AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

<div align="right">Report: A
(A-21)</div>

Introduced by: RFS Governing Council

Prepared by: RFS Committees on Medical Education and Quality and Patient Safety

Subject: The Effect of the COVID-19 Pandemic on Graduate Medical Education

Referred to: Reference Committee

INTRODUCTION

The COVID-19 pandemic has disrupted global healthcare in an unprecedented manner for modern times. Inherent in this disruption has been the effect on medical trainees worldwide. Resident and fellow physicians have experienced lower clinical volume, cancellation of didactic learning opportunities and career networking, redeployment to unfamiliar clinical environments and impacts on their progress towards board certification. In addition, they frequently have not had resources such as adequate personal protective equipment, mental health support or adequate compensation for their extra work-related duties, emotional and physical stress. In this light, we seek to characterize the impact of COVID-19 on resident and fellow physicians taking into context their vulnerable stage of training and unique status as employees and learners.

DISCUSSION

1. *Surgical Training Programs*

The COVID-19 pandemic has significantly impacted various components of training including surgical case exposure and opportunities to care for various patient populations in a variety of settings. For those residents in surgical training programs, hands-on learning was impacted by the systems level effects of COVID-19. Multiple surveys of residents in general surgery, plastic surgery, and urology have quantified over 50% reduction in surgical case volumes due to delays and cancellation of elective surgical cases. In fact 60% of US Program Directors in urology were concerned about their residents' ability to meet case minimums for graduation in one study. This impact was shown to affect residents most adversely in their final years of training, and fellows whose programs are often only 1-2 years in length.

2. *Nonsurgical Training Programs*

Although the impact of COVID-19 has had a significant impact on surgical specialty residency training, there are also a number of areas of non-surgical residency training that have been affected. As part of pandemic mitigation efforts, social distancing led to suspension of traditional in-person lectures, simulations and educational meetings that have been the cornerstone of medical education for decades. Although these have largely been transformed to a virtual platform with options of recorded lectures, there are limitations on content.

Due to social distancing and fluctuating healthcare policy changes to reduce potential resident exposure to COVID-19 and conserve personal protective equipment (PPE), changed trainees' inpatient experiences. Prior to COVID-19, it was standard practice for residents to discuss cases and plan with the attending and patient. However, after the start of the pandemic, patient exposure was initially limited. Trainees have been pulled from subspeciality electives to cover more essential services such as general wards and intensive care units.

In-person clinic visits have been drastically reduced. Now telemedicine has been in the forefront, however, there has not been any dedicated resident training for telemedicine. As of March 6, 2020, the Centers for Medicare and Medicaid Services (CMS) reimbursed office and hospital telehealth visits.[24] Unfortunately while ACGME allows for indirect supervision, the attending is required to have direct patient contact for billing purposes, which makes the workflow of a telemedicine visit difficult to navigate.[25]

a. Didactic Learning and Career Networking

Didactic learning opportunities have been changing, with many institutions shifting to video conference meetings, multi-institutional lecture series and virtual journal clubs. There has been increased interest and reliance on surgical and procedural simulation especially in fields such as ophthalmology which is almost entirely based in the outpatient setting. Wet labs with animal and cadaveric models, computer and robotics-based virtual reality simulators, online video banks and other technologies have become more important. While these are useful to learn or practice certain technical skills, they are not used to demonstrate proficiency and therefore do not address the issue of readiness for independent practice. In addition, due to the size of these lectures, interactive or problem-based discussion can be challenging and does not always allow for networking or mentorship from fellow academicians.

b. Progress Towards Board Certification

Preparatory materials for board certification have become less centralized in multi-institutional and multi-specialty efforts to increase trainee access to learning material. Question banks such as OrthoBullets or ResStudy, podcasts such as Headmirror's ENT in a Nutshell UCSF Urology's Collaborative Online Video Didactics (COVID) lecture series and social media have been crucial for physician trainees to bolster independent learning. However, the delivery of board exams has been affected by social distancing and local health regulatory body restrictions, and this has had various effects on physician trainees. Delayed testing dates have resulted in trainees being unable to appropriately allot study time; whereas at-home test taking requirements have not always taken into account trainee living situations and socioeconomic status (e.g., ability to isolate in a private room without interference from small children or pets, with up-to-date computer and internet capabilities that are adequate for official examination software).

c. Redeployment to Unfamiliar Clinical Environments

Redeployment of surgical trainees in clinical environments outside of their core area of expertise has been controversial. Certain disciplines are grounded in critical care and emergency-based patient care settings, enabling residents and fellows to transition with

perhaps less difficulty than other surgical specialties which are entirely outpatient and elective based. Redeployment has not always involved adequate training for the clinical duties expected nor adequate PPE. These clinical duties have not been associated with increased compensation unlike ancillary staff compensation, despite the risk, physical and emotional toll associated with non-board-certified physicians with financial burdens taking on unfamiliar roles across the hospital. For example, of 332 Urology residents who responded to the survey, 72 (22%) were redeployed.[23]

3. *Statements from Specialty Boards*

During the COVID-19 pandemic, several Specialty Boards issued statements and provided guidance on the aforementioned topics. Below is a summary of the findings based on the Committees' outreach and research.

American Board of Physician Specialties (ABMS)
COVID-19 Response Webpage: https://www.abms.org/initiatives/covid-19-information/
With regard to recertification, 16 ABMS Member Boards have been able to adjust their programs to allow diplomates to complete their necessary continuing certification activities and will recertify per their normal procedures or, in the case of the American Board of Otolaryngology – Head and Neck Surgery, offer the option to defer the exam until 2021. The following, eight Member Boards have opted to provide an extension of the certification date for their diplomates:
- American Board of Anesthesiology (12/31/2021)
- American Board of Allergy and Immunology (12/31/2021)
- American Board of Dermatology (6/30/2021)
- American Board of Emergency Medicine (6/30/2021)
- American Board of Internal Medicine (Grace period 12/31/2021)
- American Board of Family Medicine (12/31/2021)
- American Board of Preventive Medicine (6/30/2021)
- American Board of Psychiatry and Neurology (12/31/2021)

Internal Medicine (ABIM)
ABIM Coronavirus Update Webpage: https://www.abim.org/media-center/Coronavirus-Updates.aspx
- 4/6/2020: ABIM began offering additional board testing dates, extending registration deadlines and waiving late fees.
- 3/13/2020: "Both ABIM and the American Board of Medical Specialties (ABMS) have notified Program Directors and Designated Institutional Officials (DIOs) that we do not anticipate interruptions of training related to COVID-19 adversely affecting Board Eligibility for the vast majority of otherwise competent residents and fellows. In particular, ABIM's recently clarified Leave of Absence and Deficits in Required Training Time policies are in full effect and applicable to absences that might occur due to COVID-19.
- 1/25/2021: From a video conversation with Dr. Furman McDonald MD, MPH (Senior Vice President for Academic and Medical Affairs, ABIM)
    - So far, issues with residents meeting graduation requirements in IM due to COVID-19 have been minimal. He noted, however, that IM has relatively fewer procedures. If a resident is not on-track to meeting graduation requirements, it is up to the individual resident program to decide how to remediate. While it is not a policy that the ABIM is able to enforce, he noted that residency programs are

able to extend a resident 1-2 months out from the typical graduation in June to allow them for additional time.

