AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (I-19)

Report of Reference Committee C

Louito C. Edje, MD, Chair

Your Reference Committee recommends the following consent calendar for acceptance:

RECOMMENDED FOR ADOPTION

1. Resolution 301 – Engaging Stakeholders for Establishment of a Two-Interval, or Pass/Fail, Grading System of Non-Clinical Curriculum in U.S. Medical Schools
2. Resolution 303 – Investigation of Existing Application Barriers for Osteopathic Medical Students Applying for Away Rotations
3. Resolution 308 – Study Expediting Entry of Qualified IMG Physicians to US Medical Practice

RECOMMENDED FOR ADOPTION AS AMENDED

4. Council on Medical Education Report 3 – Standardization of Medical Licensing Time Limits Across States (Resolution 305-A-18)
5. Council on Medical Education Report 4 – Board Certification Changes Impact Access to Addiction Medicine Specialists (Resolution 314-A-18)
6. Council on Medical Education Report 6 – Veterans Health Administration Funding of Graduate Medical Education (Resolution 954-I-18)
7. Resolution 302 – Strengthening Standards for LGBTQ Medical Education
8. Resolution 305 – Ensuring Access to Safe and Quality Care for our Veterans
9. Resolution 310 – Protection of Resident and Fellow Training in the Case of Hospital or Training Program Closure

RECOMMENDED FOR ADOPTION IN LIEU OF

10. Council on Medical Education Report 2 – Healthcare Finance in the Medical School Curriculum (Resolution 307-A-18)
    Resolution 307 – Implementation of Financial Education Curriculum for Medical Students and Physicians in Training

RECOMMENDED FOR REFERRAL

11. Resolution 304 – Issues with the Match, The National Residency Matching Program (NRMP)
12. Resolution 309 – Follow-up on Abnormal Medical Test Findings

The following resolutions were handled via the reaffirmation consent calendar:

Resolution 306 – Financial Burden of USMLE Step 2 CS on Medical Students

RECOMMENDED FOR ADOPTION

(1) RESOLUTION 301 – ENGAGING STAKEHOLDERS FOR ESTABLISHMENT OF A TWO-INTERVAL, OR PASS/FAIL, GRADING SYSTEM OF NON-CLINICAL CURRICULUM IN U.S. MEDICAL SCHOOLS

RECOMMENDATION:

Resolution 301 be <u>adopted</u>.

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 <u>will work with stakeholders to encourage the establishment of</u> ~~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)

Your Reference Committee heard mixed testimony that was largely in favor of adoption, due chiefly to the negative emotional and physical health impacts of grades on students. Testimony was provided noting that studies show that students in pass/fail grading systems for preclinical curricula exhibit better mental health and greater satisfaction compared to those in multi-tiered grading systems. Furthermore, the widespread adoption of pass/fail curriculum has not been found to negatively affect student performance on United States Medical Licensing Examination Step 1 and Step 2 examinations. Those providing testimony in opposition to adoption argued for the need for flexibility among the individual needs of a given medical school. As with curricular mandates, the AMA should not propagate a monolithic system of pass/fail grading in all medical schools—which could also make it more difficult for program directors to distinguish the qualifications of one school's applicants from another. Furthermore, with anticipated changes to the grading and scoring of USMLE Step 1, program directors may very well need this data point to evaluate residency candidates. The AMA should help schools maintain flexibility in appropriate stratification and evaluation of student performance. With these caveats in mind, your Reference Committee nonetheless believes that the weight of the testimony supports adoption. A holistic approach to review of residency program applicants is needed; this resolution helps move the AMA towards this laudable goal. Further, the current policy already acknowledges the benefits of a pass/fail system; the resolution simply moves the ball down the field (versus punting) and helps move the policy from words to action. For these reasons, we urge adoption of Resolution 301 as written.

(2) RESOLUTION 303 – INVESTIGATION OF EXISTING APPLICATION BARRIERS FOR OSTEOPATHIC MEDICAL STUDENTS APPLYING FOR AWAY ROTATIONS

RECOMMENDATION:

Resolution 303 be <u>adopted</u>.

