Reference Committee C

CME Report(s)

01 An Update on Continuing Board Certification
02 Graduate Medical Education and the Corporate Practice of Medicine
03 Protection of Resident and Fellow Training in the Case of Hospital or Training Program Closure

Resolution(s)

301 Creating a More Accurate Accounting of Medical Education Financial Costs
302 Student Loan Forgiveness
303 CME for Preceptorship
304 Establishing Minimum Standards for Parental Leave During Graduate Medical Education Training
305 Parental Leave and Planning Resources for Medical Students
306 Retirement of the National Board of Medical Examiners Step 2 Clinical Skills Exam for US Medical Graduates: Call for expedited action by the American Medical Association
307 USMLE Step Examination Failures During the COVID-19 Pandemic
308 ECFMG 2024 Accreditation Requirement for World Federation Medical Education (WFME) Recognition
309 Preserve and Increase Graduate Medical Education Funding

Reference Committee D

401 Fatigue Mitigation Respite for Faculty and Residents
406 Face Masking in Hospitals During Flu Season

Informational report, Council on Medical Education

04 Preparedness for Pandemics Across the Medical Education Continuum

REPORT 1 OF THE COUNCIL ON MEDICAL EDUCATION (November 2020)
An Update on Continuing Board Certification
(Resolutions 301-A-19 and 308-A-19)
(Reference Committee C)

EXECUTIVE SUMMARY

The Council on Medical Education has monitored continuing board certification (CBC) during the last year. This annual report, mandated by American Medical Association (AMA) Policy D-275.954, "Continuing Board Certification," provides an update on some of the changes that have occurred as a result of AMA efforts with the American Board of Medical Specialties (ABMS), ABMS member boards, and key stakeholders, to improve the CBC process.

In early 2018, the Continuing Board Certification: Vision for the Future Commission was established by the ABMS and charged with reviewing continuing certification within the current context of the medical profession. Later that year, the Council on Medical Education provided comments to strengthen the draft recommendations of the Commission. In February 2019, the Commission completed its final report based on research, testimony, and public feedback from stakeholders throughout the member boards and health care communities. The Commission's report contained 14 recommendations intended to modernize CBC so that it is meaningful, contemporary, and a relevant professional development activity for diplomates who are striving to be up to date in their specialty.[1] The ABMS and ABMS member boards, in collaboration with professional organizations and other stakeholders, agreed, prioritized these recommendations, and developed strategies to implement them. A summary of these strategies is provided in this report.

This report also highlights the following initiatives that are underway to improve CBC:

- The ABMS member boards have signaled their intent to offer alternatives to the high-stakes, 10-year examination. Three-fourths of the boards (75 percent) have completed or are administering longitudinal assessment pilots that combine adult learning principles with state-of-the-art technology, enabling delivery of assessments that promote learning and are less stressful. Appendix B in this report summarizes these new models.
- The ABMS member boards have broadened the range of acceptable activities that meet the Improvement in Medical Practice (IMP) requirements, including those offered at the physician's institution and/or individual practices, to address physician concerns about the relevance, cost, and burden associated with fulfilling the IMP requirements. Appendix B includes a summary of these initiatives.
- Studies published during the last year describe how new assessment models and IMP activities have resulted in improved quality and patient care and physician satisfaction. Appendix C provides a bibliography of recent studies and editorials published in peer-reviewed journals.

The Council on Medical Education is committed to ensuring that CBC supports physicians' ongoing learning and practice improvement and can assure the public that physicians are providing high-quality patient care. The Council will remain actively engaged in the implementation of the Commission's recommendations and continue to identify and suggest improvements to CBC programs.

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 1, November 2020

Subject: An Update on Continuing Board Certification (Resolutions 301-A-19 and 308-A-19)

Presented by: Liana Puscas, MD, MHS, Chair

Referred to: Reference Committee C

Resolution 301-A-19, "American Board of Medical Specialties Advertising," introduced by Virginia, the American Association of Clinical Urologists, Louisiana, and Mississippi and referred by the American Medical Association (AMA) House of Delegates (HOD), asks the AMA to oppose the use of any physician fees, dues, etc., for any advertising by the American Board of Medical Specialties or any of their component boards to the general public.

Resolution 308-A-19, "Maintenance of Certification Moratorium," introduced by New York and referred by the AMA HOD, asks the AMA to:

1. Call for an immediate end to the high stakes examination components as well as an end to the Quality Initiative (QI)/Practice Improvement (PI) components of Maintenance of Certification (MOC).
2. Call for retention of continuing medical education (CME) and professionalism components (how physicians carry out their responsibilities safely and ethically) of MOC only.
3. Petition the American Board of Medical Specialties for the restoration of certification status for all diplomates who have lost certification status solely because they have not complied with MOC requirements.

Policy D-275.954(1), "Continuing Board Certification," asks that the AMA continue to monitor the evolution of Continuing Board Certification (CBC), continue its active engagement in discussions regarding their implementation, encourage specialty boards to investigate and/or establish alternative approaches for CBC, and prepare a yearly report to the HOD regarding the CBC process." It should be noted that "CBC" is a new term for the MOC Program being used by the American Board of Medical Specialties (ABMS) Board of Directors and some ABMS member boards (other member boards are still referring to the program as MOC). Policy D-275.954 was revised in 2019 to be consistent with this change.

This report is in response to this policy and the two referenced resolutions noted above.

BACKGROUND

During the 2019 Annual Meeting, testimony before Reference Committee C was mixed regarding Resolution 301-A-19. Testimony noted that hospitals, insurance companies, malpractice insurers, and others often require board certification for a physician to practice medicine and that physicians are essentially required to maintain active certification and pay yearly fees to their specialty boards. Testimony also noted that, although the AMA maintains robust policy on CBC, including policy

related to the cost of development and administration of the CBC components and transparency of finances of the ABMS and the ABMS member boards, this policy does not attempt to exert control over ABMS policies and procedures. In addition, this resolution is not consistent with AMA policy that supports informing the public about the value of board certification. Although the reference committee recommended that Resolution 301 not be adopted, the HOD voted to refer this resolution for further study.

Reference Committee C also heard mixed testimony regarding Resolution 308-A-19. It was stated that continuing certification has become another element that contributes to stress and burnout, and that many physicians find elements of continuous certification/MOC problematic. So, the Council on Medical Education continues to study the issues raised in this resolution. In addition, the ABMS convened a Stakeholders Council to address the recommendations of the recently released report of the Continuing Board Certification: Vision for the Future Commission that addresses some of these concerns. The AMA also has representation on the ABMS Continuing Certification Committee, which monitors and approves alternative models within the existing components of continuing certification. The committee is considering how to integrate the assessment of standards into everyday practice activities. The reference committee felt that a thorough review and analysis of the issues raised in this item was needed and recommended that Resolution 308 be referred with a report back to the HOD at the 2020 Annual Meeting.

CONTINUING BOARD CERTIFICATION: VISION FOR THE FUTURE COMMISSION

In early 2018, the Continuing Board Certification: Vision for the Future Commission (https://visioninitiative.org/), an independent body of 27 individuals representing diverse stakeholders, was established by the ABMS and charged with reviewing continuing certification within the current context of the medical profession. Later that year, the AMA Council on Medical Education provided comments to strengthen the draft recommendations of the Commission. In February 2019, the Commission completed its final report, which was the culmination of research, testimony, and public feedback from stakeholders throughout the member boards and health care communities. As noted in CME Report 2-A-19, the Commission's report contained 14 recommendations intended to modernize CBC so that it is meaningful, contemporary, and a relevant professional development activity for diplomates who are striving to be up to date in their specialty.[1] The ABMS and ABMS member boards, in collaboration with professional organizations and other stakeholders, agreed, prioritized these recommendations, and developed the following strategies as first steps to implement them:

- Creation of the "Achieving the Vision for Continuing Board Certification" Oversight Committee, charged with directing the implementation strategy.

- Establishment of the following task forces to implement key recommendations outlined by the Commission in its final report.
    - Standards Task Force – will obtain appropriate input from stakeholders including practicing physicians to develop new, integrated continuing certification standards, consistent with the Commission's recommendations, which will be implemented by the ABMS member boards.
    - Advancing Practice Task Force – will engage specialty societies, the Council on Medical Education, continuing professional development communities, and other expert stakeholders to identify practice environment changes necessary to support learning and improvement activities that produce data-driven advances in physicians' clinical practices.
    - Information and Data Sharing Task Force – will make recommendations regarding the processes and infrastructure necessary to facilitate data and information sharing between

ABMS member boards and key stakeholders in order to support development of future educational and assessment programs and activities.

- Professionalism Task Force – will address the aspirational Commission recommendation calling for the ABMS and the ABMS member boards to develop approaches to evaluate professionalism and professional standing and will work with other stakeholder organizations to explore approaches to future assessment of professionalism and enhance consistency in judgments regarding professional standards.
- Remediation Task Force – will define aspects and suggest pathways for remediation of gaps prior to certification loss as well as pathways for regaining eligibility after loss of certification.

- Agreement of all 24 ABMS member boards to commit to longitudinal or other formative assessment strategies and offer alternatives to the highly secure, point-in-time examinations of knowledge.

- Commitment by the ABMS to develop new, integrated standards for continuing certification programs by 2020. The standards will address the Commission recommendations for flexibility in knowledge assessment and advancing practice, feedback to diplomates, and consistency.

Additional information about the progress of the ABMS and member boards is available at: vision.abms.org.

CONTINUING BOARD CERTIFICATION: AN UPDATE

The AMA Council on Medical Education and the HOD have carried out extensive and sustained work in developing policy on CBC (Appendix A), including working with the ABMS and the American Osteopathic Association (AOA) to provide physician feedback to improve the CBC processes, informing our members about progress on CBC through annual reports to the HOD, and developing strategies to address the concerns about the CBC processes raised by physicians. The Council has prepared reports covering CBC (formerly known as Maintenance of Certification and Osteopathic Continuous Certification) for the past 11 years.[1-11] During the last year, Council members, AMA trustees, and AMA staff have participated in the following meetings with the ABMS and its member boards:

- ABMS Committee on Continuing Certification
- ABMS Stakeholder Council
- ABMS 2019 Conference
- ABMS Board of Directors Meeting
- Academic Physicians Section November 2019 Meeting
- AMA/ABMS March 2020 Joint Meeting

ABMS Committee on Continuing Certification

The ABMS Committee on Continuing Certification (3C) is charged with overseeing the review process to CBC programs as well as policies and procedures. During 2018 and 2019, the 3C approved substantive program changes that have been implemented and announced new active pilot programs intended to enhance relevance to practice and improve diplomate satisfaction, while maintaining the rigor of educational, assessment, and improvement components. The 3C and the individual member boards continue to receive input from experts who research physician competence and administer assessment programs to discuss the future development of continuing professional development programs as well as security considerations, performance standards, and

psychometric characteristics of longitudinal assessment programs. Additionally, the 3C is currently addressing issues of importance to multiple certificate holders, holders of co-sponsored certificates, and physicians trained through non-Accreditation Council for Graduate Medical Education-approved pathways.

ABMS Stakeholder Council

Formed in 2018, the Stakeholder Council is an advisory body representing the interests of active diplomate physicians, patients, and the public. It was established to ensure that the decisions of the ABMS Board of Directors are grounded in an understanding of the perspectives, concerns, and interests of the multiple constituents impacted by the ABMS's work. The Stakeholder Council also provides guidance to the Achieving the Vision Oversight Commission as it rolls out the Achieving the Vision implementation plan.

At its May 2019 meeting, the Stakeholder Council discussed how the ABMS and its member boards can effectively communicate the evolving process of continuing certification that better balances learning and assessment, in enhancing its value to physicians while meeting the needs of the public for a meaningful credential. Issues identified as an important part of the Council's charge included sharing research, promoting best practices for new/emerging technologies, developing novel assessment techniques, aligning continuing certification activities with national reporting and licensure requirements, strengthening relationships between boards and specialty societies, and engaging in patient advocacy.

ABMS Accountability and Resolution Committee

In 2018, the ABMS also established the Accountability and Resolution Committee (ARC). The ARC, which is comprised of members of the ABMS Board of Directors on a rotating basis, including the Board's public members, is authorized by the ABMS Board to address and make recommendations regarding complaint resolution and allegations of noncompliance by the member boards, when issues have not been resolved through other mechanisms. The ARC is intended to collectively empower the larger ABMS member board community and promote shared accountability and responsibility.

Academic Physicians Section November 2019 Meeting

The November 2019 Academic Physicians Section featured a CME session, "Update on ABMS Continuing Board Certification," that was cosponsored by the Council on Medical Education and Young Physicians Section. The panel discussed the new paradigm of CBC, which has replaced MOC, the advantages of participation in CBC, and the current position of the AMA and its contributions to improvements in MOC/CBC, based on Council on Medical Education reports and AMA policy.

AMA/ABMS March 2020 Joint Meeting

On March 16, the Council on Medical Education facilitated a joint conference call with the ABMS and representatives from some of the ABMS member boards to hear an update on the work of the ABMS Standards Task Force formed to develop new continuing certification standards consistent with the recommendations of the Vision for the Future Commission. The draft revised Standards for the ABMS Program for Continuing Board Certification were also presented to the Council. The ABMS plans to circulate the revised standards for public comment in late summer. The Council also plans to schedule an additional meeting with the ABMS and the ABMS member boards in

2020 to discuss the work of the other four task forces that are implementing the charges of the Commission.

Update on New Continuing Medical Education Models

The ABMS Continuing Certification Directory™ (https://www.abms.org/initiatives/abms-continuing-certification-directory/) continues to offer physicians access to a comprehensive, centralized, web-based repository of CME activities that have been approved for CBC credit by the ABMS member boards. Users can search practice-relevant activities that have been approved by one or more member boards. During the past year, the directory has increased its inventory and now indexes more than 1,000 open-access accredited CME activities from more than 60 CME providers, including Opioid Prescriber Education Programs, to help diplomates from across specialties meet CBC requirements for Lifelong Learning and Self-Assessment (Part II) and Improvement in Medical Practice (Part IV). Many of the member boards collaborate with specialty societies to develop continuing certification and/or CME activities through which physicians can satisfy CBC requirements.

The following types of activities are currently included in the directory: internet enduring activities, journal-based CME, internet point of care, live activities, and performance improvement CME. All CME activities are qualified to award credit(s) from one or more of the CME credit systems: *AMA PRA Category 1 Credit™,* American Academy of Family Physicians (AAFP) Prescribed Credit, American College of Obstetricians and Gynecologists (ACOG) Cognates, and AOA Category 1-A.

Many member boards also employ technology to personalize assessments that promote greater self-awareness and support participation in CME. For example, the American Board of Anesthesiology (ABA) is now able to link assessment results from its MOCA Minute® program with CME opportunities. More than half (53 percent) of MOCA Minute® questions can be linked to at least one CME activity, and more than 110 accredited CME providers have been able to link a combined total of 3,261 activities to the MOCA content outline.[12] This technology facilitates identification of knowledge gaps and targets learning strategies.

Update on Innovative Knowledge Assessments being Offered as an Option to the Secure, High-Stakes Examination

The ABMS member boards have signaled their intent to offer alternatives to the high-stakes, 10-year examination. Twenty-three ABMS member boards (95.8 percent) have moved away from the secure, high-stakes exam, and more than 90 percent have completed, or will soon be launching assessment pilots that combine adult learning principles with state-of-the-art technology, enabling delivery of assessments that promote learning and are less stressful (Appendix B).

Fourteen member boards have implemented and/or are piloting a longitudinal assessment approach which involves administering shorter assessments of specific content, such as medical knowledge, repeatedly over a period of time. Seven of these boards are using CertLink® a technology platform developed by the ABMS to support the boards in delivering more frequent, practice-relevant, and user-friendly competence assessments to physicians (https://www.abms.org/initiatives/certlink-platform-and-pilot-programs/). This platform provides technology to enable boards to create assessments focused on practice-relevant content; offers convenient access on desktop or mobile device (depending on each board's program); provides immediate, focused feedback and guidance to resources for further study; and provides a personalized dashboard that displays participating physicians' areas of strength and weakness. In a recent ABMS survey, 95 percent of physicians using CertLink® indicated a reduction in test anxiety, 98 percent preferred CertLink® and

longitudinal assessment over the every-10-year exam, and most considered CertLink® as a feasible method for keeping up-to-date with developments and an adequate assessment of fundamental knowledge used in everyday practice.[13] To date, more than 10,000 physicians are active on CertLink® and have answered more than 800,000 questions across the seven member boards.

The transition to new, formative approaches to the assessment of knowledge and clinical judgment has created unique opportunities for ABMS member boards and specialty societies to work together to design the future of continuing board certification. The American Board of Internal Medicine (ABIM), American Board of Obstetrics and Gynecology (ABOG), and American Board of Plastic Surgery are adopting these new approaches.[14]

The ABIM also announced that it anticipates launching a longitudinal assessment option in 2022 in as many specialties as possible.[15] As part of this option, internists will be able to:

- Answer a question at any place or time and receive immediate feedback;
- See the rationale behind the answer, along with links related to educational material;
- Proceed at their preferred pace answering questions during each administration window; and,
- Access all the resources used in practice, such as journals or websites.

The ABIM has invited the internal medicine community to provide suggestions on this new pathway through its Community Insights Network and share feedback through surveys, interviews, user tests, and ABIM's online community ABIM Engage.[15] The ABIM convened a Physician Advisory Panel from members of the Community Insights Network representing a range of practice settings, specialties, and geographies to provide input and feedback throughout the project's development and implementation. The ABIM staff are attending society meetings throughout 2020 to offer physicians individualized guidance and ask for their feedback. ABIM will also work with interested societies to explore ways of linking ABIM assessment content with society educational materials.

Other member board efforts to improve knowledge assessments include more diplomate input into exam content; integrating journal article-based core questions into assessments; modularization of exam content that allows for tailoring of assessments to reflect physicians' actual areas of practice; access during the exam to knowledge resources similar to those used at the point of care; remote proctoring to permit diplomates to be assessed at home or in their office; and performance feedback mechanisms. All boards also provide multiple opportunities for physicians to retake the exam. These program enhancements will significantly reduce the cost diplomates incur to participate in CBC by reducing the need to take time off or travel to a testing center to prepare for the assessment; ensure that the assessment is practice-relevant; emphasize the role of assessment for learning; assure opportunities for remediation of knowledge gaps; and reduce the stress associated with a high-stakes test environment.

Seventeen member boards have retained the traditional secure exam option for reentry purposes and for diplomates who prefer this exam method. The American Board of Urology has customized its traditional secure exam to practice with feedback and assigns CME for areas of substandard performance on the exam.

Progress with Refining Part IV, Improvement in Medical Practice

The ABMS member boards have broadened the range of acceptable activities that meet the Improvement in Medical Practice (IMP) requirements, including those offered at the physician's institution and/or individual practices, to address physician concerns about the relevance, cost, and burden associated with fulfilling the IMP requirements (Appendix B). In addition to improving alignment between national value-based reporting requirements and continuing certification programs, the boards are implementing several activities related to registries, practice audits, and systems-based practice.

Patient registries (also known as clinical data registries) provide information to help physicians improve the quality and safety of patient care—for example, by comparing the effectiveness of different treatments for the same disease. While many member boards allow physicians to earn Part IV credit for participating in externally developed patient registries, the American Board of Ophthalmology, American Board of Otolaryngology-Head and Neck Surgery, and American Board of Family Medicine have designed board-specific initiatives that are supported by registry data.

Several ABMS member boards have developed online practice assessment protocols that allow physicians to assess patient care using evidence-based quality indicators. For example:

- The American Board of Pediatrics (ABP) and American Board of Radiology (ABR) offer free tools to complete an IMP project, including a simplified and flexible template to document small improvements, educational videos, infographics, and enhanced web pages;
- The American Board of Preventive Medicine has partnerships with specialty societies to design quality and performance improvement activities for diplomates with a population-based clinical focus;
- Fourteen boards have successfully integrated patient experience and peer review into several of the boards' IMP requirements (the American Board of Psychiatry and Neurology has aggressively addressed the issue of cost and unnecessary procedures with an audit and feedback program);
- Six boards including the ABA and ABOG, have integrated simulation options; and
- Two boards (the ABP and ABR) have a process for individual physicians to develop their own improvement exercises that address an issue of personal importance, using data from their own practices, built around the basic Plan-Do-Study-Act (PDSA) process.

The ABMS member boards are aligning CBC activities with other organizations' QI efforts to reduce redundancy and physician burden while promoting meaningful participation. Eighteen of the boards encourage participation in organizational QI initiatives through the ABMS Multi-Specialty Portfolio Program™ (described below). Many boards encourage involvement in the development and implementation of safety systems or the investigation and resolution of organizational quality and safety problems. For physicians serving in research or executive roles, some boards have begun to give IMP credit for having manuscripts published, writing peer-reviewed reports, giving presentations, and serving in institutional roles that focus on QI (provided that an explicit PDSA process is used). Physicians who participate in QI projects resulting from morbidity and mortality conferences and laboratory accreditation processes resulting in the identification and resolution of quality and safety issues can also receive IMP credit from some boards.

ABMS Multi-Specialty Portfolio Program

The ABMS Multi-Specialty Portfolio Program (Portfolio Program™) offers health care organizations a way to support physician involvement in their institution's quality and performance improvement initiatives by offering credit for the IMP component of the ABMS Program for MOC (mocportfolioprogram.org). Originally designed as a service for large hospitals, the Portfolio Program™ is extending its reach to physicians whose practices are not primarily in institutions. This includes non-hospital organizations such as academic medical centers, integrated delivery systems, interstate collaboratives, specialty societies, and state medical societies. More than 3,735 types of QI projects have been approved by the Portfolio Program™ in which 18 ABMS member boards participate, focusing on such areas as advanced care planning, cancer screening, cardiovascular disease prevention, depression screening and treatment, provision of immunizations, obesity counseling, patient-physician communication, transitions of care, and patient-safety-related topics including sepsis and central line infection reduction. Many of these projects have had a profound impact on patient care and outcomes. There have been nearly 32,000 instances of physicians receiving IMP credit through participation in the program. Recent additions among the nearly 100 current sponsors include Abt Associates, Lexington Medical Center, Gundersen Health System, Aspirus, and Dayton Children's Hospital.

Update on the Emerging Data and Literature Regarding the Value of CBC

The Council on Medical Education has continued to review published literature and emerging data as part of its ongoing efforts to critically review CBC issues. The annotated bibliography in Appendix C provides a summary of recent studies and editorials published in peer-reviewed journals on the following topics:

- Continuing medical education—A recent article explains new options for completing CME to meet the American Board of Surgery's CBC requirements.

- Knowledge assessments—Recently published articles provide information on the implementation of innovative knowledge assessment programs, such as the longitudinal approach, and describe how physicians prepare for assessments. Several studies show that examination performance correlates with better learning and retention of information and in many instances results in practice changes and better patient care.

- Association between continuous certification and practice related outcomes—Several peer-reviewed studies demonstrate the benefits of participating in a practice improvement program and show that integrating quality and patient safety activities in board-approved continuing certification programs is associated with quality care and improved patient outcomes.

- The impact of continuous certification on medical licensure—Recent studies show that examination performance and level of participation are associated with disciplinary action against medical licensure.

- ABMS and ABMS member board policies and initiatives—Several articles describe the ABMS Vision for the Future Commission's recommendations and the ABMS and ABMS member boards implementation plans.

- Physician satisfaction with continuous certification—Four studies describe physician satisfaction levels with new CBC requirements and longitudinal assessments.

- Concerns about CBC—These editorials discuss the lingering discontent with participation in continuing certification in order to satisfy federal government, insurer, employer, and credentialing requirements. Concerns about the cost, time, value, and relevance to practice are also discussed.

- Challenges and considerations—Two articles review current issues and challenges associated with CBC.

OSTEOPATHIC CONTINUOUS CERTIFICATION: AN UPDATE

The AOA Department of Certifying Board Services assists the osteopathic medical specialty certifying boards with the development and implementation of certification programs and assessments. Under the guidance of the AOA Bureau of Osteopathic Specialists, the specialty certifying boards are committed to enhancing certification services to better serve candidates and diplomates pursing and maintaining AOA certification.

In October 2019, the American Osteopathic Board of Family Physicians established an early entry pathway for initial board certification in family medicine. Physicians who meet eligibility requirements and complete two osteopathic in-service examinations may pursue specialty board certification while still completing residency. Upon passing the Early Entry Initial Certification board certification exam in the final year of residency, diplomates will begin the process of Osteopathic Continuous Certification (OCC).

The American Osteopathic Board of Internal Medicine (AOBIM) will offer an early entry examination for candidates pursuing initial certification beginning in March 2020. The early entry examination provides flexibility and options for completing examination requirements pursuant to certification for internal medicine residents.

The AOA is developing options for future certification and continuous certification pathways in recognition of the uniqueness of the contemporary practice of medicine and the value of flexible and sustainable certification models. In recognition of the osteopathic-centered approach to patient assessment, evaluation, and treatment, the certification pathways will focus on targeting the medical knowledge, skills, and critical thinking of the competent practicing physician.

Leading the charge for innovation and change, the American Osteopathic Board of Radiology implemented a self-assessment module (SAM) to meet the cognitive assessment OCC requirement, replacing the 10-year interval examination. Following suit, the American Osteopathic Board of Anesthesiology and American Osteopathic Board of Obstetrics and Gynecology have recently launched innovative assessment models in fulfillment of the requirement to demonstrate competency in specialty medical subject matter. The new models provide increased flexibility by leveraging technology to deliver content at prescribed intervals, relevant to the specialty board's scope of practice.

Four additional boards—the American Osteopathic Board of Family Physicians, American Osteopathic Board of Emergency Medicine, American Osteopathic Board of Internal Medicine, and the American Osteopathic Board of Surgery—are pursuing changes to their cognitive assessment component of OCC in 2020 to provide a fluid, adaptive process to the diplomates.

The AOA offers board certification in 27 primary specialties and 49 subspecialties (including certifications of added qualifications). Nine of the 49 subspecialties are conjoint certifications

managed by multiple AOA specialty boards. As of May 31, 2019, a total of 34,294 osteopathic physicians held 39,968 active certifications issued by the AOA's specialty certifying boards. During the 2019 membership year, 2,376 new certifications were processed:

- Primary Specialty: 1,925
- Subspecialty: 386
- Certification of Added Qualifications (Family Medicine and Preventive Medicine only): 65

During the 2019 membership year, 1,644 osteopathic continuing certifications were processed.

ABMS ADVERTISING

Resolution 301-A-19, "American Board of Medical Specialties Advertising" asks that the AMA oppose the use of any physician fees, dues, etc., for any advertising by the ABMS or any of their component boards to the general public. The ABMS does not have any public marketing campaigns. However, the ABMS does have "Certification Matters," a public website that provides information on currently certified physicians. The purpose of the site is to provide consumers with a free resource to confirm that a physician they are considering is certified by an ABMS member board. There is some paid promotion of the site to increase awareness of its existence, and the ABMS published articles in two of its newsletters when the website was launched.

In August 2011, the ABMS began to display the CBC participation status of member board-certified physicians online (www.CertificationMatters.org). The information displayed includes the physician's name, certifying board(s), and "yes" or "no" as to whether the physician is meeting CBC standards. The AOA (though not mentioned in the resolution, the AOA maintains a continuous certification program) also provides information about the OCC status of member board-certified physicians upon request through its online DO Directory (www.doprofiles.org).

The ABMS website is being revised due to a request from the AMA adopted at the 2017 Annual Meeting, based on AMA Policy H-275.924 (26), which states, "The initial certification status of time-limited diplomates shall be listed and publicly available on all American Board of Medical Specialties (ABMS) and ABMS Member Boards' websites and physician certification databases. The names and initial certification status of time-limited diplomates shall not be removed from ABMS and ABMS Member Boards' websites or physician certification databases even if the diplomate chooses not to participate in MOC."

It is important to note that board certification assures the public that an independent third party has evaluated a physician's skills and abilities and that a physician conducts his or her practice according to a professional code of ethics and remains current with medical practices and procedures. Studies show that the public values physicians' participation in a board certification program and that the public views board certification as an important marker of trust regarding quality care.

During the past two years, the ABMS has funded research to better understand the public's perception of board certification and a small communication program to promote its value. The research included qualitative (focus groups) and quantitative (National Opinion Research Center at the University of Chicago) survey research. The communication program included posted social media (no costs) and promoted social media (under $25,000). ABMS funding comes from general revenue sources, including dues from ABMS member boards, and non-dues revenue sources, including ABMS' credentials verification service—ABMS Solutions, which serves as a leading method of primary source verification of a physician's board certification status to hospitals, health

systems, and insurers across the county. Through research the ABMS has confirmed that consumers implicitly understand that certification is important and look for information about it when they seek care for themselves and their families. In addition, ABMS board certification is frequently highlighted in consumer media stories which requires no direct costs.

The AMA's "Truth in Advertising" campaign highlights the need to improve transparency, clarity, and reliability of physician credentials for the patient and public. The AMA opposes any action, regardless of intent, that appears likely to confuse the public about the unique credentials of ABMS- or AOA-BOS-board certified physicians in any medical specialty or that takes advantage of the prestige of any medical specialty for purposes contrary to the public good and safety (H-275.926 [1], Maintaining Medical Specialty Board Certification Standard.)

The ABMS currently does not have plans to increase investments in the paid public promotion of board certification. However, it is important for the ABMS to reserve the right to advertise and promote board certification to build awareness and accurately communicate its value to the public. The more than 900,000 ABMS board certified physicians derive value from a trusted and recognized credential.[16] This is especially important considering competitive communications for other professions and credentials, some of which are much less rigorous.

While the AMA maintains robust policy on CBC, including policy related to the cost of development and administration of the CBC components, this policy does not attempt to exert control over ABMS/AOA policies and procedures. Existing AMA Policy H-275.924 (19) states that "the CBC process should be reflective of and consistent with the cost of development and administration of the CBC components, ensure a fair fee structure, and not present a barrier to patient care." Policy D-275.954 (9, 10) also states that our AMA will "encourage the ABMS to ensure that all ABMS member boards provide full transparency related to the costs of preparing, administering, scoring and reporting CBC and certifying examinations" and "encourage the ABMS to ensure that CBC and certifying examinations do not result in substantial financial gain to ABMS member boards, and advocate that the ABMS develop fiduciary standards for its member boards that are consistent with this principle."

CURRENT AMA POLICIES RELATED TO CBC

As noted above, the ABMS Board of Directors and some of the ABMS member boards are currently using a new name, "Continuing Board Certification," for their MOC Program (although some ABMS member boards are still referring to the program as MOC). To be consistent with this change, AMA policy was revised in 2019 to change the terms "Maintenance of Certification" that appeared in HOD Policies H-275.924, "AMA Principles on Maintenance of Certification," and D-275.954, "Maintenance of Certification and Osteopathic Continuous Certification," to "Continuing Board Certification" or "CBC," as shown in Appendix A.

DISCUSSION

The Council on Medical Education is actively engaged in the implementation of the Vision for the Future Commission's recommendations to improve the process for approximately 590,000 physicians who participate in CBC.[13] The member boards are engaging physicians in surveys and focus groups and in their committee appointments. This report highlights the progress the ABMS and ABMS member boards have made to ease the burden and improve the CBC process for physicians.

Resolution 308-A-19, "Maintenance of Certification Moratorium," calls for the immediate end to the high-stakes examination components and the quality initiative/practice improvement components of MOC. However, as noted in this report, the ABMS member boards have moved away from the secure high-stakes secure examination and more than three-fourths of the boards have completed (or soon will be launching) assessment pilots that combine adult learning principles with state-of-the-art technology, enabling delivery of assessments that are a more relevant, less onerous, and cost-efficient process for physicians. Appendix B in this report summarizes these new models. The ABMS member boards have also broadened the range of acceptable activities that meet the IMP requirements, including those offered at the physician's institution and/or individual practices, to address physician concerns about the relevance, cost, and burden associated with fulfilling the IMP requirements. Appendix B also includes a summary of these initiatives.

The second item in Resolution 308-A-19 calls for the retention of CME and professionalism components (how physicians carry out their responsibilities safely and ethically) of MOC only. Existing HOD Policy D-275.954 (32) already states, "Our AMA will…Continue to support the requirement of CME and ongoing, quality assessments of physicians, where such CME is proven to be cost-effective and shown by evidence to improve quality of care for patients." This policy aligns with the AMA *Code of Medical Ethics* which states, "Physicians should strive to further their medical education throughout their careers, to ensure that they serve patients to the best of their abilities and live up to professional standards of excellence. Participating in certified continuing medical education (CME) activities is critical to fulfilling this professional commitment to lifelong learning."[17] The Council on Medical Education is committed to ensuring that CBC programs support physicians' ongoing learning and practice improvement and serve to assure the public that physicians are providing high-quality patient care.

The third item in Resolution 308-A-19, asking that certification status be restored for all diplomates who have lost certification status solely because they have not complied with MOC requirements, will be addressed by the recently established ABMS Remediation Task Force. As noted in this report, the ABMS established the Task Force to address the Vision Commission's eighth recommendation, which reads, "The ABMS Boards must have clearly defined remediation pathways to enable diplomates to meet continuing certification standards in advance of and following any loss of certification." The Task Force will be responsible for defining aspects and suggest pathways for remediation of gaps prior to certification loss as well as pathways for regaining eligibility after loss of certification.

SUMMARY AND RECOMMENDATIONS

Throughout the past year, the Council has continued to monitor the development of continuing board certification programs and to work with the ABMS, ABMS member boards, AOA, and state and specialty medical societies to identify and suggest improvements to these programs. The AMA has also been actively engaged in the implementation of the Continuing Board Certification: Vision for the Future Commission's recommendations for the future continuing board certification process.

The Council on Medical Education therefore recommends that the following recommendation be adopted in lieu of Resolutions 301-A-19 and 308-A-19 and the remainder of the report be filed.

1. That our American Medical Association (AMA), through its Council on Medical Education, continue to work with the American Board of Medical Specialties (ABMS) and ABMS member boards to implement key recommendations outlined by the Continuing Board Certification: Vision for the Future Commission in its final report, including the development of new, integrated standards for continuing certification programs by 2020 that will address the Commission's recommendations for flexibility in knowledge assessment and advancing practice, feedback to diplomates, and consistency. (New HOD Policy)

Fiscal Note: $2,500.

APPENDIX A:
CURRENT HOD POLICIES RELATED TO CONTINUING BOARD CERTIFICATION

H-275.924, "Continuing Board Certification"

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

15. The CBC program should not be a mandated requirement for licensure, credentialing, recredentialing, privileging, reimbursement, network participation, employment, or insurance panel participation.
16. Actively practicing physicians should be well-represented on specialty boards developing CBC.
17. Our AMA will include early career physicians when nominating individuals to the Boards of Directors for ABMS member boards.
18. CBC activities and measurement should be relevant to clinical practice.
19. The CBC process should be reflective of and consistent with the cost of development and administration of the CBC components, ensure a fair fee structure, and not present a barrier to patient care.
20. Any assessment should be used to guide physicians' self-directed study.
21. Specific content-based feedback after any assessment tests should be provided to physicians in a timely manner.
22. There should be multiple options for how an assessment could be structured to accommodate different learning styles.
23. Physicians with lifetime board certification should not be required to seek recertification.
24. No qualifiers or restrictions should be placed on diplomates with lifetime board certification recognized by the ABMS related to their participation in CBC.
25. Members of our House of Delegates are encouraged to increase their awareness of and participation in the proposed changes to physician self-regulation through their specialty organizations and other professional membership groups.
26. The initial certification status of time-limited diplomates shall be listed and publicly available on all American Board of Medical Specialties (ABMS) and ABMS Member Boards websites and physician certification databases. The names and initial certification status of time-limited diplomates shall not be removed from ABMS and ABMS Member Boards websites or physician certification databases even if the diplomate chooses not to participate in CBC.
27. Our AMA will continue to work with the national medical specialty societies to advocate for the physicians of America to receive value in the services they purchase for Continuing Board Certification from their specialty boards. Value in CBC should include cost effectiveness with full financial transparency, respect for physicians' time and their patient care commitments, alignment of CBC requirements with other regulator and payer requirements, and adherence to an evidence basis for both CBC content and processes.
(Policy Timeline: CME Rep. 16, A-09 Reaffirmed: CME Rep. 11, A-12 Reaffirmed: CME Rep. 10, A-12 Reaffirmed in lieu of Res. 313, A-12 Reaffirmed: CME Rep. 4, A-13 Reaffirmed in lieu of Res. 919, I-13 Appended: Sub. Res. 920, I-14 Reaffirmed: CME Rep. 2, A-15 Appended: Res. 314, A-15 Modified: CME Rep. 2, I-15 Reaffirmation A-16 Reaffirmed: Res. 309, A-16 Modified: Res. 307, I-16 Reaffirmed: BOT Rep. 05, I-16 Appended: Res. 319, A-17 Reaffirmed in lieu of: Res. 322, A-17 Modified: Res. 953, I-17 Reaffirmation: A-19 Modified: CME Rep. 02, A-19)

D-275.954, "Continuing Board Certification"

Our AMA will:
1. Continue to monitor the evolution of Continuing Board Certification (CBC), continue its active engagement in discussions regarding their implementation, encourage specialty boards to investigate and/or establish alternative approaches for CBC, and prepare a yearly report to the House of Delegates regarding the CBC process.
2. Continue to review, through its Council on Medical Education, published literature and emerging data as part of the Council s ongoing efforts to critically review CBC issues.
3. Continue to monitor the progress by the American Board of Medical Specialties (ABMS) and its member boards on implementation of CBC, and encourage the ABMS to report its research findings on the issues surrounding certification and CBC on a periodic basis.

4. Encourage the ABMS and its member boards to continue to explore other ways to measure the ability of physicians to access and apply knowledge to care for patients, and to continue to examine the evidence supporting the value of specialty board certification and CBC.
5. Work with the ABMS to streamline and improve the Cognitive Expertise (Part III) component of CBC, including the exploration of alternative formats, in ways that effectively evaluate acquisition of new knowledge while reducing or eliminating the burden of a high-stakes examination.
6. Work with interested parties to ensure that CBC uses more than one pathway to assess accurately the competence of practicing physicians, to monitor for exam relevance and to ensure that CBC does not lead to unintended economic hardship such as hospital de-credentialing of practicing physicians.
7. Recommend that the ABMS not introduce additional assessment modalities that have not been validated to show improvement in physician performance and/or patient safety.
8. Work with the ABMS to eliminate practice performance assessment modules, as currently written, from CBC requirements.
9. Encourage the ABMS to ensure that all ABMS member boards provide full transparency related to the costs of preparing, administering, scoring and reporting CBC and certifying examinations.
10. Encourage the ABMS to ensure that CBC and certifying examinations do not result in substantial financial gain to ABMS member boards, and advocate that the ABMS develop fiduciary standards for its member boards that are consistent with this principle.
11. Work with the ABMS to lessen the burden of CBC on physicians with multiple board certifications, particularly to ensure that CBC is specifically relevant to the physician s current practice.
12. Work with key stakeholders to (a) support ongoing ABMS member board efforts to allow multiple and diverse physician educational and quality improvement activities to qualify for CBC; (b) support ABMS member board activities in facilitating the use of CBC quality improvement activities to count for other accountability requirements or programs, such as pay for quality/performance or PQRS reimbursement; (c) encourage ABMS member boards to enhance the consistency of quality improvement programs across all boards; and (d) work with specialty societies and ABMS member boards to develop tools and services that help physicians meet CBC requirements.
13. Work with the ABMS and its member boards to collect data on why physicians choose to maintain or discontinue their board certification.
14. Work with the ABMS to study whether CBC is an important factor in a physician s decision to retire and to determine its impact on the US physician workforce.
15. Encourage the ABMS to use data from CBC to track whether physicians are maintaining certification and share this data with the AMA.
16. Encourage AMA members to be proactive in shaping CBC by seeking leadership positions on the ABMS member boards, American Osteopathic Association (AOA) specialty certifying boards, and CBC Committees.
17. Continue to monitor the actions of professional societies regarding recommendations for modification of CBC.
18. Encourage medical specialty societies leadership to work with the ABMS, and its member boards, to identify those specialty organizations that have developed an appropriate and relevant CBC process for its members.
19. Continue to work with the ABMS to ensure that physicians are clearly informed of the CBC requirements for their specific board and the timelines for accomplishing those requirements.
20. Encourage the ABMS and its member boards to develop a system to actively alert physicians of the due dates of the multi-stage requirements of continuous professional development and performance in practice, thereby assisting them with maintaining their board certification.
21. Recommend to the ABMS that all physician members of those boards governing the CBC process be required to participate in CBC.

22. Continue to participate in the National Alliance for Physician Competence forums.
23. Encourage the PCPI Foundation, the ABMS, and the Council of Medical Specialty Societies to work together toward utilizing Consortium performance measures in Part IV of CBC.
24. Continue to assist physicians in practice performance improvement.
25. Encourage all specialty societies to grant certified CME credit for activities that they offer to fulfill requirements of their respective specialty board s CBC and associated processes.
26. Support the American College of Physicians as well as other professional societies in their efforts to work with the American Board of Internal Medicine (ABIM) to improve the CBC program.
27. Oppose those maintenance of certification programs administered by the specialty boards of the ABMS, or of any other similar physician certifying organization, which do not appropriately adhere to the principles codified as AMA Policy on Continuing Board Certification.
28. Ask the ABMS to encourage its member boards to review their maintenance of certification policies regarding the requirements for maintaining underlying primary or initial specialty board certification in addition to subspecialty board certification, if they have not yet done so, to allow physicians the option to focus on continuing board certification activities relevant to their practice.
29. Call for the immediate end of any mandatory, secured recertifying examination by the ABMS or other certifying organizations as part of the recertification process for all those specialties that still require a secure, high-stakes recertification examination.
30. Support a recertification process based on high quality, appropriate Continuing Medical Education (CME) material directed by the AMA recognized specialty societies covering the physician s practice area, in cooperation with other willing stakeholders, that would be completed on a regular basis as determined by the individual medical specialty, to ensure lifelong learning.
31. Continue to work with the ABMS to encourage the development by and the sharing between specialty boards of alternative ways to assess medical knowledge other than by a secure high stakes exam.
32. Continue to support the requirement of CME and ongoing, quality assessments of physicians, where such CME is proven to be cost-effective and shown by evidence to improve quality of care for patients.
33. Through legislative, regulatory, or collaborative efforts, will work with interested state medical societies and other interested parties by creating model state legislation and model medical staff bylaws while advocating that Continuing Board Certification not be a requirement for: (a) medical staff membership, privileging, credentialing, or recredentialing; (b) insurance panel participation; or (c) state medical licensure.
34. Increase its efforts to work with the insurance industry to ensure that continuing board certification does not become a requirement for insurance panel participation.
35. Advocate that physicians who participate in programs related to quality improvement and/or patient safety receive credit for CBC Part IV.
36. Continue to work with the medical societies and the American Board of Medical Specialties (ABMS) member boards that have not yet moved to a process to improve the Part III secure, high-stakes examination to encourage them to do so.
37. Our AMA will, through its Council on Medical Education, continue to work with the American Board of Medical Specialties (ABMS), ABMS Committee on Continuing Certification (3C), and ABMS Stakeholder Council to pursue opportunities to implement the recommendations of the Continuing Board Certification: Vision for the Future Commission and AMA policies related to continuing board certification.
(Policy Timeline: CME Rep. 2, I-15 Appended: Res. 911, I-15 Appended: Res. 309, A-16 Appended: CME Rep. 02, A-16 Appended: Res. 307, I-16 Appended: Res. 310, I-16 Modified: CME Rep. 02, A-17 Reaffirmed: Res. 316, A-17 Reaffirmed in lieu of: Res. 322, A-17 Appended: CME Rep. 02, A-18 Appended: Res. 320, A-18 Appended: Res. 957, I-18 Reaffirmation: A-19 Modified: CME Rep. 02, A-19)

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) Opposes any action, regardless of intent, by 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.
(4) 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.
(5) Advocates for nomenclature to better distinguish those physicians who are in the board certification pathway from those who are not.
(6) 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.
(Policy Timeline: Res. 318, A-07 Reaffirmation A-11 Modified: CME Rep. 2, I-15 Modified: Res. 215, I-19)

APPENDIX B:
IMPROVEMENTS TO THE AMERICAN BOARD OF MEDICAL SPECIALTIES (ABMS) PART III, ASSESSMENT OF KNOWLEDGE, JUDGMENT, AND SKILLS AND PART IV, IMPROVEMENT IN MEDICAL PRACTICE*

American Board of:	Original Format	New Models/Innovations
Allergy and Immunology (ABAI) abai.org	**Part III:** Computer-based, secure exam was administered at a proctored test center once a year. Diplomates were required to pass the exam once every 10 years. *Traditional secure exam only offered for re-entry.*	**Part III:** In 2018, ABAI-Continuous Assessment Program Pilot was implemented in place of 10-year secure exam: • A 10-year program with two 5-year cycles; • Open-book annual exam with approximately 80 questions; • Customized to practice; • Mostly article-based with some core questions during each 6-month cycle; • Diplomates must answer 3 questions for each of 10 journal articles in each cycle posted in February and August; • Questions can be answered independently for each article; • Diplomate feedback required on each question; • Opportunity to drop the two lowest 6-month cycle scores during each 5-year period to allow for unexpected life events; and • Diplomates can take exam where and when it is convenient and have the ability to complete questions on PCs, laptops, MACs, tablets, and smart phones by using the new diplomate dashboard accessed via the existing ABAI Web Portal page.
	Part IV: ABAI diplomates receive credit for participation in registries.	**Part IV:** In 2018, new Part IV qualifying activities provided credit for a greater range of Improvement in Medical Practice (IMP) activities that physicians complete at their institutions and/or individual practices. A practice assessment/quality improvement (QI) module must be completed once every 5 years.

