

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 324  
(A-22)

Introduced by: Medical Student Section

Subject: Sexual Harassment Accreditation Standards for Medical Training Programs

Referred to: Reference Committee \_\_\_

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1 Whereas, Sexual harassment is defined as “sexual advances, requests for sexual favors, and  
2 other verbal or physical conduct of a sexual nature when (1) such conduct interferes with an  
3 individual’s work or academic performance or creates an intimidating, hostile, or offensive work  
4 or academic environment or (2) accepting or rejecting such conduct affects or may be perceived  
5 to affect employment decisions or academic evaluations concerning the individual” by the AMA  
6 Journal of Ethics and is “unethical...[and] raise[s] concerns because of inherent inequalities in  
7 the status and power that medical supervisors wield in relation to medical trainees and may  
8 adversely affect patient care”<sup>1</sup>; and  
9

10 Whereas, According to the 2018 report from the National Academies of Sciences, Engineering,  
11 and Medicine, 49.6% of female students in medical school or in graduate school for a  
12 healthcare field have reported having experienced sexual harassment during their training<sup>2</sup>; and  
13

14 Whereas, Female medical students are 220% more likely to experience unwanted crude  
15 behavior from faculty or staff compared to female students studying non-scientific fields<sup>2</sup>; and  
16

17 Whereas, At one medical program, female medical students were more likely than their male  
18 colleagues to be physically sexually harassed and to be harassed by a person of higher  
19 professional status, resulting in 79% of female survivors and 45% of male survivors saying that  
20 the experience of sexual harassment created a “hostile environment” or interfered with work  
21 performance<sup>3</sup>; and  
22

23 Whereas, Sexual harassment during training has been shown to have a significant impact on  
24 the specialty and residency program choices of female trainees<sup>4</sup>; and  
25

26 Whereas, Female residents are more likely to experience sexual harassment during graduate  
27 medical education in fields such as surgery and emergency medicine compared to other  
28 specialties, with one study finding that 70.8% of female general surgery residents reported  
29 experiencing sexual harassment during training<sup>2,5</sup>; and  
30

31 Whereas, Female residents are more likely to experience sexual harassment in male-dominated  
32 workplaces, especially when leadership is male-dominated, and male physicians continue to be  
33 dramatically overrepresented in healthcare leadership positions, with 84% to 85% of department  
34 chair and medical dean appointments in 2013 to 2014, despite approximately equal female  
35 entrance into medicine<sup>2,6-9</sup>; and  
36

37 Whereas, Experiencing sexual harassment has been linked to poor job-related outcomes such  
38 as work withdrawal, a decrease in commitment to the organization, and reduction of job  
39 satisfaction, and sexual harassment has a stronger negative impact on a woman’s well-being

1 through psychological consequences such as anxiety and depression compared to general job  
2 stressors such as workload and meeting deadlines<sup>2,10</sup>; and

3  
4 Whereas, Sexual harassment continues to be a problem in medicine despite federal protection  
5 such as Title VII, Title IX, and the Clery Act, which intend to protect victims of sexual  
6 harassment from gender discrimination and unwanted sexual attention<sup>11-14</sup>; and

7  
8 Whereas, Under Title IX, educational institutions are required to provide students and trainees  
9 with resources for reporting sexual harassment, including information on their rights under Title  
10 IX, how to contact the institution's Title IX coordinator, and how to file a complaint of sexual  
11 harassment, and the institution must also have a policy how it will investigate and respond to  
12 reported allegations of sexual harassment<sup>15</sup>; and

13  
14 Whereas, Legal protections do not adequately protect trainees from covert retaliation, and fear  
15 of retaliation accounts for 28% of the approximately 79% of cases of sexual harassment that go  
16 unreported<sup>11</sup>; and

17  
18 Whereas, In the absence of an institutional culture that promotes sexual harassment training at  
19 all levels and the importance of incident reporting as part of the solution to mitigate sexual  
20 harassment, sexual harassment training and reporting methods are not effective at reducing  
21 sexual harassment of medical trainees<sup>16-18</sup>; and

22  
23 Whereas, A recent survey of pediatric, gastroenterology, and internal medicine residents  
24 revealed that only 43% knew of institutional policies to support sexual harassment victims and a  
25 2017 AAMC survey of medical students found that only 21% of students reported experiences  
26 of sexual harassment, with 37% of those not reporting stating "I did not think anything would be  
27 done about it" and 9% of those not reporting stating "I did not know what to do"<sup>11,19</sup>; and