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)

Your Reference Committee heard supportive online and in-person testimony regarding Resolution 303. As noted in testimony, this resolution identifies the significant challenges that osteopathic medical students face when pursuing clinical rotations away from their home educational campus. The resolution's authors identified potential and real sources of discrimination among MD and DO students, which is averse to AMA policies that call for fairness balanced with flexibility. Speakers also noted the potential for unequal treatment by some institutions, such that osteopathic medical students bear the brunt of higher rotation fees versus their allopathic colleagues when applying for away rotations through the Visiting Student Application Services program. This is a complex issue with shades of nuance, meriting a full examination and study by our AMA Council on Medical Education, to forfend ongoing adverse consequences for osteopathic medical students. Therefore, your Reference Committee recommends that Resolution 303 be adopted.

(3) RESOLUTION 308 – STUDY EXPEDITING ENTRY OF QUALIFIED IMG PHYSICIANS TO US MEDICAL PRACTICE

RECOMMENDATION:

Resolution 308 be <u>adopted</u>.

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)

Your Reference Committee received online and in-person testimony in overwhelming support of Resolution 308. Speakers noted that this resolution, which calls for a study, will evaluate how "qualified" foreign-born international medical graduates (IMGs) can be placed into an expeditious pathway of learning the American health care system while fulfilling credentialing, licensure, and certification requirements. Speakers noted the diverse educational and professional experiences that foreign-born IMGs offer and were supportive of expediting the process of entry for those deemed to have the appropriate knowledge and skills required for US medical practice. Speakers also noted that this study is important to prevent the possibility of a tiered level of physician credentialing and to ensure high quality medical care regardless of the patient's geographic location. Therefore, your Reference Committee recommends that Resolution 308 be adopted.

RECOMMENDED FOR ADOPTION AS AMENDED

(4) COUNCIL ON MEDICAL EDUCATION REPORT 3 – STANDARDIZATION OF MEDICAL LICENSING TIME LIMITS ACROSS STATES (RESOLUTION 305-A-18)

RECOMMENDATION A:

Recommendation 1 in Council on Medical Education Report 3 be <u>amended by deletion</u>, to read as follows:

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)

RECOMMENDATION B:

Recommendation 3 in Council on Medical Education Report 3 be <u>deleted</u>:

~~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)~~

RECOMMENDATION C:

Recommendations in Council on Medical Education Report 3 be <u>adopted as amended</u> and the remainder of the report be <u>filed</u>.

The Council on Medical Education recommends that the following recommendations be adopted in lieu of Resolution 305-A-18 and the remainder of the 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)

Testimony was offered in unanimous support of the first and second recommendations in Council on Medical Education Report 3. Speakers noted that seven-year limits on licensure eligibility becomes problematic for medical students who need to take leaves of absence or for those pursuing dual degrees in a state that does not grant exception for these students. One speaker offered testimony to amend Recommendation 3 to set a floor on the time limit to avoid states implementing a uniform but lower limit that could negatively impact trainees in a single-degree program. However, the deletion made to the first recommendation extended the time limits for all licensure candidates and eliminated the need for the third recommendation. Therefore, your Reference Committee encourages adoption as amended of the recommendations in Council on Medical Education Report 3.

(5) COUNCIL ON MEDICAL EDUCATION REPORT 4 – BOARD CERTIFICATION CHANGES IMPACT ACCESS TO ADDICTION MEDICINE SPECIALISTS (RESOLUTION 314-A-18)

RECOMMENDATION A:

Council on Medical Education Report 4 be amended by the addition of a third Recommendation, to read as follows:

That our AMA recognize the American Osteopathic Association Bureau of Osteopathic Specialists for developing and providing a pathway for all qualified physicians to obtain subspecialty certification in addiction medicine, in order to improve access to care for patients with substance use disorder. (Directive to Take Action)

RECOMMENDATION B:

Council on Medical Education Report 4 be amended by the addition of a fourth Recommendation, to read as follows:

That our AMA recognize the American Osteopathic Association (AOA) for developing and providing a pathway for qualified physicians (DOs and MDs) with an active primary AOA board certification in any specialty to obtain subspecialty certification in Addiction Medicine, in order to improve access to care for patients with substance use disorder. (Directive to Take Action)

RECOMMENDATION C:

Recommendations in Council on Medical Education Report 4 be adopted as amended and the remainder of the report be filed.