In 2020, ABIM gave the option for physicians to take the test then or defer to future dates. Some had studied and wanted to get it done at the time, while others were relieved that they could push it back given their busy pandemic schedules which often made studying difficult.

American Board of Pediatrics (ABP)
- 1/21/2021: From an email with Angela Godwin, Assistant Manager, American Board of Pediatrics:
  - "The American Board of Pediatrics sets the standards for physicians who wish to seek certification with our Board. Our examination admission requirements do not include any requirements for specialty procedures, either for type or number of pediatric procedures. Criteria for pediatric procedures, as well as all other training program requirements and accreditation, are instead the role of the ACGME. The ACGME outlines the core requirements for programs to follow for all trainees, while the ABP's focus is on whether individual trainees have achieved competence in these core areas as part of our standards for certification."
  - "The ABP has a long-standing policy that, under certain circumstances, permits a program director to request a waiver of elective training for medical or parental leave. Since the onset of the pandemic, the ABP has offered training programs significant flexibility, such as expanding the waiver policy to include required rotations, permitting waivers for additional training pathways not covered under the standard waiver policy, and approving a reduction in the number of required continuity clinics. Your statement that Board certification policies may still require the pre-COVID standards may be the case for other ABMS member Boards rather than for the ABP."

American Board of Obstetrics and Gynecology (ABOG)
ABOG COVID-19 Update Webpage: https://www.abog.org/covid-19-updates
- 10/6/2020: Specialty Certifying Exams are now computer-based starting Feb 2021 (previously were oral, in-person)
- 12/15/2021: eligibility for certification is extended
- 1/5/2021: Subspecialty certifying exams will be virtual in April 2021
- 1/13/2021: Contacted via email and was only provided their website
- 3/13/2021: (first major response to COVID-19): https://www.abog.org/about-abog/policies/covid-19-policy-for-ob-gyn-and-subspecialty-standards
  - Board certification eligibility period will be extended for one year if requested
  - Program has final authority to make decisions about duration & completion of residency or fellowship. This includes verification that a resident or fellow has met the program's requirements, ABOG's certification eligibility standards, and is capable to practice independently and without supervision in OB/GYN or a subspecialty
  - Time spent by residents or fellows caring for a family member, partner, or dependent in mandatory COVID-19 quarantine, social distancing, or working from home may be considered clinical experience. This is a local decision based on local program requirements and institutional policy. Residents, fellows, and their programs can arrange to complete academic, research, or study activities
- Spring-Summer 2020: specialty and subspecialty exam dates rescheduled

- 5/6/2021: Graduates can take qualifying exams without Fundamentals of Laparoscopic Surgery requirements completed.

American Board of Family Medicine (ABFM)
ABFM COVID-19 Webpage: https://www.theabfm.org/covid-19
- Statement issued 3/20/2020 regarding Certification Activities
- Widespread virtualization of care and "scrubbing" schedules of nonurgent visits and redeployment of faculty, residents, fellows, and staff to different settings
- ABFM and the ACGME Family Medicine Review Committee are jointly responsible for family medicine residency training in the US
- ABFM will allow precepted televisits and visits in other settings toward the 1650 visit minimum
- ABFM expects program directors in collaboration with the residency Clinical Competency Committee to make final decisions about readiness for autonomous practice
- Any COVID-19 mandated quarantine or personal illness will count towards clinical time and will not violate the ABFM One Month Away from Continuity Care rule nor require extension of training

The American Board of Surgery (ABS)
- ABS COVID-19 Webpage: https://www.absurgery.org/default.jsp?news_covid19_trainingreq
- 3/26/2020: Modifications to Training Requirements
  - Nonvoluntary offside time can be counted as clinical time
  - Required clinical time decreased by 10%
  - Residency Program Directors make the ultimate decision on if a resident is ready for independent practice
  - Qualifying Exams are changed to online, at home
- 1/12/2021: Contacted, no reply

American Board of Physical Medicine and Rehabilitation (ABPMR)
- ABPMR COVID-19 Webpage: https://www.abpmr.org/NewsCenter/Detail/covid-19-updates
- 1/13/21: Email with Kim Van Brunt, Communications Manager "The only specific guideline from the ABPMR is the additional time off allowance, but otherwise a resident's readiness for board certification/PM&R practice is at the discretion of the program director (including things like procedure counts)"
- 4/30/2021: Guidance for COVID-19 Effects on Residency Training—if not meeting procedures numbers, final decision on competence is left to residency Program Directors

American Board of Psychiatry and Neurology (ABPN)
- ABPN COVID-19 Webpage: https://www.abpn.com/coronavirus-covid-19-updates/
- 12/7/2021: "Program Directors can be assured that the Board will continue to follow their lead with respect to whether or not a particular resident has completed the specific training needed for graduation. The ABPN will continue to be flexible with respect to senior residents as long as the Program Director agrees. In addition, through June 30, 2021, the ABPN will continue to accept virtual CSEs completed via a remote conferencing platform such as Zoom for all psychiatry and neurology residents as part of the credentialing requirements to sit for an ABPN initial certification exam."
- Contacted 1/31/2021: replied with the above link.

American Board of Emergency Medicine (ABEM)
- ABEM COVID-19 Webpage: https://www.abem.org/public/news-events/news/2020/06/12/abem-message-regarding-covid-19-monitoring
- 3/19/2021: Open letter to EM residents
  - ABEM does not define what constitutes 44 weeks of training, but ABEM supports asynchronous learning if you are quarantined.
  - Oral Certification Exam will not be offered at all in 2020. The Board is discussing options for 2021.
  - Subspecialty certification deadlines have been relaxed to later in 2021.
  - ABEM will accommodate a two-week quarantine period without negatively affecting your eligibility.
- Email 2/11/2021:
  - "Please note, ABEM does not define the content of the training time (e.g., procedure numbers), rather, ABEM defines the minimum training time required to be successfully completed for board eligibility. ABEM's Board of Directors and staff worked swiftly during the pandemic to make decisions that would assist residents in quarantine; some of highlights are as follows:
    - In mid-March 2020, the Board communicated to EM program directors that ABEM would consider requests for minimum training exceptions on a case-by-case basis if the request was submitted to ABEM prior to the end of the academic year, June 30, 2020. In late April 2020, the Board provided further will accommodate a two-week COVID quarantine period without negatively affecting a resident's graduation date, and ultimately, his/her board eligibility if the program director believes the resident has achieved necessary EM competencies. The accommodation was extended to June 30, 2021. Finally, due to the unprecedented training residents experienced during the pandemic, ABEM publicly and strongly support nontraditional learning approaches during periods of quarantine."

