify Account. You'll see your confirmation code has already been carried over. Just tap Finish. You'll be taken back to the Event Guide with all those features unlocked.

I've requested log-in information, but I never received an email.

If you haven't received your log-in information, one likely culprit may be your spam filter. We try to tailor our email communications to avoid this filter, but some emails end up there anyway. Please first check the spam folder of your email. The sender may be listed as CrowdCompass.

I lost my log-in info, and I forgot my confirmation code. How do I log myself back in?

To have a verification email resent to you, start by accessing the sign-in page.

1. **Access the Sign In page:** Tap the hamburger icon in the upper-left corner to open the side nav, then Log In.

2. **Enter your info:** You'll be prompted to enter your first and last name. Tap Next.

3. **Click on Forgot Code:** If you've already logged in before, the app will already know your email address and will send a verification email to you again.

4. **Verify your account:** A verification email will be sent to your inbox. Open it and tap Verify Account. You'll see your confirmation code has already been carried over. Just tap Finish. You'll be taken back to the Event Guide with all those features unlocked.

How do I create my own schedule?

1. **Open the Schedule.** After logging in, tap the Schedule icon.

2. **Browse the Calendar.** Switch days by using the date selector at the top of the screen. Scroll up and down to see all the sessions on a particular day.

3. **See something interesting?** Tap the plus sign to the right of its name to add it to your personal schedule.

How can I export my schedule to my device's calendar?

1. **Access your schedule.** After logging in, tap the hamburger icon in the top right, then My Schedule.

2. Here you'll see a personalized calendar of the sessions you'll be attending. You can tap a session to see more details.

3. **Export it.** Tap the download icon at the top right of the screen. A confirmation screen will appear. Tap Export and your schedule will be added directly to your device's calendar.

How do I allow notifications on my device?

Allowing Notifications on iOS:

1. **Access the Notifications menu.** From the home screen, tap Settings, then Notifications.

2. **Turn on Notifications for the app.** Find your event's app on the list and tap its name. Switch Allow Notifications on.

Allowing Notifications on Android:

Note: Not all Android phones are the same. The directions below walk you through the most common OS, Android 5.0.

1. **Access the Notification menu.** Swipe down on the home screen, then click the gear in the top right. Tap Sounds and notifications.

2. **Turn on Notifications for your event's App.** Scroll down and tap App notifications. Find your event's app on the list. Switch notifications from off to on.

How do I manage my privacy within the app?

Set Your Profile to Private…

1. **Access your profile settings.** If you'd rather have control over who can see your profile, you can set it to private.

2. After logging in, tap the hamburger icon in the top left, and then tap your name at the top of the screen.

3. **Check the box.** At the top of your Profile Settings, make sure that the box next to "Set Profile to Private" is checked.

…Or Hide Your Profile Entirely

1. **Access the Attendee List.** Rather focus on the conference? Log in, open the Event Directory, and tap the Attendees icon.

2. **Change your Attendee Options.** Click the Silhouette icon in the top right to open Attendee Options.

3. **Make sure the slider next to "Show Me On Attendee List" is switched off.** Fellow attendees will no longer be able to find you on the list at all.

How do I message other attendees within the app?

1. **Access the Attendee List.** After logging in, tap the Attendees icon.

2. **Send your message.** Find the person you want to message by either scrolling through the list or using the search bar at the top of the screen. Tap their name, then the chat icon to start texting.

3. **Find previous chats.** If you want to pick up a chat you previously started, tap the hamburger icon in the top right, then **My Messages**.

How do I block a person from chatting with me?

1. **Access the Attendee List.** Rather focus on the conference? Just as before, log in and tap the Attendees icon.

2. **Block the person.** Find the person you'd like to block about by scrolling through the list or using the search bar at the top of the screen. Tap their name, then the chat icon. But, don't type anything, instead tap Block in the top right.

I want to network with other attendees. How do I share my contact info with them?

1. **Access the Attendee List.** After logging in, tap the Attendees icon.

2. **Send a request.** Find the person you want to share your contact information by either scrolling through the list or using the search bar at the top of the screen.

3. Tap their name, then the plus icon to send a contact request. If they accept, the two of you will exchange info.

I want to schedule an appointment with other attendees. How do I do that?

1. **Navigate to My Schedule.** Tap the hamburger icon in the top left, then My Schedule.

2. **Create Your Appointment.** In the top right corner of the My Schedule page you'll see a plus sign. Tap on it to access the Add Activity page.

3. **Give your appointment a name, a start and end time, and some invitees.** When you're finished, tap done. Invitations will be immediately sent to all relevant attendees.

How do I take notes within the app?

Write Your Thoughts...

1. **Find your Event Item.** After logging in, find the session, speaker, or attendee you'd like to create a note about by tapping on the appropriate icon in the Event Directory, then scrolling through the item list. Once you've found the item you're looking for, tap on it.

2. **Write your note.** Tap the pencil icon to bring up a blank page and your keyboard. Enter your thoughts, observations, and ideas. Tap done when you've finished.

…Then Export Them

1. **Navigate to My Notes.** Tap the hamburger icon in the top right, then My Notes. Here you'll find all the notes you've taken organized by session.

2. **Choose where to send your notes.** Tap the share icon in the top right and CrowdCompass will automatically generate a draft of an email that contains all your notes. All you have to do is enter an email address, and then tap Send.

Policy materials

House of Delegates grid
House of Delegates reports/resolutions of interest

For the best user experience, please download a copy of this handbook to your personal device

Academic Physicians Section (AMA-APS): Proposed actions on AMA HOD items

November 5, 2019

#	Item	Title	Consent Calendar			Discussion					
			Adopt	Not adopt	No position	Adopt	Amend	Refer	Reaffirm	Not adopt	No position
Reference Committee B											
1.	BOT 03	Restriction on IMG Moonlighting (Resolution 204-I-18)									
2.	Res 206	Improvement of Healthcare Access in Underserved Areas by Retaining and Incentivizing IMG Physicians									
3.	Res 215	Board Certification of Physician Assistants									
Reference Committee C											
4.	CME 02	Healthcare Finance in the Medical School Curriculum (Resolution 307-A-18)									
5.	CME 03	Standardization of Medical Licensing Time Limits Across States (Resolution 305-A-18)									
6.	CME 04	Board Certification Changes Impact Access to Addiction Medicine Specialists (Resolution 314-A-18)									
7.	CME 06	Veterans Health Administration Funding of Graduate Medical Education (Resolution 954-I-18)									
8.	Res 301	Engaging Stakeholders for Establishment of a Two-Interval, or Pass/Fail, Grading System of Non-Clinical Curriculum in U.S. Medical Schools									
9.	Res 302	Strengthening Standards for LGBTQ Medical Education									
10.	Res 303	Investigation of Existing Application Barriers for Osteopathic Medical Students Applying for Away Rotations									
11.	Res 304	Issues with the Match, The National Residency Matching Program (NRMP)									
12.	Res 305	Ensuring Access to Safe and Quality Care for our Veterans									

#	Item	Title	Consent Calendar			Discussion					
			Adopt	Not adopt	No position	Adopt	Amend	Refer	Reaffirm	Not adopt	No position
13.	Res 306	Financial Burden of USMLE Step 2 CS on Medical Students									
14.	Res 307	Implementation of Financial Education Curriculum for Medical Students and Physicians in Training									
15.	Res 308	Study Expediting Entry of Qualified IMG Physicians to US Medical Practice									
16.	Res 309	Follow-up on Abnormal Medical Test Findings									

Reference Committee F

17.	BOT 06	Physician Health Policy Opportunity (Resolution 604-I-18) Request to AMA for Training in Health Policy and Health Law (Resolution 612-A-19)									
18.	CLR PD 01	Academic Physicians Section Five-Year Review									

Reference Committee J

19.	Res 801	Reimbursement for Post-Exposure Protocol for Needlestick Injuries									

Reference Committee I

20.	CME 01	For-Profit Medical Schools or Colleges									
21.	CME 05	The Transition from Undergraduate Medical Education to Graduate Medical Education									

HOD business items of relevance to medical education and academic physicians

October 30, 2019

	Item	RC	Title
1.	BOT 03	B	Restriction on IMG Moonlighting (Resolution 204-I-18)
2.	Res 206	B	Improvement of Healthcare Access in Underserved Areas by Retaining and Incentivizing IMG Physicians
3.	Res 215	B	Board Certification of Physician Assistants
4.	CME 02	C	Healthcare Finance in the Medical School Curriculum (Resolution 307-A-18)
5.	CME 03	C	Standardization of Medical Licensing Time Limits Across States (Resolution 305-A-18)
6.	CME 04	C	Board Certification Changes Impact Access to Addiction Medicine Specialists (Resolution 314-A-18)
7.	CME 06	C	Veterans Health Administration Funding of Graduate Medical Education (Resolution 954-I-18)
8.	Res 301	C	Engaging Stakeholders for Establishment of a Two-Interval, or Pass/Fail, Grading System of Non-Clinical Curriculum in U.S. Medical Schools
9.	Res 302	C	Strengthening Standards for LGBTQ Medical Education
10.	Res 303	C	Investigation of Existing Application Barriers for Osteopathic Medical Students Applying for Away Rotations
11.	Res 304	C	Issues with the Match, The National Residency Matching Program (NRMP)
12.	Res 305	C	Ensuring Access to Safe and Quality Care for our Veterans
13.	Res 306	C	Financial Burden of USMLE Step 2 CS on Medical Students
14.	Res 307	C	Implementation of Financial Education Curriculum for Medical Students and Physicians in Training
15.	Res 308	C	Study Expediting Entry of Qualified IMG Physicians to US Medical Practice
16.	Res 309	C	Follow-up on Abnormal Medical Test Findings
17.	BOT 06	F	Physician Health Policy Opportunity (Resolution 604-I-18) Request to AMA for Training in Health Policy and Health Law (Resolution 612-A-19)
18.	CLRPD 01	F	Academic Physicians Section Five-Year Review
19.	Res 801	J	Reimbursement for Post-Exposure Protocol for Needlestick Injuries
20.	CME 01	I	For-Profit Medical Schools or Colleges
21.	CME 05	I	The Transition from Undergraduate Medical Education to Graduate Medical Education

REPORT OF THE BOARD OF TRUSTEES

B of T Report 3-I-19

Subject:	Restriction on IMG Moonlighting (Resolution 204-I-18)
Presented by:	Jesse M. Ehrenfeld, MD, MPH, Chair
Referred to:	Reference Committee B (, MD, Chair)

INTRODUCTION

At the 2018 Interim Meeting, the American Medical Association (AMA) House of Delegates (HOD) referred Resolution 204-I-18, "Restriction on IMG Moonlighting." Resolution 204 was introduced by the Resident and Fellow Section.

> Resolution 204 asks that our AMA advocate for changes to federal legislation allowing physicians with a J-1 visa in fellowship training programs the ability to moonlight.

This report provides a brief background on the J-1 visa program and discusses the issues that are raised when considering changes to federal legislation that would allow physicians with a J-1 visa in fellowship training programs the ability to moonlight.

BACKGROUND

The U.S. generally requires citizens of foreign countries to obtain a U.S. visa prior to entry. Based on the purpose of travel, an individual may receive one of two types of visas: immigrant and non-immigrant. Immigrant visas are issued to individuals who wish to live in the U.S. permanently, while non-immigrant visas are issued to individuals with permanent residence outside the U.S. who wish to be in the U.S. temporarily for tourism, business, temporary work, or other specified purposes.

The Exchange Visitor (J) non-immigrant visa category is for individuals approved to participate in work- and study-based exchange visitor programs. The first step in pursuing an exchange visitor visa is to apply through a designated sponsoring organization in the U.S. Physicians may be sponsored for J-1 status by the Educational Commission for Foreign Medical Graduates (ECFMG) for participation in accredited clinical programs or directly associated fellowship programs. These sponsored physicians have J-1 "alien physician" status and pursue graduate medical education or training at a U.S. accredited school of medicine or scientific institution, or pursue programs involving observation, consultation, teaching, or research. The J-1 classification is explicitly reserved for educational and cultural exchange.

J-1 status physicians are participants in the U.S. Department of State (DoS) Exchange Visitor Program. The primary goals of the Exchange Visitor Program are to allow participants the opportunity to engage broadly with Americans, share their culture, strengthen their English language abilities, and learn new skills or build skills that will help them in future careers.

According to the DoS, for Calendar Year 2018, there were 2,738 new J-1 physicians participating in the exchange program. For CY 2018 the top three "sending countries" for J-1 physicians were: Canada 689; India 489; and Pakistan 248. The top three "receiving U.S. states" for J-1 physicians were: New York 556; Michigan 182; and Texas 163.[1]

DISCUSSION

A J-1 visa holder may only perform the curricular activity listed on his/her Form DS-2019, or as provided for in the regulations for the specific category for which entry was obtained and with the approval of the Sponsor's Responsible or Alternate Responsible Officer. As a result, J-1 physician participants are not currently permitted to engage in any work outside of their approved program of graduate medical education. If the proposed activity by the J-1 physician falls outside of the normal scope and/or is not a required component of the training program, then it is deemed to be "work outside of the approved training program" and not permitted for J-1 physicians.

In June 1999, the U.S. Information Agency issued a statement of policy on the Exchange Visitor Program. In the statement of policy, the agency specifically comments on the ability of J-1 physicians to moonlight, stating that, "…a foreign medical graduate is not authorized to 'moonlight' and is without work authorization to do so. A foreign medical graduate may receive compensation from the medical training facility for work activities that are an integral part of his or her residency program. The foreign medical graduate is not authorized to work at other medical facilities or emergency rooms at night or on weekends. Such outside employment is a violation of the foreign medical graduate's program status and would subject the foreign medical graduate to termination of his or her program."[2]

The Administration has further outlined its rationale on this issue in a formal Notice of Proposed Rulemaking (NPRM) and later a final rule which strengthens the program's oversight by requiring management reviews for Private Sector Program sponsors of, for instance, alien physicians. The final rule confirmed the policy prohibiting moonlighting as outlined in 22 U.S. Code of Federal Regulations (CFR) §62.16:

> 22 CFR (§62.16) – Employment
> (a) An exchange visitor may receive compensation from the sponsor or the sponsor's appropriate designee, such as the host organization, when employment activities are part of the exchange visitor's program.
> (b) An exchange visitor who engages in unauthorized employment shall be deemed to be in violation of his or her program status and is subject to termination as a participant in an exchange visitor program.
> (c) The acceptance of employment by the accompanying spouse and dependents of an exchange visitor is governed by Department of Homeland Security regulations.

Currently, 42 CFR §415.208 provides substantial regulations for the services of moonlighting residents who are not foreign nationals. Again, the particular purpose of the J-1 program is to increase mutual understanding between the people of the U.S. and the people of other countries by means of educational and cultural exchanges. Thus, because J-1 physicians are foreign nationals participating in an educational/cultural exchange program offered by the DoS, they are not permitted to moonlight or receive additional compensation outside of the J-1 visa program.

DoS' final rule states that strict oversight of the exchange program is critical as an affirmative step "to protect the health, safety and welfare of foreign nationals." When problems occur, "the U.S. Government is often held accountable by foreign governments for the treatment of their nationals,

regardless of who is responsible." Any changes to program policy that may weaken protections could have "direct and substantial adverse effects on the foreign affairs of the U.S.."[3]

In accordance with the DoS policy, the AMA also has strong and lengthy policy outlining the rights of residents/fellows and limiting duty hours to ensure patient safety and an optimal learning environment for these physicians.

Those in support of Resolution 204 argue that moonlighting will improve access to care for underserved populations in certain areas around the U.S. facing a physician shortage. Allowing J-1 physicians to moonlight would provide these physicians with an increased opportunity to provide care to underserved populations while at the same time garner increased training and education during their time in the U.S. However, under the current program's purpose and restrictions, as set out by the Administration, this activity is not possible without significant changes to the J-1 program.[4]

Both the DoS and ECFMG ultimately desire that the J-1 visa program remain as a training/education program for which participants are paid. According to the DoS and ECFMG, if the alien physician program shifts to something other than a training/education program, then it will receive increased scrutiny (as is the case regarding the au pair and summer work travel programs) and could potentially be absorbed into the current immigration discussions between the U.S. Congress and the Administration. While the Board understands and appreciates the intent of the sponsors of Resolution 204, we conclude that the focus of the J-1 program should remain on the training and education of the physicians in the program and that our AMA should not pursue changes that could create a risk to those physicians and potentially the entire program.

RECOMMENDATION

The Board recommends that our American Medical Association not adopt Resolution 204-I-18, "Restriction on IMG Moonlighting," and that the remainder of the report be filed.

Fiscal Note: Less than $500

[1] https://j1visa.state.gov/wp-content/uploads/2019/03/Alien-Physician-Flyer-2018-web.pdf
[2] https://www.govinfo.gov/content/pkg/FR-1999-06-30/pdf/99-16757.pdf, 64 Federal Register 34983
[3] https://www.govinfo.gov/content/pkg/FR-2014-10-06/pdf/2014-23510.pdf, 79 Federal Register 60305
[4] Id.

RELEVANT AMA POLICY

CME Report on Duty Hours, CME Report 5, A-14

Policy H-255.970, "Employment of Non-Certified IMGs"
Our AMA will: (1) oppose efforts to employ graduates of foreign medical schools who are neither certified by the Educational Commission for Foreign Medical Graduates, nor have met state criteria for full licensure; and (2) encourage states that have difficulty recruiting doctors to underserved areas to explore the expanded use of incentive programs such as the National Health Service Corps or J1 or other visa waiver programs. Citation: (Res. 309, A-03; Reaffirmed: CME Rep. 2, A-13)

Policy H-310.907, "AMA Duty Hours Policy"
Our AMA adopts the following Principles of Resident/Fellow Duty Hours, Patient Safety, and Quality of Physician Training: 1. Our AMA reaffirms support of the 2003 Accreditation Council for Graduate Medical Education (ACGME) duty hour standards. 2. Our AMA will continue to monitor the enforcement and impact of duty hour standards, in the context of the larger issues of patient safety and the optimal learning environment for residents. 3. Our AMA encourages publication and supports dissemination of studies in peer-reviewed publications and educational sessions about all aspects of duty hours, to include such topics as extended work shifts, handoffs, in-house call and at-home call, level of supervision by attending physicians, workload and growing service demands, moonlighting, protected sleep periods, sleep deprivation and fatigue, patient safety, medical error, continuity of care, resident well-being and burnout, development of professionalism, resident learning outcomes, and preparation for independent practice. 4. Our AMA endorses the study of innovative models of duty hour requirements and, pending the outcomes of ongoing and future research, should consider the evolution of specialty- and rotation-specific duty hours requirements that are evidence-based and will optimize patient safety and competency-based learning opportunities. 5. Our AMA encourages the ACGME to: a) Decrease the barriers to reporting of both duty hour violations and resident intimidation. b) Ensure that readily accessible, timely and accurate information about duty hours is not constrained by the cycle of ACGME survey visits. c) Use, where possible, recommendations from respective specialty societies and evidence-based approaches to any future revision or introduction of resident duty hour rules. d) Broadly disseminate aggregate data from the annual ACGME survey on the educational environment of resident physicians, encompassing all aspects of duty hours.6. Our AMA recognizes the ACGME for its work in ensuring an appropriate balance between resident education and patient safety, and encourages the ACGME to continue to: a) Offer incentives to programs/institutions to ensure compliance with duty hour standards. b) Ensure that site visits include meetings with peer-selected or randomly selected residents and that residents who are not interviewed during site visits have the opportunity to provide information directly to the site visitor. c) Collect data on at-home call from both program directors and resident/fellow physicians; release these aggregate data annually; and develop standards to ensure that appropriate education and supervision are maintained, whether the setting is in-house or at-home. d) Ensure that resident/fellow physicians receive education on sleep deprivation and fatigue. 7. Our AMA supports the following statements related to duty hours: a) Resident physician total duty hours must not exceed 80 hours per week, averaged over a four-week period (Note: Total duty hours' includes providing direct patient care or supervised patient care that contributes to meeting educational goals; participating in formal educational activities; providing administrative and patient care services of limited or no educational value; and time needed to transfer the care of patients). b) Scheduled on-call assignments should not exceed 24 hours. Residents may remain on-duty for an additional 4 hours to complete the transfer of care, patient follow-up, and education; however, residents may not be assigned new patients, cross-coverage of other providers' patients, or continuity clinic during that time. c) Time spent in the hospital by residents on at-home call must count towards the 80-hour maximum weekly hour limit, and on-call frequency must not exceed every third night averaged over four weeks. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one-day-in-seven free of duty, when averaged over four weeks. d) At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident. e) Residents are permitted to return to the hospital while on at-home call to care for new or established patients. Each episode of this type of care, while it must be included in the 80-hour weekly maximum, will not initiate a new "off-duty period." f) Given the different education and patient care needs of the various specialties and changes in resident responsibility as training progresses, duty hour requirements should allow for flexibility for different disciplines and different training levels to ensure appropriate resident

education and patient safety; for example, allowing exceptions for certain disciplines, as appropriate, to the 16-hour shift limit for first-year residents, or allowing a limited increase to the total number of duty hours when need is demonstrated. g) Resident physicians should be ensured a sufficient duty-free interval prior to returning to duty. h) Duty hour limits must not adversely impact resident physician participation in organized educational activities. Formal educational activities must be scheduled and available within total duty hour limits for all resident physicians. i) Scheduled time providing patient care services of limited or no educational value should be minimized. j) Accurate, honest, and complete reporting of resident duty hours is an essential element of medical professionalism and ethics. k) The medical profession maintains the right and responsibility for self-regulation (one of the key tenets of professionalism) through the ACGME and its purview over graduate medical education, and categorically rejects involvement by the Centers for Medicare & Medicaid Services, The Joint Commission, Occupational Safety and Health Administration, and any other federal or state government bodies in the monitoring and enforcement of duty hour regulations, and opposes any regulatory or legislative proposals to limit the duty hours of practicing physicians. l) Increased financial assistance for residents/fellows, such as subsidized child care, loan deferment, debt forgiveness, and tax credits, may help mitigate the need for moonlighting. At the same time, resident/fellow physicians in good standing with their programs should be afforded the opportunity for internal and external moonlighting that complies with ACGME policy. m) Program directors should establish guidelines for scheduled work outside of the residency program, such as moonlighting, and must approve and monitor that work such that it does not interfere with the ability of the resident to achieve the goals and objectives of the educational program. n) The costs of duty hour limits should be borne by all health care payers. o) The general public should be made aware of the many contributions of resident/fellow physicians to high-quality patient care and the importance of trainees' realizing their limits (under proper supervision) so that they will be able to competently and independently practice under real-world medical situations. 8. Our AMA is in full support of the collaborative partnership between allopathic and osteopathic professional and accrediting bodies in developing a unified system of residency/fellowship accreditation for all residents and fellows, with the overall goal of ensuring patient safety. CME Rep. 5, A-14

Policy H-310.912, “Residents and Fellows' Bill of Rights”
1. Our AMA continues to advocate for improvements in the ACGME Institutional and Common Program Requirements that support AMA policies as follows: a) adequate financial support for and guaranteed leave to attend professional meetings; b) submission of training verification information to requesting agencies within 30 days of the request; c) adequate compensation with consideration to local cost-of-living factors and years of training, and to include the orientation period; d) health insurance benefits to include dental and vision services; e) paid leave for all purposes (family, educational, vacation, sick) to be no less than six weeks per year; and f) stronger due process guidelines. 2. Our AMA encourages the ACGME to ensure access to educational programs and curricula as necessary to facilitate a deeper understanding by resident physicians of the US health care system and to increase their communication skills. 3. Our AMA regularly communicates to residency and fellowship programs and other GME stakeholders through various publication methods (e.g., the AMA GME e-letter) this Residents and Fellows' Bill of Rights. 4. Our AMA: a) will promote residency and fellowship training programs to evaluate their own institution's process for repayment and develop a leaner approach. This includes disbursement of funds by direct deposit as opposed to a paper check and an online system of applying for funds; b) encourages a system of expedited repayment for purchases of $200 or less (or an equivalent institutional threshold), for example through payment directly from their residency and fellowship programs (in contrast to following traditional workflow for reimbursement); and c) encourages training programs to develop a budget and strategy for planned expenses versus unplanned expenses, where planned expenses should be estimated using historical data, and should include trainee reimbursements for items such as educational materials, attendance at conferences, and entertaining applicants. Payment in advance or within one month of document submission is strongly recommended. 5. Our AMA encourages teaching institutions to explore benefits to residents and fellows that will reduce personal cost of living expenditures, such as allowances for housing, childcare, and transportation. 6. Our AMA adopts the following 'Residents and Fellows' Bill of Rights' as applicable to all resident and fellow physicians in ACGME-accredited training programs:

RESIDENTS AND FELLOWS' BILL OF RIGHTS

Residents and fellows have a right to:

A. An education that fosters professional development, takes priority over service, and leads to independent practice. With regard to education, residents and fellows should expect: (1) A graduate medical education experience that facilitates their professional and ethical development, to include regularly scheduled didactics for which they are released from clinical duties. Service obligations should not interfere with educational opportunities and clinical education should be given priority over service obligations; (2) Faculty who devote sufficient time to the educational program to fulfill their teaching and supervisory responsibilities; (3) Adequate clerical and clinical support services that minimize the extraneous, time-consuming work that draws attention from patient care issues and offers no educational value; (4) 24-hour per day access to information resources to educate themselves further about appropriate patient care; and (5) Resources that will allow them to pursue scholarly activities to include financial support and education leave to attend professional meetings. B. Appropriate supervision by qualified faculty with progressive resident responsibility toward independent practice. With regard to supervision, residents and fellows should expect supervision by physicians and non-physicians who are adequately qualified and which allows them to assume progressive responsibility appropriate to their level of education, competence, and experience. C. Regular and timely feedback and evaluation based on valid assessments of resident performance. With regard to evaluation and assessment processes, residents and fellows should expect: (1) Timely and substantive evaluations during each rotation in which their competence is objectively assessed by faculty who have directly supervised their work; (2) To evaluate the faculty and the program confidentially and in writing at least once annually and expect that the training program will address deficiencies revealed by these evaluations in a timely fashion; (3) Access to their training file and to be made aware of the contents of their file on an annual basis; and (4) Training programs to complete primary verification/credentialing forms and recredentialing forms, apply all required signatures to the forms, and then have the forms permanently secured in their educational files at the completion of training or a period of training and, when requested by any organization involved in credentialing process, ensure the submission of those documents to the requesting organization within thirty days of the request. D. A safe and supportive workplace with appropriate facilities. With regard to the workplace, residents and fellows should have access to: (1) A safe workplace that enables them to fulfill their clinical duties and educational obligations; (2) Secure, clean, and comfortable on-call rooms and parking facilities which are secure and well-lit; (3) Opportunities to participate on committees whose actions may affect their education, patient care, workplace, or contract. E. Adequate compensation and benefits that provide for resident well-being and health. (1) With regard to contracts, residents and fellows should receive: a. Information about the interviewing residency or fellowship program including a copy of the currently used contract clearly outlining the conditions for (re)appointment, details of remuneration, specific responsibilities including call obligations, and a detailed protocol for handling any grievance; and b. At least four months advance notice of contract non-renewal and the reason for non-renewal. (2) With regard to compensation, residents and fellows should receive: a. Compensation for time at orientation; and b. Salaries commensurate with their level of training and experience, and that reflect cost of living differences based on geographical differences. (3) With Regard to Benefits, Residents and Fellows Should Receive: a. Quality and affordable comprehensive medical, mental health, dental, and vision care; b. Education on the signs of excessive fatigue, clinical depression, and substance abuse and dependence; c. Confidential access to mental health and substance abuse services; d. A guaranteed, predetermined amount of paid vacation leave, sick leave, maternity and paternity leave and educational leave during each year in their training program the total amount of which should not be less than six weeks; and e. Leave in compliance with the Family and Medical Leave Act. F. Duty hours that protect patient safety and facilitate resident well-being and education. With regard to duty hours, residents and fellows should experience: (1) A reasonable work schedule that is in compliance with duty-hour requirements set forth by the ACGME or other relevant accrediting body; and (2) At-home call that is not so frequent or demanding such that rest periods are significantly diminished or that duty-hour requirements are effectively circumvented. G. Due process in cases of allegations of misconduct or poor performance. With regard to the complaints and appeals process, residents and fellows should have the opportunity to defend themselves against any allegations presented against them by a patient, health professional, or training program in accordance with the due process guidelines established by the AMA. H. Access to and protection by institutional and accreditation authorities when reporting violations. With regard to reporting violations to the ACGME, residents and fellows should: (1) Be informed by their program at the beginning of their training and again at each semi-annual review of the resources and processes available within the residency program

for addressing resident concerns or complaints, including the program director, Residency Training Committee, and the designated institutional official; (2) Be able to file a formal complaint with the ACGME to address program violations of residency training requirements without fear of recrimination and with the guarantee of due process; and (3) Have the opportunity to address their concerns about the training program through confidential channels, including the ACGME concern process and/or the annual ACGME Resident Survey.
CME Rep. 8, A-11 Appended: Res. 303, A-14 Reaffirmed: Res. 915, I-15 Appended: CME Rep. 04, A-16

Policy H-310.979, "Resident Physician Working Hours and Supervision"
(1) Our AMA supports the following principles regarding the supervision of residents and the avoidance of the harmful effects of excessive fatigue and stress: (a) Exemplary patient care is a vital component for any program of graduate medical education. Graduate medical education enhances the quality of patient care in the institution sponsoring an accredited residency program. Graduate medical education must never compromise the quality of patient care. (b) Institutions sponsoring residency programs and the director of each program must assure the highest quality of care for patients and the attainment of the program's educational objectives for the residents. (c) Institutional commitment to graduate medical education must be evidenced by compliance with Section III.B.4 of the ACGME Institutional Requirements, effective July 1, 2007: The sponsoring institution's GME Committee must [m]onitor programs' supervision of residents and ensure that supervision is consistent with: (i) Provision of safe and effective patient care; (ii) Educational needs of residents; (iii) Progressive responsibility appropriate to residents' level of education, competence, and experience; and (iv) Other applicable Common and specialty/subspecialty specific Program Requirements. (d) The program director must be responsible for the evaluation of the progress of each resident and for the level of responsibility for the care of patients that may be safely delegated to the resident. (e) Each patient's attending physician must decide, within guidelines established by the program director, the extent to which responsibility may be delegated to the resident, and the appropriate degree of supervision of the resident's participation in the care of the patient. The attending physician, or designate, must be available to the resident for consultation at all times. (f) The program director, in cooperation with the institution, is responsible for maintaining work schedules for each resident based on the intensity and variability of assignments in conformity with Residency Review Committee (RRC) recommendations, and in compliance with the ACGME duty hour standards. (g) The program director, with institutional support, must assure for each resident effective counseling as stated in Section II.D.4.k of the Institutional requirements: "Counseling services: The Sponsoring Institution should facilitate residents' access to confidential counseling, medical, and psychological support services." (h) As stated in the ACGME Institutional Requirements (II.F.2.a-c), "The Sponsoring Institution must provide services and develop health care delivery systems to minimize residents' work that is extraneous to their GME programs' educational goals and objectives." These include patient support services, laboratory/pathology/radiology services, and medical records. (i) Is neither feasible nor desirable to develop universally applicable and precise requirements for supervision of residents. As stated in the ACGME Common Program Requirements (VI.B) "the program must ensure that qualified faculty provide appropriate supervision of residents in patient care activities." (j) Individual resident compensation and benefits must not be compromised or decreased as a result of these recommended changes in the graduate medical education system. (2) These problems should be addressed within the present system of graduate medical education, without regulation by agencies of government.
CME Rep. C, I-87 Modified: Sunset Report, I-97 Modified and Reaffirmed: CME Rep. 2, A-08

Policy D-310.987, "Impact of ACGME Resident Duty Hour Limits on Physician Well-Being and Patient Safety"
Our American Medical Association will actively participate in ongoing efforts to monitor the impact of resident duty hour limitations to ensure that patient safety and physician well-being are not jeopardized by excessive demands on post-residency physicians.
Res. 314, A-03 Reaffirmation A-12

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 206
(I-19)

Introduced by: International Medical Graduates Section
Minority Affairs Section

Subject: Improvement of Healthcare Access in Underserved Areas by Retaining and Incentivizing IMG Physicians

Referred to: Reference Committee B

Whereas, One in four of the practicing physician workforce in the United States of America are trained at an international medical school[1]; and

Whereas, 41% of the international medical graduates (IMG) serve in the primary care disciplines, as defined by the Association of American Medical Colleges (AAMC), including internal medicine, family medicine, pediatrics and geriatrics[2]; and

Whereas, An American Medical Association and American Osteopathic Association database study showed that the IMGs are more likely to serve in the rural persistent poverty areas in primary care, compared to their U.S, counterparts and DOs[3]; and

Whereas, By 2030, an estimated shortage of between 14,800 and 49,300 primary care physicians has been projected by a recent American Association of Medical Colleges report[4]; and

Whereas, The U.S. population aged over 65 is estimated to grow over 50% by 2030 and one third of the currently active physicians will be older than 65 in the next decade[4]; and

Whereas, If people in the underserved and rural areas and people without insurance would use healthcare the same way as the people with insurance and the people in the metropolitan areas; an additional 31,600 physicians were needed in 2016[4]; and

Whereas, Critical access hospitals in underserved areas continue to face a crisis due to uncompensated care and limited retention of physicians; and

Whereas, The residents of the rural and underserved areas tend to be older, more chronically ill, of a lower socioeconomic background and uninsured[5], resulting in significant disparities in rural and urban health care status and life expectancy[6]; and

Whereas, The overall number of U.S. medical graduates choosing careers as general internist has declined over many years and retention of general practice physicians remained a persistent challenge in improving health care access in these areas[7]; and

Whereas, A current Conrad 30 Reauthorization Bill (Senate Bill S948) has proposed a pathway for IMGs to serve in the federally designated health professional shortage area (HPSA) with a majority of Medicare/Medicaid and uninsured population for a longer duration, an increased number of IMGs to be available in each state to serve in these areas and have incentives to serve and settle in these areas; therefore be it

RESOLVED, That our American Medical Association support efforts to retain and incentivize international medical graduates serving in federally designated health professional shortage areas after the current allocated period. (Directive to Take Action).

