REPORTS OF THE COUNCIL ON MEDICAL EDUCATION

The following reports were presented by Niranjan V. Rao, MD, Chair:

1. COUNCIL ON MEDICAL EDUCATION SUNSET REVIEW OF 2012 HOUSE POLICIES

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: RECOMMENDATIONS ADOPTED
REMAINDER OF REPORT FILED

Policy G-600.110, "Sunset Mechanism for AMA Policy," calls for the decennial review of American Medical Association policies to ensure that our AMA's policy database is current, coherent, and relevant:

1. As the House of Delegates adopts policies, a maximum ten-year time horizon shall exist. A policy will typically sunset after ten years unless action is taken by the House of Delegates to retain it. Any action of our AMA House that reaffirms or amends an existing policy position shall reset the sunset "clock," making the reaffirmed or amended policy viable for another 10 years.

2. In the implementation and ongoing operation of our AMA policy sunset mechanism, the following procedures shall be followed: (a) Each year, the Speakers shall provide a list of policies that are subject to review under the policy sunset mechanism; (b) Such policies shall be assigned to the appropriate AMA councils for review; (c) Each AMA council that has been asked to review policies shall develop and submit a report to the House of Delegates identifying policies that are scheduled to sunset; (d) For each policy under review, the reviewing council can recommend one of the following actions: (i) retain the policy; (ii) sunset the policy; (iii) retain part of the policy; or (iv) reconcile the policy with more recent and like policy; (e) For each recommendation that it makes to retain a policy in any fashion, the reviewing council shall provide a succinct, but cogent justification; (f) The Speakers shall determine the best way for the House of Delegates to handle the sunset reports.

3. Nothing in this policy shall prohibit a report to the HOD or resolution to sunset a policy earlier than its 10-year horizon if it is no longer relevant, has been superseded by a more current policy, or has been accomplished.

4. The AMA councils and the House of Delegates should conform to the following guidelines for sunset: (a) when a policy is no longer relevant or necessary; (b) when a policy or directive has been accomplished; or (c) when the policy or directive is part of an established AMA practice that is transparent to the House and codified elsewhere such as the AMA Bylaws or the AMA House of Delegates Reference Manual: Procedures, Policies and Practices.

5. The most recent policy shall be deemed to supersede contradictory past AMA policies.

6. Sunset policies will be retained in the AMA historical archives.

RECOMMENDATION

The Council on Medical Education recommends that the House of Delegates policies listed in the appendix to this report be acted upon in the manner indicated and the remainder of this report be filed.

APPENDIX - Recommended Actions

Policy Number	Title	Text	Recommendation
H-35.975	Ratio of Physician to Physician Extenders	Our AMA endorses the principle that the appropriate ratio of physician to non-physician practitioners should be determined by physicians at the practice level, consistent with good medical practice, and state law where	Retain; still relevant.

		relevant, taking into consideration the physician's specialty, physician's panel size and disease burden of the patient case mix. (CME Rep. 10, I-98; Reaffirmed: CME Rep. 2, A-08; Reaffirmed: BOT Rep. 28, A-09; Modified: Joint CME-CMS Rep., I-12)	
H-160.940	Free Clinic Support	Our AMA supports: (1) organized efforts to involve volunteer physicians, nurses and other appropriate providers in programs for the delivery of health care to the indigent and uninsured and underinsured through free clinics; and (2) efforts to reduce the barriers faced by physicians volunteering in free clinics, including medical liability coverage under the Federal Tort Claims Act, liability protection under state and federal law, and state licensure provisions for retired physicians and physicians licensed in other United States jurisdictions. (Sub. Res. 113, I-96; Reaffirmed: BOT 17, A-04; CMS Rep. 1, A-09; Reaffirmed in lieu of Res. 105, A-12; Appended: CME Rep. 6, A-12)	Retain; still relevant. In addition, revise to incorporate relevant principles of H-160.953, "Free Clinics," which is rescinded through this report. Our AMA supports: (1) organized efforts to involve volunteer physicians, nurses and other appropriate providers in programs for the delivery of health care to the indigent and uninsured and underinsured through free clinics, to include potential partnerships with state and county medical societies to establish a jointly sponsored free clinic pilot program; and (2) efforts to reduce the barriers faced by physicians volunteering in free clinics, including medical liability coverage under the Federal Tort Claims Act, liability protection under state and federal law, and state licensure provisions for retired physicians and physicians licensed in other United States jurisdictions, in partnership with state and county medical societies; medical liability insurance providers; and state, county, and local government.
H-160.953	Free Clinics	The AMA: (1) encourages the establishment of free clinics as an immediate partial solution to providing access to health care for indigent and underserved populations; (2) will explore the potential for a partnership with state and county medical societies to establish a jointly-sponsored free clinic pilot program to provide health services and information to indigent and underserved populations; and (3) will develop strategies that will allow the AMA, along with one or more state or county medical societies, to join in partnership with private sector liability insurers and government - especially at the state, county, and local levels - to establish programs that will have appropriate levels of government pay professional liability premiums or indemnify physicians who deliver free services in free clinics or otherwise provide free care to the indigent. (BOT Rep. 27-A-94; Reaffirmed: BOT 17, A-04; Reaffirmed: CME Rep. 6, A-12)	Rescind and incorporate relevant principles into H-160.940, Free Clinic Support, as shown above. Clause 1 is already reflected in H-160.940 (1), which reads: Our AMA supports: (1) organized efforts to involve volunteer physicians, nurses and other appropriate providers in programs for the delivery of health care to the indigent and uninsured and underinsured through free clinics. Relevant segments of clauses 2 and 3 are incorporated into clauses 1 and 2 of H-160.940, as shown above.
H-275.922	Short-Term Physician Volunteer Opportunities Within the United States	Our AMA encourages the Federation of State Medical Boards to develop model policy for state licensure boards to streamline and	Rescind and incorporate into D-275.984, "Licensure and Liability for Senior Physician Volunteers," as shown below.