American Board of Urology (ABU)
- ABU COVID-19 Webpage: https://www.abu.org/covid19
- 5/5/2020: Certifying exam Part 1 deferred to Jan 2021.
- 1/18/2021: Certifying exam Part 2 (oral exam) is now virtual.
- Email 2/8/2021: "The ABU will handle residents with training deficiencies on a case-by-case basis, in conjunction with the Program Director. ABU residency requirements have not been modified."

American Board of Radiology (ABR)
- ABR COVID-19 Webpage: https://www.theabr.org/announcements/coronavirus-updates#residents
- ACGME has made it clear that case log numbers are suggested targets and not absolute requirements, and that the absolute sine qua non of satisfactory completion of a post-graduate training program is consensus of the program's Clinical Competency Committee that an individual trainee has satisfied all required milestones inherent in that program, and attestation to that consensus by the program director.
- The ABR will continue to rely on program directors, supported by their Clinical Competency Committees, to provide attestation to the completion of individual training.
- 6/22/2020: ABR is moving all currently unscheduled and future oral and computer-based exams to remote platforms beginning in the first half of 2021.

American Board of Dermatology (ABD)
- 3/6/2020: <u>Impact on Dermatology Resident Education</u>
  - "Time spent by residents in mandated COVID-19 quarantine will be counted as clinical education if residents are able to work with their program to complete independent structured academic activity during that time."
  - "In lieu of the July exam in Tampa, the ABD will offer the exam October 15-24. Candidates can take the exam at any U.S. Prometric testing center or from the safety of their homes via online proctoring."
- Email 1/31/2021: no response.

American Board of Anesthesiology (ABA)
- ABA COVID-19 News & Updates: https://aba-news.org/
- 5/15/2020: fellows can take 2020 subspecialty exams without first being certified in anesthesiology
- 6/26/2020: APPLIED exams are cancelled (this exam includes oral component)
- 8/21/2020 APPLIED exams will be virtual starting spring 2021
- 8/27/2020 MOCA exam (to ensure board certification) 2020: all requirements were waived

American Board of Pathology (ABP)
- ABP COVID-19 Webpage: https://aba-news.org/
- 4/27/20: Multiple reasons for absence allowed from on-site training to count as clinical training if the resident/fellow arranges with their program director to continue learning and training activities. Residents/fellows to keep a daily log/description of activities. Program Director attests to final overall competency.
- ABP will consider additional requests for absences on a case-by-case basis from residents who miss training for an extended period of time for other reasons.

4. Patient Safety and Trainee Wellbeing

The COVID-19 pandemic has also adversely affected the well-being of trainees as well as patient safety, especially when trainees are being redeployed into unfamiliar clinical environments. Decisions had to be carefully considered in medical centers across the country between redeploying trainees versus placing faculty and advanced practice providers who could serve in a similar capacity and who were more familiar with these clinical settings' workflow and protocols. Regardless of specialty, it must be acknowledged that even those who have not been redeployed, there has been uncertainty and/or interruptions in training and board organizations are still maintaining case minimums (for surgical residents) and clinic visit minimums (for nonsurgical residents) to determine board certification eligibility adding pressure to already stressed physicians in training.

a. Consequences

Training interruptions have likely led to reductions in case or clinic visit volume that may have unintended consequences for years to come. In fact, it seems reasonable that strict criteria for case minimums should be suspended for at least the next 3 years and arguably, programs should find independent ways to judge clinical competence that is appropriate for graduation. Lastly, given the unique challenges for trainees during this time, it seems reasonable that residents should be given at least a minimum 4 months' notice if there are concerns that would prevent a trainee from being advanced within or graduating from a residency or fellowship

program. If concerns exist that would prevent advancement or graduation, the trainee should be provided with a realistic corrective plan with specific goals and objectives that will allow them to advance or graduate on time. The ACGME recently addressed the above issues with their guidance statements specifically regarding the educational disruptions during the COVID-19 pandemic. The recommendations include creating individualized learning plans (ILPs) for all residents and fellows scheduled to graduate in 2021 that are not meeting milestones geared to address competency gaps with enhanced feedback. These authors applaud these recommendations and commend the ACGME for recognizing the difficulties soon-to-be graduates are struggling with during their final year of training. [22]

b. Compensation

For trainees being redeployed, it should be recognized that time spent redeployed most likely will not count towards training requirements. This is important as trainee salary is based on the notion that some of the trainee's work is going towards career and skill advancement towards competency in a specific specialty. The notion of redeployment fundamentally puts service needs over training. Accordingly, redeployment should be treated in a similar manner to moonlighting (which would provide a useful structure for program directors and other leaders to incorporate guiding principles for redeployment in carefully determining which trainees would be most appropriate for redeployment and these trainees could be rewarded for their time of service). If moonlighting is unable to be offered, then it would be beneficial for these redeployed trainees to be eligible for a letter of additional certification for this time of service.

For example, if time is spent in an ICU managing patient airways and sedation, this could count towards certification that would allow that provider to give outpatient sedation. The AMA conducted a nationwide survey of GME trainees and only 3 in 10 trainees noted receiving educational credit for COVID-19-related patient care and 83% noted not receiving additional pay for treating COVID-19 patients. Furthermore, at least 41% of trainee respondents noted being very or somewhat concerned about their readiness to practice post-pandemic. All in all, these survey statistics illustrate the importance of these proposed changes mentioned in this report.

Finally, while long-term impacts on quality of care provided by these affected GME trainees is yet to be seen, it is something that needs to be carefully monitored going forward. It may be determined that more focus on objective competency measurements may in turn provide a better guide of resident and/or fellow training than case or clinical volume with the potential to create more robust training programs with shorter durations.

RECOMMENDATIONS

Based on the report prepared by the RFS Committees on Education and Quality and Patient Safety, your RFS Governing Council recommends the following:

1) That our AMA work with the ACGME and other relevant stakeholders to provide additional benefits for compensation, such as moonlighting, hazard pay, and/or additional certifications for residents and fellows who are redeployed to fulfill service needs that are outside the scope of their specialty training.