Fiscal Note: Minimal - less than $1,000

Received: 10/01/19

1. About ECFMG: overview. Educational Commission for Foreign Medical Graduates website. http://www.ecfmg.org/about/index.html. Accessed February 8, 2015.
2. Center for Workforce Studies. *2013 State Physician Workforce Data Book.* Washington, DC: American Association of Medical Colleges; 2013. https://www.aamc.org/download/362168/data/2013statephysicianworkforcedatabook.pdf. Accessed August 14, 2019.
3. Fordyce MA, Doescher MP, Chen FM, Hart LG. Osteopathic physicians and international medical graduates in the rural primary care physician workforce. Fam Med. 2012;44(6):396-403.
4. Dall T, Reynolds R, Jones K, Chakrabarti R, Lacobuci W. Center for Workforce Studies. *The Complexities of Physician Supply and Demand: Projections from 2017-2032.* Washington, DC; Association of American Medical Colleges; 2019. https://aamc-black.global.ssl.fastly.net/production/media/filer_public/31/13/3113ee5c-a038-4c16-89af-294a69826650/2019_update_-_the_complexities_of_physician_supply_and_demand_-_projections_from_2017-2032.pdf. Accessed August 14, 2019.
5. Rosenblatt RA, Chen FM, Lishner DM, et al.. The future of family medicine and implications for rural primary care physician supply. University of Washington, School of Medicine 2010; Available at: http://depts.washington.edu/uwrhrc/uploads/RHRC_FR125_Rosenblatt.pdf. Accessed August 14, 2019
6. Singh GK, Siahpush M. Widening rural-urban disparities in life expectancy, U.S., 1969-2009. Am J Prev Med. 2014
7. Whitcomb ME. The challenge of providing doctors for rural America. Acad Med. 2005;80:715-716

RELEVANT AMA POLICY

US Physician Shortage H-200.954
Our AMA:
(1) explicitly recognizes the existing shortage of physicians in many specialties and areas of the US;
(2) supports efforts to quantify the geographic maldistribution and physician shortage in many specialties;
(3) supports current programs to alleviate the shortages in many specialties and the maldistribution of physicians in the US;
(4) encourages medical schools and residency programs to consider developing admissions policies and practices and targeted educational efforts aimed at attracting physicians to practice in underserved areas and to provide care to underserved populations;
(5) encourages medical schools and residency programs to continue to provide courses, clerkships, and longitudinal experiences in rural and other underserved areas as a means to support educational program objectives and to influence choice of graduates' practice locations;
(6) encourages medical schools to include criteria and processes in admission of medical students that are predictive of graduates' eventual practice in underserved areas and with underserved populations;
(7) will continue to advocate for funding from public and private payers for educational programs that provide experiences for medical students in rural and other underserved areas;
(8) will continue to advocate for funding from all payers (public and private sector) to increase the number of graduate medical education positions in specialties leading to first certification;
(9) will work with other groups to explore additional innovative strategies for funding graduate medical education positions, including positions tied to geographic or specialty need;
(10) continues to work with the Association of American Medical Colleges (AAMC) and other relevant groups to monitor the outcomes of the National Resident Matching Program; and
(11) continues to work with the AAMC and other relevant groups to develop strategies to address the current and potential shortages in clinical training sites for medical students.
(12) will: (a) promote greater awareness and implementation of the Project ECHO (Extension for Community Healthcare Outcomes) and Child Psychiatry Access Project models among academic health

centers and community-based primary care physicians; (b) work with stakeholders to identify and mitigate barriers to broader implementation of these models in the United States; and (c) monitor whether health care payers offer additional payment or incentive payments for physicians who engage in clinical practice improvement activities as a result of their participation in programs such as Project ECHO and the Child Psychiatry Access Project; and if confirmed, promote awareness of these benefits among physicians.
Citation: Res. 807, I-03; Reaffirmation I-06; Reaffirmed: CME Rep. 7, A-08; Appended: CME Rep. 4, A-10; Appended: CME Rep. 16, A-10; Reaffirmation: I-12; Reaffirmation A-13; Appended: Res. 922, I-13; Modified: CME Rep. 7, A-14; Reaffirmed: CME Rep. 03, A-16; Appended: Res. 323, A-19

Principles of and Actions to Address Primary Care Workforce H-200.949
1. Our patients require a sufficient, well-trained supply of primary care physicians--family physicians, general internists, general pediatricians, and obstetricians/gynecologists--to meet the nation's current and projected demand for health care services.
2. To help accomplish this critical goal, our American Medical Association (AMA) will work with a variety of key stakeholders, to include federal and state legislators and regulatory bodies; national and state specialty societies and medical associations, including those representing primary care fields; and accreditation, certification, licensing, and regulatory bodies from across the continuum of medical education (undergraduate, graduate, and continuing medical education).
3. Through its work with these stakeholders, our AMA will encourage development and dissemination of innovative models to recruit medical students interested in primary care, train primary care physicians, and enhance both the perception and the reality of primary care practice, to encompass the following components: a) Changes to medical school admissions and recruitment of medical students to primary care specialties, including counseling of medical students as they develop their career plans; b) Curriculum changes throughout the medical education continuum; c) Expanded financial aid and debt relief options; d) Financial and logistical support for primary care practice, including adequate reimbursement, and enhancements to the practice environment to ensure professional satisfaction and practice sustainability; and e) Support for research and advocacy related to primary care.
4. Admissions and recruitment: The medical school admissions process should reflect the specific institution's mission. Those schools with missions that include primary care should consider those predictor variables among applicants that are associated with choice of these specialties.
5. Medical schools, through continued and expanded recruitment and outreach activities into secondary schools, colleges, and universities, should develop and increase the pool of applicants likely to practice primary care by seeking out those students whose profiles indicate a likelihood of practicing in primary care and underserved areas, while establishing strict guidelines to preclude discrimination.
6. Career counseling and exposure to primary care: Medical schools should provide to students career counseling related to the choice of a primary care specialty, and ensure that primary care physicians are well-represented as teachers, mentors, and role models to future physicians.
7. Financial assistance programs should be created to provide students with primary care experiences in ambulatory settings, especially in underserved areas. These could include funded preceptorships or summer work/study opportunities.
8. Curriculum: Voluntary efforts to develop and expand both undergraduate and graduate medical education programs to educate primary care physicians in increasing numbers should be continued. The establishment of appropriate administrative units for all primary care specialties should be encouraged.
9. Medical schools with an explicit commitment to primary care should structure the curriculum to support this objective. At the same time, all medical schools should be encouraged to continue to change their curriculum to put more emphasis on primary care.
10. All four years of the curriculum in every medical school should provide primary care experiences for all students, to feature increasing levels of student responsibility and use of ambulatory and community-based settings.
11. Federal funding, without coercive terms, should be available to institutions needing financial support to expand resources for both undergraduate and graduate medical education programs designed to increase the number of primary care physicians. Our AMA will advocate for public (federal and state) and private payers to a) develop enhanced funding and related incentives from all sources to provide education for medical students and resident/fellow physicians, respectively, in progressive, community-based models of integrated care focused on quality and outcomes (such as the patient-centered medical home and the chronic care model) to enhance primary care as a career choice; b) fund and foster innovative pilot programs that change the current approaches to primary care in undergraduate and graduate medical education, especially in urban and rural underserved areas; and c) evaluate these

efforts for their effectiveness in increasing the number of students choosing primary care careers and helping facilitate the elimination of geographic, racial, and other health care disparities.
12. Medical schools and teaching hospitals in underserved areas should promote medical student and resident/fellow physician rotations through local family health clinics for the underserved, with financial assistance to the clinics to compensate their teaching efforts.
13. The curriculum in primary care residency programs and training sites should be consistent with the objective of training generalist physicians. Our AMA will encourage the Accreditation Council for Graduate Medical Education to (a) support primary care residency programs, including community hospital-based programs, and (b) develop an accreditation environment and novel pathways that promote innovations in graduate medical education, using progressive, community-based models of integrated care focused on quality and outcomes (such as the patient-centered medical home and the chronic care model).
14. The visibility of primary care faculty members should be enhanced within the medical school, and positive attitudes toward primary care among all faculty members should be encouraged.
15. Support for practicing primary care physicians: Administrative support mechanisms should be developed to assist primary care physicians in the logistics of their practices, along with enhanced efforts to reduce administrative activities unrelated to patient care, to help ensure professional satisfaction and practice sustainability.
16. There should be increased financial incentives for physicians practicing primary care, especially those in rural and urban underserved areas, to include scholarship or loan repayment programs, relief of professional liability burdens, and Medicaid case management programs, among others. Our AMA will advocate to state and federal legislative and regulatory bodies, among others, for development of public and/or private incentive programs, and expansion and increased funding for existing programs, to further encourage practice in underserved areas and decrease the debt load of primary care physicians. The imposition of specific outcome targets should be resisted, especially in the absence of additional support to the schools.
17. Our AMA will continue to advocate, in collaboration with relevant specialty societies, for the recommendations from the AMA/Specialty Society RVS Update Committee (RUC) related to reimbursement for E&M services and coverage of services related to care coordination, including patient education, counseling, team meetings and other functions; and work to ensure that private payers fully recognize the value of E&M services, incorporating the RUC-recommended increases adopted for the most current Medicare RBRVS.
18. Our AMA will advocate for public (federal and state) and private payers to develop physician reimbursement systems to promote primary care and specialty practices in progressive, community-based models of integrated care focused on quality and outcomes such as the patient-centered medical home and the chronic care model consistent with current AMA Policies H-160.918 and H-160.919.
19. There should be educational support systems for primary care physicians, especially those practicing in underserved areas.
20. Our AMA will urge urban hospitals, medical centers, state medical associations, and specialty societies to consider the expanded use of mobile health care capabilities.
21. Our AMA will encourage the Centers for Medicare & Medicaid Services to explore the use of telemedicine to improve access to and support for urban primary care practices in underserved settings.
22. Accredited continuing medical education providers should promote and establish continuing medical education courses in performing, prescribing, interpreting and reinforcing primary care services.
23. Practicing physicians in other specialties--particularly those practicing in underserved urban or rural areas--should be provided the opportunity to gain specific primary care competencies through short-term preceptorships or postgraduate fellowships offered by departments of family medicine, internal medicine, pediatrics, etc., at medical schools or teaching hospitals. In addition, part-time training should be encouraged, to allow physicians in these programs to practice concurrently, and further research into these concepts should be encouraged.
24. Our AMA supports continued funding of Public Health Service Act, Title VII, Section 747, and encourages advocacy in this regard by AMA members and the public.
25. Research: Analysis of state and federal financial assistance programs should be undertaken, to determine if these programs are having the desired workforce effects, particularly for students from disadvantaged groups and those that are underrepresented in medicine, and to gauge the impact of these programs on elimination of geographic, racial, and other health care disparities. Additional research should identify the factors that deter students and physicians from choosing and remaining in primary care disciplines. Further, our AMA should continue to monitor trends in the choice of a primary care specialty and the availability of primary care graduate medical education positions. The results of these

and related research endeavors should support and further refine AMA policy to enhance primary care as a career choice.
Citation: CME Rep. 04, I-18

Improving Rural Health H-465.994
1. Our AMA (a) supports continued and intensified efforts to develop and implement proposals for improving rural health care, (b) urges physicians practicing in rural areas to be actively involved in these efforts, and (c) advocates widely publicizing AMA's policies and proposals for improving rural health care to the profession, other concerned groups, and the public.
2. Our AMA will work with other entities and organizations interested in public health to:

- Identify and disseminate concrete examples of administrative leadership and funding structures that support and optimize local, community-based rural public health.
- Develop an actionable advocacy plan to positively impact local, community-based rural public health including but not limited to the development of rural public health networks, training of current and future rural physicians in core public health techniques and novel funding mechanisms to support public health initiatives that are led and managed by local public health authorities.
- Study efforts to optimize rural public health.

Citation: Sub. Res. 72, I-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmed: CEJA Rep. 06, A-18; Appended: Res. 433, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 215
(I-19)

Introduced by: American Academy of Dermatology, American College of Mohs Surgery, American Society for Dermatologic Surgery Association, Society for Investigative Dermatology, American Society of Dermatopathology, American Association of Neurological Surgeons, Congress of Neurological Surgeons, American College of Emergency Physicians, Iowa, Maryland, Wisconsin, Virginia

Subject: Board Certification of Physician Assistants

Referred to: Reference Committee B

Whereas, In 2019, state legislatures considered over 1,000 bills seeking to expand the scope of practice of non-physicians; and

Whereas, Physician assistants sought legislation consistent with elements of the optimal team practice act, which was adopted by the American Academy of Physician Assistants. While many states attempted to remove direct physician supervision or allow PAs to perform certain functions without physician supervision, most of the legislation was defeated or made minimal change in practice; and

Whereas, Physician assistants are a valuable member of the physician-led team; and

Whereas, Physician assistants complete a 26-month physician assistant program followed by 2,000 hours of clinical rotations, which emphasize primary care in ambulatory clinics, physician offices and acute or long-term care facilities; and

Whereas, After finishing a rigorous undergraduate academic curriculum, physicians receive an additional four years of education in medical school, followed by 3-7 years of residency and 12,000-16,000 hours of patient care training; and

Whereas, There are substantial differences in the education of physician assistants and physicians, both in depth of knowledge and length of training; and

Whereas, According to four nationwide surveys, 84% of respondents prefer a physician to have primary responsibility for diagnosing and managing their health care, and 91% of respondents said that a physician’s years of medical education and training are vital to optimal patient care, especially in the event of a complication or medical emergency; and

Whereas, A recent survey conducted by the American Medical Association’s Scope of Practice Partnership confirms increasing patient confusion regarding the many types of health care providers - including physicians, nurses, physician assistants, technicians and other varied providers. The survey revealed that 55 percent of patients believe it is difficult to identify who is a licensed medical doctor and who is not by reading what services they offer, their title and other licensing credentials in advertising or other marketing materials; and

Whereas, An organization independent of the National Commission on Certification of Physician Assistants is providing board certification exams for physician assistants working within dermatology; and

Whereas, This certification can deceive the public and allow physician assistants to advertise themselves as being “board certified;” and

Whereas, This can lead to significant patient safety issues; therefore be it

RESOLVED, That our American Medical Association amend Policy H-35.965, “Regulation of Physician Assistants,” by addition and deletion to read as follows:

Our AMA: (1) will advocate in support of maintaining the authority of medical licensing and regulatory boards to regulate the practice of medicine through oversight of physicians, physician assistants and related medical personnel; ~~and~~ (2) opposes legislative efforts to establish autonomous regulatory boards meant to license, regulate and discipline physician assistants outside of the existing state medical licensing and regulatory bodies' authority and purview; and (3) opposes efforts by independent organizations to board certify physician assistants in a manner that misleads the public to believe such certification is equivalent to medical specialty board certification. (Modify Current HOD Policy); and be it further

RESOLVED, That our AMA amend Policy H-275.926, “Medical Specialty Board Certification Standards,” by addition to read as follows

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. Opposes any action, regardless of intent, by independent organizations providing board certification for non-physicians that appears likely to confuse the public about the unique credentials of medical specialty board certification or take advantage of the prestige of medical specialty board certification for purposes contrary to the public good and safety.
3. 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. (Modify Current HOD Policy)

Fiscal Note: Not yet determined

Received: 10/16/19

RELEVANT AMA POLICY

Regulation of Physician Assistants H-35.965
Our AMA: (1) will advocate in support of maintaining the authority of medical licensing and regulatory boards to regulate the practice of medicine through oversight of physicians, physician assistants and related medical personnel; and (2) opposes legislative efforts to establish autonomous regulatory boards meant to license, regulate, and discipline physician assistants outside of the existing state medical licensing and regulatory bodies' authority and purview. Citation: Res. 233, A-17

Physician Assistants H-35.989
1. Our AMA opposes legislation to increase public funding for programs to train physician assistants and supports a careful reevaluation of the need for public funding at the time that present legislative authorities expire.
2. A physician assistant should provide patient care services only in accord with the medical practice act and other applicable state law, and such law should provide that the physician assistant's utilization by a physician or group of physicians be approved by the medical licensing board. A licensed physician or group of physicians seeking to utilize a physician assistant should submit to the medical licensing board an application for utilization that identifies: the qualifications and experience of the physician assistant, the qualifications and experience of the supervising physician and a description of his or her practice, and a description of the manner and the health care settings in which the assistant will be utilized, and the arrangements for supervision by the responsible physician. Such an application should also specify the number of physician assistants that the physician or group of physicians plans to employ and supervise. A physician assistant should be authorized to provide patient care services only so long as the assistant is functioning under the direction and supervision of a physician or group of physicians whose application for utilization has been approved by the medical licensing board. State medical licensing boards, in their review of applications for utilization of a physician assistant, should take special care to insure that the proposed physician assistant functions not be of a type which: (a) would unreasonably expand the professional scope of practice of the supervising physician, (b) cannot be performed safely and effectively by the physician assistant, or (c) would authorize the unlicensed practice of medicine.
3. The physician assistant should function under the direction of and supervision by a duly qualified licensed physician. The physician must always maintain the ultimate responsibility to assure that high quality care is provided to every patient. In discharging that responsibility, the physician should exercise that amount of control or supervision over a physician assistant which is appropriate for the maintenance of quality medical care and in accord with existing state law and the rules and regulations of the medical licensing authority. Such supervision in most settings includes the personal presence or participation of the physician. In certain instances, such as remote practice settings, where the physician assistant may function apart from the supervising physician, such remote function (if permitted by state law) should be approved by the state medical licensing board on an individual basis. Such approval should include requirements for regular reporting to the supervising physician, frequent site visits by that physician, and arrangements for immediate communication with the supervising physician for consultation at all times. The physician assistant may serve the patients of the supervising physician in all types of health care settings, including but not limited to: physician's office, ambulatory or outpatient facility, clinic, hospital, patient's home, long-term care facility or nursing home. The state medical licensing board should determine on an individual basis the number of physician assistants that a particular physician may supervise or a group of physicians may employ.
4. While it is preferable and desirable that the physician assistant be employed by a physician or group of physicians so as to ensure appropriate physician supervision in the interests of the

patient, where a physician assistant is employed by a hospital, the physician assistant must provide patient care services in accordance with the rules and procedures established by the organized medical staff for utilization of physician-employed physician assistants functioning in that institution, and under the direction and supervision of a designated physician who has been approved by the state medical licensing board to supervise that physician assistant in accordance with a specific utilization plan and who shall be directly responsible as the attending physician for the patient care services delegated to his physician assistant.
5. The AMA opposes legislation or proposed regulations authorizing physician assistants to make independent medical judgments as to the drug of choice for an individual patient.
6.In view of an announced interest by HHS in considering national legislation which would override state regulatory systems for health manpower, the AMA recommends that present Association policy supporting state prerogatives in this area be strongly reaffirmed.
7.Our AMA opposes legislation or regulation that allows physician assistant independent practice.
Citation: BOT/CME/CMS Joint Rep., I-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmation A-99; Reaffirmed: CME Rep. 2, A-09; Reaffirmed: BOT Rep. 9, I-11; Appended: Res. 230, I-17

Medical Specialty Board Certification Standards H-275.926
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.
Citation: Res. 318, A-07; Reaffirmation A-11; Modified: CME Rep. 2, I-15

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

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

For 2016-17 and 2017-18, schools were also asked where in the curriculum the specific topics were 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

The accreditation standards of the Commission on Accreditation of Osteopathic Colleges (COCA) do not explicitly state a requirement for curriculum related to medical economics or health care financing.[10]

The Accreditation Council for Graduate Medical Education common program requirements IV.B.1.f).(1).(f) and (g) require residents to demonstrate competence in "incorporating considerations of value, cost awareness, delivery and payment…" and "understanding health care finances and its impact on individual patients' health decisions." [11] A limited review of specialty-specific milestones, the mechanism by which residents are assessed for achievement of competency, revealed that family medicine, internal medicine, emergency medicine, and diagnostic radiology have milestones that assess residents' competency in delivering cost-conscious care, cost-effective care, or consideration of health care costs.[12]

CURRENT INITIATIVES

Despite the UME and GME requirements noted above, there has been a growing realization of the need for additional training in health systems, including health care financing and medical economics during UME. To address this concern, the concept of health systems science (HSS) has recently taken hold as a "third pillar" of medical education[13] (basic science and clinical science being the traditional two pillars). In recognition of the need to change the medical education system to train physicians in HSS, the AMA funded the Accelerating Change in Medical Education initiative, with the goal of enhancing medical school curricula to better train future physicians in the competencies needed to provide high quality care in health systems. HSS curriculum, which includes medical economics content, is a focus of the initiative. A tangible outcome from the consortium was the publication of the first HSS textbook.[14] The initial 11-school consortium has grown to 37 schools. The AMA also supports a learning module, "Health Care Delivery Systems - AMA Health Systems Science Learning Series," through the AMA Ed Hub.[15] In addition, through its GME Competency Education Program (GCEP), the AMA offers a series of online educational modules designed to complement teachings in residency and fellowship programs, with a library of 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

INTRODUCTION

Resolution 305-A-18, introduced by the American Medical Association Medical Student Section (AMA-MSS), asked that our AMA:

> Amend Policy H-275.978, "Medical Licensure," by addition to read as follows
>
> The AMA… (23) urges the state medical and osteopathic licensing boards which maintain a time limit on complete licensing examination sequences to adopt a time limit of no less than 10 years for completion of a licensing examination sequence for either USMLE or COMLEX.

Testimony before Reference Committee C at the 2018 Annual Meeting was in favor of referring this complex item for further study. Some states have no time limit for completion of the licensing examination sequence; some set a time limit of seven years; and some cap eligibility at 10 years (to accommodate the longer timeline for dual-degree individuals, e.g., those seeking to hold MD and PhD credentials). Testimony was heard concerning the perception that physicians who have academic troubles will take longer to complete the sequence, such that the time limit becomes a mechanism through which to ensure patient safety by eliminating these individuals from the practice of medicine. This belief, however, does not take into account the legitimate health or personal issues that may affect a given physician's ability to complete all exams within a prescribed timeframe, or the challenges faced by those pursuing dual degrees. Testimony in favor of a time limit was that this would ensure that examinees are being assessed based on their current medical knowledge. Accordingly, the AMA House of Delegates referred this item, to ensure a comprehensive, holistic review and study of all the relevant factors and consideration of potential unintended consequences, with the involvement of all relevant stakeholders, such as the Federation of State Medical Boards (FSMB) and the 70 state medical and osteopathic regulatory boards it represents.

BACKGROUND

State medical boards are entrusted to protect the public from unprofessional, unlawful or incompetent physician behavior. To ensure that physicians practicing in a state or jurisdiction are minimally competent to provide patient care, physicians under the board's purview are required to complete either the United States Medical Licensing Examination (USMLE), for allopathic medical school graduates, or the Comprehensive Osteopathic Medical Licensing Examination (COMLEX-USA), if a graduate of an osteopathic medical college. Passage of the USMLE or the COMLEX-USA is necessary to be eligible for a full and unrestricted license to practice medicine. Both the USMLE and COMLEX-USA are composed of a series of exams. Most students studying medicine

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

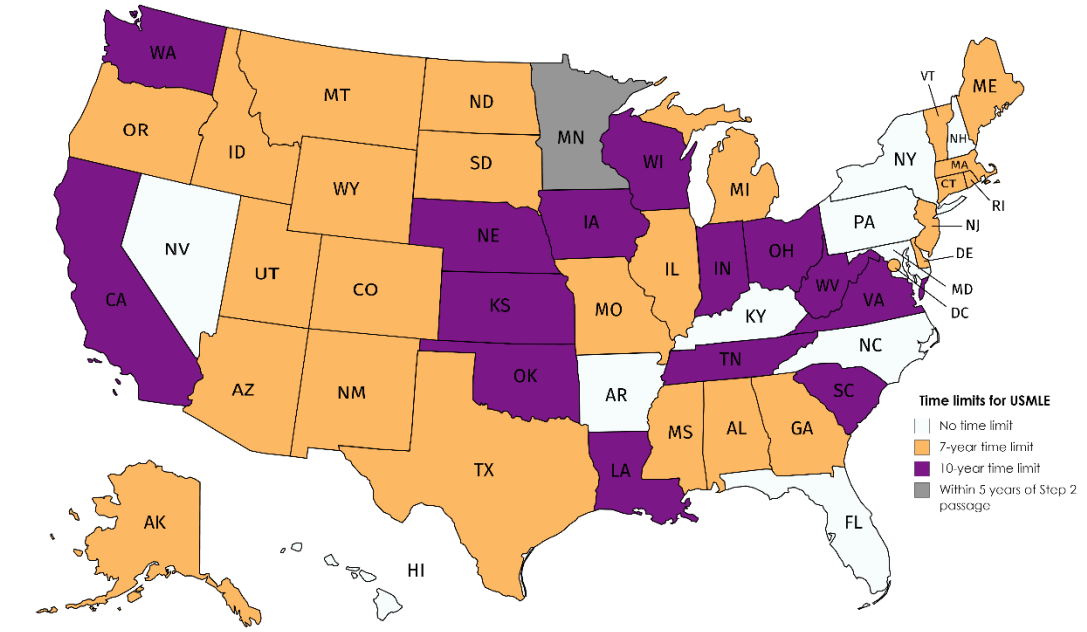
	No limit	7 years	8 years	9 years	10 years	12 years
USMLE	10	28			13	
COMLEX-USA	22	14			8	
MD/DO-PhD/dual degree	4		1	1	14	1

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.

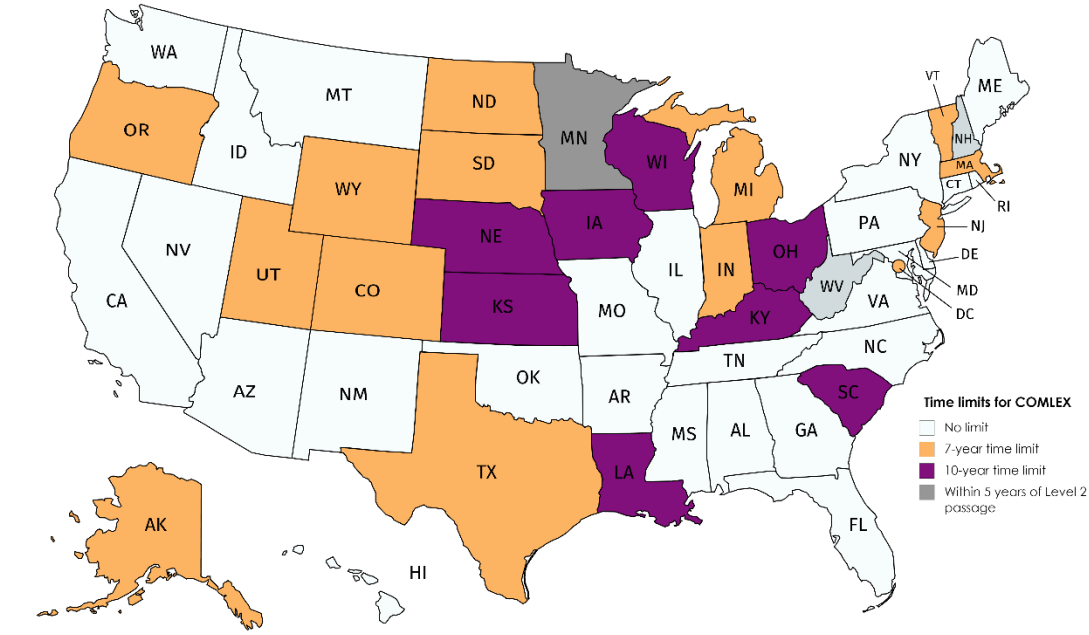
Table 2.
USMLE or COMLEX-USA completion and dual-degree time limits of U.S. medical boards that do not waive time limits

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).

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.

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

Whereas, Students in two-interval, or pass/fail, grading systems have better mental well-being compared to students in multi-tiered grading systems, including experiencing less emotional exhaustion, fewer feelings of depersonalization, less consideration for dropping out of school, decreased perceived stress, and greater satisfaction with their medical education and personal lives[1,2,3,4]; and

Whereas, Students in a pass/fail grading system experienced increased group cohesion, collaboration, and cooperation compared to students in a multi-tiered grading system[4,5]; and

Whereas, Students in a pass/fail grading system had more time to devote to extracurricular activities, student organizations, and volunteer/service activities compared to students in a multi-tiered grading system[6]; and

Whereas, Multiple medical schools that changed to a pass/fail grading system did not have a statistical difference in United States Medical Licensing Examination (USMLE) Step 1 scores and USMLE Step 2 scores[3,4,6,7,8]; and

Whereas, Even though there is no study on osteopathic schools with two-interval grading systems and Comprehensive Osteopathic Medical Licensing Examination of the United States (COMLEX-USA) Level 1 Scores, the previous literature suggests that COMLEX-USA Level 1 scores will not be affected, since the correlation between COMLEX-USA Level 1 and USMLE Step 1 scores is statistically significant[9]; and

Whereas, Non-clinical, or preclinical, grades were ranked 12th out of 14 academic criteria when selecting for residency according to the 2006 National Program Director Survey, and as of 2016, residency program directors are no longer surveyed to rank the importance of preclinical grades[10]; and

Whereas, There is a growing trend for allopathic and osteopathic medical schools to adopt a pass/fail grading system for preclinical courses, from 87 to 108 allopathic schools from 2013 to 2017, and 21 to 27 osteopathic schools from 2012 to 2016[11,12,13]; and

Whereas, U.S. medical students want a pass/fail grading system; in 2011, pass/fail was the most requested form of preclinical grading, as exhibited by the responses of 52 medical schools to the American Association of Medical Colleges (AAMC) Organization of Student 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

Whereas, Approximately 8 million adults in the United States identify as lesbian, gay, or bisexual, and 700,000 U.S. adults identify as transgender[1]; and

Whereas, Individuals with disorders/differences of sex development (DSD) have "congenital conditions in which development of chromosomal, gonadal, or anatomic sex is atypical," as defined by the 2006 Consensus Statement[2]; and

Whereas, Individuals with DSD comprise approximately 1% of the population and are at increased risk of cancer, infertility, psychosocial distress, and other issues[2]; and

Whereas, Research has shown significant disparities between sexual and gender minorities and the general public, with poorer health outcomes in areas including: 1) modifiable risk factors for cardiovascular disease such as mental distress, obesity, hypertension, and average blood glucose levels[3]; 2) risk of mortality from breast cancer[4]; 3) substance use disorders, including use of tobacco and electronic nicotine vapor devices[5]; 4) sexually transmitted infections such as human immunodeficiency virus and syphilis[6]; and 5) mental health disorders, including suicidal behavior[7]; and

Whereas, The Association of American Medical Colleges recommends comprehensive coverage of the specific health care needs of lesbian, gay, bisexual, transgender, and queer (LGBTQ) patients in medical school curricula[8] but these recommendations are not reflected in Liaison Committee for Medical Education (LCME) or American Osteopathic Association (AOA) accreditation requirements for medical schools, nor are they reflected in the Accreditation Council for Graduate Medical Education (ACGME) accreditation requirements for medical residency programs; and

Whereas, A survey of American and Canadian medical school deans found that medical schools allocate five hours of instruction to LGBTQ health care on average[9]; and

Whereas, Most medical students rate their LGBTQ curriculum as "fair" or worse but feel more prepared and comfortable caring for LGBTQ patients after additional LGBTQ-focused medical education[10]; and

Whereas, LGBTQ medical education has been demonstrated to improve knowledge, behavior, and beliefs regarding this patient population among medical students[11-13]; and

Whereas, Pursuant to existing AMA policy H-160.991, our AMA believes in educating 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

Whereas, By June 30, 2020, all U.S. osteopathic and allopathic residencies will be accredited under a single graduate medical education (GME) system that is managed under a single National Resident Matching Program (NRMP)[1]; and

Whereas, The Accreditation Council for Graduate Medical Education (ACGME) states that the benefits of the single GME accreditation system include offering all U.S. medical graduates a uniform education pathway, increasing collaboration among the medical education community, providing consistency across all residency and fellowship programs, reducing costs and increasing opportunities for osteopathic graduate medical education[1]; and

Whereas, Undergraduate medical education will continue to be accredited by the two separate accreditation bodies of the Liaison Committee of Medical Education (LCME) for allopathic schools and the Commission on Osteopathic College Accreditation (COCA) for osteopathic schools[2,3]; and

Whereas, The Executive Summary of the Agreement among ACGME, American Osteopathic Association (AOA), and American Association of Colleges of Osteopathic Medicine (AACOM) specifically outlines that graduates of osteopathic medical schools will be eligible for all ACGME-accredited programs[4]; and

Whereas, Both osteopathic and allopathic physicians practice medicine across all specialties, in all 50 US states and are licensed under the same state licensing boards, as well as have completed similar undergraduate paths, medical school, clinical rotations and a residency program[5]; and

Whereas, Elective visiting clinical rotations -- also known as ‘Sub-Internships’ or ‘Away Rotations’ -- are beneficial to fourth year medical students by providing additional clinical experiences in varying specialties, often at their residencies of interest, promoting networking opportunities, and allowing students to obtain letters of recommendations to submit with their residency program application[6]; and

Whereas, The majority of U.S. medical schools offering visiting medical student clinical rotations participate in the Visiting Student Application Services program (VSAS), serviced by the Association of American Medical Colleges (AAMC), which enables students to browse and apply to electives offered by host institutions[7]; and

Whereas, The AAMC strives “to assure that all medical students possess equal freedom and opportunity to pursue the career directions of their choice”[8]; and

Whereas, Despite AMA policy Equal Fees for Osteopathic and Allopathic Medical Students H-295.876 that states: "Our AMA, in collaboration with the American Osteopathic Association, discourages discrimination against medical students by institutions and programs based on osteopathic or allopathic training. 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," other programs participating in VSAS have differing rotation fees between allopathic and osteopathic medical students[13, 25, 29]; and

Whereas, Despite having such policy in place, osteopathic medical students continue to face financial barriers in applying for away rotations[25,29] and

Whereas, An osteopathic student upon finding such language while searching for potential rotation sites, would likely be deterred from pursuing the away rotation and thus would not possess equal freedom of opportunity to pursue their desired career direction; and

Whereas, In our primary research, including contacting aforementioned programs, we were not able to determine a cause for the discrepancies between accepting osteopathic students for away rotations at specific programs; therefore be it

RESOLVED, That our American Medical Association work with relevant stakeholders to explore reasons behind application barriers that result in discrimination against osteopathic medical students when applying to elective visiting clinical rotations, and generate a report with the 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

Whereas, A record number of physicians applied for residency programs through the National Residency Matching Program (NRMP) in 2019. The total was 44,603 with ultimately 2,718 withdrawing and 3,509 not fully completing the application process. Of the remainder who completed the Match program, only 79.6% of 38,376 matched, with 7,826 unmatched; and

Whereas, Applicants who do not match quickly the first time go through a secondary match called the SOAP (Supplemental Offer and Acceptance Program); and

Whereas, A growing discrepancy exists between the number of medical school graduates and available residency slots, causing the number of applicants who do not match each year to grow at a time when there is also a growing shortage of physicians, with a large number over age 60 who will be retiring within 10 years; and

Whereas, Medical school graduates typically incur a significant burden of academic loans through their years of education that is worsened by the fees charged to go through The Match process. (Costs ranging from $85 up to thousands of dollars.) The residency programs also pay the NRMP for their services, which range from $370 up to many thousands of dollars. Income generated by the match has become quite lucrative as the number of applicants grows from year to year. The Board of the NRMP has an obligation to be good stewards of these funds and to ensure that are spent wisely and frugally; and

Whereas, The SOAP gives applicants who fail to match in the first round an opportunity to find a position in a second-round matching process. This year, the SOAP website crashed on the first day it came online, preventing participants from entering their program of choice and the programs from seeing the list of those interested in positions. While the board extended the SOAP one additional day, this system failure undoubtedly affected the outcome of the secondary match for some individuals in both negative and positive ways. In other words, changing the procedure and process produced a different outcome than if the SOAP system had not failed; and

Whereas, Failure to match initially is an extremely stressful and difficult time, as applicants try to learn about residencies that have remaining slots. Applicants who do not match must scramble to sort out what they will do during the next year, when they typically apply again after discerning what contributed to their failure to match; and

Whereas, Failure to match for one year is serious, but the bigger tragedy is to have expended resources to become a physician and yet never match. This is also a waste of taxpayer dollars, since these individuals can never independently practice as physicians, and yet the state and 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

Whereas, Studies have identified barriers related to physicians not employed by the Veterans Administration (VA) and their ability to care for veterans as patients in addressing veterans' status and addressing the military associated needs of this population[1,2]; and

Whereas, Training of VA physicians require completion of educational modules for addressing specific veteran needs[3-6]; and

Whereas, Recognition and treatment of these needs can be taught through the Talent Management System 2.0 modules such as Veterans Health Administration Mandatory Training for Trainees, Military Sexual Trauma, Traumatic Brain Injury, and Suicide Awareness Voices of Education (SAVE)-Suicide[3-6]; and

Whereas, The availability of similar training resources could help physicians not employed by the VA provide better care for veterans; therefore be it

RESOLVED, That our American Medical Association amend AMA Policy H-510.986, "Ensuring Access to Care for our Veterans," by addition to read as follows:

Ensuring Access to <u>Safe and Quality</u> 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. <u>Our AMA supports access to similar clinical educational resources for all health care professionals involved in the care of veterans as those provided by the U.S. Department of Veterans Affairs to their employees with the goal of providing better care for all veterans.</u>
<u>6.</u> 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. (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

Whereas, The cost of medical education and testing is rising, with no relief in sight for medical students; and