The Council on Medical Education 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)

Your Reference Committee heard mostly supportive testimony favoring adoption of Council on Medical Education Report 4, which calls attention to the urgent need to train physicians in addiction medicine and recognizes the American Board of Preventive Medicine for providing a time-limited pathway for subspecialty certification in addiction medicine for the American Board of Addiction Medicine diplomates. In online and in-person testimony, speakers also noted that the American Osteopathic Association (AOA) and the AOA Bureau of Osteopathic Specialists have both developed and are independently providing a pathway for all qualified physicians to obtain subspecialty certification in addiction medicine. One speaker offered recommendations that asked the AMA to encourage hospitals and health systems to establish departments or sections of addiction medicine and to delineate clinical privileges in addiction medicine. However, a member of the Council on Medical Education testified that these additional recommendations could potentially lead to confusion of credentialing with certification. Therefore, your Reference Committee recommends that Council on Medical Education Report 4 be adopted as amended.

(6) COUNCIL ON MEDICAL EDUCATION REPORT 6 – VETERANS HEALTH ADMINISTRATION FUNDING OF GRADUATE MEDICAL EDUCATION (RESOLUTION 954-I-18)

RECOMMENDATION A:

Recommendation 1 in Council on Medical Education Report 6 be amended by addition and deletion, to read as follows:

That our AMA support postgraduate medical education service obligations through ~~any~~ programs where the expectation for service, such as military service, is reasonable and explicitly delineated in the contract with the trainee. (New HOD Policy)

RECOMMENDATION B:

Recommendations in Council on Medical Education Report 6 be adopted as amended and the remainder of the report be filed.

The Council on Medical Education recommends that the following recommendations be adopted in lieu of Resolution 954-I-18 and the remainder of the 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)

Testimony was offered online and in-person in unanimous support of Council on Medical Education Report 6. Speakers noted that this report ensures support for postgraduate medical education service obligations, where that expectation is explicitly delineated in a trainee's contract, and opposition to a "blanket imposition" of service obligations on physician trainees who simply rotate through a Veterans Health Administration facility as one of their training sites. Speakers also offered an amendment to clarify that this report focuses on military service, since the Council on Medical Education will address other types of services in an upcoming report on graduate medical education and the corporate practice of medicine planned for the 2020 Annual Meeting. Therefore, your Reference Committee recommends that Council on Medical Education Report 6 be adopted as amended.

(7) RESOLUTION 302 – STRENGTHENING STANDARDS FOR LGBTQ MEDICAL EDUCATION

RECOMMENDATION A:

Resolution 302 be amended by addition and deletion, to read as follows:

RESOLVED, That our AMA 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:

**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~~ related to sexual orientation and gender identity; and (3) encourages ~~the Liaison Committee on Medical Education (LCME), the American Osteopathic Association (AOA), and the Accreditation Council for Graduate Medical Education (ACGME)~~ medical education accreditation bodies to both continue to encourage and periodically reassess ~~include Lesbian, Gay, Bisexual, Transgender and Queer~~ education on health issues related to sexual orientation and gender identity in the basic science, clinical care, and cultural competency ~~curriculum~~ curricula ~~for both~~ in 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~~.

RECOMMENDATION B:

Resolution 302 be adopted as amended.

RECOMMENDATION C:

The title of Policy H-295.878 be changed, to read as follows:

Eliminating Health Disparities - Promoting Awareness and Education of Sexual Orientation and Gender Identity Health Issues in Medical Education

RESOLVED, That our AMA 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)

Your Reference Committee heard unanimous testimony in overwhelming support of this resolution. Additionally, there was testimony that the term "LGBTQ" may not represent individuals who are "non-binary," a more prevalent term and that leaving the language open to sexual orientation and gender identity may be more inclusive than the current policy's specificity. The Accreditation Council for Graduate Medical Education provides a model in this regard, referencing education on "sexual orientation." Your Reference Committee found this language compelling and clarifying for the purpose of AMA policy enhancement, and therefore has included this verbiage in its proffered revisions to Resolution 302, and urges adoption as amended.

(8) RESOLUTION 305 – ENSURING ACCESS TO SAFE AND QUALITY CARE FOR OUR VETERANS

RECOMMENDATION A:

Resolution 305 be amended by addition and deletion, to read as follows:

Ensuring Access to Safe and Quality 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 supports access to ~~similar~~ clinical educational resources for all health care professionals involved in the care of veterans such as those provided by the U.S. Department of Veterans Affairs to their employees with the goal of providing better care for all veterans.