2) That our AMA urge ACGME to work with relevant stakeholders including residency and fellowship programs to ensure each graduating resident or fellow is provided with documentation explicitly stating his/her board eligibility and identifying areas of training

that have been impacted by COVID-19 that can be presented to the respective board certifying committee.

3) That our AMA urge ACGME and specialty boards to consider replacing minimums on case numbers and clinic visits with more holistic measures to indicate readiness for graduation and board certification eligibility, especially given the drastic educational barriers confronted during the COVID-19 pandemic.

REFERENCES

1) Coleman, J.R., et al., *COVID-19 Pandemic and the Lived Experience of Surgical Residents, Fellows, and Early-Career Surgeons in the American College of Surgeons.* J Am Coll Surg, 2021. 232(2): p. 119-135 e20.
2) Amparore, D., et al., *Impact of the COVID-19 pandemic on urology residency training in Italy.* Minerva Urol Nefrol, 2020. 72(4): p. 505-509.
3) Zingaretti, N., et al., *The Impact of COVID-19 on Plastic Surgery Residency Training.* Aesthetic Plast Surg, 2020. 44(4): p. 1381-1385.
4) Rosen, G.H., et al., *Effect of COVID-19 on Urology Residency Training: A Nationwide Survey of Program Directors by the Society of Academic Urologists.* J Urol, 2020. 204(5): p. 1039-1045.
5) Aljuboori, Z.S., et al., *Early Effects of COVID-19 Pandemic on Neurosurgical Training in the United States: A Case Volume Analysis of 8 Programs.* World Neurosurg, 2021. 145: p. e202-e208.
6) Newsome, H.A., O.M.T. Davies, and K.W. Doerfer, *Coronavirus Disease 2019-An Impetus for Resident Education Reform?* JAMA Otolaryngol Head Neck Surg, 2020. 146(9): p. 785-786.
7) Kogan, M., et al., *Orthopaedic Education During the COVID-19 Pandemic.* J Am Acad Orthop Surg, 2020. 28(11): p. e456-e464.
8) Chick, R.C., et al., *Using Technology to Maintain the Education of Residents During the COVID-19 Pandemic.* J Surg Educ, 2020. 77(4): p. 729-732.
9) Smigelski, M., M. Movassaghi, and A. Small, *Urology Virtual Education Programs During the COVID-19 Pandemic.* Curr Urol Rep, 2020. 21(12): p. 50.
10) Feudner, E.M., et al., *Virtual reality training improves wet-lab performance of capsulorhexis: results of a randomized, controlled study.* Graefes Arch Clin Exp Ophthalmol, 2009. 247(7): p. 955-63.
11) Ferris, J.D., et al., *Royal College of Ophthalmologists' National Ophthalmology Database study of cataract surgery: report 6. The impact of EyeSi virtual reality training on complications rates of cataract surgery performed by first and second year trainees.* Br J Ophthalmol, 2020. 104(3): p. 324-329.
12) Ng, D.S., et al., *Impact of virtual reality simulation on learning barriers of phacoemulsification perceived by residents.* Clin Ophthalmol, 2018. 12: p. 885-893.
13) Ferriss, J.S., et al., *Society of Gynecologic Oncology recommendations for fellowship education during the COVID-19 pandemic and beyond: Innovating programs to optimize trainee success.* Gynecol Oncol, 2021. 160(1): p. 271-278.
14) Potts, J.R., 3rd, *Residency and Fellowship Program Accreditation: Effects of the Novel Coronavirus (COVID-19) Pandemic.* J Am Coll Surg, 2020. 230(6): p. 1094-1097.
15) Dedeilia, A., et al., *Medical and Surgical Education Challenges and Innovations in the COVID-19 Era: A Systematic Review.* In Vivo, 2020. 34(3 Suppl): p. 1603-1611.
16) Keneally RJ, Frazier HA 2nd, Berger JS. COVID-19 and Graduate Medical Education Trainee Protections and Finances. J Grad Med Educ. 2020;12(6):647-650. doi:10.4300/JGME-D-20-01295.1
17) Meo N, Kim CS, Ilgen JS, Choe JH, Singh N, Joyner B. Redeploying Residents and Fellows in Response to COVID-19: Tensions, Guiding Principles, and Lessons From the University of Washington. J Grad Med Educ. 2020;**12**(6):678-681. doi:10.4300/JGME-D-20-00430.1
18) Monroig-Bosque PDC, Hsu JW, Lin MS, et al. Pathology Trainee Redeployment and Education During the COVID-19 Pandemic: An Institutional Experience. Acad Pathol. 2020;7:2374289520953548. Published 2020 Sep 18. doi:10.1177/2374289520953548

19) Coleman JR, Abdelsattar JM, Glocker RJ; RAS-ACS COVID-19 Task Force. COVID-19 Pandemic and the Lived Experience of Surgical Residents, Fellows, and Early-Career Surgeons in the American College of Surgeons. J Am Coll Surg. 2021;232(2):119-135.e20. doi:10.1016/j.jamcollsurg.2020.09.026

20) Newsome HA, Davies OMT, Doerfer KW. Coronavirus Disease 2019-An Impetus for Resident Education Reform?. JAMA Otolaryngol Head Neck Surg. 2020;146(9):785-786. doi:10.1001/jamaoto.2020.1587

21) AlGaeed M, Grewal M, Richardson PK, Leon Guerrero CR. COVID-19: Neurology residents' perspective. J Clin Neurosci. 2020;78:452-453. doi:10.1016/j.jocn.2020.05.032

22) Guidance Statement on Competency-Based Medical Education during COVID-19 Residency and Fellowship Disruptions. ACGME https://acgme.org/Newsroom/Newsroom-Details/ArticleID/10639/Guidance-Statement-on-Competency-Based-Medical-Education-during-COVID-19-Residency-and-Fellowship-Disruptions

23) Well-being and education of urology residents during the COVID-19 pandemic: Results of an American National Survey - Khusid - 2020 - International Journal of Clinical Practice - Wiley Online Library

24) https://acgme.org/Stage-1-Business-as-Usual

25) https://www.acc.org/membership/sections-and-councils/fellows-in-training-section/section-updates/2020/04/13/12/42/telemedicine-and-cv-training-during-the-covid-19-pandemic

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

<div align="right">Report: B
(A-21)</div>

Introduced by: RFS Governing Council

Prepared by: RFS Committee on Legislation and Advocacy

Subject: Improving Access to Physician Health Programs for Physician Trainees

Referred to: Reference Committee

INTRODUCTION

At its 2020 Interim Meeting, the AMA-RFS Assembly adopted RFS Report G, "Facilitating Physicians in Training Seeking Mental Health Care Through Physician Health Programs", which states the following:

1) That our AMA-RFS Governing Council propose amendments to the AMA Advocacy Resource Center regarding the AMA Model Bill: Physician Health Programs Act, to include changing the definition of "physicians in training" in Section 6. "Definitions" to be: (1) medical students in medical schools accredited by the Liaison Committee on Medical Education (LCME) or Commission on Osteopathic College Accreditation (COCA), (2) residents in training programs accredited by the Accreditation Council for Graduate Medical Education (ACGME), or (3) fellows in ACGME or non-ACGME accredited training programs.