Whereas, The cost of USMLE Step 2 CS Exam will be $1,300 in 2020 and most medical students will have to travel and stay near one of the five national testing centers; and

Whereas, The USMLE Step 2 CS Exam costs approximately $27.5 million annually and nationally to medical students, not including travel expenses; and

Whereas, It should be noted that there is no good correlation between Board certification and physician competency; and

Whereas, There are no data to support a link between the USMLE Step 2 CS Exam and improved patient outcomes, and 95% of U.S. medical students pass on their first attempt; therefore be it

RESOLVED, That our American Medical Association work with the Federation of State Medical Boards/United States Medical Licensing Examination (USMLE) to reduce the cost of the USMLE Step 2 CS exam and allow medical students to take this exam locally to defray 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

Whereas, Burnout is a crisis affecting the physician community in the United States. Burnout is reported to have a deleterious influence on more than half of the practicing physicians[1-7], up to 70% of medical students[8,9] and up to 75% of the physicians in training[5,10-15]; and

Whereas, The causes of burnout are multifactorial, but severity of burnout has been reported to increase with increase in financial debt[6,14,16-18]. Financial pressures had been found to increase resident burnout and negatively impact professionalism[19]. The residents with higher debt were found to have lower Quality of Life (QOL), lower satisfaction with work-life balance, higher emotional exhaustion and depersonalization[16]; and

Whereas, Medical students have high amounts of debt[14,20-24] contributed by a rapid increase both undergraduate[25] and medical education expenses[23,26]. African American medical students are reported to have more debt compared to others.[27] The high amount of student loan debt has a big impact on medical student's decision to choose a higher paying specialty[28-32]. This results in decreased interest in primary care specialties as the pay is low resulting in shortage of primary care providers[28-30,32]. There has been many proposals and initiatives to improve the crisis of medical school debt, but are not implemented widely[23,33]; and

Whereas, Debt grows significantly during the residency and fellowship period, up to 20 - 50% by the end of the training[14]. Once the residents graduate, the physicians will have to pay off the student loans which will take up 9-12% of their post-tax income[23], which will add a significant amount of financial stress on an early career physician; and

Whereas, Physicians are found to have poor financial literacy[14,34-40]. From a survey of orthopedic residents, it was reported that only 4% of the residents had a formal financial education, but 85% are interested in learning[41]; and

Whereas, There have been few attempts to improve the financial literacy by implementing a curriculum in personal finance during medical school and residency, but these opportunities are not widely available[14,34,36,41-48]; therefore be it

RESOLVED, That our American Medical Association work with relevant stakeholders to study the development of a curriculum during medical school and residency/fellowship training to 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

Whereas, There continues to be a steady influx of immigrants from strife-torn regions of the world; and

Whereas, Some of these immigrants are highly trained physicians fleeing their country because of political or religious persecution; and

Whereas, In order to be able to practice in the United States these physicians often have to repeat complete cycles of training including medical school, residency, and subspecialty training; and

Whereas, There is projected to be a shortage of physicians[1] given the aging of the present physician and general civilian populations; and

Whereas, The immigrant physician may have beneficial skills such as language proficiency; and

Whereas, It is possible to retrain immigrant physicians in 18–24 months to be able to practice medicine in their host country after they have demonstrated proficiency in language, medicine, and the culture of the host country as demonstrated by a program of the National Health Service of Scotland[2] profiled in a recent BBC America program; and

Whereas, Immigrant physicians in Scotland who have been retrained on an accelerated path and who have demonstrated proficiency in language, medicine, and Scottish culture are obligated by the NHS of Scotland to practice in the NHS in specific areas of need.[3] and

Whereas, Minnesota's International Medical Graduate Assistance Program was established in 2015 and is the first program of its kind in the United States and may serve as a model for other states; and

Whereas, The Minnesota program was created by state statute and the program has achieved considerable successes, including: developing a roster of IMG physicians in the state, forming grant agreements with nonprofits to provide career support to IMGs, working with residency directors to carve out pathways for IMGs to demonstrate the clinical expertise required to enter 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

changes that would be needed to facilitate full IMG integration into the Minnesota physician workforce[5]; therefore be it

RESOLVED, That our American Medical Association study and make recommendations for the best means for evaluating, credentialing and expediting entry of competently trained international medical graduate (IMG) physicians of all specialties into medical practice in the USA. (Directive to Take Action)

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

Received: 10/02/19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 309
(I-19)

Introduced by: Georgia

Subject: Follow-up on Abnormal Medical Test Findings

Referred to: Reference Committee C

Whereas, Failure to review radiology reports[1] or to appropriately communicate or follow up on abnormal radiologic findings is a common occurrence;[2,3,4,5] and

Whereas, This can lead to delays in diagnosis, malpractice lawsuits[6] and negative outcomes; and

Whereas, QI initiatives have been shown to improve the likelihood of appropriate follow up of abnormal radiologic findings;[7,8] therefore be it

RESOLVED, That our American Medical Association advocate for the adoption of evidence-based guidelines on the process for communication and follow-up of abnormal medical test findings to promote better patient outcomes (Directive to Take Action); and be it further

RESOLVED, That our AMA work with appropriate state and specialty medical societies to enhance opportunities for continuing education regarding professional guidelines and other clinical resources to enhance the process for communication and follow-up of abnormal medical test findings to promote better patient outcomes. (Directive to Take Action)

Fiscal Note: Not yet determined

Received: 10/24/19

[1] https://doi.org/10.1016/j.jacr.2018.08.022
[2] https://www.ajronline.org/doi/full/10.2214/AJR.18.20586
[3] https://www.ajronline.org/doi/full/10.2214/AJR.18.20083
[4] AJR Am J Roentgenol. 2019 Mar;212(3):589-595. doi: 10.2214/AJR.18.20083. Epub 2019 Jan 8.
[5] https://www.jacr.org/article/S1546-1440(14)00591-2/abstract
[6] https://www.degruyter.com/view/j/dx.2014.1.issue-4/dx-2014-0034/dx-2014-0034.xml?intcmp=trendmd
[7] https://www.ajronline.org/doi/10.2214/AJR.17.18332
[8] https://link.springer.com/article/10.1007/s10278-017-9989-y

REPORT OF THE BOARD OF TRUSTEES

B of T Report 6-I-19

Subject:	Physician Health Policy Opportunity (Resolution 604-I-18) Request to AMA for Training in Health Policy and Health Law (Resolution 612-A-19)
Presented by:	Jesse M. Ehrenfeld, MD, MPH, Chair
Referred to:	Reference Committee F Ann R. Stroink, MD, Chair

At the 2018 Interim Meeting, the American Medical Association (AMA) House of Delegates (HOD) considered Resolution 604-I-18, "Physician Health Policy Opportunity," introduced by Washington State, which included the following three resolves:

> That our AMA, working with the state and specialty societies, make it a priority to give physicians the opportunity to serve in federal and state health care agency positions by providing the training and transitional opportunities to move from clinical practice to health policy; and
>
> That our AMA study and report back to the House of Delegates at the 2019 Interim Meeting with findings and recommendations for action on how best to increase opportunities to train physicians in transitioning from clinical practice to health policy; and
>
> That our AMA explore the creation of an AMA health policy fellowship, or work with the Robert Wood Johnson Foundation to ensure that there are designated physician fellowship positions with their Health Policy Fellowship program to train physicians in transitioning from clinical practice to health policy.

The reference committee heard conflicting testimony on Resolution 604 and recommended its referral. Testimony agreed that it is critical to have physicians with clinical experience serve in government regulatory agencies to help shape health policy, and favored the AMA studying how best to increase opportunities to train physicians in transitioning from clinical practice to health policy. Testimony recommended broadening partnerships beyond the Robert Wood Johnson Foundation (RWJF), and also noted that developing a health policy fellowship program can be an intricate process, that should be carefully evaluated.

At the 2019 Annual Meeting, the HOD considered a second resolution on a similar topic, Resolution 612-A-19, "Request to AMA for Training in Health Policy and Health Law," introduced by New Mexico, which asked that the AMA "offer its members training in health policy and health law, and develop a fellowship in health policy and health law." Testimony on Resolution 612 was also mixed and the reference committee recommended its referral. Those testifying supported the AMA sharing resources and opportunities to serve its members but were uncertain whether the AMA should implement its own fellowship program.

This report responds to both referred resolutions. It reviews the currently available health policy fellowship programs for physicians and recommends that, in lieu of Resolutions 604-I-18 and

612-A-19, the AMA: significantly increase its collaborative efforts with the National Academy of Medicine (NAM) to make physicians aware of existing health policy fellowship opportunities and help them to apply for and participate in them; engage with alumni of the existing programs and provide opportunities for them to share their health policy fellowship experiences with medical students, residents, fellows, and practicing physicians; and disseminate information to medical students and physicians about opportunities to join the Commissioned Corps of the U.S. Public Health Service.

EXISTING HEALTH POLICY OPPORTUNITIES FOR PHYSICIANS

The RWJF Health Policy Fellows program is funded by the RWJF but is administered by NAM. Initiated in 1973, the RWJF program is for mid-career health professionals, behavioral and social scientists, and others with an interest in health and health care. Fellows reside for 12 months in Washington, DC, beginning in September of each year. The AMA is one of the organizations that meets with the RWJF fellows during a 3.5-month orientation period at the beginning of their year during which they meet with national health policy leaders, think tanks, executive branch officials, and members of Congress and their staffs. Afterward, the fellows are placed in full-time positions with members of Congress, a congressional committee, or the executive branch. Under the supervision of the office in which they are placed, fellows:

- Help develop legislative or regulatory proposals;
- Organize hearings, briefings, and stakeholder meetings;
- Meet with constituents; and
- Brief legislators or administration officials on various health issues.

RWJF Fellows receive a stipend of $104,000 for the year of their Washington residency. Fellows who are affiliated with a sponsoring institution may have their stipends supplemented by the sponsoring institution.

Testimony on Resolution 604 indicated concern that the number of slots for physicians in the RWJF program has been declining, but NAM data show otherwise. Physicians have always been an important part of this fellowship, and 58 percent of the nearly 300 program alumni are physicians. It is true that the percentage of physician *applicants* for the fellowship has been declining, but nonetheless 50 percent of the 2019-20 fellows will be physicians. Physicians who apply for the RWJF program fare extremely well in the selection process, so if more physicians apply, more are likely to be selected.

At the same time, there are some barriers to greater physician participation. It is very difficult for practicing physicians to participate in a year-long, full-time, residence program in Washington, DC. Academic medical centers have become less willing over time to let their medical staff members leave for a year, and many physicians face pressure to continue providing billable services. The $104,000 stipend represents a payment reduction for most practicing physicians, as does the transition to a policy role if they continue in health policy after their fellowship has ended.

In addition to the RWJF program, NAM administers seven endowed fellowships for professionals who are early in their careers, of which five are only for physicians:

- Norman F. Gant/American Board of Obstetrics and Gynecology Fellowship;
- James C. Puffer, MD/American Board of Family Medicine Fellowship;
- Gilbert S. Omenn Fellowship (combining biomedical science and population health);
- American Board of Emergency Medicine Fellowship;

- Greenwall Fellowship in Bioethics;
- NAM Fellowship in Pharmacy; and
- NAM Fellowship in Osteopathic Medicine.

Also, NAM's Emerging Leaders in Health and Medicine (ELHM) Scholars program annually selects up to 10 early- and mid-career professionals with demonstrated leadership and professional achievement in biomedical science, population health, health care and related fields for three-year terms as ELHM scholars. Unlike the full-time residency required in the RWJF program, the ELHM scholars continue to work at their primary institution while also participating in this NAM program. Participants provide input and feedback to help shape NAM's priorities and advance its work in science, medicine, policy, and health equity. Five of the 10 current ELHM scholars are physicians.

Another pathway that many physicians take to become involved in public service careers in the executive branch is joining the Commissioned Corps of the U.S. Public Health Service. Physicians serving as Commissioned Corps officers may be found throughout the federal government, including the Food and Drug Administration, Centers for Disease Control and Prevention, Centers for Medicare & Medicaid Services, National Institutes of Health, and the other agencies within the U.S. Department of Health and Human Services, as well as the U.S. Department of Homeland Security, Federal Bureau of Prisons, and the U.S. Department of Defense. The women and men of the Commissioned Corps fill essential public health, clinical, and leadership roles throughout the nation's federal departments and agencies, particularly those supporting care to underserved and vulnerable populations. The U.S. Surgeon General oversees the Commissioned Corps.

For medical students, according to the Association of American Medical Colleges, more than 80 medical schools provide opportunities to pursue a master's degree in public health. Some physicians also obtain their MPH degree separately from their MD degree, either before or after medical school. Adding an MPH degree can be an effective means for physicians to pursue health policy careers. Some medical schools with health policy departments or schools of public health also welcome participation by practicing physicians in their educational programs and activities. Also, the AMA Government Relations Advocacy Fellow (GRAF) program provides medical students with the opportunity to be a full-time member of the AMA federal advocacy team for one year. A key goal of this program is to educate medical student, resident and young physician AMA members about health policy and encourage activism and leadership in local communities. To date, 15 students have participated in the GRAF program.

HEALTH LAW OPPORTUNITIES FOR PHYSICIANS

In addition to training and experience in health policy, Resolution 612-A-19 also called for the AMA to offer members training and develop a fellowship in health law. It would probably be considerably more difficult for a mid-career practicing physician to transition to health law than health policy, as the practice of health law would likely require the individual to obtain a law degree. There are many physicians who pursue dual degree programs, and several universities offer joint MD/JD degree programs, including the University of Pennsylvania, Duke University, University of Miami, Boston University, Stanford University, and University of Virginia. Graduates of joint MD/JD programs may often be found in leadership positions in federal government regulatory agencies where they can use their expertise in both law and medicine.

Unlike medicine's specialty board certification process, the legal profession is dominated by state boards and does not offer legal specialty board certification in health law or similar topics. There are interest groups for professionals who focus in this area, such as the American Health Lawyers

Association. There do not appear to be fellowship opportunities that would allow physicians to transition to health law without obtaining a law degree.

AMA POLICY

AMA policy supports educating medical students, residents, and fellows in health policy. Policy H-310.911, "ACGME Allotted Time off for Health Care Advocacy and Health Policy Activities," encourages the Accreditation Council for Graduate Medical Education and other regulatory bodies to adopt policy that resident and fellow physicians be allotted additional time, beyond scheduled vacation, for scholarship and activities of organized medicine, including but not limited to health care advocacy and health policy. Policy H-295.953, "Medical Student, Resident and Fellow Legislative Awareness," advocates that elective political science classes be offered in the medical school curriculum, establishes health policy and advocacy rotations in Washington, DC for medical students and residents, and states that the AMA will support and encourage institutional, state, and specialty organizations to offer health policy and advocacy opportunities for medical students, residents, and fellows. Policy H-440.969, "Meeting Public Health Care Needs Through Health Professions Education," also states that courses in health policy are appropriate for health professions education. Current AMA policies focus on training medical students, residents and fellows in health policy, but the AMA does not currently have policy on mid-career physicians transitioning to health policy careers.

RECOMMENDATIONS

Based upon its review of existing opportunities for practicing physicians to pursue training and careers in health policy, the Board of Trustees does not believe it is necessary or desirable for the AMA to offer its own training and transitional opportunities for physicians to move from clinical practice to health policy. There are multiple avenues already available for physicians who wish to pursue careers in health policy, whether they choose to begin down this path during medical school, residency, or after some years in clinical practice. The Board does agree that the AMA should take a more active role in informing physicians of these opportunities; however, and in helping them to make these career choices. The Board of Trustees recommends that the following recommendations be adopted in lieu of Resolutions 604-I-18 and 612-A-19 and the remainder of the report be filed.

1. That our American Medical Association encourage and support efforts to educate interested medical students, residents, fellows, and practicing physicians about health policy and assist them in starting or transitioning to careers that involve health policy. (New HOD Policy)

2. That our AMA significantly increase its collaborative efforts with the National Academy of Medicine (NAM) to make physicians aware of existing health policy fellowship opportunities and help them to apply for and participate in them. (Directive to Take Action)

3. That our AMA engage with alumni of health policy fellowship programs and joint degree programs and provide opportunities for them to share their health policy experiences with medical students, residents, fellows, and practicing physicians. (Directive to Take Action)

4. That our AMA include health policy content in its educational resources for members. (Directive to Take Action)

5. That our AMA work with the Office of the U.S. Surgeon General to disseminate information to medical students, residents, fellows, and practicing physicians about opportunities to join the Commissioned Corps of the U.S. Public Health Service. (Directive to Take Action)

Fiscal Note: Less than $5000

REPORT OF THE COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT

CLRPD Report 1-I-19

Subject: Academic Physicians Section Five-Year Review

Presented by: James Goodyear, MD, Chair

Referred to: Reference Committee F

AMA Bylaw 7.0.9 states, "A delineated section must reconfirm its qualifications for continued delineated section status and associated representation in the House of Delegates by demonstrating at least every 5 years that it continues to meet the criteria adopted by the House of Delegates." AMA Bylaw 6.6.1.5 states that one function of the Council on Long Range Planning and Development (CLRPD) is "to evaluate and make recommendations to the House of Delegates, through the Board of Trustees, with respect to the formation and/or change in status of any section. The Council will apply criteria adopted by the House of Delegates."

The Council analyzed information from a letter of application submitted in June 2018 from the Academic Physicians Section (APS) for renewal of delineated section status and representation in the AMA House of Delegates (HOD). The letter focuses on activities beginning in June 2014.

APPLICATION OF CRITERIA

Criterion 1: Issue of Concern - Focus will relate to concerns that are distinctive to the subset within the broader, general issues that face medicine. A demonstrated need exists to deal with these matters, as they are not currently being addressed through an existing AMA group.

The APS remains the only AMA constituent group focused specifically on the perspectives of academic physicians. The APS identified the following priority issues/concerns on which the Section has focused over the last five years:

1. Academic physician wellness/burnout
2. Graduate medical education funding and sustainability
3. Business of medicine
4. Health systems science and the work of the Accelerating Change in Medical Education (ACE) Consortium

The Section listed the following issues/concerns as current priority areas, and ones that the APS will continue to focus on in the coming years, in addition to those previously listed:

1. The transition from undergraduate medical education (UME) to graduate medical education (GME)
2. Recent guidance from the Centers for Medicare & Medicaid Services (CMS) on medical student documentation
3. The Match
4. Graduate medical education

The APS provided rationales for increased focus on these issues, and outlined strategies by which the Section has attempted, and will attempt, to address them. As the transition from UME to GME will be a key focus area for the ACE Consortium moving forward, the APS will assist by providing a forum/venue for discussion of this topic and sharing of best practices among all medical schools and teaching hospitals. During the I-17 meeting, the APS held a session on the challenges and ways to improve the residency selection process. At the A-18 meeting, the APS hosted a learning and discussion session on the Accreditation Council on Graduate Medical Education's (ACGME) work to improve GME, and the APS Chair hosted a session, "Implementing the new CMS guidance on medical student evaluation and management (E/M) documentation at your institution." Future APS efforts will include educational sessions, presentations, webinars, forums for discussion and sharing of best practices, and collaboration with other AMA units to develop messaging for physician leaders in academic medical centers.

CLRPD Assessment: The APS is focused on issues that are significant and not currently being addressed through another existing AMA group. The APS is the only section that represents the perspectives of academic physicians.

Criterion 2: Consistency - Objectives and activities of the group are consistent with those of the AMA. Activities make good use of available resources and are not duplicative.

The APS works to increase awareness of the AMA's strategic focus areas, and the priority areas identified by the Section align closely with the AMA strategic direction. APS efforts have included webinars held in collaboration with the ACE Consortium, and a three-part series of educational sessions held at the 2016 Annual Meeting on physician wellness and resiliency throughout the medical education and practice continuum.

Additionally, the APS often collaborates with the AMA Council on Medical Education (CME). The APS Liaison to the CME is a key position for ensuring interchange of news/updates and collaborative work. APS meetings that occur during annual meetings of the HOD are timed to ensure no conflicts with the CME stakeholders forum. At interim meetings, the Section adjourns in sufficient time so that attendees can participate as judges in the AMA Research Symposium.

APS members have also worked to increase AMA membership through outreach to colleagues and promotion of AMA products/services of interest, such as the Academic Leadership Program, GME Competency Education Program, and FREIDA Online.

CLRPD Assessment: The APS has selected areas of focus that align closely with the AMA's strategic direction, particularly Accelerating Change in Medical Education. Additionally, the Section has worked to increase awareness of the strategic focus areas and other AMA efforts/products, and sought opportunities for collaboration on cross-cutting medical education issues and programs with other groups within the AMA.

Criterion 3: Appropriateness - The structure of the group will be consistent with its objectives and activities.

The Section on Medical Schools (SMS) was renamed the APS in June 2015 through action of the HOD. Through strategic planning reviews and nationwide surveys of academic physicians, the Section determined that the former name inhibited interest and involvement of academic physicians outside the leadership and administration of medical schools, including those serving as faculty at non-medical school affiliated medical centers and residency programs. Findings also indicated that the name implied an exclusive focus on undergraduate medical education, even though the SMS

welcomed academic physicians interested in graduate medical education and continuing medical education, as well as those who served in a clinical/research capacity with an academic medical center, community hospital, or other health care setting. Additionally, the focus on the physician's institution (i.e., medical school) rather than the physician's role (i.e., an academic physician) was seen as a barrier to expanded membership in the SMS.

Further, the HOD approved changes put forth by the Section to address membership challenges experienced by the Section and streamline the membership categories and processes of the former SMS to help increase membership and engagement. These new membership categories are now part of APS Bylaws, and are outlined later in this report.

The primary opportunities for APS members to participate in the Section occur during its biannual meetings, held in conjunction with the annual and interim meetings of the HOD. During this time, members may review medical education reports and resolutions, voice opinions, and vote on recommended APS action. Periodic emails to the APS Listserv provide news and updates on key APS and AMA activities, as well as inviting applications for leadership positions on national medical education organizations, and on the Section. Other opportunities for APS involvement include:

- Participating in the APS membership committee, formed in June 2016, with seven regionally based slots throughout the country
- Participating in the CLRPD's annual solicitation of stakeholder input on future health care trends
- Serving on committees to explore special interest topics on behalf of the Section
- Informing Section policies, products and services through participation in surveys and focus groups
- Participating in educational programming tailored to develop the knowledge, skills and attitudes that faculty physicians need to effectively prepare the next generation of physicians
- Networking and interacting with peers who have similar interests at other institutions
- Engaging with the ACE Consortium through participation in consortium-sponsored webinars and online discussions

CLRPD Assessment: The structure of the APS allows members to participate in the deliberations and pursue the objectives of the Section. The APS instituted an orientation and networking session to help new members gain an understanding of the Section's role within the AMA. The APS Listserv provides news and updates on key APS and AMA activities, and provides networking and leadership opportunities for Section members.

Criterion 4: Representation Threshold - Members of the formal group would be based on identifiable segments of the physician population and AMA membership. The formal group would be a clearly identifiable segment of AMA membership and the general physician population. A substantial number of members would be represented by this formal group. At minimum, this group would be able to represent 1,000 AMA members.

AMA member academic physicians can now seek membership in the APS through three routes:

1. Appointment by the dean of their allopathic or osteopathic medical school
2. Self-nomination as an academic physician for those with a current faculty appointment at a U.S. medical school

3. Self-nomination as a physician who does not hold a medical school faculty appointment but has an active role in student (undergraduate), resident/fellow (graduate), and/or continuing medical education, or serves in a clinical/research position with an academic medical center, community hospital, or other health care setting

Data provided by the APS show that the Section had 513 members at the time the letter of application was submitted, with the majority (157 of 176) of allopathic and osteopathic medical schools in the United States represented by at least one member.

Masterfile data provided by the Section shows the total physician population eligible for APS membership to be 20,786, and the total number of AMA members eligible for APS membership to be 2,561.

Type of Practice	**Present Employment**	**Major Professional Activity**	**Total**	**AMA members**
Medical Teaching	Any	Medical Teaching	12,408	1,368
Administration	Medical School	Administration	960	189
Direct Patient Care	Medical School	Office Based Practice	7,271	987
Non-Patient Care	Medical School	Other	147	17
			20,786	**2,561**

CLRPD Assessment: The APS has over 500 members, who represent the majority of medical schools in the country. It is comprised of members from an identifiable segment of AMA membership and the general physician population. The Section's potential membership within the AMA is over 2,500, greater than minimum threshold of 1,000 AMA members.

Criterion 5: Stability - The group has a demonstrated history of continuity. This segment can demonstrate an ongoing and viable group of physicians will be represented by this section and both the segment and the AMA will benefit from an increased voice within the policymaking body.

The APS (then the SMS) was established in 1976 to "allow more direct participation in the AMA by physician members who are active in medical school administration" (AMA Board of Trustees Report P C-76). The following table shows the attendance from the last five meetings of the APS; the average number of attendees (61 members) over the last five meetings represents over ten percent of APS membership.

Meeting	**Attendance**
June 2018	55
November 2017	34
June 2017	73
November 2016	66
June 2016	79

The APS noted that its Listserv is used to provide periodic updates to members on Section activities and news/updates, including pre-meeting invitations and post-meeting wrap-up documents, and invitations to apply for positions on national medical education organizations through the CME. This latter effort has led to greater awareness of and a significant increase in

applications to these positions. From 2016 through 1Q 2018, APS members submitted 44 of 79 applications for positions with nine external organizations.

The Section has submitted three resolutions over the last five years that have led to AMA policy. At the 2014 Annual Meeting of the HOD, the APS (then the SMS) submitted resolutions 311-A-14, "Impact of Competency-Based Medical Education Programs as Opposed to Time-Based Programs," and 312-A-14, "Assessing the Impact of Limited GME Residency Positions in the Match," which led to amendments to AMA Policies D-295.318, "Competency-Based Portfolio Assessment of Medical Students," and D-310.977, "National Resident Matching Program Reform." Resolution 312-A-14 and the resulting policy prompted the development of two reports from the CME, CME Report 3-A-16, "Addressing the Increasing Number of Unmatched Medical Students," and follow-up CME Report 5-A-17, "Options for Unmatched Medical Students." Additionally, the APS submitted Resolution 608-A-17, "Improving Medical Student, Resident/Fellow and Academic Physician Engagement in Organized Medicine," which led to the creation of AMA Policy G-615.103, "Improving Medical Student, Resident/Fellow and Academic Physician Engagement in Organized Medicine and Legislative Advocacy."

Further, the APS reviews, assesses and provides testimony on a wide variety of reports and resolutions related to academic medicine and medical education that are considered by the HOD during annual and interim meetings.

CLRPD Assessment: The APS has a history of more than 40 years at the AMA. In addition to the APS biannual meetings, the Section uses its Listserv to sustain member engagement in APS issues and activities. The Section has introduced or significantly contributed to resolutions and reports that resulted in new policies; therefore, the HOD has benefited from the distinct voice of the APS in its deliberations and policymaking processes.

Criterion 6: Accessibility - Provides opportunity for members of the constituency who are otherwise under-represented to introduce issues of concern and to be able to participate in the policymaking process within the AMA House of Delegates (HOD).

The APS is the only AMA component group that specifically represents the perspectives of academic physicians and works to ensure that the interests of academic physicians and medical school administrators are reflected in broader AMA policy.

At its meetings on the Fridays prior to the annual and interim meetings of the HOD, the APS Governing Council (GC) reviews all relevant business items and develops a consent calendar for consideration by the entire Section. These recommendations are shared with APS members the following morning during the APS business meeting, which provides sufficient time for review, deliberation, discussion and voting.

Through the work of the APS Liaison to the CME, as well as APS GC members appointed to serve as ex officio liaisons on various committees of the Council, the APS GC reviews and provides feedback on draft CME reports prior to HOD meetings to ensure a united front on contributions to AMA medical education policy.

Additionally, the Academic Medicine Caucus, developed by the APS Delegate in 2011, allows a larger group of current and potential APS members (i.e., those who attend the AMA HOD meeting on behalf of their state or specialty delegation and may be less likely to be involved in the activities of AMA sections) to review proposed AMA policy, including the positions of the APS on HOD business items.

CLRPD Assessment: The APS provides numerous ways for its constituents to speak on issues and business items relevant to the work of the Section, and allows more direct participation in the AMA by physician members who are active in medical school administration, and those who serve in a clinical/research position with an academic medical center, community hospital or other health care setting. The APS has introduced or significantly contributed to several resolutions/reports, which resulted in new AMA policies over the past five years. Additionally, the Academic Medicine Caucus, developed in 2011, allows a larger group of academic physicians to participate in the HOD policymaking process.

CONCLUSION

The CLRPD has determined that the APS meets all required criteria, and it is therefore appropriate to renew the delineated section status of the APS.

RECOMMENDATIONS

The Council on Long Range Planning and Development recommends that our American Medical Association renew delineated section status for the Academic Physicians Section through 2024 with the next review no later than the 2024 Interim Meeting. (Directive to Take Action)

Fiscal Note: Less than $500

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 801
(I-19)

Introduced by: Medical Student Section

Subject: Reimbursement for Post-Exposure Protocol for Needlestick Injuries

Referred to: Reference Committee J

Whereas, Needlestick injuries (NSI) occur in a clinical setting and introduce the risk of transmitting bloodborne pathogens such as Hepatitis B, Hepatitis C, and HIV[1]; and

Whereas, The Centers for Disease Control and Prevention (CDC) estimates that about 385,000 sharps-related injuries occur annually among health care workers with medical students also at risk of sustaining NSIs[2,3]; and

Whereas, Due to the risk of contracting aforementioned bloodborne pathogens, the protocol for NSIs is to receive the appropriate post-exposure prophylaxis (PEP) as a means of disease prevention with appropriate diagnostic follow up[2,3]; and

Whereas, According to recommendations from the International Antiviral Society, the protocol for PEP of HIV specifically for health care workers includes at least 4 weeks of three antiretroviral drug regimen with appropriate laboratory and clinical follow up[3]; and

Whereas, A systematic review that analyzed the costs associated with NSIs among healthcare workers found these costs to range from $650 to $750, while also noting extraneous factors, such as time lost at work, that led to variations in costs[4]; and

Whereas, The review also noted that frequent changes in the indicated antiretroviral therapy further leads to a greater variation and increase in costs, with an approximated median cost of $1,187[4]; and

Whereas, A cost analysis published by the Kaiser Family Foundation indicated that since 2014, the prices of branded common and specialty drugs have risen by 60% and 57%, respectively[5]; and

Whereas, In addition to presenting a significant financial implication, aforementioned processes related to PEP potentially create a severe emotional burden on those who sustain such an injury[1,2,4]; and

Whereas, Many NSIs often go unreported, with studies citing the fear of punishment, the financial costs, and the “time consuming process” as a major factor for not immediately reporting an injury[2,6-8]; and

Whereas, Health care workers that sustain NSI are required to undergo appropriate protocol for exposure, of which all related costs are financially covered under their employer’s workers’ compensation program[9]; and

Whereas, While these programs vary by state, medical students are often exempt from the mandatory coverage of workers' compensation that their institution offer to health care workers since they are not considered employees[10]; and

Whereas, As an exception to this, the state of Utah amended policy 53B-14-401 to include medical students within its definition of "interns" stating that interns can become recipients of medical benefits from workers' compensation in the event of occupational injuries and diseases[11]; and

Whereas, Although a majority of medical schools require medical students to have a form of health insurance prior to matriculation, the comprehensive costs associated with NSIs are not explicitly stated, and insurance providers inconsistently provide complete coverage of these costs[4]; and

Whereas, Existing AMA policy addresses the costs and debts associated with undergraduate medical education (H-305.925); therefore be it

RESOLVED, That our American Medical Association encourage medical schools to ensure medical students can be reimbursed for the costs associated with post-exposure protocol for blood or body substance exposure sustained during clinical rotations either by their insurance provider or the state's workers' compensation fund, where applicable (Directive to Take Action); and be it further

RESOLVED, That our AMA encourage state societies to work with their respective workers' compensation fund to include medical students as recipients of medical benefits in the event of blood or body substance exposure during clinical rotations. (Directive to Take Action)

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

Received: 08/28/19

References:

1. Cooke, C.E., Stephens, J.M. Clinical, economic, and humanistic burden of needlestick injuries in healthcare workers. *Medical Devices: Evidence and Research*. 2017; 10: 225-235.
2. National Institute for Occupational Safety and Health, Centers for Disease Control and Prevention. Stop Sticks Campaign.
3. Marrazzo, J.M., *et al*. HIV Prevention in Clinical Care Settings. *JAMA.* 2014; 312(4): 390-409.
4. Mannocci, A. *et al*. How Much do Needlestick Injuries Cost? A Systematic Review of the Economic Evaluations of Needlestick and Sharps Injuries Among Healthcare Personnel. *Infection Control and Hospital Epidemiology*. 2016 Jun.; 37(6): 635-646.
5. Kamal, R., *et al*. What are the recent and forecasted trends in prescription drug spending? *Kaiser Family Foundation*. 2019 Feb 20.
6. Choi, L.Y. *et al.* Sharps and Needlestick Injuries Among Medical Students, Surgical Residents, Faculty, and Operating Room Staff at a Single Academic Institution. *Journal of Surgical Education*. 2017 Jan.-Feb.; 74(1):131-6.
7. Lauer, A.C. *et al*. Needlestick and sharp injuries among medical undergraduate students. *American Journal of Infection Control.* 2014 Mar.; 42(3):235-9.
8. Hasak, J.M. *et al.* Prevalence of Needlestick Injuries, Attitude Changes, and Prevention Practices Over 12 Years in an Urban Academic Hospital Surgery Department. *Annals of Surgery*. 2018 Feb.; 267(2):291-6.
9. Worker Safety in Hospitals. *Occupational Safety and Health Administration*. https://www.osha.gov/dsg/hospitals/understanding_problem.html. Accessed 19 Apr 2019.
10. Workers' Compensation Law - State by State Comparison. *National Federation of Independent Business*. 2017 Jun 07.
11. Utah Code. Title 53B, Chapter 16, 401-403. https://le.utah.gov/xcode/Title53B/Chapter16/C53B-16-P4_1800010118000101.pdf. Accessed 17 Apr 2019.