6. 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)

RECOMMENDATION B:

Resolution 305 be adopted as amended.

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 Safe and Quality 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 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.
6. 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)

Your Reference Committee heard strong support for the purpose and intent of Resolution 305. Speakers unanimously agreed that physicians should continuously strive to provide optimal care for our nation's veterans. During testimony it was noted that the resolution, as written, may be perceived as placing the onus of developing clinical educational resources on the VA system, which has strict regulations about accessing and completing required compliance and education-related training. An amendment was offered to clarify the goal of developing, and making readily available, these clinical educational resources which could be developed by any entity hopefully in conjunction with the VA. Speakers also noted that communications between VA and non-VA communities should be improved and that further policy changes related to communication merit consideration in the future. Therefore, your Reference Committee recommends that Resolution 305 be adopted as amended.

(9) RESOLUTION 310 – PROTECTION OF RESIDENT AND FELLOW TRAINING IN THE CASE OF HOSPITAL OR TRAINING PROGRAM CLOSURE

RECOMMENDATION A:

The first Resolve of Resolution 310 be <u>amended by addition and deletion</u>, to read as follows:

RESOLVED, That our American Medical Association study and provide recommendations on how the process of assisting <u>displaced</u> ~~orphaned~~ residents and fellows could be improved in the case of training hospital or training program closure, including:

1) The current processes by which a displaced resident or fellow may seek and secure an alternative training position; and

2) How the Centers for Medicare and Medicaid Services (CMS) and other additional or supplemental <u>graduate medical education (GME)</u> funding is re-distributed, including but not limited to:

a. The direct or indirect classification of residents and fellows as financial assets and the implications thereof;

b. The transfer of training positions between institutions and the subsequent impact on resident and fellow funding lines in the event of closure;

c. The transfer of full versus partial funding for new training positions; and

d. The transfer of funding for <u>displaced</u> ~~orphaned~~ residents and fellows who switch specialties (Directive to Take Action); and be it further

RECOMMENDATION B:

The second Resolve of Resolution 310 be amended by addition and deletion, to read as follows:

RESOLVED, That our AMA work with the Centers for Medicare and Medicaid Services (CMS) to establish regulations that ~~which~~ protect residents and fellows impacted by program or hospital closure, which may include recommendations for:
1) Notice by the training hospital, intending to file for bankruptcy within 30 days, to all residents and fellows primarily associated with the training hospital, as well as those contractually matched at that training institution who may not yet have matriculated, of its intention to close, along with provision of reasonable and appropriate procedures to assist current and matched residents and fellows to find and obtain alternative training positions that ~~which~~ minimize undue financial and professional consequences, including but not limited to maintenance of specialty choice, length of training, initial expected time of graduation, location and reallocation of funding, and coverage of tail medical malpractice insurance that would have been offered had the program or hospital not closed;
2) Revision of the current CMS guidelines that may prohibit transfer of funding prior to formal financial closure of a teaching institution;
3) Improved provisions regarding transfer of GME funding for displaced residents and fellows for the duration of their training in the event of program closure at a training institution; and
4) Protections against the discrimination of displaced ~~orphaned~~ residents and fellows consistent with H-295.969 (Directive to Take Action); and be it further

RECOMMENDATION C:

The third Resolve of Resolution 310 be amended by addition and deletion, to read as follows:

RESOLVED, That our AMA work with the Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, National Resident Matching Program, Educational Commission for Foreign Medical Graduates, ~~the~~ Centers for Medicare and Medicaid Services, and other relevant stakeholders to identify a process by which displaced ~~orphaned~~ residents and fellows may be directly represented in

proceedings surrounding the closure of a training hospital or program (Directive to Take Action); and be it further

RECOMMENDATION D:

The fourth Resolve of Resolution 310 be amended by addition and deletion, to read as follows:

RESOLVED, That our AMA work with the Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, National Resident Matching Program, Educational Commission for Foreign Medical Graduates, ~~the~~ Centers for Medicare and Medicaid Services, and other relevant stakeholders to:
1) Develop a stepwise algorithm for designated institutional officials and program directors to assist residents and fellows with finding and obtaining alternative training positions; ~~and~~
2) Create a centralized, regulated process for displaced ~~orphaned~~ residents and fellows to obtain new training positions;
3) Develop pathways that ensure that closing and accepting institutions provide liability insurance coverage to residents, at no cost to residents. (Directive to Take Action)

RECOMMENDATION E:

Resolution 310 be adopted as amended.