2) That our AMA-RFS Governing Council propose amendments to the AMA Advocacy Resource Center regarding the AMA Model Bill: Physician Health Programs Act, to include changing the following subsection within the section "Application to a PHP for voluntary assistance" to read: "a physician in training who voluntarily requests participation in a PHP for a substance use disorder, mental health condition or other medical disease shall, only if they desire, have their medical school or training program involved any stage of PHP assessment, treatment planning, enrollment, and monitoring."

3) That the AMA-RFS Governing Council report back the outcome of these actions to the AMA-RFS assembly at A-21.

Accordingly, your AMA-RFS Governing Council referred this report to your RFS Committee on Legislation and Advocacy (COLA). Your COLA has identified the appropriate changes required to the AMA Model Bill: Physician Health Programs Act and will propose these amendments as described here in this report.

DISCUSSION

At its 2019 Annual Meeting, the AMA-RFS Assembly referred for study RFS Resolution 12, "Facilitating Physicians in Training Seeking Mental Health Care Through Physician Health Programs," which states the following:

RESOLVED, That our AMA amend the AMA Model Bill: Physician Health Programs Act, adding the definition of a "physicians in training" as a physician in an ACGME-accredited training program to Section 6. "Definitions"; and be it further

RESOLVED, That our AMA amend the AMA Model Bill: Physician Health Programs Act, adding the following subsection within the section "Application to a PHP for voluntary assistance": "a physician in training who voluntarily requests participation in a PHP for a substance use disorder, mental health condition or other medical disease shall have his or her training program directly and actively involved in all stages of PHP assessment, treatment planning, enrollment, and monitoring"; and be it further

RESOLVED, That this resolution be immediately forwarded to the AMA HOD at A-19.

Accordingly, your AMA-RFS Governing Council referred this report to your RFS Committee on Medical Education (CME). Your CME performed an analysis of pertinent policies on physician health programs (PHPs) so that the RFS could account for a broad scope of perspectives, including those outside of the AMA-RFS. Your Governing Council then prepared recommendations which were ultimately presented to the RFS Assembly at Interim Meeting 2020 as RFS Report G described above.

Background on the Mental Health of Physician Trainees

It is now commonly accepted that burnout is a significant issue among US physicians who experience higher levels of burnout than other US workers and groups that attain a similar higher-level of education.[1] A study that further looked at burnout among medical students, residents, and early career physicians suggested an even higher risk among physician trainees.[2] The authors reported that medical students were most susceptible to depression and suicidal ideation while residents had the highest fatigue. Medical students and residents/fellows had higher emotional exhaustion in comparison to early career physicians, with burnout and depersonalization reaching a peak during residency and lowest in early career. Burnout has far-reaching negative effects that can eventually lead to physician impairment through its association with alcohol abuse/dependence, worsened suicidal ideation, and increased self-perception of medical errors.[3-5] Maintaining mental health and wellness across the entire lifespan of a physician's career is important but can be especially critical in the stages of training from medical school to fellowship. To ensure the continuation of a healthy physician workforce, there must be emphasis on providing adequate support for physician trainees.

Resources Available to Physician Trainees for Mental Health Care

The main governing bodies of medical education have implemented measures to address the poor mental health reported among physicians-in-training. The Association of American Medical Colleges (AAMC) has a working group on medical student well-being that provided recommendations for medical schools during COVID-19 to offer services such as support and therapy groups, meditation sessions, and a peer support network.[6] In 2017, the Accreditation Council for Graduate Medical Education (ACGME) released revisions to the Common Program Requirements on the learning and working environment to make residency programs and their sponsoring institutions responsible for promoting wellness among their trainees.[7] There are some guidelines detailed in the requirements including education on recognizing and seeking appropriate care for burnout, depression and substance abuse, and providing access to mental health counseling and treatment.[8] In reality, resources vary between programs and range from

comprehensive resident wellness programs and curriculums to specific interventions such as stress management workshops, meditation and mindfulness, peer and faculty mentoring, resiliency training, reflective writing, incentivized exercise programs, and individual counseling.[9-12] One study of a structured resident wellness program with dedicated professionals including two psychologists and a psychiatrist that offered both counseling and referrals to community providers showed good success with engaging residents.[9] They were clear about the limits of confidentiality up to concerns about harm to self or others including patients, and most trainees were willing to consider seeking help there. Access to a physician health program (PHP) would then be a logical expansion of services beyond the capabilities of any one program or institution.

The History of Physician Health Programs

The Council of Science and Public Health has previously studied Physician Health Practices to a) understand their historical context, b) understand their effectiveness, and c) understand limitations to their use (Council of Science and Public Health Report 2-A-11). A brief summary of the AMA's involvement in the development of PHPs follows.

Currently, understanding and discourse around physician mental health and burnout is widespread. However, as recently as the 1970s, physicians were considered immune from ailments such as mental health and addiction disorders and, even when identified, presumed to be responsible for their own wellbeing. The AMA played a crucial role in identifying the need for PHPs in its landmark report titled "The Sick Physician: Impairment by Psychiatric Disorders, including Alcoholism and Drug Dependence." The "Sick Physician" argued that physicians were not only susceptible to chronic corporeal illnesses, but also mental health disorders such as depression, and addiction. It called for the medical community to do a better job of identifying and assisting struggling physicians. Barriers listed in the report included failure to recognize illness, a lack of knowledge and competence about how to best intervene and help ill physicians, and a prevailing "conspiracy of silence" among practitioners.

Subsequently, four crucial events led to the widespread development of PHPs: As previously mentioned, the 1973 AMA report "The Sick Physician," The AMA's Council of Mental Health's 1974 report that addressed physician impairment, the U.S. Disabled Doctors Act of 1974 that legislated mandatory reporting of impaired physicians and whistleblower immunity, and the two conferences hosted by the AMA in 1975 and 1977 to specifically address physician impairment. Formal PHPs quickly developed in most states within the next 10 years. In 1990, the nation's PHPs were linked organizationally by the formation of the Federation of State Physician Health Programs (FSPHP).