RELEVANT AMA POLICY

Insurance Coverage for Medical Students and Resident Physicians H-295.942
1. Our AMA urges all medical schools to pay for or offer affordable policy options and, assuming the rates are appropriate, require enrollment in disability insurance plans by all medical students;

2. Our AMA urges all residency programs to pay for or offer affordable policy options for disability insurance, and strongly encourage the enrollment of all residents in such plans;
3. Our AMA urges medical schools and residency training programs to pay for or offer comprehensive and affordable health insurance coverage, including but not limited to medical, dental, and vision care, to medical students and residents which provides no less than the minimum benefits currently recommended by the AMA for employer-provided health insurance and to require enrollment in such insurance.
4. Our AMA urge carriers offering disability insurance to: (a) offer a range of disability policies for medical students and residents that provide sufficient monthly disability benefits to defray any educational loan repayments, other living expenses, and an amount sufficient to continue payment for health insurance providing the minimum benefits recommended by the AMA for employer-provided health insurance; and (b) include in all such policies a rollover provision allowing continuation of student disability coverage into the residency period without medical underwriting.
5. Our AMA: (a) actively encourages medical schools, residency programs, and fellowship programs to provide access to portable group health and disability insurance, including human immunodeficiency virus positive indemnity insurance, for all medical students and resident and fellow physicians; (b) will work with the ACGME and the LCME, and other interested state medical societies or specialty organizations, to develop strategies and policies to ensure access to the provision of portable health and disability insurance coverage, including human immunodeficiency virus positive indemnity insurance, for all medical students, resident and fellow physicians; and (c) will prepare informational material designed to inform medical students and residents concerning the need for both disability and health insurance and describing the available coverage and characteristics of such insurance.
Citation: (BOT Rep. W, I-91; Reaffirmed: BOT Rep. 14, I-93; Appended: Res. 311, I-98; Modified: Res. 306, A-04; Modified: CME Rep. 2, A-14)

HIV Postexposure Prophylaxis for Medical Students During Electives Abroad D-295.970
1. Our AMA recommends that US medical schools ensure that medical students who engage in clinical rotations abroad have immediate access to HIV prophylaxis.
2. Our AMA encourages medical schools to provide information to medical students regarding the potential health risks of completing a medical rotation abroad, and on the appropriate precautions to take to minimize such risks.
Citation: (Res. 303, A-02; Reaffirmed: CCB/CLRPD Rep. 4, A-12)

Pre-Exposure Prophylaxis (PrEP) for HIV H-20.895
1. Our AMA will educate physicians and the public about the effective use of pre-exposure prophylaxis for HIV and the US PrEP Clinical Practice Guidelines.
2. Our AMA supports the coverage of PrEP in all clinically appropriate circumstances.
3. Our AMA supports the removal of insurance barriers for PrEP such as prior authorization, mandatory consultation with an infectious disease specialist and other barriers that are not clinically relevant.
4. Our AMA advocates that individuals not be denied any insurance on the basis of PrEP use.
Citation: Res. 106, A-16; Modified: Res. 916, I-16; Appended: Res. 101, A-17

Prophylaxis for Medical Students Exposed to Bloodborne Pathogens D-365.999
1. Our AMA will work with the Department of Health and Human Services to seek that references to "staff" in the proposed conditions of participation for hospitals expressly include "students and/or trainees" before they are finalized.
2. Our AMA is unsuccessful in achieving the desired outcome in Recommendation 1, our AMA will work with OSHA to obtain a clarifying interpretation of the current OSHA requirements that would have the effect of broadening the application of their bloodborne pathogen standards to include medical students and trainees.
3. Our AMA is unsuccessful in fulfilling Recommendation 2, our AMA will develop model legislation to establish new standards to ensure appropriate prophylaxis and counseling are made available to medical students and trainees exposed to bloodborne pathogens.
4. Our AMA will make a concerted effort to encourage medical schools to require, as part of their affiliation agreements with medical centers, that CDC and other applicable guidelines and standards be applied also to medical students and trainees. Additionally, Our AMA draft and disseminate model contract language for medical schools to use when contracting with hospitals. And further, Our AMA incorporate an effective enforcement mechanism into the model contract language.

Health and Disability Coverage for Health Care Workers at Risk for HIV and Other Serious Infectious Diseases H-20.906

1. Health Insurance

A currently held health insurance policy of a healthcare worker should not be terminated, coverage reduced or restricted, or premiums increased solely because of HIV infection.

2. Disability Coverage

a) Each health care worker should consider the risks of exposure to infectious agents posed by his/her type of practice and the likely consequences of infection in terms of changes needed in that practice mode and select disability insurance coverage accordingly. The policy selected should contain a reasonable definition of "sickness" or "disability," an own-occupation clause, and guaranteed renewability, future insurability, and partial disability provisions;

b) In making determinations of disability, carriers should take into consideration the recommendations of the professional and institutional staff with whom an infected health care worker is associated, including the worker's own personal physician;

c) Since there are a variety of disability insurance coverages available and a diversity of practice modes, each health care professional should individually assess his/her risk of infection and that of his/her employees and select disability coverage accordingly.

Citation: (BOT Rep. 21, I-00; Reaffirmed: CSAPH Rep. 1, A-10)

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.

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

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 1-I-19

Subject: For-Profit Medical Schools or Colleges

Presented by: Jacqueline A. Bello, MD, Chair

American Medical Association (AMA) Policy D-305.954, "For-Profit Medical Schools or Colleges," states:

> That our American Medical Association study issues related to medical education programs offered at for-profit versus not-for-profit medical schools, to include the: (1) attrition rate of students, (2) financial burden of non-graduates versus graduates, (3) success of graduates in obtaining a residency position, and (4) level of support for graduate medical education, and report back at the 2019 Annual Meeting.

The Council on Medical Education recognized the importance and timeliness of this topic and agreed that appropriate resources and data collection were needed to study this issue and prepare the report. However, meaningful and constructive review of this issue and the data collection required additional time. The Council therefore is presenting this report at the 2019 Interim Meeting.

For-profit medical schools are a rare phenomenon within the United States, and the numbers of these schools have not increased substantially, with only six for-profit U.S. medical schools. That said, there are a large and growing number of for-profit medical schools located in the Caribbean that are attended by U.S. citizens. This report focuses on for-profit medical schools located in the United States, and provides available attrition rates, general financial information associated with students who attend for-profit vs. not-for-profit medical schools, and data on student transition into residency programs. Very limited data are also included on for-profit medical schools located in the Caribbean, as such data are not publicly available.

BACKGROUND

In the 19th century, the majority of medical schools were the property of the faculty and, therefore, could be considered "for-profit." In 1906, early accreditation standards from the Council on Medical Education required that schools not be conducted for the financial benefit of the faculty. A 1996 ruling against the American Bar Association, related to restraint of trade, opened up the possibility of accreditation of for-profit law schools and set a legal precedent for the establishment of for-profit medical schools.[1-3] Currently, medical school accreditation bodies, including the Liaison Committee on Medical Education (LCME) and American Osteopathic Association Commission on Osteopathic College Accreditation (COCA), are responsible for reviewing the financial status of U.S. medical schools and monitoring graduation rates and student debt.

Four for-profit osteopathic medical schools are in various stages of becoming accredited by COCA. In 2007, provisional accreditation was granted to investor-owned Rocky Vista University College of Osteopathic Medicine in Colorado.[1] The College was founded to address the need for community-based primary care physicians in the Mountain West region. The Burrell College of

Osteopathic Medicine at New Mexico State University, a privately funded osteopathic medical school founded in 2013, holds pre-accreditation status from COCA, and is expected to be fully accredited when its first class graduates in 2020.[4] In 2016, the Idaho College of Osteopathic Medicine and the California Health Sciences University College of Osteopathic Medicine were founded to help address regional physician shortages in underserved areas.[5] Both schools have initiated the accreditation process with COCA.

The LCME, by comparison, has granted accreditation to two for-profit allopathic medical schools. In 2013, the LCME modified its standards to remove mention of "for-profit" in the accreditation of allopathic medical schools.[1] One year later, Ponce Health Sciences University School of Medicine (a 35-year-old not-for profit institution in Puerto Rico reported to be in financial distress) was acquired by Arist Medical Sciences University, a for-profit public benefit corporation, making it the first for-profit allopathic medical school accredited by the LCME.[1] In 2015, California Northstate University College of Medicine, a private, for-profit medical school focused on educating, developing, and training physicians to address the primary care physician shortage in northern California, gained preliminary accreditation from the LCME and enrolled its first class of students.[6]

FOR-PROFIT MEDICAL SCHOOLS IN THE CARIBBEAN

There is a growing number of for-profit medical schools located in the Caribbean, often referred to as "offshore medical schools."[7] Accreditation/approval of these schools is the purview of a variety of bodies, each with varying standards and requirements for quality and duration of education. Currently,75 offshore medical schools are acceptable to the Educational Commission for Foreign Medical Graduates (ECFMG) for graduates to obtain ECFMG certification.[8] Offshore schools typically engage in minimal clinical or scientific research. As a result, offshore proprietary schools have a profitable business model in that their costs are mainly related to the educational program. These schools use their tuition revenue to pay faculty to teach in the basic sciences at U.S. hospitals, and as part of their tuition third- and fourth-year medical students pay to take clinical rotations in the United States.

There are no summary data available on the enrollment of U.S. citizens in offshore medical schools. However, an estimate can be made based on the number of U.S. citizens pursuing certification by the ECFMG. Of the 9,430 ECFMG certificates issued in 2018, 2,398 (25.4 percent) were issued to U.S. citizen graduates of offshore medical schools.[9] The students/graduates registering for certification were from medical schools located in countries in the Caribbean.

ATTRITION RATES

Not-for-profit U.S. Medical Schools

The Association of America Medical Colleges (AAMC) reports that from 1993-1994 through 2012-2013, the total national attrition rate for not-for-profit medical schools remained relatively stable at an average of 3.3 percent (Appendix A, Table 1).[10] The AAMC notes that more medical students left medical school for nonacademic than for academic reasons, and that attrition rates appeared to vary by type of degree program—that is, the attrition rates of students in combined degree programs, such as MD-MPH programs, differ from those for students in MD programs.

The American Association of Colleges of Osteopathic Medicine (AACOM) calculates attrition rate by dividing the sum of students who withdrew or took a leave of absence by total enrollment. Withdrawals and dismissals are types of permanent attrition from the colleges of osteopathic

medicine (COM), while leaves of absence are types of temporary attrition that may become a withdrawal or dismissal after a period of time.[11] Reasons for students' withdrawals/dismissals include academic failure or school policy violation; poor academic standing; transferring to another medical school; medical or personal reasons; changes in career plans; and failure to take or pass COMLEX (per COM policy). Reasons for leaves of absence include poor academic performance/remediation; academic enrichment/research/study for another degree; medical or personal reasons; and failure to take or pass COMLEX (per COM policy). AACOM only reports on those schools with a full four-year enrollment.

Attrition rates for all COMs ranged from a low of 2.63 percent (2009-2010) to a high of 3.59 percent (2012-2013), with an average 3.03 percent attrition rate from 2009-2010 through 2018-2019 (Table 1).[11] AACOM reports that first-and third-year students had a higher rate of attrition than their second- and fourth-year counterparts, due largely to the struggles first-year students experience when adjusting to the rigors of medical school and to COMLEX being administered to third-year students.

For-profit Medical Schools

Ponce Health Sciences University School of Medicine reports on its website that its average attrition rate for 2016-2017 was 2.3 percent (Table 1).[12] Although actual attrition rates are not available for California Northstate University College of Medicine, the school's website notes that a total of 60 new students enrolled in fall 2015, one student left the program, and three students fell back a year, with a total attrition of one student (1.7 percent).[13] Rocky Vista University College of Osteopathic Medicine, the only COM that has a full class (four years of students enrolled), reports on its website that 91 percent of Title IV students complete the program within four years.[14] Data on attrition rates for newer U.S. medical and osteopathic schools as well as offshore medical schools are not available.

FINANCIAL BURDEN

Not-for-profit U.S. Medical Schools

In 2018-2019, the median annual tuition and fees at state medical schools were $38,202; at private medical schools the median cost was $61,533 (Appendix B, Table 2).[15] In 2019, for students who attended state medical schools, the median debt was $190,000; for students who attended private medical schools, the median debt was $210,000.[15] The overall mean osteopathic medical education debt reported by academic year 2017-2018 graduates is $254,953 ($222,972 for public schools and $261,133 for private schools).[16]

For-profit Medical Schools

The four-year estimated tuition, fees, and cost of attending a for-profit U.S. medical school can range from $209,000 to $342,000 (Table 2). Rocky Vista University College of Osteopathic Medicine reports that four-year estimated tuition, fees, and costs is $215,748, and its typical graduate leaves with $294,018 debt.[17] Median student loan debt accrued for attending an offshore medical school ranges from $191,500 (Ross University School of Medicine) to $253,072 (American University of the Caribbean School of Medicine).[7]

SUCCESS OF U.S. GRADUATES IN OBTAINING A RESIDENCY POSITION

Not-for-profit U.S. Medical Schools

The National Resident Matching Program (NRMP) defines a successful match into a residency program as "one that is measured not just by volume, but also by how well it matches the preferences of applicants and program directors."[18] In 2019, U.S. allopathic medical school senior students comprised 18,925 of the active applicants, and the first-year post-graduate (PGY-1) Match rate for U.S. seniors was 93.9 percent.[18]

In 2019, the transition to a single accreditation system resulted in higher participation among students and graduates of U.S. osteopathic medical schools. An all-time high of 6,001 DO candidates submitted NRMP rank and order lists of programs, and the 84.6 percent PGY-1 match rate was the highest in history.[18]

Earlier Match data reflected NRMP and AOA National Matching Service (NMS) systems. Data reported by the COMs show that 98.7 percent of spring 2018 graduates seeking GME successfully placed into GME as of April 12, 2018.[19] This represents 6,224 new physicians beginning their graduate medical education in July 2018.[19] This compares to the 2017 match/placement process, when 5,898 new physicians entered GME (99.3 percent of graduates seeking GME) and 2016, when 5,356 graduates were successfully matched/placed—99.6 percent of graduates seeking to enter GME.[19]

The 2020 Match will be the first single match system administered by the NRMP, to include both allopathic and osteopathic residency programs. This single system will simplify the matching process for osteopathic medical school students. A result of the new process will be a shift in the way the Match rate percentage is reported.

For-profit Medical Schools

The California Northstate University College of Medicine class of 2019 had a 96.3 percent overall Match rate.[20] Rocky Vista University College of Osteopathic Medicine reported that the majority of students (79 percent) found a residency placement through the 2019 NRMP match, while other students matched into their top choices through the AOA Intern/Resident Registration Program (12 percent) or into military-specific residency programs (nine percent).[21]

However, fewer students matched into U.S. residency programs at some of the other for-profit schools. For example, Ponce Health Sciences University School of Medicine reported that its 2016-2017 initial residency Match rate (aside from the Supplemental Offer and Acceptance Program, or SOAP) was 89.4 percent, vs. 84.4 percent in 2017-2018.[12] In 2019, 5,080 U.S. IMGs (primarily graduates of offshore medical schools) participated in the NRMP, and 59 percent (n=2,997) successfully matched.[18]

LEVEL OF SUPPORT FOR GRADUATE MEDICAL EDUCATION

All U.S. allopathic and osteopathic medical schools are required to prepare their students to successfully transition into Accreditation Council for Graduate Medical Education (ACGME)-accredited GME programs. Two new for-profit osteopathic medical schools are in the process of developing their GME programs. Burrell College of Osteopathic Medicine at New Mexico State University has facilitated the ongoing development of new residency programs in family medicine, internal medicine, orthopaedic surgery, and osteopathic neuromusculoskeletal medicine, and

additional new GME programs are under development.[22] The leadership at the Idaho College of Osteopathic Medicine body is also focused on being able to provide its students with a high-quality academic and clinical clerkship experience and facilitating their placement into ACGME-accredited residency programs.[23]

Concern has been raised about the paucity of academic teaching hospitals associated with some for-profit medical schools. For example, students who attend Rocky Vista University College of Osteopathic Medicine complete clinical rotations at various hospitals throughout the state of Colorado and the mountain west region.[24] Third- and fourth-year medical students in their clerkships could be sent for rotations to nonacademic community hospitals without a strong background in education and research.[24] Although the college was established on the premise that physicians practice in locations close to their residency or fellowship programs, many of the graduates have had to leave the state to complete residency training requirements.[24]

Offshore for-profit medical schools, including those in the Caribbean, continue to provide a large number of medical school graduates who return to the United States for GME.[24] However, the accreditation standards these schools are held to, if any, vary widely and may not require that the schools provide career counseling or support for the transition of their students into ACGME-accredited programs.[25]

RELEVANT AMA POLICY

The AMA has extensive policy related to the cost and financing of medical education.

Policy H-305.925 (20f), "Principles of and Actions to Address Medical Education Costs and Student Debt," states that 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 related to the Public Service Loan Forgiveness (PSLF) Program, the AMA will advocate that the profit status of a trainee's institution not be a factor for PSLF eligibility.

Policy H-200.949 (3), "Principles of and Actions to Address Primary Care Workforce," directs the AMA, through its work with stakeholders, to encourage development and dissemination of innovative models to recruit medical students interested in primary care, train primary care physicians, and enhance both the perception and the reality of primary care practice, to encompass the following components: a) Changes to medical school admissions and recruitment of medical students to primary care specialties, including counseling of medical students as they develop their career plans; b) Curriculum changes throughout the medical education continuum; c) Expanded financial aid and debt relief options; d) Financial and logistical support for primary care practice, including adequate reimbursement, and enhancements to the practice environment to ensure professional satisfaction and practice sustainability; and e) Support for research and advocacy related to primary care.

Policy D-295.309, "Promoting and Reaffirming Domestic Medical School Clerkship Education," directs the AMA to support agreements for clerkship rotations, where permissible, for U.S. citizen international medical students between foreign medical schools and teaching hospitals in regions that are medically underserved and/or that lack medical schools and clinical sites for training medical students, to maximize the cumulative clerkship experience for all students and to expose these students to the possibility of medical practice in these areas.

Additional related policies are provided in Appendix C.

SUMMARY

Stigma and reputational challenges associated with for-profit medical schools can be traced back to the 1910 Flexner Report on Medical Education in the United States and Canada, which called for quality education that linked medical schools with universities and teaching hospitals.[3] The report criticized for-profit schools, and the subsequent linkage between accreditation and licensure requirements led to the collapse of many proprietary medical schools. However, for-profit medical education has reemerged in the United States and has expanded in the Caribbean and elsewhere around the world.[7, 24] The Ponce Health Sciences University School of Medicine was recently incorporated to facilitate the retention of public benefit.[1]

For-profit schools are based on a tuition-dependent business model. For example, at Rocky Vista University College of Medicine approximately 80 percent of revenue, as with the other private osteopathic medical schools, comes from tuition and fees. In contrast, tuition and fees constitute only 14 percent of public osteopathic medical schools' revenues.[24]

As with any medical school, for-profit medical schools may have a positive impact on the physician workforce. For example, the mission of California Northstate University College of Medicine is to train primary care physicians to serve the needs in underserved areas in northern California. As with other medical schools, however, the graduates of U.S. for-profit medical schools are subject to competition for residency placements. Graduates from for-profit medical schools in the Caribbean need to complete the requirements for ECFMG certification before they can apply for residency training in the United States.

Through its Council on Medical Education, the AMA will continue to monitor the development of for-profit medical schools, both allopathic and osteopathic, and report back to the House of Delegates as needed.

APPENDIX A
TABLE 1. ATTRITION RATE OF STUDENTS ATTENDING U.S. MEDICAL SCHOOLS

Not-for-profit	***Attrition Rate:***
U.S. allopathic medical schools	From 1993-1994 through 2012-2013, the total national attrition rate remained relatively stable at an average of 3.3%[1]
U.S. osteopathic medical schools	From a low of 2.63% (2009-10) to a high of 3.59% (2012-13), with an average of 3.03% attrition rate from 2009-10 through 2018-19.[2]
For-profit*	***Attrition Rate:***
Ponce Health Sciences University School of Medicine	Average attrition rate is 2.3%; retention rate is 97.7% (2016-2017)[3]
California Northstate University College of Medicine**	Total of 60 new students enrolled in the Fall of 2015: one student left the program and three students fell back a year; the total attrition of 1 student (1.7%).[4]
Rocky Vista University College of Osteopathic Medicine**	91% of Title IV students complete the program within 4 years with an attrition rate of 9%.[5]
Burrell College of Osteopathic Medicine at New Mexico State University**	Matriculated 162 students in 2018; retained 154 (95.06%) with an attrition rate of 4.94%.[6]
Idaho College of Osteopathic Medicine***	Matriculated its inaugural class in August 2018. This class of 2022 is composed of graduates from 97 U.S. colleges and universities, with above average composite medical board (MCAT) scores and highly competitive undergraduate grade point averages.[7]
California Health Sciences University College of Osteopathic Medicine***	Campus construction underway with targeted completion date of Spring 2020.

* *Similar quality data are not available from offshore medical schools*
** *Attrition rate is extrapolated from the retention rate posted on the medical school's website.*
*** *Data on attrition rates for newer U.S. medical schools are not yet available.*

1. AAMC Data Snapshot. Association of American Medical Colleges. Available at: https://www.aamc.org/download/492842/data/graduationratesandattritionratesofu.s.medicalstudents.pdf (Accessed April 9, 2019).
2. 2019-2020 Student Guide to Osteopathic Medical Colleges. American Association of Colleges of Osteopathic Medicine. 2019. Available at: https://www.aacom.org/docs/default-source/presentations/student-guide-for-web-5-28-19.pdf?sfvrsn=4aab3d97_2 (Accessed July 2, 2019).
3. Consumer Information and Student Achievement Guide 2017-2018. Ponce Health Sciences University. Available at: https://www.psm.edu/wp-content/uploads/2016/09/Ponce-Health-Sciences-University-Consumer-Information-and-Student-Achievement-Guide.pdf (Accessed July 2, 2019).
4. California Northstate University Fact Book, 2017-2018. California Northstate University. Available at: https://www.cnsu.edu/shareddocs/Fact-Book-2017-2018.pdf (Accessed July 2, 2019).
5. RVU At A Glance. Rocky Vista University. Available at: http://www.rvu.edu/about/rvu-at-a-glance/ (Accessed July 2, 2019).
6. Burrell College of Osteopathic Medicine Institutional Snapshot. Burrell College of Osteopathic Medicine. Available at: https://bcomnm.org/wp-content/uploads/2019/05/Institutional-Snapshot.pdf (Accessed July 2, 2019).
7. Idaho College of Osteopathic Medicine. About ICOM. Available at: https://www.idahocom.org/ (Accessed July 2, 2019).

APPENDIX B
TABLE 2. FINANCIAL BURDEN OF NON-GRADUATES VERSUS GRADUATES OF U.S. MEDICAL SCHOOLS

Not-for-profit	***Financial Burden***
U.S. allopathic medical schools	In 2018-2019, the median annual tuition and fees at state medical schools were $38,202; at private medical schools the median cost was $61,533.[6] In 2019, for students who attended state medical schools the median debt was $190,000; for students who attended private medical schools the median debt was $210,000.[1]
U.S. osteopathic medical schools	The overall mean osteopathic medical education debt reported for academic year 2017-2018 graduates is $254,953 ($222,972 for public schools and $261,133 for private schools).[2]
For-profit*	***Financial Burden***
Ponce Health Sciences University School of Medicine	4-year estimated tuition, fees and costs range from $233,456 to $342,069.[3]
California Northstate University College of Medicine	4-year estimated tuition, fees, and costs range from $240,000 to $255,000.[4]
Rocky Vista University College of Osteopathic Medicine	4-year estimated tuition, fees, and cost are $215,748; typical graduate leaves with $294,018 in debt.[5]
Burrell College of Osteopathic Medicine at New Mexico State University**	2018-2019 annual cost of attendance is $80,165.[6]
Idaho College of Osteopathic Medicine**	2018-2019 academic year annual tuition is $49,750 plus $2,500 in fees.[7]
California Health Sciences University College of Osteopathic Medicine**	Fall 2020 enrollment annual cost of tuition is $53,500.[8]

**Data not available from offshore medical schools*
***Data on student debt for newer U.S. medical schools are not yet available*

1. Medical Student Education: Debt, Costs, and Loan Repayment Fact Card. Association of American Medical Colleges. Available at: https://store.aamc.org/downloadable/download/sample/sample_id/240/ (Accessed July 2, 2019).
2. 2017-2018 Academic Year Survey of Graduating Seniors Summary. American Association of Colleges of Osteopathic Medicine. Available at: https://www.aacom.org/docs/default-source/data-and-trends/aacom-2017-2018-academic-year-graduating-seniors-survey-summary-report.pdf?sfvrsn=e14d2197_6 (Accessed July 2, 2019).
3. Ponce Health Sciences University Educational Budget Academic Year 2019-2020 Doctor in Medicine Program (4 years). Ponce Health Sciences University. Available at: https://www.psm.edu/coa/EDUC%20BUDGETS%20MD%204%20YRS.pdf (Accessed July 23, 2019).
4. Cost of Attendance and Tuition and Fees. California Northstate University College of Medicine. Available at: https://www.cnsu.edu/shareddocs/StudentFA/TuitionandFeesCOM2.pdf (Accessed July 23, 2019).
5. Rocky Vista University. Available at: http://www.rvu.edu/gedt/gedt.html (Accessed July 16, 2019).
6. BCOM Estimated Cost of Attendance (COA). Burrell College of Osteopathic Medicine. Available at: https://bcomnm.org/budgeting-your-education/ (Accessed July 23, 2019).
7. Idaho College of Osteopathic Medicine. Tuition, Fees & Financial Aid. Available at: https://choosedo.org/idaho-college-of-osteopathic-medicine-icom/ (Accessed July 23, 2019).
8. California Health Sciences University College of Osteopathic Medicine. Tuition, Fees & Financial Aid. Available at: https://choosedo.org/california-health-sciences-university-college-of-osteopathic-medicine-chsu-com/ (Accessed July 23, 2019).

APPENDIX C
AMA POLICY

D-305.954, "For-Profit Medical Schools or Colleges"
Our AMA will study issues related to medical education programs offered at for-profit versus not-for-profit medical schools, to include the: (a) attrition rate of students; (b) financial burden of non-graduates versus graduates; (c) success of graduates in obtaining a residency position; and (d) level of support for graduate medical education; and report back at the 2019 Annual Meeting.
(Res. 302, A-18)

H-305.988, "Cost and Financing of Medical Education and Availability of First-Year Residency Positions"
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-93 Res. 313, I-95 Reaffirmed by CME Rep. 13, A-97 Modified: CME Rep. 7, A-05 Modified: CME Rep. 13, A-06 Appended: Res. 321, A-15 Reaffirmed: CME Rep. 05, A-16 Modified: CME Rep. 04, A-16)

H-305.925, "Principles of and Actions to Address Medical Education Costs and Student Debt"
The costs of medical education should never be a barrier to the pursuit of a career in medicine nor to the decision to practice in a given specialty. To help address this issue, our American Medical Association (AMA) will:
1. Collaborate with members of the Federation and the medical education community, and with other interested organizations, to address the cost of medical education and medical student debt through public- and private-sector advocacy.
2. Vigorously advocate for and support expansion of and adequate funding for federal scholarship and loan repayment programs such as those from the National Health Service Corps, Indian Health Service, Armed Forces, and Department of Veterans Affairs, and for comparable programs from states and the private sector to promote practice in underserved areas, the military, and academic medicine or clinical research.
3. Encourage the expansion of National Institutes of Health programs that provide loan repayment in exchange for a commitment to conduct targeted research.
4. Advocate for increased funding for the National Health Service Corps Loan Repayment Program to assure adequate funding of primary care within the National Health Service Corps, as well as to permit: (a) inclusion of all medical specialties in need, and (b) service in clinical settings that care for the underserved but are not necessarily located in health professions shortage areas.

5. Encourage the National Health Service Corps to have repayment policies that are consistent with other federal loan forgiveness programs, thereby decreasing the amount of loans in default and increasing the number of physicians practicing in underserved areas.
6. Work to reinstate the economic hardship deferment qualification criterion known as the 20/220 pathway, and support alternate mechanisms that better address the financial needs of trainees with educational debt.
7. Advocate for federal legislation to support the creation of student loan savings accounts that allow for pre-tax dollars to be used to pay for student loans.
8. Work with other concerned organizations to advocate for legislation and regulation that would result in favorable terms and conditions for borrowing and for loan repayment, and would permit 100% tax deductibility of interest on student loans and elimination of taxes on aid from service-based programs.
9. Encourage the creation of private-sector financial aid programs with favorable interest rates or service obligations (such as community- or institution-based loan repayment programs or state medical society loan programs).
10. Support stable funding for medical education programs to limit excessive tuition increases, and collect and disseminate information on medical school programs that cap medical education debt, including the types of debt management education that are provided.
11. Work with state medical societies to advocate for the creation of either tuition caps or, if caps are not feasible, pre-defined tuition increases, so that medical students will be aware of their tuition and fee costs for the total period of their enrollment.
12. Encourage medical schools to (a) Study the costs and benefits associated with non-traditional instructional formats (such as online and distance learning, and combined baccalaureate/MD or DO programs) to determine if cost savings to medical schools and to medical students could be realized without jeopardizing the quality of medical education; (b) Engage in fundraising activities to increase the availability of scholarship support, with the support of the Federation, medical schools, and state and specialty medical societies, and develop or enhance financial aid opportunities for medical students, such as self-managed, low-interest loan programs; (c) Cooperate with postsecondary institutions to establish collaborative debt counseling for entering first-year medical students; (d) Allow for flexible scheduling for medical students who encounter financial difficulties that can be remedied only by employment, and consider creating opportunities for paid employment for medical students; (e) Counsel individual medical student borrowers on the status of their indebtedness and payment schedules prior to their graduation; (f) Inform students of all government loan opportunities and disclose the reasons that preferred lenders were chosen; (g) Ensure that all medical student fees are earmarked for specific and well-defined purposes, and avoid charging any overly broad and ill-defined fees, such as but not limited to professional fees; (h) Use their collective purchasing power to obtain discounts for their students on necessary medical equipment, textbooks, and other educational supplies; (i) Work to ensure stable funding, to eliminate the need for increases in tuition and fees to compensate for unanticipated decreases in other sources of revenue; mid-year and retroactive tuition increases should be opposed.
13. Support and encourage state medical societies to support further expansion of state loan repayment programs, particularly those that encompass physicians in non-primary care specialties.
14. Take an active advocacy role during reauthorization of the Higher Education Act and similar legislation, to achieve the following goals: (a) Eliminating the single holder rule; (b) Making the availability of loan deferment more flexible, including broadening the definition of economic hardship and expanding the period for loan deferment to include the entire length of residency and fellowship training; (c) Retaining the option of loan forbearance for residents ineligible for loan deferment; (d) Including, explicitly, dependent care expenses in the definition of the cost of attendance ; (e) Including room and board expenses in the definition of tax-exempt scholarship income; (f) Continuing the federal Direct Loan Consolidation program, including the ability to lock in a fixed interest rate, and giving consideration to grace periods in renewals of federal loan programs; (g) Adding the ability to refinance Federal Consolidation Loans; (h) Eliminating the cap on the student loan interest deduction; (i) Increasing the income limits for taking the interest deduction; (j) Making permanent the education tax incentives that our AMA successfully lobbied for as part of Economic Growth and Tax Relief Reconciliation Act of 2001; (k) Ensuring that loan repayment programs do not place greater burdens upon married couples than for similarly situated couples who are cohabitating; (l) Increasing efforts to collect overdue debts from the present medical student loan programs in a manner that would not interfere with the provision of future loan funds to medical students.

15. Continue to work with state and county medical societies to advocate for adequate levels of medical school funding and to oppose legislative or regulatory provisions that would result in significant or unplanned tuition increases.
16. Continue to study medical education financing, so as to identify long-term strategies to mitigate the debt burden of medical students, and monitor the short-and long-term impact of the economic environment on the availability of institutional and external sources of financial aid for medical students, as well as on choice of specialty and practice location.
17. Collect and disseminate information on successful strategies used by medical schools to cap or reduce tuition.
18. Continue to monitor the availability of and encourage medical schools and residency/fellowship programs to (a) provide financial aid opportunities and financial planning/debt management counseling to medical students and resident/fellow physicians; (b) work with key stakeholders to develop and disseminate standardized information on these topics for use by medical students, resident/fellow physicians, and young physicians; and (c) share innovative approaches with the medical education community.
19. Seek federal legislation or rule changes that would stop Medicare and Medicaid decertification of physicians due to unpaid student loan debt. The AMA believes that it is improper for physicians not to repay their educational loans, but assistance should be available to those physicians who are experiencing hardship in meeting their obligations.
20. Related to the Public Service Loan Forgiveness (PSLF) Program, our AMA supports increased medical student and physician benefits the program, and will: (a) Advocate that all resident/fellow physicians have access to PSLF during their training years; (b) Advocate against a monetary cap on PSLF and other federal loan forgiveness programs; (c) Work with the United States Department of Education to ensure that any cap on loan forgiveness under PSLF be at least equal to the principal amount borrowed; (d) Ask the United States Department of Education to include all terms of PSLF in the contractual obligations of the Master Promissory Note; (e) Encourage the Accreditation Council for Graduate Medical Education (ACGME) to require residency/fellowship programs to include within the terms, conditions, and benefits of program appointment information on the PSLF program qualifying status of the employer; (f) Advocate that the profit status of a physician s training institution not be a factor for PSLF eligibility; (g) Encourage medical school financial advisors to counsel wise borrowing by medical students, in the event that the PSLF program is eliminated or severely curtailed; (h) Encourage medical school financial advisors to increase medical student engagement in service-based loan repayment options, and other federal and military programs, as an attractive alternative to the PSLF in terms of financial prospects as well as providing the opportunity to provide care in medically underserved areas; (i) Strongly advocate that the terms of the PSLF that existed at the time of the agreement remain unchanged for any program participant in the event of any future restrictive changes.
21. Advocate for continued funding of programs including Income-Driven Repayment plans for the benefit of reducing medical student load burden.
(CME Report 05, I-18 Appended: Res. 953, I-18 Reaffirmation: A-19)

H-200.949, "Principles of and Actions to Address Primary Care Workforce"
1. Our patients require a sufficient, well-trained supply of primary care physicians--family physicians, general internists, general pediatricians, and obstetricians/gynecologists--to meet the nation's current and projected demand for health care services.
2. To help accomplish this critical goal, our American Medical Association (AMA) will work with a variety of key stakeholders, to include federal and state legislators and regulatory bodies; national and state specialty societies and medical associations, including those representing primary care fields; and accreditation, certification, licensing, and regulatory bodies from across the continuum of medical education (undergraduate, graduate, and continuing medical education).
3. Through its work with these stakeholders, our AMA will encourage development and dissemination of innovative models to recruit medical students interested in primary care, train primary care physicians, and enhance both the perception and the reality of primary care practice, to encompass the following components: a) Changes to medical school admissions and recruitment of medical students to primary care specialties, including counseling of medical students as they develop their career plans; b) Curriculum changes throughout the medical education continuum; c) Expanded financial aid and debt relief options; d) Financial and logistical support for primary care practice, including adequate reimbursement, and

enhancements to the practice environment to ensure professional satisfaction and practice sustainability; and e) Support for research and advocacy related to primary care.

4. Admissions and recruitment: The medical school admissions process should reflect the specific institution s mission. Those schools with missions that include primary care should consider those predictor variables among applicants that are associated with choice of these specialties.

5. Medical schools, through continued and expanded recruitment and outreach activities into secondary schools, colleges, and universities, should develop and increase the pool of applicants likely to practice primary care by seeking out those students whose profiles indicate a likelihood of practicing in primary care and underserved areas, while establishing strict guidelines to preclude discrimination.

6. Career counseling and exposure to primary care: Medical schools should provide to students career counseling related to the choice of a primary care specialty, and ensure that primary care physicians are well-represented as teachers, mentors, and role models to future physicians.

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

8. Curriculum: Voluntary efforts to develop and expand both undergraduate and graduate medical education programs to educate primary care physicians in increasing numbers should be continued. The establishment of appropriate administrative units for all primary care specialties should be encouraged.

9. Medical schools with an explicit commitment to primary care should structure the curriculum to support this objective. At the same time, all medical schools should be encouraged to continue to change their curriculum to put more emphasis on primary care.

10. All four years of the curriculum in every medical school should provide primary care experiences for all students, to feature increasing levels of student responsibility and use of ambulatory and community-based settings.

11. Federal funding, without coercive terms, should be available to institutions needing financial support to expand resources for both undergraduate and graduate medical education programs designed to increase the number of primary care physicians. Our AMA will advocate for public (federal and state) and private payers to a) develop enhanced funding and related incentives from all sources to provide education for medical students and resident/fellow physicians, respectively, in progressive, community-based models of integrated care focused on quality and outcomes (such as the patient-centered medical home and the chronic care model) to enhance primary care as a career choice; b) fund and foster innovative pilot programs that change the current approaches to primary care in undergraduate and graduate medical education, especially in urban and rural underserved areas; and c) evaluate these efforts for their effectiveness in increasing the number of students choosing primary care careers and helping facilitate the elimination of geographic, racial, and other health care disparities.

12. Medical schools and teaching hospitals in underserved areas should promote medical student and resident/fellow physician rotations through local family health clinics for the underserved, with financial assistance to the clinics to compensate their teaching efforts.