28  
29 Whereas, The Liaison Committee on Medical Education (LCME) serves as the accrediting body  
30 that holds all medical schools to 12 standards which ensure graduates have been adequately  
31 trained to begin graduate medical education<sup>20</sup>; and

32  
33 Whereas, The LCME does not explicitly address sexual harassment in the written standards for  
34 Anti-Discrimination and Student Mistreatment<sup>21</sup>; and

35  
36 Whereas, LCME Standard 12 does explicitly address the need for medical schools to provide  
37 "effective student services to all medical students to assist them in achieving the program's  
38 goals for its students"<sup>21</sup>; and

39  
40 Whereas, LCME Standard 12.3: Personal Counseling/Well-Being Programs states that, "A  
41 medical school has in place an effective system of personal counseling for its medical students  
42 that includes programs to promote their well-being and to facilitate their adjustment to the  
43 physical and emotional demands of medical education," thereby establishing precedent for  
44 specific standards on student well-being including for the concerns addressed herein<sup>21</sup>; and

45  
46 Whereas, The Accreditation Council for Graduate Medical Education (ACGME) serves as the  
47 accrediting body that evaluates all residency and fellowship programs to ensure programs meet  
48 the established quality standards for each specialty and subspecialty<sup>22</sup>; and

49  
50 Whereas, The ACGME requires residency and fellowship programs to maintain a professional  
51 environment free from sexual harassment, but does not explicitly state how that standard is  
52 evaluated<sup>23,24</sup>; therefore be it

1 RESOLVED, That our AMA encourage the LCME and ACGME to create a standard for  
2 accreditation that includes sexual harassment training, policies, and repercussions for sexual  
3 harassment in undergraduate and graduate medical programs; (Directive to Take Action) and  
4 be it further

5  
6 RESOLVED, That our AMA encourage the LCME and ACGME to assess: 1) medical trainees'  
7 perception of institutional culture regarding sexual harassment and preventative trainings and 2)  
8 sexual harassment prevalence, reporting, investigation of allegations, and Title IX resource  
9 utilization in order to recommend best practices. (Directive to Take Action)

Fiscal Note: Not yet determined

Received: 05/11/22

DRAFT

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**RELEVANT AMA POLICY**

**9.1.3 Sexual Harassment in the Practice of Medicine**

Sexual harassment can be defined as unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature.

Sexual harassment in the practice of medicine is unethical. Sexual harassment exploits inequalities in status and power, abuses the rights and trust of those who are subjected to such conduct; interferes with an individual's work performance, and may influence or be perceived as influencing professional advancement in a manner unrelated to clinical or academic performance harm professional working relationships, and create an intimidating or hostile work environment; and is likely to jeopardize patient care. Sexual relationships between medical supervisors and trainees are not acceptable, even if consensual. The supervisory role should be eliminated if the parties wish to pursue their relationship.

Physicians should promote and adhere to strict sexual harassment policies in medical workplaces. Physicians who participate in grievance committees should be broadly representative with respect to gender identity or sexual orientation, profession, and employment status, have the power to enforce harassment policies, and be accessible to the persons they are meant to serve.

AMA Principles of Medical Ethics: II,IV,VII

The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law.

Issued: 2016

### **Principles for Advancing Gender Equity in Medicine H-65.961**

Principles for Advancing Gender Equity in Medicine:

Our AMA:

1. declares it is opposed to any exploitation and discrimination in the workplace based on personal characteristics (i.e., gender);
2. affirms the concept of equal rights for all physicians and that the concept of equality of rights under the law shall not be denied or abridged by the U.S. Government or by any state on account of gender;
3. endorses the principle of equal opportunity of employment and practice in the medical field;
4. affirms its commitment to the full involvement of women in leadership roles throughout the federation, and encourages all components of the federation to vigorously continue their efforts to recruit women members into organized medicine;
5. acknowledges that mentorship and sponsorship are integral components of one's career advancement, and encourages physicians to engage in such activities;
6. declares that compensation should be equitable and based on demonstrated competencies/expertise and not based on personal characteristics;
7. recognizes the importance of part-time work options, job sharing, flexible scheduling, re-entry, and contract negotiations as options for physicians to support work-life balance;
8. affirms that transparency in pay scale and promotion criteria is necessary to promote gender equity, and as such academic medical centers, medical schools, hospitals, group practices and other physician employers should conduct periodic reviews of compensation and promotion rates by gender and evaluate protocols for advancement to determine whether the criteria are discriminatory; and
9. affirms that medical schools, institutions and professional associations should provide training on leadership development, contract and salary negotiations and career advancement strategies that include an analysis of the influence of gender in these skill areas.