The process of improving the quality of and standardizing the resources provided by PHPs was separate and began in earnest in the 1990s. The Federation of State Medical Boards (FSMB) led the development of a model program of probation and rehabilitation that could be adopted by individual state boards. The resolution also proposed that statutory provisions should enable treatment rather than disciplinary action for the sick physician. In 1996, a national PHP conference was convened in Colorado with representation from the FSPHP, AMA, American Psychiatric Association, American Academy of Addiction Psychiatry, American Society of Addiction Medicine, and the FSMB. Several internal reviews were conducted by established PHPs to improve their functionality and utility. In 2001, The Joint Commission issued a standard to require a process for addressing physician health and broadened the standard to include other practitioners in 2004. In 2008, the AMA released the following statement with respect to physician health programs

The AMA supports state health programs that provide medical treatment and monitoring for physicians with substance abuse or other health concerns. Patient safety is paramount, and well-run state health programs with proper treatment and monitoring for physicians are essential to ensure the safety and protection of patients. As patients, physicians are entitled to the same right to privacy and confidentiality of personal medical information as any other patient.

Today, nearly every state has developed a PHP which operates within the parameters of state regulation and legislation.

1. https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/about-ama/councils/Council%20Reports/council-on-science-public-health/a11-csaph-physician-health-programs.pdf
2. Council on Mental Health. American Medical Association. The sick physician: impairment by psychiatric disorders, including alcoholism and drug dependence. JAMA. 1973; 223:684-687.
3. Department of State Legislation, Div of Legislative Activities. Model Impaired Physician Treatment Act. American Medical Association, Chicago, Ill. June 1985.
4. Board of Trustees. Statement on Physician Health Programs. American Medical Association, Chicago, IL. February 6, 2008.

Examples of Physician Trainees Utilizing PHPs

Medical trainees have been hit particularly hard by burnout and mental health problems that are endemic among the medical profession. The PHP program is one of the available resources that trainees can turn to for treatment. While the effectiveness and utilization of the PHP program is more firmly established in the literature, the use of PHPs among fellows, residents, and medical students is not well studied. A single published retrospective review of the Colorado PHP program reported 312 residents treated between 2003 and 2013, of which 52% were mandated and 48% reported voluntarily. Stress, anxiety, depression, and substance use were among the most common presenting symptoms. The authors noted that resident physicians made up 18% of the patients who presented to the Colorado PHP over the 10 year period but made up only 9% of the overall physician population within the state[13]. Furthermore, a testimony on the federal PHP website, recounts a personal experience where a physician was suffering from depression and pills as a resident and was referred to a PHP for treatment where she was connected with a network and a treatment program that became an integral part of her path to recovery and to become a successful practicing physician[14]. While more data regarding the trainee experience with PHPs is required, PHPs can offer potential treatment for the rising rates of mental health disorders endemic within the medical training system.

Current AMA Stance on Physician Health Programs

As discussed earlier, the AMA is arguably one of the chief organizations responsible for the development of PHPs in the 1970s and has remained a supporter of the model since. The AMA has passed several policies to both encourage the use of, and ensure the quality of PHPs. The AMA's support of PHPs is based in its Code of Medical Ethics which emphasizes physicians' ethical responsibility to report, assist and promote wellness amongst themselves and their colleagues to provide optimum patient care (Physician Responsibilities to Impaired Colleagues; Code of Medical Ethics 9.3.2). More specifically, policy H-95.9555 defines physician impairment as "physical, mental or behavioral disorder that interferes with ability to engage safely in professional activities" and specifically names PHPs as a tool to address such ailments. In general, AMA policy seeks to expand and encourage the use of PHPs. Policy H-405.961 "Physician Health Programs," affirms the importance of physician health and urges state medical societies to work with their respective medical boards to promote the use of physician health programs. Additional policies encourage collaboration with Federation of State Physician

Health Programs to educate AMA members about PHPs, develop state legislative guidelines addressing the design and implementation of physician health programs, and design review processes to ensure accountability and excellence across programs (Policy D-405.990 "Educations Physicians about Physician Health Programs and Advocating for Standards").

Other policies aim to address factors which may limit use of PHPs; A 2015 policy addresses the need to work with multiple organizations including the Joint Commission and national health insurers to avoid questions on applications that may negatively impact physicians who have participated in PHPs (Confidentiality of Enrollment in Physicians (Professional) Health Programs; Policy D-405.984)

Next Steps to Expand Access for Physician Trainees

Further steps to expand access for physician trainees includes educating residents that physician health programs are available to those struggling with mental health or substance use issues. Medical trainees need to know that they can turn to PHP's as a safe space in order to seek help. In a 2010 JAMA study, 33% of physicians who reported having direct knowledge of physician impairment actually reported a colleague. The biggest obstacles to reporting were belief that someone else was taking care of the problem, fear of retribution, and that the physician would be heavily punished. There need to be systems in place within the ACGME that ensure confidential referral or participation in PHP's and that resident participants within PHP programs are not discriminated against within their institution. Furthermore, resident physicians who have completed or are currently in a PHP should not have this reflect upon their competency as a resident. Participating in a PHP shall not hinder the resident's future career prospects and ability to obtain a medical license in the future.

While physician health programs are certainly a useful tool in providing care for physician trainees they should not be regarded as the only option for mental and substance use care. We emphasize the use of evidence-based research in determining if a PHP is right for a trainee. There is much variation amongst states as to what a PHP looks like and no standardization of the process that physicians have to undergo within a PHP. Lenzer et al. reports concerns raised over PHP's within the states of North Carolina and Florida. In North Carolina, psychiatrists outside of the PHP reported diagnoses of substance use and mental health problems that were at "marked variance" from their own diagnoses. Furthermore, while the data on PHP's is overall positive, Lenzer et al questions whether there are flaws in the methods and reporting of PHP studies, stating that it may not reflect treatment efficacy. All of these factors should be taken into account when choosing and referring to a PHP.