Anesthesiology (ABA) theaba.org	**Part III:** MOCA 2.0 introduced in 2014 to provide a tool for ongoing low-stakes assessment with more extensive, question-specific feedback. Also provides focused content that could be reviewed periodically to refresh knowledge and document cognitive expertise. *All diplomates with time-limited certification in anesthesiology that expired on or before December 31, 2015 and diplomates whose subspecialty certificates expired on or before December 31, 2016, must complete the traditional MOCA® requirements before they can register for MOCA 2.0®.*	**Part III:** MOCA Minute® replaced the MOCA exam: • Customized to practice; • Diplomates must answer 30 questions per calendar quarter (120 per year), no matter how many certifications they are maintaining; and • Knowledge Assessment Report shows details on the MOCA Minute questions answered incorrectly, peer performance, and links to related CME.
	Part IV[2]: Traditional MOCA requirements include completion of case evaluation and simulation course during the 10-year MOCA cycle. One activity must be completed between Years 1 to 5, and the second between Years 6 to 10. An attestation is due in Year 9.	**Part IV[2]:** ABA added and expanded multiple activities for diplomates to demonstrate that they are participating in evaluations of their clinical practice and are engaging in practice improvement. Diplomates may choose activities that are most relevant to their practice; reporting templates no longer required for self-report activities; and simulation activity not required. An attestation is due in Year 9.
Colon and Rectal Surgery (ABCRS) abcrs.org	**Part III:** Computer-based secure exam administered at a proctored test center once a year (in May). Diplomates must pass the exam once every 10 years. *The secure exam is no longer offered.*	**Part III[1]:** New Continuous Certification Longitudinal Assessment Program (CertLink®) replaced the high-stakes Part III Cognitive Written Exam which was required every 10 years: • Diplomates must complete 12 to 15 questions per quarter through the CertLink® platform. • The fifth year of the cycle can be a year free of questions or used to extend the cycle if life events intervene.
	Part IV: Requires ongoing participation in a local, regional, or national outcomes registry or quality assessment program.	**Part IV:** If there are no hospital-based or other programs available, diplomates can maintain a log of their own cases and morbidity outcomes utilizing the ACS Surgeon Specific Case Log System (with tracking of 30-day complications). Resources are provided to enable completion of QI activities based on the results.

Dermatology (ABD) abderm.org	**Part III:** Computer-based secure modular exam still administered at a proctored test center twice a year or by remote proctoring technology. Diplomates must pass the exam once every 10 years. Test preparation material available 6 months before the exam at no cost. The material includes diagnoses from which the general dermatology clinical images will be drawn and questions that will be used to generate the subspecialty modular exams. Examinees are required to take the general dermatology module, consisting of 100 clinical images to assess diagnostic skills, and can then choose among 50-item subspecialty modules.	**Part III[1]:** ABD completed trials employing remote proctoring technology to monitor exam administration in the diplomates' homes or offices. On January 6, 2020, diplomates can participate in CertLink®: • Diplomates must complete 13 questions per quarter for a total of 52 questions; • Diplomates will receive a mix of visual recognition questions, specialty area questions, and article-based questions; • Written references and online resources are allowed while answering questions; and • Diplomates are permitted to take one quarter off per year without advanced permission or penalty, using the "Time Off" feature (if diplomate opts not to take a quarter off, his/her lowest scoring quarter during that year will be eliminated from scoring).
	Part IV[2]: Tools diplomates can use for Part IV include: • Focused practice improvement modules. • ABD's basal cell carcinoma registry tool. Partnering with specialty society to transfer any MOC-related credit directly to Board.	**Part IV[2]:** ABD developed more than 40 focused practice improvement modules that are simpler to complete and cover a wide range of topics to accommodate different practice types. Peer and patient communication surveys are now optional.
Emergency Medicine (ABEM) abem.org	**Part III:** ABEM's ConCert™, computer-based, secure exam administered at a proctored test center twice a year. Diplomates must pass the exam once every 10 years.	**Part III:** In 2020, a ConCert™ alternative, known as MyEMCert,will be piloted. MyEMCert will consist of: • Short assessment modules, consisting of up to 50 questions each; • Each module addresses a category of common patient presentations in the emergency department; • Eight modules are required in each 10-year certification. (ABEM-diplomates who have less than 10 years remaining on their current certification and who choose to participate in MyEMCert will have less time to complete 8 modules before their certification expires); • Each module includes recent advances in Emergency Medicine (that may or may not be related to

		the category of patient presentation). Participants in MyEMCert do not also have to take LLSAs; • Three attempts are available for each registration; • MyEMCert modules will be available 24/7/365; and • Diplomates can look up information—for example, textbooks or online resources to which they subscribe—while completing a module.
	Part IV[2]: Physicians may complete practice improvement efforts related to any of the measures or activities listed on the ABEM website. Others that are not listed, may be acceptable if they follow the four steps ABEM requirements.	**Part IV[2]:** ABEM is developing a pilot program to incorporate clinical data registry. ABEM diplomates receive credit for improvements they are making in their practice setting. Must complete and attest to two PI activities, one in years one through five of certification, and one in years six through ten.
Family Medicine (ABFM) theabfm.org	**Part III:** One-day Family Medicine Certification Exam. Traditional computer-based secure exam administered at a proctored test center twice a year or by remote proctoring technology. Diplomates must pass the exam once every 10 years. The exam day schedule consists of four 95-minute sections (75 questions each) and 100 minutes of pooled break time available between sections.	**Part III:** In 2018, ABFM launched Family Medicine Certification Longitudinal Assessment (FMCLA), a pilot to study the feasibility and validity of an alternative to the 10-year examination. The FMCLA pilot evaluation will be conducted over several years to collect feedback and data to evaluate the quality, effectiveness, and acceptability to the program. • Limited to Diplomates currently certified and in the tenth year of certification that ended in 2020; • Diplomates must complete 25 questions per quarter; 300 questions over a 4-year time period; • Diplomates receive immediate feedback after each response; • Clinical references similar to those used in practice allowed during the assessment; and • Questions can be completed at the place and time of the diplomate's choice.
	Part IV[2]: IMP Projects include: • Collaborative Projects: Structured projects that involve physician teams	**Part IV[2]:** ABFM developed and launched the national primary care registry (PRIME)

	collaborating across practice sites and/or institutions to implement strategies designed to improve care. • Projects Initiated in the Workplace: These projects are based on identified gaps in quality in a local or small group setting. • Web-based Activities: Self-paced activities that physicians complete within their practice setting (these activities are for physicians, who do not have access to other practice improvement initiatives).	to reduce time and reporting requirements.
Internal Medicine (ABIM) abim.org	**Part III:** Computer-based secure exam administered at a proctored test center. Diplomates must pass the exam once every 10 years. This option includes open-book access (to UpToDate®) that physicians requested. *ABIM introduced grace period for physicians to retry assessments for additional study and preparation if initially unsuccessful.*	**Part III:** In 2020, the Knowledge Check-In, will be an option for diplomates in most specialties: • New 2-year open-book (access to *UpToDate®*) assessment; • Diplomates receive immediate performance feedback; and • Assessments can be taken at the diplomate's home or office, or at a computer testing facility. ABIM anticipates launching a longitudinal assessment option in 2022. *ABIM has developed collaborative pathways with the American College of Cardiology and American Society of Clinical Oncology for physicians to maintain board certification in several subspecialties. ABIM is working with other specialty societies to explore the development of pathways.*
	Part IV[2]: Practice assessment/QI activities include identifying an improvement opportunity in practice, implementing a change to address that opportunity, and measuring the impact of the change. Diplomates can earn MOC points for many practice assessment/QI projects through their medical specialty societies, hospitals, medical groups, clinics, or other health-related organizations.	**Part IV[2]:** Optional; incentive for participation in approved activities. Increasing number of specialty-specific IMP activities recognized for credit (activities that physicians are participating in within local practice and institutions).

Medical Genetics and Genomics (ABMGG) abmgg.org	**Part III:** Computer-based secure exam administered at a proctored test center once a year (August). Diplomates must pass the exam once every 10 years. *The secure exam is no longer offered.*	**Part III[1]:** In 2020, a longitudinal assessment program (CertLink®) will replace the 10-year, Continuing Certification (MOC) high-stakes examination: • Diplomates receive 24 questions every 6 months, regardless of number of specialties in which a diplomate is certified; • Diplomates must answer all questions by the end of each 6-month timeframe (5 minutes allotted per question); • Resources allowed, collaboration with colleagues not allowed; • Realtime feedback and performance provided for each question; and • "Clones" of missed questions will appear in later timeframes to help reinforce learning.
	Part IV[2]: Diplomates can choose from the list of options to complete practice improvement modules in areas consistent with the scope of their practice.	**Part IV[2]:** ABMGG is developing opportunities to allow diplomates to use activities already completed at their workplace to fulfill certain requirements. *Expanding accepted practice improvement activities for laboratorians.*
Neurological Surgery (ABNS) abns.org	**Part III:** The 10-year secure exam can be taken from any computer, i.e., in the diplomate's office or home. Access to reference materials is not restricted; it is an open book exam. On applying to take the exam, a diplomate must assign a person to be his or her proctor. Prior to the exam, that individual will participate in an on-line training session and "certify" the exam computers. *The secure exam is no longer offered.*	**Part III:** In 2018, Core Neurosurgical Knowledge, an annual adaptive cognitive learning tool and modules, replaced the 10-year secure exam: • Open book exam focusing on 30 or so evidence-based practice principles critical to emergency, urgent, or critical care; • Shorter, relevant, and more focused questions than the prior exam; • Diplomates receive immediate feedback for each question and references with links and/or articles are provided; and • Web-based format with 24/7 access from the diplomates' home or office.

	Part IV: Diplomates receive credit for documented participation in an institutional QI project.	**Part IV:** Diplomates are required to participate in a meaningful way in morbidity and morality conferences (local, regional, and/or national). For those diplomates participating in the Pediatric Neurosurgery, CNS-ES, NeuCC focused practice programs, a streamlined case log is required to confirm that their practice continues to be focused and the diplomate is required to complete a learning tool that includes core neurosurgery topics and an additional eight evidence-based concepts critical to providing emergency, urgent, or critical care in their area of focus.
Nuclear Medicine (ABNM) abnm.org	**Part III:** Computer-based secure exam administered at a proctored test center once a year (October). Diplomates must pass the exam once every 10 years.	**Part III[1]:** Diplomates can choose between the 10-year exam or a longitudinal assessment pilot program (CertLink®). • Diplomates receive 9 questions per quarter and up to 4 additional questions that are identical or very similar to questions previously answered (called "clones") and many will have images; • Educational resources can be used; • Diplomates receive immediate feedback with critiques and references; and • Allows for emergencies and qualifying life events.
	Part IV: Diplomates must complete one of the three following requirements each year. 1) Attestation that the diplomate has participated in QI activities as part of routine clinical practice, such as participation in a peer review process, attendance at tumor boards, or membership on a radiation safety committee. 2) Participation in an annual practice survey related to approved clinical guidelines released by the ABNM. The survey has several questions based on review of actual cases. Diplomates receive a summary of the answers provided by other physicians that allows them to compare their practice to peers. 3) Improvement in Medical Practice projects designed by diplomates or provided by professional groups such as	**Part IV:** ABNM recognizes QI activities in which physicians participate in their clinical practice.

	the SNMMI. Project areas may include medical care provided for common/major health conditions, physician behaviors, such as communication and professionalism, as they relate to patient care, and many others. The projects typically follow the model of Plan, Do, Study, Act. The ABNM has developed a few IMP modules for the SNMMI, Alternatively, diplomates may design their own project.	
Obstetrics and Gynecology (ABOG) abog.org	**Part III:** The secure, external assessment is offered in the last year of each ABOG diplomate's 6-year cycle in a modular test format; diplomates can choose two selections that are the most relevant to their current practice. The exam administered at a proctored test center.	**Part III:** ABOG completed a pilot program and integrated the article-based self-assessment (Part II) and external assessment (Part III) requirements, allowing diplomates to continuously demonstrate their knowledge of the specialty. The pilot allowed diplomates to earn an exemption from the current computer-based exam in the sixth year of the program if they reach a threshold of performance during the first 5 years of the self-assessment program. Since 2019, diplomates can choose to take the 6-year exam or participate in Performance Pathway, an article-based self-assessment (with corresponding questions) which showcases new research studies, practice guidelines, recommendations, and up-to-date reviews. Diplomates who participate in Performance Pathway are required to read a total of 180 selected articles and answer 720 questions about the articles over the 6-year MOC cycle.
	Part IV^2: Diplomates required to participate in one of the available IMP activities yearly in MOC Years 1-5. ABOG will consider structured QI projects (IMP modules, QI efforts, simulation courses) in obstetrics and gynecology for Part IV credit. These projects must demonstrate improvement in care and be based on accepted improvement science and methodology. Newly developed QI projects from organizations with a history of successful QI projects are also eligible for approval.	**Part IV^2:** ABOG recognizes work with QI registries for credit. ABOG continues to expand the list of approved activities which can be used to complete the Part IV.

Ophthalmology (ABO) abop.org	**Part III:** The Demonstration of Ophthalmic Cognitive Knowledge (DOCK) high-stakes, 10-year exam administered through 2018. *The secure exam is no longer offered.*	**Part III:** In 2019, Quarterly Questions™ replaced the DOCK Examination for all diplomates: • Diplomates receive 50 questions (40 knowledge-based and 10 article-based); • The questions should not require preparation in advance, but a content outline for the questions will be available; • The journal portion will require reading five articles from a list of options key ophthalmic journal articles with questions focused on the application of this information to patient care; • Diplomates receive immediate feedback and recommendations for resources related to gaps in knowledge; and • Questions can be completed remotely at home or office through computer, tablet, or mobile apps.
	Part IV[2]: Diplomates whose certificates expire on or before December 31, 2020 must complete one of the following options; all other diplomates complete two activities: • Read QI articles through Quarterly Questions; • Choose a QI CME activity; • Create an individual IMP activity; or • Participate in the ABMS multi-specialty portfolio program pathway.	**Part IV[2]:** Diplomates can choose to: • Select 3 QI journal articles from ABO's reading list and answer two questions about each article (this activity option may be used only once during each 10-year cycle). • Design a registry-based IMP Project using their AAO IRIS® Registry Data; • Create a customized, self-directed IMP activity; or • Participate in the ABMS multi-specialty portfolio program through their institution.
Orthopaedic Surgery (ABOS) abos.org	**Part III:** Computer-based secure modular exam administered at a proctored test center. Diplomates must pass the exam once every 10 years. The optional oral exam is given in Chicago in July. Diplomates without subspecialty certifications can take practice-profiled exams in orthopaedic sports medicine and surgery of the hand. General orthopaedic questions were eliminated from the practice-profiled exams so diplomates are only tested in areas relevant to their practice.	**Part III:** In 2020, a new longitudinal assessment program (ABOS WLA) the Knowledge Assessment, will be available to all diplomates. This pathway may be chosen instead of an ABOS computer-based or oral recertification 10-year exam: • Diplomates must answer 30 questions (from each Knowledge Source chosen by the diplomate); • The assessment is open-book and diplomates can use the Knowledge Sources, if the questions are answered within the 3-minute window and that the answer

	Detailed blueprints are being produced for all exams to provide additional information for candidates to prepare for and complete the exams. Eight different practice-profiled exams offered to allow assessment in the diplomate's practice area.	represents the diplomate's own work; and • Questions can be answered remotely at home or office through computer, tablet, or mobile apps.
	Part IV: Case lists allow diplomates to review their practice including adhering to accepted standards, patient outcomes, and rate and type of complications. Case list collection begins on January 1st of the calendar year that the diplomate plans to submit their recertification application and is due by December 1. The ABOS recommends that this be done in Year 7 of the 10-year MOC Cycle, but it can be done in Year 8 or 9. A minimum of 35 cases is required for the recertification candidate to sit for the recertification exam of their choice. Diplomates receive a feedback report based on their submitted case list.	**Part IV:** ABOS is streamlining the case list entry process to make it easier to enter cases and classify complications.
Otolaryngology – Head and Neck Surgery (ABOHNS) aboto.org	**Part III:** Computer-based secure modular exam administered at a proctored test center. Diplomates must pass the exam once every 10 years.	**Part III[1]:** ABOHNS is piloting a CertLink®-based longitudinal assessment: • Diplomates receive 10 to 15 questions per quarter; • Immediate, personalized feedback provided regarding the percentage of questions answered correctly; • Questions can be answered at a diplomate's convenience so long as all questions are answered by the end of each quarter; and • Remote access via desktop or laptop computer (some items will contain visuals).
	Part IV[2]: The three components of Part IV include: • A patient survey; • A peer survey; and • A registry that will be the basis for QI activities.	**Part IV[2]:** ABOHNS is partnering with the American Academy of Otolaryngology-Head and Neck Surgery in their development of a RegentSM registry. Selected data will be extracted from RegentSM for use in practice improvement modules that diplomates can use to meet IMP requirements. ABOHNS is working to identify and accept improvement activities that diplomates engage in as part of their practice.

		ABOHNS will roll out the last section of MOC, Part IV, which is still under development. Part IV will consist of three components, a patient survey, a professional survey, and a Performance Improvement Module (PIM).
Pathology (ABPath) abpath.org	**Part III:** Computer-based secure modular exam administered at the ABP Exam Center in Tampa, Florida twice a year (March and August). Remote computer exams can be taken anytime 24/7 that the physician chooses during the assigned 2-week period (spring and fall) from their home or office. Physicians can choose from more than 90 modules, covering numerous practice areas for a practice-relevant assessment. Diplomates must pass the exam once every 10 years.	**Part III[1]:** The ABPath CertLink® pilot program is available for all diplomates: • Customization allows diplomates to select questions from practice (content) areas relevant to their practice. • Diplomates can log in anytime to answer 15 to 25 questions per quarter; • Each question must be answered within 5 minutes; • Resources (e.g. internet, textbooks, journals) can be used; and • Diplomates receive immediate feedback on whether each question is answered correctly or incorrectly, with a short narrative about the topic (critique), and references.
	Part IV[2]: Diplomates must participate in at least one inter-laboratory performance improvement and quality assurance program per year appropriate for the spectrum of anatomic and clinical laboratory procedures performed in that laboratory.	**Part IV[2]:** IMP requirements must be reported as part of a reporting period every 2 years via PATHway. There are three aspects to IMP: • Laboratory Accreditation; • Laboratory Performance Improvement and Quality Assurance; and • Individual Performance Improvement and Quality Assurance.
Pediatrics (ABP) abp.org	**Part III:** Computer-based secure exam administered at a proctored test center. Diplomates must pass the exam once every 10 years.	**Part III:** In 2019, a new testing platform with shorter and more frequent assessments, Maintenance of Certification Assessment for Pediatrics (MOCA-Peds), was implemented: • Allows for questions to be tailored to the pediatrician's practice profile; • A series of questions released through mobile devices or a web browser at regular intervals; • Diplomates receive 20 questions per quarter (may be answered at any time during the quarter);

		• Diplomates receive immediate feedback and references; • Resources (i.e., internet, books) can be used. *Those who wish to continue taking the exam once every 5 years in a secure testing facility will be able to do so.*
	Part IV[2]: Diplomates must earn at least 40 points every 5 years, in one of the following activities: • Local or national QI projects • Diplomates' own project • National Committee for Quality Assurance Patient-Centered Medical Home or Specialty Practice • Institutional QI leadership • Online modules (PIMS)	**Part IV[2]:** ABP is enabling new pathways for pediatricians to claim Part IV QI credit for work they are already doing. These pathways are available to physicians who are engaged in QI projects alone or in groups and include a pathway for institutional leaders in quality to claim credit for their leadership. ABP is also allowing trainees (residents and fellows) to "bank" MOC credit for QI activities in which they participate. The pediatricians supervising these trainees also may claim MOC credit for qualifying projects.
Physical Medicine and Rehabilitation (ABPMR) abpmr.org	**Part III:** Computer-based secure exam administered at a proctored test center. Diplomates must pass the exam once every 10 years. Released MOC 100, a set of free practice questions pulled directly from the ABPMR exam question banks to help physicians prepare for the exam. There is a separate computer-based secure exam administered at a proctored test center that is required to maintain subspecialty certification. *After the last administration of secure exam in 2020, the exam will be replaced with the Longitudinal Assessment for PM&R (LA-PM&R).*	**Part III[1]:** In 2020, the Longitudinal Assessment for PM&R (LA-PM&R) will be available for all diplomates: • Diplomates receive 20 questions per quarter; after that: between 15 and 18 questions depending on performance (higher performance = fewer questions); • Maximum of 2 minutes to answer each question; • Diplomates can customize their question content; • Diplomates receive immediate feedback indicating whether the answer was correct or incorrect, followed by a critique; and • Available from a desktop or tablet (some features may not work on a phone's web browser). The ABPMR is exploring the use of longitudinal assessment for its subspecialty assessment requirement, but these plans, IT infrastructure, customer service support, and item banks take time to develop. More information on longitudinal assessment for subspecialties will be available in the next few years.

	Part IV²: Guided practice improvement projects are available through ABPMR. Diplomates must complete: • Clinical module (review of one's own patient charts on a specific topic), or • Feedback module (personal feedback from peers or patients regarding the diplomates clinical performance using questionnaires or surveys). Each Module consists of three steps to complete within a 24-month period: initial assessment, identify and implement improvement, and reassessment.	**Part IV²:**ABPMR introduced several free tools to complete an IMP project, including: simplified and flexible template to document small improvements and educational videos, infographic, and enhanced web pages. ABPMR is seeking approval from the National Committee for Quality Assurance Patient-Centered Specialty Practice Recognition for Part IV IMP credit. ABPMR is also working with its specialty society to develop relevant registry-based QI activities.
Plastic Surgery (ABPS) abplasticsurgery.org	**Part III:** Computer-based secure exam administered at a proctored test center once a year (October). Diplomates must pass the exam once every 10 years. Modular exam to ensure relevance to practice. ABPS offers a Part III Study Guide with multiple choice question items derived from the same sources used for the exam.	**Part III:** In April 2020, the continuous certification exam will move to an internet-based testing format: • Diplomate receives 30 questions per year; • Diplomates receive immediate feedback on answers with links to references and educational resources are offered with an opportunity to respond again; and • Available on any computer with an internet connection;
	Part IV: ABPS provides Part IV credit for registry participation. ABPS also allows Part IV credit for IMP activities that a diplomate is engaged in through their hospital or institution. Diplomates are asked to input data from 10 cases from any single index procedure every 3 years, and ABPS provides feedback on diplomate data across five index procedures in four subspecialty areas.	**Part IV:** Allowing MOC credit for IMP activities that a diplomate is engaged in through their hospital or institution. Physician participation in one of four options can satisfy the diplomate's Practice Improvement Activity: • Quality Improvement Publication • Quality Improvement Project • Registry Participation • Tracer Procedure Log
Preventive Medicine (ABPM) theabpm.org	**Part III:** In-person, pencil-and-paper, secure exam administered at secure test facility. MOC exams follow the same content outline as the initial certification exam (without the core portion). *In 2016, new multispecialty subspecialty of Addiction Medicine was established. In 2017, Addiction Medicine subspecialty certification exam was administered to diplomates of any of the 24 ABMS member boards who meet the eligibility requirements.*	**Part III:** In 2019, the ABPM began offering all diplomates remotely-proctored MOC exams: • Must be completed by the examinee in a single sitting; • Given in two 50-question sections with an optional 15-minute break between sections; • Diplomates are not allowed to consult outside resources or notes; • Results available on diplomate's dashboard in the physician portal 4 weeks after the completion of the exam; and

		• Available on smart phone or computer. In 2020, ABPM announced plans to offer a longitudinal assessment program for the Clinical Informatics subspecialty certificate starting in 2011.
	Part IV²: Diplomates must complete two IMP activities during each 10-year cycle. One of the activities must be completed through a Preventive Medicine specialty or subspecialty society (ACOEM, ACPM, AMIA, AsMA, or UHMS).	**Part IV²:** Partnering with specialty societies to design quality and performance improvement activities for diplomates with population-based clinical focus (i.e. Public Health).
Psychiatry and Neurology (ABPN) abpn.com	**Part III:** Computer-based secure exam administered at a proctored test center. Diplomates must pass the exam once every 10 years. ABPN is developing MOC exams with committees of clinically active diplomates to ensure relevance to practice. ABPN is also enabling diplomates with multiple certificates to take all of their MOC exams at once and for a reduced fee. Grace period so that diplomates can retake the exam.	**Part III:** ABPN is implementing a Part III pilot program through 2021 to allow physicians to select 30-40 lifelong learning articles and demonstrate learning by high performance on the questions accompanying the article, to earn exemption from the 10-year MOC high-stakes exam.
	Part IV²: Diplomates satisfy the IMP requirement by completing one of the following: 1) Clinical Module: Review of one's own patient charts on a specific topic (diagnosis, types of treatment, etc.). 2) Feedback Module: Obtain personal feedback from either peers or patients regarding your own clinical performance using questionnaires or surveys.	**Part IV²:** ABPN is allowing Part IV credit for IMP and patient safety activities diplomates complete in their own institutions and professional societies, and those completed to fulfill state licensure requirements. Diplomates participating in registries, such as those being developed by the American Academy of Neurology and the American Psychiatric Association, can have 8 hours of required self-assessment CME waived.

Radiology (ABR) theabr.org	**Part III:** Computer-based secure modular exam administered at a proctored test center. Diplomates must pass the exam once every 10 years. *The secure exam is needed only in limited situations.*	**Part III:** An Online Longitudinal Assessment (OLA) model was implemented in place of the 10-year traditional exam. OLA includes modern and more relevant adult learning concepts to provide psychometrically valid sampling of the diplomate's knowledge. • Diplomates must create a practice profile of the subspecialty areas that most closely fit what they do in practice, as they do now for the modular exams; • Diplomates will receive weekly emails with links to questions relevant to their registered practice profile. • Questions may be answered singly or, for a reasonable time, in small batches, in a limited amount of time. • Diplomates receive immediate feedback about questions answered correctly or incorrectly and will be presented with a rationale, critique of the answers and brief educational material. *Those who answer questions incorrectly will receive future questions on the same topic to gauge whether they have learned the material.*
	Part IV^2: Diplomates must complete at least one practice QI project or participatory QI activity in the previous 3 years at each MOC annual review. A project or activity may be conducted repeatedly or continuously to meet Part IV requirements.	**Part IV^2:** ABR is automating data feeds from verified sources to minimize physician data reporting. ABR is also providing a template and education about QI to diplomates with solo or group projects.
Surgery (ABS) absurgery.org	**Part III:** Computer-based secure exam administered at a proctored test center. Diplomates must pass the exam once every 10 years. Transparent exam content, with outlines, available on the ABS website and regularly updated. ABS is coordinating with the American College of Surgeons and other organizations to ensure available study materials align with exam content.	**Part III:** In 2018, ABS began offering shorter, more frequent, open-book, modular, lower-stakes assessments required every 2 years in place of the high-stakes exam: • Diplomates will select from four practice-related topics: general surgery, abdomen, alimentary tract, or breast; • More topics based on feedback from diplomates and surgical societies are being planned;

	The secure exam is no longer offered for general surgery, vascular surgery, pediatric surgery, surgical critical care, or complex general surgical oncology.	• Diplomates must answer 40 questions total (20 core surgery, 20 practice-related; • Open book with topics and references provided in advance; • Individual questions are untimed (with 2 weeks to complete); • Diplomate receives immediate feedback and results (two opportunities to answer a question correctly); and • Diplomates can use their own computer at a time and place of their choosing within the assessment window. The new assessment is available for general surgery, vascular surgery, pediatric surgery, or surgical critical care with other ABS specialties launching over the next few years.
	Part IV²: ABS allows ongoing participation in a local, regional or national outcomes registry or quality assessment program, either individually or through the Diplomate's institution. Diplomates must describe how they are meeting this requirement—no patient data is collected. The ABS audits a percentage of submitted forms each year.	**Part IV²:** ABS allows multiple options for registry participation, including individualized registries, to meet IMP requirements.
Thoracic Surgery (ABTS) abts.org	**Part III:** Remote, secure, computer-based exams can be taken any time (24/7) that the physician chooses during the assigned 2-month period (September-October) from their home or office. Diplomates must pass the exam once every 10 years. Modular exam, based on specialty, and presented in a self-assessment format with critiques and resources made available to diplomates.	**Part III:** ABTS developed a web-based self-assessment tool (SESATS) that includes all exam material, instant access to questions, critiques, abstracts and references.
	Part IV²: ABTS diplomates must complete at least one practice QI project within 2 years, prior to their 5-year and 10-year milestones. There are several pathways by which diplomates may meet these requirements: individual, group or institutional. A case summary and patient safety module must also be completed.	**Part IV²:** *No changes to report at this time.*

Urology (ABU) abu.org	**Part III:** Computer-based secure exam administered at a proctored test center once a year (October). Diplomates must pass the exam once every 10 years. Clinical management emphasized on the exam. Questions are derived from the American Urological Association (AUA) Self-Assessment Study Program booklets from the past five years, AUA Guidelines, and AUA Updates. Diplomates required to take the 40-question core module on general urology and choose one of four 35-question content specific modules. ABU provides increased feedback to reinforce areas of knowledge deficiency.	**Part III:** ABU will continue the modular format for the Lifelong Learning knowledge assessment. The knowledge assessment portion of the Lifelong Learning program will not be used as a primary single metric that influences certificate status but rather to help the diplomate to identify those areas of strength versus weakness in their medical knowledge that is pertinent to their practice. The knowledge assessment is based on Criterion referencing, thus allowing the identification of two groups, those who unconditionally pass the knowledge assessment and those who are given a conditional pass. The group getting a conditional pass will consist of those individuals who score in the band of one standard error of measurement above the pass point down to the lowest score. That group would be required to complete additional CME in the areas where they demonstrate low scores. After completion of the designated CME activity, they would continue in the Lifelong Learning process and the condition of their pass would be lifted.
	Part IV[2]: Completion of Practice Assessment Protocols. ABU uses diplomate practice logs and diplomate billing code information to identify areas for potential performance or QI.	**Part IV[2]:** ABU allows credit for registry participation (i.e., participation in the MUSIC registry in Michigan, and the AUA AQUA registry). Another avenue to receive credit is participation in the ABMS multi-specialty portfolio program (this is more likely to be used by Diplomates who are part of a large health system, e.g. Kaiser, or those in academic practices).

*The information in this table is sourced from ABMS Member Board websites and is current as of January 31, 2020.

[1]Utilizing CertLink®, an ABMS web-based platform that leverages smart mobile technology to support the design, delivery, and evaluation of longitudinal assessment programs, some of which launched in 2017-2018. More information is available at: https://www.abms.org/initiatives/certlink/member-board-certlink-programs/ (accessed 1-13-20).

[2]Participates in the ABMS Portfolio Program™ which offers an option for organizations to support physician involvement in quality, performance, and process improvement (QI/PI) initiatives at their institution and award physician IMP credit for continuing certification.

APPENDIX C:
ANNOTATED BIBLIOGRAPHY

Continuing Medical Education

Howard-McNatt M, Sabel M, Agnese D, et al. Maintenance of Certification and Continuing Medical Education: Are They Still Required? *Ann Surg Oncol*. 2019;26(12):3820-3823.
The authors believe that many surgeons may find the new recommendations for continuing medical education (CME) and maintenance of certification (MOC) confusing. For example, some wonder if they still need MOC, how much CME currently is required by the American Board of Surgery (ABS), and where MOC and CME credits can be obtained. This article reviews the current MOC and CME requirements and lists options for completion of these requisites available through the Society of Surgical Oncology and its official journal, Annals of Surgical Oncology. The ABS and the Society for Surgical Oncology aim for their members to have lifelong learning, with the goal of improving patient care.

Knowledge Assessments

Vandergrift JL, Gray BM. Physician Clinical Knowledge, Practice Infrastructure, and Quality of Care. *Am J Manag Care*. 2019;25(10):497-503.
A study was conducted to understand if and how one dimension of physician skill, clinical knowledge, as measured by performance on the American Board of Internal Medicine (ABIM) Maintenance of Certification (MOC) exam, moderates the relationship between practice infrastructure and the quality of diabetes or hypertension care among general internists. The study included 1301 physicians who certified in internal medicine between 1991 and 1993 or 2001 and 2003 and took the ABIM's MOC exam and completed ABIM's diabetes or hypertension registry during their 10-year recertification period between 2011 and 2014. The study showed that a physician's exam performance significantly moderated the association between practice infrastructure and care quality, and that physician skill, such as clinical knowledge, is important to translating patient-centered practice infrastructure into better care quality.

O'Neill TR, Newton WP, Brady JE, Spogen D. Using the Family Medicine Certification Longitudinal Assessment to Make Summative Decisions. *JABFM*. 2019;32:951-953.
This article reviews the Family Medicine Certification Longitudinal Assessment 1 (FMCLA) pilot launched by the American Board of Family Medicine (ABFM) on January 4, 2019. The ABFM hopes that FMCLA will provide both summative feedback—assessing whether a candidate has the cognitive expertise to be a board-certified family physician—as well as formative feedback—to help diplomates know more accurately what they do not know and, thus, focus their learning. The authors note that with respect to the formative component, early reports are very positive. Of the eligible diplomates, 71 percent took advantage of the pilot. The technology platform is functioning well. Very few diplomates have withdrawn, and many reported that the tool is helping them learn. Evaluation from this quarter and the next will begin to give the ABFM a better understanding of how FMCLA fits into the other ways diplomates learn, and the ABFM will explore new formats of reports to support diplomates' learning efforts.

Turner AL, Olmsted M, Smith AC, et al. Pediatrician Perspectives on Learning and Practice Change in the MOCA-Peds 2017 Pilot. *Pediatrics*. 2019;144(6). doi: 10.1542/peds.2019-2305.
Researchers found that nearly all (98 percent) of 5,081 pediatricians surveyed reported they "learned, refreshed, or enhanced their medical knowledge" because of MOCA-Peds. Of those participating pediatricians, 62 percent reported a practice change associated with pilot participation,

particularly for practice regarding ear, nose, and throat; well-child and preventive care; and mental and behavioral health.

Robinson, LR, Raddatz MM, Kinney, C. Evaluation of Longitudinal Assessment for use in Maintenance of Certification. *Am J Phys Med Rehabil*. 2019 Dec 5. doi: 10.1097/PHM.0000000000001359

This study evaluates a longitudinal assessment process (LA-PM&R) as a replacement for the American Board of Physical Medicine and Rehabilitation (ABPMR) MOC Examination. Design: In this quality improvement study, randomly selected ABPM&R diplomates were invited to participate in LA-PM&R. Participants' MOC scaled scores were compared to LA-PM&R non-participants. The ABPMR examined the association between LA-PM&R scores and MOC Scaled scores and performance on clone items placed on both examinations. The study showed that the LA-PM&R group scored higher on the MOC examination than the control group ($P < .05$). Performance on the 2 examinations was highly correlated, $r = .50$, $P < .0001$. On clone items, LA-PM&R participants had 74 percent correct on LA-PM&R but 86 percent correct on the MOC Examination ($P < .01$). This study indicates the LA-PM&R program leads to better learning and retention of information than the traditional 10-year summative multiple-choice examination and that it is a superior method of assessment for ongoing ABPMR certification. Based on these results, the ABPMR has adopted the LA-PM&R program to replace its MOC Examination – Part III in the four-part framework for maintenance of certification.

Stratman EJ. Dermatology Continuing Certification changes for the Better. *Dermatology News*. 2020;105(1):14-15.

This article discusses major changes to the American Board of Dermatology's (ABD) continuing board certification examination. On January 6, 2020, the ABD launched its new web-based longitudinal assessment program called CertLink®. This new platform is designed to eventually replace the sit-down, high-stakes, once-every-10-year medical knowledge examination that dermatologists take to remain board certified. With this alternative, every participating dermatologist will receive a batch of 13 web-based questions every quarter that he/she may answer at a convenient time and place. Questions are answered one at a time or in batches, depending on the test taker's preference, and can be completed on home or office computers (and eventually on smartphones). Participating in this type of testing will not require shutting down practice, traveling to a test center, or paying for expensive board review courses. CertLink® is designed to be convenient, affordable, and relevant to an individual's practice.

Rosenkrantz AB, Berland LL, Heitkamp DE, Duszak, Jr. R. Diagnostic Radiologists' Participation in the American Board of Radiology Maintenance of Certification Program. *AJR Am J Roentgenol*. 2019;213(6):1284-1290.

The purpose of this study was to characterize diagnostic radiologists' participation in the American Board of Radiology (ABR) MOC program, the framework for its new Online Longitudinal Assessment program. The study showed that although diagnostic radiologists with time-limited certificates nearly universally participate in MOC, those with lifetime certificates (particularly general radiologists and those in smaller and nonacademic practices) participate infrequently. Low rates of nonmandated participation may reflect diplomate dissatisfaction or negative perceptions about MOC.

Chesluk B, Gray B, Eden A, et al. "That Was Pretty Powerful": A Qualitative Study of What Physicians Learn When Preparing for Their Maintenance-of-Certification Exams. *J Gen Intern Med*. 2019;34(9):1790-1796.

The purpose of this study was to understand how maintenance of certification (MOC) exam preparation can affect knowledge and practice. The study included general physicians certified by

the American Board of Family Medicine (ABFM) and the American Board of Internal Medicine (ABIM) who had recently taken a joint ABFM/ABIM MOC exam. Out of the 80 physicians surveyed, 67 stated that during their MOC preparation they gained knowledge relevant to their practice. Sixty-three physicians gave concrete examples of how this new knowledge positively affected their practice. These examples are summarized in this article.

Chesluk BJ, Eden AR, Hansen ER, et al. How Physicians Prepare for Maintenance of Certification Exams: A Qualitative Study. Academic Medicine. *Acad Med*. 2019;94(12):1931-1938.
This qualitative study explores how physicians experience MOC exam preparation: how they prepare for the exams and decide what to study and how exam preparation compares with what they normally do to keep their medical knowledge current. The study showed that most interviewees studied for their MOC exams by varying from their routines for staying current with medical knowledge, both by engaging with a different scope of information and by adopting different study methods. Physicians described exam preparation as returning to a student/testing mindset, which some welcomed and others experienced negatively or with ambivalence. The authors concluded that what physicians choose to study bounds what they can learn from the MOC exam process and therefore also bounds potential improvements to their patient care. Knowing how physicians actually prepare, and how these preparation activities compare with what they do when not preparing for an exam, may inform debates over the value of requiring such exams, as well as conversations about how physicians, certification boards, and other key stakeholders in physicians' continuing professional development could improve the MOC process.

Gold L. Reflections Prompted by the Maintenance of Certification. *J Am Acad Psythiatry Law*. 2019;47(3):347-349.
In this editorial, the author describes her retreat to Bywater, Virginia to study for the American Board of Psychiatry and Neurology (ABPN) Forensic Psychiatry Maintenance of Certification (MOC) 10-year high-stakes examination. Although the author served on the ABPN Forensic Committee for 11 years, writing test questions for the Certification and MOC examinations, reviewing questions written by other people, helping to assemble tests (not this particular one), and reviewing test and question data, there was still a need to study for the exam to avoid the embarrassment of failing.

Poniatowski PA, Dugosh JW, Baranowski RA, et al. Incorporating Physician Input Into a Maintenance of Certification Examination: A Content Validity Tool. *Acad Med*. 2019 Sep;94(9):1369-1375.
As part of the American Board of Internal Medicine's (ABIM's) continuing effort to update its Maintenance of Certification (MOC) program, a content validity tool was used to conduct structured reviews of the MOC exam blueprints (i.e., tables of test specifications) by the physician community. Results from the Cardiovascular Disease MOC blueprint review are presented in this article as an example of the process ABIM conducted for several internal medicine disciplines. Responses from 441 review participants were analyzed. The blueprint review garnered valuable feedback from the physician community and provided new evidence for the content validity of the Cardiovascular Disease MOC exam.

Fain R, Newton WP, O'Neill TR. Creating a New Blueprint for ABFM Examinations. *Ann Fam Med*. 2019;17:562-564.
This report from the American Board of Family Medicine (ABFM) described efforts underway to develop a new blueprint for its examinations, including the Certification Examination, the In-Training Examination taken by residents, and longitudinal assessments.

Association between Continuous Certification and Practice Related Outcomes

Nyenhuis SM, Akkoyun E, Liu L, et al. Real-world Assessment of Asthma Control and Severity in Children, Adolescents, and Adults with Asthma: Relationships to Care Settings and Comorbidities. *J Allergy Clin Immunol Pract*. 2019 Nov 7. doi: 10.1016/j.jaip.2019.10.032
This article discusses Asthma IQ, developed by the American Academy of Allergy, Asthma, and Immunology, which was used to examine the rates and relative contributions of co-morbidities and care settings in terms of asthma severity and control among pediatric and adolescent/adult patients in a large national sample. This was the first time that patient data collected from Part IV of Maintenance of Certification (MOC) has been utilized to help understand the characteristics of patients in different care settings. The web-based Asthma IQ helps clinicians to: 1) use evidence-based medicine to make treatment decisions; 2) graph and report patients' asthma status over time; 3) analyze statistics for the asthma patients in their practice; and 4) report quality improvement measures for Pay for Performance and MOC.

Scott E, Downs S. Pottenger A, Saysana M. Quality Improvement Learning Collaborative Improves Timely Newborn Follow-Up Appointments. *Jt Comm J Qual Patient Saf*. 2019;45(12):808-813
A project involving 11 practices and 24 physicians with a goal to improve rates of timely newborn follow-up through a nine-month quality improvement learning collaborative (QILC) resulted in continual improvement in all measured newborn scheduling metrics throughout the nine-month learning collaborative, with sustainment of progress over the last three months of the QILC. Timely newborn follow-up was defined as an appointment scheduled within three days of newborn discharge. A valuable lesson learned from the QILC was the importance of tying quality improvement work to Part IV Maintenance of Certification (MOC). When surveyed at the end of the learning collaborative, participating pediatricians cited the availability of MOC Part IV credit from the American Board of Pediatrics as a major driver for participation.

Mathur M, Campbell S. Statewide Pediatric Quality Improvement Collaborative for HPV Vaccine Initiation. *WMJ*. 2019;118(1):42-43.
A study involving pediatricians participating in a quality improvement project, for which they received Maintenance of Certification (MOC) credit from the American Board of Pediatrics, resulted in improved human papillomavirus (HPV) vaccination rates at hospitals across Wisconsin. During the program's two-month intervention, the HPV vaccination initiation rates rose in participating practices from 56.4 percent to 71.2 percent, which exceeds state and national averages. In addition, Tdap vaccine initiation rates increased from 92.9 percent to 97.2 percent, and meningococcal vaccine rates increased from 89.7 percent to 92.8 percent. This study showed that a statewide learning collaborative can be a useful and productive way to improve the quality of care, and it is valued by the participants, particularly when MOC credit is awarded.

Willis TS, Yip T, Brown K, et al. Improved Teamwork and Implementation of Clinical Pathways in a Congenital Heart Surgery. *Pediatr Qual Saf*. 2019;4(e126):1-7.
A project to improve teamwork and decrease variations in care in a pediatric congenital heart surgery population by implementing Integrated Clinical Pathways (ICPs) on a foundation of teamwork training resulted in three of the four units experiencing a significant improvement in teamwork after training and coaching. The area without a significant change was one with high-level teamwork training already in place. ICPs were implemented in two patient subpopulations. There was a detected a decrease in total hours intubated using statistical process control charts in both of the ICP patient populations, but no reduction in length of stay in days. The infrastructure for the program was successfully implemented and remains in place six years later. This project

was approved for the quality improvement portion of Maintenance of Certification through the American Board of Pediatrics and was an incentive for participation.

Tew PW, Yard R. Improving Access to Screening, Brief Intervention, and Referral to Treatment in Primary Care for Adolescents: Implementation Considerations. The Center for Health Care Strategies. Available at: https://www.chcs.org/media/SBIRT-BRIEF-101019.pdf (accessed 1-22-20)
This article discusses how the University of Pittsburgh Medical Center (UPMC) Health Plan created a learning collaborative framework for engaging provider practices to participate in their Screening, Brief Intervention, and Referral to Treatment (SBIRT) initiative. SBIRT can be applied to various segments of the population to screen for risky substance use and provide early intervention when appropriate. Based on "The Model for Improvement," their learning collaborative incorporated Plan-Do-Study-Act principles, which is a tool for documenting change. Two separate cohorts of practices participated in an initial training session, a mid-point, and a final convening. At the end of each cohort, UPMC saw screening rates of more than 95 percent in most practices and high rates of brief interventions for youth who screened positively for high-risk substance use. Providers reported positive feedback on the process and welcomed the support in developing their SBIRT workflow and reinforcing the use of MI. Outcomes of the collaborative included providing continuing medical education and/or maintenance of certification credits. By addressing these professional requirements, providers may be better able to justify the time out of the office. UPMC offered MOCs for their training, which requires a more intensive set-up process, and they determined that it added value beyond the more easily obtainable CMEs for their providers.

The Impact of Continuous Certification on Medical Licensure

Young A, Chaudhry HJ, Pei X, et al. FSMB Census of Licensed Physicians in the United States, 2018. *Journal of Medical Regulation*. 2019;105(2):7-23.
This article provides physician census data compiled by the Federation of State Medical Boards (FSMB). The article notes that there are 985,026 physicians with Doctor of Medicine (MD) and Doctor of Osteopathic Medicine (DO) degrees licensed to practice medicine in the United States and the District of Columbia. These qualified physicians graduated from 2,089 medical schools in 167 countries and are available to serve a U.S. national population of 327,167,434. While the percentage of physicians who are international medical graduates have remained relatively stable over the last eight years, the percentage of physicians who are women, possess a DO degree, have three or more licenses, or are graduates of a medical school in the Caribbean have increased by varying degrees during that same period. This report marks the fifth biennial physician census that the FSMB has published, highlighting key characteristics of the nation's available physician workforce, including numbers of licensees by geographic region and state, type of medical degree, location of medical school, age, gender, specialty certification, and number of active licenses per physician.

Farrell ML. The Effect of State Medical Board Action on ABMS Specialty Board Certification. *Journal of Medical Regulation*. 2019;105(2):33-41.
In this article, the author discusses how state medical board action that is deemed a restriction by an American Board of Medical Specialties (ABMS) member board can result in a loss of board certification, impacting a physician's ability to practice, and frustrating a medical board's efforts to rehabilitate the physician and improve the quality of care provided to patients. State medical boards have difficulty predicting what types of actions constitute a restriction by a specialty board and imposing appropriate discipline because specialty boards use varying criteria to evaluate state medical board action. ABMS member boards experience frustration of their own when attempting

to interpret actions from 70 separate state medical boards, each governed by its own laws and using its own nomenclature. This article summarizes the inconsistency of both specialty boards and state medical boards, describes the efforts to resolve this issue, and proposes a series of steps that will bring a higher degree of predictability to this process and meet the needs of all stakeholders.

Nelson LS, Duhigg LM, Arnold GK, et al. The Association between Maintaining ABEM Certification and State Medical Board Disciplinary Actions. *J Emerg Med*. 2019 Dec;57(6):772-779.
A study was undertaken to determine if maintaining American Board of Emergency Medicine (ABEM) certification was associated with a lower risk of disciplinary action. This study which included 23,002 physicians in the study cohort showed that the absolute incidence of physicians with a disciplinary action was low (3.0 percent), and that maintaining ABEM certification was associated with a lower risk of state medical board disciplinary actions.

Nathan N. Regular Maintenance Is Strongly Recommended: The Road to Board Certification and Beyond. *Anesth Analg*. 2019;129(5):1191.
This infographic summarizes the educational pathway that leads to board certification in anesthesiology.