Our AMA encourages: (1) state and specialty societies, academic medical centers, medical schools, hospitals, group practices and other physician employers to adopt the AMA Principles for Advancing Gender Equity in Medicine; and (2) academic medical centers, medical schools, hospitals, group practices and other physician employers to: (a) adopt policies that prohibit harassment, discrimination and retaliation; (b) provide anti-harassment training; and (c) prescribe disciplinary and/or corrective action should violation of such policies occur.

BOT Rep. 27, A-19

### **Policy on Conduct at AMA Meetings and Events H-140.837**

It is the policy of the American Medical Association that all attendees of AMA hosted meetings, events and other activities are expected to exhibit respectful, professional, and collegial behavior during such meetings, events and activities, including but not limited to dinners, receptions and social gatherings held in conjunction with such AMA hosted meetings, events and other activities. Attendees should exercise consideration and respect in their speech and actions, including while making formal presentations to other attendees, and should be mindful of their surroundings and fellow participants.

Any type of harassment of any attendee of an AMA hosted meeting, event and other activity, including but not limited to dinners, receptions and social gatherings held in conjunction with an AMA hosted meeting, event or activity, is prohibited conduct and is not tolerated. The AMA is committed to a zero tolerance for harassing conduct at all locations where AMA business is conducted. This zero tolerance policy also applies to meetings of all AMA sections, councils, committees, task forces, and other leadership entities (each, an "AMA Entity"), as well as other AMA-sponsored events. The purpose of the policy is to protect participants in AMA-sponsored events from harm.

### **Definition**

Harassment consists of unwelcome conduct whether verbal, physical or visual that denigrates or shows hostility or aversion toward an individual because of his/her race, color, religion, sex, sexual orientation, gender identity, national origin, age, disability, marital status, citizenship or otherwise, and that: (1) has the purpose or effect of creating an intimidating, hostile or offensive environment; (2) has the purpose or effect of unreasonably interfering with an individual's participation in meetings or proceedings of the HOD or any AMA Entity; or (3) otherwise adversely affects an individual's participation in such meetings or proceedings or, in the case of AMA staff, such individual's employment opportunities or tangible job benefits.

Harassing conduct includes, but is not limited to: epithets, slurs or negative stereotyping; threatening, intimidating or hostile acts; denigrating jokes; and written, electronic, or graphic material that denigrates or shows hostility or aversion toward an individual or group and that is placed on walls or elsewhere on the AMA's premises or at the site of any AMA meeting or circulated in connection with any AMA meeting.

### **Sexual Harassment**

Sexual harassment also constitutes discrimination, and is unlawful and is absolutely prohibited. For the purposes of this policy, sexual harassment includes:

- making unwelcome sexual advances or requests for sexual favors or other verbal, physical, or visual conduct of a sexual nature; and
- creating an intimidating, hostile or offensive environment or otherwise unreasonably interfering with an individual's participation in meetings or proceedings of the HOD or any AMA Entity or, in the case of AMA staff, such individual's work performance, by instances of such conduct.

Sexual harassment may include such conduct as explicit sexual propositions, sexual innuendo, suggestive comments or gestures, descriptive comments about an individual's physical appearance, electronic stalking or lewd messages, displays of foul or obscene printed or visual material, and any unwelcome physical contact.

Retaliation against anyone who has reported harassment, submits a complaint, reports an incident witnessed, or participates in any way in the investigation of a harassment claim is forbidden. Each complaint of harassment or retaliation will be promptly and thoroughly investigated. To the fullest extent possible, the AMA will keep complaints and the terms of their resolution confidential.

### **Operational Guidelines**

The AMA shall, through the Office of General Counsel, implement and maintain mechanisms for reporting, investigation, and enforcement of the Policy on Conduct at AMA Meetings and Events in accordance with the following:

### 1. Conduct Liaison and Committee on Conduct at AMA Meetings and Events (CCAM)

The Office of General Counsel will appoint a “Conduct Liaison” for all AMA House of Delegates meetings and all other AMA hosted meetings or activities (such as meetings of AMA councils, sections, the RVS Update Committee (RUC), CPT Editorial Panel, or JAMA Editorial Boards), with responsibility for receiving reports of alleged policy violations, conducting investigations, and initiating both immediate and longer-term consequences for such violations. The Conduct Liaison appointed for any meeting will have the appropriate training and experience to serve in this capacity, and may be a third party or an in-house AMA resource with assigned responsibility for this role. The Conduct Liaison will be (i) on-site at all House of Delegates meetings and other large, national AMA meetings and (ii) on call for smaller meetings and activities. Appointments of the Conduct Liaison for each meeting shall ensure appropriate independence and neutrality, and avoid even the appearance of conflict of interest, in investigation of alleged policy violations and in decisions on consequences for policy violations.