1. DesRoches CM, Rao SR, Fromson JA, et al. Physicians' Perceptions, Preparedness for Reporting, and Experiences Related to Impaired and Incompetent Colleagues. *JAMA.* 2010;304(2):187–193. doi:10.1001/jama.2010.921
2. Lawson ND, Boyd JW. Flaws in the methods and reporting of physician health program outcome studies. Gen Hosp Psychiatry. 2018 Sep-Oct;54:65-66. doi: 10.1016/j.genhosppsych.2018.06.002. Epub 2018 Jun 9. PMID: 29914651.
3. Lenzer J. Physician health programs under fire*BMJ* 2016; 353 :i3568 doi:10.1136/bmj.i3568

Amending the AMA Model Bill: Physicians Health Programs Act

In 1974, the AMA published a policy paper that first identified psychiatric disorders among physicians as a matter of impairment requiring rehabilitation as opposed to discipline. Then in 1985, the AMA published the first major model bill in this advocacy arena entitled Model Impaired Physician Treatment Act. This was updated recently in 2016 with the Model Physicians

Health Programs Act which intended to improve public safety by providing a clear framework for the creation and management of state-based physician health programs. This new model bill has served as a guide for state programs across the US and has helped support active legislation including Senate Bill 4349 that was introduced in July 2020.

As discussed above, there is a need to expand advocacy for physician trainee mental health by promoting and protecting resident and fellow access to physician health programs. PHPs are unique and evidence-based solutions to rehabilitate and manage impairment for licensed physicians and these are already supported in the AMA's Model Physicians Health Programs Act. However, this advocacy should be expanded to support physician trainees that are experiencing growing rates of burnout and mental health disorders. As such, we are proposing amendments to Sections 4 and 6 as detailed in our recommendations below.

1. FSPHP - Model Physician Health Programs Act: (https://www.fsphp.org/ama-model-bill-physician-health-programs-act and https://www.fsphp.org/assets/docs/ama_physicians_health_programs_act_-_2016.pdf
2. Senate Bill 4349: https://www.congress.gov/bill/116th-congress/senate-bill/4349

RECOMMENDATIONS

Based on the report and recommendations prepared by the AMA-RFS Committee on Legislation and Advocacy, your AMA-RFS Governing Council recommends the following:

1) That our AMA amend AMA Model Bill: Physician Health Programs Act, Section 4 by addition to read as follows:

    (3) The AMA supports the early detection, evaluation and treatment of <u>licensed</u> physicians<u>, physicians in training,</u> and other licensed healthcare professionals suffering from a substance use disorder, mental health condition, or other medical disease or potentially impairing conditions. Appropriate evaluation and treatment of these physicians at programs experienced with the treatment of professionals in a safety sensitive environment will ultimately enhance the health of the provider and better protect the public."

2) That our AMA amend AMA Model Bill: Physician Health Programs Act, Section 6 by addition and deletion to read as follows:

    (h) "Participant" shall mean a <u>licensed physician, physician in training, or other licensed</u> health care professional <s>or those in training</s> enrolled in a PHP pursuant to an agreement between the health care professional and the PHP.

3) That our AMA support the widespread use of physician health programs by physicians in training including residents and fellows in ACGME and AOA accredited training programs; and be it further

4) That our AMA work with the ACGME, AOA, and other relevant stakeholders to ensure physician health programs are promoted by training programs and transparent information is disseminated by programs to their trainees about PHP reporting requirements, benefits of participation, and limitations of such programs; and be it further

5) That our AMA recognize physician health programs as one of many resources available to support physician trainee mental health.

REFERENCES

1. Shanafelt, T., Boone, S., Tan, L., Dyrbye, L., Sotile, W., Satele, D., West, C., Sloan, J. and Oreskovich, M., 2012. Burnout and Satisfaction With Work-Life Balance Among US Physicians Relative to the General US Population. Archives of Internal Medicine, 172(18), p.1377.
2. Dyrbye, L., West, C., Satele, D., Boone, S., Tan, L., Sloan, J. and Shanafelt, T., 2014. Burnout Among U.S. Medical Students, Residents, and Early Career Physicians Relative to the General U.S. Population. Academic Medicine, 89(3), pp.443-451.
3. Jackson, E., Shanafelt, T., Hasan, O., Satele, D. and Dyrbye, L., 2016. Burnout and Alcohol Abuse/Dependence Among U.S. Medical Students. Academic Medicine, 91(9), pp.1251-1256.
4. Dyrbye, L., Thomas, M., Massie, F., Power, D., Eacker, A., Harper, W., Durning, S., Moutier, C., Szydlo, D., Novotny, P., Sloan, J. and Shanafelt, T., 2008. Burnout and Suicidal Ideation among U.S. Medical Students. Annals of Internal Medicine, 149(5), p.334.
5. West, C., Huschka, M., Novotny, P., Sloan, J., Kolars, J., Habermann, T. and Shanafelt, T., 2006. Association of Perceived Medical Errors With Resident Distress and Empathy. JAMA, 296(9), p.1071.
6. AAMC. 2021. COSA Working Group: Medical Student Well-Being. [online] Available at: <https://www.aamc.org/professional-development/affinity-groups/group-student-affairs/cosa-working-group-medical-student-well-being> [Accessed 30 March 2021].
7. ACGME. 2021. ACGME Releases Revised Common Program Requirements, Section VI, The Learning and Working Environment. [online] Available at: <https://acgme.org/Newsroom/Newsroom-Details/ArticleID/7802/ACGME-Releases-Revised-Common-Program-Requirements-Section-VI-The-Learning-and-Working-Environment> [Accessed 30 March 2021].
8. Acgme.org. 2021. [online] Available at: <https://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/CPRResidency2020.pdf> [Accessed 30 March 2021].
9. Ey, S., Moffit, M., Kinzie, J., Choi, D. and Girard, D., 2013. "If You Build It, They Will Come": Attitudes of Medical Residents and Fellows About Seeking Services in a Resident Wellness Program. Journal of Graduate Medical Education, 5(3), pp.486-492.
10. Eckleberry-Hunt, J., Van Dyke, A., Lick, D. and Tucciarone, J., 2009. Changing the Conversation From Burnout to Wellness: Physician Well-being in Residency Training Programs. Journal of Graduate Medical Education, 1(2), pp.225-230.
11. Eskander, J., Rajaguru, P. and Greenberg, P., 2020. Evaluating Wellness Interventions for Resident Physicians: A Systematic Review. Journal of Graduate Medical Education, 13(1), pp.58-69.
12. Parsons, M., Baillitz, J., Chung, A., Mannix, A., Battaglioli, N., Clinton, M. and Gottlieb, M., 2020. Evidence-Based Interventions that Promote Resident Wellness from the Council of Emergency Residency Directors. WestJEM 21.2 March Issue, 21(2), pp.412-422.
13. Parry, A. L., Brooks, E., & Early, S. R. (2018). A Retrospective Cross-Sectional Review of Resident Care-Seeking at a Physician Health Program. Academic Psychiatry, 42(5), 636-641. doi:10.1007/s40596-018-0917-3
14. PHP Stories. (n.d.). Retrieved March 30, 2021, from https://www.fsphp.org/php-participant-stories