Zhou Y, Sun H, Macario A, et al. Association Between Participation and Performance in MOCA Minute and Actions Against the Medical Licenses of Anesthesiologists. *Anesth Analg*. 2019;129:1401-7.
A study to examine the association between participation and performance in the Maintenance of Certification in Anesthesiology (MOCA) Minute (the American Board of Anesthesiology's web-based longitudinal assessment) and disciplinary actions against medical licenses of anesthesiologists showed that both timely participation and meeting the performance standard in MOCA Minute are associated with a lower likelihood of being disciplined by a state medical board. Using 2016 data, the study found that the cumulative incidence of license actions was 1.2 percent in anesthesiologists required to register for MOCA Minute. Nonregistration was associated with a 2.93 percent higher incidence of license actions. For the 18,534 (96.2 percent) who registered, later registration (after June 30, 2016) was associated with a higher incidence of license actions.

Jones AT, Kopp JP, Malangoni MA. Recertification Exam Performance in General Surgery is Associated With Subsequent Loss of License Actions. *Ann Surg*. 2019 Apr 23. doi: 10.1097/SLA.0000000000003330
A study to measure associations between first-time performance on the American Board of Surgery (ABS) recertification exam with subsequent state medical licensing board disciplinary actions showed that failing the first recertification exam attempt was associated with a greater rate of subsequent loss-of-license actions.

Kinney CL, Raddatz MM, Sliwa JA, et al. Association of Participation in the American Board of Physicial Medicine and Rehabilitation Maintenance of Certification Program and Physician Disciplinary Actions. *Am J Phys Med Rehabil*. 2019 Oct 18. doi: 10.1097/PHM.0000000000001331.
A study to analyze the relationship between participation in the American Board of Physical Medicine and Rehabilitation (ABPMR) maintenance of certification (MOC) program and the incidence of disciplinary actions by state medical boards over a physician's career showed that physicians in physical medicine and rehabilitation who had a lapse in completing ABPMR's MOC program had a 2.5-fold higher incidence of receiving a disciplinary action and had higher severity violations than physicians whose certificate never lapsed.

ABMS and ABMS Member Board Policies and Initiatives

Colenda CC, Scanlon WJ, Hawkins RE. Vision for the Future of Continuing Board Certification. *JAMA*. 2019 Jun 18;321(23):2279-2280..
This article provides an overview of the Vision Initiative process, the Commission's Final Report recommendations, and the American Board of Medical Specialties and ABMS member boards implementation program.

Bartley GB. The Vision for the Future Commission on Continuing Board Certification: Initial Perspectives from the American Board of Ophthalmology. *Ophthalmology*. 2019;126(7):922-925.
This article reviews the recommendations from the Continuing Board Certification: Vision for the Future Commission and discusses the implications of the Commission's report for the ophthalmic community.

Williams GA, Parke II DW. Continuing Professional Certification: Perspective of the American Academy of Ophthalmology. *Ophthalmology*. 2019;126(7):926-927.
This article reviews the recommendations from the Continuing Board Certification: Vision for the Future Commission and discusses the implications of the Commission's report for the ophthalmic community. The authors also provide background information on why the American Board of Ophthalmology (ABO) was established in 1916 and required certification based on examination at the initiation of clinical practice and subsequently established the continuing medical education (CME) system and the linkage of participation in accredited CME offerings with maintenance of state licensure and organizational credentialing

Newton WP, Baxley E, Lefebvre A. Improving Quality Improvement. *Ann Fam Med*. 2019;17:381-382.
In February 2019, the Vision Committee recommended that the American Board of Medical Specialties chart a new course for Improvement in Medical Practice. Arguing that the Maintenance of Certification requirement for Improvement in Medical Practice had become onerous for some diplomates and challenging to implement for many specialties, the Vision Committee called for the identification of new approaches to advancing practice while recognizing what Diplomates are already doing. This article discusses how the American Board of Family Medicine has begun to develop measures to better capture what is unique to family medicine and primary care, such as continuity, comprehensiveness, and patient centered outcomes.

Grayson MH, Oppenheimer J, Castells M, Nowak-Wegrzyn A. Life-long Learning and the ABAI: Practice Improvement Comes of Age. *Ann Allergy Asthma Immunol*. 2019 Jul;123(1):6-8.
This article discusses how the American Board of Allergy and Immunology (ABAI) developed "Alternatives to Practice Assessment/Quality Improvement Modules" to provide diplomates with opportunities to showcase the continual improvement activities they are involved in that apply to their specific career path.

Bradley J, Theobald M. Preliminary Results of the ABFM/STFM Precepting Performance Improvement Pilot. *Ann Fam Med*. 2019;17:185-186.
This article discusses how the Society of Teachers of Family Medicine and the American Board of Family Medicine completed a pilot program that offered Performance Improvement continuing certification credit (previously Maintenance of Certification Part IV) to ABFM diplomates who provide personal instruction, training, and supervision to a medical student or resident and who participate in a teaching improvement activity. Forty-two academic units (sponsors) were selected

to participate through an application process. Thirty-three completed the requirements of the program and submitted a final report.

Newton WP, Baxley E, Rode K, et al. Improving Continuing Education for Family Physicians: The Role of the American Board of Family Medicine. *JABFM*. 2019;32(5):756-8.
This article touches on the history of the American Board of Family Medicine (ABFM) and looks at the role the ABFM should play in the larger continuing medical education system for family physicians. At its founding, ABFM required reassessment of cognitive expertise every seven years. In the early 2000s, ABFM implemented a maintenance of certification model with requirements to participate in knowledge self-assessments and performance improvement activities every three years The organization also extended time between examinations to every 10 years. Currently, the ABFM is offering an optional national Family Medicine Journal Club. This offering will provide practice changing articles selected for relevance and methodological rigor from 140 clinical journals to expand opportunities for ABFM, its chapters, and CME providers to develop continuing education opportunities to meet the needs of ABFM Diplomates.

Bass EB. Strengthening Our Voice in Public Policy on Medical Education. *Trans Am Clin Climatol Assoc.* 2019;130:156–165.
This article provides an overview of medical education issues that are receiving attention by public policymakers. Many forces contribute to the interest of policymakers in medical education, including public awareness of how policies can affect access to and quality of clinical care. Governmental legislatures are getting more involved in medical education policy, with less acceptance of the profession's autonomy. The author notes that professional societies are not positioned to respond optimally to governmental involvement in medical education policy due to limited resources, poor coordination, and competing concerns. In response to concerns of many physicians about maintenance of certification programs, policymakers at the state level have been asked to consider new policies for regulating the approach to maintenance of certification. At the federal level, policymakers have been asked to consider new ways to support the training of physician-investigators.

Nguyen XV, Adams SJ, Hobbs SK, et al. Radiologist as Lifelong Learner: Strategies for Ongoing Education. *Acad Radiol*. 2019 Aug;26(8):1120-1126.
The Association of University Radiologists-Radiology Research Alliance Lifelong Learning Task Force convened to explore the current status and future directions of lifelong learning in radiology and summarized its findings in this article. The authors review the various learning platforms and resources available to radiologists in their self-motivated and self-directed pursuit of lifelong learning. They also discuss the challenges and perceived barriers to lifelong learning and strategies to mitigate those barriers and optimize learning outcomes. The American Board of Radiology's maintenance of certification (MOC) program demonstrates the board's commitment and support for continuous quality improvement, quality patient care, and professional development. More recently, online longitudinal assessment has been introduced as a progressive online assessment that will replace the requirement of a MOC exam every 10 years.

Kates AM, Morris PB. Highlights of the American College of Cardiology Annual Scientific Sessions 2019. *Circulation*. 2019;139:2793-2795.
The authors provide an overview of the American College of Cardiology's (ACC) new strategic plan and announced the groundbreaking agreement between ACC and the American Board of Internal Medicine, establishing a new pathway for the maintenance of certification through the Collaborative Maintenance Pathway.

Shivraj P, Novak A, Aziz S, et al. The Certification Process Driving Patient Safety. *Obstet Gynecol* Clin N Am. 2019;46:269-280.
In 2016, the American Board of Medical Specialties (ABMS) and the National Patient Safety Foundation issued a joint call encouraging each ABMS member board to integrate patient safety principles and activities into their initial and continuous certification processes. This article describes how the American Board of Obstetrics and Gynecology integrates various aspects of patient safety principles into its initial and continuous certification processes. The authors first describe how they assess patient safety within their initial certification processes. They then describe each component of their maintenance of certification program, and how they intentionally embed patient safety principles within each component.

Physician Satisfaction with Continuous Certification

Peabody MR, Peterson LE, Dai M, et al. Motivation for Participation in the American Board of Family Medicine Certification Program. *FamMed.* 2019;51(9):728-36.
This study involving 7,545 family physicians who provide direct patient care and participate in continuing certification showed that approximately one-fifth (21.4 percent) were motivated to continue their board certification solely by intrinsic factors (e.g., to maintain professional image, personal preference, etc.). Less than one-fifth (17.3 percent) were motivated only by extrinsic factors (e.g., required by employers, for credentialing purposes, etc.), and the majority (61.2 percent) reported mixed motivations for continuing their board certification. Only 38 respondents (0.5 percent) included a negative opinion about the certification process in their open-text responses. Approximately half of family physicians in this sample noted a requirement to continue their certification, suggesting that there has been no significant increase in the requirements from employers, credentialing bodies, or insurers for physicians to continue board certification noted in previously cited work. Furthermore, only 17.5 percent of the physicians in this study reported solely external motivation to continue certification, indicating that real or perceived requirements are not the primary driver for most physicians to maintain certification.

Leslie LK, Turner AL, Smith AC, et al. Pediatrician Perspectives on Feasibility and Acceptability of the MOCA-Peds 2017 Pilot. *Pediatrics*. 2019;144(6). doi: 10.1542/peds.2019-2303.
This study involving 4,238 pediatricians who participated in MOCA-Peds showed that 93 percent considered MOCA-Peds to be a feasible and acceptable alternative to the traditional MOC exam. The pediatricians surveyed participated in a pilot MOCA-Peds program in 2017 and completed two questionnaires. Of the pediatricians who completed the fourth-quarter survey, 82 percent agreed the questions assessed clinical judgment, 82 percent agreed the questions were relevant to the practice of general pediatrics, and 59 percent agreed the questions were relevant to their specific practice setting. Most of them (89 percent) reported feeling less anxious about participating in MOCA-Peds than taking the proctored exam. The majority of general pediatricians and subspecialists (97 percent and 95 percent, respectively) said they planned to participate in MOCA-Peds to maintain their certification.

ABOS Web-Based Longitudinal Assessment (ABOS WLA). American Board of Orthopaedic Surgery. Available at: https://www.abos.org/moc/abos-web-based-longitudinal-assessment-abos-wla/ (accessed 1-15-20)
In 2019, the American Board of Orthopaedic Surgery (ABOS) launched the ABOS Web-Based Longitudinal Assessment (ABOS WLA) Program. Nearly 10,000 Diplomates—about 55 percent of those eligible (diplomates whose certification expires 2019 through 2028)—chose to participate in the inaugural program. As the results of this ABOS survey demonstrate, the majority of ABOS Diplomates who participated in the ABOS WLA thought it was a high-quality program and want to

continue with it next year. Diplomates felt that the Knowledge Sources were relevant to their practice and a more appropriate assessment of their knowledge. ABOS' report of survey results includes a list of changes to next year's ABOS WLA based on diplomate feedback.

Dai M, Hagen M, Eden AR, Peterson LE. Physician opinions about American Board of Family Medicine self-assessment modules (2006 –2016). *J Am Board Fam Med*. 2019;32(1):79-88.
An evaluation of the American Board of Family Medicine (ABFM) diplomate feedback survey data to examine family physician opinions about ABFM self-assessment module (SAM) content (448,408 SAM feedback surveys were completed within the period 2006-2016) showed that family medicine diplomates generally value SAMs. Respondents felt that the SAM content is appropriate, and favorability ratings increased as diplomates engaged in more SAM activities.

Concerns about CBC

Singleton MM. Let's Put the Act in Activism. *Journal of American Physicians and Surgeons*. 2019;24(3):75-76.
In this editorial, the author discusses how the requirements of the federal government, insurers and managed care entities, large health care systems, state medical boards, medical specialty boards, and pharmaceutical companies are placing burdensome demands on physicians. In addition, the author notes that, "to apply for or renew hospital staff privileges, hospitals are demanding Maintenance of Certification (MOC), an expensive process of questionable value. MOC places onerous burdens on physicians and worse, takes away physicians' time with their patients. It is up to us to demand and maintain self-governance at the hospital and in our private practices."

Chazal RA. RESPONSE: Dealing With Multiple Certifications and Recertifications. *JACC*. 2019;73(11):1360-1361.
In this editorial, the author discusses concerns about the cost, time, and efficacy of multiple board certifications (and recertifications) that are widespread among trainees and practicing physicians. Limiting the number of board certifications that an individual pursues would seem logical, but it may be more practical for the practicing clinician than a trainee not yet certain of his or her career path.

Berlin J. Closing a Loophole: Medicine Works to Clarify MOC Law. *Texas Medicine*. Mar 2019. Available at: https://www.texmed.org/Template.aspx?id=49952 (accessed 1-23-20).
This editorial discusses the 2017 Texas legislature's Senate Bill 1148 that prohibits health plans from using maintenance of certification (MOC) as a requirement for contracts; prevents the Texas Medical Board from using it as a condition of licensure or license renewal; and prohibits most hospitals and other health care facilities from using MOC status for credentialing, hiring, or retaining physicians. Exceptions include facilities required to use MOC by law, rule, or certification or accreditation standard; medical schools or comprehensive cancer centers; and entities in which the voting physician members of the medical staff vote to authorize the use of MOC. The Texas Medical Association (TMA) is working with lawmakers after receiving complaints that Memorial Hermann Health System is attempting to work around the law. TMA also supports the recommendations of the Vision for the Future Commission to strengthen the MOC reforms it proposed for the American Board of Medical Specialties (ABMS) and the ABMS member boards.

Challenges and Considerations

Cordovani L, Wong A, Monteiro S. Maintenance of certification for practicing physicians: a review of current challenges and considerations. *Canadian Medical Education Journal*. 2019. Available at: http://www.cmej.ca. Accessed December 16, 2019.
This paper reviews current issues and challenges associated with maintenance of certification (MOC) in medicine, including how to define medical competencies for practicing physicians, assessment, and how best to support physicians' lifelong learning in a continuous and self-motivated way. The authors discuss how the combination of self-monitoring, regular feedback, and peer support could improve self-assessment. They note that effective MOC programs are learner-driven, focused on everyday practice, and incorporate educational principles. They also discuss the importance of MOC to the physicians' actual practice to improve acceptability, the benefits of tailored programs, and decentralization of MOC programs to better characterize the physician's practice. Lastly, they discuss the value of simulation-based medical education in MOC programs. Simulation-based education could be used to practice uncommon complications, life-threatening scenarios, and non-technical skills improvement. This type of education can also be used to become proficient with new technology. As learners find simulation experiences educationally valuable, clinically relevant, and positive, simulation could be a way of increasing physicians' participation in MOC programs.

Gabel J, O'Dell T, Masuda E, et al. Who is treating venous disease in America today? *J Vasc Surg: Venous and Lym Dis*. 2019;7:610-614.
A study to examine the specialty, board certification, and training of physicians who are treating venous disease in the United States showed there are a large number of physicians treating venous disease who do not have an active board certification. This was more common for physicians employed by a large multistate venous corporation. Physicians employed by a corporation were more likely to advertise a board certification from the American Board of Venous and Lymphatic Medicine (a certification not endorsed by the American Board of Medical Specialties).

REFERENCES

1. Report 2-A-19, Update on Maintenance of Certification and Osteopathic Continuous Certification. AMA Council on Medical Education. Available at: https://www.ama-assn.org/system/files/2019-07/a19-cme-2.pdf (accessed 1-14-20).
2. Report 2-A-18, Update on Maintenance of Certification and Osteopathic Continuous Certification. AMA Council on Medical Education. Available at: https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/council-on-med-ed/a18-cme-02.pdf (accessed 1-14-20).
3. Report 2-A-17, Update on Maintenance of Certification and Osteopathic Continuous Certification. AMA Council on Medical Education. Available at: https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/about-ama/councils/Council%20Reports/council-on-medical-education/a17-cme-02.pdf (accessed 1-14-20).
4. Report 2-A-16, Update on Maintenance of Certification and Osteopathic Continuous Certification. AMA Council on Medical Education. Available at: ama-assn.org/sites/default/files/media-browser/public/about-ama/councils/Council%20Reports/council-on-medical-education/a16-cme-02.pdf (accessed 1-14-20).
5. Report 2-A-15, Update on Maintenance of Certification and Osteopathic Continuous Certification. AMA Council on Medical Education. Available at: ama-assn.org/sites/default/files/media-browser/public/about-ama/councils/Council%20Reports/council-on-medical-education/cme-report-02-a-15-moc-final.pdf (accessed 1-14-20).
6. Report 6-A-14, Update on Maintenance of Certification, Osteopathic Continuous Certification, and Maintenance of Licensure. AMA Council on Medical Education. Available at: ama-assn.org/sites/default/files/media-browser/public/about-ama/councils/Council%20Reports/council-on-medical-education/cme-rpt6-a-14.pdf (accessed 1-14-20).
7. Report 4-A-13, An Update on Maintenance of Certification, Osteopathic Continuous Certification, and Maintenance of Licensure. AMA Council on Medical Education. Available at: ama-assn.org/sites/default/files/media-browser/public/about-ama/councils/Council%20Reports/council-on-medical-education/cme-rpt4-a-13.pdf (accessed 1-14-20).
8. Report 10-A-12, An Update on Maintenance of Certification, Osteopathic Continuous Certification, and Maintenance of Licensure. AMA Council on Medical Education. Available at: ama-assn.org/sites/default/files/media-browser/public/about-ama/councils/Council%20Reports/council-on-medical-education/a-12cmerpt10.pdf (accessed 1-14-20).
9. Report 11-A-12, Impact of Maintenance of Certification, Osteopathic Continuous Certification, Maintenance of Licensure on the Physician Workforce. AMA Council on Medical Education. Available at: ama-assn.org/sites/default/files/media-browser/public/about-ama/councils/Council%20Reports/council-on-medical-education/a-12cmerpt11.pdf (accessed 1-14-20).
10. Report 3-A-10, Specialty Board Certification and Maintenance of Licensure AMA Council on Medical Education. Available at: ama-assn.org/sites/default/files/media-browser/public/about-ama/councils/Council%20Reports/council-on-medical-education/a10-cme-specialty-board-certification-maintenance-licensure.pdf (accessed 1-14-20).
11. Report 16-A-09, Maintenance of Certification/Maintenance of Licensure. AMA Council on Medical Education. Available at: ama-assn.org/sites/default/files/media-browser/public/about-

ama/councils/Council%20Reports/council-on-medical-education/a09-cme-maintenance-certification-licensure.pdf (accessed 1-14-20).
12. Macario A, Harman AE, Hosansky T, et al. Evolving Board Certification – Glimpses of Success. N Engl J Med. 2019;380(2):115-118.
13. Hawkins RE. Update on ABMS Continuing Certification. Presented at the American Medical Association Academic Physician Section Meeting. November 16, 2019. Available at: https://www.ama-assn.org/system/files/2019-11/i19-abms-board-cert.pdf (accessed 1-14-19).
14. ABMS Member Boards Engage with Societies on Innovative Knowledge Assessments. American Board of Medical Specialties. Available at: https://www.abms.org/news-events/abms-member-boards-engage-with-societies-on-innovative-knowledge-assessments/?utm_source=abms&utm_medium=email&utm_campaign=kristin&utm_content=201910&utm_source=abms&utm_medium=email&utm_campaign=kristin&utm_content=201910 (accessed 1-28-20).
15. ABIM Quarterly News & Notes | Fall 2019. American Board of Internal Medicine. Available at: http://blog.abim.org/abim-quarterly-news-and-notes-fall-2019/#longitudinal (accessed 1-15-19).
16. ABMS Board Certification Report 2018-2019. American Board of Medical Specialties. Available at: tps://www.abms.org/news-events/abms-releases-2018-2019-board-certification-report/ (accessed 3-23-20).
17. Code of Medical Ethics Opinion 9.2.6. American Medical Association. Available at: https://www.ama-assn.org/delivering-care/ethics/continuing-medical-education (accessed 1-28-20).

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 2, November 2020

Subject: Graduate Medical Education and the Corporate Practice of Medicine

Presented by: Liana Puscas, MD, MHS, Chair

Referred to: Reference Committee C

INTRODUCTION

American Medical Association (AMA) Policy H-310.904, "Graduate Medical Education and the Corporate Practice of Medicine," states that our AMA:

> (1) recognizes and supports that the environment for education of residents and fellows must be free of the conflict of interest created between a training site's fiduciary responsibility to shareholders and the educational mission of residency or fellowship training programs;
>
> (2) encourages the Accreditation Council for Graduate Medical Education (ACGME) to update its "Principles to Guide the Relationship between Graduate Medical Education, Industry, and Other Funding Sources for Programs and Sponsoring Institutions Accredited by the ACGME" to include corporate-owned lay entity funding sources; and
>
> (3) will study issues, including waiver of due process requirements, created by corporate-owned lay entity control of graduate medical education sites.

The report describes the corporate practice of medicine doctrine (as developed by the AMA),[1] the increase in the number of physicians as employees, the potential effects of corporate medicine on graduate medical education (GME), and protections provided against undue influence in GME.

BACKGROUND

As a country of innovation and new ideas, the United States is a natural laboratory for the development of corporate-funded sponsorships in medical education. That said, the unintended consequences of a potentially pernicious influence in medical education and interference in training by corporate interests highlights the need for hyper-vigilance by the house of medicine.

The corporate practice of medicine doctrine describes the general principle that limits the practice of medicine to licensed physicians, prohibits corporations from practicing medicine, and protects the practice of medicine from corporations' and other lay entities' overriding desire to generate profits.[1] In some cases, the doctrine may prohibit a corporation from directly employing a physician to provide medical services. The doctrine is based on a number of policy concerns, including the following:

1. Allowing corporations to practice medicine or employ physicians will result in the commercialization of the practice of medicine;
2. A corporation's obligation to its shareholders may not align with a physician's obligation to patients; and
3. Employment of a physician by a corporation may interfere with the physician's independent medical judgment.

Most states, but not all, have laws that prohibit the corporate practice of medicine, which may address the corporate influence on the practice of medicine in contexts other than physician employment. For example, a state's corporate practice of medicine laws frequently limit or prohibit non-physicians from owning, investing in, or otherwise controlling medical practices.[2] Almost every state, however, provides broad exceptions to various forms of the doctrine. For example, all states allow for professional corporations or associations wholly owned by physicians to provide care. Some states allow nonphysicians or shareholders to hold an ownership interest in a professional corporation, but often limit such ownership to a minority percent. Hospitals are also exempted in many states, as many states permit hospitals to employ physicians. In these situations, it is stipulated that the employer not interfere with or attempt to control the independent medical judgment of physicians on staff.[1,2]

THE CORPORATE PRACTICE OF MEDICINE AND INCREASING PHYSICIAN EMPLOYMENT STATUS

More physicians are now employees rather than owners of their own practices. The year 2018 was the first in which there were fewer patient care physicians with ownership stakes in their practices (45.9 percent) than were employees (47.4 percent). The employee status of physicians varies by specialty. Emergency medicine, the specialty that has been most concerned with the corporate practice of medicine, has the lowest proportion of physicians who are owners (26.2 percent). Emergency medicine also has the highest share of physicians who are independent contractors (27.3 percent) and the highest proportion of physicians who are directly employed by or with a contract with a hospital, at 23.3 percent.[3]

As more physicians become employees, the profession should monitor physician professional autonomy within that employment status. One issue of particular concern, which may be part of a physician's employment contract, is post-employment non-compete clauses. Non-compete clauses may negatively affect a physician's ability to find new employment if current employment should cease. For example, the increasing number of hospital and health system mergers can create a local health care environment with few employers who would not be considered as competition under a non-compete clause.[2]

A second issue is due process. The Fifth Amendment requires that the federal government provide due process protections to its citizens, while the 14th Amendment extends those same requirements to states and to state actors. Due process protections, however, do not necessarily apply to private hospitals or other health care facilities that grant medical staff privileges (non-federal or state actors).[4] Generally, medical staff bylaws describe how termination of a physician's privileges must proceed. Hospitals may require that physicians waive any due process rights contained in the hospital bylaws to maintain a quality medical staff while limiting the number of contentious and costly due process hearings. Contracts with third parties can also allow hospitals to avoid adhering to any applicable due process requirements. If a hospital contracts with a staffing company to hire physicians, the hospital may require that the staffing company's contract with physicians contain a due process waiver. If the staffing company does not agree to the hospital's requests, then the hospital may choose to contract with another group. As it is highly likely that emergency medicine

physicians are either employees of hospitals or under contract with a staffing company that has required a due process waiver as a condition of contracting, due process waivers remain an issue of great concern to the specialty. Legislation has been introduced to eliminate the ability of a third-party contract to waive a physician's due process rights.[2,4]

THE CORPORATE PRACTICE OF MEDICINE AND GRADUATE MEDICAL EDUCATION

Currently, at least 14 emergency medicine residency programs are owned by lay entity corporations (i.e., no physician owner) in 10 different states.[5] The potential of the medical education learning environment being unduly influenced by the interests of a corporation, which is beholden to the concerns of shareholders, is disquieting.

The Resident and Student Association of the American Academy of Emergency Medicine has developed questions related to ownership/sponsorship of a program that students can ask of programs during the application or interview process.[6] These include:

> "Are the faculty employed by the hospital/medical school/a group?
> Which type of group? Do the faculty have incentives built around their teaching scores?
>
> Is there a particular type of post-residency practice you try and direct your graduates to?
> How do they get educated as to the various post-residency options?
>
> What type of position do most residents go to after they complete training?
> If mostly academic, do they go to work for physician-owned groups or large companies?
>
> Is the residency sponsored by any entity other than Medicare?
> If so, by whom? If a large amount is sponsored by an entity other than Medicare, does this sponsor affect my education in any way? Have there been issues with this sponsor in relation to this residency program in the past? Would this entity sponsoring my training bias me in any way?"

One of the largest for-profit hospital companies in the U.S., HCA Healthcare, currently has 19 hospitals sponsoring 162 ACGME-accredited programs in 12 states. HCA Healthcare also operates hospitals that are affiliated with training programs (but are not sponsors). One positive outcome of increased involvement in GME by this and other for-profit entities has been the growth of GME in areas with high-population growth, such as Florida, Georgia, Texas, and Nevada, that have long been stymied in their ability to increase GME positions. As with non-profit training institutions, for-profit sponsors likely benefit from the health care workforce that residents provide, as well as the built-in pool of physician candidates for employment.[7]

At the same time, concerns of physician professional autonomy, due process, and conflict of interest may be more common when there is a fiduciary responsibility to shareholders by the sponsors or affiliates of training programs. Recent incidents in which for-profit corporations have purchased and then unexpectedly closed training hospitals have raised apprehensions regarding the long-term interests of corporations and their disconnect to GME. In 2019, for example, Hahnemann University Hospital (HUH) was abruptly closed shortly after being purchased in 2018 by American Academic Health System, LLC (a private equity-backed company).[8,9] Also in 2019, Ohio Valley Medical Center was closed after being purchased by Alecto Healthcare Services, LLC in 2017.[10] The closure of HUH resulted in the displacement of 570 residents from over 30 residency and fellowship programs; the closure of Ohio Valley displaced 32 residents from two programs. The efforts of many individuals, programs, and organizations to successfully provide continuing

training opportunities for these physicians has been described elsewhere. Currently, the situation created by the closure of HUH is still being litigated; however, attention has been increasing regarding the future of health care delivery, as well as GME, in light of financial pressures on training institutions and affiliated practice sites.[11,12] AMA Policy H-310.943 "Closing of Residency Programs" includes many recommendations resulting from the sudden closure of the HUH residency programs.

REQUIREMENTS PROTECTING GME FROM CONFLICT OF INTEREST AND OTHER CORPORATE INFLUENCE

The ACGME accredits residency and fellowship programs and sets requirements for training programs as well as the institutions in which training occurs. A review of ACGME institutional requirements reveals general concerns about due process, conflict of interest, and competition. For example, IV.D. "Grievances: The Sponsoring Institution must have a policy that outlines the procedures for submitting and processing resident/fellow grievances at the program and institutional level and that minimizes conflicts of interest." The contract of appointment must include a reference to grievance and due process [IV.B.2.e)]. Regarding promotion, appointment renewal and dismissal, the sponsoring institution must have policy that provides residents and fellows with due process for suspension, non-renewal, non-promotion, or dismissal [IV.C.1.b)].

Finally, "Sponsoring Institution[s] must maintain a policy which states that neither the Sponsoring Institution nor any of its ACGME-accredited programs will require a resident/fellow to sign a non-competition guarantee or restrictive covenant." [IV.L.][13]

The ACGME's Common Program Requirements (CPRs) include slightly more specificity. In the Common Program Requirements, it is noted that the program director must:

> II.A.4.a).(10) provide a learning and working environment in which residents have the opportunity to raise concerns and provide feedback in a confidential manner as appropriate, without fear of intimidation or retaliation;
> II.A.4.a).(11) ensure the program's compliance with the Sponsoring Institution's policies and procedures related to grievances and due process;
> II.A.4.a).(12) ensure the program's compliance with the Sponsoring Institution's policies and procedures for due process when action is taken to suspend or dismiss, not to promote, or not to renew the appointment of a resident;
> and
> II.A.4.a).(13).(a) Residents must not be required to sign a noncompetition guarantee or restrictive covenant.

The CPRs do require that the learning environment encourage the development of residents and fellows into ethical and caring professionals, which could forearm trainees from negative, undue influence of corporate medicine. For example, faculty are to "demonstrate commitment to the delivery of safe, quality, cost effective, patient-centered care." [II.B.2.b)] The curriculum is to advance "residents' knowledge of ethical principles foundational to medical professionalism." [IV.A.5.]. As part of the ACGME core competency of professionalism, residents are to demonstrate competence in "responsiveness to patient needs that supersedes self-interest," "accountability to patients, society, and the profession" and "appropriately disclosing and addressing conflict or duality of interest." [IV.B.1.a).(1).(b) (d) and (g)] More generally, the core competency of practice-based learning and improvement requires that physicians investigate and evaluate the care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and lifelong learning. [IV.B.1.d)][14]

The ACGME published in 2012 the "Principles to Guide the Relationship between Graduate Medical Education, Industry, and Other Funding Sources for Programs and Sponsoring Institutions Accredited by the ACGME,"[15] as referenced in H-310.904. Written at a time of growing influence of the pharmaceutical industry via funding graduate and undergraduate medical education by sponsoring educational programs, medical research, and promotional marketing, the Principles state that "The relationship of a company to its shareholders defines values and influences behaviors held by the industry." However, the "industry" of the Principles "includes pharmaceutical companies, manufacturers of medical devices, and biotechnology companies," but does not encompass corporate-owned lay entity funding sources. This absence led to adoption of H-310.904 at the 2019 Annual Meeting of the AMA House of Delegates—in particular: "Our AMA … (2) encourages the Accreditation Council for Graduate Medical Education (ACGME) to update its 'Principles to Guide the Relationship between Graduate Medical Education, Industry, and Other Funding Sources for Programs and Sponsoring Institutions Accredited by the ACGME' to include corporate-owned lay entity funding sources."

CURRENT AMA POLICY

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

SUMMARY AND RECOMMENDATIONS

Corporate involvement in GME is likely to grow with the increase in mergers and acquisitions involving hospitals, health systems, and physician practice management companies, with resulting disruptions to existing relationships. As much of GME is now taking place outside of major teaching hospitals, adherence to professional and ethical principles may be obscured by organizational stresses due to financial accountability to owners not involved in or knowledgeable of the practice of medicine. Negative impacts to the learning environment through the "hidden curriculum" are an additional concern. Enhanced oversight may be needed to protect residents and fellows from potential conflicts between GME and the fiduciary responsibilities of training programs and their institutions.

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

1. That Policy H-310.904, "Graduate Medical Education and the Corporate Practice of Medicine," be amended by addition and deletion to read as follows: "Our AMA: … (3) will ~~study~~ continue to monitor issues, including waiver of due process requirements, created by corporate ~~owned lay entity~~ control of graduate medical education sites." (Modify Current HOD Policy)

2. That our AMA reaffirm Policy H-310-904 (2), "Graduate Medical Education and the Corporate Practice of Medicine." (Reaffirm HOD Policy)

Fiscal note: $1,000.

APPENDIX: RELEVANT AMA POLICY

H-255.950, "AMA Principles for Physician Employment"

1. Addressing Conflicts of Interest

a) A physician's paramount responsibility is to his or her patients. Additionally, given that an employed physician occupies a position of significant trust, he or she owes a duty of loyalty to his or her employer. This divided loyalty can create conflicts of interest, such as financial incentives to over- or under-treat patients, which employed physicians should strive to recognize and address.

b) Employed physicians should be free to exercise their personal and professional judgement in voting, speaking and advocating on any manner regarding patient care interests, the profession, health care in the community, and the independent exercise of medical judgment. Employed physicians should not be deemed in breach of their employment agreements, nor be retaliated against by their employers, for asserting these interests. Employed physicians also should enjoy academic freedom to pursue clinical research and other academic pursuits within the ethical principles of the medical profession and the guidelines of the organization.

c) In any situation where the economic or other interests of the employer are in conflict with patient welfare, patient welfare must take priority.

d) Physicians should always make treatment and referral decisions based on the best interests of their patients. Employers and the physicians they employ must assure that agreements or understandings (explicit or implicit) restricting, discouraging, or encouraging particular treatment or referral options are disclosed to patients.

(i) No physician should be required or coerced to perform or assist in any non-emergent procedure that would be contrary to his/her religious beliefs or moral convictions; and

(ii) No physician should be discriminated against in employment, promotion, or the extension of staff or other privileges because he/she either performed or assisted in a lawful, non-emergent procedure, or refused to do so on the grounds that it violates his/her religious beliefs or moral convictions.

e) Assuming a title or position that may remove a physician from direct patient-physician relationships--such as medical director, vice president for medical affairs, etc.--does not override professional ethical obligations. Physicians whose actions serve to override the individual patient care decisions of other physicians are themselves engaged in the practice of medicine and are subject to professional ethical obligations and may be legally responsible for such decisions. Physicians who hold administrative leadership positions should use whatever administrative and governance mechanisms exist within the organization to foster policies that enhance the quality of patient care and the patient care experience.

Refer to the AMA Code of Medical Ethics for further guidance on conflicts of interest.

2. Advocacy for Patients and the Profession

a) Patient advocacy is a fundamental element of the patient-physician relationship that should not be altered by the health care system or setting in which physicians practice, or the methods by which they are compensated.

b) Employed physicians should be free to engage in volunteer work outside of, and which does not interfere with, their duties as employees.

3. Contracting

a) Physicians should be free to enter into mutually satisfactory contractual arrangements, including employment, with hospitals, health care systems, medical groups, insurance plans, and other entities as permitted by law and in accordance with the ethical principles of the medical profession.

b) Physicians should never be coerced into employment with hospitals, health care systems, medical groups, insurance plans, or any other entities. Employment agreements between physicians and their employers should be negotiated in good faith. Both parties are urged to obtain the advice of legal counsel experienced in physician employment matters when negotiating employment contracts.

c) When a physician's compensation is related to the revenue he or she generates, or to similar factors, the employer should make clear to the physician the factors upon which compensation is based.

d) Termination of an employment or contractual relationship between a physician and an entity employing that physician does not necessarily end the patient-physician relationship between the employed physician and persons under his/her care. When a physician's employment status is unilaterally terminated by an employer, the physician and his or her employer should notify the physician's patients that the physician will no longer be working with the employer and should provide them with the physician's new contact information. Patients should be given the choice to continue to be seen by the physician in his or her new practice setting or to be treated by another physician still working with the employer. Records for the physician's patients should be retained for as long as they are necessary for the care of the patients or for addressing legal issues faced by the physician; records should not be destroyed without notice to the former employee. Where physician possession of all medical records of his or her patients is not already required by state law, the employment agreement should specify that the physician is entitled to copies of patient charts and records upon a specific request in writing from any patient, or when such records are necessary for the physician's defense in malpractice actions, administrative investigations, or other proceedings against the physician.

(e) Physician employment agreements should contain provisions to protect a physician's right to due process before termination for cause. When such cause relates to quality, patient safety, or any other matter that could trigger the initiation of disciplinary action by the medical staff, the physician should be afforded full due process under the medical staff bylaws, and the agreement should not be terminated before the governing body has acted on the recommendation of the medical staff. Physician employment agreements should specify whether or not termination of employment is grounds for automatic termination of hospital medical staff membership or clinical privileges. When such cause is non-clinical or not otherwise a concern of the medical staff, the physician should be afforded whatever due process is outlined in the employer's human resources policies and procedures.

(f) Physicians are encouraged to carefully consider the potential benefits and harms of entering into employment agreements containing without cause termination provisions. Employers should never terminate agreements without cause when the underlying reason for the termination relates to quality, patient safety, or any other matter that could trigger the initiation of disciplinary action by the medical staff.

(g) Physicians are discouraged from entering into agreements that restrict the physician's right to practice medicine for a specified period of time or in a specified area upon termination of employment.

(h) Physician employment agreements should contain dispute resolution provisions. If the parties desire an alternative to going to court, such as arbitration, the contract should specify the manner in which disputes will be resolved.

Refer to the AMA Annotated Model Physician-Hospital Employment Agreement and the AMA Annotated Model Physician-Group Practice Employment Agreement for further guidance on physician employment contracts.

4. Hospital Medical Staff Relations

a) Employed physicians should be members of the organized medical staffs of the hospitals or health systems with which they have contractual or financial arrangements, should be subject to the bylaws of those medical staffs, and should conduct their professional activities according to the bylaws, standards, rules, and regulations and policies adopted by those medical staffs.

b) Regardless of the employment status of its individual members, the organized medical staff remains responsible for the provision of quality care and must work collectively to improve patient care and outcomes.

c) Employed physicians who are members of the organized medical staff should be free to exercise their personal and professional judgment in voting, speaking, and advocating on any matter regarding medical staff matters and should not be deemed in breach of their employment agreements, nor be retaliated against by their employers, for asserting these interests.

d) Employers should seek the input of the medical staff prior to the initiation, renewal, or termination of exclusive employment contracts.

Refer to the AMA Conflict of Interest Guidelines for the Organized Medical Staff for further guidance on the relationship between employed physicians and the medical staff organization.

5. Peer Review and Performance Evaluations

a) All physicians should promote and be subject to an effective program of peer review to monitor and evaluate the quality, appropriateness, medical necessity, and efficiency of the patient care services provided within their practice settings.

b) Peer review should follow established procedures that are identical for all physicians practicing within a given health care organization, regardless of their employment status.

c) Peer review of employed physicians should be conducted independently of and without interference from any human resources activities of the employer. Physicians--not lay administrators--should be ultimately responsible for all peer review of medical services provided by employed physicians.

d) Employed physicians should be accorded due process protections, including a fair and objective hearing, in all peer review proceedings. The fundamental aspects of a fair hearing are a listing of specific charges, adequate notice of the right to a hearing, the opportunity to be present and to rebut evidence, and the opportunity to present a defense. Due process protections should extend to any disciplinary action sought by the employer that relates to the employed physician's independent exercise of medical judgment.

e) Employers should provide employed physicians with regular performance evaluations, which should be presented in writing and accompanied by an oral discussion with the employed physician. Physicians should be informed before the beginning of the evaluation period of the general criteria to be considered in their performance evaluations, for example: quality of medical services provided, nature and frequency of patient complaints, employee productivity, employee contribution to the administrative/operational activities of the employer, etc.

(f) Upon termination of employment with or without cause, an employed physician generally should not be required to resign his or her hospital medical staff membership or any of the clinical privileges held during the term of employment, unless an independent action of the medical staff calls for such action, and the physician has been afforded full due process under the medical staff bylaws. Automatic rescission of medical staff membership and/or clinical privileges following termination of an employment agreement is tolerable only if each of the following conditions is met:
i. The agreement is for the provision of services on an exclusive basis; and
ii. Prior to the termination of the exclusive contract, the medical staff holds a hearing, as defined by the medical staff and hospital, to permit interested parties to express their views on the matter, with the medical staff subsequently making a recommendation to the governing body as to whether the contract should be terminated, as outlined in AMA Policy H-225.985; and
iii. The agreement explicitly states that medical staff membership and/or clinical privileges must be resigned upon termination of the agreement.

Refer to the AMA Principles for Incident-Based Peer Review and Disciplining at Health Care Organizations (AMA Policy H-375.965) for further guidance on peer review.

6. Payment Agreements

a) Although they typically assign their billing privileges to their employers, employed physicians or their chosen representatives should be prospectively involved if the employer negotiates agreements for them for professional fees, capitation or global billing, or shared savings. Additionally, employed physicians should be informed about the actual payment amount allocated to the professional fee component of the total payment received by the contractual arrangement.

b) Employed physicians have a responsibility to assure that bills issued for services they provide are accurate and should therefore retain the right to review billing claims as may be necessary to verify that such bills are correct. Employers should indemnify and defend, and save harmless, employed physicians with respect to any violation of law or regulation or breach of contract in connection with the employer's billing for physician services, which violation is not the fault of the employee.

Our AMA will disseminate the AMA Principles for Physician Employment to graduating residents and fellows and will advocate for adoption of these Principles by organizations of physician employers such as, but not limited to, the American Hospital Association and Medical Group Management Association.

11.2.1 Code of Ethics, "Professionalism in Health Care Systems,"

Containing costs, promoting high-quality care for all patients, and sustaining physician professionalism are important goals. Models for financing and organizing the delivery of health care services often aim to promote patient safety and to improve quality and efficiency. However, they can also pose ethical challenges for physicians that could undermine the trust essential to patient-physician relationships.

Payment models and financial incentives can create conflicts of interest among patients, health care organizations, and physicians. They can encourage undertreatment and overtreatment, as well as dictate goals that are not individualized for the particular patient.

Structures that influence where and by whom care is delivered—such as accountable care organizations, group practices, health maintenance organizations, and other entities that may emerge in the future—can affect patients' choices, the patient-physician relationship, and physicians' relationships with fellow health care professionals.

Formularies, clinical practice guidelines, and other tools intended to influence decision making, may impinge on physicians' exercise of professional judgment and ability to advocate effectively for their patients, depending on how they are designed and implemented.

Physicians in leadership positions within health care organizations should ensure that practices for financing and organizing the delivery of care:

(a) Are transparent.

(b) Reflect input from key stakeholders, including physicians and patients.

(c) Recognize that over reliance on financial incentives may undermine physician professionalism.

(d) Ensure ethically acceptable incentives that:

(i) are designed in keeping with sound principles and solid scientific evidence. Financial incentives should be based on appropriate comparison groups and cost data and adjusted to reflect complexity, case mix, and other factors that affect physician practice profiles. Practice guidelines, formularies, and other tools should be based on best available evidence and developed in keeping with ethics guidance;

(ii) are implemented fairly and do not disadvantage identifiable populations of patients or physicians or exacerbate health care disparities;

(iii) are implemented in conjunction with the infrastructure and resources needed to support high-value care and physician professionalism;

(iv) mitigate possible conflicts between physicians' financial interests and patient interests by minimizing the financial impact of patient care decisions and the overall financial risk for individual physicians.

(e) Encourage, rather than discourage, physicians (and others) to:

(i) provide care for patients with difficult to manage medical conditions;

(ii) practice at their full capacity, but not beyond.
(f) Recognize physicians' primary obligation to their patients by enabling physicians to respond to the unique needs of individual patients and providing avenues for meaningful appeal and advocacy on behalf of patients.

(g) Are routinely monitored to:

(i) identify and address adverse consequences;

(ii) identify and encourage dissemination of positive outcomes.

All physicians should:

(h) Hold physician-leaders accountable to meeting conditions for professionalism in health care systems.

(i) Advocate for changes in health care payment and delivery models to promote access to high-quality care for all patients.

H-295.961, "Medicolegal, Political, Ethical and Economic Medical School Course"

(1) The AMA urge every medical school and residency program to teach the legal, political, ethical and economic issues which will affect physicians. (2) The AMA will work with state and county medical societies to identify and provide speakers, information sources, etc., to assist with the courses. (3) An assessment of professional and ethical behavior, such as exemplified in the AMA Principles of Medical Ethics, should be included in internal evaluations during medical school and residency training, and also in evaluations utilized for licensure and certification. (4) The Speaker of the HOD shall determine the most appropriate way for assembled physicians at the opening sessions of the AMA House of Delegates Annual and Interim Meetings to renew their commitment to the standards of conduct which define the essentials of honorable behavior for the physician, by reaffirming or reciting the seven Principles of Medical Ethics which constitute current AMA policy. (5) There should be attention to subject matter related to ethics and to the doctor-patient relationship at all levels of medical education: undergraduate, graduate, and continuing. Role modeling should be a key element in helping medical students and resident physicians to develop and maintain professionalism and high ethical standards. (6) There should be exploration of the feasibility of improving an assessment of ethical qualities in the admissions process to medical school. (7) Our AMA pledges support to the concept that professional attitudes, values, and behaviors should form an integral part of medical education across the continuum of undergraduate, graduate, and continuing medical education.

REFERENCES

[1] Issue brief: corporate practice of medicine. Advocacy Resource Center. American Medical Association. 2015. https://www.ama-assn.org/practice-management/economics/business-medicine#downloads-1

[2] *Emergency Medicine Advocacy Handbook*. Emergency Medicine Residents' Association. 2019. https://www.emra.org/books/advocacy-handbook/corporate-practice. Accessed December 20,2019.

[3] Kane CK. Updated data on physician practice arrangements: For the first time, fewer physicians are owners than employees. Chicago, IL. American Medical Association; 2019. Policy Research Perspectives. https://www.ama-assn.org/system/files/2019-07/prp-fewer-owners-benchmark-survey-2018.pdf.

[4] Sullivan W. Is due process good for emergency physicians? Emergency Physicians Monthly. February 1, 2018. https://epmonthly.com/article/due-process-good-emergency-physicians/.

[5] American Academy of Emergency Medicine Resident and Student Association. Lay Corporations Running Residency Programs. https://www.aaemrsa.org/get-involved/committees/advocacy/lay-corporations-running-residency-programs. Accessed January 26, 2020.

[6] Questions for Medical Students Interviewing for Residency. https://www.aaemrsa.org/UserFiles/file/InterviewQuestions_Reformatted.pdf. Accessed January 26, 2020.