		standardize the process by which a physician who holds an unrestricted license in one state/district/territory may participate in physician volunteerism in another US state/district/territory in which the physician volunteer does not hold an unrestricted license. (Sub. Res. 915, I-10; Appended: CME Rep. 6, A-12)	
D-275.984	Licensure and Liability for Senior Physician Volunteers	Our AMA (1) and its Senior Physician Group will inform physicians about special state licensing regulations for volunteer physicians; and (2) will support and work with state medical licensing boards and other appropriate agencies, including the sharing of model state legislation, to establish special reduced-fee volunteer medical license for those who wish to volunteer their services to the uninsured or indigent. (BOT Rep. 17, A-04; Reaffirmed: CCB/CLRPD Rep. 1, A-14)	Retain; still relevant. In addition, revise to append information from similar policy H-275.922, "Short-Term Physician Volunteer Opportunities Within the United States," which is rescinded through this report. Also, revise the title of this policy to remove references to senior physicians, as it now reflects all physician volunteers, regardless of age. Licensure and Liability for Senior Physician Volunteers Our AMA (1) and its Senior Physician Group will (1) inform physicians about special state licensing regulations for volunteer physicians providing their services to the uninsured or indigent; and (2) will support and work with state medical licensing boards and other appropriate agencies, including the Federation of State Medical Boards, to develop sharing of model policy and state legislation, to (a) streamline and standardize the process by which a physician who holds an unrestricted license in one state/district/territory may participate in physician volunteerism in another U.S. state/district/territory in which the individual does not hold an unrestricted license and (b) establish special reduced-fee volunteer medical licenses for those who wish to volunteer their services to the uninsured or indigent.
H-210.991	The Education of Physicians in Home Care	It is the policy of the AMA that: (1) faculties of the schools of medicine be encouraged to teach the science and art of home care as part of the regular undergraduate curriculum; (2) graduate programs in the fields of family practice, general internal medicine, pediatrics, obstetrics, general surgery, orthopedics, physiatry, and psychiatry be encouraged to incorporate training in home care practice; (3) the concept of home care as part of the continuity of patient care, rather than as an alternative care mode, be promoted to physicians and other health care professionals; (4) assessment for home care be incorporated in all hospital discharge planning;	Retain; still relevant, with editorial revisions as shown to reflect the full (and current) names of the organizations in clause 6.

		(5) our AMA develop programs to increase physician awareness of and skill in the practice of home care; (6) our AMA foster physician participation (and itself be represented) at all present and future home care organizational planning initiatives (e.g., JCAHO, ASTM, FDA, The Joint Commission, ASTM International, Food and Drug Administration, etc.); (7) our AMA encourage a leadership role for physicians as active team participants in home care issues such as quality standards, public policy, utilization, and reimbursement issues, etc.; and (8) our AMA recognize the responsibility of the physician who is involved in home care and recommend appropriate reimbursement for those health care services. (Joint CSA/CME Rep., A-90; Reaffirmed: Sunset Report, I-00; Reaffirmation A-02; Modified: CSAPH Rep. 1, A-12)	
H-255.968	Advance Tuition Payment Requirements for International Students Enrolled in US Medical Schools	Our AMA: 1. supports the autonomy of medical schools to determine optimal tuition requirements for international students; 2. encourages medical schools and undergraduate institutions to fully inform international students interested in medical education in the US of the limited options available to them for tuition assistance; 3. supports the Association of American Medical Colleges (AAMC) in its efforts to increase transparency in the medical school application process for international students by including school policy on tuition requirements in the Medical School Admission Requirements (MSAR); and 4. encourages medical schools to explore alternative means of prepayment, such as a letter of credit, for four years of medical school. (CME Rep. 5, A-12)	Retain; still relevant.
H-255.987	Foreign Medical Graduates	1. Our AMA supports continued efforts to protect the rights and privileges of all physicians duly licensed in the US regardless of ethnic or educational background and opposes any legislative efforts to discriminate against duly licensed physicians on the basis of ethnic or educational background.	Still relevant; append to H-255.988, "AMA Principles on International Medical Graduates," as these are central tenets related to IMGs that should be reflected in that overarching policy: Our AMA supports: … 23. Continued efforts to protect the rights and privileges of all physicians duly licensed in the