The AMA shall establish and maintain a Committee on Conduct at AMA Meetings and Events (CCAM), to be comprised of 5-7 AMA members who are nominated by the Office of General Counsel (or through a nomination process facilitated by the Office of General Counsel) and approved by the Board of Trustees. The CCAM should include one member of the Council on Ethical and Judicial Affairs (CEJA); provided, however, that such CEJA member on the CCAM shall be recused from discussion and vote concerning referral by the CCAM of a matter to CEJA for further review and action. The remaining members may be appointed from AMA membership generally, with emphasis on maximizing the diversity of membership. Appointments to the CCAM shall ensure appropriate independence and neutrality, and avoid even the appearance of conflict of interest, in decisions on consequences for policy violations. Appointments to the CCAM should be multi-year, with staggered terms.

### 2. Reporting Violations of the Policy

Any persons who believe they have experienced or witnessed conduct in violation of Policy H-140.837, “Policy on Conduct at AMA Meetings and Events,” during any AMA House of Delegates meeting or other activities associated with the AMA (such as meetings of AMA councils, sections, the RVS Update Committee (RUC), CPT Editorial Panel or JAMA Editorial Boards) should promptly notify the (i) Conduct Liaison appointed for such meeting, and/or (ii) the AMA Office of General Counsel and/or (iii) the presiding officer(s) of such meeting or activity.

Alternatively, violations may be reported using an AMA reporting hotline (telephone and online) maintained by a third party on behalf of the AMA. The AMA reporting hotline will provide an option to report anonymously, in which case the name of the reporting party will be kept confidential by the vendor and not be released to the AMA. The vendor will advise the AMA of any complaint it receives so that the Conduct Liaison may investigate.

These reporting mechanisms will be publicized to ensure awareness.

### 3. Investigations

All reported violations of Policy H-140.837, “Policy on Conduct at AMA Meetings and Events,” pursuant to Section 2 above (irrespective of the reporting mechanism used) will be investigated by the Conduct Liaison. Each reported violation will be promptly and thoroughly investigated. Whenever possible, the Conduct Liaison should conduct incident investigations

on-site during the event. This allows for immediate action at the event to protect the safety of event participants. When this is not possible, the Conduct Liaison may continue to investigate incidents following the event to provide recommendations for action to the CCAM. Investigations should consist of structured interviews with the person reporting the incident (the reporter), the person targeted (if they are not the reporter), any witnesses that the reporter or target identify, and the alleged violator.

Based on this investigation, the Conduct Liaison will determine whether a violation of the Policy on Conduct at AMA Meetings and Events has occurred.

All reported violations of the Policy on Conduct at AMA Meetings and Events, and the outcomes of investigations by the Conduct Liaison, will also be promptly transmitted to the AMA's Office of General Counsel (i.e. irrespective of whether the Conduct Liaison determines that a violation has occurred).

#### 4. Disciplinary Action

If the Conduct Liaison determines that a violation of the Policy on Conduct at AMA Meetings and Events has occurred, the Conduct Liaison may take immediate action to protect the safety of event participants, which may include having the violator removed from the AMA meeting, event or activity, without warning or refund.

Additionally, if the Conduct Liaison determines that a violation of the Policy on Conduct at AMA Meetings and Events has occurred, the Conduct Liaison shall report any such violation to the CCAM, together with recommendations as to whether additional commensurate disciplinary and/or corrective actions (beyond those taken on-site at the meeting, event or activity, if any) are appropriate.

The CCAM will review all incident reports, perform further investigation (if needed) and recommend to the Office of General Counsel any additional commensurate disciplinary and/or corrective action, which may include but is not limited to the following:

- Prohibiting the violator from attending future AMA events or activities;
- Removing the violator from leadership or other roles in AMA activities;
- Prohibiting the violator from assuming a leadership or other role in future AMA activities;
- Notifying the violator's employer and/or sponsoring organization of the actions taken by AMA;
- Referral to the Council on Ethical and Judicial Affairs (CEJA) for further review and action;
- Referral to law enforcement.