[7] *Emergency Medicine Advocacy Handbook*. Emergency Medicine Residents' Association. 2019. https://www.emra.org/books/advocacy-handbook/graduate-funding. Accessed December 20,2019.

[8] Hamilton RJ. The Hahnemann University Hospital Closure and What Matters: A Department Chair's Perspective. *Acad Med*. 2019 Dec 3. doi: 10.1097/ACM.0000000000003104.

[9] DePillis L. Rich investors may have let Hahnemann Hospital go bankrupt. Now, they could profit from the land. *The Philadelphia Tribune*. Jul 29, 2019. https://www.phillytrib.com/news/local_news/rich-investors-may-have-let-hahnemann-hospital-go-bankrupt-now/article_283087b3-13a4-533a-918d-3f1a1d869d59.html. Accessed January 13, 2020.

[10] Griffith C. Ohio Valley Medical Center in Wheeling, WV, suspending acute and emergency services. *WVNews*. https://www.wvnews.com/news/wvnews/ohio-valley-medical-center-in-wheeling-wv-suspending-acute-and/article_3ce6c435-2a8b-5c09-9cb8-9de09b1d84d4.html. Accessed January 13, 2020.

[11] Gondi S, Song Z. Potential Implications of Private Equity Investments in Health Care Delivery. *JAMA* 2019;321(11):1047-1048. doi:10.1001/jama.2019.1077.

[12] Orlowski JM, Thompson T. Lessons to Learn from Hahnemann University Hospital's Closure. *Acad Med*. 2020. 10.1097/ACM.0000000000003170.

[13] ACGME Institutional Requirements, effective July 1, 2019. https://www.acgme.org/Portals/0/PFAssets/InstitutionalRequirements/000InstitutionalRequirements2018.pdf. Accessed January 14, 2020.

[14] ACGME Common Program Requirements, effective July 1, 2019. https://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/CPRResidency2019.pdf. Accessed January 14, 2020.

[15] ACGME. Principles to Guide the Relationship between Graduate Medical Education, Industry, and Other Funding Sources for Programs and Sponsoring Institutions Accredited by the ACGME. 2012. https://www.acgme.org/Portals/0/PFAssets/PublicationsPapers/GME-Funding-Industry-Other-Sources.pdf. Accessed January 14, 2020.

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 3, November 2020

Subject: Protection of Resident and Fellow Training in the Case of Hospital or Training Program Closure

Presented by: Liana Puscas, MD, MHS, Chair

Referred to: Reference Committee C

INTRODUCTION

Policy H-310.943, (2), "Closing of Residency Programs," directs our AMA to:

> Study and provide recommendations on how the process of assisting displaced residents and fellows could be improved in the case of training hospital or training program closure, including:
>
> A. The current processes by which a displaced resident or fellow may seek and secure an alternative training position; and
>
> B. How the Centers for Medicare and Medicaid Services (CMS) and other additional or supplemental graduate medical education (GME) funding is re-distributed, including but not limited to: (1) the direct or indirect classification of residents and fellows as financial assets and the implications thereof; (2) the transfer of training positions between institutions and the subsequent impact on resident and fellow funding lines in the event of closure; (3) the transfer of full versus partial funding for new training positions; and (4) the transfer of funding for displaced residents and fellows who switch specialties.

Strong testimony in support of this policy's underlying resolution was heard during the 2019 Interim Meeting, due to the fall 2019 closure of Hahnemann University Hospital (HUH) in Philadelphia and the urgent need for AMA action to aid the individuals affected and to develop policies to ensure adequate protections in the future. Concerns were expressed related to the graduate medical education (GME) 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. This report addresses displacement as a result of program closure.

BACKGROUND

The events preceding and following the abrupt closure of HUH have been well documented in the academic medicine press as well as in the popular press. What follows is a brief summary.

HUH, a large, academic safety-net hospital in Philadelphia, had struggled financially for years. It had been purchased twice by for-profit investors, first in 1998 by Tenet Healthcare Corporation and then in 2018 by American Academic Health System (AAHS). In 2019, AAHS concluded that HUH

was no longer financially viable; subsequently, in late June 2019, HUH announced its closure and then filed for Chapter 11 bankruptcy in July. AAHS announced on July 24 that it was withdrawing from accreditation its 25 medical residency/fellowship programs. This left more than 550 resident and fellow physicians (referred to as residents in this report), including 140 new residents who had not even started training at the time of the announcement, without a program accredited by the Accreditation Council for Graduate Medical Education (ACGME) in which to continue their medical education.[1,2,3,4].

Withdrawal from accreditation by an entire program "displaces" the residents in the program. At that point, the resident is allowed to pursue training in another program, with allocated funding from the Centers for Medicare & Medicaid Services (CMS).[4] The ACGME has policy, developed after the training disruption of Hurricane Katrina in 2005, to assist residents and fellows with temporary and permanent transfers to other programs.[3] This assistance, and the call to action by the ACGME asking for programs to post availability of positions, enabled all residents displaced by the closure of HUH to secure new positions within 43 days, half of them within a 60-mile radius of Philadelphia.[1,2] Interestingly, the same process came into play only a few months later with the closure of Ohio Valley Medical Center (OVMC) in West Virginia, also for financial reasons. OVMC operated only two ACGME-accredited programs, and therefore substantially fewer residents were displaced.

"ORPHANED" RESIDENT PLACEMENT PROCESS

ACGME

On June 28, 2019, the ACGME invoked its Extraordinary Circumstances Policy in response to the announcement of HUH's closing. The ACGME created a database on its website, accessible to GME leaders and residents at HUH, for programs to post potential training position openings for displaced HUH residents. This database was updated daily, with 1,530 positions offered from 90 sponsoring institutions in 39 states.[3] Program directors and designated institution officials (DIOs) submitted requests to ACGME review committees for complement increases to accept some of the residents. In late July, the ACGME announced that it was accepting applications for new training programs, and eventually accredited 31 new programs in Pennsylvania.[2] Residents started interviewing at other institutions that had offered potential positions, and while GME Resident Displacement Agreements were developed by HUH, CMS funding was in question until the programs were officially unaccredited and residents released. Even then (July 29 for one group of residents, August 6 for another), the CMS funding was complicated by both CMS regulations and the stated intent of AAHS to sell the residency slots as an asset.[2]

CMS

Prior to the passage of the Affordable Care Act (ACA), if a teaching hospital closed, its direct GME and indirect resident cap slots would be "lost," because those slots were associated with the specific hospital's terminated Medicare provider agreement. However, Section 5506 of the ACA addressed this situation by establishing a process that would redistribute slots from closing teaching hospitals to hospitals that met certain criteria, with priority given to hospitals located in the same Core Based Statistical Area (CBSA) or in a contiguous CBSA as the closing hospital. As a result, Section 5506 applies to teaching hospitals that closed on or after March 23, 2008.

Despite Section 5506, residents and receiving hospitals have still found it difficult to receive cap slot adjustments, and the associated funding, due to a CMS rule that requires residents to be "physically present" at a closing hospital to be considered displaced. "Physically present" is

defined as training at a hospital on the day prior to, or the day of, hospital or program closure. This definition creates problems for: 1) residents who leave the program after the closure is publicly announced to start training at another hospital but before the actual closure, 2) residents assigned to and training at planned rotations at other hospitals who cannot return to their rotation at the closing hospital or program, and 3) residents who matched into GME programs at the closing hospital or program but have not yet started training at that hospital or program. As such, CMS regulations regarding the funding of displaced residents are perceived as burdensome and inflexible by residents, program directors, and DIOs. Moreover, CMS regulations added uncertainty about the financial risk that institutions that intended to accept transferring residents could potentially incur.[2]

Additionally, CMS regulations assert that it is at the discretion of the closing hospital or program to allocate whatever amount of full-time equivalent (FTE) cap it deems fit. This has caused uncertainty for residents and receiving hospitals regarding the amount of funding that will travel with the transferring resident. For example, in the case of HUH, residents did not receive a 1.0 FTE and instead were given about 80 percent of their allotted funding, per an arrangement with Thomas Jefferson University Hospital and the University of Pennsylvania.[4]

Finally, there have been discrepancies in the past regarding if residency slots are, or are not, "assets" of the closing hospital or program. When HUH tried to sell its 550 residency slots as "assets" during bankruptcy proceedings, the presiding judge initially allowed bidding on the slots. As a result, a coalition of local hospitals bid $55 million on the slots with the goal of keeping them in the Philadelphia region, while a health care firm in California bid $60 million for the valuable chance to increase the number of funded physicians in its hospitals. However, CMS objected to the judge's ruling and asserted that CMS has sole discretion concerning the allocation of Medicare-funded slots. CMS argued that the auction would set a dangerous precedent, in that struggling hospitals with training positions could be purchased by investors, leaving certain hospitals severely understaffed. As a result, the auction did not go forward.[5,6]

Further Complications: Visa Regulations, Medical Liability Coverage, and Economic Impacts

Among the residents training in HUH programs were 59 individuals on J-1 visas who were required to find a position with another GME program within 30 days of the hospital closing or face deportation from the U.S. The AMA wrote a letter to the U.S. Department of State (DoS) urging the DoS to work with U.S. Citizenship and Immigration Services and the Educational Commission for Foreign Medical Graduates (ECFMG) to waive the 30-day grace period requirement and provide needed support for these individuals to find an appropriate alternative GME program. The DoS agreed to review, on a case-by-case basis, anyone who did not have a position lined up within the 30-day period. The ECFMG was instrumental in assisting these residents as they moved to new programs, including meeting with them in person, providing financial assistance, and waiving ECFMG fees. All residents with J-1 visas found positions.[3,7,8]

After HUH residents had found new positions, it was revealed in December that they would lose long-tail medical liability coverage for claims made after January 10, 2020—this, despite an ACGME institutional requirement that sponsoring institutions must have malpractice insurance covering any claims made while the resident is training or any future claims stemming from the resident's training period. AAHS had intended to purchase the coverage through the sale of the residency slots, which was tied up in court, and ultimately did not go through. In February, AAHS agreed to pay $6.2 million to purchase medical liability insurance for the residents and other medical professionals who had worked at HUH during its ownership.[9] In the meantime, the AMA underwrote the costs of a legal team assisting residents in their fight to obtain medical liability coverage from HUH. The AMA also joined the Philadelphia County Medical Society (PCMS),

Pennsylvania Medical Society (PAMED), ECFMG, ACGME, and Association of American Medical Colleges (AAMC) in urging the institutions that accepted HUH residents to help purchase tail coverage, especially important in the state of Pennsylvania, which requires, as do other states, that all physicians have tail coverage from previous employers.[10]

The extensive disruption to the lives of residents and their families cannot be discounted. Besides suddenly potentially uprooting families to move to locations that may be distant, residents stood to forfeit large deposits on rental housing, while having to make new deposits in the new location.[3] The AMA committed $50,000 to assist the residents affected, and the AMA Foundation committed another $20,000 to help. The American Osteopathic Association, American Board of Medical Specialties, AAMC, Council of Medical Specialty Societies, National Board of Medical Examiners, PAMED, PCMS, and many other organizations financially committed funds to support residents during this difficult transition, with the goal of raising $150,000 all told for the Hahnemann University Displaced Resident Fund. The ECFMG created a fund for residents who had J-1 visas.[11]

CMS CHANGES PROPOSED

As mentioned above, CMS has regulations defining a displaced resident as one who is "physically present" at a hospital on the day prior to, or the day of, hospital or program closure. This significantly hampers the ability of residents to seek and find new positions should a program or institution suddenly close and excludes residents who have matched to the closing program but have not started their residencies. On July 25, 2019, the AMA sent a letter to CMS requesting that CMS: 1) address the physical presence requirement; 2) resolve the question of transitional residents who had matched to HUH programs but were not currently employed by HUH or in a program at the time of closure, and who therefore did not have federal funding that transferred with them, and 3) provide full funding for residents.[12]

While CMS was not able to address these issues in the case of HUH residents, CMS has proposed rule changes that will link Medicare temporary funding for displaced residents to the day program or hospital closures are publicly announced (for example, via a press release or a formal notice to the ACGME). This provides greater flexibility for residents to transfer while the hospital operations or residency programs are winding down, rather than waiting until the last day of hospital or program operation. In addition, CMS has proposed to allow funding to be transferred temporarily for residents who are not physically at the closing hospital or closing program, but had intended to train at (or return to training at, in the case of residents on rotation) the closing hospital or closing program.[13] Thus, two of the concerns raised by the AMA and other stakeholders are likely to be resolved. However, not all of the AMA's concerns have been addressed, and CMS continues to allow the closing hospital or program to allocate whatever amount of FTE cap it deems fit. As such, the AMA will continue to request that CMS fully fund displaced residency slots.

Also not addressed in the proposed changes, but included in AMA Policy H-310.943 (2), is the desire to have CMS ensure transfer of funding for displaced residents who switch specialties. Currently, CMS regulations provide funding of 1.0 FTE for an initial residency period (IRP), which consists of the number of years required for residents to attain board certification in their chosen specialty. However, this value does not change, even if a resident switches to a specialty that requires additional training. On the other hand, if a displaced resident switches to a specialty with the same IRP value, CMS will continue with the resident's 1.0 FTE funding. For any additional years of training, the teaching hospital will only count the resident as 0.5 FTE.[14]

CURRENT AMA POLICY

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

SUMMARY AND RECOMMENDATIONS

Suggestions have been made to better prepare for a future event similar to the closing of HUH. For example, should financially struggling institutions be required to prepare financial "disaster plans?"[1] The ACGME intends to amplify the voices of residents and to make sure they participate in discussions on how to manage future disruptions to GME that result from instability in the health care system.[3] Should a special Match/SOAP (Supplemental Offer and Acceptance Program) be used to process the application, interview, and offer situation, complete with Match rules (e.g., inappropriate questions about family status/plans)?[3] The experience of Philadelphia-based DIOs informs their suggestion, as described in their article in *Academic Medicine*, that the ACGME, CMS, ECFMG, AAMC, and National Resident Matching Program (NRMP) create a "playbook" to avoid the chaos experienced for HUH and its residents and program directors. They have proposed the following action items.[2]

Recommended Action Items to Improve Relocation of Residents Displaced in Future Teaching Hospital Closures

1. Improve alignment of CMS and ACGME policies regarding closure of programs and teaching hospitals and release of CMS funding linked to individual trainees
2. Increase communication to sponsoring institutions, program directors, and residents regarding the rights and responsibilities of residents when seeking new training positions if displaced
3. Establish procedures and policies allowing the ACGME or the AAMC to serve as a primary source of information, collaboration, and implementation of plans for resident relocation
4. Ensure expedited decisions by ACGME Review Committees regarding temporary complement increases
5. Establish clear guidelines as to whether, and under what circumstances, hospitals can submit applications to the ACGME for accreditation of new programs
6. Set policies in advance regarding granting of automatic NRMP Match waivers
7. Explore a special NRMP-sponsored Match to relocate displaced residents
8. Anticipate and address potential lapses in medical professional liability coverage; require training institutions to provide "tail" coverage for any displaced residents; and consider creation of a national insurance "pool" to provide such coverage if necessary.

The closure of a large, long-standing teaching institution due to the financial decisions of its for-profit owner may have been sudden, and certainly historic, but such closures may become more frequent given the current health care financial environment; as noted, OVMC also closed during 2019, stranding 34 residents. The same environment may make non-profit teaching institutions also vulnerable to sudden closures. The eroding of health care institutions' financial health as a result of the COVID-19 pandemic further exacerbates the current instability of our health care system.

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

1. That our AMA rescind Policy H-310.943 (2), "Closing of Residency Programs," as having been fulfilled by this report. (Rescind HOD Policy)

2. That our AMA ask the Centers for Medicare & Medicaid Services (CMS) to stipulate in its regulations that residency slots are not assets that belong to the teaching institution. (Directive to Take Action)

3. That our AMA encourage the Association of American Medical Colleges (AAMC) and National Resident Matching Program (NRMP) to develop a process similar to the Supplemental Offer and Acceptance Program (SOAP) that could be used in the event of a sudden teaching institution or program closure. (Directive to Take Action)

4. That our AMA encourage the Accreditation Council for Graduate Medical Education (ACGME) to specify in its Institutional Requirements that sponsoring institutions are to provide residents and residency applicants information regarding the financial health of the institution, such as its credit rating, or if it has recently been part of an acquisition or merger. (Directive to Take Action)

5. That our AMA encourage the Association of American Medical Colleges (AAMC) and the Accreditation Council for Graduate Medical Education (ACGME) to coordinate and collaborate on the communication with sponsoring institutions, residency programs, and resident physicians in the event of a sudden institution or program closure to minimize confusion, reduce misinformation, and increase clarity. (Directive to Take Action)

6. That our AMA encourage the Accreditation Council for Graduate Medical Education (ACGME) to revise its Institutional Requirements, under section IV.E., Professional Liability Insurance, to state that sponsoring institutions must create and maintain a fund that will ensure professional liability coverage for residents in the event of an institution or program closure. (Directive to Take Action)

Fiscal note: $1,000.

APPENDIX: RELEVANT AMA POLICY

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

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

14. Our AMA will advocate that the Centers for Medicare and Medicaid Services allow for rural and other underserved rotations in Accreditation Council for Graduate Medical Education (ACGME)-accredited residency programs, in disciplines of particular local/regional need, to occur in the offices of physicians who meet the qualifications for adjunct faculty of the residency program's sponsoring institution.
15. Our AMA encourages the ACGME to reduce barriers to rural and other underserved community experiences for graduate medical education programs that choose to provide such training, by adjusting as needed its program requirements, such as continuity requirements or limitations on time spent away from the primary residency site.
16. Our AMA encourages the ACGME and the American Osteopathic Association (AOA) to continue to develop and disseminate innovative methods of training physicians efficiently that foster the skills and inclinations to practice in a health care system that rewards team-based care and social accountability.
17. Our AMA will work with interested state and national medical specialty societies and other appropriate stakeholders to share and support legislation to increase GME funding, enabling a state to accomplish one or more of the following: (a) train more physicians to meet state and regional workforce needs; (b) train physicians who will practice in physician shortage/underserved areas; or (c) train physicians in undersupplied specialties and subspecialties in the state/region.
18. Our AMA supports the ongoing efforts by states to identify and address changing physician workforce needs within the GME landscape and continue to broadly advocate for innovative pilot programs that will increase the number of positions and create enhanced accountability of GME programs for quality outcomes.
19. Our AMA will continue to work with stakeholders such as Association of American Medical Colleges (AAMC), ACGME, AOA, American Academy of Family Physicians, American College of Physicians, and other specialty organizations to analyze the changing landscape of future physician workforce needs as well as the number and variety of GME positions necessary to provide that workforce.
20. Our AMA will explore innovative funding models for incremental increases in funded residency positions related to quality of resident education and provision of patient care as evaluated by appropriate medical education organizations such as the Accreditation Council for Graduate Medical Education.
21. Our AMA will utilize its resources to share its content expertise with policymakers and the public to ensure greater awareness of the significant societal value of graduate medical education (GME) in terms of patient care, particularly for underserved and at-risk populations, as well as global health, research and education.
22. Our AMA will advocate for the appropriation of Congressional funding in support of the National Healthcare Workforce Commission, established under section 5101 of the Affordable Care Act, to provide data and healthcare workforce policy and advice to the nation and provide data that support the value of GME to the nation.
23. Our AMA supports recommendations to increase the accountability for and transparency of GME funding and continue to monitor data and peer-reviewed studies that contribute to further assess the value of GME.
24. Our AMA will explore various models of all-payer funding for GME, especially as the Institute of Medicine (now a program unit of the National Academy of Medicine) did not examine those options in its 2014 report on GME governance and financing.
25. Our AMA encourages organizations with successful existing models to publicize and share strategies, outcomes and costs.
26. Our AMA encourages insurance payers and foundations to enter into partnerships with state and local agencies as well as academic medical centers and community hospitals seeking to expand GME.

27. Our AMA will develop, along with other interested stakeholders, a national campaign to educate the public on the definition and importance of graduate medical education, student debt and the state of the medical profession today and in the future.
28. Our AMA will collaborate with other stakeholder organizations to evaluate and work to establish consensus regarding the appropriate economic value of resident and fellow services.
29. Our AMA will monitor ongoing pilots and demonstration projects, and explore the feasibility of broader implementation of proposals that show promise as alternative means for funding physician education and training while providing appropriate compensation for residents and fellows.
30. Our AMA will monitor the status of the House Energy and Commerce Committee's response to public comments solicited regarding the 2014 IOM report, Graduate Medical Education That Meets the Nation's Health Needs, as well as results of ongoing studies, including that requested of the GAO, in order to formulate new advocacy strategy for GME funding, and will report back to the House of Delegates regularly on important changes in the landscape of GME funding.
31. Our AMA will advocate to the Centers for Medicare & Medicaid Services to adopt the concept of "Cap-Flexibility" and allow new and current Graduate Medical Education teaching institutions to extend their cap-building window for up to an additional five years beyond the current window (for a total of up to ten years), giving priority to new residency programs in underserved areas and/or economically depressed areas.
32. Our AMA will: (a) encourage all existing and planned allopathic and osteopathic medical schools to thoroughly research match statistics and other career placement metrics when developing career guidance plans; (b) strongly advocate for and work with legislators, private sector partnerships, and existing and planned osteopathic and allopathic medical schools to create and fund graduate medical education (GME) programs that can accommodate the equivalent number of additional medical school graduates consistent with the workforce needs of our nation; and (c) encourage the Liaison Committee on Medical Education (LCME), the Commission on Osteopathic College Accreditation (COCA), and other accrediting bodies, as part of accreditation of allopathic and osteopathic medical schools, to prospectively and retrospectively monitor medical school graduates' rates of placement into GME as well as GME completion.
33. Our AMA encourages the Secretary of the U.S. Department of Health and Human Services to coordinate with federal agencies that fund GME training to identify and collect information needed to effectively evaluate how hospitals, health systems, and health centers with residency programs are utilizing these financial resources to meet the nation's health care workforce needs. This includes information on payment amounts by the type of training programs supported, resident training costs and revenue generation, output or outcomes related to health workforce planning (i.e., percentage of primary care residents that went on to practice in rural or medically underserved areas), and measures related to resident competency and educational quality offered by GME training programs.

H-305.929, "Proposed Revisions to AMA Policy on the Financing of Medical Education Programs"

1. It is AMA policy that:
A. Since quality medical education directly benefits the American people, there should be public support for medical schools and graduate medical education programs and for the teaching institutions in which medical education occurs. Such support is required to ensure that there is a continuing supply of well-educated, competent physicians to care for the American public.
B. Planning to modify health system organization or financing should include consideration of the effects on medical education, with the goal of preserving and enhancing the quality of medical education and the quality of and access to care in teaching institutions are preserved.

C. Adequate and stable funding should be available to support quality undergraduate and graduate medical education programs. Our AMA and the federation should advocate for medical education funding.
D. Diversified sources of funding should be available to support medical schools' multiple missions, including education, research, and clinical service. Reliance on any particular revenue source should not jeopardize the balance among a medical school's missions.
E. All payers for health care, including the federal government, the states, and private payers, benefit from graduate medical education and should directly contribute to its funding.
F. Full Medicare direct medical education funding should be available for the number of years required for initial board certification. For combined residency programs, funding should be available for the longest of the individual programs plus one additional year. There should be opportunities to extend the period of full funding for specialties or subspecialties where there is a documented need, including a physician shortage.
G. Medical schools should develop systems to explicitly document and reimburse faculty teaching activity, so as to facilitate faculty participation in medical student and resident physician education and training.
H. Funding for graduate medical education should support the training of resident physicians in both hospital and non-hospital (ambulatory) settings. Federal and state funding formulas must take into account the resources, including volunteer faculty time and practice expenses, needed for training residents in all specialties in non-hospital, ambulatory settings. Funding for GME should be allocated to the sites where teaching occurs.
I. New funding should be available to support increases in the number of medical school and residency training positions, preferably in or adjacent to physician shortage/underserved areas and in undersupplied specialties.
2. Our AMA endorses the following principles of social accountability and promotes their application to GME funding: (a) Adequate and diverse workforce development; (b) Primary care and specialty practice workforce distribution; (c) Geographic workforce distribution; and (d) Service to the local community and the public at large.
3. Our AMA encourages transparency of GME funding through models that are both feasible and fair for training sites, affiliated medical schools and trainees.
4. Our AMA believes that financial transparency is essential to the sustainable future of GME funding and therefore, regardless of the method or source of payment for GME or the number of funding streams, institutions should publicly report the aggregate value of GME payments received as well as what these payments are used for, including: (a) Resident salary and benefits; (b) Administrative support for graduate medical education; (c) Salary reimbursement for teaching staff; (d) Direct educational costs for residents and fellows; and (e) Institutional overhead.
5. Our AMA supports specialty-specific enhancements to GME funding that neither directly nor indirectly reduce funding levels for any other specialty.

H-310.917, "Securing Funding for Graduate Medical Education"

Our American Medical Association: (1) continues to be vigilant while monitoring pending legislation that may change the financing of medical services (health system reform) and advocate for expanded and broad-based funding for graduate medical education (from federal, state, and commercial entities); (2) continues to advocate for graduate medical education funding that reflects the physician workforce needs of the nation; (3) encourages all funders of GME to adhere to the Accreditation Council for Graduate Medical Education's requirements on restrictive covenants and its principles guiding the relationship between GME, industry and other funding sources, as well as the AMA's Opinion 8.061, and other AMA policy that protects residents and fellows from exploitation, including physicians training in non-ACGME-accredited programs; and (4) encourages entities planning to expand or start GME programs to develop a clear statement of the

benefits of their GME activities to facilitate potential funding from appropriate sources given the goals of their programs.

REFERENCES

[1] Olowski J, Thompson T. Lessons to learn from Hahnemann University Hospital's closure. *Acad Med*. 2020 Apr;95(4):509-511. doi: 10.1097/ACM.0000000000003170.

[2] Berns JS, Coull S, Paskin D, Spevetz A, Boyer WC. Reflections on a crisis in graduate medical education: The closure of Hahnemann University Hospital. *Acad Med*. 2020 Apr;95(4):499-502. doi: 10.1097/ACM.0000000000003156.

[3] Nasca TJ, Johnson PF, Weiss KB, Brigham TP. Elevating resident voices in health systems change: Lessons from the closure of Hahnemann University Hospital. *Acad Med*. 2020 Apr;95(4):499-502. doi: 10.1097/ACM.0000000000003156.

[4] Feldman N. Hahnemann frees funding so medical residents can take new jobs. July 24, 2019. https://whyy.org/articles/hahnemann-frees-funding-so-medical-residents-can-take-new-jobs/. Accessed August 26, 2019.

[5] Patel NS. Private equity is trying to sell medical residencies for profit. October 21, 2019. https://slate.com/technology/2019/10/private-equity-selling-medical-residencies-for-profit.html. Accessed October 22, 2019.

[6] Kirkner RM. Residencies for sale. December 19, 2019. https://www.managedcaremag.com/archives/2019/11/residencies-sale. Accessed June 14, 2020.

[7] AMA Letter to DoS, USCIS and ECMFG. https://searchlf.ama-assn.org/undefined/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2019-7-25-Letter-to-DoS-USCIS-and-ECFMG-Hahnemann-Closure.pdf

[8] Udo J. To avoid deportation, Hahnemann international residents scramble to find new places to work. August 19, 2019. https://kywnewsradio.radio.com/articles/news/avoid-deportation-hahnemann-international-residents-scramble-find-new-places-work. Accessed June 14, 2020.

[9] Krebs R. Bankrupt Philly hospital owners set to pay $6M for insurance. February 21, 2020. https://www.law360.com/articles/1246386/bankrupt-philly-hospital-owners-set-to-pay-6m-for-insurance. Accessed February 24, 2020.

[10] O'Reilly KB. Hahnemann residents left in lurch seek bankruptcy court's help. December 20, 2019. https://www.ama-assn.org/residents-students/residency/hahnemann-residents-left-lurch-seek-bankruptcy-court-s-help. Accessed December 27, 2019.

[11] O'Reilly KB. Grants will help residents displaced by record hospital closure. August 27, 2019. https://www.ama-assn.org/residents-students/residency/grants-will-help-residents-displaced-record-hospital-closure. Accessed June 14, 2020.

[12] AMA letter to CMS Administrator. https://searchlf.ama-assn.org/undefined/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2019-7-25-Letter-to-Verma-re-Hahnemann-Closure.pdf

[13] Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2021 Rates; Quality Reporting and Medicare and Medicaid Promoting Interoperability Programs Requirements for Eligible Hospitals and Critical Access Hospitals. A Proposed Rule by the Centers for Medicare & Medicaid Services on 05/29/2020. https://www.federalregister.gov/documents/2020/05/29/2020-10122/medicare-program-hospital-inpatient-prospective-payment-systems-for-acute-care-hospitals-and-the

[14] Association of American Medical Colleges: Medicare Payments for Graduate Medical Education: What Every Medical Student, Resident, and Advisor Needs to Know. April 2019. https://www.aamc.org/data-reports/faculty-institutions/report/medicare-payments-graduate-medical-education-what-every-medical-student-resident-and-advisor-needs. Accessed June 14, 2020.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 301
(November 2020)

Introduced by: Illinois

Subject: Creating a More Accurate Accounting of Medical Education Financial Costs

Referred to: Reference Committee C

Whereas, The usual reference to the cost of medical education typically is the summation of tuition for the period of 4 years of medical education; and

Whereas, There are 3 years of required postgraduate training prior to a medical school graduate's ability to fully practice medicine, during which time school loans are typically deferred and interest is compounded; and

Whereas, Matriculation into medical school typically requires completion of a four-year undergraduate degree; and

Whereas, The demands of medical education typically prohibit students from undertaking simultaneous endeavors that provide remuneration for their work; and

Whereas, Most postgraduate medical education is performed in large urban settings where cost-of-living consumes much of the stipend paid to interns and residents leaving little for repayment of school loans; and

Whereas, The frequently publicized cost of medical education underrepresents the actual financial responsibility of the prospective medical student and the general public; therefore be it

RESOLVED, That our American Medical Association study the costs of medical education, taking into account medical student tuition and accrued loan interest, to come up with a more accurate description of medical education financial costs. (Directive to Take Action)

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

Received: 07/17/20

RELEVANT AMA POLICY

D-305.984 - Reduction in Student Loan Interest Rates

…

3. Our AMA will consider the total cost of loans including loan origination fees and benefits of federal loans such as tax deductibility or loan forgiveness when advocating for a reduction in student loan interest rates.

4. Our AMA will advocate for policies which lead to equal or less expensive loans (in terms of loan benefits, origination fees, and interest rates) for Grad-PLUS loans as this would change the status quo of high-borrowers paying higher interest rates and fees in addition to having a higher overall loan burden.

5. Our AMA will work with appropriate organizations, such as the Accreditation Council for Graduate Medical Education and the Association of American Medical Colleges, to collect data and report on student indebtedness that includes total loan costs at completion of graduate medical education training. Res. 316, A-03 Reaffirmed: BOT Rep. 28, A-13 Appended: Res. 302, A-13 Modified and Appended: 301, A-16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 302
(November 2020)

Introduced by: Illinois

Subject: Student Loan Forgiveness

Referred to: Reference Committee C

Whereas, The cost of medical education, all facets included, is a significant burden for resident physicians as well as for young physicians beginning practice; and

Whereas, Such costs and burdens significantly influence medical specialty and location of practice selection and it is widely thought that this limits the numbers of students selecting primary care specialties; and

Whereas, The Public Service Loan Forgiveness Program, a federal program, allows payment for 10 years against the loan balance then the application for loan forgiveness of the remaining loan amounts at that point; and

Whereas, Ninety-eight percent of applications for loan forgiveness under the Public Service Loan Forgiveness Program are denied; therefore be it

RESOLVED, That our American Medical Association study the cause for the unacceptably high denial rate of applications made to the Public Health Services Student Loan Forgiveness Program, and advocate for improvements in the administration and oversight of the program, including but not limited to increasing transparency of and streamlining program requirements; ensuring consistent and accurate communication between loan services and borrowers; and establishing clear expectations regarding oversight and accountability of the loan servicers responsible for the program. (Directive to Take Action)

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

Received: 07/17/20

References:

https://students-residents.aamc.org/financial-aid/article/public-service-loan-forgiveness-pslf/

https://www.nytimes.com/2019/11/28/us/politics/student-loan-forgiveness.html

RELEVANT AMA POLICY

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).
…
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.
…
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: 303
(November 2020)

Introduced by: Oklahoma

Subject: CME for Preceptorship

Referred to: Reference Committee C

Whereas, Continuing Medical Education (CME) credits are vital to all physicians; and

Whereas, Being a "preceptor" for medical students, residents, and fellows requires countless hours of reading and self-study; and

Whereas, Currently only the American Osteopathic Association (AOA) offers category 1B credit for participation in the Osteopathic Medicine Didactic and Preceptor Program; and

Whereas, Sixty AOA category 1B credits may be applied to the required 120 hours of CME for Osteopathic physicians; and

Whereas, The American Medical Association gives no credit for any amount of AOA credits for being a preceptor; and

Whereas, Recognizing such teaching efforts would encourage more practicing, private physicians to be involved in preceptor programs, which in turn would expose more students to the world of private practice and the practice of medicine in rural and underserved areas; therefore be it

RESOLVED, That our American Medical Association study awarding Category 1 credit to physicians serving as preceptors for medical students, residents, and fellows training at Liaison Committee on Medical Education (LCME) accredited medical schools. (Directive to Take Action)

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

Received: 08/17/20

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 304
(November 2020)

Introduced by: Resident and Fellow Section

Subject: Establishing Minimum Standards for Parental Leave During Graduate Medical Education Training

Referred to: Reference Committee C

Whereas, A substantial number of trainees become parents during their training as a resident or fellow; and

Whereas, PGY-1 trainees will not meet eligibility for the Family Medical Leave Act, which has a 12-month employment eligibility threshold; and

Whereas, Unlike other industries, such as technology and law, "there is no standardized approach to parental leave across GME programs" [1]; and

Whereas, The Accreditation Council for Graduate Medical Education does not establish minimum standards for duration of parental leave for trainees; and

Whereas, A lack of minimum national standards may result in some trainees receiving substandard resources and benefits[2]; and

Whereas, Current AMA policy (H-405.960) encourages residency programs, among other stakeholders, to incorporate a "six-week minimum leave allowance;" therefore be it

RESOLVED, That our American Medical Association support current efforts by the Accreditation Council for Graduate Medical Education (ACGME), the American Board of Medical Specialties (ABMS), and other relevant stakeholders to develop and align minimum requirements for parental leave during residency and fellowship training and urge these bodies to adopt minimum requirements in accordance with AMA Policy H-405.960 (New HOD Policy); and be it further

RESOLVED, That our AMA petition the ACGME to recommend strategies to prevent undue burden on trainees related to parental leave (Directive to Take Action); and be it further

RESOLVED, That our AMA petition the ACGME, ABMS, and other relevant stakeholders to develop specialty specific pathways for residents and fellows in good standing, who take maximum allowable parental leave, to complete their training within the original time frame. (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000

Received: 08/25/20

References:
1. Vassallo P, Jeremiah J, Forman L, et al. Parental Leave in Graduate Medical Education: Recommendations for Reform. Am J Med. 2019;132(3):385-389. doi:10.1016/j.amjmed.2018.11.006
2. Baril N. Parenting during Graduate Medical Training — Practical Policy. 2019:995-997. doi:10.1056/NEJMp1902966

RELEVANT AMA POLICY:

Principles for Graduate Medical Education H-310.929
Our AMA urges the Accreditation Council for Graduate Medical Education (ACGME) to incorporate these principles in its Institutional Requirements, if they are not already present.
(1) PURPOSE OF GRADUATE MEDICAL EDUCATION AND ITS RELATIONSHIP TO PATIENT CARE. There must be objectives for residency education in each specialty that promote the development of the knowledge, skills, attitudes, and behavior necessary to become a competent practitioner in a recognized medical specialty.
Exemplary patient care is a vital component for any residency/fellowship program. Graduate medical education enhances the quality of patient care in the institution sponsoring an accredited program. Graduate medical education must never compromise the quality of patient care. Institutions sponsoring residency programs and the director of each program must assure the highest quality of care for patients and the attainment of the program's educational objectives for the residents.
(2) RELATION OF ACCREDITATION TO THE PURPOSE OF RESIDENCY TRAINING. Accreditation requirements should relate to the stated purpose of a residency program and to the knowledge, skills, attitudes, and behaviors that a resident physician should have on completing residency education.
(3) EDUCATION IN THE BROAD FIELD OF MEDICINE. GME should provide a resident physician with broad clinical experiences that address the general competencies and professionalism expected of all physicians, adding depth as well as breadth to the competencies introduced in medical school.
(4) SCHOLARLY ACTIVITIES FOR RESIDENTS. Graduate medical education should always occur in a milieu that includes scholarship. Resident physicians should learn to appreciate the importance of scholarly activities and should be knowledgeable about scientific method. However, the accreditation requirements, the structure, and the content of graduate medical education should be directed toward preparing physicians to practice in a medical specialty. Individual educational opportunities beyond the residency program should be provided for resident physicians who have an interest in, and show an aptitude for, academic and research pursuits. The continued development of evidence-based medicine in the graduate medical education curriculum reinforces the integrity of the scientific method in the everyday practice of clinical medicine.
(5) FACULTY SCHOLARSHIP. All residency faculty members must engage in scholarly activities and/or scientific inquiry. Suitable examples of this work must not be limited to basic biomedical research. Faculty can comply with this principle through participation in scholarly meetings, journal club, lectures, and similar academic pursuits.
(6) INSTITUTIONAL RESPONSIBILITY FOR PROGRAMS. Specialty-specific GME must operate under a system of institutional governance responsible for the development and implementation of policies regarding the following; the initial authorization of programs, the appointment of program directors, compliance with the accreditation requirements of the ACGME, the advancement of resident physicians, the disciplining of resident physicians when this is appropriate, the maintenance of permanent records, and the credentialing of resident physicians who successfully complete the program. If an institution closes or has to reduce the size of a residency program, the institution must inform the residents as soon as possible. Institutions must make every effort to allow residents already in the program to complete their education in the affected program. When this is not possible, institutions must assist residents to enroll in another program in which they can continue their education. Programs must also make arrangements, when necessary, for the disposition of program files so that future confirmation of the completion of residency education is possible. Institutions should allow residents to form housestaff organizations, or similar organizations, to address patient care and resident work environment concerns. Institutional committees should include resident members.

(7) COMPENSATION OF RESIDENT PHYSICIANS. All residents should be compensated. Residents should receive fringe benefits, including, but not limited to, health, disability, and professional liability insurance and parental leave and should have access to other benefits offered by the institution. Residents must be informed of employment policies and fringe benefits, and their access to them. Restrictive covenants must not be required of residents or applicants for residency education.
(8) LENGTH OF TRAINING. The usual duration of an accredited residency in a specialty should be defined in the "Program Requirements." The required minimum duration should be the same for all programs in a specialty and should be sufficient to meet the stated objectives of residency education for the specialty and to cover the course content specified in the Program Requirements. The time required for an individual resident physician's education might be modified depending on the aptitude of the resident physician and the availability of required clinical experiences.
(9) PROVISION OF FORMAL EDUCATIONAL EXPERIENCES. Graduate medical education must include a formal educational component in addition to supervised clinical experience. This component should assist resident physicians in acquiring the knowledge and skill base required for practice in the specialty. The assignment of clinical responsibility to resident physicians must permit time for study of the basic sciences and clinical pathophysiology related to the specialty.
(10) INNOVATION OF GRADUATE MEDICAL EDUCATION. The requirements for accreditation of residency training should encourage educational innovation and continual improvement. New topic areas such as continuous quality improvement (CQI), outcome management, informatics and information systems, and population-based medicine should be included as appropriate to the specialty.
(11) THE ENVIRONMENT OF GRADUATE MEDICAL EDUCATION. Sponsoring organizations and other GME programs must create an environment that is conducive to learning. There must be an appropriate balance between education and service. Resident physicians must be treated as colleagues.
(12) SUPERVISION OF RESIDENT PHYSICIANS. Program directors must supervise and evaluate the clinical performance of resident physicians. The policies of the sponsoring institution, as enforced by the program director, and specified in the ACGME Institutional Requirements and related accreditation documents, must ensure that the clinical activities of each resident physician are supervised to a degree that reflects the ability of the resident physician and the level of responsibility for the care of patients that may be safely delegated to the resident. The sponsoring institution's GME Committee must monitor programs' supervision of residents and ensure that supervision is consistent with: (A) Provision of safe and effective patient care; (B) Educational needs of residents; (C) Progressive responsibility appropriate to residents' level of education, competence, and experience; and (D) Other applicable Common and specialty/subspecialty specific Program Requirements. The program director, in cooperation with the institution, is responsible for maintaining work schedules for each resident based on the intensity and variability of assignments in conformity with ACGME Review Committee recommendations, and in compliance with the ACGME clinical and educational work hour standards. Integral to resident supervision is the necessity for frequent evaluation of residents by faculty, with discussion between faculty and resident. It is a cardinal principle that responsibility for the treatment of each patient and the education of resident and fellow physicians lies with the physician/faculty to whom the patient is assigned and who supervises all care rendered to the patient by residents and fellows. Each patient's attending physician must decide, within guidelines established by the program director, the extent to which responsibility may be delegated to the resident, and the appropriate degree of supervision of the resident's participation in the care of the patient. The attending physician, or designate, must be available to the resident for consultation at all times.
(13) EVALUATION OF RESIDENTS AND SPECIALTY BOARD CERTIFICATION. Residency program directors and faculty are responsible for evaluating and documenting the continuing

development and competency of residents, as well as the readiness of residents to enter independent clinical practice upon completion of training. Program directors should also document any deficiency or concern that could interfere with the practice of medicine and which requires remediation, treatment, or removal from training. Inherent within the concept of specialty board certification is the necessity for the residency program to attest and affirm to the competence of the residents completing their training program and being recommended to the specialty board as candidates for examination. This attestation of competency should be accepted by specialty boards as fulfilling the educational and training requirements allowing candidates to sit for the certifying examination of each member board of the ABMS.
(14) GRADUATE MEDICAL EDUCATION IN THE AMBULATORY SETTING. Graduate medical education programs must provide educational experiences to residents in the broadest possible range of educational sites, so that residents are trained in the same types of sites in which they may practice after completing GME. It should include experiences in a variety of ambulatory settings, in addition to the traditional inpatient experience. The amount and types of ambulatory training is a function of the given specialty.
(15) VERIFICATION OF RESIDENT PHYSICIAN EXPERIENCE. The program director must document a resident physician's specific experiences and demonstrated knowledge, skills, attitudes, and behavior, and a record must be maintained within the institution.
Citation: CME Rep. 9, A-99; Reaffirmed: CME Rep. 2, A-09; Reaffirmed: CME Rep. 14, A-09; Modified: CME Rep. 06, I-18

Policies for Parental, Family and Medical Necessity Leave H-405.960
AMA adopts as policy the following guidelines for, and encourages the implementation of, Parental, Family and Medical Necessity Leave for Medical Students and Physicians:
1. Our AMA urges medical schools, residency training programs, medical specialty boards, the Accreditation Council for Graduate Medical Education, and medical group practices to incorporate and/or encourage development of leave policies, including parental, family, and medical leave policies, as part of the physician's standard benefit agreement.
2. Recommended components of parental leave policies for medical students and physicians include: (a) duration of leave allowed before and after delivery; (b) category of leave credited; (c) whether leave is paid or unpaid; (d) whether provision is made for continuation of insurance benefits during leave, and who pays the premium; (e) whether sick leave and vacation time may be accrued from year to year or used in advance; (f) how much time must be made up in order to be considered board eligible; (g) whether make-up time will be paid; (h) whether schedule accommodations are allowed; and (i) leave policy for adoption.
3. AMA policy is expanded to include physicians in practice, reading as follows: (a) residency program directors and group practice administrators should review federal law concerning maternity leave for guidance in developing policies to assure that pregnant physicians are allowed the same sick leave or disability benefits as those physicians who are ill or disabled; (b) staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in other physicians' workloads, particularly in residency programs; and (c) physicians should be able to return to their practices or training programs after taking parental leave without the loss of status.
4. Our AMA encourages residency programs, specialty boards, and medical group practices to incorporate into their parental leave policies a six-week minimum leave allowance, with the understanding that no parent should be required to take a minimum leave.
5. Residency program directors should review federal and state law for guidance in developing policies for parental, family, and medical leave.
6. Medical students and physicians who are unable to work because of pregnancy, childbirth, and other related medical conditions should be entitled to such leave and other benefits on the same basis as other physicians who are temporarily unable to work for other medical reasons.

