HOD ACTION: Council on Medical Education Report 2 adopted and the remainder of the report filed.

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 (, MD, Chair)

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.

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