13. The curriculum in primary care residency programs and training sites should be consistent with the objective of training generalist physicians. Our AMA will encourage the Accreditation Council for Graduate Medical Education to (a) support primary care residency programs, including community hospital-based programs, and (b) develop an accreditation environment and novel pathways that promote innovations in graduate medical education, using progressive, community-based models of integrated care focused on quality and outcomes (such as the patient-centered medical home and the chronic care model).

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

15. Support for practicing primary care physicians: Administrative support mechanisms should be developed to assist primary care physicians in the logistics of their practices, along with enhanced efforts to reduce administrative activities unrelated to patient care, to help ensure professional satisfaction and practice sustainability.

16. There should be increased financial incentives for physicians practicing primary care, especially those in rural and urban underserved areas, to include scholarship or loan repayment programs, relief of professional liability burdens, and Medicaid case management programs, among others. Our AMA will advocate to state and federal legislative and regulatory bodies, among others, for development of public and/or private incentive programs, and expansion and increased funding for existing programs, to further encourage practice

in underserved areas and decrease the debt load of primary care physicians. The imposition of specific outcome targets should be resisted, especially in the absence of additional support to the schools.
17. Our AMA will continue to advocate, in collaboration with relevant specialty societies, for the recommendations from the AMA/Specialty Society RVS Update Committee (RUC) related to reimbursement for E&M services and coverage of services related to care coordination, including patient education, counseling, team meetings and other functions; and work to ensure that private payers fully recognize the value of E&M services, incorporating the RUC-recommended increases adopted for the most current Medicare RBRVS.
18. Our AMA will advocate for public (federal and state) and private payers to develop physician reimbursement systems to promote primary care and specialty practices in progressive, community-based models of integrated care focused on quality and outcomes such as the patient-centered medical home and the chronic care model consistent with current AMA Policies H-160.918 and H-160.919.
19. There should be educational support systems for primary care physicians, especially those practicing in underserved areas.
20. Our AMA will urge urban hospitals, medical centers, state medical associations, and specialty societies to consider the expanded use of mobile health care capabilities.
21. Our AMA will encourage the Centers for Medicare & Medicaid Services to explore the use of telemedicine to improve access to and support for urban primary care practices in underserved settings.
22. Accredited continuing medical education providers should promote and establish continuing medical education courses in performing, prescribing, interpreting and reinforcing primary care services.
23. Practicing physicians in other specialties--particularly those practicing in underserved urban or rural areas--should be provided the opportunity to gain specific primary care competencies through short-term preceptorships or postgraduate fellowships offered by departments of family medicine, internal medicine, pediatrics, etc., at medical schools or teaching hospitals. In addition, part-time training should be encouraged, to allow physicians in these programs to practice concurrently, and further research into these concepts should be encouraged.
24. Our AMA supports continued funding of Public Health Service Act, Title VII, Section 747, and encourages advocacy in this regard by AMA members and the public.
25. Research: Analysis of state and federal financial assistance programs should be undertaken, to determine if these programs are having the desired workforce effects, particularly for students from disadvantaged groups and those that are underrepresented in medicine, and to gauge the impact of these programs on elimination of geographic, racial, and other health care disparities. Additional research should identify the factors that deter students and physicians from choosing and remaining in primary care disciplines. Further, our AMA should continue to monitor trends in the choice of a primary care specialty and the availability of primary care graduate medical education positions. The results of these and related research endeavors should support and further refine AMA policy to enhance primary care as a career choice.
(CME Rep. 04, I-18)

D-295.309, "Promoting and Reaffirming Domestic Medical School Clerkship Education"
1. Our American Medical Association:
A. Will work with the Association of American Medical Colleges, American Association of Colleges of Osteopathic Medicine, and other interested stakeholders to encourage local and state governments and the federal government, as well as private sector philanthropies, to provide additional funding to support: (1) infrastructure and faculty development and capacity for medical school expansion; and (2) delivery of clinical clerkships and other educational experiences.
B. Encourages clinical clerkship sites for medical education (to include medical schools and teaching hospitals) to collaborate with local, state, and regional partners to create additional clinical education sites and resources for students.
C. Advocates for federal and state legislation/regulations to: (1) Oppose any extraordinary compensation granted to clinical clerkship sites that would displace or otherwise limit the education/training opportunities for medical students in clinical rotations enrolled in medical school programs accredited by the Liaison Committee on Medical Education (LCME) or Commission on Osteopathic College Accreditation (COCA); (2) Ensure that priority for clinical clerkship slots be given first to students of LCME- or COCA-accredited medical school programs; and (3) Require that any institution that accepts students for clinical placements ensure that all such students are trained in programs that meet requirements for educational quality,

curriculum, clinical experiences and attending supervision that are equivalent to those of programs accredited by the LCME and COCA.
D. Encourages relevant stakeholders to study whether the public service community benefit commitment and corporate purposes of not for profit, tax exempt hospitals impose any legal and/or ethical obligations for granting priority access for teaching purposes to medical students from medical schools in their service area communities and, if so, advocate for the development of appropriate regulations at the state level.
E. Will work with interested state and specialty medical associations to pursue legislation that ensures the quality and availability of medical student clerkship positions for U.S. medical students.
2. Our AMA supports the practice of U.S. teaching hospitals and foreign medical schools entering into appropriate relationships directed toward providing clinical educational experiences for advanced medical students who have completed the equivalent of U.S. core clinical clerkships. Policies governing the accreditation of U.S. medical education programs specify that core clinical training be provided by the parent medical school; consequently, the AMA strongly objects to the practice of substituting clinical experiences provided by U.S. institutions for core clinical curriculum of foreign medical schools. Moreover, it strongly disapproves of the placement of medical students in teaching hospitals and other clinical sites that lack appropriate educational resources and experience for supervised teaching of clinical medicine, especially when the presence of visiting students would disadvantage the institution s own students educationally and/or financially and negatively affect the quality of the educational program and/or safety of patients receiving care at these sites.
3. Our AMA supports agreements for clerkship rotations, where permissible, for U.S. citizen international medical students between foreign medical schools and teaching hospitals in regions that are medically underserved and/or that lack medical schools and clinical sites for training medical students, to maximize the cumulative clerkship experience for all students and to expose these students to the possibility of medical practice in these areas.
4. AMA policy is that U.S. citizens should have access to factual information on the requirements for licensure and for reciprocity in the various U.S. medical licensing jurisdictions, prerequisites for entry into graduate medical education programs, and other relevant factors that should be considered before deciding to undertake the study of medicine in schools not accredited by the LCME or COCA.
5. AMA policy is that existing requirements for foreign medical schools seeking Title IV Funding should be applied to those schools that are currently exempt from these requirements, thus creating equal standards for all foreign medical schools seeking Title IV Funding.
(CME Rep. 01, I-17)

REFERENCES

1. Adashi EY, Krishna GR, Gruppuso PA. For-Profit Medical Schools-A Flexnerian Legacy Upended. *JAMA*. March 28, 2017;317(12):1209-1210.
2. US Department of Justice. [Revised] final judgment: United States of America v American Bar Association. June 25, 1996. https://www.justice.gov /atr/case-document/revised-final-judgment-0 (Accessed July 12, 2019).
3. Flexner A. Medical Education in the United States and Canada: A Report to the Carnegie Foundation for the Advancement of Teaching. New York, NY: Carnegie Foundation for the Advancement of Teaching; 1910. http://archive.carnegiefoundation.org/pdfs/elibrary/Carnegie_Flexner_Report.pdf (Accessed July 12, 2019).
4. Accreditation. Burrell College of Osteopathic Medicine. Available at: https://bcomnm.org/wp-content/uploads/2019/02/COCA-Status.pdf (Accessed July 12, 2019).
5. 2019-2020 Student Guide to Osteopathic Medical Colleges. American Association of Colleges of Osteopathic Medicine. Available at: https://www.aacom.org/student-guide (Accessed July 12, 2019).
6. Robertson K. California Northstate University wins accreditation to launch medical school, will open in fall, June 11, 2015. Available at: https://www.bizjournals.com/sacramento/news/2015/06/11/california-northstate-university-accreditation.html (Accessed July 12, 2019).
7. Halperin EC, Goldberg RB. Offshore Medical Schools Are Buying Clinical Clerkships in U.S. Hospitals: The Problem and Potential Solutions. *Acad Med*. May 2016;91:639-644.
8. Pinsky WW. "The Medical School Accreditation Requirement for ECFMG Certification: Why, and Why Now?" Presented at the AMA House of Delegates Meeting. June 10, 2019.
9. Data obtained from the Educational Commission for Foreign Medical Graduates. Philadelphia, Pennsylvania. August 2, 2019.
10. AAMC Data Snapshot. Association of American Medical Colleges. Available at: https://www.aamc.org/download/492842/data/graduationratesandattritionratesofu.s.medicalstudents.pdf (Accessed April 9, 2019).
11. 2019-2020 Student Guide to Osteopathic Medical Colleges. American Association of Colleges of Osteopathic Medicine. 2019. Available at: https://www.aacom.org/docs/default-source/presentations/student-guide-for-web-5-28-19.pdf?sfvrsn=4aab3d97_2 (Accessed June 27, 2019).
12. Consumer Information and Student Achievement Guide 2017-2018. Ponce Health Sciences University. Available at: https://www.psm.edu/wp-content/uploads/2016/09/Ponce-Health-Sciences-University-Consumer-Information-and-Student-Achievement-Guide.pdf (Accessed July 17, 2019).
13. California Northstate University Fact Book, 2017-2018. California Northstate University. Available at: https://www.cnsu.edu/shareddocs/Fact-Book-2017-2018.pdf (Accessed July 2, 2019).
14. RVU At A Glance. Rocky Vista University. Available at: http://www.rvu.edu/about/rvu-at-a-glance/ (Accessed July 2, 2019).
15. Medical Student Education: Debt, Costs, and Loan Repayment Fact Card. Association of American Medical Colleges. Available at: https://store.aamc.org/downloadable/download/sample/sample_id/240/ (Accessed July 2, 2019).
16. 2017-2018 Academic Year Survey of Graduating Seniors Summary. American Association of Colleges of Osteopathic Medicine. Available at: https://www.aacom.org/docs/default-source/data-and-trends/aacom-2017-2018-academic-year-graduating-seniors-survey-summary-report.pdf?sfvrsn=e14d2197_6 (Accessed July 2, 2019).
17. Rocky Vista University. Available at: http://www.rvu.edu/gedt/gedt.html (Accessed July 16, 2019).
18. Results and Data: 2019 Main Residency Match. National Resident Matching Program. April 2019. Available at: www.nrmp.org (Accessed July 16, 2019).
19. Report on Osteopathic Medicine Placements in 2018 Matches. AACOM. Available at: https://www.aacom.org/docs/default-source/data-and-trends/osteopathicmed-grad-placements-in-2018.pdf?sfvrsn=d82d2597_10 (Accessed July 16, 2019).
20. Congrats to our CNUCOM Class of 2019 on their outstanding match results (96.3% overall match rate)! California Northstate University College of Medicine. Available at: https://medicine.cnsu.edu/ (Accessed July 16, 2016).
21. RVUCOM-CO Graduates Match into Medical Residency Programs. Rocky Vista University. Available at: http://www.rvu.edu/news/rvucom-co-graduates-match-into-medical-residency-programs/ (Accessed July 2, 2019).

22. GME. Burrell College of Osteopathic Medicine. Available at: https://bcomnm.org/academics/clinical-partners-and-gme/ (Accessed July 2, 2019)
23. About the ICOM Strategic Plan & Process. Idaho College of Osteopathic Medicine. Available at: https://www.idahocom.org/strategic-plan (Accessed July 16, 2016).
24. Babcock JM, Babcock BD, Schwartz MZ. Maintaining a Sufficient and Quality Physician Workforce: The Role of For-profit Medical Schools. Health Services Insights. 2013;6:87-98.
25. Eckhert NL. Private Schools of the Caribbean: Outsourcing Medical Education. Academic Medicine 2010; 85:622-630. Available at: http://journals.lww.com/academicmedicine/Fulltext/2010/04000/Perspective__Private_Schools_of_the_Caribbean_.21.aspx. (Accessed July 17, 2019).

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 5-I-19

Subject: The Transition from Undergraduate Medical Education to Graduate Medical Education

Presented by: Jacqueline A. Bello, MD, Chair

INTRODUCTION

A critical step in the development of a physician is the transition from undergraduate medical education (UME), or medical school, to graduate medical education (GME), or residency training. Ensuring a seamless transition supports learners' well-being and their readiness to take on and master the many challenges in their chosen field of medicine. In addition, patient safety in our nation's teaching hospitals is paramount in the public eye, as evidenced by coverage of the "July Effect" in the media. This underscores the need for preparedness among first-year resident physicians as well as the need for a highly effective, efficient, and supportive educational environment.

The American Medical Association (AMA) has taken a lead role to address these issues and call for medical education to "mind the gap" between the various stages of medical education—in particular, the UME to GME transition—in part through its Accelerating Change in Medical Education initiative and Reimagining Residency initiative, as described in this report. The AMA is working to help smooth the transition from UME to GME as part of its effort to encourage innovation in the development of medical students, trainees, and physicians throughout their career. This report also provides relevant AMA policy on this topic (see the Appendix).

MEDICAL SCHOOL PREPARATION OF GRADUATES FOR RESIDENCY

One body of data that measures medical student preparedness for entry into residency is the Association of American Medical Colleges' (AAMC) Graduation Questionnaire (GQ), a national questionnaire administered to graduates of U.S. MD-granting medical schools accredited by the Liaison Committee on Medical Education (LCME).[1] The GQ is an important tool for medical schools to use in program evaluation and to improve the medical student experience.

The AAMC's All Schools Summary Report for 2018[2] includes GQ data for the five-year period 2014 to 2018. Eighty-three percent (16,223) of medical school graduates in academic year 2017-2018 (19,537) participated in the 2018 GQ.

Question 12 of the questionnaire asks respondents, "Indicate whether you agree or disagree with the following statements about your preparedness for beginning a residency program." Averaging the data for the five-year period (2014 to 2018) produces the following numbers. In the right-hand column, the percentages from the "Agree" and "Strongly agree" fields are combined; the table is sorted based on this variable, which ranges from a high of 98.3 percent ("I have the communication skills necessary to interact with patients and health professionals") to 90.2 percent ("I am confident that I have acquired the clinical skills required to begin a residency program").

Percentage of Respondents Selecting Each Rating					
Strongly disagree	**Disagree**	**Neutral**	**Agree**	**Strongly agree**	**Total: Agree and Strongly agree**
I have the communication skills necessary to interact with patients and health professionals.					
0.2	0.2	1.4	26.2	72.1	98.3
I understand the ethical and professional values that are expected of the profession.					
0.2	0.2	1.5	29.9	68.2	98.1
I believe I am adequately prepared to care for patients from different backgrounds.					
0.3	0.6	3.4	35.9	59.9	95.8
I have basic skills in clinical decision making and the application of evidence based information to medical practice.					
0.3	0.7	4.7	46.2	48.2	94.4
I have a fundamental understanding of the issues in social sciences of medicine (e.g., ethics, humanism, professionalism, organization and structure of the health care system).					
0.3	1.0	4.9	40.9	52.8	93.7
I have the fundamental understanding of common conditions and their management encountered in the major clinical disciplines.					
0.3	1.0	5.2	52.0	41.5	93.5
I am confident that I have acquired the clinical skills required to begin a residency program.					
0.5	1.9	7.4	47.9	42.3	90.2

Another assessment of medical schools' efforts in preparing medical students for residency is the LCME's Annual Medical School Questionnaire Part II.

Particularly relevant to this report are data from the question, "Indicate where in the curriculum the following topics to specifically prepare students for entry to residency training are covered" (question 19 for the 2018-2019 questionnaire). Aggregate data for 151 medical schools are shown, sorted by the sum of the numbers for the five places in the curriculum where the specific topic is taught, as shown in the right-hand column.

Topic	**Required 4th Year Transition to Residency Course**		**Required Sub-internship**	**Required 3rd Year Clinical Clerkship**	**Inter-session in 3rd or 4th Year**	**Total**
	Specialty-specific	**One course for all students**				
Training in clinical procedures	55	57	105	135	51	403
Disease management (general or specialty-specific)	44	53	124	140	30	391
Working in teams	32	76	105	124	53	390
Working with the EHR/health records	22	43	110	135	48	358
Hand-off procedures	35	68	100	93	28	324

Patient safety/reporting medical errors	16	77	70	104	51	318
Advanced communication skills	26	68	84	85	44	307
Stress, wellness, and burnout in residency training	19	81	21	63	58	242
Health system content (e.g., team care, health care financing)	12	72	38	73	47	242
On-call emergencies	39	50	84	73	18	264
Experiencing the life of a resident (e.g., night call/float)	24	35	85	75	6	225
Medical regulatory content (e.g., licensure, discipline, DEA)	8	55	10	23	32	128
ACLS/ATLS training and certification	9	47	9	25	35	125

THE AMA'S ACCELERATING CHANGE IN MEDICAL EDUCATION AND REIMAGING RESIDENCY INITIATIVES

Phase one of the AMA's Accelerating Change in Medical Education initiative, launched in 2013, was intended to:

> [F]oster… a culture of medical education advancement, leading to the development and scaling of innovations at the undergraduate medical education level across the country. After awarding initial grants to 11 U.S. medical schools, the AMA convened these schools to form the Accelerating Change in Medical Education Consortium—an unprecedented collective that facilitated the development and communication of groundbreaking ideas and projects. The AMA awarded grants to an additional 21 schools in 2016. Today, almost one-fifth of all U.S. allopathic and osteopathic medical schools are represented in the 32-member consortium [expanded to 37 schools in 2019], which is delivering revolutionary educational experiences to approximately 19,000 medical students—students who one day will provide care to a potential 33 million patients annually.[3]

Building upon that impetus, in early 2019 the AMA established the Reimagining Residency initiative—a five-year, $15 million grant program to address challenges associated with the transition from UME to GME and the maintenance of progressive development through residency and across the continuum of physician training. Grants are intended to promote systemic change in GME and support bold, creative innovations that establish new curricular content and experiences to enhance readiness for practice, support well-being in training, and (of particular relevance to this report) provide a meaningful and safe transition from UME to GME. Learn more at: ama-assn.org/education/improve-gme/ama-reimagining-residency-initiative.

Included in the Accelerating Change in Medical Education and Reimagining Residency initiatives are grantees that are focusing on the UME/GME transition. For example, at Florida International University (FIU) Herbert Wertheim College of Medicine, readiness for residency is monitored by way of competency-based assessments using the Entrustable Professional Activities (EPAs).

As an awardee for both the UME and GME phases of the AMA's grants, New York University Langone School of Medicine is using its latest grant to further its coaching experience through the "NYU Transition to Residency Advantage." The goal of this work is to "enhance the transition from UME to GME through robust coaching, individualized pathways, and enhanced assessment

tools to enable GME programs to shift away from one-size-fits-all education."[4] Similarly, the University of North Carolina School of Medicine received funding from the Reimagining Residency initiative for Fully Integrated Readiness for Service Training (FIRST): Enhancing the Continuum from Medical School to Residency to Practice. Its goals include "implementing a generalizable health systems science curriculum for GME and competency-based assessment tools that span the educational continuum."[5] In addition, the Association of Professors of Gynecology and Obstetrics received a planning grant for its "Right Resident, Right Program, Ready Day One" project, intended to transform the UME to GME transition for residents entering obstetrics and gynecology programs.

CHALLENGES TO CHANGE

As noted in the introduction, certain innovations that improve the transition from UME to GME may challenge existing processes/systems managed by organizations responsible for medical education accreditation, certification, licensing, and residency matching. For example, one of the innovations being studied in the AMA-led consortium is competency-based medical education, in which learners are advanced to the next level of training upon satisfactory demonstration of the requisite knowledge and skills, versus a strictly time-based system that treats all learners alike. Despite the considerable value of this new paradigm from the learner perspective, it may present hurdles to the system of medical education accreditation, funding, and certification and further inhibit (at least in the short run) the development of a smoother UME/GME transition.

Another concern, which relates to the match into residency, is the growing number of residency program applications being submitted by applicants. This is due, in part, to a growing number of medical school graduates in the U.S. and concerns among residency applicants about limited availability of residency program slots. This issue is particularly pointed in competitive specialties. The increased number of applications is expensive and inefficient for applicants and burdensome for residency program directors and personnel, who must review and prioritize these applications. The rising volume of applications leads programs to employ applicants' scores on the United States Medical Licensing Examination (USMLE) for screening purposes, eliminating applications below a certain arbitrary line.

This process for applicant screening, while understandable given the circumstances, runs counter to AMA policy, which reflects the principle that "selection of residents should be based on a broad variety of evaluative criteria," and asks that ACGME requirements "state clearly that residency program directors must not use NBME or USMLE ranked passing scores as a screening criterion for residency selection."[6] It also lessens the opportunity for holistic review of candidates, through which more intangible attributes and life experience are given equal (if not greater) weight than school grades and examination scores. Indeed, as noted by the authors of a recent perspective in *JAMA*, "the current USMLE 3-digit scores may be distracting the medical education system from the goal of building an innovative, diverse, and resilient physician workforce."[7]

Invitational Conference on USMLE Scoring (InCUS)

The AMA and other leading organizations in medical education convened an invitational conference in March 2019, the Invitational Conference on USMLE Scoring (InCUS), to explore issues around unintended uses of USMLE scores. As noted in a summary report and preliminary recommendations from the meeting, the general consensus among participants is that "[t]he current UME-GME transition system is flawed and not meeting the needs of various stakeholders. Over time, various stakeholder groups have tried to optimize the system for their own purposes, but this has left some, including applicants, with an undue burden and at worst negatively impacted

diversity."[8] One of the recommendations arising from the conference, also noted in the report, is to "[c]onvene a cross-organizational panel to create solutions for the assessment and transition challenges from UME to GME, targeting an approved proposal, including scope/timelines by end of calendar year 2019." As further noted in the report, these challenges would include "[r]educing the number of applications perceived by residency applicants as necessary to obtain a position," "[i]mproving Residency Program Directors' ability to more holistically evaluate candidates," and "[i]mproving the trust of school-based assessments for residency screening and selection."

During the ensuing public comment period, the Council on Medical Education developed and submitted comments on the InCUS recommendations; key points included the following:

- The overemphasis on USMLE performance in the residency application process is unacceptable; a single three-digit score detracts from learning and engaging fully in the medical student experience, and may inhibit schools' implementation of curricular innovation. A holistic approach to assessing applicants, in contrast, with attention given to life experience and emotional intelligence, among other qualities, allows for individual talents to emerge and minimizes the impact of any one point, and may help increase the number of successful applicants from racial/ethnic minority populations.

- Any changes made to the residency application process need to consider the alternative tools for evaluation that remain. Preclinical grades, clinical rotation evaluations, and school-based assessments such as the MSPE/Dean's letter all have considerable shortcomings. Equally problematic is reliance on the reputation of the medical school, which is often determined by research dollars, not the quality of the teaching. Removing the numerical score may discriminate against medical students from new and lesser known U.S. medical schools and U.S. students attending international schools.

- All stakeholders in the process will need to "give" something as part of this transition. For example, students will need to be limited on the number of applications they submit, accrediting bodies (e.g., ACGME, LCME) will need to prohibit the use of USMLE as a program-level metric, and we need to reexamine the Match to see if it is really meeting the current needs. For program directors, a move to pass/fail scores may increase the burden they face in evaluating an ever-growing number of candidates.

- The overarching goal of this work needs to be broadened beyond "to decrease reliance on the USMLE Step 1 score for residency screening" and more toward "to improve and enhance the holistic evaluation of resident applicants."

The dialogue leading to the Council's response encompassed a rich and robust exchange of viewpoints among Council members—reflecting the complexity of these issues and the multiple levers, processes, and people affected by "the system" (including, and most importantly, our patients). Through the Council on Medical Education and senior staff, the AMA will continue to monitor, provide feedback on, and report back to the HOD on the status of outcomes from InCUS.

Additional issues in the UME/GME transition were limned in a forum hosted by the Council on Medical Education during the AMA's 2019 Annual Meeting. These include:

For students:
- The need for honest self-reflection and assessment of strengths and weaknesses.
- The need for honest and effective coaching and mentoring.

For medical schools:

- The need for transparency, accuracy, and honesty in assessments of students.
- The need to balance the responsibility to students (to help them successfully match) with the responsibility to residency programs (to be honest about students' strengths and weaknesses).
- The fear of unsuccessful matches reflecting poorly on the institution.
- "Failure to fail" (that is, the failure to fail those students who should not be advanced).

For residency program directors:

- The need to provide feedback to schools about interns' performance.
- The growing popularity of the "residency boot camp" model (e.g., the Resident Prep Curriculum, a weeklong boot camp to help ease the transition into surgical residency[9]).
- The need for a more holistic review of applications and less reliance on USMLE scores.

Overall:

- Inadequacy of the medical student performance evaluation (MSPE) to distinguish among applicants to residency (in other words, the "Lake Wobegon" effect).
- The need to move beyond the UME, GME, and CME silos to the lifelong learning model.
- Consider high-frequency, low-stakes assessment models, to look at a learner's real-time, cumulative trajectory of growth in knowledge, clinical skills, and professionalism.
- Multiple "scouts" evaluating performance in many types of venues/situations (not just clinical), to average out multiple direct observations.
- The need for free flow of information (in particular, the "right" information—i.e., that which is insightful, without being overwhelming, such that the signal to noise ratio becomes weak).
- Lack of trust among all parties and "gaming" the system; the match process, by its very nature, encourages masking faults and flaws. "Warm handoffs" may help increase trust in the system.

ENTRUSTABLE PROFESSIONAL ACTIVITIES

One framework that may provide a more useful assessment of learners to improve the UME/GME transition are the Core Entrustable Professional Activities (EPAs) for Entering Residency of the AAMC. The EPAs "provide expectations for both learners and teachers that include 13 activities that all medical students should be able to perform upon entering residency, regardless of their future career specialty. The guidelines are based on emerging literature documenting a performance gap at the transition point between medical school and residency training."[10]

SUMMARY

The AMA has taken a lead role in improving and easing the transition from UME to GME for learners, program directors, and patients alike. The process has a wide array of variables and stakeholders. Chief pain points are students submitting an inordinate and increasing number of applications in an attempt to match into programs in their chosen fields, and the (mis)use of USMLE Step 1 scores as a primary screening criterion for interviews. The complexity of the issue demands a wide-ranging solution. Through InCUS and related work, such as the Reimagining Residency initiative, the AMA is working to encourage a transition of the residency application/matching system towards a more holistic evaluation of applicants' full range of competencies and traits that would provide a broader assessment of a student's capabilities and "fit" with a program. In addition, through its Council on Medical Education and its ability to convene key stakeholders involved in medical education, the AMA will continue working to ensure that new residents are ready to undertake the rigors of residency from day one and learn (under supervision) how to serve their patients, from both an individual and a population perspective.

APPENDIX: RELEVANT AMA POLICY

H-295.895, "Progress in Medical Education: Structuring the Fourth Year of Medical School"

It is the policy of the AMA that: (1) Trends toward increasing structure in the fourth year of medical school should be balanced by the need to preserve opportunities for students to engage in elective clinical and other educationally appropriate experiences.
(2) The third and fourth years as a continuum should provide students with a broad clinical education that prepares them for entry into residency training.
(3) There should be a comprehensive assessment of clinical skills administered at a time when the results can be used to plan each student's fourth-year program, so as to remedy deficiencies and broaden clinical knowledge.
(4) Medical schools should develop policies and procedures to ensure that medical students receive counseling to assist them in their choice of electives.
(5) Adequate and timely career counseling should be available at all medical schools.
(6) The ability of medical students to choose electives based on interest or perceived academic need should not be compromised by the residency selection process. The American Medical Association should work with the Association of American Medical Colleges, medical schools, and residency program directors groups to discourage the practice of excessive audition electives.
(7) Our AMA should continue to work with relevant groups to study the transition from the third and fourth years of medical school to residency training, with the goal of ensuring that a continuum exists in the acquisition of clinical knowledge and skills.
(CME Rep. 1, I-98 Reaffirmed: CME Rep. 9, A-07 Reaffirmed: CME Rep. 01, A-17)

H-295.862, "Alignment of Accreditation Across the Medical Education Continuum"

1. Our AMA supports the concept that accreditation standards for undergraduate and graduate medical education should adopt a common competency framework that is based in the Accreditation Council for Graduate Medical Education (ACGME) competency domains.

2. Our AMA recommends that the relevant associations, including the AMA, Association of American Medical Colleges (AAMC), American Osteopathic Association (AOA), and American Association of Colleges of Osteopathic Medicine (AACOM), along with the relevant accreditation bodies for undergraduate medical education (Liaison Committee on Medical Education, Commission on Osteopathic College Accreditation) and graduate medical education (ACGME, AOA) develop strategies to:
a. Identify guidelines for the expected general levels of learners' competencies as they leave medical school and enter residency training.
b. Create a standardized method for feedback from medical school to premedical institutions and from the residency training system to medical schools about their graduates' preparedness for entry.
c. Identify areas where accreditation standards overlap between undergraduate and graduate medical education (e.g., standards related to the clinical learning environment) so as to facilitate coordination of data gathering and decision-making related to compliance.
All of these activities should be codified in the standards or processes of accrediting bodies.

3. Our AMA encourages development and implementation of accreditation standards or processes that support utilization of tools (e.g., longitudinal learner portfolios) to track learners' progress in achieving the defined competencies across the continuum.

4. Our AMA supports the concept that evaluation of physicians as they progress along the medical education continuum should include the following: (a) assessments of each of the six competency domains of patient care, medical knowledge, interpersonal and communication skills, professionalism, practice-based learning and improvement, and systems-based practice; and (b) use of assessment instruments and tools that are valid and reliable and appropriate for each competency domain and stage of the medical education continuum.

5. Our AMA encourages study of competency-based progression within and between medical school and residency.
a. Through its Accelerating Change in Medical Education initiative, our AMA should study models of competency-based progression within the medical school.
b. Our AMA should work with the Accreditation Council for Graduate Medical Education (ACGME) to study how the Milestones of the Next Accreditation System support competency-based progression in residency.

6. Our AMA encourages research on innovative methods of assessment related to the six competency domains of the ACGME/American Board of Medical Specialties that would allow monitoring of performance across the stages of the educational continuum.

7. Our AMA encourages ongoing research to identify best practices for workplace-based assessment that allow performance data related to each of the six competency domains to be aggregated and to serve as feedback to physicians in training and in practice.
(CME Rep. 4, A-14 Appended: CME Rep. 10, A-15)

D-295.317, “Competency Based Medical Education Across the Continuum of Education and Practice”

1. Our AMA Council on Medical Education will continue to study and identify challenges and opportunities and critical stakeholders in achieving a competency-based curriculum across the medical education continuum and other health professions that provides significant value to those participating in these curricula and their patients.

2. Our AMA Council on Medical Education will work to establish a framework of consistent vocabulary and definitions across the continuum of health sciences education that will facilitate competency-based curriculum, andragogy and assessment implementation.

3. Our AMA will continue to explore, with the Accelerating Change in Medical Education initiative and with other stakeholder organizations, the implications of shifting from time-based to competency-based medical education on residents’ compensation and lifetime earnings.
(CME Rep. 3, A-14 Appended: CME Rep. 04, A-16)

H-275.953, “The Grading Policy for Medical Licensure Examinations”

1. Our AMA’s representatives to the ACGME are instructed to promote the principle that selection of residents should be based on a broad variety of evaluative criteria, and to propose that the ACGME General Requirements state clearly that residency program directors must not use NBME or USMLE ranked passing scores as a screening criterion for residency selection.
2. Our AMA adopts the following policy on NBME or USMLE examination scoring: (a) Students receive "pass/fail" scores as soon as they are available. (If students fail the examinations, they may request their numerical scores immediately.) (b) Numerical scores are reported to the state licensing authorities upon request by the applicant for licensure. At this time, the applicant may

request a copy of his or her numerical scores. (c) Scores are reported in pass/fail format for each student to the medical school. The school also receives a frequency distribution of numerical scores for the aggregate of their students.
3. Our AMA will co-convene the appropriate stakeholders to study possible mechanisms for transitioning scoring of the USMLE and COMLEX exams to a Pass/Fail system in order to avoid the inappropriate use of USMLE and COMLEX scores for screening residency applicants while still affording program directors adequate information to meaningfully and efficiently assess medical student applications, and that the recommendations of this study be made available by the 2019 Interim Meeting of the AMA House of Delegates.
4. Our AMA will: (a) promote equal acceptance of the USMLE and COMLEX at all United States residency programs; (b) work with appropriate stakeholders including but not limited to the National Board of Medical Examiners, Association of American Medical Colleges, National Board of Osteopathic Medical Examiners, Accreditation Council for Graduate Medical Education and American Osteopathic Association to educate Residency Program Directors on how to interpret and use COMLEX scores; and (c) work with Residency Program Directors to promote higher COMLEX utilization with residency program matches in light of the new single accreditation system. (CME Rep. G, I-90 Reaffirmed by Res. 310, A-98 Reaffirmed: CME Rep. 3, A-04 Reaffirmed: CME Rep. 2, A-14 Appended: Res. 309, A-17 Modified: Res. 318, A-18 Appended: Res. 955, I-18)

REFERENCES

[1] Medical School Graduation Questionnaire 2018: All Schools Summary Report, July 2018. Association of American Medical Colleges. Available at: https://www.aamc.org/download/490454/data/2018gqallschoolssummaryreport.pdf. Accessed July 19, 2019.

[2] Ibid.

[3] American Medical Association Council on Medical Education Report 2-I-18, "Accelerating Change in Medical Education Consortium Outcomes."

[4] AMA Reimagining Residency initiative. American Medical Association. Available at: https://www.ama-assn.org/education/improve-gme/ama-reimagining-residency-initiative. Accessed July 22, 2019.

[5] Ibid.

[6] The Grading Policy for Medical Licensure Examinations H-275.953. AMA Policy Finder. Available at: https://policysearch.ama-assn.org/policyfinder/detail/residency%20USMLE?uri=%2FAMADoc%2FHOD.xml-0-1931.xml. Accessed July 22, 2019.

[7] Swails JL, Aibana O, Stoll BJ. The Conundrum of the United States Medical Licensing Examination Score Reporting Structure. *JAMA*. Published online July 19, 2019. doi:10.1001/jama.2019.9669

[8] Summary Report and Preliminary Recommendations from the Invitational Conference on USMLE Scoring (InCUS), March 11-12, 2019. United States Medical Licensing Examination website. https://www.usmle.org/pdfs/incus/incus_summary_report.pdf. Accessed July 22, 2019.

[9] Pre-residency boot camps prep med school grads for new realities. American Medical Association. Available at: https://www.ama-assn.org/residents-students/residency/pre-residency-boot-camps-prep-med-school-grads-new-realities. Accessed July 22, 2019.

[10] The Core EPA for Entering Residency Frequently Asked Questions (FAQ). Association of American Medical Colleges. Available at: https://www.aamc.org/initiatives/coreepas/coreepasfaq/. Accessed July 30, 2019.

Elections

Election for APS Governing Council at-large member
Nominations for 2020-2021 APS Governing Council members

For the best user experience, please download a copy of this handbook to your personal device

Election for APS Governing Council at-large member

The officers of the APS are the nine Governing Council (GC) members:

- Chair
- Chair-elect
- Immediate Past Chair
- Delegate
- Alternate Delegate
- At-large member (3)
- Liaison to the AMA Council on Medical Education

For November 2019, the APS GC has one opening for at-large member, due to the election of Sharon Douglas, MD to the Council on Medical Education in June.