7. Residency programs should develop written policies on parental leave, family leave, and medical leave for physicians. Such written policies should include the following elements: (a) leave policy for birth or adoption; (b) duration of leave allowed before and after delivery; (c) category of leave credited (e.g., sick, vacation, parental, unpaid leave, short term disability); (d) whether leave is paid or unpaid; (e) whether provision is made for continuation of insurance benefits during leave and who pays for premiums; (f) whether sick leave and vacation time may be accrued from year to year or used in advance; (g) extended leave for resident physicians with extraordinary and long-term personal or family medical tragedies for periods of up to one year, without loss of previously accepted residency positions, for devastating conditions such as terminal illness, permanent disability, or complications of pregnancy that threaten maternal or fetal life; (h) how time can be made up in order for a resident physician to be considered board eligible; (i) what period of leave would result in a resident physician being required to complete an extra or delayed year of training; (j) whether time spent in making up a leave will be paid; and (k) whether schedule accommodations are allowed, such as reduced hours, no night call, modified rotation schedules, and permanent part-time scheduling.
8. Our AMA endorses the concept of equal parental leave for birth and adoption as a benefit for resident physicians, medical students, and physicians in practice regardless of gender or gender identity.
9. Staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in the workloads of other physicians, particularly those in residency programs.
10. Physicians should be able to return to their practices or training programs after taking parental leave, family leave, or medical leave without the loss of status.
11. Residency program directors must assist residents in identifying their specific requirements (for example, the number of months to be made up) because of leave for eligibility for board certification and must notify residents on leave if they are in danger of falling below minimal requirements for board eligibility. Program directors must give these residents a complete list of requirements to be completed in order to retain board eligibility.
12. Our AMA encourages flexibility in residency training programs, incorporating parental leave and alternative schedules for pregnant house staff.
13. In order to accommodate leave protected by the federal Family and Medical Leave Act, our AMA encourages all specialties within the American Board of Medical Specialties to allow graduating residents to extend training up to 12 weeks after the traditional residency completion date while still maintaining board eligibility in that year.
14. These policies as above should be freely available online and in writing to all applicants to medical school, residency or fellowship. Citation: CCB/CLRPD Rep. 4, A-13; Modified: Res. 305, A-14; Modified: Res. 904, I-14

Parental Leave H-405.954
1. Our AMA encourages the study of the health implications among patients if the United States were to modify one or more of the following aspects of the Family and Medical Leave Act (FMLA): a reduction in the number of employees from 50 employees; an increase in the number of covered weeks from 12 weeks; and creating a new benefit of paid parental leave.
2. Our AMA will study the effects of FMLA expansion on physicians in varied practice environments.
3. Our AMA: (a) encourages employers to offer and/or expand paid parental leave policies; (b) encourages state medical associations to work with their state legislatures to establish and promote paid parental leave policies; (c) advocates for improved social and economic support for paid family leave to care for newborns, infants and young children; and (d) advocates for federal tax incentives to support early child care and unpaid child care by extended family members. Citation: Res. 215, I-16; Appended: BOT Rep. 11, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 305
(November 2020)

Introduced by: Illinois

Subject: Parental Leave and Planning Resources for Medical Students

Referred to: Reference Committee C

Whereas, The number of women enrolled as first year medical students has recently risen to the majority of 51.6% in 2018[1]; and

Whereas, The average age of matriculated first year medical students is 24[2]; the average amount of time specialized physicians spend in post high school training is 14 years[3], and the average age of mothers at first birth in the United States is 26.8 years[4]; and

Whereas, 9.2% of medical students are parents by graduation[5], and thus it is essential to address the potential of pregnancy and parenthood during the course of medical education; and

Whereas, The rate of attrition for premedical females who ultimately attend medical school is significantly higher than expected due to social factors including policies regarding parental leave, which influence students to opt for a more accommodative career[6]; and

Whereas, The perceived higher compatibility of maintaining a family life with a career as a physician assistant rather than a physician has led to an increase in female physician assistant students at a rate higher than the rate of increase of female medical students[7]; and

Whereas, A survey of students from the South Dakota Sanford School of Medicine shows that medical students of all genders largely want schools to provide “clear, well-defined guidelines, scheduling flexibility and administrators who are approachable and understanding of their individual circumstances” regarding pregnancy and parenthood[5]; and

Whereas, Amongst the barriers that have been identified by female faculty physicians that prevent the advancement of qualified women in academic medicine are workplace policies that do not allow for women to maintain a balanced lifestyle in fear of not advancing in their careers[8]; and

Whereas, A survey across 11 academic medical institutions of residents in internal medicine, family practice, pediatrics, medicine–pediatrics, surgery, and obstetrics–gynecology, found that women residents were more likely than their male counterparts to intentionally postpone pregnancy because of perceived threats to their careers[9]; and

Whereas, Though there is limited research on medical student family planning, research focusing on residents and physicians, summarized above, suggests that early-career professionals of all genders express a desire for well-defined guidelines and policies promoting work-life harmony without effects on career opportunities. It is reasonable to assume that the opinions of residents, in conjunction with the data from South Dakota Sanford School of Medicine, can be extrapolated to medical students; and

Whereas, The Family and Medical Leave Act (FMLA) requires qualifying employers to give up to 12 weeks of unpaid leave to bond with a newborn or newly adopted child and the ability to apply other paid leave time towards FMLA-protected parental leave[10]; and

Whereas, The FMLA does not have protections for students, and thus schools are not required by law to accommodate parental leave[10]; and

Whereas, Current AMA, LCME and COCA policy does not require medical schools to help medical students in family planning or lay out clear policy addressing how assignments and/or classes can be made up in a way that would be amenable to family planning, and thus many schools do not provide resources outside of individual consultation; and

Whereas, The average proportion of medical students who are parents nearly triples between matriculation (3.0%)[11] and graduation (8.9%)[12]; and

Whereas, Medical students from every medical school have anecdotally expressed difficulties regarding family planning in medical school; and

Whereas, A majority of female physicians surveyed have regrets about family planning decisions and career decision-making, and if given the chance would have made decisions such as attempting conception earlier (28.6%), choosing a different specialty (17.1%), or using cryopreservation to extend fertility (7%)[13]; and

Whereas, 68.2% of medical students whose first pregnancy was in medical school and 88.6% of those whose first pregnancies occurred in training perceived substantial workplace support, indicating a lack of policy and support at medical schools comparative to residency training programs[14]; and

Whereas, It is unrealistic and inappropriate to expect trainees to delay childbearing or to forgo spending critical time with their infants, indicating the necessity of alternative solutions to improve family leave in undergraduate medical education; and

Whereas, There is little to no literature on medical students who are fathers, but they should also be allowed to spend critical time with their newborns; and

Whereas, A study addressing, “the common personal and professional challenges that medical students who are also parents face during their undergraduate medical education” found that by addressing the following: lack of career advisory and support networks for parents/expecting parents, unaccommodating schedules requiring formal leaves of absence, and childcare facilitated by the institution and challenges of breastfeeding support, medical schools can support the health and promote the education of their students[15]; and

Whereas, Students who take leaves for family planning may be negatively impacted during their training and the residency application process due to the opinions of faculty evaluators regarding leave, and residency programs’ negative perception of gaps in medical training[16]; and

Whereas, There are clear burdens and stress on medical students, particularly female medical students, and medical school administrators do not counsel and provide trainees with clear information about the impact of childbearing and family leave on coursework; and

Whereas, Medical educators should have established resources and policies that are as accommodating as possible; and

Whereas, Requesting information is often a barrier to access of knowledge, and this information is not freely and publicly available to students; therefore be it

RESOLVED, That our American Medical Association encourage medical schools to create comprehensive informative resources that promote a culture that is supportive of their students who are parents, including information and policies on parental leave and relevant make up work, options to preserve fertility, breastfeeding, accommodations during pregnancy, and resources for childcare that span the institution and the surrounding area (New HOD Policy); and be it further

RESOLVED, That our AMA encourage medical schools to give students a minimum of 6 weeks of parental leave without academic or disciplinary penalties that would delay anticipated graduation based on time of matriculation (New HOD Policy); and be it further

RESOLVED, That our AMA encourage that medical schools formulate, and make readily available, plans for each year of schooling such that parental leave may be flexibly incorporated into the curriculum (New HOD Policy); and be it further

RESOLVED, That our AMA urge medical schools to adopt policy that will prevent parties involved in medical training (including but not limited to residency programs, administration, fellowships, away rotations, physician evaluators, and research opportunities) from discriminating against students who take family/parental leave (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate for medical schools to make resources and policies regarding family leave and parenthood transparent and openly accessible to prospective and current students. (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000

Received: 10/07/20

References:

1. 2018 Fall Applicant and Matriculant Data Tables. AAMC; 2018. https://aamc-black.global.ssl.fastly.net/production/media/filer_public/92/94/92946165-0060-4376-9736-18c89688efd0/applicant_and_matriculant_data_tables.pdf. Accessed September 20, 2019.
2. “Table A-6: Age of Applicants to U.S. Medical Schools at Anticipated Matriculation by Sex and Race/Ethnicity, 2014-2015 through 2017-2018.” Association of American Medical Colleges. November 13, ,2017. <https://www.aamc.org/download/321468/data/factstablea6.pdf>
3. Emanuel, Ezekiel J, Fuchs, Victor R. “Shortening Medical Training by 30%.” Journal of the American Medical Association, 307(11):1143-1144. 2012. doi:10.1001/jama.2012.292 <https://jamanetwork.com/journals/jama/article-abstract/1105095>
4. Martin, Joyce, et al. “Births: Final Data for 2017.” National Vital Statistics Reports, vol. 67, no. 8. 7 Nov. 2018. <https://www.cdc.gov/nchs/data/nvsr/nvsr67/nvsr67_08-508.pdf>
5. Bye EM, Brisk BW, Reuter SD, Hansen KA, Nettleman MD. Pregnancy and Parenthood During Medical School. South Dakota medicine : the Journal of the South Dakota State Medical Association. https://www.ncbi.nlm.nih.gov/pubmed/29334444. Published December 2017. Accessed August 24, 2019.
6. White K. Balancing it All: Women and Medicine. National Women's Health Network. https://www.nwhn.org/balancing-it-all-women-and-medicine/. Published March 21, 2017. Accessed August 24, 2019.
7. Lindsay S. The feminization of the physician assistant profession. Women & health. https://www.ncbi.nlm.nih.gov/pubmed/16260413. Published 2005. Accessed August 24, 2019.
8. Bates C, Gordon L, Travis E, et al. Striving for Gender Equity in Academic Medicine Careers: A Call to Action. Academic medicine : Journal of the Association of American Medical Colleges. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5954825/. Published August 2016. Accessed August 24, 2019.
9. Willet L, Wellons M, Hartig J, et al. Do Women Residents Delay Childbearing Due to Perceived... : Academic Medicine. Journal of the Association of American Medical Colleges.

https://journals.lww.com/academicmedicine/Fulltext/2010/04000/Medical_School_Deans__Perceptions_of.24.aspx. Published April 2010. Accessed August 24, 2019.
10. I Family and Medical Leave Act. US Department of Labor. https://www.dol.gov/whd/fmla/#targetText=Family%20and%20Medical%20Leave%20Act&targetText=The%20FMLA%20entitles%20eligible%20employees,employee%20had%20not%20taken%20leave. Accessed September 19, 2019
11. Medical Student Questionnaire: 2017 All Schools Summary Report. AAMC; 2017. https://www.aamc.org/system/files/reports/1/msq2017report.pdf. Accessed October 24, 2019.
12. Medical School Graduation Questionnaire: 2018 All Schools Summary Report. AAMC; 2018. https://www.aamc.org/system/files/reports/1/2018gqallschoolssummaryreport.pdfAccessed October 24, 2019.
13. Clark Stentz N, Griffith K, Perkins E, De Castro Jones R, Jagsi R, . Fertility and Childbearing Among American Female Physicians. Journal of Women's Health. https://www.liebertpub.com/doi/abs/10.1089/jwh.2015.5638. Published October 2016. Accessed August 24, 2019.
14. Bristol M, Abbuhl S, Cappola A, Sonnad S. Work-Life Policies for Faculty at the Top Ten Medical Schools. Journal of Women's Health. https://www.liebertpub.com/doi/abs/10.1089/jwh.2007.0682. Published September 2008. Accessed August 24, 2019.
15. Taylor J, MacNamara M, Groskin A, Petras L. Medical Student Mothers . http://www.rimed.org/rimedicaljournal/2013/03/2013-03-42-cont-medmothers.pdf. Published March 2013. Accessed August 24, 2019.
16. Brown, N, Nettleman, M. Inclusion of Students' Marital and Parental Status in the MSPE. Academic Medicine. November 2019 - 94.11,p1629-1630

RELEVANT AMA POLICY

Policies for Parental, Family and Medical Necessity Leave H-405.960
AMA adopts as policy the following guidelines for, and encourages the implementation of, Parental, Family and Medical Necessity Leave for Medical Students and Physicians:
1. Our AMA urges medical schools, residency training programs, medical specialty boards, the Accreditation Council for Graduate Medical Education, and medical group practices to incorporate and/or encourage development of leave policies, including parental, family, and medical leave policies, as part of the physician's standard benefit agreement.
2. Recommended components of parental leave policies for medical students and physicians include: (a) duration of leave allowed before and after delivery; (b) category of leave credited; (c) whether leave is paid or unpaid; (d) whether provision is made for continuation of insurance benefits during leave, and who pays the premium; (e) whether sick leave and vacation time may be accrued from year to year or used in advance; (f) how much time must be made up in order to be considered board eligible; (g) whether make-up time will be paid; (h) whether schedule accommodations are allowed; and (i) leave policy for adoption.
3. AMA policy is expanded to include physicians in practice, reading as follows: (a) residency program directors and group practice administrators should review federal law concerning maternity leave for guidance in developing policies to assure that pregnant physicians are allowed the same sick leave or disability benefits as those physicians who are ill or disabled; (b) staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in other physicians' workloads, particularly in residency programs; and (c) physicians should be able to return to their practices or training programs after taking parental leave without the loss of status.
4. Our AMA encourages residency programs, specialty boards, and medical group practices to incorporate into their parental leave policies a six-week minimum leave allowance, with the understanding that no parent should be required to take a minimum leave.
5. Residency program directors should review federal and state law for guidance in developing policies for parental, family, and medical leave.
6. Medical students and physicians who are unable to work because of pregnancy, childbirth, and other related medical conditions should be entitled to such leave and other benefits on the same basis as other physicians who are temporarily unable to work for other medical reasons.
7. Residency programs should develop written policies on parental leave, family leave, and medical leave for physicians. Such written policies should include the following elements: (a) leave policy for birth or adoption; (b) duration of leave allowed before and after delivery; (c) category of leave credited (e.g., sick, vacation, parental, unpaid leave, short term disability); (d) whether leave is paid or unpaid; (e) whether provision is made for continuation of insurance benefits during leave and who pays for premiums; (f) whether sick leave and vacation time may

be accrued from year to year or used in advance; (g) extended leave for resident physicians with extraordinary and long-term personal or family medical tragedies for periods of up to one year, without loss of previously accepted residency positions, for devastating conditions such as terminal illness, permanent disability, or complications of pregnancy that threaten maternal or fetal life; (h) how time can be made up in order for a resident physician to be considered board eligible; (i) what period of leave would result in a resident physician being required to complete an extra or delayed year of training; (j) whether time spent in making up a leave will be paid; and (k) whether schedule accommodations are allowed, such as reduced hours, no night call, modified rotation schedules, and permanent part-time scheduling.

8. Our AMA endorses the concept of equal parental leave for birth and adoption as a benefit for resident physicians, medical students, and physicians in practice regardless of gender or gender identity.

9. Staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in the workloads of other physicians, particularly those in residency programs.

10. Physicians should be able to return to their practices or training programs after taking parental leave, family leave, or medical leave without the loss of status.

11. Residency program directors must assist residents in identifying their specific requirements (for example, the number of months to be made up) because of leave for eligibility for board certification and must notify residents on leave if they are in danger of falling below minimal requirements for board eligibility. Program directors must give these residents a complete list of requirements to be completed in order to retain board eligibility.

12. Our AMA encourages flexibility in residency training programs, incorporating parental leave and alternative schedules for pregnant house staff.

13. In order to accommodate leave protected by the federal Family and Medical Leave Act, our AMA encourages all specialties within the American Board of Medical Specialties to allow graduating residents to extend training up to 12 weeks after the traditional residency completion date while still maintaining board eligibility in that year.

14. These policies as above should be freely available online and in writing to all applicants to medical school, residency or fellowship.

CCB/CLRPD Rep. 4, A-13; Modified: Res. 305, A-14; Modified: Res. 904, I-14

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 306
(November 2020)

Introduced by: North Dakota, South Dakota, Iowa

Subject: Retirement of the National Board of Medical Examiners Step 2 Clinical Skills Exam for US Medical Graduates: Call for Expedited Action by the American Medical Association

Referred to: Reference Committee C

Whereas, The teaching of clinical skills in history taking, physical examination, documentation and communication with patients has been the foundation of the education of new physicians; and

Whereas, Perceived inadequacies in the teaching of these skills to medical students in medical schools both in the United States and elsewhere led to the implementation of a clinical skills examination component of the certification processes of the United States Medical Licensing Exam (USMLE Step 2 CS) and National Board of Osteopathic Medical Examiners (COMLEX Level 2 PE) in 2004; and

Whereas, Concurrent improvements since that date in the teaching of clinical skills to medical students utilizing case-based learning, clinical simulation techniques and intensified testing protocols have greatly enhanced the emphasis given to clinical skills acquisition by those students; and

Whereas, Increased emphasis on the teaching of clinical skills by the Liaison Committee on Medical Education (LCME), the accrediting organization for allopathic medical schools and the Commission on Osteopathic College Accreditation (COCA), the accrediting organization for osteopathic medical schools, has produced an environment where the documentation and enhancement of clinical skills teaching and assessment is now firmly embedded in medical school curricula; and

Whereas, In 2019, the overall pass rate of USMLE Step 2 CS and COMLEX Level 2-CE for first-time test takers are greater than 95% and 92% respectively suggesting that students who have failed to acquire satisfactory clinical skills during their medical school training are rarely encountered; and

Whereas, It has been estimated that the cost to identify one inadequate trainee using the clinical skills exams may be in excess of $1 million dollars, suggesting a very low value proposition for medical students and medical schools. (NEJM 2013; 368:889-891 DOI 10.1056/ NEJMp1213760); and

Whereas, The USMLE Step 2 CS Exam is only offered in 5 sites, and the COMLEX Level 2-CE at 2 sites in the US, requiring all medical students desiring state medical licensure to spend up to 3 days travelling to these sites which further adds to their educational debt beyond the test fees themselves; and

Whereas, Validation of the exam's long-term effectiveness on individual physician's clinical skill effectiveness has not been demonstrated; and

Whereas, Previous AMA policy, most recently updated at I-19, has called for transition from and replacement for this examination with a more accessible, locally available examination which would be offered as a replacement for the present USMLE and COMLEX formats; and

Whereas, A replacement examination could also be used on a contract basis to credential international medical graduates as part of the ECFMG credentialing process; and

Whereas, The ongoing COVID-19 pandemic has forced USMLE to cancel all Step 2 CS exams for the indefinite future, which places tremendous stress on students and their ability to complete USMLE in a timely fashion for medical school graduation as well as temporary/permanent licensure, therefore be it

RESOLVED, That our American Medical Association take immediate, expedited action to encourage the NBME, FSMB and COCA to eliminate centralized clinical skills examinations used as a part of state licensure, including the USMLE Step 2 CS Exam and the COMLEX Level 2 PE Exam (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate that a replacement examination process be administered within the medical schools that verifies each medical student's competence in key clinical skills required to be a physician (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate that an equivalent examination process as those offered at US medical schools be made available on a contract basis to foreign medical graduates (Directive to Take Action); and be it further

RESOLVED, That our AMA strongly encourage all state delegations in the AMA House of Delegates and other interested member organizations of the AMA to engage their respective state medical licensing boards, the Federation of State Medical Boards, their medical schools and other interested credentialling bodies to encourage the elimination of these centralized, costly and low-value exams (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate that any replacement examination mechanisms be instituted immediately in lieu of resuming existing USMLE Step 2-CS and COMLEX Level 2-PE examinations when the COVID-19 restrictions subside. (Directive to Take Action)

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

Received: 10/13/20

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 307
(November 2020)

Introduced by: Alma B. Littles, MD, Delegate

Subject: USMLE Step Examination Failures During the COVID-19 Pandemic

Referred to: Reference Committee C

Whereas, Students at allopathic schools of medicine in the United States are required to achieve a passing score on all three United States Medical Licensing Examination (USMLE) Step Examinations, conducted under the auspices of the National Board of Medical Examiners (NBME), in order to obtain a license to practice medicine in every state of the United States[1]; and

Whereas, Fifteen of the 50 states will not permit physicians to obtain a license to practice medicine in that state if they have had two or three failures of any of the individual USMLE Step examinations[1] (while other states have varied but less stringent requirements); and

Whereas, Many medical students and resident physicians arrange their schedules to permit a study period of several days or weeks before taking these examinations, especially Step 1 and Step 2-CK (Clinical Knowledge); and

Whereas, During the early months of the SARS-CoV-2 pandemic in the United States, from approximately March 1 through September 30, 2020, scheduled USMLE Step 1 and Step 2-CK examination appointments were delayed or postponed, due to factors beyond students' control, such as pandemic-related closure of available testing sites, resulting in a large backlog of potential examinees awaiting their opportunity to sit for the examination[4]; and

Whereas, The time period applicable for this resolution therefore begins on March 1, 2020 and ends on September 30 (as testing centers have been newly opened, including some newly opened at medical schools, to enable medical students to take USMLE examinations where they attend medical school); and

Whereas, The disruption of the testing schedule prevented many medical students from being able to sit for these examinations at times during which they had reserved the opportunity to prepare, which caused various forms of turmoil for these students[5,6,7]; and

Whereas, In a number of instances, students had subsequently received conflicting information regarding when their examination would be scheduled, as reflected in Internet forum discussions of a "chaotic" process[5,7,8]; and

Whereas, The delay and disruption around the scheduling of USMLE examinations likely caused some students and residents to be forced to take or re-take these examinations at inconvenient times, during which their ability to prepare appropriately was impaired by other educational obligations; and

Whereas, Some students also encountered added obligations of travel to other cities to access an available testing center[8], and further may have had their testing opportunity postponed after they began to travel to the reassigned examination site[9];, leading to extra financial expenses due to last-minute changes in travel; and

Whereas, These circumstances are likely to have negatively impacted examinees' USMLE Step exam passing score rates while adding avoidable expense to these examinees' fees and expenses; and

Whereas: Although the impact of these circumstances would have been large to an individual medical student's budget, the overall failure rates for these examinations appear to have remained relatively low on a nation-wide basis, such that any financial impact of this proposal upon the National Board of Medical Examiners would be minimal to that Board; and

Whereas, Failure to pass any Step examinations typically must be revealed by applicants when applying for state medical licensure or for privileges to practice medicine at and/or admit patients to hospitals in the United States[10,11]; therefore be it

RESOLVED, That our American Medical Association advocate to the National Board of Medical Examiners (NBME) that students at allopathic schools of medicine who failed the United States Medical Licensing Examination (USMLE) Step 1 Examination or the USMLE Step 2-CK Examination that was scheduled between March 1, 2020 and September 30, 2020 be allowed the opportunity to be re-examined one time at no additional examination fee charged to the student (Directive to Take Action); and be it further

RESOLVED, That our AMA ask that the various state and territorial medical boards, through outreach to the NBME and Federation of State Medical Boards (FSMB), not require students who failed any USMLE Step 1 or USMLE Step 2 CK examination, between March 1 and September 30, 2020 to reveal this information to state medical licensure boards during the processes of obtaining or renewing state licensure (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate to the NBME and FSMB that such failures not count toward the total number of exam attempts by a potential licensee (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate to hospital accreditation organizations such as, but not limited to, The Joint Commission and American Hospital Association, that those who have failed any USMLE Step 1 or USMLE Step 2-CK examination between March 1 and September 30, 2020 not be required to disclose this information to hospital boards and other accrediting bodies that determine a physician's fitness to practice at or admit patients to hospitals in the United States. (Directive to Take Action)

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

Received: 10/14/20

References

1. https://www.fsmb.org/step-3/state-licensure/. Accessed Sept 19, 2020.
2. https://www.usmle.org/step-1/. Accessed Sept 19, 2020.
3. https://usmle.org/step-2-ck/. Accessed October 2, 2020.
4. https://covid.usmle.org/announcements/preparations-event-testing. Accessed September 19, 2020.
5. https://www.ama-assn.org/residents-students/usmle/delays-miscommunications-add-even-more-stress-usmle-step-exams. Accessed September 19, 2020.
6. https://www.medpagetoday.com/infectiousdisease/covid19/86059. Accessed September 19, 2020.
7. https://www.medscape.com/viewarticle/929388. Accessed September 21, 2020.
8. https://www.ama-assn.org/residents-students/usmle/delays-miscommunications-add-even-more-stress-usmle-step-exams. Accessed September 19, 2020.
9. https://www.medscape.com/viewarticle/932366. Accessed September 19, 2020.
10. https://www.sos.mo.gov/cmsimages/adrules/csr/current/20csr/20c2150-2.pdf Page 4. Accessed September 19, 2020.
11. https://www.barnesjewish.org/About-Us. Accessed September 20, 2020.

RELEVANT AMA POLICY

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

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

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)

D-295.988, "Clinical Skills Assessment During Medical School"
1. Our AMA will encourage its representatives to the Liaison Committee on Medical Education (LCME) to ask the LCME to determine and disseminate to medical schools a description of what constitutes appropriate compliance with the accreditation standard that schools should "develop a system of assessment" to assure that students have acquired and can demonstrate core clinical skills.
2. Our AMA will work with the Federation of State Medical Boards, National Board of Medical Examiners, state medical societies, state medical boards, and other key stakeholders to pursue the transition from and replacement for the current United States Medical Licensing Examination (USMLE) Step 2 Clinical Skills (CS) examination and the Comprehensive Osteopathic Medical Licensing Examination (COMLEX) Level 2-Performance Examination (PE) with a requirement to pass a Liaison Committee on Medical Education-accredited or Commission on Osteopathic College Accreditation-accredited medical school-administered, clinical skills examination.
3. Our AMA will work to: (a) ensure rapid yet carefully considered changes to the current examination process to reduce costs, including travel expenses, as well as time away from educational pursuits, through immediate steps by the Federation of State Medical Boards and National Board of Medical Examiners; (b) encourage a significant and expeditious increase in the number of available testing sites; (c) allow international students and graduates to take the same examination at any available testing site; (d) engage in a transparent evaluation of basing this examination within our nation's medical schools, rather than administered by an external organization; and (e) include active participation by faculty leaders and assessment experts from U.S. medical schools, as they work to develop new and improved methods of assessing medical student competence for advancement into residency.
4. Our AMA is committed to assuring that all medical school graduates entering graduate medical education programs have demonstrated competence in clinical skills.
5. Our AMA will continue to work with appropriate stakeholders to assure the processes for assessing clinical skills are evidence-based and most efficiently use the time and financial resources of those being assessed.
6. Our AMA encourages development of a post-examination feedback system for all USMLE test-takers that would: (a) identify areas of satisfactory or better performance; (b) identify areas of suboptimal performance; and (c) give students who fail the exam insight into the areas of unsatisfactory performance on the examination.
7. Our AMA, through the Council on Medical Education, will continue to monitor relevant data and engage with stakeholders as necessary should updates to this policy become necessary.
(CME Rep. 7, I-99; Reaffirmed: CME Rep. 2, A-09; Appended: Alt. Res. 311, A-16; Appended: CME Rep. 9, A-17; Reaffirmation: I-19)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 308
(November 2020)

Introduced by: International Medical Graduates Section

Subject: ECFMG 2024 Accreditation Requirement for World Federation for Medical Education (WFME) Recognition

Referred to: Reference Committee C

Whereas, The exponential growth of the private sector medical schools, their varying quality of medical education, clinical rotations, and accreditation requirements have become a severe concern to ECFMG; and

Whereas, A standard global accreditation process would help ensure patient safety, good quality clinical outcomes, and professional accountability; and

Whereas, There has always been a need for a transparent and rigorous method of accreditation of medical schools, worldwide, to meet an internationally accepted standard; and

Whereas, After the international task force meeting in 2005, The World Health Organization (WHO) and the World Federation for Medical Education (WFME) jointly published Guidelines for Accreditation of Basic Medical Education[1,] which formed the basis of the 2013 WHO policy briefing on medical accreditation and the 2016 International Association Medical Regulatory Authorities (IAMRA) statement on accreditation of medical education programs[2]; and

Whereas, In 2010, ECFMG stated that effective in 2023, applicants for ECFMG Certification would be required to be a student or graduate of a medical school accredited by a WFME-recognized accrediting agency[3]; and

Whereas, During the last ten years, of the 130 - 147 countries whose medical students apply for ECFMG certification, only 23 countries have obtained WFME recognition status, and only 13 more have applied[4]; and

Whereas, Because of the COVID-19 pandemic, the current deadline for implementing the WFME based accreditation standards has been extended to 2024[5]. Given the time constraints, it is unlikely that most countries will have their accrediting bodies obtain the WFME recognition status by 2024; and

Whereas, One in four physicians in the U.S. is a graduate of an international medical school who fills 54.6% of primary care specialty positions[6,7] and fills in the physician workforce gaps that would remain vacant; and

Whereas, IMG physicians have provided ongoing primary health care services to the American people of equivalent quality to those who have completed medical school in the U.S.; and

Whereas, There is a predicted shortage of 21,400 to 55,200 primary care physicians and a total physician shortfall of 54,100 to 139,000 by 2033, and the new prerequisites for WFME based certification requirements will significantly limit the applicant pool for primary healthcare positions, thus negatively impacting the health care of the nation; therefore be it

RESOLVED, That our American Medical Association work with the state and specialty medical associations and other stakeholders to apprise them of the ECFMG requirements and the foreseeable shortage of IMG physicians in underserved populations and primary health care settings to be prepared with alternative options (Directive to Take Action); and be it further

RESOLVED, That our AMA work with the Federation of State Medical Boards and ECFMG to develop more robust communication channels with participating medical schools and explore reasons for the low rate of accreditation and possible ways to address those barriers in meeting accreditation requirements. (Directive to Take Action)

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

Received: 10/19/20

1.WHO/WFME Guidelines for Accreditation of Basic Medical Education https://bit.ly/3j03bVB, Accessed on September 19, 2020.
2. Policy Brief on Accreditation of Institutions for Health Professional Education World Health organization 2013; https://bit.ly/32Unf6n, Accessed on September 19, 2020.
3. 2023 Medical School Accreditation Requirement https://www.ecfmg.org/accreditation/, Accessed on September 12, 2020.
4. WFME Agencies with Recognition Status and applying https://bit.ly/330jE6K, Accessed on September 12, 2020.
5. ECFMG Medical School Accreditation Requirement Moved to 2024, https://bit.ly/3429jqq, Accessed on September 11, 2020.
6. Inside the numbers behind the record-setting 2019 Match; https://bit.ly/364GyM4, Accessed on September 20, 2020.
7. Press Release: Thousands of Resident Applicants Celebrate NRMP Match Results https://bit.ly/3i7XqEp, Accessed on September 15, 2020.
8. The Complexities of Physician Supply and Demand: Projections From 2018 to 2033, https://bit.ly/2FW7RO9, Accessed on September 23, 2020.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 309
(November 2020)

Introduced by: Michigan

Subject: Preserve and Increase Graduate Medical Education Funding

Referred to: Reference Committee C

Whereas, The U.S. General Accountability Office (GAO) recently announced their fiscal year budget; and

Whereas, Their announcement included information about potential changes in graduate medical education (GME) funding; and

Whereas, The GAO released a report in December 2019, entitled, "Views on Expanding Medicare Graduate Medical Education Funding to Nurse Practitioners and Physician Assistants"; and

Whereas, This report contains potential errors that may adversely influence legislative decisions; and

Whereas, GME funding, direct and indirect funding, has been earmarked for resident physicians to support their education and training in teaching hospitals; and

Whereas, Advanced practice professionals, such as nurse practitioners or physician assistants, have a shorter training period with an associated lower overall cost for the trainee and no requirement for a residency; and

Whereas, The number of residency slots has not been increased for most residency programs since 1997 due to the restrictions imposed by the Balanced Budget Act; and

Whereas, Teaching hospitals rely on GME funding to offset the increased cost of providing care that may occur in a teaching hospital setting due to the presence of additional health care personnel who are trainees; and

Whereas, An increase in GME funding has been an ongoing request to our legislators for the past few years due to concerns about the rising expenses of providing education coupled with the stagnation of GME funding; and

Whereas, The United States is facing a significant and severe physician shortage based on current predictors and estimates; and

Whereas, The diversion of GME funding to non-physicians will only make this situation worse with potential serious consequences for the health of our nation due to lack of physician access; therefore be it

RESOLVED, That our American Medical Association work with the Liaison Committee on Medical Education, the Accreditation Council for Graduate Medical Education, and other interested stakeholders to encourage the U.S. Government Accountability Office to oppose and refrain from further consideration of the diversion of direct and indirect graduate medical education funding to non-physicians. (Directive to Take Action)

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

Received: 10/27/20

Sources:
1. U.S. Government Accountability Office Report to Congressional Committees December 2019 HEALTH CARE WORKFORCE "Views on Expanding Medicare Graduate Medical Education Funding to Nurse Practitioners and Physician Assistants"
2. "Residency: The Bottleneck in Physician Training" Physicians for Patient Protection/PPP Response to GAO Report, on-line resource, accessed February 10, 2020.

RELEVANT AMA POLICY

Funding to Support Training of the Health Care Workforce H-310.916
1. Our American Medical Association will insist that any new GME funding to support graduate medical education positions be available only to Accreditation Council for Graduate Medical Education (ACGME) and/or American Osteopathic Association (AOA) accredited residency programs, and believes that funding made available to support the training of health care providers not be made at the expense of ACGME and/or AOA accredited residency programs.
2. Our AMA strongly advocates that: (A) there be no decreases in the current funding of MD and DO graduate medical education while there is a concurrent increase in funding of graduate medical education (GME) in other professions; and (B) there be at least proportional increases in the current funding of MD and DO graduate medical education similar to increases in funding of GME in other professions.
Citation: (Sub. Res. 913, I-09; Appended: Res. 917, I-15)

Securing Funding for Graduate Medical Education H-310.917
Our American Medical Association: (1) continues to be vigilant while monitoring pending legislation that may change the financing of medical services (health system reform) and advocate for expanded and broad-based funding for graduate medical education (from federal, state, and commercial entities); (2) continues to advocate for graduate medical education funding that reflects the physician workforce needs of the nation; (3) encourages all funders of GME to adhere to the Accreditation Council for Graduate Medical Education's requirements on restrictive covenants and its principles guiding the relationship between GME, industry and other funding sources, as well as the AMA's Opinion 8.061, and other AMA policy that protects residents and fellows from exploitation, including physicians training in non-ACGME-accredited programs; and (4) encourages entities planning to expand or start GME programs to develop a clear statement of the benefits of their GME activities to facilitate potential funding from appropriate sources given the goals of their programs.
Citation: (CME Rep. 3, I-09; Modified: CME Rep. 15, A-10; Reaffirmed in lieu of Res. 324, A-12; Reaffirmed: CME Rep. 5, A-13; Appended: CME Rep. 1, I-15)

The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education D-305.967
1. Our AMA will actively collaborate with appropriate stakeholder organizations, (including Association of American Medical Colleges, American Hospital Association, state medical societies, medical specialty societies/associations) to advocate for the preservation, stability and expansion of full funding for the direct and indirect costs of graduate medical education (GME) positions from all existing sources (e.g. Medicare, Medicaid, Veterans Administration, CDC and others).
2. Our AMA will actively advocate for the stable provision of matching federal funds for state Medicaid programs that fund GME positions.
3. Our AMA will actively seek congressional action to remove the caps on Medicare funding of GME positions for resident physicians that were imposed by the Balanced Budget Amendment of 1997 (BBA-1997).
4. Our AMA will strenuously advocate for increasing the number of GME positions to address the future physician workforce needs of the nation.
5. Our AMA will oppose efforts to move federal funding of GME positions to the annual appropriations process that is subject to instability and uncertainty.

6. Our AMA will oppose regulatory and legislative efforts that reduce funding for GME from the full scope of resident educational activities that are designated by residency programs for accreditation and the board certification of their graduates (e.g. didactic teaching, community service, off-site ambulatory rotations, etc.).
7. Our AMA will actively explore additional sources of GME funding and their potential impact on the quality of residency training and on patient care.
8. Our AMA will vigorously advocate for the continued and expanded contribution by all payers for health care (including the federal government, the states, and local and private sources) to fund both the direct and indirect costs of GME.
9. Our AMA will work, in collaboration with other stakeholders, to improve the awareness of the general public that GME is a public good that provides essential services as part of the training process and serves as a necessary component of physician preparation to provide patient care that is safe, effective and of high quality.
10. Our AMA staff and governance will continuously monitor federal, state and private proposals for health care reform for their potential impact on the preservation, stability and expansion of full funding for the direct and indirect costs of GME.
11. Our AMA: (a) recognizes that funding for and distribution of positions for GME are in crisis in the United States and that meaningful and comprehensive reform is urgently needed; (b) will immediately work with Congress to expand medical residencies in a balanced fashion based on expected specialty needs throughout our nation to produce a geographically distributed and appropriately sized physician workforce; and to make increasing support and funding for GME programs and residencies a top priority of the AMA in its national political agenda; and (c) will continue to work closely with the Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, American Osteopathic Association, and other key stakeholders to raise awareness among policymakers and the public about the importance of expanded GME funding to meet the nation's current and anticipated medical workforce needs.
12. Our AMA will collaborate with other organizations to explore evidence-based approaches to quality and accountability in residency education to support enhanced funding of GME.
13. Our AMA will continue to strongly advocate that Congress fund additional graduate medical education (GME) positions for the most critical workforce needs, especially considering the current and worsening maldistribution of physicians.
14. Our AMA will advocate that the Centers for Medicare and Medicaid Services allow for rural and other underserved rotations in Accreditation Council for Graduate Medical Education (ACGME)-accredited residency programs, in disciplines of particular local/regional need, to occur in the offices of physicians who meet the qualifications for adjunct faculty of the residency program's sponsoring institution.
15. Our AMA encourages the ACGME to reduce barriers to rural and other underserved community experiences for graduate medical education programs that choose to provide such training, by adjusting as needed its program requirements, such as continuity requirements or limitations on time spent away from the primary residency site.
16. Our AMA encourages the ACGME and the American Osteopathic Association (AOA) to continue to develop and disseminate innovative methods of training physicians efficiently that foster the skills and inclinations to practice in a health care system that rewards team-based care and social accountability.
17. Our AMA will work with interested state and national medical specialty societies and other appropriate stakeholders to share and support legislation to increase GME funding, enabling a state to accomplish one or more of the following: (a) train more physicians to meet state and regional workforce needs; (b) train physicians who will practice in physician shortage/underserved areas; or (c) train physicians in undersupplied specialties and subspecialties in the state/region.
18. Our AMA supports the ongoing efforts by states to identify and address changing physician workforce needs within the GME landscape and continue to broadly advocate for innovative pilot programs that will increase the number of positions and create enhanced accountability of GME programs for quality outcomes.
19. Our AMA will continue to work with stakeholders such as Association of American Medical Colleges (AAMC), ACGME, AOA, American Academy of Family Physicians, American College of Physicians, and other specialty organizations to analyze the changing landscape of future physician workforce needs as well as the number and variety of GME positions necessary to provide that workforce.
20. Our AMA will explore innovative funding models for incremental increases in funded residency positions related to quality of resident education and provision of patient care as evaluated by appropriate medical education organizations such as the Accreditation Council for Graduate Medical Education.
21. Our AMA will utilize its resources to share its content expertise with policymakers and the public to ensure greater awareness of the significant societal value of graduate medical education (GME) in terms of patient care, particularly for underserved and at-risk populations, as well as global health, research and education.
22. Our AMA will advocate for the appropriation of Congressional funding in support of the National Healthcare Workforce Commission, established under section 5101 of the Affordable Care Act, to provide data and healthcare workforce policy and advice to the nation and provide data that support the value of GME to the nation.

23. Our AMA supports recommendations to increase the accountability for and transparency of GME funding and continue to monitor data and peer-reviewed studies that contribute to further assess the value of GME.
24. Our AMA will explore various models of all-payer funding for GME, especially as the Institute of Medicine (now a program unit of the National Academy of Medicine) did not examine those options in its 2014 report on GME governance and financing.
25. Our AMA encourages organizations with successful existing models to publicize and share strategies, outcomes and costs.
26. Our AMA encourages insurance payers and foundations to enter into partnerships with state and local agencies as well as academic medical centers and community hospitals seeking to expand GME.
27. Our AMA will develop, along with other interested stakeholders, a national campaign to educate the public on the definition and importance of graduate medical education, student debt and the state of the medical profession today and in the future.
28. Our AMA will collaborate with other stakeholder organizations to evaluate and work to establish consensus regarding the appropriate economic value of resident and fellow services.
29. Our AMA will monitor ongoing pilots and demonstration projects, and explore the feasibility of broader implementation of proposals that show promise as alternative means for funding physician education and training while providing appropriate compensation for residents and fellows.
30. Our AMA will monitor the status of the House Energy and Commerce Committee's response to public comments solicited regarding the 2014 IOM report, Graduate Medical Education That Meets the Nation's Health Needs, as well as results of ongoing studies, including that requested of the GAO, in order to formulate new advocacy strategy for GME funding, and will report back to the House of Delegates regularly on important changes in the landscape of GME funding.
31. Our AMA will advocate to the Centers for Medicare & Medicaid Services to adopt the concept of “Cap-Flexibility” and allow new and current Graduate Medical Education teaching institutions to extend their cap-building window for up to an additional five years beyond the current window (for a total of up to ten years), giving priority to new residency programs in underserved areas and/or economically depressed areas.
32. Our AMA will: (a) encourage all existing and planned allopathic and osteopathic medical schools to thoroughly research match statistics and other career placement metrics when developing career guidance plans; (b) strongly advocate for and work with legislators, private sector partnerships, and existing and planned osteopathic and allopathic medical schools to create and fund graduate medical education (GME) programs that can accommodate the equivalent number of additional medical school graduates consistent with the workforce needs of our nation; and (c) encourage the Liaison Committee on Medical Education (LCME), the Commission on Osteopathic College Accreditation (COCA), and other accrediting bodies, as part of accreditation of allopathic and osteopathic medical schools, to prospectively and retrospectively monitor medical school graduates’ rates of placement into GME as well as GME completion.
33. Our AMA encourages the Secretary of the U.S. Department of Health and Human Services to coordinate with federal agencies that fund GME training to identify and collect information needed to effectively evaluate how hospitals, health systems, and health centers with residency programs are utilizing these financial resources to meet the nation’s health care workforce needs. This includes information on payment amounts by the type of training programs supported, resident training costs and revenue generation, output or outcomes related to health workforce planning (i.e., percentage of primary care residents that went on to practice in rural or medically underserved areas), and measures related to resident competency and educational quality offered by GME training programs.

Citation: Sub. Res. 314, A-07; Reaffirmation I-07; Reaffirmed: CME Rep. 4, I-08; Reaffirmed: Sub. Res. 314, A-09; Reaffirmed: CME Rep. 3, I-09; Reaffirmation A-11; Appended: Res. 910, I-11; Reaffirmed in lieu of Res. 303, A-12; Reaffirmed in lieu of Res. 324, A-12; Reaffirmation: I-12; Reaffirmation A-13; Appended: Res. 320, A-13; Appended: CME Rep. 5, A-13; Appended: CME Rep. 7, A-14; Appended: Res. 304, A-14; Modified: CME Rep. 9, A-15; Appended: CME Rep, 1, I-15; Appended: Res. 902, I-15; Reaffirmed: CME Rep. 3, A-16; Appended: Res. 320, A-16; Appended: CME Rep. 04, A-16; Appended: CME Rep. 05, A-16; Reaffirmation A-16; Appended: Res. 323, A-17; Appended: CME Rep. 03, A-18; Appended: Res. 319, A-18; Reaffirmed in lieu of: Res. 960, I-18; Modified: Res. 233, A-19; Modified: BOT Rep. 25, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 401
(November 2020)

Introduced by: Women Physicians Section

Subject: Fatigue Mitigation Respite for Faculty and Residents

Referred to: Reference Committee D

Whereas, AMA Policy H-15.958, "Fatigue, Sleep Disorders, and Motor Vehicle Crashes," notes the risks associated with sleep deprivation and actions physicians can take to help protect patients; and

Whereas, About 20-30 percent of shift workers experience prominent insomnia symptoms and excessive daytime sleepiness consistent with circadian rhythm sleep disorder, also known as shift work disorder;[5] and

Whereas, Drowsy driving causes almost 1,000 estimated fatal motor vehicle crashes in the United States (2.5 percent of all fatal crashes), 37,000 injury crashes, and 45,000 property damage-only crashes;[2] and

Whereas, Physicians have a higher likelihood of dying from accidents than from other causes relative to the general populations;[4] and

Whereas, Physicians' risk of crashing while driving after working extended shifts (≥24 hours) was 2.3 times greater and the risk for a "near miss" crash was 5.9 times greater, compared to a non-extended shift. The estimated risk of a crash rose by 9.1 percent for every additional extended work shift hour;[3] and

Whereas, Forty-one percent (41%) of physicians report falling asleep at the wheel after a night shift;[6] and

Whereas, A simulation study demonstrated that being awake for 18 hours, which is common for physicians working a swing shift (i.e., from 6 p.m. to 2 a.m.), produced an impairment equal to a blood alcohol concentration (BAC) of 0.05 and rose to equal 0.10 after 24 hours without sleep;[7] and

Whereas, Driving simulator studies show driving home from the night shift is associated with two to eight times the incidents of off track veering, decreased time to first accident, increased eye closure duration, and increased subjective sleepiness. Night-shift work increases driver drowsiness, degrading driving performance and increasing the risk of near-crash drive events;[8] and

Whereas, Actual driving studies post-night shift versus post-sleep night showed eleven near-crashes occurred in 6 of 16 post night-shift drives (37.5 percent), and 7 of 16 post night-shift drives (43.8 percent) were terminated early for safety reasons, compared with zero near-crashes or early drive terminations during 16 post-sleep drives;[9] and

Whereas, Institutional support for self-care and fatigue mitigation can help protect physician well-being and model appropriate behaviors for physicians in training; therefore be it

RESOLVED, That our American Medical Association advocate for legislation and policies that support fatigue mitigation programs, which include, but are not limited to, a quiet place to rest or funding for alternative transport and return to work for vehicle recovery at a later time for all medical staff who feel unsafe driving due to fatigue after working overnight or extended shifts. (Directive to Take Action)

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

Received: 09/30/20

References:
1. Fatigue Mitigation Transportation Reimbursement for Trainees. Available at https://medschool.ucla.edu/gme/transportation-reimbursement-for-fatigued-trainees.
2. Research on Drowsy Drive. Available at https://one.nhtsa.gov/Driving-Safety/Drowsy-Driving/scope%E2%80%93of%E2%80%93the%E2%80%93problem.
3. Barger LK, Cade BE, Ayas NT, Cronin JW, Rosner B, Speizer FE, et al. Extended work shifts and the risk of motor vehicle crashes among interns. N Engl J Med. 2005;352(2):125–34.
4. Frank, E, Biola, H, Burnett, CA. Mortality rates and causes among U.S. physicians. Am J Prev Med 2000; 19: 155–9.
5. Booker LA, Magee M, Rajaratnam SMW, Sletten TL, Howard ME. Individual vulnerability to insomnia, excessive sleepiness and shift work disorder amongst healthcare shift workers. A systematic review. Sleep Med Rev. 2018;41:220–33.
6. https://www.bbc.com/news/uk-england-suffolk-36767868
7. Williamson AM, Feyer AM. Moderate sleep deprivation produces impairments in cognitive and motor performance equivalent to legally prescribed levels of alcohol intoxication. Occup Environ Med. 2000;57(10):649–655. doi:10.1136/oem.57.10.649.
8. Akerstedt T1, Peters B, Anund A, Kecklund G. Impaired alertness and performance driving home from the night shift: a driving simulator study. J Sleep Res. 2005 Mar;14(1):17-20.
9. Lee Ml1, Howard Me2, Horrey Wj3, Liang Y3, Anderson C4, Shreeve Ms5, O'brien Cs5, Czeisler Ca6. High Risk Of Near-Crash Driving Events Following Night-Shift Work.Proc Natl Acad Sci U S A. 2016 Jan 5;113(1):176-81. doi: 10.1073/pnas.1510383112.