The CCAM may, but is not required to, confer with the presiding officer(s) of applicable events activities in making its recommendations as to disciplinary and/or corrective actions. Consequence for policy violations will be commensurate with the nature of the violation(s).

#### 5. Confidentiality

All proceedings of the CCAM should be kept as confidential as practicable. Reports, investigations, and disciplinary actions under Policy on Conduct at AMA Meetings and Events will be kept confidential to the fullest extent possible, consistent with usual business practices.

#### 6. Assent to Policy

As a condition of attending and participating in any meeting of the House of Delegates, or any council, section, or other AMA entities, such as the RVS Update Committee (RUC), CPT Editorial Panel and JAMA Editorial Boards, or other AMA hosted meeting or activity, each attendee will be required to acknowledge and accept (i) AMA policies concerning conduct at AMA HOD meetings, including the Policy on Conduct at AMA Meetings and Events and (ii) applicable adjudication and disciplinary processes for violations of such policies (including those implemented pursuant to these Operational Guidelines), and all attendees are expected to conduct themselves in accordance with these policies.

Additionally, individuals elected or appointed to a leadership role in the AMA or its affiliates will be required to acknowledge and accept the Policy on Conduct at AMA Meetings and Events and these Operational Guidelines.

[Editor's note: Violations of this Policy on Conduct at AMA Meetings and Events may be reported at 800.398.1496 or online at <https://www.lighthouse-services.com/ama>. Both are available 24 hours a day, 7 days a week.

Please note that situations unrelated to this Policy on Conduct at AMA Meetings and Events should not be reported here. In particular, patient concerns about a physician should be reported to the state medical board or other appropriate authority.]

BOT Rep. 23, A-17 Appended: BOT Rep. 20, A-18 Modified: BOT Rep. 10, A-19; Modified: CCB Rep. 2, I-20

CME Rep. 7, A-03 Modified and Appended: BOT Rep. 16, A-12

### **Teacher-Learner Relationship In Medical Education H-295.955**

The AMA recommends that each medical education institution have a widely disseminated policy that: (1) sets forth the expected standards of behavior of the teacher and the learner; (2) delineates procedures for dealing with breaches of that standard, including: (a) avenues for complaints, (b) procedures for investigation, (c) protection and confidentiality, (d) sanctions; and (3) outlines a mechanism for prevention and education. The AMA urges all medical education programs to regard the following Code of Behavior as a guide in developing standards of behavior for both teachers and learners in their own institutions, with appropriate provisions for grievance procedures, investigative methods, and maintenance of confidentiality.

#### **CODE OF BEHAVIOR**

The teacher-learner relationship should be based on mutual trust, respect, and responsibility. This relationship should be carried out in a professional manner, in a learning environment that places strong focus on education, high quality patient care, and ethical conduct.

A number of factors place demand on medical school faculty to devote a greater proportion of their time to revenue-generating activity. Greater severity of illness among inpatients also places heavy demands on residents and fellows. In the face of sometimes conflicting demands on their time, educators must work to preserve the priority of education and place appropriate emphasis on the critical role of teacher.

In the teacher-learner relationship, each party has certain legitimate expectations of the other. For example, the learner can expect that the teacher will provide instruction, guidance, inspiration, and leadership in learning. The teacher expects the learner to make an appropriate professional investment of energy and intellect to acquire the knowledge and skills necessary to become an effective physician. Both parties can expect the other to prepare appropriately for the educational interaction and to discharge their responsibilities in the educational relationship with unflinching honesty.

Certain behaviors are inherently destructive to the teacher-learner relationship. Behaviors such as violence, sexual harassment, inappropriate discrimination based on personal characteristics must never be tolerated. Other behavior can also be inappropriate if the effect interferes with professional development. Behavior patterns such as making habitual demeaning or derogatory remarks, belittling comments or destructive criticism fall into this category. On the behavioral level, abuse may be operationally defined as behavior by medical school faculty, residents, or students which is consensually disapproved by society and by the academic community as either exploitive or punishing. Examples of inappropriate behavior are: physical punishment or physical threats; sexual harassment; discrimination based on race, religion, ethnicity, sex, age, sexual orientation, gender identity, and physical disabilities; repeated episodes of psychological punishment of a student by a particular superior (e.g., public humiliation, threats and intimidation, removal of privileges); grading used to punish a student rather than to evaluate objective performance; assigning tasks for punishment rather than educational purposes; requiring the performance of personal services; taking credit for another individual's work; intentional neglect or intentional lack of communication.