RESOLVED, That our American Medical Association study and provide recommendations on how the process of assisting orphaned residents and fellows could be improved in the case of training hospital or training program closure, including:
1) The current processes by which a displaced resident or fellow may seek and secure an alternative training position; and
2) How the Centers for Medicare and Medicaid Services (CMS) and other additional or supplemental GME funding is re-distributed, including but not limited to:
a. The direct or indirect classification of residents and fellows as financial assets and the implications thereof;
b. The transfer of training positions between institutions and the subsequent impact on resident and fellow funding lines in the event of closure;
c. The transfer of full versus partial funding for new training positions; and
d. The transfer of funding for orphaned residents and fellows who switch specialties (Directive to Take Action); and be it further

RESOLVED, That our AMA work with the Centers for Medicare and Medicaid Services (CMS) to establish regulations which protect residents and fellows impacted by program or hospital closure which may include recommendations for:

1) Notice by the training hospital, intending to file for bankruptcy within 30 days, to all residents and fellows primarily associated with the training hospital, as well as those contractually matched at that training institution who may not yet have matriculated, of its intention to close, along with provision of reasonable and appropriate procedures to assist current and matched residents and fellows to find and obtain alternative training positions which minimize undue financial and professional consequences, including but not limited to maintenance of specialty choice, length of training, initial expected time of graduation, location and reallocation of funding, and coverage of tail medical malpractice insurance that would have been offered had the program or hospital not closed;
2) Revision of the current CMS guidelines that may prohibit transfer of funding prior to formal financial closure of a teaching institution;
3) Improved provisions regarding transfer of GME funding for displaced residents and fellows for the duration of their training in the event of program closure at a training institution; and
4) Protections against the discrimination of orphaned residents and fellows consistent with H-295.969 (Directive to Take Action); and be it further

RESOLVED, That our AMA work with the Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, National Resident Matching Program, Educational Commission for Foreign Medical Graduates, the Centers for Medicare and Medicaid Services and other relevant stakeholders to identify a process by which orphaned residents and fellows may be directly represented in proceedings surrounding the closure of a training hospital or program (Directive to Take Action); and be it further

RESOLVED, That our AMA work with the Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, National Resident Matching Program, Educational Commission for Foreign Medical Graduates, the Centers for Medicare and Medicaid Services, and other relevant stakeholders to:
1) Develop a stepwise algorithm for designated institutional officials and program directors to assist residents and fellows with finding and obtaining alternative training positions; and
2) Create a centralized, regulated process for orphaned residents and fellows to obtain new training positions. (Directive to Take Action)

Your Reference Committee heard strong testimony in support of this resolution, due to the recent events that occurred earlier this year at Hahnemann University Hospital in Philadelphia, and the urgent need for AMA action on this issue for those individuals affected and for future policies to ensure adequate protections going forward. Speakers noted concerns related to the funding for residents inadvertently displaced, as might occur with a natural disaster (e.g., Hurricane Katrina)—versus those who are removed from a residency program due to issues with clinical performance and/or professionalism. Similarly, the loss of liability coverage when a hospital goes bankrupt was a cogent concern. Speakers also noted the time sensitivity associated with those residents with J-1 Visa contractual obligations. To address the issue of end-to-end liability coverage for residents, additional text was added to the end of Resolve 4 to ensure that neither closing nor accepting institutions capitulate to financial exigencies and eliminate this needed coverage. Therefore, your Reference Committee recommends that Resolution 310 be adopted as amended.

RECOMMENDED FOR ADOPTION IN LIEU OF

(10) COUNCIL ON MEDICAL EDUCATION REPORT 2 – HEALTHCARE FINANCE IN THE MEDICAL SCHOOL CURRICULUM (RESOLUTION 307-A-18)

RESOLUTION 307 – IMPLEMENTATION OF FINANCIAL EDUCATION CURRICULUM FOR MEDICAL STUDENTS AND PHYSICIANS IN TRAINING

RECOMMENDATION:

Recommendation in Council on Medical Education Report 2 be <u>adopted in lieu of Resolution 307</u> and the remainder of the report be <u>filed</u>.