RELEVANT AMA POLICY

Resident/Fellow Clinical and Educational Work Hours H-310.907
Our AMA adopts the following Principles of Resident/Fellow Clinical and Educational Work Hours, Patient Safety, and Quality of Physician Training:
1. Our AMA supports the 2017 Accreditation Council for Graduate Medical Education (ACGME) standards for clinical and educational work hours (previously referred to as “duty hours”).
2. Our AMA will continue to monitor the enforcement and impact of clinical and educational work hour standards, in the context of the larger issues of patient safety and the optimal learning environment for residents.
3. Our AMA encourages publication and supports dissemination of studies in peer-reviewed publications and educational sessions about all aspects of clinical and educational work hours, to include such topics as extended work shifts, handoffs, in-house call and at-home call, level of supervision by attending physicians, workload and growing service demands, moonlighting, protected sleep periods, sleep deprivation and fatigue, patient safety, medical error, continuity of care, resident well-being and burnout, development of professionalism, resident learning outcomes, and preparation for independent practice.
4. Our AMA endorses the study of innovative models of clinical and educational work hour requirements and, pending the outcomes of ongoing and future research, should consider the evolution of specialty- and rotation-specific requirements that are evidence-based and will optimize patient safety and competency-based learning opportunities.
5. Our AMA encourages the ACGME to:
a) Decrease the barriers to reporting of both clinical and educational work hour violations and resident intimidation.
b) Ensure that readily accessible, timely and accurate information about clinical and educational work hours is not constrained by the cycle of ACGME survey visits.
c) Use, where possible, recommendations from respective specialty societies and evidence-based approaches to any future revision or introduction of clinical and educational work hour rules.
d) Broadly disseminate aggregate data from the annual ACGME survey on the educational environment of resident physicians, encompassing all aspects of clinical and educational work hours.

6. Our AMA recognizes the ACGME for its work in ensuring an appropriate balance between resident education and patient safety, and encourages the ACGME to continue to:
a) Offer incentives to programs/institutions to ensure compliance with clinical and educational work hour standards.
b) Ensure that site visits include meetings with peer-selected or randomly selected residents and that residents who are not interviewed during site visits have the opportunity to provide information directly to the site visitor.
c) Collect data on at-home call from both program directors and resident/fellow physicians; release these aggregate data annually; and develop standards to ensure that appropriate education and supervision are maintained, whether the setting is in-house or at-home.
d) Ensure that resident/fellow physicians receive education on sleep deprivation and fatigue.
7. Our AMA supports the following statements related to clinical and educational work hours:
a) Total clinical and educational work hours must not exceed 80 hours per week, averaged over a four-week period (Note: “Total clinical and educational work hours” includes providing direct patient care or supervised patient care that contributes to meeting educational goals; participating in formal educational activities; providing administrative and patient care services of limited or no educational value; and time needed to transfer the care of patients).
b) Scheduled on-call assignments should not exceed 24 hours. Residents may remain on-duty for an additional 4 hours to complete the transfer of care, patient follow-up, and education; however, residents may not be assigned new patients, cross-coverage of other providers’ patients, or continuity clinic during that time.
c) Time spent in the hospital by residents on at-home call must count towards the 80-hour maximum weekly hour limit, and on-call frequency must not exceed every third night averaged over four weeks. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one-day-in-seven free of duty, when averaged over four weeks.
d) At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident.
e) Residents are permitted to return to the hospital while on at-home call to care for new or established patients. Each episode of this type of care, while it must be included in the 80-hour weekly maximum, will not initiate a new “off-duty period.”
f) Given the different education and patient care needs of the various specialties and changes in resident responsibility as training progresses, clinical and educational work hour requirements should allow for flexibility for different disciplines and different training levels to ensure appropriate resident education and patient safety; for example, allowing exceptions for certain disciplines, as appropriate, or allowing a limited increase to the total number of clinical and educational work hours when need is demonstrated.
g) Resident physicians should be ensured a sufficient duty-free interval prior to returning to duty.
h) Clinical and educational work hour limits must not adversely impact resident physician participation in organized educational activities. Formal educational activities must be scheduled and available within total clinical and educational work hour limits for all resident physicians.
i) Scheduled time providing patient care services of limited or no educational value should be minimized.
j) Accurate, honest, and complete reporting of clinical and educational work hours is an essential element of medical professionalism and ethics.
k) The medical profession maintains the right and responsibility for self-regulation (one of the key tenets of professionalism) through the ACGME and its purview over graduate medical education, and categorically rejects involvement by the Centers for Medicare & Medicaid Services, The Joint Commission, Occupational Safety and Health Administration, and any other federal or state government bodies in the monitoring and enforcement of clinical and educational work hour regulations, and opposes any regulatory or legislative proposals to limit the work hours of practicing physicians.
l) Increased financial assistance for residents/fellows, such as subsidized child care, loan deferment, debt forgiveness, and tax credits, may help mitigate the need for moonlighting. At the same time, resident/fellow physicians in good standing with their programs should be afforded the opportunity for internal and external moonlighting that complies with ACGME policy.
m) Program directors should establish guidelines for scheduled work outside of the residency program, such as moonlighting, and must approve and monitor that work such that it does not interfere with the ability of the resident to achieve the goals and objectives of the educational program.
n) The costs of clinical and educational work hour limits should be borne by all health care payers. Individual resident compensation and benefits must not be compromised or decreased as a result of changes in the graduate medical education system.

o) The general public should be made aware of the many contributions of resident/fellow physicians to high-quality patient care and the importance of trainees' realizing their limits (under proper supervision) so that they will be able to competently and independently practice under real-world medical situations.
8. Our AMA is in full support of the collaborative partnership between allopathic and osteopathic professional and accrediting bodies in developing a unified system of residency/fellowship accreditation for all residents and fellows, with the overall goal of ensuring patient safety.
9. Our AMA will actively participate in ongoing efforts to monitor the impact of clinical and educational work hour limitations to ensure that patient safety and physician well-being are not jeopardized by excessive demands on post-residency physicians, including program directors and attending physicians.
Citation: CME Rep. 5, A-14; Modified: CME Rep. 06, I-18

Fatigue, Sleep Disorders, and Motor Vehicle Crashes H-15.958
Our AMA: (1) recognizes sleepiness behind the wheel as a major public health issue and continues to encourage a national public education campaign by appropriate federal agencies and relevant advocacy groups.
(2) recommends that the National Institutes of Health and other appropriate organizations support research projects to provide more accurate data on the prevalence of sleep-related disorders in the general population and in motor vehicle drivers, and provide information on the consequences and natural history of such conditions.
(3) recommends that the U.S. Department of Transportation (DOT) and other responsible agencies continue studies on the occurrence of highway crashes and other adverse occurrences in transportation that involve reduced operator alertness and sleep.
(4) encourages continued collaboration between the DOT and the transportation industry to support research projects for the devising and effectiveness- testing of appropriate countermeasures against driver fatigue, including technologies for motor vehicles and the highway environment.
(5) urges responsible federal agencies to improve enforcement of existing regulations for truck driver work periods and consecutive working hours and increase awareness of the hazards of driving while fatigued. If changes to these regulations are proposed on a medical basis, they should be justified by the findings of rigorous studies and the judgments of persons who are knowledgeable in ergonomics, occupational medicine, and industrial psychology.
(6) recommends that physicians: (a) become knowledgeable about the diagnosis and management of sleep-related disorders; (b) investigate patient symptoms of drowsiness, wakefulness, and fatigue by inquiring about sleep and work habits and other predisposing factors when compiling patient histories; (c) inform patients about the personal and societal hazards of driving or working while fatigued and advise patients about measures they can take to prevent fatigue-related and other unintended injuries; (d) advise patients about possible medication-related effects that may impair their ability to safely operate a moto vehicle or other machinery; (e) inquire whether sleepiness and fatigue could be contributing factors in motor vehicle-related and other unintended injuries; and (f) become familiar with the laws and regulations concerning drivers and highway safety in the state(s) where they practice.
(7) encourages all state medical associations to promote the incorporation of an educational component on the dangers of driving while sleepy in all drivers education classes (for all age groups) in each state.
(8) recommends that states adopt regulations for the licensing of commercial and private drivers with sleep-related and other medical disorders according to the extent to which persons afflicted with such disorders experience crashes and injuries.
(9) reiterates its support for physicians' use of E-codes in completing emergency department and hospital records, and urges collaboration among appropriate government agencies and medical and public health organizations to improve state and national injury surveillance systems and more accurately determine the relationship of fatigue and sleep disorders to motor vehicle crashes and other unintended injuries.
Citation: CSA Rep. 1, A-96; Appended: Res. 418, I-99; Reaffirmed: CSAPH Rep. 1, A-09; Modified: CSAPH Rep. 01, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 406
(November 2020)

Introduced by: Alma B. Littles, MD, Delegate

Subject: Face Masking in Hospitals During Flu Season

Referred to: Reference Committee D

Whereas, Studies of COVID-19 disease epidemiology during the SARS-CoV-2 pandemic clearly demonstrate that facial masks covering the mouth and nose decrease transmission of this disease; and

Whereas, Influenza viruses and the SARS-CoV-2 virus are of approximately the same size, yielding a logical conclusion that facial masks worn to blunt SARS-CoV-2 transmission should also decrease influenza transmission to a similar degree; and

Whereas, The populations of Australia (representative for Oceania), Chile (representative for South America) and South Africa (representative for Africa) have experienced extremely low rates of influenza during their recently concluded "flu" seasons of 2020[1], a time overlapping the SARS-CoV-2 pandemic and thus a time during which facial mask-wearing was being practiced by most of these nations' populations; and

Whereas, Similar trends of extremely low summer seasonal influenza rates have been observed in the United States during 2020[1]; and

Whereas, The precipitous decline of influenza activity worldwide has been attributed to widespread facial mask-wearing that has emerged to counter the SARS-CoV-2 pandemic[1]; and

Whereas, Influenza, like COVID-19, is a disease that most persons survive but also a disease that has caused thousands of premature deaths, ranging from about 12,000 to about 61,000 annually during the "influenza seasons" (approximately October 1 through March 31) of the past 10 years[2,3]; and

Whereas, During flu season, the death toll due to pneumonia, which in most cases is caused by a bacterial agent, is roughly three to five times larger than that due to influenza viruses[4]; and

Whereas, The death tolls of influenza and pneumonia fall disproportionately upon persons with multiple chronic illnesses or who are elderly (aged 65 or greater[5]), a demographic group that constitutes the majority of hospitalized patients; and

Whereas, It can therefore be anticipated that mandatory wearing of facial masks that cover the nose and mouth by patients, all hospital-based health care workers, and all hospital visitors during flu season should help greatly decrease transmission not only of influenza but also of pneumonia within hospitals, as has been observed in general regarding transmission of SARS-CoV-2; and

Whereas, Visitors to hospitalized patients, as well as physicians and hospital employees providing care to hospitalized patients during flu season may or may not have been immunized themselves against influenza and/or pneumonia; and

Whereas, Even immunized visitors, physicians or hospital employees may not have developed immunity to influenza, despite being immunized, because every year's influenza immunization effectiveness has fallen far short of 100% (being ~45% in 2019-20[6]; ~47% in 2018-19[7]; and ~36% in 2017-18[8]); and

Whereas, Unmasked physicians, nurses, other health care workers, other hospital employees and hospital visitors, as well as patients when in areas outside of their assigned bed or room, represent potential vectors for the transmission of influenza and pneumonia to other persons present within hospitals; and

Whereas, Hospital organizations should work to minimize any hospital-acquired disease transmission to their hospitalized patients, physicians, employees, and visitors; and

Whereas, Hospital organizations may fear a negative public relations consequence if they choose to require facial masks of all physicians, hospital employees, patients, and hospital visitors during flu season, partly because the wearing of facial masks has become a politicized matter,[9] despite voluminous scientific data on the topic that affirm the wisdom of such a requirement; and

Whereas, It is logical to therefore assert that a requirement for all hospital employees, physicians, and visitors to wear a facial mask may require imposition by a third-party accrediting organization in order to become enacted; and

Whereas, The Joint Commission is a third-party organization, which accredits the majority of US hospitals[10] and which has the power to strongly influence hospital and hospital system policies and procedures via its quasi-regulatory powers; and

Whereas, Other third-party organizations with similar powers also exist to accredit much smaller numbers of hospitals in the United States; therefore be it

RESOLVED, That our American Medical Association encourage The Joint Commission and other hospital accreditation organizations recognized by major insurers to stipulate that all hospitals require hospital employees, physicians, patients, and visitors to wear a facial mask that completely covers the mouth and nose while within hospital walls (unless they are consuming food while "socially distanced," or unless they are patients in their own rooms while "socially distanced") (Directive to Take Action); and be it further

RESOLVED, That our AMA encourage publication of commentaries supportive of such regulations and standards in scientific journals and other publications (Directive to Take Action); and be it further

RESOLVED, That our AMA study the comparative disease-reduction effectiveness of various types of masks (N-95 masks versus "surgical" masks versus simple cloth facial coverings), toward potentially refining or making more specific any future mandates for facial coverings for persons while in-hospital as a visitor, patient or health care worker. (Directive to Take Action)

Fiscal Note: Moderate - between $5,000 - $10,000

Received: 10/14/20

References

1. https://www.cdc.gov/mmwr/volumes/69/wr/mm6937a6.htm?s_cid=mm6937a6_w Accessed September 19, 2020
2. https://www.cdc.gov/flu/about/burden/past-seasons.html Accessed July 17, 2020
3. https://www.cdc.gov/flu/about/season/flu-season.htm Accessed September 21, 2020
4. https://www.cdc.gov/coronavirus/2019-ncov/covid-data/pdf/covidview.pdf Accessed September 19, 2020
5. https://www.cdc.gov/flu/about/burden/2018-2019.html Accessed July 17, 2020
6. https://www.cdc.gov/mmwr/volumes/69/wr/mm6907a1.htm Accessed August 13, 2020
7. https://www.cdc.gov/mmwr/volumes/68/wr/mm6806a2.htm Accessed August 13, 2020
8. https://www.cdc.gov/mmwr/volumes/67/wr/mm6706a2.htm Accessed August 13, 2020
9. https://www.nbcnews.com/health/health-news/wearing-mask-has-become-politicized-science-says-it-shouldn-t-n1232604 Accessed August 13, 2020
10. Jha, AK. Accreditation, quality and making hospital care better. JAMA. 2018;320:2410-11

RELEVANT AMA POLICY

H-45.977, "Flu Protection Guidelines for Air Travel"

Our AMA supports the efforts of the Centers for Disease Control and Prevention to develop and disseminate guidelines on influenza and other contagious pathogens for all airline personnel and passengers.
(Sub. Res. 426, A-09; Reaffirmed: CSAPH Rep. 01, A-19)

H-440.831, "Protecting Patients and the Public Through Physician, Health Care Worker, and Caregiver Immunization"

1. AMA policy is that, in the context of a highly transmissible disease that poses significant medical risk for vulnerable patients or colleagues or threatens the availability of the health care workforce, particularly a disease that has the potential to become epidemic or pandemic, including influenza, and for which there is an available, safe, and effective vaccine, physicians, health care workers (HCWs), and family caregivers who have direct patient care responsibilities or potential direct exposure have an obligation to accept immunization unless there is a recognized medical reason to not be immunized. In scenarios in which there is a documented medical contraindication to immunization of a physician or HCW, appropriate protective measures should be taken.
2. Our AMA (a) encourages hospitals, health care systems, and health care providers to provide immunizations to HCWs against influenza and other highly transmissible diseases, at no cost to the employee, both for their own protection and to reduce the risk of infectious disease transmission to others; and (b) encourages health care institutions to develop mechanisms to maximize the rate of influenza immunization for HCWs, including the option of making immunization a condition of employment.
(Res. 8, A-15; Modified: CSAPH Rep. 1, I-15)

REPORT 4 OF THE COUNCIL ON MEDICAL EDUCATION (November 2020)
Preparedness for Pandemics Across the Medical Education Continuum
(Informational)

EXECUTIVE SUMMARY

As the coronavirus (COVID-19) spread throughout the United States, the nation's medical education community was forced to prepare for a variety of issues across the medical education continuum. While the 2017 Department of Health and Human Services Pandemic Influenza Plan offered guidance on how to respond to a pandemic, education, including medical education at all levels, was not included as a distinct domain that needed to be supported with planning. At the March 15, 2020, meeting of the Council of Medical Education, members decided to develop an informational report on preparedness for pandemics across the medical education continuum in the context of COVID-19 for the November 2020 House of Delegates meeting. This informational report provides a framework for preparedness for pandemics and other large-scale public health emergencies across medical education based on lessons learned from the COVID-19 pandemic.

This report provides an overview of COVID-19 in the United States and discusses the following:

- The impact of COVID-19 on U.S. undergraduate medical education (UME),
- The impact of COVID-19 on U.S. graduate medical education (GME),
- The impact on international medical graduates entering GME programs in the U.S.,
- The impact of COVID-19 on continuing medical education (CME) in the U.S.,
- The impact of COVID-19 on mental health of students, residents, and physicians, and
- Efforts by key stakeholders to address issues in medical education, training, licensure, and credentialing.

The Council on Medical Education is committed to best equipping individuals for success at various points in their medical career while ensuring patient safety. As such, the Council on Medical Education anticipates there will be evolving issues related to COVID-19 and will continue to monitor the evolution of these issues.

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 4, November 2020

Subject: Preparedness for Pandemics Across the Medical Education Continuum

Presented by: Liana Puscas, MD, MHS, Chair

INTRODUCTION

The first confirmed coronavirus (COVID-19) case in the United States was reported on January 21, 2020. As COVID-19 increasingly spread throughout the United States, the nation's medical education community was forced to prepare for a variety of issues across the medical education continuum, including, but not limited to:

- Conscientious oversight of the deployment of medical students;
- Recommended trajectory for medical students transitioning from graduation to residency;
- Student and trainee movement across geographic areas for interviews and clinical rotations;
- Field promotion of fellows to attending roles;
- Access to, and instruction in, the use of adequate personal protective equipment;
- Accreditation, licensure, examination, and certification requirements;
- Flexibility in graduate medical education reimbursements;
- Guidelines for volunteer clinical work;
- Maintaining standards for credentialing and competencies during this time of emergency;
- Continuing education offerings for practicing physicians.

Based on lessons learned from the COVID-19 pandemic, the Council on Medical Education offers this informational report to provide a framework for preparedness for pandemics and other large-scale public health emergencies across the medical education continuum.

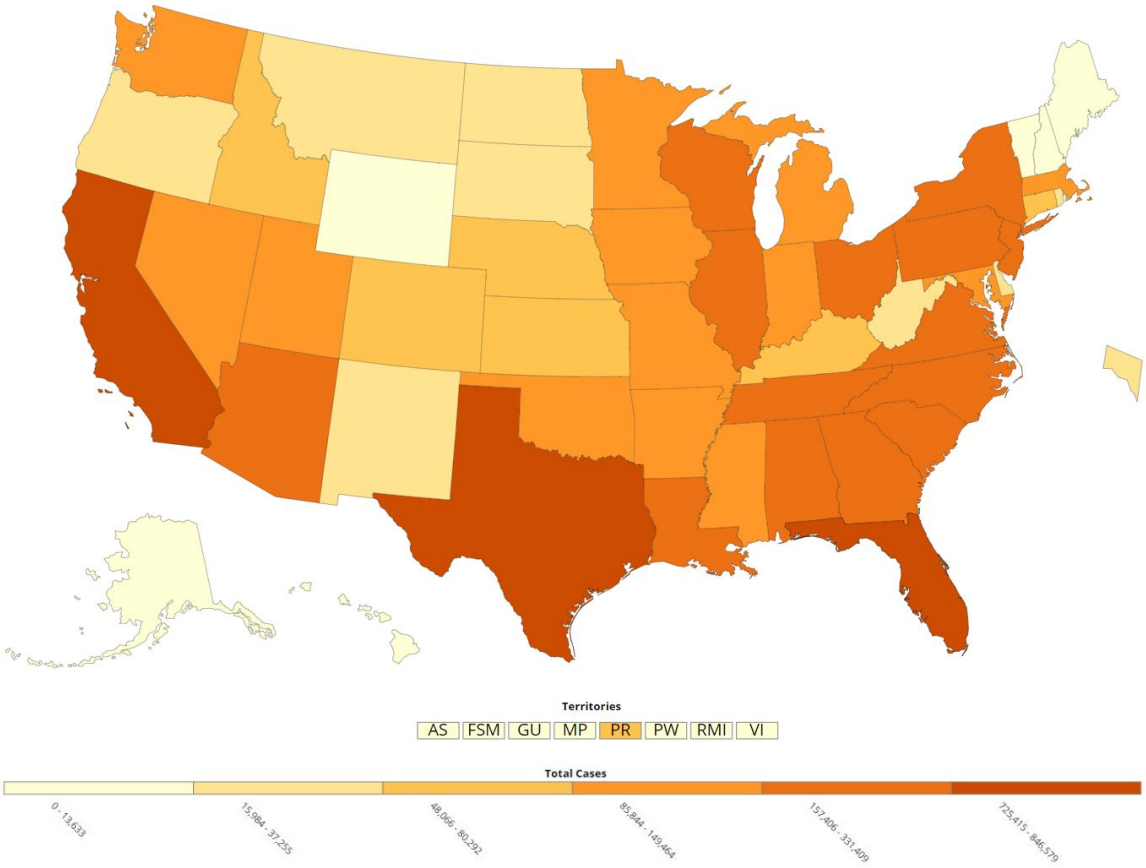
OVERVIEW OF COVID-19 IN THE UNITED STATES

In late December 2019, officials in Wuhan, the capital of China's central Hubei province, confirmed dozens of cases of pneumonia from an unknown cause in the region.[1] In January 2020, the outbreak was confirmed as a new coronavirus, and on March 11, the World Health Organization declared the outbreak of coronavirus (COVID-19) to "be characterized as a pandemic."[2] The first confirmed COVID-19 case in the United States was reported on January 21, 2020.[3] The outbreak initially appeared contained through February; however, by mid-March, transmission of SARS-CoV-2, the virus that causes COVID-19, had accelerated, with rapidly increasing case counts indicating established transmission in the United States. Factors that contributed to the rapid acceleration of the spread of COVID-19 included continued importation of the virus by travelers infected elsewhere; attendance at professional and social events, which amplified the transmission of COVID-19 in the host locations and multistate spread; introduction of the virus into facilities or settings prone to amplification such as long-term care facilities and high-density urban areas; and challenges in virus detection, including limited testing, emergence

during the peak months of influenza circulation and influenza and pneumonia hospitalizations, and other cryptic transmission including from persons who were asymptomatic or presymptomatic.[3]

As of October 12, 2020, a total of 7,740,934 cases and 214,108 deaths in the United States were reported to the Centers for Disease Control and Prevention (CDC) since January 21, 2020. The states with the highest number of cases include California (846,579); Texas (792,478); Florida (725,415); New York (475,540) and Georgia (331,409). New York City leads the country in the number of total cases (251,618) in a city.[4] The map in Figure 1 highlights the total number of COVID-19 cases in the U.S. reported to the CDC by state/territory.

Figure 1 Total number of COVID-19 Cases in the US by state/territory reported to the CDC as of September 15, 2020



Source: CDC COVID Data Tracker, 2020

As the number of confirmed cases in the United States continued to grow, so did concern for the hospitals and health care facilities' capacity to respond to the pandemic. In 2005, the U.S. Department of Health and Human Services (HHS) developed the inaugural Pandemic Influenza Plan, which was most recently updated in 2017 to model the potential health care impact of moderate and severe influenza pandemics.[5] It suggested that a moderate pandemic would infect about 64 million Americans, with about 800,000 (1.25%) requiring hospitalization and 160,000 (0.25%) requiring beds in the intensive care unit (ICU). The plan also suggested that a severe pandemic would dramatically increase these demands. The 2017 Plan identified the following seven domains to support planning for the next decade:

- Surveillance, epidemiology, and laboratory activities;
- Community mitigation measures;
- Medical countermeasures: diagnostic devices, vaccines, therapeutics, and respiratory devices;
- Health care system preparedness and response activities;
- Communications and public outreach;
- Scientific infrastructure and preparedness; and
- Domestic and international response policy, incident management, and global partnerships and capacity building.

These domains expanded upon the original four key pandemic response elements of the original 2005 plan to reflect an end-to-end systems approach to improving the way preparedness and response are integrated across sectors and disciplines, while remaining flexible for the conditions surrounding a specific pandemic.[6] Of note, education, including medical education at all levels, was not included as a distinct domain that needed to be supported with planning, which complicated the development of a strategic response.

According to the American Hospital Association, there were 5,198 community hospitals and 209 federal hospitals in the United States in 2018. In community hospitals, there were 792,417 beds, with 3,532 emergency departments and 96,500 ICU beds, of which 23,000 were neonatal and 5,100 pediatric, leaving just under 68,400 ICU beds of all types for the adult population.[6] The extraordinary and sustained demands of responding to patients affected by COVID-19 on public health, health systems, and providers of essential community services created the need to ration medical equipment and interventions.[7] The earliest example was the near-immediate recognition that there were not enough high-filtration N-95 masks for health care workers, prompting contingency guidance on how to reuse masks designed for single use.[8] In addition, acute care hospitals in the United States currently have about 62,000 full-function ventilators and about 98,000 basic ventilators, with an additional 8,900 in the Office of the Assistant Secretary for Preparedness and Response Strategic National Stockpile.[9] While all hospitals have some lifesaving ventilators, that number of available ventilators is proportional to the number of hospital beds in the institution. As a surge of need develops in a particular community, all hospitals in the area then compete for a finite number of resources, which could lead to difficult decisions regarding who gets access to a ventilator and who does not.[10]

To prevent overburdening U.S. hospitals and health care facilities, immediate efforts were implemented to slow the spread of COVID-19. This was known as “flattening the curve.” These efforts included strict social distancing practices and stay-at-home orders. Social distancing has been identified as the most effective preventive strategy since the emergence of COVID-19 pending development of a vaccine, treatment, or both.[11] California Governor Gavin Newsom was the first governor to issue a stay-at-home order on March 19, and by early April many states had restrictions in place to mitigate the spread of the disease.[12]

THE IMPACT OF COVID-19 ON U.S. UNDERGRADUATE MEDICAL EDUCATION

Prior to COVID-19, most medical schools convened students in physical settings during the first 12 to 18 months of classes for interactive problem-solving or discussions in small groups, the students’ physical presence in both inpatient and outpatient settings being an accepted tenet of early clinical immersion experiences and the clerkship curriculum. The last 18 months of medical school may be individualized, with students participating in advanced clinical rotations, subinternships prior to residency, or scholarly projects. While efforts to provide individualized

instruction for asynchronous learning existed prior to COVID-19, students still convened in-person for small-group interactions, laboratory sessions, simulations, and technology sessions, as well as for clinical instruction with standardized patients and in authentic patient care environments.[13] The advent of strict social distancing altered undergraduate medical education in a multitude of ways. The traditional classroom experience shifted to virtual instruction, which severely limited on-campus activities and interactions, to minimize gathering in large groups and spending prolonged time in close proximity with faculty, staff, and students in spaces such as classrooms, learning studios, lecture halls, or small-group rooms. These changes also required faculty to rethink how they teach.

On March 17, 2020, the Association of American Medical Colleges (AAMC) issued a guidance document recommending that member schools suspend medical student participation in activities that involve patient contact.[14] The high probability that medical students in the hospital would be exposed to COVID-19 and the need to conserve personal protective equipment (PPE) seemed to outweigh the educational benefits of students' participation. By decreasing non-essential personnel in health care settings, including medical students, medical schools contributed to national and global efforts to "flatten the curve."[15]

With the removal of students from clinical sites, medical schools quickly developed curricula for their clinical students who were unable to see patients in person. For example, a teaching hospital affiliate of the University of Minnesota Medical School created a database of about 1,400 patients at risk of SARS-CoV-2 infection. The hospital implemented a system to send daily emails to these patients asking about COVID-19 relevant symptoms, such as fever, cough, and shortness of breath. Any patient who reported one or more of the symptoms would then receive a call from a third- or fourth-year medical student. The student would take a history and staff the patient with a supervising resident. Similarly, the Boonshoft School of Medicine in Ohio created an elective in which students worked through online modules on psychological first aid and behavioral activation. Each student was then paired with an isolated older adult in the community with whom they made weekly virtual social visits to ensure patient access to food, water, shelter, and medications, as well as the ability to pay bills. In another example, the Association of Professors of Gynecology and Obstetrics (APGO) at the University of Vermont Larner School of Medicine developed a two-week elective using APGO's medical student educational objectives and vast library of basic science videos. Students completed about six video cases per day in obstetrics and gynecology, sexuality, intimate partner violence, and sexual assault; with each requiring critical thinking and the development of differential diagnoses. An assessment of the student's knowledge was done through APGO-developed quizzes.[16] The AMA Medical Education Department curated a crowdsourced list of potential resources—both free and paid—for virtual or remote clinical and non-clinical learning (https://www.ama-assn.org/delivering-care/public-health/covid-19-resources-medical-educators). The AMA did not review or endorse any of the listings, aside from those created directly by the AMA. Rather, they were are provided as a resource to help medical educators determine the best ways to teach remote learners during the coronavirus pandemic.

Medical students also identified numerous ways to volunteer their time and efforts to support health care teams and patients during COVID-19. For example, medical students at the University of Texas Southwestern launched a wave of volunteerism as campus educational programs and research activities scaled back amid concerns over COVID-19. These students collaborated with institutional leadership to identify immediate as well as long-term needs to support and supplement the efforts of front-line clinical teams and staff; these efforts, which aligned with national guidelines for medical student volunteerism, allowed learners to provide maximum support while minimizing their own risk. Volunteer activities included helping to screen hospital visitors, answering phones, moving furniture, and delivering supplies.[17] In Chicago, students from

Northwestern University, Rosalind Franklin University of Medicine and Science, University of Chicago, Rush Medical College, Loyola University, Midwestern University, and University of Illinois at Chicago recruited more than 500 volunteers for the COVID Rapid Response Team Chicago to secure PPE and distribute them to the front lines of the epidemic, in addition to working to boost support for blood drives, performing laboratory tests, and organizing food drives for health care workers who did not have time to buy groceries.[18] Additionally, the AAMC established *iCollaborative (*https://icollaborative.aamc.org/collection/covid-19-student-service-projects*)* a compendium of student volunteer and relief initiatives

COVID-19 also prompted the creation of a process for early graduation of final-year medical students. On March 24, 2020, the Grossman School of Medicine at New York University (NYU) became the first medical school in the United States to announce an offer of early graduation to eligible students. The school's decision came as its hospitals were overwhelmed with an increasing number of COVID-19 patient cases, including in critical care.[19] Similar actions were taken by the medical schools at Tufts University, Boston University, and the University of Massachusetts following a request from the state of Massachusetts to help expand the medical work force. Massachusetts also provided 90-day provisional licenses for early graduates, allowing almost automatic entry into clinical work and making approximately 700 medical students in the state eligible to offer patient care at least eight weeks earlier than expected.[20]

While innovative efforts to respond to the health care demands of COVID-19 were rapidly and successfully implemented in some areas, uncertainty in other aspects of medical education proved problematic for medical students including administration of medical college admission and licensing examinations as well as the impact of testing center closures.

Aspiring premed college students were also impacted by disruptions to medical education. For example, the Medical College Admission Test (MCAT) is required by the AAMC to be taken in person. Due to COVID-19, the AAMC cancelled MCATs scheduled for March, April, and most of May, and the lack of communication regarding the cancellation of tests proved to be problematic. On May 7, the AAMC opened its MCAT scheduling system for applicants who needed to reschedule or make their initial testing appointment. However, the system was not prepared to handle the volume of individuals trying to schedule their exams, and it crashed. Additionally, those who needed special testing accommodations found the process to secure the necessary accommodations to be difficult. Additionally, MCAT test-taking stations were to be set up in accordance with social and physical distancing guidelines: Eight people can take the test together at one time and masks are required, among other changes. However, students expressed concern that the changes were insufficient to ensure safety or equality in taking the test and, in July, it was reported that three students had tested positive for COVID-19 from 2 to 7 days after taking the in-person MCAT exam.[20]

On March 18, 2020, Prometric, the private company that administers the United States Medical Licensure Examinations® (USMLE®) Step 1, Step 2 Clinical Knowledge (CK), and Step 3 exams closed its test centers in the U.S. and Canada through May 1, 2020. On May 1, 2020, Prometric resumed testing in a limited capacity in the U.S. and Canada for essential services programs and opened some of its locations for USMLE testing at 50% capacity. To accommodate this change, the company randomly selected thousands of appointments for cancellation.[21] On June 1, 2020, Prometric resumed testing, where possible, for all programs in numerous states and regions across North America. It is estimated that cancellations affected 17,000 medical students and residents through mid-May. Criticisms of Prometric's administration of the exams describe the process as "chaotic, poorly communicated, discriminatory, and outright harmful."[22] Inconsistent and often conflicting information from Prometric and the USMLE resulted in confusion and frustration for

test-takers. Last-minute cancellations of these exams continued through early June, sometimes just hours before exams were to start. Students also reported arriving at testing centers for exams, only to find them closed. In response to demand for increased testing capacity, USMLE developed a phased approached to expand testing centers. Phase one established a small number of testing sites in medical schools using Prometric equipment for different geographical regions across the U.S. Phase two sought to determine the school's level of interest and ability to participate in event-based testing to administer Step 1 and Step 2 CK among Liaison Committee on Medical Education (LCME)-accredited medical schools and American Osteopathic (AOA)-accredited medical schools.[22]

The situation also exposed inherent inequities in the system. Those who required testing accommodations were even further disadvantaged as they could not use the online system. People with learning disabilities, mobility impairments, type 1 diabetes, and anyone who was pregnant or breastfeeding was required to reschedule their exam by phone during business hours and often encountered hours-long waits. Additionally, equity concerns were raised when the National Board of Medical Examiners (NBME) announced that an abbreviated version of the examinations would be made available to those participating in event-based testing held at medical schools in July and August. The proposed changes would have cut approximately two hours from the total eight-hour test time. The shorter version also included the elimination of experimental questions, which are not scored but are used to determine whether they are valid indicators of a test-taker's performance. This plan met with an immediate backlash, and the USMLE announced on June 9, 2020, that a reduced-length test would not be offered to students taking Step 1 and Step 2 CK exams.[23]

Additionally, on May 26, 2020, the USMLE announced that Step 2 Clinical Skills (CS) exams would be suspended for a period of 12 to 18 months.[23] Step 2 CS aims to examine clinical skills in a performance-based setting; its primary purpose is medical licensure. Additionally, Step 2 CS is an important metric for international medical graduates looking to match into a U.S. residency program. Successful completion of Step 2 CS is a graduation requirement to begin the first year of residency. Suspension of the exam made meeting that requirement impossible for some medical students in the upcoming residency application cycle. A variety of factors influenced the suspension of Step 2 CS, including discouragement of non-essential travel as well as health and safety risks associated with using standardized patients.[24]

Similar to Prometric, the National Board of Osteopathic Medical Examiners' (NBOME) National Center for Clinical Skills Testing (NCCST), which administers the COMLEX-USA Level 2-Performance Evaluation, also temporarily closed its testing center due to COVID-19. On June 3, 2020, the NBOME announced its decision to postpone resumption of COMLEX-USA Level 2-PE testing until September 1, 2020. The scheduling change has complicated the ability of some students with 2021 graduation dates to complete examinations by the end of the 2020-21 academic year and has impacted DO students differently than their MD student counterparts. Following that decision, the Commission on Osteopathic College Accreditation (COCA) announced its decision to allow deans at colleges of osteopathic medicine to waive the requirement to pass the COMLEX Level 2-PE clinical skills exam for 2021 graduates.[25] Concerns have been raised by both DO and MD students regarding the differences in NBME & NBOME policies regarding testing during COVID-19.

The process for residency interview and selection was also impacted by COVID-19. The Coalition for Physician Accountability (CPA)—a national group of organizations concerned with the oversight, education, and assessment of medical students and physicians throughout their medical careers and of which the AMA is a member—issued recommendations concerning three major issues facing applicants and training programs as they prepare for the 2020-2021 residency

application cycle: away rotations, in-person interviews for residency, and the ERAS® (Electronic Residency Application Service) timeline. Specifically, the CPA recommended discouraging away rotations with limited exceptions; committing to online interviews and virtual visits for all applicants rather than in-person interviews for the entire cycle; and delaying both the opening of ERAS® for residency programs and the release of the medical student performance evaluation.[26]

These recommendations were not without consequences. For example, participation in away rotations is especially common within the competitive surgical subspecialties. In many of these fields, 50 percent or more of students completing away rotations match at a program where they rotated so suspension of these rotations could weaken students' applications.[27] Furthermore, as regions of the United States lift social distancing measures at different times throughout the coming year, a potential inequity could be created if some institutions accept external students for clinical rotations while other programs do not. Additionally, students attending school in an area where they must remain quarantined may be disadvantaged if students in other geographic areas are able return more quickly to clinical activities and travel to externship rotations.[27] Additional concerns were raised regarding the removal of financial constraints from in-person interviews, leading to a rise in qualified applicants over-applying for the limited number of available residency slots. Prior to COVID-19, the number of interviews an applicant could attend was limited by time and travel expense, but these constraints will be less relevant with virtual interviews. Students who are fearful of how their applications will be evaluated may respond by applying to even more programs and accepting more interview invitations which could lead to an increase in both the number of unmatched applicants and unfilled programs.[28]

To support and protect medical students during this time of uncertainty, the AMA Council on Medical Education developed guiding principles for conscientious oversight of the deployment of medical students. (see Appendix 2).

THE IMPACT OF COVID-19 ON U.S. GRADUATE MEDICAL EDUCATION

The process for onboarding early graduation medical students into residency programs was an evolving one beginning in April 2020. At NYU Langone Health, early graduates were initially anticipated to be supplemental to the teams caring for non-COVID-19 patients. However, due to the demand, these graduates were integrated into the health system's internal medicine and emergency medicine departments regardless of their match specialty. While both the current residents and early graduates expressed concerns about the transition from medical school to the wards during a national pandemic, NYU created a boot camp for them to address circumstances specifically related to COVID-19. The curriculum focused on the proper use of PPE, treatment protocols related to the virus, physician and patient isolation, and the moral distress physicians may feel treating COVID-19 patients. NYU also paired early graduates with residents who were not on service during the boot camp as part of the orientation.[29] To conform with their Match agreements, early graduates were not part of any specific residency program at NYU. Under an executive order from New York Governor Andrew Cuomo, graduates of medical schools accredited by the LCME and AOA, and matched into an Accreditation Council for Graduate Medical Education (ACGME)-accredited residency program in or outside New York, were eligible to temporarily practice medicine in New York under the supervision of a licensed physician prior to reporting to their matched program and did not have to apply for a license to do so.

Residents have been on the front lines during the COVID-19 response and like other health care workers, experienced some of the highest exposure risk situations and have the same need for PPE. Unfortunately, health care systems across the United States have reported substantial PPE shortages since the start of COVID-19 pandemic, compromising their ability to keep health care

professionals (including residents) safe while treating increasing numbers of patients.[30] The situation became so dire that some providers utilized social media with tags like #GetMePPE to raise public awareness. The Society for Healthcare Epidemiology of America (SHEA) conducted a survey in April 2020, among epidemiologists and infectious disease specialists at health care facilities in the United States, Canada, and abroad regarding how their facilities were adapting their PPE policies as shortages and knowledge about the coronavirus evolved. SHEA found that 52 percent of respondents said they had to ask health care workers in certain hospital units to use the same disposable N95 respirator for a whole day, 71 percent who reported PPE at "limited" or "crisis" levels practiced extended respirator use or reuse, and 48 percent said they reprocessed respirators. Some health care workers used surgical or cloth masks over their respirators and stored them in a paper bag to preserve them for reuse. Moreover, 59 percent of respondents who said their hospitals' supply of gowns was "limited" or "crisis-level" were having to wear gowns for an extended time or reuse them, and 13 percent said they were making their own PPE, including face shields, eye shields, coveralls, gowns, and surgical masks.[31]

Involvement of residents and fellows in COVID-19 care has varied by specialty and rapidly evolved. Some of these residents may have cared for patients with COVID-19 during assigned rotations. Others were asked to assume roles that were not a prescribed part of their specialty training, being deployed to medical units and emergency departments away from their roles in operating rooms and outpatient clinics. Residents may have been compelled to acquire skills on the job that were not an expectation when they began residency. Furthermore, time spent providing these services may not meet the requirements for graduation and certification in their discipline, leading to concerns that their training may need to be extended when routine clinical duties resume. Additionally, some subspecialty fellows were asked to serve in attending physician roles in their core disciplines (e.g., gastroenterology fellows serving as general internal medicine attending physicians). While they may have been board-certified in these specialties, their compensation and malpractice coverage were not guaranteed to be commensurate with the role. This is important, since resident salaries are low compared to those of other health care workers, particularly on an hourly basis. Given average resident salaries and an 80-hour work week, resident salaries equate to approximately $15 to $20 per hour. In addition, residents carry significant debt loads related to their undergraduate medical education. The average student loan burden at medical school graduation exceeds $200,000.

COVID-19 also highlighted the need for flexibility in GME reimbursement. Medicare GME affiliated group agreements are often in place at the beginning of the academic year (i.e., prior to July 1) to transfer cap slots between institutions and allow the host institution to claim the inbound rotator for reimbursement. If a rotation is canceled, the home hospital may find itself claiming more resident full-time equivalents (FTEs) than its cap allows, and the host hospital may find itself with more cap slots than resident FTEs it has to claim, impacting the GME reimbursement for both. It should be noted, however, that it is possible to amend a Medicare GME affiliated group agreement during the ongoing academic year (i.e., prior to June 30), provided that any changes are made only to the original parties to the agreement. Additionally, financial issues may arise if residents become "off cycle" and require additional time to complete their training. Residents are only eligible for funding for the accredited length of their program, and additional time is not reimbursed by the Centers for Medicare & Medicaid Services (CMS).

On top of the issues already presented, some residents who became ill and/or required quarantine while caring for COVID-19 patients learned that their residency program leave policies did not adequately account for these unplanned absences during the pandemic response. In response to the concerns of residents and fellows, the AMA developed guidance for residency programs to

adequately address the personal, physical, and economic stresses that trainees face. Some key points of the guidance include:

- Residents who become ill as a result of their participation in the COVID-19 response must not be required to use vacation or personal time off while ill or quarantined.
- Residents who require leave under these circumstances must continue to receive their salary and benefits.
- Residents deployed to clinical areas unfamiliar to them must receive appropriate training and supervision for the tasks they will be asked to perform.
- Clinical work that residents perform during the pandemic response should be considered in assessments of a trainee's qualifications for program completion. Where possible, credit should be given for the work residents are doing during this time.
- Bodies overseeing certification requirements should allow flexibility in assessments of the competence of trainees, in light of the pandemic. Where possible, these assessments should not delay program completion nor eligibility for certification.
- Fellows who assume attending physician roles in core disciplines in which they are licensed and certified should receive pay and benefits commensurate with these roles. The impact of this activity on progress toward completion of the training program must be openly discussed with fellows prior to them assuming these responsibilities.

The guiding principles to protect resident and fellow physicians responding to COVID-19 are featured in Appendix 3.

THE IMPACT OF COVID-19 ON INTERNATIONAL MEDICAL GRADUATES ENTERING GME PROGRAMS IN THE U.S.

As states called for more doctors to help meet the demand of the growing number of COVID-19 cases, non-U.S. citizen international medical graduates (IMGs) faced unique challenges that prevented them from responding due to visa limitations. Currently, non-U.S. citizen IMGs with H-1B visas and J-1 waivers face restrictions on where they can work.[32] Furthermore, the U.S. Citizenship and Immigration Services (USCIS) announced on March 20, 2020, its suspension of premium processing for all Form I-129, Petition for a Nonimmigrant Worker and I-140, Immigrant Petition for Alien Workers due to the coronavirus (COVID-19) pandemic.[33] This suspension was anticipated to exacerbate physician shortages, particularly in rural areas, and at the leading academic and research organizations that depend on health care provided by non-U.S. citizen IMGs. On April 9, 2020, U.S. Senators Dick Durbin (D-IL), Tammy Duckworth (D-IL), Amy Klobuchar (D-MN) along with colleagues in both the House and the Senate wrote a bipartisan, bicameral letter urging the Administration to resume premium processing for physicians seeking employment-based visas.[34] On May 29, 2020, USCIS announced it would resume premium processing for Form I-129 and Form I-140 in phases beginning June 1, 2020.[35] Moreover, USCIS announced that non-U.S. citizen IMGs can deliver telehealth services during the public health emergency without having to apply for a new or amended Labor Condition Application and that it is temporarily waiving certain immigration consequences for failing to meet the full-time work requirement.

On June 22, 2020, the President of the United States issued a Presidential Proclamation. As it pertains to physicians, the Proclamation states that there are exemptions for:

- Sec. 4(a)(i)… [individuals who] are involved with the provision of medical care to individuals who have contracted COVID-19 and are currently hospitalized; are

involved with the provision of medical research at United States facilities to help the United States combat COVID-19…

- Or Sec. 3(b)(iv) any alien whose entry would be in the national interest as determined by the Secretary of State, the Secretary of Homeland Security, or their respective designees.

J-1 physicians have been given an exemption from the June 22, 2020 Proclamation. However, the Proclamation still applies to most H-1B physicians. Per the AMA letter to Vice President Pence sent on May 4, 2020, urging the Administration to allow J-1, H-1B, and O-1 International Medical Graduates (IMGs) to be exempt from any future immigration bans or limitations, AMA has been aware of, and advocating against, any physician immigration bans since before this Proclamation was issued.

In response to the Proclamation, the Department of State (DOS) issued a statement that "as resources allow, embassies and consulates may continue to provide emergency and mission-critical visa services. Mission-critical immigrant visa categories include applicants who may be eligible for an exception under these presidential proclamations, such as…certain medical professionals." As such, on June 26, 2020, the AMA sent a letter to the Department of Homeland Security (DHS) and the Department of State strongly urging the Administration to consider J-1 and H-1B IMGs and their families' entry into the U.S. to be in the national interest of the country so that families can remain together and non-U.S. citizen IMG physicians can immediately begin to provide health care to U.S. patients. The AMA understands that every physician is mission critical, especially at this time. Moreover, the AMA spearheaded a sign-on letter for specialty societies. The letter urges the DOS and DHS to issue clarifying guidance pertaining to the Proclamation by directing Consular Affairs to advise embassies and consulates that H-1B physicians and their dependent family members' entry into the U.S. is in the national interest of the country.