On the institutional level, abuse may be defined as policies, regulations, or procedures that are socially disapproved as a violation of individuals' rights. Examples of institutional abuse are: policies, regulations, or procedures that are discriminatory based on race, religion, ethnicity, sex, age, sexual orientation, gender identity, and physical disabilities; and requiring individuals to perform unpleasant tasks that are entirely irrelevant to their education as physicians.

While criticism is part of the learning process, in order to be effective and constructive, it should be handled in a way to promote learning. Negative feedback is generally more useful when delivered in a private setting that fosters discussion and behavior modification. Feedback should focus on behavior rather than personal characteristics and should avoid pejorative labeling.

Because people's opinions will differ on whether specific behavior is acceptable, teaching programs should encourage discussion and exchange among teacher and learner to promote effective educational strategies. People in the teaching role (including faculty, residents, and students) need guidance to carry out their educational responsibilities effectively.

Medical schools are urged to develop innovative ways of preparing students for their roles as educators of other students as well as patients.

BOT Rep. ZZ, I-90 Reaffirmed by CME Rep. 9, A-98 Reaffirmed: CME Rep. 2, I-99 Modified: BOT Rep. 11, A-07 Reaffirmed: CME Rep. 9, A-13; Reaffirmed: BOT Rep. 9, I-20

### **Recommendations for Future Directions for Medical Education H-295.995**

Our AMA supports the following recommendations relating to the future directions for medical education:

- (1) The medical profession and those responsible for medical education should strengthen the general or broad components of both undergraduate and graduate medical education. All medical students and resident physicians should have general knowledge of the whole field of medicine regardless of their projected choice of specialty.
- (2) Schools of medicine should accept the principle and should state in their requirements for admission that a broad cultural education in the arts, humanities, and social sciences, as well as in the biological and physical sciences, is desirable.
- (3) Medical schools should make their goals and objectives known to prospective students and premedical counselors in order that applicants may apply to medical schools whose programs are most in accord with their career goals.

- (4) Medical schools should state explicitly in publications their admission requirements and the methods they employ in the selection of students.
- (5) Medical schools should require their admissions committees to make every effort to determine that the students admitted possess integrity as well as the ability to acquire the knowledge and skills required of a physician.
- (6) Although the results of standardized admission testing may be an important predictor of the ability of students to complete courses in the preclinical sciences successfully, medical schools should utilize such tests as only one of several criteria for the selection of students. Continuing review of admission tests is encouraged because the subject content of such examinations has an influence on premedical education and counseling.
- (7) Medical schools should improve their liaison with college counselors so that potential medical students can be given early and effective advice. The resources of regional and national organizations can be useful in developing this communication.
- (8) Medical schools are chartered for the unique purpose of educating students to become physicians and should not assume obligations that would significantly compromise this purpose.
- (9) Medical schools should inform the public that, although they have a unique capability to identify the changing medical needs of society and to propose responses to them, they are only one of the elements of society that may be involved in responding. Medical schools should continue to identify social problems related to health and should continue to recommend solutions.
- (10) Medical school faculties should continue to exercise prudent judgment in adjusting educational programs in response to social change and societal needs.
- (11) Faculties should continue to evaluate curricula periodically as a means of insuring that graduates will have the capability to recognize the diverse nature of disease, and the potential to provide preventive and comprehensive medical care. Medical schools, within the framework of their respective institutional goals and regardless of the organizational structure of the faculty, should provide a broad general education in both basic sciences and the art and science of clinical medicine.
- (12) The curriculum of a medical school should be designed to provide students with experience in clinical medicine ranging from primary to tertiary care in a variety of inpatient and outpatient settings, such as university hospitals, community hospitals, and other health care facilities. Medical schools should establish standards and apply them to all components of the clinical educational program regardless of where they are conducted. Regular evaluation of the quality of each experience and its contribution to the total program should be conducted.
- (13) Faculties of medical schools have the responsibility to evaluate the cognitive abilities of their students. Extramural examinations may be used for this purpose, but never as the sole criterion for promotion or graduation of a student.
- (14) As part of the responsibility for granting the MD degree, faculties of medical schools have the obligation to evaluate as thoroughly as possible the non-cognitive abilities of their medical students.
- (15) Medical schools and residency programs should continue to recognize that the instruction provided by volunteer and part-time members of the faculty and the use of facilities in which they practice make important contributions to the education of medical students and resident physicians. Development of means by which the volunteer and part-time faculty can express their professional viewpoints regarding the educational environment and curriculum should be encouraged.
- (16) Each medical school should establish, or review already established, criteria for the initial appointment, continuation of appointment, and promotion of all categories of faculty. Regular evaluation of the contribution of all faculty members should be conducted in accordance with institutional policy and practice.
- (17a) Faculties of medical schools should reevaluate the current elements of their fourth or final year with the intent of increasing the breadth of clinical experience through a more formal