The APS nominations committee solicited nominations and reviewed a number of well qualified candidates for this opening. The committee recommended to the APS GC that the following APS member be considered by the APS to fill this position; the GC approved this recommendation:

Name	Institution	Position	Past APS experience
Mark Meyer, MD	University of Kansas School of Medicine	Associate Dean for Student Affairs	APS membership committee, 2019 to present

Respectfully submitted,

Hal B. Jenson, MD, MBA, Chair, Academic Physicians Section Nominations Committee

Nominations for 2020-2021 APS Governing Council and Membership Committee members

The officers of the APS are the nine Governing Council (GC) members:

- Chair
- Chair-elect
- Immediate Past Chair
- Delegate
- Alternate Delegate
- At-large member (3)
- Liaison to the AMA Council on Medical Education

For June 2020, the APS GC and APS Membership Committee have the following openings:

Position	Opening(s)	Term length (years)	Maximum number of terms	Maximum length of service (years)
Chair-elect	1	1	1	1*
Delegate	1	2	3	6
Alternate delegate	1	2	3	6
Member-at-Large	3	1	3	3
Membership Committee Member-at-Large	3	2	3	6

** Three-year cycle—one year each as chair-elect, chair, and immediate past chair.*

The APS nominations committee solicits qualified candidates for these openings beginning in January of each year, with a deadline of early March for submission of applications. The committee then meets to review the applications and develop a proposed slate of candidates. This slate is presented by the committee to the APS Governing Council in April; if approved by the GC, this slate is then presented to the APS at its business meeting in June for voting by APS members.

To learn more about the duties of the GC and the Membership Committee and seek nomination to these positions, contact APS staff at fred.lenhoff@ama-assn.org or (312) 464-4635.

Educational materials

Session descriptions
Educational session faculty
Other AMA meeting educational programming

For the best user experience, please download a copy of this handbook to your personal device

AMA AMERICAN MEDICAL ASSOCIATION | MEMBERSHIP MOVES MEDICINE™

The Power and Promise of Project ECHO to Enhance Patient Care through Empowered Learner Communities

2019 AMA Interim Meeting

1:45 p.m. – 2:45 p.m. | Friday, November 15 | Harbor G
Manchester Grand Hyatt | San Diego, California
1.0 AMA PRA Category 1 Credits

Program Description

Participants in this live session during the American Medical Association 2019 Interim Meeting will learn about the Project ECHO model for delivering medical education to and from diverse and far-flung educator/trainee communities. Learners will be able to describe how ECHO is used to support the health care needs of underserved communities and the educational needs of students, physicians, and trainees in medical schools and teaching hospitals, and explain the role of these institutions and their faculty in providing an ECHO program. Project ECHO facilitates the delivery of specialist-quality care across the "last kilometer" between medical centers and far-flung communities of patients, physicians, and other members of health care teams, and empowers community-based physicians to deliver a quality of care previously limited to large medical centers.

To claim your credit, visit the AMA Ed Hub™—your center for personalized learning from sources you trust. amaedhub.com/pages/ama-interim-meeting-2019

Deadline for claiming CME credit is **December 31, 2019**. For questions, contact us at (800) 337-1599 or HODmeetingsupport@ama-assn.org

AMA AMERICAN MEDICAL ASSOCIATION | MEMBERSHIP MOVES MEDICINE™

Recruiting, Retaining, 'Retraining,' and Rewarding Community Physicians

2019 AMA Interim Meeting

Co-hosted by the AMA Senior Physicians Section (AMA-SPS)

3 p.m. – 4 p.m. | Friday, November 15 | Harbor G
Manchester Grand Hyatt | San Diego, California
1.0 AMA PRA Category 1 Credits

Program Description

Join fellow medical educators nationwide to learn strategies for recruiting, training, rewarding, and retaining community-based faculty for your medical students and residents. During this session, participants will learn tools and strategies to best engage community-based physicians in medical education. After a general presentation, the faculty will engage the audience in discussion of currently validated strategies as well as solicitation of new ideas and innovations.

To claim your credit, visit the AMA Ed Hub™—your center for personalized learning from sources you trust. amaedhub.com/pages/ama-interim-meeting-2019

Deadline for claiming CME credit is **December 31, 2019**. For questions, contact us at (800) 337-1599 or HODmeetingsupport@ama-assn.org

Update on ABMS Continuing Board Certification

2019 AMA Interim Meeting

Co-hosted by the AMA Academic Physicians Section (AMA-APS), the AMA Young Physicians Section (AMA-YPS), and the AMA Council on Medical Education

9:45 a.m. – 11 a.m. | Saturday, November 16 | Grand Hall D
Manchester Grand Hyatt | San Diego, California
1.25 AMA PRA Category 1 Credits

Program Description

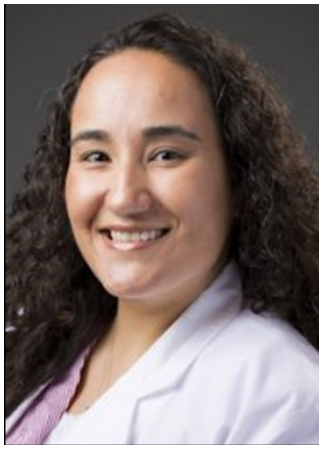
This live session at the American Medical Association 2019 Interim Meeting focuses on the work of the Continuing Board Certification (CBC): Vision for the Future Commission. This independent body of 27 individuals representing diverse stakeholders came together to envision a CBC system that is meaningful, relevant, and of value to physicians while continuing to be responsive to the patients, hospitals, and others who rely on certification as an indicator of current knowledge and skills in a specialty.

Participants will learn about CBC, which has replaced Maintenance of Certification (MOC), and the advantages of participation in board certification. Learners will also be able to explain the AMA's current position on CBC and its ongoing contributions to improvements in MOC/CBC to ensure optimal benefit to physician participants.

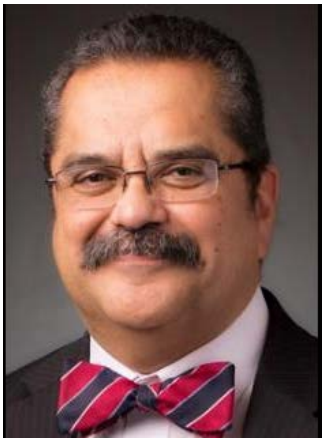
To claim your credit, visit the AMA Ed Hub™—your center for personalized learning from sources you trust. amaedhub.com/pages/ama-interim-meeting-2019

Deadline for claiming CME credit is **December 31, 2019**. For questions, contact us at (800) 337-1599 or HODmeetingsupport@ama-assn.org

Educational session faculty *(listed in alphabetical order)*



Lisa Ayoub-Rodriguez, MD is an Assistant Professor at Texas Tech Health Science Center El Paso and works as a hospitalist at El Paso Children's Hospital. She also serves as Division Chief of Pediatric Hospital Medicine. She earned her medical degree at University of Texas Southwestern and trained at Cincinnati Children's for pediatric residency. Her goal was to strengthen her skill set as much as possible before returning home to El Paso to fulfill her dream of improving health care in the border region. She is passionate about the border community, given its high rates of un- and underinsured along with high rates of poverty that have colored the region's medical milieu. She has dedicated her career path to developing local experts in the field of border health by developing a Border Health Curriculum for the Texas Tech pediatric residency program and working toward expansion to other programs. She is an advocate for underserved and immigrant children and has spoken nationally as an expert on immigrant child health. She is also married and has a young child with Down Syndrome, which has brought tremendous joy and new life adventures.



Jose Manuel de la Rosa, MD, currently serves as chair of the AMA Academic Physicians Section Governing Council. He is Vice President for Outreach and Community Engagement, Professor of Pediatrics, and Founding Dean at Texas Tech University Health Sciences Center Paul L. Foster School of Medicine in El Paso. He also works closely with local and federal public and private entities, along with school districts and medical societies, to strengthen and develop community relations. As Professor of Pediatrics, Dr. de la Rosa's involvement with the community led to the establishment of the Kellogg Community Partnership Clinics, four school-based clinics that provided services to *colonia* residents in El Paso's Lower Valley. Appointed by former President George Bush in 2003, Dr. de la Rosa continues to serve on the United States/Mexico Border Health Commission. He represents the American Academy of Pediatrics in its partnership with the Centers for Disease Control and Prevention in addressing Zika awareness on the border and is active as a member of the American Association of Medical Colleges, American Academy of Pediatrics, and other national organizations.

Richard E. Hawkins, MD, is President and Chief Executive Officer of the American Board of Medical Specialties (ABMS). Dr. Hawkins has more than 35 years of professional experience ranging from service in the United States Navy as an officer in the Medical Corps to leadership positions at national medical associations. Prior to joining ABMS in 2018, he served for five years as AMA's Vice President for Medical Education Outcomes, providing leadership for the Accelerating Change in Medical Education initiative, as well as to the Council on Medical Education and Academic Physicians Section. Previously, he was Senior Vice President for Professional and Scientific Affairs at ABMS, where he led educational, assessment, and international initiatives. Prior to that, he was Vice President for Assessment Programs at the National Board of Medical Examiners. Dr. Hawkins is Board Certified in Internal Medicine and Infectious Diseases by the American Board of Internal Medicine.

Cynda Ann Johnson, MD, MBA currently serves as AMA Academic Physicians Section Liaison to the Council on Medical Education. Dr. Johnson is Founding Dean Emerita of Virginia Tech Carilion School of Medicine. She has also served as Dean of the Brody School of Medicine at East Carolina University Chair of Family Medicine and Director of the Family Care Center at the University of Iowa; and Residency Director and Interim Chair of Family Medicine at the University of Kansas. A family medicine physician, Dr. Johnson has held a number of national roles in medical education, including Chair, American Board of Medical Specialties; Chair, American Board of Family Medicine; Trustee, Society of Teachers of Family Medicine Foundation; Vice President, The Foundation for the History of Women in Medicine; At Large-Member, Association of American Medical Colleges Council of Deans Administrative Board; and Chair, Commonwealth Health Research Board. She is also an active community leader and volunteer and philanthropic supporter of many organizations.

Cynthia Jumper, MD, MPH is a Professor of Medicine and Vice President of Health Policy at Texas Tech University Health Sciences Center. As a former Chair of Internal Medicine and with over 25 years of experience as an academic physician, she has served on many academic and professional committees and has been active in policy/advocacy at the local, state and national level. She holds elected positions in the Texas Medical Association, American Medical Association, and Texas Chapter of the American College of Physicians. After working in intensive care units for decades, she has turned her focus to population health and policy. Helping to start a new Masters of Public Health program at TTUHSC and watching it grow has been a privilege. Honors include AOA, induction as a Master in the American College of Physicians and in the TTUHSC Teaching Academy.

Alma B. Littles, MD, APS alternate delegate, is Senior Associate Dean for Medical Education and Academic Affairs at Florida State University College of Medicine. As the school's chief academic officer, Dr. Littles oversees the curriculum leading to the M.D. degree. She joined FSU in 2002 as founding chair of the Department of Family Medicine and Rural Health and led the development of the college's curriculum and its six regional campuses and rural educational programs for clinical training. Dr. Littles also served as the college's first Designated Institutional Official when it assumed sponsorship of its first two residency programs in 2006. A graduate of the University of Florida College of Medicine and Tallahassee Memorial Hospital Family Medicine Residency Program, Dr. Littles has been involved in medical education since 1989, when she began precepting medical students and residents in her solo family practice in Quincy, Florida. Past and current service includes as president of the Florida Academy of Family Physicians and the Capital Medical Society; chair of the APS; and member of the Advisory Board of the Robert Graham Center as well as the National Board of Medical Examiners Advisory Committee for Medical School Programs. Dr. Littles continues to advocate for quality health care for citizens in rural communities and fully understands the need to recruit students from rural and other underserved populations to pursue the medical profession.

Christie L. Morgan, MD is a board-certified otolaryngologist – head and neck surgeon. She completed her undergraduate education at Johns Hopkins University, her Master of Science in Biophysics at Georgetown University, and her medical degree from Boston University School of Medicine. She completed her otolaryngology residency at Boston University Medical Center. Dr. Morgan is a Senior Staff Surgeon in the Henry Ford Health System Department of Otolaryngology and a Clinical Assistant Professor at Wayne State University School of Medicine. She is actively engaged in clinical practice, teaching, and research. She is the Service Chief for Quality and Patient Safety for the Otolaryngology Department at Henry Ford Hospital and oversees the activities of the Peer Review Committee. She is a member of the Henry Ford Hospital Medical Staff Quality Committee. She is the Chair of the American Board of Medical Specialties Task Force on Professionalism and currently serves as Immediate Past Chair of the AMA Young Physicians Section.

Ron Stock, MD, MA, is Clinical Innovation Advisor to the Oregon Rural Practice-based Research Network (ORPRN) at Oregon Health & Sciences University (OHSU), where he is accountable for development of the Oregon ECHO Network, a multi-stakeholder consortium to support a statewide Project ECHO tele-mentoring infrastructure. He is currently a Clinical Associate Professor of Family Medicine at OHSU, former Director of Clinical Innovation at the Oregon Health Authority Transformation Center, geriatrician, family physician and clinical health services researcher. With support from public and private non-profit grants, he has dedicated his career to improving the quality of health care for vulnerable populations with complex care needs, through redesigning the primary care delivery system in the community using an interdisciplinary team model. Dr. Stock has participated in numerous invited expert panels, including the Institute of Medicine Best Practices Innovation Collaborative on Team-Based Care, an IOM Task Force exploring the role of patients on teams, Agency for Healthcare Research and Quality panels on measurement of team-based primary care, and a National Quality Forum workgroup advising HHS on quality measures for public reporting and pay-for-performance. He is co-editor of the book “Health Reform Policy to Practice: Oregon’s Path to a Sustainable Health System.”

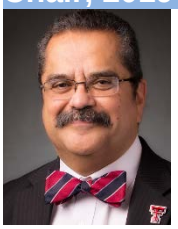
About the APS

Governing Council
Members
Membership form
APS 2019 Annual Meeting highlights
APS 2019 Annual Meeting recommendations on HOD items
Future meeting dates
Internal Operating Procedures
Contact information

For the best user experience, please download a copy of this handbook to your personal device

Academic Physicians Section Governing Council, 2019-2020

Chair, 2019-2020



Jose Manuel de la Rosa, MD *(Pediatrics)*
Vice President for Outreach and Community Engagement, and Professor of Pediatrics
Texas Tech University Health Sciences Center Paul L. Foster School of Medicine

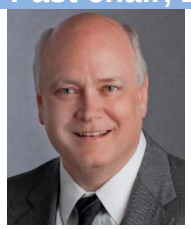
Work: (915) 215-4299 Cell: (915) 892-9008
jmanuel.delarosa@ttuhsc.edu

Chair-elect, 2019-2020

Gary M. Gaddis, MD, PhD *(Emergency medicine)*
Professor of Emergency Medicine
Washington University in Saint Louis School of Medicine

Work: (816) 932-2057 Cell: (913) 221-5307
gary.gaddis@wustl.edu

Past chair, 2019-2020



Hal B. Jenson, MD, MBA *(Pediatrics)*
Founding Dean
Western Michigan University Homer Stryker M.D. School of Medicine

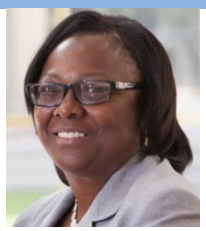
Work: (269) 337-4505 Cell: (269) 569-2777
hal.jenson@med.wmich.edu

Delegate, 2018-2020

Kenneth B. Simons, MD *(Ophthalmology)*
Senior Associate Dean for Graduate Medical Education and Accreditation, Medical College of Wisconsin; Executive Director and DIO, MCWAH

Work: (414) 955-4396 Cell: (414) 416-6940
ksimons@mcw.edu

Alternate delegate, 2018-2020



Alma B. Littles, MD *(Family medicine)*
Senior Associate Dean for Medical Education and Academic Affairs
Florida State University College of Medicine

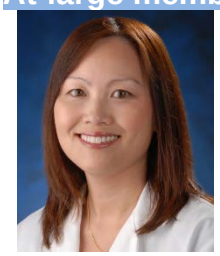
Work: (850) 644-5905 Cell: (850) 597-1018
alma.littles@med.fsu.edu

Liaison to Council on Medical Education, 2018-2021

Cynda Ann Johnson, MD, MBA *(Family medicine)*
Founding Dean Emerita
Virginia Tech Carilion School of Medicine

Cell: (540) 589-0069
Samstolte@yahoo.com

At-large member, 2019-2020



Khanh-Van T. Le-Bucklin, MD *(Pediatrics)*
Vice Dean,
Medical Education
University of California, Irvine School of Medicine

Work: (949) 824-8405 Cell: (714) 322-6746
klebuckl@uci.edu

At-large member, 2019-2020

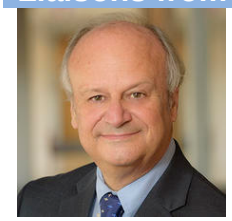
Charles Kent Smith, MD *(Family medicine)*
Senior Associate Dean for Student Affairs, and Professor of Family Medicine and Community Health, Case Western Reserve U SOM

Work: (216) 368-3164 Cell: (216) 973-1492
cks@case.edu

At-large member, 2019-2020

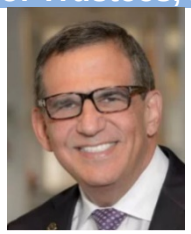
Vacant, due to Sharon Douglas's election to the Council on Medical Education in June 2019; vacancy to be filled via election at next APS business meeting, November 2019

Liaisons from the AMA Board of Trustees, 2019-2020



Mario E. Motta, MD
Cardiovascular medicine
Salem, Massachusetts
Associate Professor of medicine,
Tufts University School of Medicine

mario.motta@ama-assn.org



Russell W.H. Kridel, MD
Facial plastic and reconstructive surgeon,
Houston, Texas

Russ.Kridel@ama-assn.org

Willie Underwood, III, MD, MSc, MPH
Urologist, Buffalo, NY

Willie.Underwood@ama-assn.org

Staff

Fred Lenhoff, MA
Director, Academic Physicians Section

Work: (312) 464-4635 Cell: 708-833-9139
fred.lenhoff@ama-assn.org

Alejandro Aparicio, MD
Director, Medical Education Programs

(312) 464-5531 Cell: (773) 640-0493
alejandro.aparicio@ama-assn.org

TeRhonda McGee
Staff Assistant

(312) 464-4579 Cell: (630) 857-8040
terhonda.mcgee@ama-assn.org

Academic Physicians Section (AMA-APS) members

The three avenues to APS membership are:

1. Dean-appointed: An AMA-member physician appointed by the dean of any United States medical school (with an educational program provided by a college of medicine or osteopathic medicine accredited by the Liaison Committee on Medical Education or the American Osteopathic Association leading to the MD or DO degree) to represent undergraduate, graduate or continuing medical education at the institution.

2. Self-nominated (faculty appointment): An AMA-member physician who holds a faculty appointment of any type at a United States medical school with an educational program provided by a college of medicine or osteopathic medicine accredited by the LCME or the AOA leading to the MD or DO degree.

3. Self-nominated (no faculty appointment): An AMA-member physician who does not hold a medical school faculty appointment, but has an active role in undergraduate, graduate, or continuing medical education or who serves in a clinical/research capacity with an academic medical center, community hospital, or other health care setting.

Alabama

University of Alabama School of Medicine

Selwyn M. Vickers, MD, SVP of Medicine and Dean

University of South Alabama College of Medicine

John V. Marymont, MD , MBA, Dean, Vice President for Medical Affairs

- Jack Di Palma, MD
  Professor, internal medicine
- David A. Gremse, MD
  Professor and Chair, Pediatrics
- Edward A. Panacek, MD
  Professor and Chair, Emergency Medicine

Arizona

University of Arizona College of Medicine - Phoenix

- Michael Grossman, MD, MACP
  Special Assistant to the Dean, and Professor emeritus, internal medicine and biomedical informatics

University of Arizona College of Medicine - Tucson

- Kevin F. Moynahan, MD, FACP
  Deputy Dean for Medical Education, and Professor of Medicine

Arkansas

University of Arkansas for Medical Sciences College of Medicine

- Omar T. Atiq, MD
  Professor of Medicine and Otolaryngology-Head and Neck Surgery, and Director, Cancer Service Line, UAMS Medical Center
- James Clardy, MD
  Associate Dean for Graduate Medical Education, and Professor of Psychiatry
- Charles James Graham, MD
  Associate Dean of Undergraduate Medical Education
- Charles W. Smith, Jr., MD
  Executive Associate Dean, Clinical Affairs

California

California Northstate University College of Medicine

Joseph Silva, Jr., MD, Dean

Kaiser Permanente School of Medicine

Mark A. Schuster, MD, PhD, Founding Dean and CEO

Keck School of Medicine of the University of Southern California

Laura Mosqueda, MD, Dean, Chair, Dept. of Family Med,Professor of Family Medicine & Geriatrics; Associate Dean of Primary Care

- Sachin "Sunny" Jha, MD, MS
  Assistant Clinical Professor of Anesthesiology
- Scott E. Nass, MD, MPA
  Director of Inpatient Education

Loma Linda University School of Medicine

Tamara Lynn Thomas, MD, Executive Vice President for Medical Affairs and Dean

- Daniel W. Giang, MD
  Associate Dean, Graduate Medical Education
- June-Anne Gold
  Professor, and AMA IMG delegate
- Sara Marie Roddy, MD
- Tamara Shankel, MD
  Associate Dean, Clinical Education, Associate Professor, Medical Education

Stanford University School of Medicine

Lloyd B. Minor, MD, Carl and Elizabeth Naumann Dean, Professor of Otolaryngology, Head & Neck Surgery

Touro University - California College of Osteopathic Medicine

Michael B. Clearfield, DO, Dean

- Peter N Bretan, MD, FACS
  Adjunct Professor of Urology

University of California, Davis School of Medicine

- Mark E. Servis, MD
  Senior Associate Dean for Medical Eduation, and Professor in Psychiatry and Behavioral Sciences

University of California, Irvine School of Medicine

Michael J. Stamos, MD, Dean

- Mark Langdorf, MD, MHPE
  Professor of Clinical Emergency Medicine
- Khanh-Van T. Le-Bucklin, MD
  Vice Dean, Medical Education
- Deena Shin McRae, MD
  Associate Dean of Graduate Medical Education and Designated Institutional Official
- Kyle Paredes, MD, MBA
  Assistant Dean for Student Affairs
- Matthew Reed, MD
  Assistant Dean for Student Affairs

University of California, Los Angeles David Geffen School of Medicine

- Carol D. Berkowitz, MD
  Chief, Division of General Pediatrics, and Distinguished Professor of Pediatrics
- Clarence H. Braddock, III, MD, MPH
  Vice Dean for Education, and Professor of Medicine

University of California, Riverside School of Medicine

Deborah Deas, MD, MPH, Mark and Pam Rubin Dean and CEO for clinical affairs

- Mahendr S. Kochar, MD
  Associate Dean, Graduate Medical Education
- Gerald A. Maguire, MD, DFAPA
  Professor and Chair, Psychiatry and Neuroscience
- Michael N. Nduati, MD, MBA, MPH
  Associate Dean, Clinical Affairs

University of California, San Diego School of Medicine

Steven Robt Garfin, MD, Interim Dean

- John F. Alksne, MD
  Vice Chancellor Health Sciences and Dean
- David Emil Jos Bazzo, MD
- Ruth M. Covell, MD
  Professor, Family and Preventive Medicine
- Kyle P. Edmonds, MD
  Clinical Associate Professor, Palliative Care, and AAHPM delegate
- William R Freeman, MD
- Lawrence Friedman, MD
  Associate Dean of Clinical Affairs
- Michael Henry Goldbaum, MD
- David Alan Guss, MD
  Chair, UC San Diego Department of Emergency Medicine
- Dilip Vishwanath Jeste, MD
- Marilyn C Jones, MD
- Don Osami Kikkawa, MD
- Thomas James Kipps, MD
- Albert Russell Laspada, MD
- Thomas Moore
  Dean of Clinical Affairs
- William Arthur Norcross, MD
- Kevin Michael Patrick, MD
- Steven Chas Plaxe, MD
- Anne Christine Roberts, MD
  Professor of Radiology
- Maria C. Savoia, MD
  Dean for Medical Education
- Angela Lynn Scioscia, MD
- Mark Vito Speziale, MD, PhD
- Maryam Tarsa, MD

University of California, San Francisco, School of Medicine

Talmadge E. King, Jr, MD, Dean, Vice Chancellor for Medical Affairs

- Bobby Baron, MD
  Associate Dean of Graduate Medical Education and CME
- Elena Fuentes-Afflick, MD
  Vice Dean, Academic Affairs, and Professor and Vice Chair, Pediatrics
- Catherine R. Lucey, MD
  Executive Vice Dean and Vice Dean for Education, and Professor of Medicine
- Jack S. Resneck, Jr., MD
  Vice Chair, Department of Dermatology, and AAD delegate

Western University of Health Sciences College of Osteopathic Medicine of the Pacific

- David A. Connett, DO, FACOFP
  Vice Dean, and Professor of Family Medicine

Colorado

Rocky Vista University College of Osteopathic Medicine

- Jan M Kief, MD
  Clinical Adjunct Faculty, Department of Primary Care
- Brandi N. Ring, MD
  Obstetrician-gynecologist, and Assistant Clinical Professor

University of Colorado School of Medicine

- Peter M. Buttrick, MD
  Sr. Associate Dean for Academic Affairs
- Donald G. Eckhoff, MD
  Professor, Orthopaedics
- Carolyn Green, MD
  Professor of Clinical Practice, Pediatrics-Neurology
- Carol M. Rumack, MD
  Associate Dean, Graduate Medical Education

Connecticut

Frank H. Netter, MD School of Medicine at Quinnipiac University

Bruce M. Koeppen, MD, PhD, Founding Dean

University of Connecticut School of Medicine

Bruce T. Liang, MD, Dean

Yale University School of Medicine

- Myron Genel, MD
  Professor Emeritus of Pediatrics, and Senior Research Scientist
- Stephen J Huot, MD, PhD
  Associate Dean for Graduate Medical Education, and Professor of Medicine

District of Columbia

Georgetown University School of Medicine

Stephen Ray Mitchell, MD, Dean for Medical Education, Professor, Pediatrics and Medicine

- William R. Ayers, MD
  Professor Emeritus, and VP, ECFMG
- Earl Harley, MD
  Professor, Otolaryngology
- Fred Hyde, MD
  Adjunct Associate Professor, and Clinical Professor, Columbia

Howard University College of Medicine

Hugh E Mighty, MD, Dean, Vice President of Clinical Affairs

- Sheik N. Hassan, MD
  Associate Dean For Academic Affairs

Florida

Charles E. Schmidt College of Medicine at Florida Atlantic University

- John Newcomer, MD
  Professor of Integrated Medical Science, and Adjunct Professor of Psychiatry, Washington University School of Medicine in St. Louis
- Sarah Wood, MD
  Senior Associate Dean for Medical Education

Florida State University College of Medicine

John P. Fogarty, MD, Dean

- John Ellis Agens, MD
- Christienne P. Alexander, MD
  Assistant Professor, family medicine and rural health
- Leslie M Beitsch, MD
- Bruce Howard Berg, MD, MBA
  Regional Campus Dean - Sarasota
- Randall Bertolette, MD
  Regional Campus Dean, Ft. Pierce
- Lisa Jeanne Granville, MD
  Associate Chair, Professor of Geriatrics
- Alma B. Littles, MD
  Senior Associate Dean for Medical Education and Academic Affairs
- Juliette Lomax-Homier, MD
  Regional Campus Dean, Fort Pierce
- Paul Allen Mc Leod, MD
  Senior Associate Dean for Regional Campuses, Pensacola Regional Campus
- Joan Younger Meek, MD, MS, RD, FAAP FABM IBCLC
  Associate Dean for Graduate Medical Education
- Michael Jos Muszynski, MD
  Regional Campus Dean, Orlando, and Associate Dean for Clinical Research
- Daniel J Van Durme, MD , MPH , FAAFP
  Associate Dean for Clinical and Community Affairs, and Professor and Chair, Department of Family Medicine & Rural Health
- Robert T. Watson, MD
  Professor of Neurology, Dept. of Clinical Sciences

Nova Southeastern University College of Osteopathic Medicine

Elaine M Wallace, DO, Dean

- James Thos Howell, MD
  Chair, Dept of Rural and Underserved Medicine; Assistant Dean for Professional Relations, and Professor of Public Health
- Mark Sandhouse, DO
  Associate Dean, Administration

Nova Southeastern University Dr Kiran C Patel College of Allopathic Medicine

- Kevin C. King, MD, MS
  Academic Chair, Residency Director, Kendall Regional Medical Center
- Vijaykumar Rajput, MD
  Professor and chair of medical education

University of Central Florida College of Medicine

Deborah C. German, MD, Vice President for UCF Medical Affairs, Dean, College of Medicine

- Bethany Ballinger, MD
  Associate Professor
- Latha Ganti, MD
  Professor, emergency medicine
- Elias A Giraldo, MD, MS
  Professor and Director, Neurology Residency Program
- Nita Kohli, MD
  Volunteer faculty, Assistant Professor
- Luis A. Mojicar, MD
  Assistant Professor of Medicine
- David A. Weinstein, MD
  Assistant Professor, Dermatology
- Lisa L Zacher, MD, MACP, FCCP
  Associate Dean for Veterans Affairs, and Associate Professor of Internal Medicine
- Vania Zayat, MD
  Assistant Professor of Pathology

University of Florida College of Medicine

J. Adrian Tyndall, MD, Interim dean, Chair, Dept of Emergency Medicine

- Joseph C. Fantone, MD
  Senior Associate Dean for Educational Affairs
- Timothy C. Flynn, MD
  Senior Associate Dean for Clinical Affairs

University of Miami Leonard M. Miller School of Medicine

Henri R. Ford, MD, Dean

- Steven Falcone, MD
  Executive Dean for Clinical Affairs, and UM CEO at Jackson Hospital

USF Health Morsani College of Medicine

Charles J. Lockwood, MD, MHCM, Dean, USF Health Morsani CoM, Senior Vice President for USF Health

- Harry Van Loveren, MD
  Professor, Chair & Associate Dean, College of Medicine Neurosurgery, and David W. Cahill Professor & Chair, Dept of Neurosurgery & Brain Repair

Georgia

Emory University School of Medicine

- William Allen Bornstein, MD, PhD
  Chief Medical Officer and Chief Quality & Patient Safety Officer, and Professor of Medicine (Endocrinology, Metabolism and Lipids)
- Sandra Fryhofer, MD
  Delegate, AMA American College of Physicians' Delegation, and Adjunct Associate Professor of Medicine, Emory
- Patrice A. Harris, MD, MA
  Adjunct Assistant Professor, Department of Psychiatry and Behavioral Sciences
- Tracey L. Henry, MD, MPH, MS, FACP
  Assistant Professor of Medicine, and Assistant Health Director, Director of Health Policy Curriculum
- Bill S Majdalany, MD
  Residency program director
- Carolyn Cidis Meltzer, MD
  Associate Dean
- Douglas Claude Morris, MD
  Chief Executive Officer and Director of Emory Clinic
- John Francis Sweeney, MD
  Chair of Surgery
- James R. Zaidan, MD, MBA
  Associate Dean, GME

Medical College of Georgia Augusta University

David C. Hess, MD, Dean

- Michael P. Diamond, MD
  Brooks Professor & Chair, Ob/Gyn
- Hadyn Williams, MD
  Assoc Professor, Radiology, and Alternate delegate, ACNM

Mercer University School of Medicine

- Jeff Stephens, MD
  Professor
- Joseph M. Van De Water, MD
  Professor Emeritus of Surgery

Morehouse School of Medicine

Valerie Montgomery Rice, MD, President and Dean

- Martha L. Elks, MD, PhD
  Senior Associate Dean of Educational Affairs
- Yolanda H. Wimberly, MD , MSc
  Associate Dean for Graduate Medical Education, Designated Institutional Official, and Associate Professor of Pediatrics

Grenada, West Indies

St George's University School of Medicine

- John Madden
  Professor and Associate Dean

Hawaii

University of Hawaii John A. Burns School of Medicine

Jerris R. Hedges, MD, MS, MMM, Dean

- Patricia Lanoie Blanchette, MD, MPH
  Interim Associate Dean for Clinical Affairs; Emeritus Professor of Geriatric Medicine, and Chief Medical Officer, University Health Partners of Hawaii
- S. Kalani Brady, MD, MPH, MACP
  Director of Continuing Medical Education, and Director of Faculty Affairs
- William F. Haning, III, MD
  Director of Undergraduate Medical Education
- Robert A. Hong, MD
  Professor of Medicine, and Program Director
- Richard Smerz, DO
  Director of the Office of Student Affairs
- Danny M. Takanishi, Jr, MD
  Professor of Surgery and Associate Chair for Academic Affairs

Illinois

Accreditation Council for Graduate Medical Education

- William A. McDade, MD, PhD
  Chief diversity and inclusion officer, and AMA BOT member

American Medical Association

- Arthur E. Angove, DO
  General Surgeon (retired), and Lifetime Member, AMA
- David Barbe, MD, MHA
  Vice president, Regional Operations, Mercy Clinic, and AMA BOT member
- William E. Kobler, MD
  Medical Director of Health Management, OSF Saint Anthony Medical Center (SAMC), and AMA BOT member
- Barbara McAneny, MD
  Oncologist/hematologist, and AMA BOT member

Carle Illinois College of Medicine

King Li, MD, MBA, Founding Dean

Chicago Medical School at Rosalind Franklin University of Medicine & Science

James M. Record, MD, JD, Dean, Executive Chair, Dept of Foundational Sciences & Humanities

- Karen O'Mara, DO, FCCP
  Associate Professor, Department of Clinical Services
- Robert J. Rogers, MD, FACP
  Professor

Feinberg School of Medicine Northwestern University

Eric G. Neilson, MD, Dean

- Irwin Benuck, MD, PhD
  Professor of Pediatrics
- Sandra F. Olson, MD
  Associate Professor, and Neurologist
- James A. Sliwa, DO
  Associate Professor
- M. Christine Stock, MD
  Professor, Department of Anesthesiology
- Robert M. Vanecko, MD
  Professor, Surgery

Loyola University of Chicago Stritch School of Medicine

Sam J. Marzo, MD, Interim Dean and Chief Diversity Officer, Professor and Chair, Department of Otolaryngology, Head and Neck Surgery, Loyola University

- Praveen S Mehta, MD
  CMO
- Eugene Schnitzler, MD
  Associate Professor, Neurology

Midwestern University - Chicago College of Osteopathic Medicine

Thomas A. Boyle, DO, Dean

- Karen J. Nichols, DO, MA
  Clinical professor of internal medicine, and Former dean

Rush Medical College of Rush University Medical Center

- Parul Barry, MD
  Assistant Professor

Southern Illinois University School of Medicine

Jerry E. Kruse, MD, Dean and Provost, CEO, SIU HealthCare

- Debra L. Klamen, MD, MHPE
  Associate Dean for Education and Curriculum
- Laura Shea, MD
  Assistant Professor of Clinical Internal Medicine

University of Chicago Division of the Biological Sciences The Pritzker School of Medicine

Kenneth S. Polonsky, MD, Dean & EVP for Medical Affairs

- Holly J Humphrey, MD
  Dean of Medical Education, and President, Josiah Macy Foundation
- Zach Jarou, MD
  Clinical Associate, and Fellow in Administration, Informatics, Quality, and Policy

University of Illinois College of Medicine

- Alejandro Aparicio, MD
  Director, Medical Education Programs, American Medical Association, and Clinical Assistant Professor of Medicine and Assistant Professor of Medical Education
- Abbas A. Hyderi, MD, MPH
  Associate Dean for Undergraduate Medical Education, and Associate Professor of Clinical Family Medicine
- Michael Miloro, MD, DMD, FACS
  Professor and Department Head, OMFS, and Program Director, Oral and Maxillofacial Surgery Residency
- Jerry Noren, MD, MPH
  Associate Dean and Professor
- Marc A. Silver, MD
  Clinical Professor of Medicine, and Chief, Div of Medical Services, Chairman, Dept of Medicine, Advocate Christ Medical Center