On July 6, 2020, the Student and Exchange Visitor Program (SEVP) announced that nonimmigrant F-1 and M-1 students attending schools operating entirely online could not take a full online course load and enter or remain in the United States. In response, on July 9, 2020, the AMA sent a letter urging the Administration to withdraw its modifications to the temporary exemptions for nonimmigrant students taking online classes due to the pandemic for the Fall 2020 semester, so that medical students seeking to study in the U.S. on an F-1 visa could enter or remain in the country. In part due to the advocacy efforts of the AMA, on July 14, 2020, the Trump Administration rescinded the directive.

In addition to advocating for non-U.S. citizen IMGs, the AMA developed guidance to help ensure that visa-related issues do not prevent non-U.S. citizen IMGs from continuing to care for patients during COVID-19; this document is featured in Appendix 4.

THE IMPACT OF COVID-19 ON EFFORTS TO INCREASE DIVERSITY AMONG MEDICAL STUDENTS AND RESIDENTS

As medical school enrollment doubled over the past two decades, the percentage of entering under-represented students actually fell by 16%.[36] Even prior to COVID-19, national data suggested medical education was already losing ground with respect to racial and ethnic parity. Diversity efforts are particularly vulnerable during times of disruption; hence institutions must heighten their commitment of attention and resources. Current disruptions related to COVID-19 may amplify underlying inequities in our educational system, similar to the pandemic's role in exacerbating health inequities. Broader initiatives to foster long-term change in medicine and address inequities in the entire United States educational system are imperative and are underway. To support these

efforts, the AMA developed guidance to protect underrepresented students and residents during COVID-19; this document is featured in Appendix 5.

THE IMPACT OF COVID-19 ON CONTINUING MEDICAL EDUCATION IN THE U.S.

With the increased demand for physicians to respond to COVID-19 cases, many physicians who had left practice had a desire to return. Like many professionals, physicians take time off to raise children, care for sick family members, or recover from their own illnesses. Some also switch to non-clinical jobs. But efforts to return to medicine are more difficult than in most careers, as clinical change occurs quickly. Drugs, devices, and surgical techniques that were standard a decade ago may now be obsolete, and a returning doctor's skills may simply be outdated. The AMA defines physician re-entry as "a return to clinical practice in the discipline in which one has been trained or certified following an extended period of clinical inactivity not resulting from discipline or impairment." Re-entry is a complicated, time-consuming, and expensive process. While inactive physicians may not lose their licenses, they must complete a physician reentry program if they stop practicing for a certain length of time (it varies by state but averages about three years). Unfortunately, there is a dearth of training programs for physicians who have already completed residency training and need retraining.[37] Reentry programs also cost most returning physicians between $3,000 and $10,000 per month, not including travel and relocation costs for the duration of the training. While each program has different features, they all require some type of assessment to determine the physician's skill set and clinical competence. After completing a reentry program, physicians who have let their license lapse have to petition their state board to reactivate it. Once licensure is granted, reentering physicians can then obtain hospital privileges and insurance coverage.

Likewise, many senior and retired physicians may have either wanted to return to work or were called upon to do so during the COVID-19 outbreak, which raised additional considerations. For example, the licensure status of retired physicians varies by state. In some states retired physicians maintain their regular license, while others create a separate category for retired or inactive physicians, and still others have no license category for retired physicians. The path to reentry from a licensing perspective also varies. For senior and retired physicians who maintain active licenses, there are no licensure restrictions on re-entry to practice. For physicians who maintain an inactive, retired physician, or similar license, their state may have temporarily waived any barriers to re-entry due to COVID-19.

The issue of whether senior physicians should be providing direct patient care for COVID-19 patients is a complex one that must balance a number of factors, such as whether the age of the physician and their family members puts them in a high risk group, whether PPE is readily available, and whether they can contribute meaningfully in a non-direct patient care role.

The Federation of State Medical Boards (FSMB) has developed a repository of state-issued guidelines for expediting licensure for health care workers whose licenses are inactive or expired. As of June 9, 2020, 39 states issued guidelines waiving some of the requirements for physician reentry in response to COVID-19, though most require that physicians be recently retired (within the last two to five years).[38] Forty-nine state medical boards have policies or regulations that dictate what physicians need to do to reenter medicine after "an extended period of clinical inactivity." That period differs for each state but ranges from 1 to 10 years. After the designated time allotment, the board usually requires an evaluation before granting a license to practice medicine.

Additional factors that need to be considered for senior physicians looking to go back to work include professional and medical liability, clarification of roles, and the effect of income on

retirement status. The AMA developed a resource guide, featured in Appendix 6, to assist senior physicians as they consider these important issues.

THE IMPACT OF COVID-19 ON THE MENTAL HEALTH OF STUDENTS, RESIDENTS, AND PHYSICIANS

Critical stressors for medical students, residents, and physicians during COVID-19 are the uncertainty surrounding the pandemic; trauma associated with knowing there is a risk to one's own health; and concern for the safety and well-being of one's patients, as well as one's family and friends.[39] Many students reported moral distress associated with watching patients in isolation from loved ones and described feeling distant from patients while wearing PPE as well as disappointment and frustration about not being able to help. Safety concerns among residents and fellows are complicated by the recognition that their decisions had implications for their loved ones and others outside the hospital. Some worried about transmitting infection to others in their homes. Feelings of vulnerability were exacerbated by rapidly changing conditions and recommendations. The fear of potential PPE shortages was prominent. Trainees not providing COVID-19 care because of personal health issues expressed guilt that colleagues had to step in. These feelings of anxiety and vulnerability among students and trainees compete internally with a desire and commitment to serve the sick.[39] A recent study reported in *JAMA* found that front-line health care workers who have been exposed to COVID-19 have a high risk of developing unfavorable mental health outcomes and may need psychological support or interventions.[41] However, many students, residents, and physicians continue to do more than has been required of them for patient care and within the community, despite the risks and challenges of COVID-19.

The AMA developed a guide, "Caring for our caregivers during COVID-19," for health system leadership to consider when supporting their physicians and care teams during COVID-19. The guide provides practical examples and strategies to encourage well-being and improve physician satisfaction as well as valuable strategies that address workload redistribution, institutional policies, meals, childcare, attention to emotional and mental well-being, and connecting with others. This guide is featured in Appendix 7.

EFFORTS BY KEY STAKEHOLDERS TO ADDRESS ISSUES ACROSS THE CONTINUUM OF EDUCATION, TRAINING, LICENSURE, CERTIFICATION, AND CREDENTIALING

The LCME is officially recognized by the U.S. Department of Education to accredit medical school programs leading to the MD degree in the United States and Canada. It is jointly overseen by the AAMC and AMA but is an independent organization. To achieve and maintain accreditation, a medical education program must meet the LCME accreditation standards and is required to demonstrate that their graduates exhibit general professional competencies appropriate for entry to the next stage of their training and that serve as the foundation for lifelong learning and proficient medical care. The LCME developed and disseminated numerous resources to offer guidance to medical schools during COVID-19. The LCME guiding principles are featured in Appendix 8.

The COCA accredits medical school programs granting the DO degree in the United States. COCA is recognized by the U.S. Department of Education as the accreditor of colleges of osteopathic medicine. COCA accreditation signifies that a college has met or exceeded the Commission's standards for educational quality. COCA developed and disseminated numerous resources to offer guidance to colleges of osteopathic medicine related to COVID-19. The guidance developed by COCA can be found on its website (https://osteopathic.org/accreditation/coca-covid-19/).

The National Resident Matching Program® (NRMP®), or The Match®, is a private, non-profit organization established to provide an orderly and fair mechanism for matching the preferences of applicants for U.S. residency positions with the preferences of residency program directors. NRMP created Frequently Asked Questions (FAQs) to address questions regarding the applicant transition to GME during the COVID-19 crisis. FAQs developed by NRMP can be found on its website (http://www.nrmp.org/covid-faqs-2-2/)

The ACGME is an independent, not-for-profit, physician-led organization that sets and monitors the professional educational standards essential to preparing physicians who deliver safe, high-quality medical care to all Americans and monitors compliance with those standards. During COVID-19, the ACGME has monitored the needs of the GME community and provided guidance, clarification, and resources. ACGME resources specific to COVID can be found on its website (https://acgme.org/COVID-19/ACGME-Guidance-Statements).

The Educational Commission for Foreign Medical Graduates (ECFMG) assesses the readiness of IMGs to enter residency or fellowship programs in the United States that are accredited by the ACGME. The ECFMG also acts as the registration and score-reporting agency for the USMLE for IMGs. It conducts three examinations: Step 1, Step 2CK, and Step 2CS. The ECFMG certificate is issued to physicians who pass the three exams within seven years. The ECFMG developed resources and launched a COVID-19 specific newsletter during the pandemic. These resources are available on the ECFMG website (https://www.ecfmg.org/annc/covid-19-coronavirus.html).

The NBME is an independent, not-for-profit organization that serves the public through its high-quality assessments of health care professionals. The NBME is also a co-sponsor of the USMLE®. The NBME provided updates related to assessments during COVID-19 which can be found on its website (https://www.nbme.org/news/coronavirus-covid-19-assessment-information-and-updates)

The American Board of Medical Specialties (ABMS) is an independent, not-for-profit organization founded to set professional standards for physician practice and board certification. The ABMS and its 24 Member Boards aim to improve the quality of health care by elevating the discipline of specialty medicine through board certification. The ABMS developed numerous resources for diplomates and their fellow health care professionals which can be found on its website (https://www.abms.org/initiatives/covid-19-information/).

The FSMB is a national, non-profit organization that represents the state medical and osteopathic boards of the United States and its territories. FSMB also co-sponsors the USMLE®. The FSMB developed recommendations for medical license portability during COVID-19 and other resources which can be found on its website (https://www.fsmb.org/advocacy/covid-19/).

The CPA is a cross-organizational group of national medical education organizations, including the AMA, concerned with the oversight, education, and assessment of medical students and physicians throughout their medical careers. During COVID-19, the CPA created several work groups to develop common recommendations to address urgent issues related to the COVID-19 pandemic and physician education. “Maintaining Quality and Safety Standards Amid COVID-19” is a product of one of the work groups and offers guidance for health care administrators and credentialing staff members supporting the contributions of new or volunteer physicians during the COVID-19 pandemic. This product is featured in Appendix 9.

RELEVANT AMA POLICY

The AMA has developed several policies in response to addressing pandemics. These policies are featured in Appendix 1.

SUMMARY

The rapid spread of COVID-19 disrupted life, including medical education. Fortunately, the response of key stakeholders was equally rapid and multifactorial. Strategic planning for future pandemics needs to focus on equipping individuals at various points in their medical careers to redeploy while ensuring patient safety. As many of the issues presented in this report are interrelated, it will also be necessary for key stakeholders to collaborate to minimize negative unintended consequences for students, residents, physicians, and most importantly patients. The Council on Medical Education expects there to be evolving issues related to COVID-19 and will continue to monitor the evolution.

APPENDIX 1: RELEVANT AMA POLICY

9.2.1, "Medical Student Involvement in Patient Care"

Having contact with patients is essential for training medical students, and both patients and the public benefit from the integrated care that is provided by health care teams that include medical students. However, the obligation to develop the next generation of physicians must be balanced against patients' freedom to choose from whom they receive treatment.

All physicians share an obligation to ensure that patients are aware that medical students may participate in their care and have the opportunity to decline care from students. Attending physicians may be best suited to fulfill this obligation. Before involving medical students in a patient's care, physicians should:

(a) Convey to the patient the benefits of having medical students participate in their care.

(b) Inform the patients about the identity and training status of individuals involved in care. Students, their supervisors, and all health care professionals should avoid confusing terms and properly identify themselves to patients.

(c) Inform the patient that trainees will participate before a procedure is undertaken when the patient will be temporarily incapacitated.

(d) Discuss student involvement in care with the patient's surrogate when the patient lacks decision-making capacity.

(e) Confirm that the patient is willing to permit medical students to participate in care.

9.2.2, "Resident & Fellow Physicians' Involvement in Patient Care"

Residents and fellows have dual roles as trainees and caregivers. Residents and fellows share responsibility with physicians involved in their training to facilitate educational and patient care goals.

Residents and fellows are physicians first and foremost and should always regard the interests of patients as paramount. When they are involved in patient care, residents and fellows should:

(a) Interact honestly with patients, including clearly identifying themselves as members of a team that is supervised by the attending physician and clarifying the role they will play in patient care. They should notify the attending physician if a patient refuses care from a resident or fellow.

(b) Participate fully in established mechanisms in their training programs and hospital systems for reporting and analyzing errors. They should cooperate with attending physicians in communicating errors to patients.

(c) Monitor their own health and level of alertness so that these factors do not compromise their ability to care for patients safely. Residents and fellows should recognize that providing patient care beyond time permitted by their programs (for example, "moonlighting" or other activities that interfere with adequate rest during off hours) might be harmful to themselves and patients.

Physicians involved in training residents and fellows should:

(d) Take steps to help ensure that training programs are structured to be conducive to the learning process as well as to promote the patient's welfare and dignity.

(e) Address patient refusal of care from a resident or fellow. If after discussion, a patient does not want to participate in training, the physician may exclude residents or fellows from the patient's care. If appropriate, the physician may transfer the patient's care to another physician or nonteaching service or another health care facility.

(f) Provide residents and fellows with appropriate faculty supervision and availability of faculty consultants, and with graduated responsibility relative to level of training and expertise.

(g) Observe pertinent regulations and seek consultation with appropriate institutional resources, such as an ethics committee, to resolve educational or patient care conflicts that arise in the course of training. All parties involved in such conflicts must continue to regard patient welfare as the first priority. Conflict resolution should not be punitive, but should aim at assisting residents and fellows to complete their training successfully.

11.1.3, "Allocating Limited Health Care Resources"

Physicians' primary ethical obligation is to promote the well-being of their patients. Policies for allocating scarce health care resources can impede their ability to fulfill that obligation, whether those policies address situations of chronically limited resources, such as ICU (intensive care unit) beds, medications, or solid organs for transplantation, or "triage" situations in times of scarcity, such as access to ventilators during an influenza pandemic.

As professionals dedicated to protecting the interests of their patients, physicians thus have a responsibility to contribute their expertise to developing allocation policies that are fair and safeguard the welfare of patients.

Individually and collectively through the profession, physicians should advocate for policies and procedures that allocate scarce health care resources fairly among patients, in keeping with the following criteria:

(a) Base allocation policies on criteria relating to medical need, including urgency of need, likelihood and anticipated duration of benefit, and change in quality of life. In limited circumstances, it may be appropriate to take into consideration the amount of resources required for successful treatment. It is not appropriate to base allocation policies on social worth, perceived obstacles to treatment, patient contribution to illness, past use of resources, or other non-medical characteristics.

(b) Give first priority to those patients for whom treatment will avoid premature death or extremely poor outcomes, then to patients who will experience the greatest change in quality of life, when there are very substantial differences among patients who need access to the scarce resource(s).

(c) Use an objective, flexible, transparent mechanism to determine which patients will receive the resource(s) when there are not substantial differences among patients who need access to the scarce resource(s).

(d) Explain the applicable allocation policies or procedures to patients who are denied access to the scarce resource(s) and to the public.

H-140.900, "A Declaration of Professional Responsibility"

Our AMA adopts the Declaration of Professional Responsibility

DECLARATION OF PROFESSIONAL RESPONSIBILITY: MEDICINE's SOCIAL CONTRACT WITH HUMANITY

Preamble

Never in the history of human civilization has the well being of each individual been so inextricably linked to that of every other. Plagues and pandemics respect no national borders in a world of global commerce and travel. Wars and acts of terrorism enlist innocents as combatants and mark civilians as targets. Advances in medical science and genetics, while promising to do great good, may also be harnessed as agents of evil. The unprecedented scope and immediacy of these universal challenges demand concerted action and response by all.

As physicians, we are bound in our response by a common heritage of caring for the sick and the suffering. Through the centuries, individual physicians have fulfilled this obligation by applying their skills and knowledge competently, selflessly and at times heroically. Today, our profession must reaffirm its historical commitment to combat natural and man-made assaults on the health and well being of humankind. Only by acting together across geographic and ideological divides can we overcome such powerful threats. Humanity is our patient.

Declaration

We, the members of the world community of physicians, solemnly commit ourselves to: (1) Respect human life and the dignity of every individual. (2) Refrain from supporting or committing crimes against humanity and condemn any such acts. (3) Treat the sick and injured with competence and compassion and without prejudice. (4) Apply our knowledge and skills when needed, though doing so may put us at risk. (5) Protect the privacy and confidentiality of those for whom we care and breach that confidence only when keeping it would seriously threaten their health and safety or that of others. (6) Work freely with colleagues to discover, develop, and promote advances in medicine and public health that ameliorate suffering and contribute to human well-being. (7) Educate the public and polity about present and future threats to the health of humanity. (8) Advocate for social, economic, educational, and political changes that ameliorate suffering and contribute to human well-being. (9) Teach and mentor those who follow us for they are the future of our caring profession. We make these promises solemnly, freely, and upon our personal and professional honor.

H-295.860, "Promoting Transparency in Medical Education and Access to Training"

Our American Medical Association: (1) strongly encourages medical schools and graduate medical education training programs to communicate with current and prospective medical students, residents and fellows how affiliations and mergers among health care organizations may impact health care delivery, medical education and training opportunities at their respective institutions; and (2) will work with the Accreditation Council for Graduate Medical Education and other appropriate stakeholders to support transparency within medical education, recommending that medical schools and graduate medical education training programs communicate with current and prospective medical students, residents and fellows how affiliations and mergers among health care organizations may impact health care delivery, medical education and training opportunities.

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

1. Our AMA recommends that formal education and training in disaster medicine and public health preparedness be incorporated into the curriculum at all medical schools and residency programs.

2. Our AMA encourages medical schools and residency programs to utilize multiple methods, including simulation, disaster drills, interprofessional team-based learning, and other interactive formats for teaching disaster medicine and public health preparedness.

3. Our AMA encourages public and private funders to support the development and implementation of education and training opportunities in disaster medicine and public health preparedness for medical students and resident physicians.

4. Our AMA supports the National Disaster Life Support (NDLS) Program Office's work to revise and enhance the NDLS courses and supporting course materials, in both didactic and electronic formats, for use in medical schools and residency programs.

5. Our AMA encourages involvement of the National Disaster Life Support Education Consortium's adoption of training and education standards and guidelines established by the newly created Federal Education and Training Interagency Group (FETIG).

6. Our AMA will continue to work with other specialties and stakeholders to coordinate and encourage provision of disaster preparedness education and training in medical schools and in graduate and continuing medical education.

7. Our AMA encourages all medical specialties, in collaboration with the National Disaster Life Support Educational Consortium (NDLSEC), to develop interdisciplinary and inter-professional training venues and curricula, including essential elements for national disaster preparedness for use by medical schools and residency programs to prepare physicians and other health professionals to respond in coordinated teams using the tools available to effectively manage disasters and public health emergencies.

8. Our AMA encourages medical schools and residency programs to use community-based disaster training and drills as appropriate to the region and community they serve as opportunities for medical students and residents to develop team skills outside the usual venues of teaching hospitals, ambulatory clinics, and physician offices.

9. Our AMA will make medical students and residents aware of the context (including relevant legal issues) in which they could serve with appropriate training, credentialing, and supervision during a national disaster or emergency, e.g., non-governmental organizations, American Red Cross, Medical Reserve Corps, and other entities that could provide requisite supervision.

10. Our AMA will work with the Federation of State Medical Boards to encourage state licensing authorities to include medical students and residents who are properly trained and credentialed to be able to participate under appropriate supervision in a national disaster or emergency.

11. Our AMA encourages physicians, residents, and medical students to participate in disaster response activities through organized groups, such as the Medical Response Corps and American Red Cross, and not as spontaneous volunteers.

12. Our AMA encourages teaching hospitals to develop and maintain a relocation plan to ensure that educational activities for faculty, medical students, and residents can be continued in times of national disaster and emergency.

H-295.939, Protecting Medical Trainees from Hazardous Exposure

1. Our AMA will encourage all health care-related educational institutions to apply the Occupational Safety and Health Administration (OSHA) Blood Borne Pathogen standard and OSHA hazardous exposure regulations, including communication requirements, equally to employees, students, and residents/fellows.

2. Our AMA recommends: (a) that the Accreditation Council for Graduate Medical Education revise the common program requirements to require education and subsequent demonstration of competence regarding potential exposure to hazardous agents relevant to specific specialties, including but not limited to: appropriate handling of hazardous agents, potential risks of exposure to hazardous agents, situational avoidance of hazardous agents, and appropriate responses when exposure to hazardous material may have occurred in the workplace/training site; (b) (i) that medical school policies on hazardous exposure include options to limit hazardous agent exposure in a manner that does not impact students' ability to successfully complete their training, and (ii) that medical school policies on continuity of educational requirements toward degree completion address leaves of absence or temporary reassignments when a pregnant trainee wishes to minimize the risks of hazardous exposures that may affect the trainee's and/or fetus' personal health status; (c) that medical schools and health care settings with medical learners be vigilant in updating educational material and protective measures regarding hazardous agent exposure of its learners and make this information readily available to students, faculty, and staff; and (d) medical schools and other sponsors of health professions education programs ensure that their students and trainees meet the same requirements for education regarding hazardous materials and potential exposures as faculty and staff.

H-310.912, Residents and Fellows' Bill of Rights

1. Our AMA continues to advocate for improvements in the ACGME Institutional and Common Program Requirements that support AMA policies as follows: a) adequate financial support for and guaranteed leave to attend professional meetings; b) submission of training verification information to requesting agencies within 30 days of the request; c) adequate compensation with consideration to local cost-of-living factors and years of training, and to include the orientation period; d) health insurance benefits to include dental and vision services; e) paid leave for all purposes (family, educational, vacation, sick) to be no less than six weeks per year; and f) stronger due process guidelines.

2. Our AMA encourages the ACGME to ensure access to educational programs and curricula as necessary to facilitate a deeper understanding by resident physicians of the US health care system and to increase their communication skills.

3. Our AMA regularly communicates to residency and fellowship programs and other GME stakeholders this Resident/Fellows Physicians' Bill of Rights.

4. Our AMA: a) will promote residency and fellowship training programs to evaluate their own institution's process for repayment and develop a leaner approach. This includes disbursement of funds by direct deposit as opposed to a paper check and an online system of applying for funds; b) encourages a system of expedited repayment for purchases of $200 or less (or an equivalent institutional threshold), for example through payment directly from their residency and fellowship programs (in contrast to following traditional workflow for reimbursement); and c) encourages training programs to develop a budget and strategy for planned expenses versus unplanned expenses, where planned expenses should be estimated using historical data, and should include trainee reimbursements for items such as educational materials, attendance at conferences, and entertaining applicants. Payment in advance or within one month of document submission is strongly recommended.

5. Our AMA encourages teaching institutions to explore benefits to residents and fellows that will reduce personal cost of living expenditures, such as allowances for housing, childcare, and transportation.

6. Our AMA will work with the Accreditation Council for Graduate Medical Education (ACGME) and other relevant stakeholders to amend the ACGME Common Program Requirements to allow flexibility in the specialty-specific ACGME program requirements enabling specialties to require salary reimbursement or "protected time" for resident and fellow education by "core faculty," program directors, and assistant/associate program directors.

7. Our AMA adopts the following 'Residents and Fellows' Bill of Rights' as applicable to all resident and fellow physicians in ACGME-accredited training programs:

RESIDENT/FELLOW PHYSICIANS' BILL OF RIGHTS

Residents and fellows have a right to:

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

With regard to education, residents and fellows should expect: (1) A graduate medical education experience that facilitates their professional and ethical development, to include regularly scheduled didactics for which they are released from clinical duties. Service obligations should not interfere with educational opportunities and clinical education should be given priority over service obligations; (2) Faculty who devote sufficient time to the educational program to fulfill their teaching and supervisory responsibilities; (3) Adequate clerical and clinical support services that minimize the extraneous, time-consuming work that draws attention from patient care issues and offers no educational value; (4) 24-hour per day access to information resources to educate themselves further about appropriate patient care; and (5) Resources that will allow them to pursue scholarly activities to include financial support and education leave to attend professional meetings.

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

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

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

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

D. A safe and supportive workplace with appropriate facilities.

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

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

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

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

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

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

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

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

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

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

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

H-310.929, Principles for Graduate Medical Education

Our AMA urges the Accreditation Council for Graduate Medical Education (ACGME) to incorporate these principles in its Institutional Requirements, if they are not already present.
(1) PURPOSE OF GRADUATE MEDICAL EDUCATION AND ITS RELATIONSHIP TO PATIENT CARE. There must be objectives for residency education in each specialty that promote the development of the knowledge, skills, attitudes, and behavior necessary to become a competent practitioner in a recognized medical specialty.
Exemplary patient care is a vital component for any residency/fellowship program. Graduate medical education enhances the quality of patient care in the institution sponsoring an accredited program. Graduate medical education must never compromise the quality of patient care. Institutions sponsoring residency programs and the director of each program must assure the highest quality of care for patients and the attainment of the program's educational objectives for the residents.
(2) RELATION OF ACCREDITATION TO THE PURPOSE OF RESIDENCY TRAINING. Accreditation requirements should relate to the stated purpose of a residency program and to the knowledge, skills, attitudes, and behaviors that a resident physician should have on completing residency education.
(3) EDUCATION IN THE BROAD FIELD OF MEDICINE. GME should provide a resident physician with broad clinical experiences that address the general competencies and professionalism expected of all physicians, adding depth as well as breadth to the competencies introduced in medical school.
(4) SCHOLARLY ACTIVITIES FOR RESIDENTS. Graduate medical education should always occur in a milieu that includes scholarship. Resident physicians should learn to appreciate the importance of scholarly activities and should be knowledgeable about scientific method. However, the accreditation requirements, the structure, and the content of graduate medical education should be directed toward preparing physicians to practice in a medical specialty. Individual educational opportunities beyond the residency program should be provided for resident physicians who have an interest in, and show an aptitude for, academic and research pursuits. The continued development of evidence-based medicine in the graduate medical education curriculum reinforces the integrity of the scientific method in the everyday practice of clinical medicine.
(5) FACULTY SCHOLARSHIP. All residency faculty members must engage in scholarly activities and/or scientific inquiry. Suitable examples of this work must not be limited to basic biomedical research. Faculty can comply with this principle through participation in scholarly meetings, journal club, lectures, and similar academic pursuits.

(6) INSTITUTIONAL RESPONSIBILITY FOR PROGRAMS. Specialty-specific GME must operate under a system of institutional governance responsible for the development and implementation of policies regarding the following; the initial authorization of programs, the appointment of program directors, compliance with the accreditation requirements of the ACGME, the advancement of resident physicians, the disciplining of resident physicians when this is appropriate, the maintenance of permanent records, and the credentialing of resident physicians who successfully complete the program. If an institution closes or has to reduce the size of a residency program, the institution must inform the residents as soon as possible. Institutions must make every effort to allow residents already in the program to complete their education in the affected program. When this is not possible, institutions must assist residents to enroll in another program in which they can continue their education. Programs must also make arrangements, when necessary, for the disposition of program files so that future confirmation of the completion of residency education is possible. Institutions should allow residents to form housestaff organizations, or similar organizations, to address patient care and resident work environment concerns. Institutional committees should include resident members.
(7) COMPENSATION OF RESIDENT PHYSICIANS. All residents should be compensated. Residents should receive fringe benefits, including, but not limited to, health, disability, and professional liability insurance and parental leave and should have access to other benefits offered by the institution. Residents must be informed of employment policies and fringe benefits, and their access to them. Restrictive covenants must not be required of residents or applicants for residency education.
(8) LENGTH OF TRAINING. The usual duration of an accredited residency in a specialty should be defined in the "Program Requirements." The required minimum duration should be the same for all programs in a specialty and should be sufficient to meet the stated objectives of residency education for the specialty and to cover the course content specified in the Program Requirements. The time required for an individual resident physician's education might be modified depending on the aptitude of the resident physician and the availability of required clinical experiences.
(9) PROVISION OF FORMAL EDUCATIONAL EXPERIENCES
Graduate medical education must include a formal educational component in addition to supervised clinical experience. This component should assist resident physicians in acquiring the knowledge and skill base required for practice in the specialty. The assignment of clinical responsibility to resident physicians must permit time for study of the basic sciences and clinical pathophysiology related to the specialty.
(10) INNOVATION OF GRADUATE MEDICAL EDUCATION. The requirements for accreditation of residency training should encourage educational innovation and continual improvement. New topic areas such as continuous quality improvement (CQI), outcome management, informatics and information systems, and population-based medicine should be included as appropriate to the specialty.
(11) THE ENVIRONMENT OF GRADUATE MEDICAL EDUCATION. Sponsoring organizations and other GME programs must create an environment that is conducive to learning. There must be an appropriate balance between education and service. Resident physicians must be treated as colleagues.
(12) SUPERVISION OF RESIDENT PHYSICIANS. Program directors must supervise and evaluate the clinical performance of resident physicians. The policies of the sponsoring institution, as enforced by the program director, and specified in the ACGME Institutional Requirements and related accreditation documents, must ensure that the clinical activities of each resident physician are supervised to a degree that reflects the ability of the resident physician and the level of responsibility for the care of patients that may be safely delegated to the resident. The sponsoring institution's GME Committee must monitor programs' supervision of residents and ensure that supervision is consistent with: (A) Provision of safe and effective patient care; (B) Educational needs of residents; (C) Progressive responsibility appropriate to residents' level of education, competence, and experience; and (D) Other applicable Common and specialty/subspecialty specific Program Requirements. The program director, in cooperation with the institution, is responsible for maintaining work schedules for each resident based on the intensity and variability of assignments in conformity with ACGME Review Committee recommendations, and in compliance with the ACGME clinical and educational work hour standards. Integral to resident supervision is the necessity for frequent evaluation of residents by faculty, with discussion between faculty and resident. It is a cardinal principle that responsibility for the treatment of each patient and the education of resident and fellow physicians lies with the physician/faculty to whom the patient is assigned and who supervises all care rendered to the patient by residents and fellows. Each patient's attending physician must decide, within guidelines established by the program director, the extent to which responsibility may be delegated to the resident, and the appropriate

degree of supervision of the resident's participation in the care of the patient. The attending physician, or designate, must be available to the resident for consultation at all times.
(13) EVALUATION OF RESIDENTS AND SPECIALTY BOARD CERTIFICATION. Residency program directors and faculty are responsible for evaluating and documenting the continuing development and competency of residents, as well as the readiness of residents to enter independent clinical practice upon completion of training. Program directors should also document any deficiency or concern that could interfere with the practice of medicine and which requires remediation, treatment, or removal from training. Inherent within the concept of specialty board certification is the necessity for the residency program to attest and affirm to the competence of the residents completing their training program and being recommended to the specialty board as candidates for examination. This attestation of competency should be accepted by specialty boards as fulfilling the educational and training requirements allowing candidates to sit for the certifying examination of each member board of the ABMS.
(14) GRADUATE MEDICAL EDUCATION IN THE AMBULATORY SETTING. Graduate medical education programs must provide educational experiences to residents in the broadest possible range of educational sites, so that residents are trained in the same types of sites in which they may practice after completing GME. It should include experiences in a variety of ambulatory settings, in addition to the traditional inpatient experience. The amount and types of ambulatory training is a function of the given specialty.
(15) VERIFICATION OF RESIDENT PHYSICIAN EXPERIENCE. The program director must document a resident physician's specific experiences and demonstrated knowledge, skills, attitudes, and behavior, and a record must be maintained within the institution.

H-440.835, "AMA Role in Addressing Epidemics and Pandemics"

1. Our AMA strongly supports U.S. and global efforts to fight epidemics and pandemics, including Ebola, and the need for improved public health infrastructure and surveillance in affected countries.
2. Our AMA strongly supports those responding to the Ebola epidemic and other epidemics and pandemics in affected countries, including all health care workers and volunteers, U.S. Public Health Service and U.S. military members. 3. Our AMA reaffirms Ethics Policy E-2.25, The Use of Quarantine and Isolation as Public Health Interventions, which states that the medical profession should collaborate with public health colleagues to take an active role in ensuring that quarantine and isolation interventions are based on science.
4. Our AMA will collaborate in the development of recommendations and guidelines for medical professionals on appropriate treatment of patients infected with or potentially infected with Ebola, and widely disseminate such guidelines through its communication channels. 5. Our AMA will continue to be a trusted source of information and education for physicians, health professionals and the public on urgent epidemics or pandemics affecting the U.S. population, such as Ebola. 6. Our AMA encourages relevant specialty societies to educate their members on specialty-specific issues relevant to new and emerging epidemics and pandemics.

H-440.847, Pandemic Preparedness for Influenza

In order to prepare for a potential influenza pandemic, our AMA: (1) urges the Department of Health and Human Services Emergency Care Coordination Center, in collaboration with the leadership of the Centers for Disease Control and Prevention (CDC), state and local health departments, and the national organizations representing them, to urgently assess the shortfall in funding, staffing, vaccine, drug, and data management capacity to prepare for and respond to an influenza pandemic or other serious public health emergency; (2) urges Congress and the Administration to work to ensure adequate funding and other resources: (a) for the CDC, the National Institutes of Health (NIH) and other appropriate federal agencies, to support implementation of an expanded capacity to produce the necessary vaccines and anti-viral drugs and to continue development of the nation's capacity to rapidly vaccinate the entire population and care for large numbers of seriously ill people; and (b) to bolster the infrastructure and capacity of state and local health department to effectively prepare for, respond to, and protect the population from illness and death in an influenza pandemic or other serious public health emergency; (3) urges the CDC to develop and disseminate electronic instructional resources on procedures to follow in an influenza epidemic, pandemic, or other serious public health emergency, which are tailored to the needs of physicians and medical office staff in ambulatory care settings; (4) supports the position that: (a) relevant national and state agencies (such as the

CDC, NIH, and the state departments of health) take immediate action to assure that physicians, nurses, other health care professionals, and first responders having direct patient contact, receive any appropriate vaccination in a timely and efficient manner, in order to reassure them that they will have first priority in the event of such a pandemic; and (b) such agencies should publicize now, in advance of any such pandemic, what the plan will be to provide immunization to health care providers; (6) will monitor progress in developing a contingency plan that addresses future influenza vaccine production or distribution problems and in developing a plan to respond to an influenza pandemic in the United States.

APPENDIX 2: AMA GUIDING PRINCIPLES TO PROTECT LEARNERS RESPONDING TO COVID-19

Updated May 1, 2020

This article is part of a series of COVID-19 articles and resources on medical education.
In their efforts to meet workforce demands in response to COVID-19, medical schools and health systems must make responsible decisions about engaging medical students. There are many opportunities for students to contribute to the clinical care of patients without engaging in direct physical contact with patients. However, in some institutions the workforce demands may be great enough that it is appropriate to consider including medical students in direct patient care.

Some students may be permitted to graduate early from medical school and may subsequently contribute as employed members of medical staffs prior to entering their planned residency training. Some students may be enlisted while retaining the status of student, on a voluntary basis, with appropriate supervision and with attention to infection control.

It is the responsibility of the AMA to support and protect medical students as we rely on them during this time. We stand with key stakeholders across the continuum of medical education, including but not limited to the Association of American Medical Colleges, Liaison Committee on Medical Education LCME), Accreditation Council for Graduate Medical Education, American Osteopathic Association, American Association of Colleges of Osteopathic Medicine and the Educational Commission for Foreign Medical Graduates in support of conscientious oversight of the deployment of medical students. The AMA Council on Medical Education recommends observance of the following principles:

For all institutions engaging medical students in physical contact with patients:

1. Thoughtful planning will allow the safe re-engagement of students in the direct care of patients and thus support the continuation of student training. For required coursework involving direct patient contact, schools should provide reasonable accommodations to learners who are unable to participate.
2. Medical students should be included in conversations as direct patient interaction activities are being explored, developed and implemented.
3. Medical students must be provided proper training and oversight in the use and reuse of personal protective equipment (PPE). This includes fit testing for N95 or other respirators, donning and doffing of enhanced PPE, and institutional policies related to the use of one's own PPE to augment hospital-supplied PPE.
4. Appropriate COVID-19 testing protocols for students and health care workers should be in place to reduce risk of transmission and to monitor trends in disease burden among students.
5. Each clinical environment in which students will come into direct contact with patients should be assessed for safety and educational readiness, including:
    - Burden of COVID-19 exposure
    - Stability of care protocols and clarity of roles
    - Appropriate patient mix to support learning goals
    - Faculty capacity to provide supervision, teaching and feedback
6. Health systems and medical schools should support the wellbeing of all providers and recognize that learners face an added stressor of uncertainty about their educational pathways.
7. Medical students should not be financially responsible for diagnosis and treatment of their own disease should they become ill due to care of COVID-19 patients through school-approved activities.
8. Medical schools should use a competency-based approach to redesign educational and assessment activities, considering alternatives to direct patient contact to meet desired learning outcomes.
9. Medical schools should work with the LCME to identify viable options to assess students' competency and meet curricular requirements in order to avoid, to the extent possible, any delay in medical students' graduation or progression in medical school.

Additionally, for institutions implementing early graduation to allow students to join the physician workforce:

10. Early graduation should be enacted on a voluntary basis and founded upon attainment of core competencies.
11. To the extent possible, early graduates should serve under the supervision of an approved graduate medical education program.
12. Medical school graduates should not be compelled to work for their matched residency institution prior to the intended date of employment.
13. Institutions deploying early graduates should grant these providers full status as health care employees with appropriate salary and benefits, while continuing efforts to mitigate their personal risk.
14. Institutions and medical school graduates should remain mindful of graduates' contractual obligations to their matched residencies, including consideration of the potential for quarantine and/or illness due to care of COVID-19 patients.
15. Financial institutions overseeing all loans, public and private, for medical school graduates deployed into the workforce between graduation and beginning residency should exercise forbearance and/or forgiveness of debt service during this time.

APPENDIX 3: GUIDING PRINCIPLES TO PROTECT RESIDENT & FELLOW PHYSICIANS RESPONDING TO COVID-19

Updated April 13, 2020

This article is part of a series of COVID-19 articles and resources on medical education.

Background
There are over 135,000 residents and fellows ("residents") working in graduate medical education (GME) programs in the United States. They are participating in supervised clinical experiences that will qualify them for certification and independent practice in a wide array of medical specialties. While acquiring this experience, residents are the frontline physician workforce in the health systems that employ them.

During the response to the COVID-19 pandemic, residents are experiencing personal, physical and economic stresses. Many of these stresses are common to all health care workers affected by the pandemic; some are unique to their status as employed trainees. These include the following:

- Residents are on the front lines during the COVID-19 response and like other health care workers, such as first responders and ED nurses, experience some of the highest risk situations for exposure and have the same need for personal protective equipment (PPE). They are at personal risk, and their work creates a risk to family members. Residents themselves may become ill and/or require quarantine while caring for COVID-19 patients, and residency program leave policies may not adequately account for these unplanned absences during the pandemic response.
- During the response to COVID-19, many residents are being asked to assume roles that are not a prescribed part of their specialty training, being deployed to medical units and emergency departments from their roles in operating rooms and outpatient clinics. Their preparation for these roles is variable, and residents may be compelled to acquire skills on the job that were not an expectation when they began residency. Furthermore, time spent providing these services may not meet the requirements for graduation and certification in their discipline, leading to concerns that their training may need to be extended when routine clinical duties resume.
- Some subspecialty fellows are being asked to serve in attending physician roles in their core disciplines (e.g., gastroenterology fellows serving as general internal medicine attending physicians). While they may be board certified in these specialties, their compensation and malpractice coverage may not be commensurate with the role.
- Resident salaries are low compared to those of other health care workers, particularly on an hourly basis. Given average resident salaries and an 80-hour work week, resident salaries equate to approximately $15 to $20/hour. In addition, residents carry significant debt loads related to their undergraduate medical education. The average student loan burden at medical school graduation exceeds $200,000.
- Residents are particularly vulnerable in their negotiating ability as a labor force. Although they are employed health care workers, their status as trainees makes them dependent upon their employer for their professional development. As such, their influence over the environment in which they work is limited.

Guiding principles
In managing the engagement of residents during the response to COVID-19, the AMA Council on Medical Education strongly supports observance of the following principles by programs, sponsoring institutions and national organizations:

1. Residents must be actively engaged in COVID-19 response planning regarding deployment of health care workers, including field promotion of fellows to attending roles, in order for the specific interests of trainees to be considered.
2. Residents must be free to raise concerns about their personal safety and the safety of those around them without recrimination or consequence to their employment and training.
3. Residents must have access to, and instruction in, the use of adequate personal protective equipment (PPE), as should all health care workers.
4. Residents deployed to clinical areas with which they are unfamiliar must receive appropriate training and supervision for the tasks they will be asked to perform.

5. Residents who become ill as a result of their participation in the COVID-19 response must not be required to use vacation and/or personal time off while ill and/or quarantined. Residents who require leave under these circumstances must continue to receive their salary and benefits.
6. Sponsoring institutions and residency programs must continue to comply with the Accreditation Council for Graduate Medical Education (ACGME) requirement to provide access to confidential, affordable mental health assessment, counseling and treatment, including access to urgent and emergency care 24 hours a day, seven days a week.
7. The clinical work that residents perform during the pandemic response must be considered in assessments of a trainee's qualifications for program completion. Where possible, credit should be given for the work residents are doing during this time.
8. The ACGME review committees (RCs), the American Board of Medical Specialties (ABMS) specialty boards and the American Osteopathic Association (AOA) specialty boards should consider their program and certification requirements, in light of the pandemic, to allow flexibility in assessments of the competence of trainees. Where possible, these assessments should not delay program completion nor eligibility for certification.
9. Residents must be permitted to remain in their programs to complete necessary requirements that qualify them for board certification. They must continue to receive salary and benefits and have access to necessary clinical experiences.
10. Residents should be candidates for hazard pay in a way that is equitable to other health care workers.
11. Residents should be granted forgiveness and/or forbearance for all or portions of their student loan debt to ease the financial stress they may experience in caring for themselves and their families. This is particularly important during this time of compromised access to opportunities to supplement their income, such as moonlighting.
12. Fellows who assume attending physician roles in core disciplines in which they are licensed and certified should receive pay and benefits commensurate with these roles. The impact of this activity on progress toward completion of the training program must be openly discussed with fellows prior to them assuming these responsibilities.
13. The Centers for Medicare & Medicaid Services (CMS) should ensure flexibility in GME reimbursements to hospitals to accommodate variations in training due to the COVID-19 response. This flexibility should lengthen the initial residency period (IRP) for residents to allow them to extend their training, if necessary, to meet program and board certification requirements. In addition, CMS should expand the residency funding cap at institutions where residents must extend their training, in order to support an increased number of residents, as new trainees begin, while existing trainees remain to complete their programs.
14. As hospitals and health systems confront the economic impact of the pandemic response, we urge early consideration of effects on the training environment and the sustainability of GME programs. Health systems should also proactively manage opportunities for residents to continue their professional development.
15. In the event of program contraction or closure that may result from the pandemic response, disruptions to resident education may be mitigated through active planning for resident relocation. In the event of closures, the AMA stands with other organizations ready to assist should the need arise.

APPENDIX 4: COVID-19 FAQS: GUIDANCE FOR INTERNATIONAL MEDICAL GRADUATES

Updated June 26, 2020

International Medical Graduate (IMG) physicians are a critical part of the U.S. health care workforce. During the COVID-19 pandemic, the AMA is advocating for IMG physicians, whether currently licensed to practice in the U.S. or seeking such licensure, and helping to ensure that visa-related issues do not stop their ability to continue to care for patients during this challenging time.

FAQs about the work the AMA is doing to support IMGs

How is the AMA working to ensure that I am supported after the COVID-19 pandemic subsides?
Ensuring that underserved and under-resourced communities have ample access to physicians is a chronic challenge in normal times, and the COVID-19 pandemic is expected to exacerbate this issue. Physicians practicing in underserved communities either via an H-1B visa or as part of the Conrad State 30 program play a key role in providing much needed health care to vulnerable populations. As such, we are supporting and working with U.S. Senator Amy Klobuchar, U.S. Representative Bradley Schneider, and the other bipartisan, bicameral Congressional members to pass legislation that will increase the number of doctors in rural and other medically underserved areas. Additionally, we are continuing to fight against a proposal by U.S. Immigration and Customs Enforcement (ICE) to modify the period of authorized stay for certain categories of nonimmigrants traveling to the United States by eliminating the availability of "duration of status" and by providing a maximum period of authorized stay with options for extensions for each applicable visa category. The AMA joined with other leading organizations in medical education and health care, to urge the Administration to not change duration of status, or to at the very least, exempt medical residents from such a proposal.

FAQs about visa processing

How will COVID-19 impact the processing of my visa?
Originally the U.S. had stopped processing visas. However, the U.S. Department of State (DoS) agreed to begin processing visa applications for foreign-born medical professionals after the AMA urged the DoS to expedite visa processing at U.S. embassies and consulates around the world.
The DoS encourages individuals with an approved U.S. non-immigrant or immigrant visa petition (I-129, I-140 or similar), or a certificate of eligibility in an approved exchange visitor program (DS-2019), to review the website of their nearest embassy or consulate for procedures to request a visa appointment. For any applicants who had an appointment scheduled with an Application Service Center (ASC) after their closure on March 18 or who have filed a Form I-765, Application for Employment Authorization, they will have their application processed using previously submitted biometrics. This announcement is consistent with U.S. Citizenship and Immigration Services' (USCIS) existing ability to reuse previously submitted biometrics. This will remain in effect until ASC resumes normal operations.
Is there premium processing for visas right now?
No. On March 20, 2020, USCIS announced that it will not accept any new requests for premium processing. This temporary suspension includes petitions filed for H-1B visas. The AMA is strongly urging USCIS to reconsider this suspension and to temporarily expand and expediate the premium processing option for H-1B physicians so they can provide health care to U.S. patients during this pandemic.

FAQs for IMG examinees and students

How will my medical licensing examination be affected?
The United States Medical Licensing Examination (USMLE) program is extending eligibility periods for all examinees who currently have a scheduling permit. The eligibility period ending in 2020 will be extended to have an end date of December 2020, regardless of the country in which examinees are testing. Extensions will be processed in order of expiration date, with all extension processing expected to be completed by the week of April 13. Examinees will receive a notification and new scheduling permit when their eligibility extension has been processed. Examinees will need to use the new permit once received. Extending the eligibility period for your Step 1, Step 2 CK, or Step 3 examination will not impact already scheduled

appointments. No fees will be charged for these eligibility extensions. Eligibility periods will be extended automatically, requiring no action from examinees. For more information, visit the USMLE program website which has published a COVID-19 page that includes information and FAQs about its responses to the pandemic.

Can special exceptions be made to allow exchange visitors to renew their J-1 visas without traveling back to their home country?