		2. Our AMA will: (a) continuously study challenges and issues pertinent to IMGs as they affect our country's health care system and our physician workforce; and (b) lobby members of the US Congress to fund studies through appropriate agencies, such as the Department of Health and Human Services, to examine issues and experiences of IMGs and make recommendations for improvements. (Res. 56, A-86; Reaffirmed: Sunset Report, I-96; Reaffirmation A-00; Reaffirmed: CME Rep. 2, A-10; Reaffirmed: CME Rep. 11, A-10; Appended: Res. 303, A-10; Reaffirmation A-11; Reaffirmation A-12)	U.S. regardless of ethnic or educational background and opposes any legislative efforts to discriminate against duly licensed physicians on the basis of ethnic or educational background. 24. Continued study of challenges and issues pertinent to IMGs as they affect our country's health care system and our physician workforce. 25. Advocacy to Congress to fund studies through appropriate agencies, such as the Department of Health and Human Services, to examine issues and experiences of IMGs and make recommendations for improvements.
H-275.949	Discrimination Against Physicians Under Supervision of Their Medical Examining Board	1. Our AMA opposes the exclusion of otherwise capable physicians from employment, business opportunity, insurance coverage, specialty board certification or recertification, and other benefits, solely because the physician is either presently, or has been in the past, under the supervision of a medical licensing board in a program of rehabilitation or enrolled in a state-wide physician health program. 2. Our AMA will communicate Policy H-275.949 to all specialty boards and request that they reconsider their policy of exclusion where such a policy exists. (Sub. Res. 3, A-92; Reaffirmed: BOT Rep. 18, I-93; Reaffirmed: CME Rep. 2, A-05; Appended: Res. 925, I-11; Reaffirmed in lieu of Res. 412, A-12; Reaffirmed: BOT action in response to referred for decision Res. 403, A-12)	Rescind; superseded by D-405.984, "Confidentiality of Enrollment in Physicians (Professional) Health Programs:" 1. Our American Medical Association will work with other medical professional organizations, the Federation of State Medical Boards, the American Board of Medical Specialties, and the Federation of State Physician Health Programs, to seek and/or support rules and regulations or legislation to provide for confidentiality of fully compliant participants in physician (and similar) health programs or their recovery programs in responding to questions on medical practice or licensure applications. 2. Our AMA will work with The Joint Commission, national hospital associations, national health insurer organizations, and the Centers for Medicare and Medicaid Services to avoid questions on their applications that would jeopardize the confidentiality of applicants who are compliant with treatment within professional health programs and who do not constitute a current threat to the care of themselves or their patients. Also see H-275.978(6-9), "Medical Licensure:" (6) urges licensing boards, specialty boards, hospitals and their medical staffs, and other organizations that evaluate physician competence to inquire only into conditions which impair a physician's current ability to practice medicine; (7) urges licensing boards to maintain strict confidentiality of reported information; (8) urges that the evaluation of information collected by licensing boards be undertaken only by persons experienced in medical licensure and competent to make judgments about physician competence. It is recommended that decisions concerning medical competence and discipline be made with the participation of physician members of the board;

			(9) recommends that if confidential information is improperly released by a licensing board about a physician, the board take appropriate and immediate steps to correct any adverse consequences to the physician;
H-275.953	The Grading Policy for Medical Licensure Examinations	1. Our AMA's representatives to the ACGME are instructed to promote the principle that selection of residents should be based on a broad variety of evaluative criteria, and to propose that the ACGME General Requirements state clearly that residency program directors must not use NBME or USMLE ranked passing scores as a screening criterion for residency selection. 2. Our AMA adopts the following policy on NBME or USMLE examination scoring: (a) Students receive "pass/fail" scores as soon as they are available. (If students fail the examinations, they may request their numerical scores immediately.) (b) Numerical scores are reported to the state licensing authorities upon request by the applicant for licensure. At this time, the applicant may request a copy of his or her numerical scores. (c) Scores are reported in pass/fail format for each student to the medical school. The school also receives a frequency distribution of numerical scores for the aggregate of their students. 3. Our AMA will co-convene the appropriate stakeholders to study possible mechanisms for transitioning scoring of the USMLE and COMLEX exams to a Pass/Fail system in order to avoid the inappropriate use of USMLE and COMLEX scores for screening residency applicants while still affording program directors adequate information to meaningfully and efficiently assess medical student applications, and that the recommendations of this study be made available by the 2019 Interim Meeting of the AMA House of Delegates. 34. Our AMA will: (a) promote equal acceptance of the USMLE and COMLEX at all United States residency programs; (b) work with appropriate stakeholders including but not limited to the National Board of Medical Examiners, Association of American Medical Colleges, National Board of Osteopathic Medical Examiners,	Retain; still relevant, with the exception of clause 3, which was fulfilled through Council on Medical Education Report 5-I-19, "The Transition from Undergraduate Medical Education to Graduate Medical Education."

		Accreditation Council for Graduate Medical Education and American Osteopathic Association to educate Residency Program Directors on how to interpret and use COMLEX scores; and (c) work with Residency Program Directors to promote higher COMLEX utilization with residency program matches in light of the new single accreditation system. 45. Our AMA will work with appropriate stakeholders to release guidance for residency and fellowship program directors on equitably comparing students who received 3-digit United States Medical Licensing Examination Step 1 or Comprehensive Osteopathic Medical Licensing Examination of the United States Level 1 scores and students who received Pass/Fail scores. (CME Rep. G, I-90; Reaffirmed by Res. 310, A-98; Reaffirmed: CME Rep. 3, A-04; Reaffirmed: CME Rep. 2, A-14; Appended: Res. 309, A-17; Modified: Res. 318, A-18; Appended: Res. 955, I-18; Appended: Res. 301, I-21)	
H-275.956	Demonstration of Clinical Competence	It is the policy of the AMA to (1) support continued efforts to develop and validate methods for assessment of clinical skills; (2) continue its participation in the development and testing of methods for clinical skills assessment; and (3) recognize that clinical skills assessment is best performed using a rigorous and consistent examination administered by medical schools and should not be used for licensure of graduates of Liaison Committee on Medical Education (LCME)- and American Osteopathic Association (AOA)-accredited medical schools or of Educational Commission for Foreign Medical Graduates (ECFMG)-certified physicians. (CME Rep. E, A-90; Reaffirmed: CME Rep. 5, A-99; Modified: Sub. Res. 821, I-02; Modified: CME Rep. 1, I-03; Reaffirmed: CME Rep. 16, A-09; Reaffirmed in lieu of Res. 313, A-12)	Rescind; superseded by D-295.988, "Clinical Skills Assessment During Medical School:" 1. Our AMA will encourage its representatives to the Liaison Committee on Medical Education (LCME) to ask the LCME to determine and disseminate to medical schools a description of what constitutes appropriate compliance with the accreditation standard that schools should "develop a system of assessment" to assure that students have acquired and can demonstrate core clinical skills. 2. Our AMA will work with the Federation of State Medical Boards, National Board of Medical Examiners, state medical societies, state medical boards, and other key stakeholders to pursue the transition from and replacement for the current United States Medical Licensing Examination (USMLE) Step 2 Clinical Skills (CS) examination and the Comprehensive Osteopathic Medical Licensing Examination (COMLEX) Level 2-Performance Examination (PE) with a requirement to pass a Liaison Committee on Medical Education-accredited or Commission on Osteopathic College Accreditation-accredited medical school-administered, clinical skills examination. 3. Our AMA will work to: (a) ensure rapid yet carefully considered changes to the current examination process to reduce costs, including travel expenses, as well as time away from