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Introduced by: RFS Governing Council

Prepared by: RFS Committee on Education

Subject: "Residents' and Fellows' Bill of Rights" Update

Referred to: Reference Committee

INTRODUCTION

In 2009, the AMA-RFS adopted a Residents' and Fellows' Bill of Rights (291.009R) to serve as a testament to the organization's support for and commitment to the education and training of competent, conscientious residents and fellows by illuminating their rights and advocating for provisions that it believes all residents should be afforded. It addressed 10 core themes:

1. Education
2. Supervision
3. Evaluations of Trainees and Assessment of Faculty and Training Program
4. Workplace
5. Contracts
6. Compensation
7. Benefits
8. Duty Hours
9. Complaints and Appeals Process
10. Reporting Violations to ACGME

DISCUSSION

Over a decade has passed since the language of this Bill of Rights has been adopted, and thus, it warrants review and revision to modernize it to issues facing the current cohort of residents and fellows. The Committee on Medical Education reviewed the terms of the Bill of Rights and similar documents, such as that put forth by the Committee of Interns and Residents of SIEU Healthcare. (https://www.cirseiu.org/billofrights/). The Committee on Medical Education reviewed the previous Residents' and Fellows' Bill of Rights and found several opportunities for improvement.

RECOMMENDATIONS

Based on the report and recommendations prepared by the AMA-RFS Committee on Education, your AMA-RFS Governing Council recommends the following:

1) That our AMA-RFS amend the Residents' and Fellows' Bill of Rights by addition and deletion to read as follows:

291.009R Resident and Fellow Bill of Rights:

That our AMA-RFS support: a *Residents' and Fellows' Bill of Rights* that will serve as a testament to the organization's support for and commitment to the education and training of competent, conscientious residents and fellows by illuminating their rights and advocating for provisions that it believes all residents should be afforded, and that have not yet been designated as rights, and that 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, including but not limited to membership to medical libraries, remote access to medical journals, and other online or mobile resources; and (5) Resources that will allow them to pursue scholarly activities to include financial support and education leave to attend professional meetings.; (6) Financial support or reimbursement for board certification, medical licensing examinations (such as the USMLE STEP 3 or specialty-specific testing), and educational conferences, to reduce the financial burden residents and fellows face; and (7) Opportunities to advance career development, such as access to leadership roles on hospital committees and adequate paid time off for job and fellowship interviews.

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.; and c. Recognition as full-time workers and a right to unionize, granting residents and fellows to advocate collectively to employers and lawmakers on behalf of patients and themselves as workers, not only as learners.

(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 enable trainees to support their families and pay educational debts, 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 and differences based on geographical location.

(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 without pressure to leave it unused or penalization for its use; 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.; and (3) Adequate hospital staffing and support, including the maintenance of back-up call schedules for every residency program.

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.

2) That our AMA-RFS review and update the Residents' and Fellows' Bill of Rights at a minimum every ten years.

REFERENCES:

1. Common Program Requirements. Accreditation Council for Graduate Medical Education. Educational Program, Section VI.A.
2. Common Program Requirements. Accreditation Council for Graduate Medical Education. Educational Program, Section II.B.1.
3. Common Program Requirements. Accreditation Council for Graduate Medical Education. Educational Program, Section II.C.
4. Common Program Requirements. Accreditation Council for Graduate Medical Education. Educational Program, Section II.E.
5. Common Program Requirements. Accreditation Council for Graduate Medical Education. Educational Program, Section IV.B.3
6. American Medical Association. Policy Compendium. HOD Policy H-310.999 (II.H)
7. Common Program Requirements. Accreditation Council for Graduate Medical Education. Educational Program, Section IV.A.4, V.A.1.b.2, and VI.B.
8. Common Program Requirements. Accreditation Council for Graduate Medical Education. Educational Program, Section V.
9. American Medical Association. Policy Compendium. HOD Policy D-310.965
10. American Medical Association. Policy Compendium. HOD Policy H-310.921
11. Institutional Requirements. Accreditation Council for Graduate Medical Education. Section II.F.3
12. Institutional Requirements. Accreditation Council for Graduate Medical Education. Section II.F.3.C
13. Institutional Requirements. Accreditation Council for Graduate Medical Education. Section II.E.2.A
14. Institutional Requirements. Accreditation Council for Graduate Medical Education. Section II.D.4
15. Institutional Requirements. Accreditation Council for Graduate Medical Education. Section II.D.4.d.1
16. Institutional Requirements. Accreditation Council for Graduate Medical Education. Section II.F.3
17. American Medical Association. Policy Compendium. HOD Policy H-310.999 (II.E.1-3)
18. American Medical Association. Policy Compendium. HOD Policy H-310.988
19. American Medical Association. Policy Compendium. HOD Policy H-305.930
20. American Medical Association. Policy Compendium. HOD Policy D-310.967
21. Institutional Review Requirements, Accreditation Council for Graduate Medical Education, Section II.D.4.g
22. American Medical Association. Policy Compendium. HOD Policy H-310.999 (II.I.1-3)
23. Institutional Review Requirements, Accreditation Council for Graduate Medical Education, Section II.D.4.k
24. American Medical Association. Policy Compendium. HOD Policy H-295.942

25. Institutional Review Requirements, Accreditation Council for Graduate Medical Education, Section II.D.4.l
26. Common Program Requirements. Accreditation Council for Graduate Medical Education. Educational Program, Section VI.C
27. American Medical Association. Policy Compendium. HOD Policy H-295.979
28. Institutional Review Requirements, Accreditation Council for Graduate Medical Education, Section II.D.4.k
29. Institutional Review Requirements, Accreditation Council for Graduate Medical Education, Section II.D.4.h
30. Institutional Review Requirements, Accreditation Council for Graduate Medical Education, Section II.D.4.h
31. Common Program Requirements, Accreditation Council for Graduate Medical Education, Section VI
32. Common Program Requirements, Accreditation Council for Graduate Medical Education, Section VI.E.4
33. American Medical Association. Policy Compendium. RFS Policy 310.572R
34. American Medical Association. Policy Compendium. HOD Policy H-265.998
35. Institutional Review Requirements, Accreditation Council for Graduate Medical Education, Section II.D.4.e
36. ACGME Complaint Process, http://www.acgme.org/acWebsite/resInfo/ri_formalcomplaint.asp
37. American Medical Association HOD Policy H-310.999 (II.L. and II.M.)
38. American Medical Association HOD Policy D-310.973

ADDENDUM 1