Indiana

Indiana University School of Medicine

Jay L. Hess, MD, Dean, Vice President of Clinical Affairs

- Richard B. Gunderman, MD, PhD
  Vice Chairman, Radiology
- Robert M. Pascuzzi, MD
  Faculty member, chair of neurology
- Paul M. Wallach, MD
  Executive Associate Dean for Educational Affairs and Institutional Improvement
- Michael A. Weiss, MD, PhD
  Robert A. Harris Chair, Department of Biochemistry and Molecular Biology

Iowa

Des Moines University College of Osteopathic Medicine

- Ralitsa Akins, MD
  Provost

University of Iowa Roy J. and Lucille A. Carver College of Medicine

Jay Brooks Jackson, MD, Dean, Vice President, Medical Affairs

- Christopher S Cooper, MD , FACS, FAAP
  Associate Dean for Student Affairs and Curriculum
- Hillary Johnson-Jahangir, MD, PhD, FAAD
  Clinical Associate Professor of Dermatology, and AAD alternate delegate
- Victoria Sharp, MD, MBA
  Clinical Professor, Urology; Medical Chief of Staff
- Marta Van Beek, MD
  Clinical Associate Professor, Dermatology, and Medical Chief of Staff
- Douglas J. Van Daele, MD
  Associate Dean for Clinical Affairs, and Physician Leader, University of Iowa Physicians

Kansas

University of Kansas School of Medicine

- Glendon G. Cox, MD
  Senior Associate Dean, Medical Education
- Tomas L. Griebling, MD, MPH
  Senior Associate Dean for Medical Education
- Mark Meyer, MD
  Senior Associate Dean for Student Affairs
- Kimberly Jo Templeton, MD
  Professor of orthopaedic surgery, and Delegate, AAOS
- Greg Unruh, MD
  Associate Dean for Graduate Medical Education

Kentucky

University of Kentucky College of Medicine

- Wendy F Hansen, MD
  Associate Director, Professor & Chair, Obstetrics & Gynecology

University of Louisville School of Medicine

Toni M. Ganzel, MD, MBA, FACS, Dean

- Jennifer R. Hamm, MD
  Associate Professor, and Director, Division of General Obstetrics & Gynecology
- Mary Nan Mallory, MD, MBA, FACEP
  Vice Dean for Clinical Affairs, and Professor of Emergency Medicine and Attending Physician
- John L. Roberts, MD
  Vice Dean for GME and CME
- Bruce A. Scott, MD
  Clinical Assistant Professor, Department of Otolaryngology

University of Pikeville School of Osteopathic Medicine

Boyd R. Buser, DO, Vice President and Dean

Louisiana

Louisiana State University School of Medicine - New Orleans

Steve Nelson, MD, Dean

- Charles W. Hilton, MD
  Associate Dean, Academic Affairs
- Fred A. Lopez, MD
  Assistant Dean, Student Affairs and Records

Louisiana State University School of Medicine - Shreveport

- Jane M. Eggerstedt, MD
  Vice Chancellor for Academic Affairs

Tulane University School of Medicine

Lotuce Lee Hamm, MD, Senior Vice President and Dean

- Marc J. Kahn, MD
  Senior Associate Dean for Admissions and Student Affairs
- Kevin Krane, MD, FACP
  Vice Dean, Academic Affairs

Maine

University of New England College of Osteopathic Medicine

- Sabesan "Saby" Karuppiah, MD, FAAFP
  Designated Institutional Official, Program Director, Eastern Connecticut Family Medicine Residency, and Associate Professor

Maryland

American Association of Colleges of Osteopathic Medicine

- Tyler Cymet, DO
  Chief of Clinical Education

Johns Hopkins University School of Medicine

Paul Rothman, MD, Dean

- Jessica Bienstock, MD
  Professor, Department of Gynecology & Obstetrics
- Shirley Reddoch, MD
  Pediatric Hematologist

Uniformed Services University of the Health Sciences F. Edward Hebert School of Medicine

- Brandon J Goff, DO, LTC, MC, US Army
  Assistant Professor Physical Medicine and Rehabilitation, and Program Director, SAUSHEC Pain Medicine Fellowship, Brooke Army Med Ctr
- William H.J. Haffner, MD
  Professor, Department of Obstetrics and Gynecology, and Editor Emeritus, Military Medicine
- John E. McManigle, MD, COL USAF, MC
  former Acting Dean, and Asst Dean, Clinical Sciences
- Arnyce Pock, MD
  Associate Dean of Curriculum
- Robert Wah, MD
  Adjunct assistant professor in the Department of Obstetrics and Gynecology, and Division head and vice chairman, US Navy ob-gyn residency program

University of Maryland School of Medicine

- Nancy R. Lowitt, MD, EDM, FACP
  Associate Dean, Faculty Affairs & Professional Development

Massachusetts

Boston University School of Medicine

Karen H. Antman, MD, Dean, Provost

- Richard Khosrov Babayan, MD
  Professor and Chairman of Urology
- Viken Leon Babikian, MD
  Professor of Neurology, and Director, Vascular Neurology Residency
- Kenneth Grundfast, MD
  Assistant Dean for Student Affairs
- Glenn R. Markenson, MD
  Professor and Director, Maternal Fetal Medicine
- Thomas Moore, MD
  Associate Provost, BU Medical Campus
- Michael Douglas Perloff, MD, PhD
  Assistant Professor of Neurology

Harvard Medical School

- Don C. Bienfang, MD
  Assistant Professor, Ophthalmology
- Henry L. Dorkin, MD
  Associate Professor, Pediatrics, and Co-Director, Cystic Fibrosis Center, Boston Children's Hospital
- Michael Sinha, MD, JD, MPH
  Post-Doctoral Fellow
- Fatima Stanford, MD, MPH, MPA
  Obesity Medicine Physician

Tufts University School of Medicine

- Craig L. Best, MD, MPH
  President and CEO, Tufts Medical Center Physicians Organization
- Henry Klapholz, MD
  Dean for Clinical Affairs
- Mario Motta, MD
  Clinical professor of medicine, and AMA trustee

University of Massachusetts Medical School

Terence R. Flotte, MD, Dean, Executive Deputy Chancellor

- Sandeep S Jubbal, MD
  Assistant Professor of Medicine
- Richard S. Pieters, MD
  Professor, Radiation Oncology & Pediatrics

Michigan

Central Michigan University College of Medicine

George Kikano, MD, Dean

- Sunil D. Parashar, MD
  CMU Health, Assistant Professor

Michigan State University College of Human Medicine

Aron C Sousa, MD, Professor of Medicine

- Michael Donald Brown, MD, MSc
  Professor and Chair, Dept of Emergency Medicine
- Ved V. Gossain, MD, FRCP(C), MACP, FACE
  Swartz Professor of Medicine and Division of Endocrinology & Metabolism (emeritus-active)
- Richard Edmund Leach, MD
- Joel Eric Maurer, MD
  Associate Professor, and Assistant Dean of Admissions
- Venkat Rao, MD
  Clinical professor, Department of Medicine
- Erin Michele Sarzynski, MD
- Kenya Ibukunoluwa Sekoni, MD
- David T. Walsworth, MD, FAAFP
  Associate Chair for Clinical Affairs, Department of Family Medicine

University of Michigan Medical School

Marschall Runge, MD, PhD, Dean

- Clifford L. Craig, MD
  Clinical Associate Professor
- Joseph C. Kolars, MD
  Sr. Associate Dean for Education and Global Initiatives
- Rajesh S. Mangrulkar, MD
  Associate Dean for Medical Student Education, and Associate Professor, Dept of Internal Medicine
- David Spahlinger, MD
  Executive Vice Dean for Clinical Affairs, and President, U of Michigan Hospitals and Health Centers and U of Michigan Medical Group

Wayne State University School of Medicine

- Tsveti Markova, MD, FAAFP
  Associate Dean of GME & DIO
- Roopina Sangha, MD
  Program Director, OBGYN Residency, and Senior Staff Physician Henry Ford Hospital, and Assistant Professor, OBGYN, Wayne State University
- Robert J. Sokol, MD
  Emeritus Dean and Emeritus Distinguished Professor, Obstetrics & Gynecology & Physiology, and Adjunct Professor of Epidemiology, Mich State U College of Human Medicine

Western Michigan University Homer Stryker M.D. School of Medicine

Hal B. Jenson, MD, MBA, Founding Dean

- Karen Michelle Bovid, MD
  Assistant Professor, Orthopaedic Surgery
- Lee Alan Bricker, MD
- Donald Everett Greydanus, MD
  Professor, Pediatric and Adolescent Medicine
- Kevin Kunzer, MD
  Assistant Professor, Psychiatry
- Saad A. Shebrain, MD
  Assistant Professor, Surgery
- Robert Danl Strung, MD
  Associate Professor, Psychiatry
- Kristi Van Der Kolk, MD
  Assistant Professor, Family and Community Medicine
- Allan J. Wilke, MD
  Professor, Family and Community Medicine
- Charles Zeller, MD
  Assistant Dean for Continuing Education

Minnesota

Mayo Medical School

- Daniel Breitkopf
  Associate Professor of Obstetrics-Gynecology
- John C. O'Horo, MD, MPH
  Senior Associate Consultant, and Assistant Professor of Medicine
- Darcy A. Reed, MD, MPHE
  Senior Associate Dean for Academic Affairs, and Associate Professor of Medicine
- Neel B Shah, MB BCh, FACP, FHM, FACMG
  Assistant Professor of Medicine & Medical Genetics
- Geoffrey Thompson, MD
  Senior Associate Dean, Faculty Affairs
- Alexandra P. Wolanskyj, MD
  Senior Associate Dean for Student Affairs

University of Minnesota Medical School

- Raymond G. Christensen, MD
  Associate Dean for Rural Health, and Assoc Prof, FM

Mississippi

University of Mississippi School of Medicine

LouAnn Woodward, MD, Vice Chancellor for Health Affairs and Dean

- Sharon P. Douglas, MD
  Associate Dean for Veterans Administration Education, and Professor of Medicine
- Loretta Jackson-Williams, MD
  Vice Dean for Medical Education, and Professor of emergency medicine
- J. Mac Majure, MD
  Assistant Dean for Graduate Medical Education, and Professor of Pediatrics
- Shirley D. Schlessinger, MD
  Associate Dean for Graduate Medical Education

William Carey University College of Osteopathic Medicine

Italo Subbarao, DO, MBA, Dean

- Melissa R. Stephens, MD, FAAFP
  Director of Graduate Medical Education & Population Health, and Associate Professor of Clinical Sciences

Missouri

Saint Louis University School of Medicine

Robert Wilmott, MD, Acting dean and vice president for medical affairs, Vice dean for medical affairs

- Robert M. Heaney, MD
  Senior Associate Dean, Clinical Affairs
- Luther James Willmore, MD
  Associate Dean, Admissions, and Professor of Neurology

University of Missouri-Columbia School of Medicine

Steven Chas Zweig, MD, MSPH, Interim Dean, School of Medicine, Jack S. and Winifred M. Colwill Endowed Chair and Professor, Dept of Family and Community Medicine

- Mohammad Agha, MD
  Assistant Professor of Clinical PM&R and Orthopaedic Surgery
- John Gay, MD
  Dean for Curricular Improvement
- Scott E. Kinkade, MD, MSPH
  Associate Professor

University of Missouri-Kansas City School of Medicine

Mary Anne Jackson, MD, Interim Dean, Professor of Pediatrics

- Richard E. Butin, MD
  Associate Professor
- Michael Ray Christian, MD
  Assistant Professor, Emergency Medicine
- Betty M. Drees, MD, FACP
  Professor of Medicine and Dean Emerita
- Stefanie R. Ellison, MD
  Associate Dean for Curriculum
- Margaret E. Gibson
  Associate Professor, Dept of Community and Family Medicine
- Matthew Chris Gratton, MD
  Academic Chair, Emergency Medicine
- Robert Stephen Griffith, MD
- Jennifer Riekhof Mc Bride, MD
- Jill Moormeier, MD, MPH
  Chair, Department of Internal Medicine, and Professor of Medicine
- J. Stuart Munro, MD
  Adjunct Professor, Department of Medical Humanities and Social Sciences
- Michael Lynn O'Dell, MD, MSHA, FAAFP
  Associate Chief Medical Officer, and Chair, Department of Community and Family Medicine
- Steven J Prstojevich, MD, DDS
  Clinical Associate Professor
- Brenda Rogers, MD
  Associate Dean, Student Affairs
- L Michael Silvers, MD
  Associate Professor, Community and Family Medicine Department
- John Albert Spertus, MD
  Professor, Daniel J. Lauer Missouri Endowed Chair in Metabolism and Vascular Disease Research
- Mark T. Steele, MD
  Associate Dean
- Christine Sullivan, MD
  Associate Dean, GME
- Charles W. Van Way, III, MD
  Professor Emeritus

Washington University in St. Louis School of Medicine

David Perlmutter, MD, Dean, Executive Vice Chancellor for Medical Affairs

- James P. Crane, MD
  Associate Dean, and Assoc Vice Chancellor, Clinical Affairs
- Gary M. Gaddis, MD, PhD, FAAEM, FACEP
  Professor of Emergency Medicine, Division of Emergency Medicine

Nebraska

Creighton University School of Medicine

Robert Dunlay, MD, MBA, Dean, Professor of medicine and pharmacology

- Stephen Lanspa, MD
  Associate Dean Clinical Affairs

University of Nebraska College of Medicine

Bradley E. Britigan, MD, Dean

- Kelly J. Caverzagie, MD
  Associate Dean for Educational Strategy
- Pierre Fayad, MD, FAHA, FAAN
  Professor, Department of Neurological Sciences
- David V. O'Dell, MD
  Professor, Internal Medicine
- Michael Wadman, MD
  Associate Dean, Graduate Medical Education

Nevada

Touro University - Nevada College of Osteopathic Medicine

- Noah B. Kohn, MD, FAAP
  Assistant Dean of Clinical Faculty, and Assistant Professor of Pediatrics

University of Nevada, Las Vegas School of Medicine

Barbara Atkinson, MD, Founding Dean

University of Nevada, Reno School of Medicine

- Deborah Kuhls, MD
  Associate Dean for Academic Affairs, and Chief Academic Officer Las Vegas Campus

New Jersey

Cooper Medical School of Rowan University

Annette C. Reboli, MD, Dean

- Lawrence Weisberg, MD
  Assistant Dean for Phase 2

Rowan University School of Osteopathic Medicine

- Carl Mogil, DO
  Acting Assistant Dean for Graduate Medical Education

Rutgers New Jersey Medical School

- Peter W. Carmel, MD
  Professor Emeritus and Chief, Neurosurgery
- David I Mayerhoff, MD, DFAPA, MACP
  Clinical professor (Voluntary), Department of Psychiatry

Rutgers Robert Wood Johnson Medical School

- Niranjan V. Rao, MD, FACS
  Clinical Assistant Professor, and Chief Medical Officer, St. Peters Health Care System
- David E. Swee, MD
  Associate Dean for Faculty Affairs
- Sunil Wimalawansa, MD
  Professor

New Mexico

University of New Mexico School of Medicine

Paul B. Roth, MD, Chancellor for Health Sciences and Dean

- Michael Richards, MD
  Executive Physician-in-Chief: UNM Health Systems
- T. Craig Timm, MD
  Senior Associate Dean, Education

New York

Albany Medical College

Vincent P. Verdile, MD, Dean, Exec VP, Health Affairs

- Joel M. Bartfield, MD
  Associate Dean, GME
- Ellen M. Cosgrove, MD, FACP
  Vice Dean for Academic Administration, and Julio Sosa, MD, Chair of the Dept of Medical Education
- Henry S. Pohl, MD
  former Vice Dean for Academic Administration, and Associate Professor

Albert Einstein College of Medicine

- Jacqueline A. Bello, MD
  Professor of Clinical Radiology and Neurosurgery, and Director of Neuroradiology
- Michael J. Reichgott, MD, PhD
  Professor of Internal Medicine, and Conflict of Interest

Arnot Ogden Residency Program

- William Touchstone, MD, FAPA
  Faculty member and preceptor

Columbia University College of Physicians and Surgeons

- Saundra Curry, MD
  Associate Clinical Professor

CUNY School of Medicine Sophie Davis School of Biomedical Education

Erica S. Friedman, MD, Interim Dean, Deputy Dean for Medical Education and Academic Affairs

Donald and Barbara Zucker School of Medicine at Hofstra/Northwell

Lawrence G. Smith, MD, MACP, Dean

- David Battinelli, MD
  Dean for Medical Education
- Subhash Chandra, MD
  Associate Professor of Psychiatry, and Unit Chief and Attending Physician

Icahn School of Medicine at Mount Sinai of New York University

Dennis S. Charney, MD, Dean, EVP for Academic Affairs, Anne and Joel Ehrenkranz Professor

- Gabriel Harry Brandeis, MD
  Professor of Geriatrics

New York Medical College School of Medicine

- Robert G. Lerner, MD
  Professor Emeritus (retired)

New York University School of Medicine

Robert I. Grossman, MD, Dean

- Zebulon C. Taintor, MD
  Professor of Psychiatry

SUNY at Stony Brook Renaissance School of Medicine

- John Aloia, MD
  Chief Academic Officer, Winthrop University Hospital, and Dean, Clinical Campus, Stony Brook School of Medicine and Professor of Medicine
- Dorothy S. Lane, MD, MPH
  SUNY Distinguished Service Professor and Associate Dean, Continuing Medical Education, and Vice Chair, Department of Vice Chair Department of Family, Population & Preventive Medicine

SUNY Buffalo Jacobs School of Medicine and Biomedical Sciences

- Roseanne C. Berger, MD
  Senior Associate Dean, Graduate Medical Education
- Nancy H. Nielsen, MD, PhD
  Senior Associate Dean, Health Policy

SUNY Upstate Medical University

- Lynn M. Cleary, MD
  Senior Associate Dean for Education, and Vice President for Academic Affairs
- Gregory Threatte, MD
  Professor Emeritus

Touro College of Osteopathic Medicine

Martin Diamond, DO, FACOFP, Interim Dean/Dean Emeritus

- Conrad T Fischer, MD
  Associate Professor of Medicine, Physiology and Pharmacology, Department of Biomedical Sciences
- Tipsuda Junsanto-Bahri, MD
  Chair, Basic Biomedical Sciences, and Assistant professor, Internal Medicine and Pathology
- Piotr Bogdan Kozlowski, MD
- William B Rosenblatt, MD
  Assistant Professor, Department of Surgery, and Chair, Admissions Committee
- Harold K Sirota, DO
  Chairman, Department of Primary Care
- Kenneth Jay Steier, DO, MBA, MPH
  Founding Dean and Professor, and Chief Academic Officer
- Robert Stern, MD
  Professor of Pathology, Division of Basic Medical Sciences

University of Rochester School of Medicine & Dentistry

- David R. Lambert, MD
  Senior Associate Dean for Medical School Education

North Carolina

Brody School of Medicine at East Carolina University

- Elizabeth (Libby) G. Baxley, MD
  Senior Associate Dean for Academic Affairs, and Professor, Family Medicine
- Herbert G. Garrison, MD, MPH
  Associate Dean for Graduate Medical Education, and Professor of Emergency Medicine
- Luan Lawson-Johnson, MD, MAEd
  Assistant Dean, Clinical Curriculum and Assessment, and Assistant Professor, Emergency Medicine
- Danielle S. Walsh, MD
  Associate Professor of Surgery, Division of Pediatric Surgery, and Program Director, General Surgery Residency

Campbell University Jerry M. Wallace School of Osteopathic Medicine

John M. Kauffman, Jr., DO, FACOI, FACP, Dean and Chief Academic Officer

Duke University School of Medicine

- Liana Puscas, MD, MHS
  Associate Professor of Surgery

University of North Carolina at Chapel Hill School of Medicine

A. Wesley Burks, Jr., MD, Dean, CEO of UNC Health Care and Vice Chancellor for Medical Affairs

- Julie Byerley, MD, MPH
  Executive Vice Dean for Education, and Professor of Pediatrics
- Cam E. Enarson, MD, MBA
  Vice Dean for Strategic Initiatives, and Professor of Anesthesiology
- Darlyne Menscer, MD
  Clinical Associate Professor, Family Medicine

Wake Forest University School of Medicine

Julie Ann Freischlag, MD, Vice Chancellor and Dean

North Dakota

University of North Dakota School of Medicine & Health Sciences

- Allen Michael Booth, MD, PhD
  Associate Dean, Southwest Campus, and Clinical Professor of Surgery
- Nicholas H. Neumann, MD
  Professor, Internal Medicine
- Marsal Sanches, MD, PhD
  Clinical Associate Professor

Ohio

Case Western Reserve University School of Medicine

- Kavita Shah Arora, MD, MBE
  Associate Professor of Reproductive Biology and Bioethics, and YPS delegate
- Charles Kent Smith, MD
  Senior Associate Dean for Student Affairs, and Professor of Family Medicine and Community Health
- James Taylor, MD
  Consultant Dermatologist
- Krystal L. Tomei, MD, MPH
  Assistant Professor of Neurological Surgery

Northeast Ohio Medical University

Elisabeth Young, MD, Dean, College of Medicine, Vice President, Health Affairs

- Timothy J Barreiro, DO
  Associate Professor of Medicine, NEOMED, and Professor of Critical Care, OUHCOM

Ohio State University College of Medicine

K. Craig Kent, MD, Dean

- Daniel M. Clinchot, MD
  Vice Dean for Education
- Richard N. Nelson, MD
  Associate Clinical Professor, Emergency Medicine
- Andrew M. Thomas, MD
  Chief Medical Officer, and Senior Associate Vice President for Health Sciences, and Associate Professor of Clinical Internal Medicine

Ohio University Heritage College of Osteopathic Medicine

- Nicole Wadsworth, DO
  Associate Dean, Academic Affairs, and Assistant Professor, Section of Emergency Medicine, Dept of Family Medicine

St. Lukes Hospital

- Louito C. Edje, MD
  Program Director, family medicine residency, and Designated Institutional Officer

University Hospitals of Cleveland

- Aashish D. Bhatt, MBBS

University of Cincinnati College of Medicine

Andrew T. Filak, Jr, MD, Interim dean, Senior vice president for health affairs

- Gregory Rouan, MD
  Chair, Department of Internal Medicine

University of Toledo College of Medicine

Christopher J. Cooper, MD, Dean, Executive VP for Clinical Affairs

- Imran I. Ali, MD
  Vice Dean for Undergraduate Medical Education
- James Kleshinski, MD
  Senior Associate Dean for Clinical Affiliation
- Carl A. Sirio, MD
  Chief operating and clinical officer, senior associate dean for clinical affairs, and professor of medicine
- Donna Woodson, MD
  Professor, Department of Medical Education, and Director of Women's Health and Professor, School of Population Health

Wright State University Boonshoft School of Medicine

Margaret M. Dunn, MD, MBA, FACS, Dean

- Evangeline C. Andarsio, MD
  Assistant Director, Remen Institute for the Study of Health and Illness (RISHI), and Director, National Healers Art Program, RISHI
- Gary L. Le Roy, MD
  Associate Dean for Student Affairs/Admissions
- Alan P. Marco, MD, MM, FACPE
  Associate Dean for Clinical Affairs, and President and CEO of Wright State Physicians
- Dean X. Parmelee, MD
  Director of Educational Scholarship and Program Development, Office of Medical Education
- Glen D. Solomon, MD, FACP
  Professor and Chair, Department of Internal Medicine, and Professor and Interim Chair, Department of Neurology

Oklahoma

University of Oklahoma College of Medicine

John Zubialde, MD, Interim Executive Dean, Senior Associate Dean for Graduate Medical Education

- Peter P. Aran, MD
  Associate Dean of Academic Affairs and Chief Medical Officer, School of Community Medicine (Tulsa)
- Steven Crawford, MD
  Professor and Chairman, Dept of Family Medicine
- Jane C.K. Fitch, MD
  Professor & Chair, Dept of Anesthesiology
- D. Robert McCaffree, MD, MSHA
  Regents' Professor of Medicine, and Co-Director, OTRC
- Mary Anne McCaffree, MD
  professor of pediatrics

Oregon

Oregon Health and Science University School of Medicine

Sharon Anderson, MD, Dean, Executive Vice President

- Tracy N. Bumsted, MD, MPH
  Associate Dean for Undergraduate Medical Education, and Clinical Associate Professor of Pediatrics
- Leslie E. Kahl, MD
  Associate Dean for Strategic Initiatives, and Professor of Medicine
- Jeffrey R. Kirsch, MD
  Associate for Clinical and Veterans Affairs
- O. John Ma, MD
  Professor and Chair, Department of Emergency Medicine
- George C. Mejicano, MD, MS, FACP
  Senior Associate Dean for Education, and Professor of Medicine
- John C. Moorhead, MD
  Professor, Emergency Medicine, and Professor, Public Health and Preventive Medicine

Pennsylvania

Drexel University College of Medicine

- Barbara A. Schindler, MD
  Vice Dean Emerita, Educational and Academic Affairs, and Professor of Psychiatry and Pediatrics

Geisinger Commonwealth School of Medicine

- William F. Iobst, MD
  Vice President for Academic and Clinical Affairs and Vice Dean, and Professor of Medicine
- Thomas Martin, MD
  Professor of Pediatrics
- Margrit Shoemaker, MD
  Assistant Professor of Medicine
- Michael J. Suk, MD, JD, MPH, MBA, FACS
  Chief Physician Officer, Geisinger System Services, and Chair, Musculoskeletal Institute & Dept. of Orthopaedic Surgery; Professor, Orthopaedic Surgery
- Gerald Tracy, MD
  Professor of Medicine

Pennsylvania State University College of Medicine

- Robert C. Aber, MD, MACP
  Senior Advisor to the Dean, and Immediate Past Chair and Professor, Department of Medicine
- Jennifer Wells Baccon, MD
- Dwight Davis, MD
  Senior Associate Dean for Student Affairs/Admissions
- Jed David Gonzalo, MD, MSc
  Associate Dean for Health Systems Education, and Assistant Professor, College of Medicine, Public Health Sciences
- David Chas Good, MD
  Professor and Chair, Department of Neurology
- Paul Haidet, MD, MPH
  Director of Medical Education Research, and Co-Director, Office for Scholarship in Learning and Education Research
- Eileen F Hennrikus, MD, FACP, FHM
  Associate Professor of Medicine, Department of General Internal Medicine
- Eileen M. Moser, MD, MHPE
  Associate Dean for Clinical Education
- Elizabeth H. Sinz, MD
  Associate Dean for Clinical Simulation
- Mark B. Stephens, MD
  Professor of Family and Community Medicine
- Therese M. Wolpaw, MD, MHPE
  Vice Dean for Educational Affairs
- Daniel Rick Wolpaw, MD
  Professor of Medicine and Humanities, and Curriculum Design Lead and Course Co-director, University Park Curriculum

Raymond and Ruth Perelman School of Medicine at the University of Pennsylvania

- Lisa M. Bellini, MD
  Senior vice dean for academic affairs
- Eve J. Higginbotham, MD
  Vice Dean for Diversity and Inclusion
- Paul N. Lanken, MD, MSCE
  Professor Emeritus and Associate Dean for Professionalism and Humanism Emeritus
- Adam I. Rubin, MD
  Associate Professor of Dermatology, Pediatrics, and Pathology and Laboratory Medicine

Sidney Kimmel Medical College of Thomas Jefferson University

- Clara A. Callahan, MD
  The Lillian H. Brent Dean of Students and Admissions
- Robert J. Laskowski, MD, MBA
  Professor of clinical medicine
- Charbel G Salamon, MD, MS
  Female pelvic medicine & Reconstructive Surgery Fellowship & Division Director, and Assistant Professor SKMC, Thomas Jefferson Univ Philadelphia PA
- Stephen L. Schwartz, MD
  Clinical Professor, Psychiatry and Human Behavior, and Director, Adult Psychiatry

Temple University Lewis Katz School of Medicine

Larry R Kaiser, MD, Dean

- Linda M. Famiglio, MD
  Chief Academic Officer, Geisinger Medical Center, and Associate Dean at Geisinger for Temple U SOM
- Enrique Hernandez, MD
  Chair, OB/Gyn
- Stephen R. Permut, MD
  Professor

The Children's Hospital of Philadelphia

- Henry Lin, MD
  Co-Medical Director, Liver Transplant Program, and Associate Medical Director of Clinical Operations

University of Pittsburgh School of Medicine

- Barbara E. Barnes, MD
  Associate Vice Chancellor
- Wendy E. Braund, MD, MPH, MSEd, FACPM
  Professor, Health Policy and Management, and Director and Associate Dean, Center for Public Health Practice, U of Pitt Grad Sch of Public Hlth
- Rita M. Patel, MD
  Professor of Anesthesiology; Vice Chair for Education, Dept of Anesthesiology, and Associate Dean for Graduate Medical Education; Designated Institutional Official, UPMC Medical Edu
- John P. Williams, MD
  Professor

Puerto Rico

Ponce School of Medicine

Olga Rodriguez de Arzola, MD, Dean, Professor of Pediatrics

San Juan Bautista School of Medicine

Yocasta Brugal, MD, President and Dean

University of Puerto Rico School of Medicine

Agustin Rodriguez Gonzalez, MD, Dean

- Rafael Rodriguez-Mercado, MD, FAANS
  Professor in Neurosurgery and Endovascular Neurosurgery, and Stroke Center Director

Rhode Island

Warren Alpert Medical School of Brown University

Jack A. Elias, MD, Dean

- Ricardo Correa Marquez, MD, Es.D CMQ FACP, ABDA
  Assistant Professor of Medicine
- Patrick J. Sweeney, MD
  Associate Dean, Continuing Medical Education

South Carolina

Medical University of South Carolina College of Medicine

Raymond N. DuBois, MD, PhD, Dean

- Leonie Gordon, MD
  Senior Associate Dean for Faculty Affairs and Faculty Development, and Professor, Department of Radiology
- Gerald E. Harmon, MD
  Professor, College of Medicine

University of South Carolina School of Medicine

Les Hall, MD, Executive Dean, CEO of Palmetto Health-USC Medical Group

- Richard A. Hoppmann, MD
  Director, Ultrasound Institute

University of South Carolina School of Medicine - Greenville

Marjorie Jenkins, MD, Dean

- Bruce A. Snyder, MD
  Vice-Chief Medical Staff Affairs, Greenville Health System Department of Surgery

South Dakota

Sanford School of Medicine of the University of South Dakota

Mary D. Nettleman, MD, MS, MACP, Dean, Vice President Health Affairs

- Archana Chatterjee, MD
  Senior Associate Dean of Faculty Development, and Chair, Department of Pediatrics
- Keith Allen Hansen, MD
- Rodney R. Parry, MD
  Emeritus faculty and former dean
- Tim Ridgway, MD
  Dean of Faculty Affairs
- Matt Edward Simmons, MD
  Campus Dean
- Timothy Soundy, MD
  Chair, Department of Psychiatry
- Gary Lee Timmerman, MD

Tennessee

East Tennessee State University James H. Quillen College of Medicine

William A. Block, MD, MBA, Dean

Lincoln Memorial University DeBusk College of Osteopathic Medicine

Brian A. Kessler, DO, FACOFP, Dean

Meharry Medical College

Veronica Thierry Mallett, MD, MMM, Dean, Senior Vice President Health Affairs

University of Tennessee Health Science Center College of Medicine

Scott E. Strome, MD, Robert Kaplan Executive Dean, Vice Chancellor for Health Affairs

- Vijayalakshmi Appareddy, MD
  Clinical assistant professor, Internal medicine
- David C. Seaberg, MD, CPE, FACEP
  University Chair of Department of Emergency Medicine
- R. Bruce Shack, MD
  Dean, COM Chattanooga

Vanderbilt University School of Medicine

Jeff Balser, MD, PhD, Dean

- Donald W. Brady, MD
  Senior Associate Dean for GME and CPD
- A. Alex Jahangir, MD, MMHC
  Associate Professor of Orthopaedic Surgery & Rehabilitation, Division of Orthopaedic Trauma, and Medical Director, Vanderbilt Center for Trauma, Burn, & Emergency Surgery
- Bonnie M. Miller, MD
  Senior Associate Dean for Health Sciences Education

Texas

Baylor College of Medicine

Jennifer G. Christner, Dean, Associate Professor, Pediatrics

Texas A&M Health Science Center College of Medicine

- Paul B. Hicks, MD, PhD
  Vice Dean, Temple Campus
- Gary C. McCord, MD
  Associate Dean for Student Affairs

Texas Tech University Health Sciences Center Paul L. Foster School of Medicine

- Jose Manuel de la Rosa, MD
  Vice President for Outreach and Community Engagement, and Professor of Pediatrics
- Manuel Schydlower, MD
  Professor Emeritus

Texas Tech University Health Sciences Center School of Medicine

Steven L. Berk, MD, Dean, Provost and Executive Vice President

- Cynthia A. Jumper, MD, MPH
  VP for Health Policy, and Professor of Medicine
- Surendra K. Varma, MD
  Executive Associate Dean for Graduate Medical Education & Resident Affairs, and Professor and Vice Chairman, Department of Pediatrics

University of Houston University Eye Institute

- Nicky R Holdeman, MD, OD
  Professor Emeritus

University of Texas at Austin Dell Medical School

S. Claiborne Johnston, MD, PhD, Dean, Vice President for Medical Affairs

University of Texas Medical Branch at Galveston School of Medicine

Charles P. Mouton, MD, MS, Executive vice president, Provost, and Dean

- Thomas A. Blackwell, MD
  Associate Dean, Graduate Medical Education
- Kevin H. Mc Kinney, MD, FACE
  Associate Professor, Dept of Internal Medicine, and AMA Delegate, Endocrinology, Diabetes & Metabolism

University of Texas Medical School at Houston McGovern Medical School

Barbara J. Stoll, MD, Dean

- Patricia M. Butler, MD
  Vice Dean, Educational Programs
- Russell W.H. Kridel, MD
  Clinical Professor, and Director of Facial Plastics Education and Fellowship Program

University of Texas Rio Grande Valley School of Medicine

John H. Krouse, MD, PhD, MBA, Dean, Executive Vice President for Health Affairs

University of Texas Southwestern Medical Center UT Southwestern Medical School

- M. Brett Cooper, MD
  Assistant Professor
- Lynne M. Kirk, MD, FACP
  Professor of Internal Medicine, and Associate Program Director, Internal Medicine Residency
- Bradley F. Marple, MD
  Chairman, Department of Otolaryngology, and Associate Dean for Graduate Medical Education
- Robert V. Rege, MD
  Associate Dean, Undergraduate Medical Education

UT Health at San Antonio Long School of Medicine

Robert A. Hromas, MD, Dean, Vice President, Medical Affairs

- Lois L. Bready, MD
  Emeritus Professor, Dept of Anesthesiology
- Flossy Eddins-Folensbee, MD
  Vice Dean, UME
- Celia Ilene Kaye, MD
  geneticist and professor of pediatrics

Utah

University of Utah School of Medicine

Michael L. Good, MD, Dean

- Eric A. Millican, MD
  Assistant Professor

Vermont

University of Vermont Robert Larner, M.D. College of Medicine

- David C. Adams, MD
  Associate Dean for Graduate Medical Education
- Christa M. Zehle, MD
  Associate Dean for Student Affairs

Virginia

Eastern Virginia Medical School

Richard V. Homan, MD, President and Provost, Dean

- Ronald W. Flenner, MD, FACP
  Vice Dean for Academic Affairs
- Clarence W Gowen, Jr, MD
  Professor and Chair, Department of Pediatrics
- Shannon M. McCole, MD
  Chairman & Residency Program Director, Ophthalmology

Edward Via College of Osteopathic Medicine

Dixie Tooke-Rawlins, DO, Provost and President, Edward Via College of Osteopathic Medicine, Auburn, Carolinas, and Virginia Campuses

- Cathleen Callahan, MD, MPH
  Associate Dean for GME, and Associate Professor of Obstetrics and Gynecology

University of Virginia School of Medicine

- Karen S. Rheuban, MD
  Senior Associate Dean for Continuing Medical Education and External Affairs