			educational pursuits, through immediate steps by the Federation of State Medical Boards and National Board of Medical Examiners; (b) encourage a significant and expeditious increase in the number of available testing sites; (c) allow international students and graduates to take the same examination at any available testing site; (d) engage in a transparent evaluation of basing this examination within our nation's medical schools, rather than administered by an external organization; and (e) include active participation by faculty leaders and assessment experts from U.S. medical schools, as they work to develop new and improved methods of assessing medical student competence for advancement into residency. 4. Our AMA is committed to assuring that all medical school graduates entering graduate medical education programs have demonstrated competence in clinical skills. 5. Our AMA will continue to work with appropriate stakeholders to assure the processes for assessing clinical skills are evidence-based and most efficiently use the time and financial resources of those being assessed. 6. Our AMA encourages development of a post-examination feedback system for all USMLE test-takers that would: (a) identify areas of satisfactory or better performance; (b) identify areas of suboptimal performance; and (c) give students who fail the exam insight into the areas of unsatisfactory performance on the examination. 7. Our AMA, through the Council on Medical Education, will continue to monitor relevant data and engage with stakeholders as necessary should updates to this policy become necessary. Also superseded by D-275.950, "Retirement of the National Board of Medical Examiners Step 2 Clinical Skills Exam for US Medical Graduates: Call for Expedited Action by the American Medical Association:" Our AMA: (1) will take immediate, expedited action to encourage the National Board of Medical Examiners (NBME), Federation of State Medical Boards (FSMB), and National Board of Osteopathic Medical Examiners (NBOME) to eliminate centralized clinical skills examinations used as a part of state licensure, including the USMLE Step 2 Clinical Skills Exam and the Comprehensive Osteopathic Medical Licensing Examination (COMLEX) Level 2 - Performance Evaluation Exam; (2) in collaboration with the Educational Commission for Foreign Medical Graduates (ECFMG), will advocate for an equivalent, equitable, and timely pathway for international medical graduates to

			demonstrate clinical skills competency; (3) strongly encourages all state delegations in the AMA House of Delegates and other interested member organizations of the AMA to engage their respective state medical licensing boards, the Federation of State Medical Boards, their medical schools and other interested credentialling bodies to encourage the elimination of these centralized, costly and low-value exams; and (4) will advocate that any replacement examination mechanisms be instituted immediately in lieu of resuming existing USMLE Step 2-CS and COMLEX Level 2-PE examinations when the COVID-19 restrictions subside.
D-275.974	Depression and Physician Licensure	Our AMA will (1) recommend that physicians who have major depression and seek treatment not have their medical licenses and credentials routinely challenged but instead have decisions about their licensure and credentialing and recredentialing be based on professional performance; and (2) make this resolution known to the various state medical licensing boards and to hospitals and health plans involved in physician credentialing and recredentialing. (Res. 319, A-05; Reaffirmed: BOT action in response to referred for decision Res. 403, A-12)	Rescind; superseded by H-275.970, "Licensure Confidentiality," which reads: 1. The AMA (a) encourages specialty boards, hospitals, and other organizations involved in credentialing, as well as state licensing boards, to take all necessary steps to assure the confidentiality of information contained on application forms for credentials; (b) encourages boards to include in application forms only requests for information that can reasonably be related to medical practice; (c) encourages state licensing boards to exclude from license application forms information that refers to psychoanalysis, counseling, or psychotherapy required or undertaken as part of medical training; (d) encourages state medical societies and specialty societies to join with the AMA in efforts to change statutes and regulations to provide needed confidentiality for information collected by licensing boards; and (e) encourages state licensing boards to require disclosure of physical or mental health conditions only when a physician is suffering from any condition that currently impairs his/her judgment or that would otherwise adversely affect his/her ability to practice medicine in a competent, ethical, and professional manner, or when the physician presents a public health danger. 2. Our AMA will encourage those state medical boards that wish to retain questions about the health of applicants on medical licensing applications to use the language recommended by the Federation of State Medical Boards that reads, "Are you currently suffering from any condition for which you are not being appropriately treated that impairs your judgment or that would otherwise adversely affect your ability to practice medicine in a competent, ethical and professional manner? (Yes/No)."
D-275.992	Unified Medical License Application	Our AMA will request the Federation of State Medical Boards to examine the issue of a standardized medical licensure application form for those data elements that are common to all	Rescind; this directive has been accomplished. Currently, 28 licensing jurisdictions use the Uniform Application for Physician State Licensure from the Federation of State Medical Boards.