The Council on Medical Education 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 <u>and residencies</u> 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)

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)

Your Reference Committee heard testimony on Council on Medical Education Report 2 in strong support of the need for adequate and appropriate education for medical students and resident/fellow physicians in curricular content related to financing of the U.S. health care system and personal economics. These issues are increasing in complexity, and importance, and our future physicians need exposure to these issues. Similarly, testimony on Resolution 307, while limited, reflected this need for targeted education on economics-related issues. Curricular content on these topics is currently required by the Liaison Committee on Medical Education and Accreditation Council for Graduate Medical

Education in undergraduate and graduate medical education, respectively. 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. Finally, our AMA provides online educational resources on health systems science (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. Accordingly, your Reference Committee recommends that Council on Medical Education Report 2 be adopted in lieu of Resolution 307.

RECOMMENDED FOR REFERRAL

(11) RESOLUTION 304 – ISSUES WITH THE MATCH, THE NATIONAL RESIDENCY MATCHING PROGRAM (NRMP)

RECOMMENDATION:

Resolution 304 be referred.

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)

Your Reference Committee heard mixed testimony in regard to Resolution 304. Online and in-person testimony suggested that this resolution, which calls for a broad investigation into several different aspects of the resident match, including data on

unmatched residents, strategies for a successful match, and last year's technological failure during the SOAP process, has already been addressed in the recent past by the Council on Medical Education (CME Report 6-A-17, Addressing the Increasing Number of Unmatched Medical Students). Speakers noted that the AMA has extensive policy on expanding graduate medical education (BOT Report, 25-A-19, All Payer Graduate Medical Education Funding). Speakers also noted that the National Resident Matching Program and the Association of American Medical Colleges release yearly authoritative reports on match outcomes with granular data for medical students to aid in their decision making. Testimony also pointed out some factual errors and erroneous statements regarding the Resolves, including the incorrect name for the "National Resident Matching Program," as well as a lack of awareness of the costs associated and pathways to successful participation with The Match. Speakers also expressed concern that current efforts to address this issue have been insufficient. Your Reference Committee initially considered reaffirmation of existing policy in lieu of Resolves 1 and 2, and deletion of Resolve 3, due to inconsistencies in terminology, among other issues, but we believe that referral of the entire item is appropriate, so that your Council on Medical Education can fully examine and address these concerns in a future study. Therefore, your Reference Committee recommends that Resolution 304 be referred.

(12) RESOLUTION 309 – FOLLOW-UP ON ABNORMAL MEDICAL TEST FINDINGS

RECOMMENDATION:

Resolution 309 be <u>referred</u>.

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)

Your Reference Committee heard testimony favoring referral of Resolution 309. Speakers noted that there are many different tests in different settings. Speakers also noted that there is no one accepted uniform guideline for communication of abnormal test results, and federal and state mandated requirements related to imaging studies vary. Speakers also stressed that this item required further study to review all relevant specialties that communicate patient results as well as to determine which published guidelines and recommendations were evidence based. Due to the complexity of this resolution, your Reference Committee recommends that Resolution 309 be referred for further study.

Mr. Speaker, this concludes the report of Reference Committee C. I would like to thank Henry Dorkin, MD; Susan Thompson Hingle, MD; Nathanial Nolan, MD, Venkat K. Rao, MD; Abigail Solom; Daniel M. Young, MD; and all those who testified before the committee, as well as our AMA staff, including Catherine Welcher, Fred Lenhoff, Tanya Lopez, and Alejandro Aparicio, MD.

Henry Dorkin, MD, FAAP (Alternate)
Massachusetts

Susan Thompson Hingle, MD, MACP, FRCP
American College of Physicians

Nathanial Nolan, MD, MPH
American College of Physicians

Venkat K. Rao, MD, FCCP
Michigan

Abigail Solom
Minnesota

Daniel M. Young, MD, FAAFP (Alternate)
New York

Louito C. Edje, MD, MHPE, FAAFP
Ohio
Chair