Virginia Commonwealth University School of Medicine

- Jonathan Bekenstein, MD
  Associate Professor of Neurology
- Judy Brannen, MD, MBA
  Clinical Director, Undergraduate and Graduate Medical Education, and Associate Professor of Internal Medicine, VCU
- Nicole Deiorio, MD
  Associate dean, student affairs, and Professor, emergency medicine

Virginia Tech Carilion School of Medicine and Research Institute

Lee A. Learman, MD, Dean

- Jonathan Carmouche, MD
  Undergraduate Academic Activities
- Daniel P. Harrington, MD
  Senior Dean for Academic Affairs
- Cynda Ann Johnson, MD, MBA
  Founding Dean Emerita (retired)
- Patrice Weiss, MD
  Graduate Academic Activities

Washington

Pacific Northwest University of Health Sciences College of Osteopathic Medicine

- Sheila Rege, MD, FACRO
  Adjunct Clinical Assistant Professor

University of Washington School of Medicine

Paul G. Ramsey, MD, CEO, UW Medicine and Dean

- Suzanne M. Allen, MD, MPH
  Vice Dean for Academic, Rural and Regional Affairs

Washington State University Elson S. Floyd College of Medicine

John Tomkowiak, MD, MOL, Founding dean

West Virginia

Joan C. Edwards School of Medicine at Marshall University

Joseph I. Shapiro, MD, Dean

- Bobby L. Miller, MD , FAAP
  Vice Dean for Medical Education

West Virginia School of Osteopathic Medicine

Lorenzo Pence, DO, Dean

West Virginia University School of Medicine

- Judie Fern Charlton, MD
  Chief Medical Officer, WVU Hospital Administration, and Professor
- Christopher C. Colenda, III, MD, MPH
  President Emeritus, WVU Health System
- Alan Marc Ducatman, MD
  Professor, Public Health
- Norman D. Ferrari, III, MD
  Vice Dean for Education and Academic Affairs, and Professor and Chair, Department of Medical Education
- David Frederick Hubbard, MD
- Maria Munoz Kolar, MD
  Professor
- John Peter Lubicky, MD, FAAOS, FAAP
  Professor, Orthopaedic Surgery
- Bonhomme Jos Prud'Homme, MD
- Rebecca Jane Schmidt, DO
  Professor and Section Chief
- James Marcus Stevenson, MD

Wisconsin

Medical College of Wisconsin

Joseph E Kerschner, MD, Dean, Executive Vice President

- Carlyle H. Chan, MD
  Professor
- Jesse M. Ehrenfeld, MD, MPH
  Senior Associate Dean, and Director, Advancing a Healthier Wisconsin (AHW) Endowment
- Jose Franco, MD
  Discovery Curriculum Director
- William John Hueston, MD
  Senior Associate Dean for Academic Affairs
- Reza Shaker, MD
  Senior Associate Dean, and Director, Clinical & Translational Science Institute
- Kenneth B. Simons, MD
  Senior Associate Dean for Graduate Medical Education and Accreditation, and Executive Director and DIO, MCWAH, Inc.
- Alonzo Patrick Walker, MD

University of Wisconsin School of Medicine and Public Health

- Daniel D Bennett, MD
  Vice Chair, and Associate Professor
- Elizabeth M. Petty, MD
  Senior Associate Dean, Academic Affairs

Medical schools with no APS members 38

Alabama

Edward Via College of Osteopathic Medicine

Alabama College of Osteopathic Medicine

Arizona

Midwestern University - Arizona College of Osteopathic Medicine

A T Still University School of Osteopathic Medicine in Arizona

Arkansas

Arkansas College of Osteopathic Medicine

California

California University of Science and Medicine - School of Medicine

District of Columbia

George Washington University School of Medicine and Health Sciences

Florida

Lake Erie College of Osteopathic Medicine Bradenton Campus

Florida International University Herbert Wertheim College of Medicine

Georgia

Georgia Campus - Philadelphia College of Osteopathic Medicine

Idaho

Idaho College of Osteopathic Medicine

Indiana

Marian University College of Osteopathic Medicine

Michigan

Oakland University William Beaumont School of Medicine

Michigan State University College of Osteopathic Medicine

Michigan State University College of Osteo Medicine-Detroit Medical Center

Michigan State University College of Osteopathic Medicine-Macomb University

Missouri

Kansas City University of Medicine and Biosciences College of Osteopathic Medicine

A T Still University Kirksville College of Osteopathic Medicine

New Hampshire

Geisel School of Medicine at Dartmouth

New Jersey

Seton Hall-Hackensack Meridian School of Medicine

New Mexico

Burrell College of Osteopathic Medicine at New Mexico State University

New York

SUNY Downstate Medical Center College of Medicine

Weill Cornell Medicine

New York University Long Island School of Medicine

New York Institute of Technology New York College of Osteopathic Medicine

New York Institute of Technology College of Osteo Med at Arkansas State

Oklahoma

Oklahoma State University Center for Health Sciences College of Osteopathic Medicine

Oregon

Western Univ Health Sci College of Osteopathic Med of the Pacific Northwest

Pennsylvania

Philadelphia College of Osteopathic Medicine

Lake Erie College of Osteopathic Medicine

Lake Erie College of Osteopathic Medicine - Seton Hill

Puerto Rico

Universidad Central del Caribe School of Medicine

South Carolina

Edward Via Carolinas College of Osteopathic Medicine

Texas

Texas Christian University and UNTHSC School of Medicine

University of the Incarnate School of Osteopathic Medicine

University of North Texas Health Sciences Center College of Osteopathic Medicine

Utah

Rocky Vista University College of Osteopathic Medicine - Utah

Virginia

Liberty University College of Osteopathic Medicine

Academic Physicians Section: Membership application form

- Complete all fields below
- Current AMA membership is required to become an AMA-APS member. Join the AMA or renew your membership now
- Email completed form to Fred Lenhoff, AMA-APS staff, at fred.lenhoff@ama-assn.org.
- Questions? Call (312) 464-4635 or email fred.lenhoff@ama-assn.org

First name	Enter First Name	Middle initial	Enter M.I.	Last name	Enter last name	
Degrees(s)	Enter degree(s)	Title	Enter title(s)	Title 2	Enter second title, if any	
Institution	Enter primary institution	City	Enter city	State	Enter statet	
Email(s)	Enter email(s)	Telephone	Enter telephone	Specialty/ subspecialty	Enter specialty/subspecialty	
AMA member?	AMA member? Y or N	How long have you been an AMA member?	AMA member for X years	AMA delegate?	AMA delegate, Y or N	
Number of AMA-APS meetings attended	Attended X APS meetings	What is your current involvement in medical education?	Current involvement in medical education	Why do you wish to join the AMA-APS?	Reason to join the APS	
How did you learn about the APS?	How did you learn about the APS?	Were you referred to join by an APS member?	Referred to join by an APS member?	Which aspect(s) of medical education is your primary role/interest?	Undergraduate (UME)	☐
					Graduate (GME)	☐
					Continuing (CME)	☐

Membership avenue (choose one):		
Avenue 1: Dean-appointed	☐	An AMA-member physician appointed by the dean of any United States medical school (with an educational program provided by a college of medicine or osteopathic medicine accredited by the Liaison Committee on Medical Education or the American Osteopathic Association leading to the MD or DO degree) to represent undergraduate, graduate or continuing medical education at the institution. *Insert name of dean and date of dean's approval of APS membership:* Name: _____ Date:_____
Avenue 2: Self-nominated, faculty appointment	☐	An AMA-member physician who holds a faculty appointment of any type at a United States medical school with an educational program provided by a college of medicine or osteopathic medicine accredited by the LCME or the AOA leading to the MD or DO degree. *Provide a) A copy of your faculty appointment letter, or* *b) A link to your institution's website showing your current status*
Avenue 3: Self-nominated, no faculty appointment	☐	An AMA-member physician who does not hold a medical school faculty appointment, but has an active role in undergraduate, graduate, or continuing medical education or who serves in a clinical/research capacity with an academic medical center, community hospital, or other health care setting. *Provide a brief bio or C.V.—three pages or fewer*

AMA Academic Physicians Section takes action on AMA policy at meeting in Chicago

AMA policy review, educational sessions and networking opportunities with academic physician colleagues were part of the Academic Physicians Section (AMA-APS) meeting, June 7-8 in Chicago.

Participants—comprising deans and faculty from a wide range of medical schools, graduate medical education programs, and academic health systems nationwide—voiced their opinions and reached decisions on recommendations for reports and resolutions to be acted upon by delegates at the Annual Meeting of the AMA House of Delegates (HOD), June 8-12. Their work guides the section delegate and alternate delegate in the discussions and voting during the AMA meeting.

Issues covered included key topics of interest to academic physicians and those in medical education, including:

- All-payer graduate medical education funding
- Standardizing the residency match system and timeline
- Maintenance of Certification and Osteopathic Continuous Certification
- Augmented intelligence in medical education
- Medical student, resident, and physician suicide
- Education on climate change in medical schools
- Scholarly activity by resident/fellow physicians
- Evaluating barriers to medical education for trainees with disabilities
- Medical student debt
- Opioid education in medical schools

In all, the AMA-APS reviewed more than 30 business items to go before the AMA HOD.

Educational sessions

The education component of the meeting featured two options of special interest to academic physicians, both of which offered the opportunity to earn continuing medical education credits:

- Connecting the dots: Unprofessional behavior, mistreatment, impairment, and their impact on burnout in education and practice

- What's in an acronym? Comparing and contrasting MD and DO education/training, clinical practice, and research

"The STEM professions in particular are very poor compared to other fields in terms of sexual harassment. And, medicine is the worst. It's time to think about what we can do about that," said lead presenter Janis M. Orlowski, MD, Chief Health Care Officer at the Association of American Medical Colleges.

"There's nothing that excuses these behaviors among our faculty," noted Alma B. Littles, MD, Senior Associate Dean for Medical Education and Academic Affairs at Florida State University College of Medicine, and alternate delegate for the APS. "We really need to look at the environment and culture that we've set up for our students."

Serving on the reactor panel with Dr. Littles (who represented the academic physician perspective on this issue) were Rohit Abraham, MPH, medical student member of the AMA Council on Medical Education, and a graduating medical student at Michigan State University College of Human Medicine, and Ellia Ciammaichella, DO, JD, a resident physician in physical medicine and rehabilitation at the McGovern Medical School at UTHealth.

Attendees discussed three real-life scenarios related to disruptive behavior, impairment, and burnout and engaged in dialogue with the faculty on the need for both individual and institutional courage to face and address inappropriate behavior and unconscious bias in the "hidden curriculum" of medical education and practice.

On Saturday, the MD/DO educational session featured four distinguished faculty:

- Tyler Cymet, DO, chief of Clinical Education, American Association of Colleges of Osteopathic Medicine
- Lynne Kirk, MD, professor in Internal Medicine, University of Texas Southwestern Medical Center, and past chair, AMA Council on Medical Education
- Karen Nichols, DO, Dean at the Midwestern University Chicago College of Osteopathic Medicine (2002 to 2018), and Vice Chair of the Board of Trustees of the Accreditation Council for Graduate Medical Education
- Johannes Vieweg, MD, Founding Dean and Chief Academic Officer, Nova Southeastern University College of Allopathic Medicine in Ft. Lauderdale, Florida.

The presenters covered the medical education, practice, and research aspects of both the allopathic and osteopathic professions, to encompass the need for cross-communication and collaboration to ensure the best quality of care for the nation's patients. "We have to learn more from each other, and we have to communicate," said Dr. Vieweg. "Talking about our differences is less productive than talking about what brings us together."

Saturday's segment also featured a joint meeting of the APS and the Academic Medicine Caucus, which brings together members of the AMA House of Delegates who are interested in medical education issues. Topics covered included inequity of compensation for female physicians, the implications of "Medicare for All" for US hospitals, and new enhancements to the AMA's GME Competency Education Program (GCEP), related to faculty development and health systems science.

In addition, Liana Puscas, MD, chair of the Council on Medical Education nominations committee, presented on opportunities for service on national medical education organizations. These are listed on the Council website.

Updates on key nationwide medical education activities

AMA staff leadership updated APS members on the association's work in addressing issues affecting academic physicians, including:

- Reducing disparities and increasing health equity to improve health of all populations
  Aletha Maybank, MD, MPH, vice president, AMA Health Equity Center

- Attacking the dysfunction in health care by removing obstacles and barriers that interfere with patient care
  Michael Tutty, PhD, group vice president, Professional Satisfaction and Practice Sustainability

- Reimagining medical education, training and lifelong learning to help physicians adapt and grow in the digital age
  John Andrews, MD, vice president, Graduate Medical Education Innovation

- Improving the health of the nation by confronting the increasing chronic disease burden
  Karen Kmetik, PhD, group vice president, Improving Health Outcomes

The APS meeting was led by Hal Jenson, MD, MBA, 2018-2019 chair, and founding dean, Western Michigan University Homer Stryker M.D. School of Medicine. Reflecting on the event, and the past year, Dr. Jenson said, "Having had the opportunity to lead this important arm of AMA policy, representing my fellow academic physicians and medical educators nationwide, has been personally and professionally fulfilling on many levels. The APS will continue to build its influence, membership, and value to our AMA now and in the future. It has been an honor and privilege to contribute to its continued success and ongoing growth."

Election of 2019-2020 APS Governing Council

For the annual elections to the AMA-APS Governing Council, the section's nine-member leadership body, and the Membership Committee, members in attendance voted to elect the proposed slate put forward by the nomination committee, as follows:

APS Governing Council			
Chair-elect	Gary M. Gaddis, MD	Professor of Emergency Medicine	Washington University in St. Louis School of Medicine
Member at-large	Sharon P. Douglas, MD	Associate Dean for Veterans Administration Education, Professor of Medicine	University of Mississippi School of Medicine
Member at-large	Khanh-Van T. Le-Bucklin, MD	Vice Dean, Medical Education	University of California, Irvine School of Medicine
Member at-large	Charles Kent Smith, MD	Senior Associate Dean for Student Affairs, and Professor of Family Medicine and Community Health	Case Western Reserve University School of Medicine
APS Membership Committee			
Committee member and chair	John L. Roberts, MD	Vice Dean for GME and CME	University of Louisville School of Medicine
Committee member	June-Anne Gold, MD, MBBS	Professor	Loma Linda University School of Medicine
Committee member	George C. Mejicano, MD, MS	Senior Associate Dean for Education, and Professor of Medicine	Oregon Health and Science University School of Medicine
Committee member	Mark Meyer, MD	Associate Dean for Student Affairs	University of Kansas School of Medicine
Committee member	Neel B Shah, MB, BCh, FACP, FHM, FACMG	Assistant Professor of Medicine & Medical Genetics	Mayo Medical School

Next AMA-APS meeting

The next meeting of the AMA-APS is November 15-16 in San Diego.

Annual Meeting 2019:
Academic Physicians Section recommendations and final AMA HOD actions

June 20, 2019

#	Item	Title, notes	APS action	HOD action	APS notes and proposed language
		Reference Committee B			
1.	Res 214	The Term Physician	Amend	Alternate resolution adopted in lieu of	Amend as follows: RESOLVED, That our American Medical Association seek the passage of federal regulation and/or legislation that mandates that the term physician be limited to those people ~~trained in accordance with Accreditation Council for Graduate Medical Education guidelines and~~ who have an MD, DO or a recognized equivalent physician degree and that the term not be used by any other organization or person involved in healthcare.
2.	Res 225	DACA in GME	Adopt	Reaffirmed in lieu of	On the reaffirmation consent calendar
3.	Res 233	GME Cap Flexibility	Amend	Policy D-305.967 adopted as amended in lieu of	Adopt as amended through deletion of second resolve: "~~RESOLVED, That our AMA advocate for CMS to provide funding to hospitals and/or universities prior to the arrival of any residents, removing the clause where "Medicare funding does not begin until the first resident is 'on-duty' at the hospital. (Directive to Take Action)~~"
		Reference Committee C			
4.	BOT 25	All Payer Graduate Medical Education Funding	Adopt	Adopted	
5.	CME 1	Council on Medical Education Sunset Review of 2009 House of Delegates' Policies	Adopt	Adopted	
6.	CME 2	An Update on Maintenance of Certification and Osteopathic Continuous Certification (Resolution 316-A-18)	Adopt	Adopted	
7.	CME 3	Standardizing the Residency Match System and Timeline (CME Report 6-A-17)	Adopt	Adopted as amended	
8.	CME 4	Augmented Intelligence in Medical Education (Resolution 317-A-18)	Adopt	Adopted as amended	
9.	CME 6	Study of Medical Student, Resident, and Physician Suicide (Resolution 959-I-18)	Adopt	Adopted as amended	Adopted as amended in lieu of Resolutions 307 and 310.
10.	CME/ CSA PH 1	Protecting Medical Trainees from Hazardous Exposure (Resolution 301-A-18)	Adopt	Adopted as amended	
11.	Res 301	American Board of Medical Specialties Advertising	Not adopt	Referred	

#	Item	Title	APS action	HOD action	APS notes and proposed language
12.	Res 302	The Climate Change Lecture for US Medical Schools	Amend	Alternate resolution adopted in lieu of	Agree with Council on Medical Education edits, to amend through deletion of Resolve clauses 1, 2, 3, 5, and 6 and editing of Resolve 4, as follows: RESOLVED, That our AMA ~~prepare~~ make available a prototype PowerPoint slide presentation and lecture notes ~~for "The Climate Change Lecture"~~ on the intersection of climate change and health for use ~~which could be used~~ by medical schools~~, or schools may create their own lecture, video or online course to fulfill the requirements of "The Climate Change Lecture"~~
13.	Res 303	Graduate Medical Education and the Corporate Practice of Medicine	Amend	Adopted as amended	Amend Resolve 1, to include the ACGME, and delete Resolve 2, as ACGME policy is already clear on this issue. RESOLVED, That our American Medical Association recognize and support the requirement by the Accreditation Council for Graduate Medical Education that the environment for education of residents and fellows must be free of the conflict of interest created between corporate-owned lay entities' fiduciary responsibility to shareholders and the educational mission of residency or fellowship training programs (New HOD Policy)~~; and be it further~~. ~~RESOLVED, That our AMA support that the Accreditation Council for Graduate Medical Education require that graduate medical education programs must be established in compliance with all state laws, including prohibitions on the corporate practice of medicine, as a condition of accreditation. (New HOD Policy)~~
14.	Res 304	Tracking Outcomes and Supporting Best Practices of Health Care Career Pipeline Programs	Adopt	Adopted as amended	
15.	Res 305	Lack of Support for Maintenance of Certification	Refer	Reaffirmed in lieu of	On reaffirmation consent calendar.
16.	Res 306	Interest Rates and Medical Education	Adopt	Reaffirmed in lieu of	On reaffirmation consent calendar.
17.	Res 307	Mental Health Services for Medical Students	Not adopt	CME Report 6 adopted as amended in lieu of	Medical student mental health is important, but asking that medical schools "provide confidential in-house mental health services at no cost to students" is a potential fiscal issue for institutions, and there is already sufficient attention to this issue, via the LCME. In addition, CME Report 6 covers much of this issue, in greater detail.
18.	Res 308	Maintenance of Certification Moratorium	Refer	Referred	
19.	Res 309	Promoting Addiction Medicine During a Time of Crisis	Not adopt	Reaffirmed in lieu of	On reaffirmation consent calendar. Opposed, as this is a curricular mandate.
20.	Res 310	Mental Health Care for Medical Students	Not adopt	CME Report 6 adopted as amended in lieu of	In favor of the concept, but not this resolution, as it is very prescriptive and overly burdensome. In addition, as noted above for Resolution 307, CME Report 6 covers much of this issue, in greater detail.

#	Item	Title	APS action	HOD action	APS notes and proposed language
21.	Res 311	Grandfathering Qualified Applicants Practicing in U.S. Institutions with Restricted Medical Licensure	No position	Referred	
22.	Res 312	Unmatched Medical Graduates to Address the Shortage of Primary Care Physicians	Not adopt	Not adopted	This raises concerns about the quality of care delivered by these individuals.
23.	Res 313	Clinical Applications of Pathology and Laboratory Medicine for Medical Students, Residents and Fellows	Not adopt; curricular mandate.	Adopted as amended	
24.	Res 314	Evaluation of Changes to Residency and Fellowship Application and Matching Processes	Adopt	Adopted as amended	
25.	Res 315	Scholarly Activity by Resident and Fellow Physicians	Adopt	Adopted as amended	
26.	Res 316	Medical Student Debt	Reaffirm	Adopted as amended	In lieu this resolution, reaffirm Policy H-200.949, ""Principles of and Actions to Address Primary Care Workforce."
27.	Res 317	A Study to Evaluate Barriers to Medical Education for Trainees with Disabilities	Adopt	Adopted as amended	
28.	Res 318	Rural Health Physician Workforce Disparities	Adopt	Adopted as amended	
29.	Res 319	Adding Pipeline Program Participation Questions to Medical School Applications	Amend	Adopted as amended	Amend title and Resolve clauses to replace "pipeline" (which may have unintended connotations) with "pathway." New title: "Adding Pathway (formerly called Pipeline) Program Participation Questions to Medical School Applications." New Resolves: RESOLVED, That our American Medical Association collaborate with the Association of American Medical Colleges (AAMC) and other stakeholders to coalesce the data to create a question for the AAMC electronic medical school application to allow applicants to identify previous pathway (formerly called pipeline) program participation to determine the effectiveness of pathway programs for those who are underrepresented in medicine in their decisions to pursue careers in medicine. RESOLVED, That our AMA develop a plan, once the question to identify previous pathway (formerly called pipeline) program participation is added to the AAMC electronic medical school application, to analyze the data ~~once this question is implemented~~ with input from key stakeholders, including AAMC, the Accreditation Council for Graduate Medical Education, and interested medical societies and premed ~~pipeline~~ pathway programs.

#	Item	Title	APS action	HOD action	APS notes and proposed language
30.	Res 320	Opioid Education in Medical Schools	Not adopt	Reaffirmed in lieu of	On reaffirmation consent calendar. Overly prescriptive, and is a curricular mandate.
31.	Res 321	Physician Health Program Accountability, Consistency, and Excellence in Provision of Service to the Medical Profession	No position	Adopted	
32.	Res 322	Support for the Study of the Timing and Causes for Leave of Absence and Withdrawal from United States Medical Schools	Adopt	Adopted as amended with change in title	
33.	Res 323	Improving Access to Care in Medically Underserved Areas Through Project ECHO and the Child Psychiatry Access Project Model	Adopt	Adopted	
34.	Res 324	Residency and Fellowship Program Director, Assistant/Associate Program Director, and Core Faculty Protected Time and Salary Reimbursement	Amend	Adopted	Amend in line with Council on Medical Education edits

Reference Committee D

35.	Res 403	White House Initiative on Asian Americans and Pacific Islanders	Adopt	Adopted	

Reference Committee F

36.	Res 606	Investigation into Residents, Fellows, and Physician Unions	Reaffirm	Adopted as amended	Title is inexact; Whereas clauses don't match the Resolve. Current AMA policy is opposed to this (as shown on last page of item). Reaffirm that existing policy, H-383.998, "Resident Physicians, Unions and Organized Labor," in lieu of adoption.
37.	Res 608	Financial Protections for Doctors in Training	Refer	Referred	May represent a significant fiscal burden for residency programs; further study is warranted.

Informational reports

38.	CME 5	Accelerating Change in Medical Education Consortium Accomplishments, 2013-2018
39.	CME 7	For-Profit Medical Schools or Colleges

Future APS meeting dates

Year	Annual Meeting		Interim Meeting	
2020	June 5-6	Hyatt Regency Chicago	Nov. 13-14	Manchester Grand Hyatt San Diego, California
2021	June 11-12	Hyatt Regency Chicago	Nov. 12-13	Walt Disney World Swan and Dolphin Resort Orlando, Florida
2022	June 10-11	Hyatt Regency Chicago	Nov. 10-11	Hilton Hawaiian Village Honolulu, Hawaii
2023	June 9-10	Hyatt Regency Chicago	Nov. 10-11	Gaylord National Harbor Hotel National Harbor, Maryland

American Medical Association Academic Physicians Section

Internal Operating Procedures

I. Name

The name of this organization shall be the Academic Physicians Section (APS) of the American Medical Association (AMA). This is a special section for academic physician members of the AMA as set forth in AMA Bylaw 7.2.

II. Purpose and Principles

The Mission of the Sections as outlined in AMA Bylaw 7.0.1 shall guide the APS. The purpose of the APS shall be to provide for academic physician participation in the activities of the AMA. The APS partners with other AMA Sections, Councils, and Special Groups to provide a unified voice representing medical education and academic medicine within the AMA.

III. Membership

Membership in the Section is defined in AMA Bylaw 7.2.1.

IV. Governing Council and Officers

A. Designations. The officers of the APS shall be the nine Governing Council members: Chair, Chair-elect, Immediate Past Chair, Delegate, Alternate Delegate, three Members-At-Large, and the APS Liaison to the AMA Council on Medical Education.

B. Authority. The Governing Council shall direct the programs and activities of the APS, subject to the approval of the AMA Board of Trustees. During the interval between meetings of the AMA House of Delegates and between business meetings of the APS, the Governing Council shall act on behalf of the APS in formulating decisions related to the development, administration, and implementation of activities, programs, goals, and objectives. The APS shall be notified of actions taken by the Governing Council on its behalf.

C. Qualifications. All members of the Governing Council must be members of the AMA and the APS.

D. Duties and Privileges.

1. Chair. The Chair shall preside at all meetings/conference calls of the Governing Council and Business Meetings of the Section, and otherwise represent the APS when appropriate.

2. Chair-elect. The Chair-elect shall:

   a. Preside at meetings/conference calls of the Governing Council and Business Meetings of the Section in the absence of the Chair or at the request of the Chair.

   b. Assist the Chair in the performance of his or her duties.

3. Immediate Past Chair. The Immediate Past Chair shall:

   a. Preside at meetings/conference calls of the Governing Council and Business Meetings of the Section in the absence of the Chair and Chair-elect.

   b. Preside at meetings/conference calls of the APS Nominations Committee.

4. Delegate and Alternate Delegate. The Delegate and Alternate Delegate shall represent the APS in the AMA House of Delegates.

5. Members-At-Large. The Members-At-Large shall perform such functions as determined by the Governing Council, and assist the other officers in the performance of their duties.

6. APS Liaison to the AMA Council on Medical Education. The Liaison shall represent the APS at Council on Medical Education meetings.

E. Terms and Tenure.

1. Chair-elect, Chair and Immediate Past Chair. The Chair-elect shall be elected annually at the Business Meeting of the Section held immediately prior to the Annual Meeting of the AMA. The member elected shall assume office at the conclusion of the Annual Meeting at which the election was held and shall serve until the conclusion of the next Annual Meeting; whereupon the Chair-elect shall succeed to the office of Chair and shall serve in that office for one year until the conclusion of the next Annual Meeting of the AMA; whereupon the Chair shall become Immediate Past Chair and shall serve in that office for one year until the conclusion of the next Annual Meeting.

No member shall serve more than one cycle as Chair-elect, Chair, or Immediate Past Chair.

2. Delegate and Alternate Delegate. The Delegate and Alternate Delegate shall be elected in even numbered years at the Business Meeting of the Section held immediately prior to the Annual Meeting of the AMA. Those elected shall assume office at the conclusion of the Annual Meeting at which the election was held and shall serve until the conclusion of the second Annual Meeting after they assume office. No member shall serve more than three two-year terms as either Delegate or Alternate Delegate (or 12 years total—six as Delegate and six as Alternate Delegate).

3. Members-At-Large. The Members-At-Large shall be elected annually at the Business Meeting of the Section held immediately prior to the Annual Meeting of the AMA. Those elected shall take office at the conclusion of the Annual Meeting at which they are elected and shall serve until the conclusion of the next Annual Meeting. No member shall serve for more than three one-year terms as Member-At-Large.

4. APS Liaison to the Council on Medical Education. The Liaison shall be elected every three years at the Business Meeting of the Section held immediately prior to the Annual Meeting of the AMA. The member elected shall assume office at the conclusion of the Annual Meeting at which the election was held and shall serve until the conclusion of the third Annual Meeting after he/she assumes office. No Liaison shall serve more than one three-year term.

5. Term Limits:

   a. Chair-elect, Chair, and Immediate Past Chair (three years total);
   b. Delegate and Alternate Delegate (12 years total);
   c. Member-At-Large (three years total);
   d. APS Liaison to the Council on Medical Education (three years total).

F. Vacancies.

1. Chair and Chair-elect.

   a. In the event the office of Chair shall become vacant for any reason, the office shall remain vacant until the conclusion of the next Annual Meeting of the AMA, at which time the

Chair-elect shall succeed to the office of chair. During any vacancy in the office of Chair, the duties and responsibilities of the office shall be assumed by the Chair-elect.

b. In the event the offices of both the Chair and Chair-elect shall become vacant for any reason, both offices shall be filled by election at the next Business Meeting of the Section. During any vacancies in the offices of both the Chair and Chair-elect, the duties and responsibilities of the Chair shall be assumed by the Immediate Past Chair.

c. The office of Chair shall be filled before an election is held to fill the office of Chair-elect. Those elected shall serve the unexpired term remaining for each office.

2. Delegate and Alternate Delegate. If the office of Delegate becomes vacant for any reason, the Alternate Delegate shall assume the office of Delegate and serve for the remainder of the unexpired term. If the office of Alternate Delegate becomes vacant for any reason, at the next Business Meeting of the Section, a successor shall be elected to serve the remainder of the unexpired term.

3. Members-At-Large. In the event of a vacancy, at the next Business Meeting of the Section, a successor shall be elected to serve the remainder of the unexpired term.

4. APS Liaison to the Council on Medical Education. In the event of a vacancy, a successor shall be elected at the next Business Meeting of the Section to serve the remainder of the unexpired term.

G. **Tenure**. A Governing Council member elected to serve an unexpired term shall not be regarded as having served a term.

H. **Quorum.** Five members of the Governing Council shall constitute a quorum.

V. Nominations

All candidates who wish to run for the Governing Council shall complete an application and the AMA conflict of interest disclosure form and submit the forms to the APS Nominations Committee (APS Chair, Chair-elect, and Immediate Past Chair) 90 days prior to the start of the APS Business Meeting at which the election is to take place. The Nominations Committee, chaired by the APS Immediate Past Chair, will review the applications and develop a proposed slate of candidates.

Previous involvement in the Section—for example, attendance at APS meetings—will be one factor for consideration of applicants by the Nominations Committee.

The proposed slate, if approved by the Governing Council, will then be included in the agenda book for the upcoming APS Business Meeting and brought before the Business Meeting of the Section for a vote. Further nominations may be made from the floor prior to the election and must be accompanied by a completed application form and the AMA conflict of interest disclosure form.

VI. Elections

A. Time of Election. The election of officers shall be held at the APS Business Meeting prior to the Annual Meeting of the AMA (except for elections to fill a vacancy, as described in IV.F). Each APS member attending the Business Meeting is eligible to vote.

B. Eligibility. Any AMA member of the APS may run for a position on the Governing Council.

C. Procedure: Uncontested Election. The Chair of the Nominations Committee shall present the slate of nominees and call for nominations from the floor for any open positions. If after the call for nominations there are no additional nominees from the floor for a specific position, that election shall be considered uncontested, and the nominee shall be elected by acclamation.

D. Contested Election. If a nomination is made from the floor, the election for that position shall be considered contested, and the following methods shall be used to elect. A majority vote of the APS members present and voting shall be required to elect.

All nominees for an open or vacant Governing Council position shall be listed alphabetically on a single ballot. Each APS member shall have as many votes as the number of nominees to be elected to each position, and each vote must be cast for a different nominee. No ballot shall be counted if it contains fewer or more votes than the number of positions to be elected, or if the ballot contains more than one vote for any nominee. A nominee shall be elected if he or she has received a vote on a majority of the legal ballots cast and is one of the nominees receiving the largest number of votes within the number of positions to be elected. (If no nominee receives a majority of the legal ballots cast, there shall be a subsequent ballot.)

E. Subsequent Ballots. If no nominee receives a majority of the legal ballots cast, the nominee who receives the fewest votes shall be removed from the subsequent ballot, and voting shall recommence. The members shall cast as

many votes as there are positions yet to be elected, and must cast each vote for different nominees. This procedure shall be repeated until all vacancies have been filled.

F. Runoff Ballot. A runoff election shall be held to fill any vacancy not filled because of a tie vote.

VII. APS Business Meeting

A. The APS Business Meeting will be held as specified in AMA Bylaw 7.0.6.

B. The purposes of the meeting shall be as outlined in AMA Bylaw 7.0.6.1.

C. Any member of the APS may participate in the Business Meeting and shall have the right to vote, make motions, and make amendments if they are in order. Any member of the AMA is welcome to attend the Business Meeting. For the purpose of conducting the business of the meeting, a Quorum shall be defined as those APS members who are attending that Business Meeting of the APS.

D. Resolutions.

1. Any member of the APS may submit resolutions to the APS 60 days prior to the start of each Annual and Interim Meeting of the AMA House of Delegates. Resolution authors and all interested members of the APS will be invited to an open session of the APS prior to or at the APS meeting, chaired by the Delegate and Alternate Delegate, to discuss the pending resolutions.

2. Following this review, the Delegate and/or Alternate Delegate will make recommendations to the APS Governing Council on whether to consider the approved resolutions as business at the upcoming APS Business Meeting. If the Governing Council recommends that a resolution not be considered, that item will not be considered by the APS at its meeting unless the sponsors resubmit the resolution for consideration at the Business Meeting.

3. Late resolutions may be brought forth from the floor of the Business Meeting at a time determined by the Governing Council.

4. All resolutions approved for consideration as business shall require a simple majority vote of APS members present to be submitted by the APS for consideration by the HOD.

5. The submission and defense of approved resolutions will be conducted by the APS Delegate and Alternate Delegate, in concert with the Governing Council, according to rules governing the HOD. Testimony by authors of a resolution and all interested APS members before the Reference Committees of the HOD is welcome and encouraged.

E. **Virtual Meeting.** To develop consensus opinions on APS resolutions and other AMA resolutions and reports, including those submitted by the APS, Section members may meet electronically and/or via teleconference prior to the HOD.

F. Meeting registration materials are sent to all APS members at least 60 days prior to the start of each meeting.

G. Non-AMA member guests may attend the Business Meeting at the discretion of the APS Governing Council.

VIII. Miscellaneous

A. **Parliamentary Authority.** The parliamentary authority of the AMA House of Delegates governs this organization in all parliamentary situations that are not provided for in the AMA Bylaws.

B. **Financial Responsibility.** The funding of the APS Governing Council is appropriated by the AMA. All necessary expenses related to Governing Council activities will be reimbursed in compliance with AMA Expense and Travel Guidelines.

C. **Candidate Endorsement.** The APS Governing Council may, on majority vote, endorse candidates for AMA Councils as well as the AMA Board of Trustees.

IX. Amendments

A. **APS Requirements.** These Internal Operating Procedures may be amended by a quorum of the members of the APS Governing Council.

B. **Other Requirements.** Per AMA Bylaw 7.0.7, all rules, regulations, and procedures adopted by the APS are subject to the approval of the Board of Trustees. Amendments to the Internal Operating Procedures may also be contingent upon corresponding changes to the AMA Bylaws, which require approval of two-thirds of the members of the AMA House of Delegates.

Contact information

AMA Academic Physicians Section (AMA-APS)
330 N Wabash Ave, Suite 39300
Chicago, IL 60611
Phone: (312) 464-4635
Email: section@ama-assn.org
Website: ama-assn.org/go/aps

Fred Lenhoff, MA
Director, Academic Physicians Section
(312) 464-4635
fred.lenhoff@ama-assn.org

Alejandro Aparicio, MD
Director, Medical Education Programs
(312) 464-5531
alejandro.aparicio@ama-assn.org

TeRhonda McGee
Staff Assistant
(312) 464-4579
terhonda.mcgee@ama-assn.org