		medical licensure applications. (Res. 308, I-01; Reaffirmed: CME Rep. 2, A-11; Reaffirmed: CME Rep. 6, A-12)	
D-295.934	Encouragement of Interprofessional Education Among Health Care Professions Students	1. Our AMA: (A) recognizes that interprofessional education and partnerships are a priority of the American medical education system; and (B) will explore the feasibility of the implementation of Liaison Committee on Medical Education and American Osteopathic Association accreditation standards requiring interprofessional training in medical schools. 2. Our AMA supports the concept that medical education should prepare students for practice in physician-led interprofessional teams. 3. Our AMA will encourage health care organizations that engage in a collaborative care model to provide access to an appropriate mix of role models and learners. 4. Our AMA will encourage the Liaison Committee on Medical Education, Commission on Osteopathic College Accreditation, American Osteopathic Association, and Accreditation Council for Graduate Medical Education to facilitate the incorporation of physician-led interprofessional education into the educational programs for medical students and residents in ways that support high quality medical education and patient care. 5. Our AMA will encourage the development of skills for interprofessional education that are applicable to and appropriate for each group of learners. (Res. 308, A-08; Appended: CME Rep. 1, I-12)	Retain in part, with edits to clauses 1 and 4, as these directives have been accomplished.
D-295.942	Patient Safety Curricula in Undergraduate Medical Education	1. Our AMA will explore the feasibility of asking the Liaison Committee on Medical Education to encourage the discussion of basic patient safety and quality improvement issues in medical school curricula. 2. Our AMA will encourage the Liaison Committee on Medical Education to include patient safety and quality of patient care curriculum within the core competencies of medical education in order to instill these fundamental skills in all undergraduate medial students.	Rescind; superseded by H-295.864, “Systems-Based Practice Education for Medical Students and Resident/Fellow Physicians.” Our AMA: (1) supports the availability of educational resources and elective rotations for medical students and resident/fellow physicians on all aspects of systems-based practice, to improve awareness of and responsiveness to the larger context and system of health care and to aid in developing our next generation of physician leaders; (2) encourages development of model guidelines and curricular goals for elective courses and rotations and fellowships in systems-based practice, to be used by state and

		(Res. 801, I-07; Appended: Res. 320, A-12)	specialty societies, and explore developing an educational module on this topic as part of its Introduction to the Practice of Medicine (IPM) product; and (3) will request that undergraduate and graduate medical education accrediting bodies consider incorporation into their requirements for systems-based practice education such topics as health care policy and patient care advocacy; insurance, especially pertaining to policy coverage, claim processes, reimbursement, basic private insurance packages, Medicare, and Medicaid; the physician's role in obtaining affordable care for patients; cost awareness and risk benefit analysis in patient care; inter-professional teamwork in a physician-led team to enhance patient safety and improve patient care quality; and identification of system errors and implementation of potential systems solutions for enhanced patient safety and improved patient outcomes.
D-295.964	Pharmaceutical Federal Regulations -- Protecting Resident Interests	Our AMA shall continue to evaluate and oppose, as appropriate, federal regulations on the pharmaceutical industry that would curtail educational and/or research opportunities open to residents and fellows that are in compliance with current AMA ethical guidelines. (Res. 921, I-02; Reaffirmed: CCB/CLRPD Rep. 4, A-12)	Retain; still relevant.
D-295.966	Pain Management Standards and Performance Measures	Our AMA, through the Council on Medical Education, shall continue to work with relevant medical specialty organizations to improve education in pain management in medical schools, residency programs, and continuing medical education programs. (CSA Rep. 4, A-02; Reaffirmed: CCB/CLRPD Rep. 4, A-12)	Rescind; superseded by D-160.981 (1), "Promotion of Better Pain Care:" 1. Our AMA: (a) will express its strong commitment to better access and delivery of quality pain care through the promotion of enhanced research, education and clinical practice in the field of pain medicine; and (b) encourages relevant specialties to collaborate in studying the following: (i) the scope of practice and body of knowledge encompassed by the field of pain medicine; (ii) the adequacy of undergraduate, graduate and post graduate education in the principles and practice of the field of pain medicine, considering the current and anticipated medical need for the delivery of quality pain care; (iii) appropriate training and credentialing criteria for this multidisciplinary field of medical practice; and (iv) convening a meeting of interested parties to review all pertinent matters scientific and socioeconomic. Also superseded by D-120.985(3), "Education and Awareness of Opioid Pain Management Treatments, Including Responsible Use of Methadone:" 3. Our AMA will work in conjunction with the Association of American Medical Colleges, American Osteopathic Association, Commission on Osteopathic College Accreditation, Accreditation Council for Graduate Medical