structure and improved faculty counseling. An appropriate number of electives or selected options should be included. (17b) Counseling of medical students by faculty and others should be directed toward increasing the breadth of clinical experience. Students should be encouraged to choose experience in disciplines that will not be an integral part of their projected graduate medical education.

(18) Directors of residency programs should not permit medical students to make commitments to a residency program prior to the final year of medical school.

(19) The first year of postdoctoral medical education for all graduates should consist of a broad year of general training. (a) For physicians entering residencies in internal medicine, pediatrics, and general surgery, postdoctoral medical education should include at least four months of training in a specialty or specialties other than the one in which the resident has been appointed. (A residency in family practice provides a broad education in medicine because it includes training in several fields.) (b) For physicians entering residencies in specialties other than internal medicine, pediatrics, general surgery, and family practice, the first postdoctoral year of medical education should be devoted to one of the four above-named specialties or to a program following the general requirements of a transitional year stipulated in the "General Requirements" section of the "Essentials of Accredited Residencies." (c) A program for the transitional year should be planned, designed, administered, conducted, and evaluated as an entity by the sponsoring institution rather than one or more departments. Responsibility for the executive direction of the program should be assigned to one physician whose responsibility is the administration of the program. Educational programs for a transitional year should be subjected to thorough surveillance by the appropriate accrediting body as a means of assuring that the content, conduct, and internal evaluation of the educational program conform to national standards. The impact of the transitional year should not be deleterious to the educational programs of the specialty disciplines.

(20) The ACGME, individual specialty boards, and respective residency review committees should improve communication with directors of residency programs because of their shared responsibility for programs in graduate medical education.

(21) Specialty boards should be aware of and concerned with the impact that the requirements for certification and the content of the examination have upon the content and structure of graduate medical education. Requirements for certification should not be so specific that they inhibit program directors from exercising judgment and flexibility in the design and operation of their programs.

(22) An essential goal of a specialty board should be to determine that the standards that it has set for certification continue to assure that successful candidates possess the knowledge, skills, and the commitment to upgrade continually the quality of medical care.

(23) Specialty boards should endeavor to develop a consensus concerning the significance of certification by specialty and publicize it so that the purposes and limitations of certification can be clearly understood by the profession and the public.

(24) The importance of certification by specialty boards requires that communication be improved between the specialty boards and the medical profession as a whole, particularly between the boards and their sponsoring, nominating, or constituent organizations and also between the boards and their diplomates.

(25) Specialty boards should consider having members of the public participate in appropriate board activities.

(26) Specialty boards should consider having physicians and other professionals from related disciplines participate in board activities.

(27) The AMA recommends to state licensing authorities that they require individual applicants, to be eligible to be licensed to practice medicine, to possess the degree of Doctor of Medicine or its equivalent from a school or program that meets the standards of the LCME or accredited by the American Osteopathic Association, or to demonstrate as individuals, comparable academic and personal achievements. All applicants for full and unrestricted licensure should provide

evidence of the satisfactory completion of at least one year of an accredited program of graduate medical education in the US. Satisfactory completion should be based upon an assessment of the applicant's knowledge, problem-solving ability, and clinical skills in the general field of medicine. The AMA recommends to legislatures and governmental regulatory authorities that they not impose requirements for licensure that are so specific that they restrict the responsibility of medical educators to determine the content of undergraduate and graduate medical education.

(28) The medical profession should continue to encourage participation in continuing medical education related to the physician's professional needs and activities. Efforts to evaluate the effectiveness of such education should be continued.

(29) The medical profession and the public should recognize the difficulties related to an objective and valid assessment of clinical performance. Research efforts to improve existing methods of evaluation and to develop new methods having an acceptable degree of reliability and validity should be supported.