Exchange visitors currently on an exchange program whose visas have expired and who do not plan to travel outside of the U.S. do not need to renew their visa. If the exchange visitor does travel outside of the United States during their current exchange visitor program and after their J-1 visa has expired, they must apply for a new J-1 visa in their home country in order to re-enter the United States to continue their program. In addition, in accordance with AMA's letter, the State Department announced that J-1 physicians (medical residents) may consult with their program sponsor, to extend their programs in the United States, and confirmed that J-1 physicians can engage in revised clinical training rotations/assignments in keeping with the ACGME's "Response to Pandemic Crisis."

FAQs for IMGs currently practicing in the United States

As a physician on a H-1B visa, can I move to a different location to practice during the COVID-19 pandemic?

A physician on a H-1B visa must obtain a certified Labor Condition Application (LCA) covering each location where the physician will perform services as required under Department of Labor (DOL) regulations. The term "place of employment" means the worksite or physical location where an H-1B nonimmigrant worker actually performs his or her work.

The LCA will apply to any worksites within this "area of employment" meaning the area within normal commuting distance of the place (address) of employment, or worksite, where the H-1B nonimmigrant is, or will be, employed. However, in certain circumstances, an H-1B visa holder can temporarily work in a different geographic location without requiring a new LCA for up to 60 days in a one-year period. Moreover, the AMA is urging the Administration to permit H-1B physicians that are currently practicing in the U.S. with an active license and an approved immigrant petition, to apply and quickly receive authorization, to work at multiple locations and facilities with a broader range of medical services for the duration of the COVID-19 pandemic.

I am a foreign doctor not licensed in the U.S. but with practice experience in another country. How can I assist with the COVID-19 pandemic in my state?

The licensure requirements and steps to practice medicine in the U.S. remain the same. The licensure requirements and steps to practice medicine in the U. S. would require you to have additional years of residency training, pass the USMLE exams, become ECFMG certified and apply for licensure within the state that you want to practice medicine.

I'm an H-1B visa holder. What happens if I lose my job during the COVID-19 pandemic? How will this affect my H-4 visa family members?

An H-1B visa holder must remain employed for their visa to continue to be valid. If an H-1B visa holder loses their job they have a 60-day grace period within which they can remain in the U.S. and try to find a new job and sponsoring employer. If they are unsuccessful in finding a new position, then they must leave the country. The AMA understands how difficult losing a job is especially during this time, as such we are advocating to temporarily extend the 60-day grace period to 180 days to try and better accommodate IMGs during this time. An H-1B visa holder's spouse and unmarried children under 21 years of age may seek admission to the U.S. as H-4 nonimmigrants. However, the H-4 visa is completely dependent on the H-1B visa holder's status. As such, the H-1B visa holder must remain in compliance with all visa requirements, including meeting relevant employment requirements. If the H-1B visa holder loses their job due to COVID-19 and cannot find new employment within the grace period, the H-4 visa is no longer valid and the H-4 visa holder must leave the country.

Can I be removed from the United States if I overstay my H-1B visa due to COVID-19?
Yes. Deportation or removal is the same for H-1B visa holders as it is for all visa holders. In order to stay in status, an H-1B employee must continue working for the H-1B employer while in the United States. Generally, an H-1B employee must be in status in order to change, extend or adjust status. If an H-1B visa holder is terminated before the end of the period of authorized stay, the employer is liable for reasonable costs of the visa holder's return transportation unless the visa holder voluntarily resigns. As a matter of prosecutorial discretion, DHS may permit an H-1B visa holder who is present in the United States unlawfully, but who has pending an application that stops the accrual of unlawful presence, to remain in the United States while that application remains pending. In this sense, the H-1B visa holder's remaining can be said to be "authorized."
However, the fact that the H-1B visa holder does not accrue unlawful presence does not mean that their presence in the United States is lawful. If an H-1B visa holder accrues unlawful presence in the United States, they may be barred from reentering the U.S. for three years, ten years, or permanently depending on how long they overstayed the visa. For example, an H-1B professional who has been legally employed in the U.S. in H-1B status is permitted by federal regulation to continue living in the U.S. and working for the sponsoring employer for up to 240 days while an extension petition is pending – as long as the extension petition is filed prior to the expiration of the prior H-1B petition. However, due to significant processing backlogs, USCIS very often takes six months or longer to adjudicate H-1B extension petitions. During that time the previous H-1B petition may expire, leaving the H-1B professional solely dependent on the 240 days of work authorization permitted under the regulation – and without any underlying H-1B status unless/until the H-1B extension petition is approved. If the petition is ultimately denied, then such a person would be deemed unlawfully present as of the date of the denial and, a Notice To Appear would be issued. Petitions for nonimmigrant (temporary) visas may be filed up to six months in advance of the anticipated work start date. Extensions may be filed up to six months in advance of the expiration date of the current petition. Employers should plan to file petitions at the earliest possible moment.

AMA advocacy efforts supporting IMGs

- AMA June 26 letter: Urging the Administration to consider J-1 and H-1B IMGs and their families' entry into the U.S. to be in the national interest of the country so that families can remain together and IMG physicians can immediately begin to provide health care to U.S. patients.
- AMA May 8 letter: Supporting the Healthcare Workforce Resilience Act and to urging the Senate and House to quickly pass the legislation so that we could recapture 15,000 unused employment-based physician immigrant visas from prior fiscal years which would help enable our U.S. physicians to have the support they need and our U.S. patients to have the care they deserve.
- AMA May 4 letter: Urging Vice President Michael Pence to allow J-1, H-1B and O-1 IMGs to be exempt from any future immigration bans or limitations so IMGs can maintain their lawful non-immigrant status while responding to the COVID-19 pandemic.
- AMA April 14 letter: Urging U.S. Citizenship and Immigration Services (USCIS) to temporarily extend visas automatically for one year and expedite approvals of extensions and changes of status for IMGs.
- AMA April 3 letter: Asking Vice President Pence and USCIS to address the situation of thousands of IMGs in temporary status.
- AMA March 24 letter: Urging U.S. Department of State to let IMGs either continue, or begin, to serve a vital role in caring for patients during the COVID-19 pandemic.
- AMA March 24 letter: Petitioning USCIS to temporarily expedite extensions and changes of status for foreign national doctors currently in the U.S.

Additional federal guidance

- USCIS: Special situations
- Department of Homeland Security (COVID-19)
- Department of State:
    - Coronavirus disease 2019 (COVID-19)
    - Update on visas for medical professionals

APPENDIX 5: PROTECTING UNDERREPRESENTED STUDENTS AND RESIDENTS DURING COVID-19

Updated July 6, 2020

The current pandemic is impacting all segments of society—but not equally—and it has created significant disruptions in medical education. Even prior to the pandemic, national data suggested medical education was already losing ground with respect to racial and ethnic parity.[1]

Recent weeks have brought additional stressors to the fore as our society continues to grapple with structural racism. The medical education community must remain vigilant for potential inequities in educational outcomes across the medical education continuum. Diversity efforts are particularly vulnerable during times of disruption, hence institutions must heighten their commitment of attention and resources.
It is the responsibility of the AMA to advocate for medical students, to act to reverse the historic active exclusion of racially marginalized groups (specifically, Blacks, Latinx and Native Americans) from the practice of medicine and to drive advancement of multiple dimensions of diversity in the medical profession. Broader initiatives to foster long-term change in medicine and address inequities in the entire United States educational system are imperative and are underway.
Current disruptions related to COVID-19, however, may amplify underlying inequities in our educational system, similar to the pandemic's role in exacerbating health inequities. Recent societal unrest in response to ongoing public racist acts of violence further compounds immediate concerns. Detailed examples of pressing risks for inequity in educational outcomes are provided here.
Concerns span the continuum of pre-medical education, transition to medical school, performance during medical school, residency selection and performance in graduate medical education. Although this highlights immediate risks posed by current circumstances, these recommendations should be applied as long-term interventions.

Recommendations

Colleges, medical schools and residency programs should:

- Increase attention to structural determinants of academic success and provide a clear process by which students can report challenges and seek assistance.
- Engage students, residents and faculty from underrepresented backgrounds (particularly racial and socioeconomic) in the process of planning adjustments to curriculum, assessment and application processes in order to better consider the diverse circumstances of students.
- Amplify efforts to create inclusive learning and working environments across the continuum of pre-medical education, medical school, graduate medical education and practice.
- Heighten monitoring of learner well-being at all levels of medical education and minimize barriers to mental health care.
- Implement a systems approach to promoting well-being that serves to complement the resilience of individuals. Organizational-level efforts should be undertaken to provide:
    - Consistent and inclusive communication.
    - Clarity regarding changes in curriculum, performance expectations or administrative processes.
    - Allyship to address microaggressions in clinical and learning environments.
    - Responsiveness to student and resident concerns.
    - Processes for addressing student and resident grievances.
- Adjust medical school admissions and residency selection processes to:
    - Mitigate bias (e.g. review of applications blinded to academic metrics bias training for admissions committees and interviewers).
    - Apply novel screening practices (e.g. situational judgment tests).
    - Incorporate more holistic, inclusive selection criteria (e.g. distance traveled score).
    - Monitor outcomes for potential bias related to any newly implemented or modified approaches in admissions and selection.
- Improve communication in medical school admissions and residency selection processes by:

    - Implementing robust outreach to students from disadvantaged and underrepresented backgrounds.
    - Developing targeted platforms to foster bilateral exchange of information between applicants and medical schools or residency programs respectively.
    - Reducing complexity and improving transparency in application and selection processes.
    - Minimizing the disparities in candidates' access to coaching in selection processes, such as by providing tips for success at the level of the receiving medical school or graduate medical education (GME) program.
- Increase commitment to, and investment in, pathway and retention programs and other initiatives that intentionally promote equity, diversity and inclusion.

Examples of inequity in educational outcomes due to recent disruptions

Similar themes apply across the continuum of pre-medical education, transition to medical school, performance during medical school, residency selection and performance in GME.

- The shift to virtual platforms of educational delivery has revealed inequities that may further limit the academic achievement of students from under-resourced urban and rural communities, such as in:
    - Access to technology, including internet access and appropriate devices.
    - Home circumstances, including dedicated space and a quiet environment in which to work.
- Students are losing enrichment activities that carry particular importance to candidates who are from backgrounds underrepresented in medicine or who have perceived weaknesses in other aspects of their portfolios. Activities such as research, shadowing, global health experiences and clinical electives serve to instill confidence in pursuing a medical career, support exploration among medical disciplines, spur mentoring, and provide opportunities for distinction that contribute to successful advancement.
- Geographic inconsistency in administration of Medical Colleges Admissions Test (MCAT) and United States Medical Licensing Examination (USMLE) Step examinations has induced some students to consider travel for testing, which will amplify existing disparity in access and in completeness of application portfolios.
- Geographic variations in COVID-19 impact and response—such as physical distancing requirements, testing availability, and availability of personal protective equipment—will create inconsistency in recovery of medical student clinical activities among schools and may disproportionately impact under-resourced schools.
- Limited clinical activities may reduce medical students' access to advocacy in the residency application process (as in the form of letters of recommendation or other communication) which is particularly valuable to disadvantaged candidates.
- Limitations on medical student participation in away rotations, of particular importance for students to demonstrate their abilities to prospective GME programs and to assess the culture of those programs, may disproportionately disadvantage candidates who are underrepresented or who have perceived weaknesses in other aspects of their portfolios.
- The shift to virtual interviews for both medical school and residency selection may have disproportionately negative impacts on students from underrepresented groups or under-resourced communities, due to limitations in technology and appropriate dedicated space as well as less time and personal presence to overcome bias.
- Because people of color are experiencing COVID-19 disproportionately, there may be a corresponding emotional toll on students and residents who lose family and friends to the disease.
- The families of students and residents of color or those who are from lower socioeconomic status may be experiencing greater economic burden from COVID-19, perhaps due to losing employment or increased costs of essential goods. Students may prioritize the need to help support their families over school-related obligations.
- The current environment of racial and societal unrest may have disproportionately negative impacts on the well-being of students and residents from minority communities, impairing their ability to succeed in course work and to navigate application processes.

- Pathway and recruitment programs may suffer from disrupted opportunities to interact with students; and financial strain on many academic centers may result in decreased support to such programs, both in financial resources and in the engagement of participating faculty.

Additional resources
ACGME News: Increasing Graduate Medical Education Diversity and Inclusion, McDade
AAMC: Holistic Review in Medical School Admissions

---

[1]Talamantes, et al. Closing the Gap - Making Medical School Admissions More Equitable. *NEJM* 2019. (As medical school enrollment doubled over the past two decades, the percentage of entering under-represented students actually fell by 16%)

APPENDIX 6: SENIOR PHYSICIAN COVID-19 RESOURCE GUIDE

Updated March 28, 2020

The AMA has curated a selection of resources to provide guidance to senior and retired physicians who may wish to return to work or are called upon to do so during the coronavirus (COVID-19) outbreak.

1. License considerations
The licensure status of retired physicians varies by state. In some states retired physicians maintain their regular license while others create a separate category for retired or inactive physicians, and still others have no license category for retired physicians. In response to COVID-19, many states have taken action to allow retired physicians to temporarily return to practice through an Executive Order, Department of Health Order or Board of Medicine directive. Often these actions specify the physician's license must have been in good standing at the time of retirement. Many states have also indicated the physician must have been in active practice within the last 2-5 years.
The path to reentry from a licensing perspective varies. For senior and retired physicians who maintain an active license, there are no licensure restrictions on re-entry to practice. For physicians who maintain an inactive, retired physician, or similar license, your state may have temporarily waived any barriers to re-entry. We encourage you to check the Federation of State Medical Boards' COVID-19 resource on state actions on license status for inactive/retired physicians for guidance: As this landscape continues to evolve, we strongly encourage physicians to check with their respective state medical boards for the latest information.

2. Providing assistance that does not involve direct patient care
Whether senior physicians should be providing direct patient care for COVID 19 patients is a complex issue that must balance a number of factors, such as whether the age of the physician and their family members puts them in a high risk group, whether personal protective equipment (PPE) is readily available, and whether they could contribute meaningfully in a non-direct patient care role. Below is a list of important contributions to consider:

- Many health systems are assigning senior physicians to telehealth and administrative activities, which may free up others to be on the front line.
- Contact your local or state health department. Many are keeping listings of needed roles for volunteer physicians and health care workers.
- Medical schools are using senior physicians for online teaching and mentoring of medical students. Contact your medical school's dean's office to find out how you can participate.
- Consider making an appointment at your local Red Cross to donate blood.
- Provide online outreach to residents of nursing homes or senior residential communities to combat isolation

Assist local practices in creating patient education materials and information sheets with local/regional resources.

3. Re-entering practice
Explore opportunities to provide mentoring or training in your practice location. Many institutions have developed algorithms for telephone triage and/or assessment of symptomatic patients.

4. Professional liability
Explore coverage with your local health system. If you are licensed and volunteer, the third federal economic COVID-19 stimulus package (H.R. 748) includes liability protections for volunteer health care professionals during COVID-19 emergency response. In addition, if you are authorized to prescribe and administer certain countermeasures to treat COVID-19, you may be immune from liability under the Public Readiness and Emergency Preparedness Act (PREP Act). Also check with your state medical association; you may have additional liability protections under state law, a recent Gubernatorial Executive Order, or other emergency response programs, such as the Uniform Emergency Volunteer Health Practitioners Act (UEVHPA) or the Emergency Management Assistance Compact (EMAC).

5. Retirement status
Some physicians are receiving retirement income that may be affected by a return to paid employment. Check the status of your retirement income according to the role you are being asked to perform.

6. Role clarification
Clarity on the following questions may be helpful if you are planning to volunteer your assistance.

- What are the activities I'm being asked to do?
- Do those activities align with my skill set?
- What types of training/refreshers/mentoring will be provided?
- Will I be provided with PPE?

7. COVID-19 resources

- *JAMA Network* Coronavirus disease 2019 resource center
- AMA COVID-19 resource center
- AMA licensure chart (PDF)

APPENDIX 7: CARING FOR OUR CAREGIVERS DURING COVID-19

Updated June 5, 2020

Resources for health care leadership
Amid the COVID-19 global outbreak, it's likely to be a stressful time for those who work on the front lines of health care.

Now more than ever, it's important for health systems and health care organizations to create and ensure an infrastructure and resources to support physicians, nurses and care team members.
The following lists provide practical strategies for health system leadership to consider in support of their physicians and care teams during COVID-19.
Note that any activities involving medical students or other health professions students should be part of a voluntary, student-led program overseen by their school in compliance with guidance from the LCME or other accreditor. No direct solicitation of individual students should occur.
Some items in the list are suggestions, while others have already been implemented by health systems.

Assess physician stress and identify specific drivers

- Surveys can be used to track trends in stress levels, identify specific drivers of stress, and develop supportive infrastructures based on these drivers. The American Medical Association is offering two no-cost surveys to help health care organizations monitor the impact COVID-19 has on their workforce during this pandemic.

Building a resilient organization

- The AMA's caregiver resource, Creating a Resilient Organization, provides 17 steps that health care organizations can take in order to effectively care for health care workers during times of crises. Successful organizations will take a systems approach and focus on becoming a resilient organization prior to times of crises, rather than limiting their efforts to a focus on individual resilience. Resilient organizations will need to rapidly reconfigure their well-being priorities to meet the biggest new drivers of stress in a crisis setting.

Workload redistribution

- Physicians/APPs who are at home (on quarantine or for childcare) manage the inboxes and phone calls of those who are at work and provide telemedicine care. Organizations have the ability to redirect or create physician work (wRVU) credit for this work.
    - Atlantic Medical Group has shifted their ambulatory practice care model to telephonic and telemedicine and has reduced office visits significantly. They are considering splitting their offices into teams of staff and physicians and rotating the teams in/out of the office. Rotating shifts would reduce staffing in the office such that everyone isn't in the same very close spaces together. Clinicians not in the office can do phone visits, telemedicine, answer patient questions or be deployed to call centers and testing centers.
- Retraining and/or enhancing the skills of who have not recently worked in the intensive care unit to increase workforce. AMA has curated guidance and resources for those who may wish to return to work or are called upon to do so during the coronavirus (COVID-19) outbreak.
- COVID Staffing provides and online resource to help hospitals understand and manage their staffing needs during the COVID-19 pandemic.
- Administrators and clinicians with extra time due to decreased regular services have offered assist with insurance needs (finding old claims, updating bad addresses, etc.).
- Set up triage hotline. Medical students at multiple states are providing extra staffing for the medical school call center. The purpose of this triage hotline is to provide students/staff/faculty who have traveled or have symptoms of COVID-19 with real-time information on protocol and next steps.
- Allow medical assistants and nurses to make contributions according to their ability, with physician or APP oversight and discretion. This may include nurses or MAs taking verbal orders, performing computerized order entry, doing medication reconciliation or assisting further with visit note documentation. This will alleviate some of the workload on physicians and APPs.

Institutional policies

- Ensure that paid time off and sick days remain unaffected for all employees for COVID-19 related illnesses.
- Ensure no out-of-pocket expenses for employees with COVID-19 related illnesses.
- CMS, Surgeon General, CDC and American College of Surgeons have called for cancellation of all elective surgeries and the rescheduling all non-urgent outpatient visits.
- CMS has implemented several blanket waivers (PDF) for COVID-19. This includes additional flexibility for verbal orders. View additional CMS policies and regulatory flexibilities.
- Six ways to address physician stress during COVID-19
- The Center for the Study of Traumatic Stress offers information for how health care teams notify families (PDF) after a COVID-19 death.

Meals

- SweetGreen will deliver free salads and bowls to hospitals in the cities they serve: DC, Philadelphia, Boston, New York City, San Francisco, Los Angeles, Chicago and Houston. To request free salads, please visit their site to order.
- GrubHub and DoorDash are now offering contact-free deliveries. Both companies have reduced or eliminated commission fees for local restaurants to support restaurants that are mandated to only have carry-out/delivery only service.
- Medical students at multiple states have volunteered to deliver supplies/meals and run errands on behalf of individuals in quarantine.
- A Denver community has reported the development of "Lunches for Clinicians" in which clinicians can order meals from local restaurants for delivery during shifts. Community members are raising funds to help pay for these meals. Many communities across the country have launched similar efforts.

Childcare and pet care

- Medical students in Minnesota, St. Louis (Washington University in St. Louis) and Chicago (Northwestern University) are offering childcare and pet care services for physicians and care teams. To facilitate logistics, both students and families register for services and students volunteer for shifts. Students are then matched with families based on need and availability. Students have reported that the need is overwhelming, with some systems reporting more than 100 families signed up for childcare or pet care services.
  Mount Sinai offers similar services through their Sinai Kids and Sinai Together initiatives. UW Health has partnered with Epic and Meriter to transform Epic's old headquarters into a 24/7 childcare center for children of clinicians that are working at local hospitals during COVID-19.
- Several organizations have partnered with their local YMCA to provide additional childcare for their health care workers.
- One system reported a program in which staff members who must stay home to care for their children are still paid their regular rate if they agree to care for children of two other staff members.

Personal protective equipment (PPE)

- American Dental Association and state dental associations are encouraging dentists to donate their PPE to local hospitals.
- Consider the use of Mask Match in order to request masks (if you are a health care professional) or to donate masks if you have extra. Masks are not for purchase or for sale. Those who are matched with a health care worker are expected to cover the cost shipping and handling.
- Mount Sinai has developed guidelines for health care workers to consider for keeping their family and friends safe when returning home from work.

Attention to emotional and mental well-being

- Headspace is a meditation and sleep app that can have a positive impact on health professionals' personal and professional lives.

- Organizations like Mount Sinai and UNC provide online toolkits where all well-being resources are centralized and easy for clinicians to access.
- Consider assigning therapists to strategic locations (e.g., cafeteria, staff lounges, emergency department) to provide easy access for staff. Several health systems offer drop-in hours with a psychologist onsite for their physicians and care teams. Several organizations are offering 24/7 emotional support through their behavioral health teams. In many cases, this includes emotional support for family members of clinicians as well.
- Continue to monitor the ability of the Employee Health and Well-Being Unit to meet workload demands, personnel health and safety, resource needs and documentation practices.
- Supervisors can conduct a 5-minute debrief at the end of every shift with their care team. Make debriefing a routine part of the day.
- Several wellness committees and Chief Wellness Officers have shared that intensive in-person rounding to frontline health care workers has proven enormously helpful. Rounding may include:
    - Supplying basic wellbeing needs (food, drinks, hygiene items)
    - Provide in the moment support, direct pathway for more intensive support needs through behavioral health teams, peer support, etc.
    - Elicit concerns/needs that require escalation and advocacy (has led to countless system changes, including prepaying of childcare, scrub service, transparency efforts, creation of a caregiver relief fund, etc)
    - Increase awareness of available support resources
- Consider making mental health resources available to families of clinicians (PDF), as traumatic experiences from COVID-19 will affect them as well.
- The Department of Psychiatry at SUNY Downstate Health Sciences Center has created a COVID-Stress Hotline that can be accessed by everyone at the medical center. The hotline can be accessed by SMS text, email, or call in and was set up using Updox. A second line was established for leadership to communicate about groups that might need help sessions or immediate group interventions.
- AMA offers strategies and resources to manage mental well-being while also caring for patients during the pandemic or any other crisis.
- With the goals of ensuring physicians and advanced practitioners receive the psychological support they need and of paving the way for them to successfully access existing resources through their Physician Assistance Program, the Washington State Medical Association called on Employee Assistance Programs/Physician Assistance Programs with clients in the health care industry to consider the following actions:
    - Change the pre-recorded greeting message on the 1-800 number to clearly communicate that all calls are confidential and HIPAA compliant.
    - Establish a triage system at entry that allows people to identify themselves as clinicians at the frontline of the COVID-19 response. Deploy your most highly trained and skilled staff to support this population, including the provision of cognitive behavioral therapy.
    - Develop custom communication materials targeted to clinicians at the frontline of the COVID-19 response that clearly explain that your mental health care professionals are equipped to help them navigate the COVID-19 crisis and that the services are completely confidential.
    - Work with each of your clients to provide just-in-time group and 1:1 sessions to frontline clinicians while protecting the health of your staff. For example, use telehealth technology to plant multiple virtual mental health professionals inside the most impacted hospitals and/or at health care provider quarantine facilities for easy on-demand access.
    - Ensure your organizations' emergency response plan includes strategies to adequately handle a surge in requests for services.

Social support

- Several organizations, including Methodist Hospital, UCSF and Mount Sinai, are using video conferencing tools to set up peer support "connection groups" in which physicians and care teams can support one another and discuss ongoing challenges. UCSF's anesthesia department provides virtual support sessions via Zoom for faculty and trainees. These sessions are held once per week—

one for faculty and one for trainees. Discussion questions for these sessions includes: What worries you? How are you feeling and what are you experiencing now? How are you processing all of this? Here are some Zoom and moderator tips provided by UCSF.

- **Virtual session tips:**
    1. Have everyone turn on their cameras (if possible)
    2. Open Zoom chat function so participants can bring up items and moderators can discuss with the group
    3. If more than 15 people consider using Zoom breakout rooms
    4. Acknowledge each person as they join the Zoom meeting
- **Moderator tips:**
    1. Psychological safety is key
    2. It may take time for participants to open up, resist the urge to "fill the silence" if there are lulls
    3. Let conversations unfold naturally
    4. Try to focus more on emotions vs. clinical details or how to fix the problem

Christiana Care is offering "COVID Conversations," topic-driven group support sessions. These sessions allow caregivers to connect with another and share thoughts, feelings and ideas about life during the pandemic.

PeerRxMed is a free, peer-to-peer program for physicians and others working in health care designed to provide support, connection, encouragement, resources and skill-building in order to help participants advance along the Burnout to Thriving Index toward optimal well-being, however you would define that state for yourself. This program provides regular reminders for weekly, monthly and quarterly check-ins with a peer. Reminders include exercises that provide structure for you to connect with a colleague or friend.

Jo Shapiro, MD (Harvard Medical School) discusses the importance of peer support, the fundamentals for operationalizing a peer-support system in health systems and practices and how it can potentially change organizational culture especially during the COVID-19 pandemic.

Nebraska Medicine offers 1:1 peer support through their Peers in Need of Support (PiNS) program. More than 120 volunteers were specifically trained for COVID-19 response using just-in-time training (PDF).

A new Slack channel, "Medical Students vs. COVID-19," allows medical students from across the country to connect and share helpful strategies for how students can continue to support physicians and care teams. Join the Slack channel.

An ambulatory care clinic in Arizona has set up games for clinicians and patients to play throughout the day to keep morale high.

AMA COVID-19 news coverage

Through interviews with health system leaders, the AMA highlights programs and initiatives from around the country that are supporting the health care workforce during the COVID-19 outbreak.

- COVID-19 front line: Mount Sinai keeps physician well-being in focus
- 6 ways to address physician stress during COVID-19 pandemic
- Peer support program strives to ease distress during pandemic
- COVID-19 physician well-being initiatives embrace family needs
- 5 wellness task force tactics designed to prioritize physician health
- 6 ways a health system attacks stress during the COVID-19 crisis

APPENDIX 8: LCME GUIDING PRINCIPLES

Barbara Barzansky, PhD, MHPE
Co-Secretary
Liaison Committee on Medical Education
American Medical Association
330 North Wabash Avenue Suite 39300
Chicago, IL 60611-5885
Phone: 312-464-4933
E-mail: barbara.barzansky@ama-assn.org

LCME®
LIAISON COMMITTEE ON MEDICAL EDUCATION
www.lcme.org

Veronica M. Catanese, MD, MBA
Co-Secretary
Liaison Committee on Medical Education
Association of American Medical Colleges
655 K Street, NW, Suite 100
Washington, DC 20001-2339
Phone: 202-828-0596
E-mail: vcatanese@aamc.org

Medical Students, Patients, and COVID-19: A Community Conversation about Education and Safety

March 12, 2020

LCME Guidance Principles

1. Your faculty has defined your school's **educational program objectives (EPOs) and graduation requirements** and the assessments you will use to ensure that those objectives and requirements are met. It is likely that you will need to change the mechanisms through which medical student learning occurs (e.g., online content delivery and/or interactive work) and is assessed (e.g., paper cases, simulation exercises when onsite clinical interactions might be limited). The LCME completely understands that, and while the LCME Secretariat is always happy to speak with, provide a sounding board to, or guide you, **you do not need to notify the LCME of these adjustments in instructional and assessment methods.**
2. The goal of accreditation is to assure all stakeholders (i.e., the public, medical students, medical schools, graduate medical education programs, health systems, licensing bodies, Department of Education) of educational program quality. This means that, together, **our goal is to provide that by ensuring that our graduates meet their school's EPOs, course and clerkship learning objectives, and required clinical experiences** in this most challenging of times. It is likely that the schools will face the greatest challenges in accomplishing this for students' required clinical experiences. From national data that you have shared, the LCME knows that most of our medical schools have several elective weeks/months in the last year or phase of the curriculum. **Should you need to interrupt or postpone clerkships or other required clinical experiences because of the real and important pressures and stresses of the clinical environment, these elective weeks are available to adjust your students' clinical training schedules without having to delay completion of these required experiences before graduation.** In other words, in looking at your own graduation requirements, you can and should be flexible with the elective weeks built into your curriculum; the LCME understands the need to repurpose elective time to achieve the required clinical experiences. The LCME also recommends that all changes in the required clerkships pass through the school's curriculum governance committee (e.g., Curriculum Committee) prior to implementation.
3. **The LCME is you.** Fifteen of its 19 members are deans and associate deans, perhaps at your school and at other LCME-accredited schools; there are two public and two medical student members. **It completely understands and is experiencing the exceptional pressures you are under,** as a result of both the national and local environment.
4. If you are contemplating **significant changes in the structure** (e.g., major shift in clinical training sites from the inpatient to outpatient setting); **timing** (e.g., delay in student progression to graduation); **duration** (e.g., below the 130-week expectation); or **location** (e.g., due to local variation in the spread of COVID-19), please email the Secretariat (lcme@aamc.org), and we will speak with and work with you to think through your particular situation and approach before you

notify the LCME of the major curriculum changes you are anticipating/making. Remember that any and all conversations you have with the Secretariat are completely confidential and are never shared with the LCME.

Know that we are being challenged along with you, learning from you, and thinking about this with you, every step of the way. We will be creating and updating a page on the LCME website for additional accreditation-related resources and information as they become available. This document, as well as the March 5, 2020 memo from Alison Whelan, Geoffrey Young, and Veronica Catanese will be posted there, and the AAMC COVID-19 resource site will contain links to this LCME resource collection.

APPENDIX 9: "MAINTAINING QUALITY AND SAFETY STANDARDS AMID COVID-19"

Coalition for Physician Accountability

Maintaining Quality and Safety Standards Amid COVID-19

May 11, 2020

The member organizations of the Coalition for Physician Accountability (www.physicianaccountability.org) have released the following statement and table of resources to provide guidance and support to healthcare administrators and credentialing staff who are supporting the contributions of new or volunteer physicians to patient care during the COVID-19 pandemic.

The Coalition for Physician Accountability (Coalition), a cross-organizational group including AACOM, AAMC, ABMS, ACCME, ACGME, AMA, AOA, CMSS (OPDA), ECFMG, FSMB, LCME, NBME, and NBOME, was established in 2009 to promote professional accountability by improving the quality, efficiency, and continuity of the education, training, and assessment of physicians. Its membership includes the national organizations responsible for the accreditation of medical education and training and the assessment, licensure and certification of physicians throughout their medical career, from medical school through practice. Our membership also includes members of the public and the profession. We share a strong commitment to protecting the public's health and safety through the delivery of quality health care.

The pandemic has created a public health emergency that is rapidly altering the provision of health care services across the country. Physicians and other clinicians have responded with offers to provide care outside of their previously licensed jurisdiction and beyond their typical scope of practice.

The Coalition members overseeing physician workforce and training have developed the following guidance and resources for the deployment of physicians, physicians in training (interns, residents and fellows), and retired or inactive physicians, to ensure the safe delivery of quality clinical care during this unprecedented emergency.

The Coalition's Guidance for Maintaining Quality and Safety Standards Amid COVID-19 Pandemic include:

- **Planning:** The pandemic poses a direct threat of over-burdening the health system. The stress to health systems is variable, but all health care facilities should be developing strategies for the optimal use of physician resources as the disease spreads and resource demands fluctuate.
- **Verification:** Acknowledging the additional flexibility that regulators have provided, administrators should access readily available licensing, credentialing, and certification data to verify the attestations of volunteers and new recruits.
- **Provision of Care:** The American Medical Association's *Code of Medical Ethics: Guidance in a Pandemic* states that physicians have an ethical obligation to "provide urgent medical care during disasters," an obligation that holds "even in the face of greater than usual risk to physicians' own safety, health or life." In a crisis, "(t)he risks of providing care to individual patients today should be evaluated against the ability to provide care in the future."
- **Protection:** Healthcare professionals must be equipped with appropriate Personal Protective Equipment (PPE) to safeguard their health and that of their patients, families, and the general public, and physicians must use this protection. The more transmissible the disease, and the higher the risk of occupational exposure, the more urgent the need for protection.
- **Training, Education, and Support:** Healthcare professionals who may be asked to practice outside their areas of training and expertise must have access to training and educational resources for the type(s) of care they are asked to provide during the COVID-19 pandemic to assure safe patient care. Appropriate mentorship, support, training, and supervision must also be available for healthcare professionals who are asked to provide care to which they are unaccustomed.
- **Maintenance of Safety Standards:** Health care facilities should have contingency plans to maintain customary safety standards in the face of a demand surge. Guidance for the adoption of crisis standards of care is available to help leaders make informed decisions that optimize resources while mitigating the risk of harm.

The following are some steps that can be taken to prepare for the arrival of a new volunteer:

	Action Step	Resource	Additional questions/resources
1	Check what licenses the physician has (and/or ECFMG certification if an international medical graduate)	www.Docinfo.org (free service) Physician Data Center www.fsmb.org/PDC/ ECFMG Certification Verification	Email: pdc@fsmb.org Email: cvsonline@ecfmg.org or call ECFMG at 215-386-5900
2	Determine applicable licensing waivers or exceptions (if licensed elsewhere)	FSMB COVID-19 Page for a summary of changes Please check applicable state or territorial medical board website	
3	Check Information on a volunteer's education and training	Physician Data Center www.fsmb.org/PDC/ ECFMG (for IMGS)	Email: pdc@fsmb.org Email: cvsonline@ecfmg.org or call ECFMG at (215) 386-5900
4	Determine if the volunteer has a valid controlled substance license	Obtain copy of existing license and see https://apps.deadiversion.usdoj.gov/webforms2/spring/dupeCertLogin?execution=e1s1	https://deanumber.com/default.aspx?relID=33637
5	Check a volunteer's board certification status	ABMS certification AOA certification https://certification.osteopathic.org/validate/	Call: ABMS Solutions at (800) 733-2267 with questions. Call: AOA at (888) 626-9262
6	Confirm: a) vaccination record b) malpractice insurance c) Review any history of malpractice	Recommended vaccinations for healthcare workers: https://www.cdc.gov/vaccines/adults/rec-vac/hcw.html Guidance on medical liability insurance during the COVID- 19 crisis available from the Medical Professional Liability Association	Call: CDC at (800) 232-4636 See also: The Coronavirus Aid, Relief, and Economic Security Act (CARES Act, H.R. 748), *Section 3215: Limitation on Liability for Volunteer Health Care Professionals During COVID-19 Emergency Response*

		National Practitioner Data Bank*: https://www.npdb.hrsa.gov/hcorg/howToSubmitAQuery.jsp	Email: help@npdb.hrsa.gov
7	Other Important Credentialing Resources	NAMSS COVID-19 Resources	Email: info@namss.org

**Only Accessible by Eligible Entities*

If the volunteer is a recently graduated physician, refer to the following resources:

8	Refer to guidance from AAMC, AACOM, ACGME and FSMB	AAMC guidance AACOM Coronavirus Resources ACGME guidance FSMB COVID-19 Page (for training license information)	

To support the volunteer as they start providing care:

9	Provide guidance to the physician	AMA volunteer guide AMA Code of Medical Ethics: Guidance in a Pandemic FSMB COVID-19 Page (for emergency licensure information) AOA COVID-19 Resources	
10	Provide training resources to the physician	ACCME training resources CDC guidance HHS COVID-19 Workforce Virtual Toolkit	Email: info@accme.org
11	Provide information on PPE	CDC guidance for PPE	

12	Share resources on managing telehealth	ACCME telehealth resources AMA Telehealth playbook HRSA Telehealth Website (hhs.telehealth.gov)	Email: info@accme.org

For more information on how to prepare for an anticipated surge in demand for scarce resources during an epidemic

13	Expand contingency plans to include a process for adopting crisis standards of care to manage scarce physician and other resources	National Academy of Medicine -Discussion Paper on Crisis Standards of Care in response to SARS-CoV-2 National Academy of Medicine -Systems framework for crisis standards of care	

Workgroup Members:

American Board of Medical Specialties (ABMS)
Accreditation Council for Continuing Medical Education (ACCME) Accreditation Council for Graduate Medical Education (ACGME) Council of Medical Specialty Societies (CMSS) Educational Commission for Foreign Medical Graduates (ECFMG) Federation of State Medical Boards (FSMB) National Resident Matching Program (NRMP) Public Member

REFERENCES

[1] Wee, S.-lee, & Mcneil, D. G. (2020, January 9). *China Identifies New Virus Causing Pneumonialike Illness*. https://www.nytimes.com/2020/01/08/health/china-pneumonia-outbreak-virus.html.

[2] World Health Organization. *Archived: WHO Timeline - COVID-19*. World Health Organization. https://www.who.int/news-room/detail/27-04-2020-who-timeline---covid-19.

[3] Schuchat, A. (2020). Public Health Response to the Initiation and Spread of Pandemic COVID-19 in the United States, February 24–April 21, 2020. *MMWR. Morbidity and Mortality Weekly Report*, *69*(18), 551–556. https://doi.org/10.15585/mmwr.mm6918e2.

[4] Centers for Disease Control and Prevention. *CDC COVID Data Tracker*. Centers for Disease Control and Prevention. https://www.cdc.gov/covid-data-tracker/.

[5] U.S. Department of Health and Human Services. (2017). (rep.). Retrieved from https://www.cdc.gov/flu/pandemic-resources/pdf/pan-flu-report-2017v2.pdf.

[6] American Hospital Association. (2005). AHA annual survey database. Washington, DC: American Hospital Association.

[7] Emanuel, E. J., Persad, G., Upshur, R., Thome, B., Parker, M., Glickman, A., … Phillips, J. P. (2020). Fair Allocation of Scarce Medical Resources in the Time of Covid-19. *New England Journal of Medicine*, *382*(21), 2049–2055. https://doi.org/10.1056/nejmsb2005114.

[8] Centers for Disease Control and Prevention. (2020, June 28). *Strategies for Optimizing the Supply of N95 Respirators: COVID-19*. Centers for Disease Control and Prevention. https://www.cdc.gov/coronavirus/2019-ncov/hcp/respirators-strategy/index.html.

[9] Johns Hopkins Bloomberg School of Public Health. (2020). *Ventilator Stockpiling and Availability in the US*. Retrieved from https://www.centerforhealthsecurity.org/resources/COVID-19/COVID-19-fact-sheets/200214-VentilatorAvailability-factsheet.pdf.

[10] Neighmond, P. (2020, March 14). *As The Pandemic Spreads, Will There Be Enough Ventilators?*NPR. https://www.npr.org/sections/health-shots/2020/03/14/815675678/as-the-pandemic-spreads-will-there-be-enough-ventilators.

[11] Rio, C. D., & Malani, P. N. (2020). 2019 Novel Coronavirus—Important Information for Clinicians. *Jama*, *323*(11), 1039. https://doi.org/10.1001/jama.2020.1490.

[12] KFF. Apr 09, 2020. (2020, April 9). *When State Stay-at-Home Orders Due to Coronavirus Went into Effect*. https://www.kff.org/other/slide/when-state-stay-at-home-orders-due-to-coronavirus-went-into-effect/.

[13] Rose, S. (2020). Medical Student Education in the Time of COVID-19. *JAMA*, *323*(21), 2131. https://doi.org/10.1001/jama.2020.5227

[14] *Important Guidance for Medical Students on Clinical Rotations During the Coronavirus (COVID-19) Outbreak*. AAMC. (2020, March 17). https://www.aamc.org/news-insights/press-releases/important-guidance-medical-students-clinical-rotations-during-coronavirus-covid-19-outbreak.

[15] Menon, A., Klein, E. J., Kollars, K., & Kleinhenz, A. L. (2020). Medical Students Are Not Essential Workers. *Academic Medicine*, *Publish Ahead of Print*. https://doi.org/10.1097/acm.0000000000003478.

[16] Smith, T. M. (2020, May 26). *How medical schools are making clerkships virtual during COVID-19*. American Medical Association. https://www.ama-assn.org/residents-students/medical-school-life/how-medical-schools-are-making-clerkships-virtual-during.

[17] Wascovich, P. (2020, March 27). *Students jump into action to volunteer during COVID-19 crisis - CT Plus - UT Southwestern*. UT Southwestern Medical Center - The future of medicine, today! https://www.utsouthwestern.edu/ctplus/stories/2020/covid-students.html.

[18] Cheung, A. (2020, March 27). *They're not seeing coronavirus patients, but Chicago medical students form volunteer teams to help in other ways: 'It felt wrong to do nothing'*. chicagotribune.com. https://www.chicagotribune.com/coronavirus/ct-coronavirus-med-students-chicago-volunteer-response-team-20200328-xfw6jfqoirfd3ifhpesmjzwzye-story.html.

[19] Goldberg, E. (2020, March 27). *Early Graduation Could Send Medical Students to Virus Front Lines*. The New York Times. https://www.nytimes.com/2020/03/26/health/coronavirus-medical-students-graduation.html.

[20] Frieden, J. (2020, July 21). *MCAT Test-Takers Come Down With COVID-19.* MedPage Today. https://www.medpagetoday.com/infectiousdisease/covid19/87663.

[21] Krupp, L. (2020, June 15). *USMLE Testing Chaos May Harm Current and Future Doctors*. Medscape. https://www.medscape.com/viewarticle/932366.

[22] Regional and Event-Based Testing Update. (2020, May 20). Retrieved 2020, from https://covid.usmle.org/announcements/regional-and-event-based-testing-update.

[23] Frellick, M. (2020, June 9). *USMLE Abandons Plan for Shorter Tests After Backlash*. Medscape. https://www.medscape.com/viewarticle/932063.

[24] USMLE. (2020, May 26). Announcements. United States Medical Licensing Examination. https://www.usmle.org/announcements/default.aspx.

[25] AOA. (2020, June 9). *Some DO students may be allowed to graduate without taking COMLEX Level 2-PE.* The DO. https://thedo.osteopathic.org/2020/06/some-do-students-may-be-allowed-to-graduate-without-taking-comlex-level-2-pe/.

[26] Murphy, B. (2020, June 4). *Step 2 CS suspended, temporary assessment measures being weighed*. American Medical Association. https://www.ama-assn.org/residents-students/usmle/step-2-cs-suspended-temporary-assessment-measures-being-weighed.

[27] The Coalition for Physician Accountability's Work Group on Medical Students in the Class of 2021 Moving Across Institutions for Post Graduate Training. Final Report and Recommendations for Medical Education Institutions of LCME-Accredited, U.S. Osteopathic, and Non-U.S. Medical School Applicants.

[28] Higgins, E., Newman, L., Halligan, K., Miller, M., Schwab, S., & Kosowicz, L. (2016). Do audition electives impact match success? *Medical Education Online*, *21*(1), 31325. https://doi.org/10.3402/meo.v21.31325.

[29] Boyd, C. J., Inglesby, D. C., Corey, B., Greene, B. J., Harrington, M. A., Johnson, M. D., … Tavana, M. L. (2020). Impact of COVID-19 on Away Rotations in Surgical Fields. *Journal of Surgical Research*, *255*, 96–98. https://doi.org/10.1016/j.jss.2020.05.049.

[30] Hammoud, M. M., Standiford, T., & Carmody, J. B. (2020). Potential Implications of COVID-19 for the 2020-2021 Residency Application Cycle. *JAMA*, *324*(1), 29. https://doi.org/10.1001/jama.2020.8911.

[31] Murphy, B. (2020, April 17). *How a med school in a COVID-19 hot spot is deploying early graduates*. American Medical Association. https://www.ama-assn.org/residents-students/residency/how-med-school-covid-19-hot-spot-deploying-early-graduates.

[32] Calderwood, M. S., Deloney, V. M., Anderson, D. J., Cheng, V. C.-C., Gohil, S., Kwon, J. H., … Lofgren, E. (2020). Policies and practices of SHEA Research Network hospitals during the COVID-19 pandemic. *Infection Control & Hospital Epidemiology*, 1–9. https://doi.org/10.1017/ice.2020.303.

[33] Wilkinson, M., & Jedynak, J. (2020, March 25). *ECG: GME Funding Implications of COVID-19 and the National Emergency Declaration*. GME Funding Implications of COVID-19 and the National Emergency Declaration - ECG Management Consultants. https://www.ecgmc.com/thought-leadership/blog/gme-funding-implications-of-covid-19-and-the-national-emergency-declaration.

[34] Mathema, S. (2020, April 2). *Removing Barriers for Immigrant Medical Professionals Is Critical To Help Fight Coronavirus*. Center for American Progress. https://www.americanprogress.org/issues/immigration/news/2020/04/02/482574/removing-barriers-immigrant-medical-professionals-critical-help-fight-coronavirus.

[35] *USCIS Announces Temporary Suspension of Premium Processing for All I-129 and I-140 Petitions Due to the Coronavirus Pandemic*. USCIS. (2020, March 20). https://www.uscis.gov/news/alerts/uscis-announces-temporary-suspension-of-premium-processing-for-all-i-129-and-i-140-petitions-due-to

[36] Talamantes, E., Henderson, M. C., Fancher, T. L., & Mullan, F. (2019). Closing the gap—making medical school admissions more equitable. *N Engl J Med*, *380*(9), 803-805.

[37] Gorman, A. (2015, July 1). *For Doctors Who Take A Break From Practice, Coming Back Can Be Tough*. Kaiser Health News. https://khn.org/news/for-doctors-who-take-a-break-from-practice-coming-back-can-be-tough/.

[38] FSMB. (2020, June 9). *U.S. States and Territories Expediting Licensure for Inactive/Retired Licensees in Response to COVID-19.* https://www.fsmb.org/siteassets/advocacy/pdf/states-expediting-licensure-for-inactive-retired-licensees-in-response-to-covid19.pdf

[39] Abbasi, J. (2020). Prioritizing Physician Mental Health as COVID-19 Marches On. *JAMA*, *323*(22), 2235. https://doi.org/10.1001/jama.2020.5205