			Education, and other interested professional organizations to develop opioid education resources for medical students, physicians in training, and practicing physicians.
D-295.970	HIV Postexposure Prophylaxis for Medical Students During Electives Abroad	Our AMA: (1) recommends that US medical schools ensure that medical students who engage in clinical rotations abroad have immediate access to HIV postexposure prophylaxis; and (2) encourages medical schools to provide information to medical students regarding the potential health risks of completing a medical rotation abroad, and on the appropriate precautions to take to minimize such risks. (Res. 303, A-02; Reaffirmed: CCB/CLRPD Rep. 4, A-12)	Retain; still relevant, with minor edit as shown so that the policy content matches the title.
D-295.972	Standardized Advanced Cardiac Life Support (ACLS) Training for Medical Students	Our AMA shall: (1) encourage standardized Advanced Cardiac Life Support (ACLS) training for medical students prior to clinical clerkships; and (2) strongly encourage medical schools to fund ACLS training for medical students. (Res. 314, A-02; Reaffirmed: CCB/CLRPD Rep. 4, A-12)	Retain by rescission and appending to related Policy H-300.945, "Proficiency of Physicians in Basic and Advanced Cardiac Life Support," to read as follows: Our AMA: (1) believes that all licensed physicians should become proficient in basic CPR and in advanced cardiac life support commensurate with their responsibilities in critical care areas; (2) recommends to state and county medical associations that programs be undertaken to make the entire physician population, regardless of specialty or subspecialty interests, proficient in basic CPR; and (3) encourages training of cardiopulmonary resuscitation and basic life support be funded by medical schools and provided to first-year medical students, preferably during the first term or prior to clinical clerkships.
H-295.876	Equal Fees for Osteopathic and Allopathic Medical Students	1. Our AMA, in collaboration with the American Osteopathic Association, discourages discrimination against medical students by institutions and programs based on osteopathic or allopathic training. 2. Our AMA encourages equitable access to and equitable fees for clinical electives for allopathic and osteopathic medical students. 3. Our AMA will work with relevant stakeholders to explore reasons behind application barriers that result in discrimination against osteopathic medical students when applying to elective visiting clinical rotations, and generate a report with the findings by the 2020 Interim Meeting. 34. Our AMA: (a) encourages the Association of American Medical	Retain; still relevant, with the exception of clause 3, which has been fulfilled through Council on Medical Education Report 5-N-21, "Investigation of Existing Application Barriers for Osteopathic Medical Students Applying for Away Rotations."

		Colleges to request that its member institutions promote equitable access to clinical electives for allopathic and osteopathic medical students and charge equitable fees to visiting allopathic and osteopathic medical students; and (b) encourages the Accreditation Council for Graduate Medical Education to require its accredited programs to work with their respective affiliated institutions to ensure equitable access to clinical electives for allopathic and osteopathic medical students and charge equitable fees to visiting allopathic and osteopathic medical students. (Res. 809, I-05; Appended: CME Rep. 6, A-07; Modified: CCB/CLRPD Rep. 2, A-14; Appended: Res. 303, I-19; Modified: CME Rep. 5, I-21)	
H-295.882	Proposed Consolidation of Liaison Committee on Medical Education	(1) Our AMA reaffirms its ongoing commitment to excellence in medical education and its continuing responsibility for accreditation of undergraduate medical education. (2). Our AMA supports a formal recognition of the organizational relationships among the AMA, the AAMC, and the LCME through a memorandum of understanding. (3) Consistent with United States Department of Education regulations and its historic role, the LCME should remain the final decision-making authority over accreditation matters, decisions, and policies for undergraduate medical education leading to the MD degree. (4) The LCME will have final decision-making authority regarding the establishment, adoption and amendment of accreditation standards, through a defined process that allows the sponsors an opportunity to review, comment, and recommend changes to, and refer back for further consideration, new or amended standards proposed by the LCME. (5) A new entity will be formed to support communications, flexibility and planning among the AMA, the AAMC and the LCME on medical school accreditation, with membership, authority and additional parameters to be defined within the new memorandum of understanding. (6) The AMA Council on Medical Education will be the entity within the AMA to determine policy	Rescind; this policy was accomplished in 2012, implemented in 2013, and remains in effect through the LCME Council and other activities of the AMA, AAMC, and LCME.

		relating to the organization or structure of the LCME. (CME Rep. 7, A-03; Modified and Appended: BOT Rep. 16, A-12)	
D-300.996	Voluntary Continuing Education for Physicians in Pain Management	Our AMA will encourage appropriate organizations to support voluntary continuing education for physicians based on effective guidelines in pain management. (Res. 308, A-01; Modified: CME Rep. 2, A-11; Reaffirmed: CME Rep. 6, A-1)	Rescind; superseded by D-160.981(1), "Promotion of Better Pain Care:" 1. Our AMA: (a) will express its strong commitment to better access and delivery of quality pain care through the promotion of enhanced research, education and clinical practice in the field of pain medicine; and (b) encourages relevant specialties to collaborate in studying the following: (i) the scope of practice and body of knowledge encompassed by the field of pain medicine; (ii) the adequacy of undergraduate, graduate and post graduate education in the principles and practice of the field of pain medicine, considering the current and anticipated medical need for the delivery of quality pain care; (iii) appropriate training and credentialing criteria for this multidisciplinary field of medical practice; and (iv) convening a meeting of interested parties to review all pertinent matters scientific and socioeconomic. Also superseded by D-120.985(3), "Education and Awareness of Opioid Pain Management Treatments, Including Responsible Use of Methadone:" 3. Our AMA will work in conjunction with the Association of American Medical Colleges, American Osteopathic Association, Commission on Osteopathic College Accreditation, Accreditation Council for Graduate Medical Education, and other interested professional organizations to develop opioid education resources for medical students, physicians in training, and practicing physicians.
D-310.974	Policy Suggestions to Improve the National Resident Matching Program	Our AMA will: (1) request that the National Resident Matching Program review the basis for the extra charge for including over 15 programs on a primary rank order list and consider modifying the fee structure to minimize such charges; (2) work with the NRMP to increase awareness among applicants of the existing NRMP waiver and violations review policies to assure their most effective implementation; (3) request that the NRMP continue to explore measures to maximize the availability of information for	Rescind as a number of aspects of this directive have been accomplished, and incorporate the remaining relevant and timely segments into D-310.977 (1) and (4), "National Resident Matching Program Reform," as shown below. Clause 1: Rescind; this runs counter to the current approach of encouraging medical students to be judicious in the number of match applications, as this increases the burden on residency program personnel and does not appreciably help the applicant, after a certain threshold of program applications is reached. Clause 2: Retain through insertion of relevant language into Clause 1 of D-310.977, as shown below. Clause 3: Rescind; this request is reflected in the NRMP's Supplemental Offer and Acceptance Program (SOAP).