(30) Methods currently being used to evaluate the readiness of graduates of foreign medical schools to enter accredited programs in graduate medical education in this country should be critically reviewed and modified as necessary. No graduate of any medical school should be admitted to or continued in a residency program if his or her participation can reasonably be expected to affect adversely the quality of patient care or to jeopardize the quality of the educational experiences of other residents or of students in educational programs within the hospital.

(31) The Educational Commission for Foreign Medical Graduates should be encouraged to study the feasibility of including in its procedures for certification of graduates of foreign medical schools a period of observation adequate for the evaluation of clinical skills and the application of knowledge to clinical problems.

(32) The AMA, in cooperation with others, supports continued efforts to review and define standards for medical education at all levels. The AMA supports continued participation in the evaluation and accreditation of medical education at all levels.

(33) The AMA, when appropriate, supports the use of selected consultants from the public and from the professions for consideration of special issues related to medical education.

(34) The AMA encourages entities that profile physicians to provide them with feedback on their performance and with access to education to assist them in meeting norms of practice; and supports the creation of experiences across the continuum of medical education designed to teach about the process of physician profiling and about the principles of utilization review/quality assurance.

(35) Our AMA encourages the accrediting bodies for MD- and DO-granting medical schools to review, on an ongoing basis, their accreditation standards to assure that they protect the quality and integrity of medical education in the context of the emergence of new models of medical school organization and governance.

(36) Our AMA will strongly advocate for the rights of medical students, residents, and fellows to have physician-led (MD or DO as defined by the AMA) clinical training, supervision, and evaluation while recognizing the contribution of non-physicians to medical education.

(37) Our AMA will publicize to medical students, residents, and fellows their rights, as per Liaison Committee on Medical Education and Accreditation Council for Graduate Medical Education guidelines, to physician-led education and a means to report violations without fear of retaliation.

CME Rep. B, A-82 Amended: CLRPD Rep. A, I-92 Res. 331, I-95 Reaffirmed by Res. 322, A-97 Reaffirmation I-03 Modified: CME Rep. 7, A-05 Modified: CME Rep. 2, I-05 Appended: CME Rep. 5, A-11 Reaffirmed: CME Rep. 3, A-11 Modified: CME Rep. 01, I-17 Appended: Res. 961, I-18

1. Our AMA supports the concept that accreditation standards for undergraduate and graduate medical education should adopt a common competency framework that is based in the Accreditation Council for Graduate Medical Education (ACGME) competency domains.
2. Our AMA recommends that the relevant associations, including the AMA, Association of American Medical Colleges (AAMC), American Osteopathic Association (AOA), and American Association of Colleges of Osteopathic Medicine (AACOM), along with the relevant accreditation bodies for undergraduate medical education (Liaison Committee on Medical Education, Commission on Osteopathic College Accreditation) and graduate medical education (ACGME, AOA) develop strategies to:
  - a. Identify guidelines for the expected general levels of learners' competencies as they leave medical school and enter residency training.
  - b. Create a standardized method for feedback from medical school to premedical institutions and from the residency training system to medical schools about their graduates' preparedness for entry.
  - c. Identify areas where accreditation standards overlap between undergraduate and graduate medical education (e.g., standards related to the clinical learning environment) so as to facilitate coordination of data gathering and decision-making related to compliance.All of these activities should be codified in the standards or processes of accrediting bodies.
3. Our AMA encourages development and implementation of accreditation standards or processes that support utilization of tools (e.g., longitudinal learner portfolios) to track learners' progress in achieving the defined competencies across the continuum.
4. Our AMA supports the concept that evaluation of physicians as they progress along the medical education continuum should include the following: (a) assessments of each of the six competency domains of patient care, medical knowledge, interpersonal and communication skills, professionalism, practice-based learning and improvement, and systems-based practice; and (b) use of assessment instruments and tools that are valid and reliable and appropriate for each competency domain and stage of the medical education continuum.
5. Our AMA encourages study of competency-based progression within and between medical school and residency.
  - a. Through its Accelerating Change in Medical Education initiative, our AMA should study models of competency-based progression within the medical school.
  - b. Our AMA should work with the Accreditation Council for Graduate Medical Education (ACGME) to study how the Milestones of the Next Accreditation System support competency-based progression in residency.
6. Our AMA encourages research on innovative methods of assessment related to the six competency domains of the ACGME/American Board of Medical Specialties that would allow monitoring of performance across the stages of the educational continuum.
7. Our AMA encourages ongoing research to identify best practices for workplace-based assessment that allow performance data related to each of the six competency domains to be aggregated and to serve as feedback to physicians in training and in practice.

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