		unmatched applicants and unfilled programs including the feasibility of creating a dynamic list of unmatched applicants;	
		(4) ask the National Resident Matching Program (NRMP) to publish data regarding waivers and violations with subsequent consequences for both programs and applicants while maintaining the integrity of the match and protecting the identities of both programs and participants;	Clause 4: Rescind; the NRMP has published two articles in this regard, on applicant non-compliance and program non-compliance, respectively.
		(5) advocate that the words "residency training" in section 8.2.10 of the NRMP Match agreement be added to the second sentence so that it reads, "The applicant also may be barred from accepting or starting a position in any residency training program sponsored by a match-participating institution that would commence training within one year from the date of issuance of the Final Report" and specifically state that NRMP cannot prevent an applicant from maintaining his or her education through rotating, researching, teaching, or otherwise working in positions other than resident training at NRMP affiliated programs; and	Clause 5: Rescind; reflected in NRMP policy on match violations, section 6.E.b.iii, which states that sanctions for a confirmed violation by an applicant include "being barred for one year from accepting an offer of a position or a new training year, regardless of the start date (or renewing a training contract for a position at a different level or for a subsequent year), in any residency or fellowship training program sponsored by a Match-participating institution and/or starting a position or a new training year in any program sponsored by a Match-participating institution if training would commence within one year from the date of issuance of the Final Report."
		(6) work with the Educational Commission for Foreign Medical Graduates, Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, and other graduate medical education stakeholders to encourage the NRMP to make the conditions of the Match agreement more transparent while assuring the confidentiality of the match and to use a thorough process in declaring that a violation has occurred. (CME Rep. 15, A-06; Appended: Res. 918, I-11; Appended: CME Rep. 12, A-12)	Clause 6: Retain through insertion of relevant language into Clause 4 of D-310.977, as shown below. The phrase "and using a thorough process in declaring that a violation has occurred" is not included in the edits below, as it is reflected in the NRMP policy noted above on match violations. Also, note editorial change below to the end of Clause 8 (adding an "s" to "applicant"). Our AMA: (1) will work with the National Resident Matching Program (NRMP) to develop and distribute educational programs to better inform applicants about the NRMP matching process, including the existing NRMP waiver and violations review policies; (2) will actively participate in the evaluation of, and provide timely comments about, all proposals to modify the NRMP Match; (3) will request that the NRMP explore the possibility of including the Osteopathic Match in the NRMP Match; (4) will continue to review the NRMP's policies and procedures and make recommendations for improvements as the need arises, to include making the conditions of the Match agreement

			more transparent while assuring the confidentiality of the match; (5) will work with the Accreditation Council for Graduate Medical Education (ACGME) and other appropriate agencies to assure that the terms of employment for resident physicians are fair and equitable and reflect the unique and extensive amount of education and experience acquired by physicians; (6) does not support the current the "All-In" policy for the Main Residency Match to the extent that it eliminates flexibility within the match process; (7) will work with the NRMP, and other residency match programs, in revising Match policy, including the secondary match or scramble process to create more standardized rules for all candidates including application timelines and requirements; (8) will work with the NRMP and other external bodies to develop mechanisms that limit disparities within the residency application process and allow both flexibility and standard rules for applicants; (9) encourages the National Resident Matching Program to study and publish the effects of implementation of the Supplemental Offer and Acceptance Program on the number of residency spots not filled through the Main Residency Match and include stratified analysis by specialty and other relevant areas; (10) will work with the NRMP and ACGME to evaluate the challenges in moving from a time-based education framework toward a competency-based system, including: a) analysis of time-based implications of the ACGME milestones for residency programs; b) the impact on the NRMP and entry into residency programs if medical education programs offer variable time lengths based on acquisition of competencies; c) the impact on financial aid for medical students with variable time lengths of medical education programs; d) the implications for interprofessional education and rewarding teamwork; and e) the implications for residents and students who achieve milestones earlier or later than their peers; (11) will work with the Association of American Medical Colleges (AAMC), American Osteopathic Association (AOA), American Association of Colleges of Osteopathic Medicine (AACOM), and National Resident Matching Program (NRMP) to evaluate the current available data or propose new studies that would help us learn how many students graduating from US medical schools each year do not enter into a US residency program; how many never enter into a US residency program; whether there is disproportionate impact on individuals of minority racial and ethnic groups; and what careers are pursued by those with an MD or DO degree who do not enter residency programs;

			(12) will work with the AAMC, AOA, AACOM and appropriate licensing boards to study whether US medical school graduates and international medical graduates who do not enter residency programs may be able to serve unmet national health care needs; (13) will work with the AAMC, AOA, AACOM and the NRMP to evaluate the feasibility of a national tracking system for US medical students who do not initially match into a categorical residency program; (14) will discuss with the National Resident Matching Program, Association of American Medical Colleges, American Osteopathic Association, Liaison Committee on Medical Education, Accreditation Council for Graduate Medical Education, and other interested bodies potential pathways for reengagement in medicine following an unsuccessful match and report back on the results of those discussions; (15) encourages the Association of American Medical Colleges to work with U.S. medical schools to identify best practices, including career counseling, used by medical schools to facilitate successful matches for medical school seniors, and reduce the number who do not match; (16) supports the movement toward a unified and standardized residency application and match system for all non-military residencies; (17) encourages the Educational Commission for Foreign Medical Graduates (ECFMG) and other interested stakeholders to study the personal and financial consequences of ECFMG-certified U.S. IMGs who do not match in the National Resident Matching Program and are therefore unable to get a residency or practice medicine; and (18) encourages the AAMC, AACOM, NRMP, and other key stakeholders to jointly create a no-fee, easily accessible clearinghouse of reliable and valid advice and tools for residency program applicants seeking cost-effective methods for applying to and successfully matching into residency.
H-310.909	ACGME Residency Program Entry Requirements	Our AMA supports entry into Accreditation Council on Graduate Medical Education (ACGME) accredited residency and fellowship programs from either ACGME-accredited programs or American Osteopathic Association-accredited programs. (Res. 920, I-12)	Rescind; the number of formerly AOA-accredited but not ACGME-accredited programs is small, and none are accepting new residents. Therefore, this policy is not needed after the unification of graduate medical education residency program accreditation through the ACGME's Single Accreditation System.
H-350.981	AMA Support of American Indian Health Career Opportunities	AMA policy on American Indian health career opportunities is as follows: (1) Our AMA, and other national, state, specialty, and county medical societies recommend special programs for the recruitment and training of American Indians in health careers at all levels and urge that these be expanded.	Retain; still relevant.

		(2) Our AMA support the inclusion of American Indians in established medical training programs in numbers adequate to meet their needs. Such training programs for American Indians should be operated for a sufficient period of time to ensure a continuous supply of physicians and other health professionals. (3) Our AMA utilize its resources to create a better awareness among physicians and other health providers of the special problems and needs of American Indians and that particular emphasis be placed on the need for additional health professionals to work among the American Indian population. (4) Our AMA continue to support the concept of American Indian self-determination as imperative to the success of American Indian programs, and recognize that enduring acceptable solutions to American Indian health problems can only result from program and project beneficiaries having initial and continued contributions in planning and program operations. (CLRPD Rep. 3, I-98; Reaffirmed: Res. 221, A-07; Reaffirmation A-12)	
H-460.982	Availability of Professionals for Research	(1) In its determination of personnel and training needs, major public and private research foundations, including the Institute of Medicine of the National Academy of Sciences, should consider the future research opportunities in the biomedical sciences as well as the marketplace demand for new researchers. (2) The number of physicians in research training programs should be increased by expanding research opportunities during medical school, through the use of short-term training grants and through the establishment of a cooperative network of research clerkships for students attending less research-intensive schools. Participation in research training programs should be increased by providing financial incentives for research centers, academic physicians, and medical students. (3) The current annual production of PhDs trained in the biomedical sciences should be maintained. (4) The numbers of nurses, dentists, and other health professionals in research training programs should be increased. (5) Members of the	Rescind; this policy, first adopted in 1987, is superseded by two more recently amended policies. H-460.930, “Importance of Clinical Research” (1) Given the profound importance of clinical research as the transition between basic science discoveries and standard medical practice of the future, the AMA will a) be an advocate for clinical research; and b) promote the importance of this science and of well-trained researchers to conduct it. (2) Our AMA continues to advocate vigorously for a stable, continuing base of funding and support for all aspects of clinical research within the research programs of all relevant federal agencies, including the National Institutes of Health, the Agency for Healthcare Research and Quality, the Centers for Medicare & Medicaid Services, the Department of Veterans Affairs and the Department of Defense. (3) The AMA believes it is an inherent obligation of capitation programs and managed care organizations to invest in broad-based clinical research (as well as in health care delivery and outcomes research) to assure continued transition of new developments from the research bench to medical practice. The

		industrial community should increase their philanthropic financial support to the nation's biomedical research enterprise. Concentration of support on the training of young investigators should be a major thrust of increased funding. The pharmaceutical and medical device industries should increase substantially their intramural and extramural commitments to meeting postdoctoral training needs. A system of matching grants should be encouraged in which private industry would supplement the National Institutes of Health and the Alcohol, Drug Abuse and Mental Health Administration sponsored Career Development Awards, the National Research Service Awards and other sources of support. (6) Philanthropic foundations and voluntary health agencies should continue their work in the area of training and funding new investigators. Private foundations and other private organizations should increase their funding for clinical research faculty positions. (7) The National Institutes of Health and the Alcohol, Drug Abuse and Mental Health Administration should modify the renewal grant application system by lengthening the funding period for grants that have received high priority scores through peer review. (8) The support of clinical research faculty from the National Institutes of Health Biomedical Research Support Grants (institutional grants) should be increased from its current one percent. (9) The academic medical center, which provides the multidisciplinary research environment for the basic and clinical research faculty, should be regarded as a vital medical resource and be assured adequate funding in recognition of the research costs incurred. (BOT Rep. NN, A-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CSA Rep. 13, I-99; Reaffirmed: CME Rep. 4, I-08; Modified: Res. 305, A-12; Modified: CME Rep. 2, A-12)	AMA strongly encourages these groups to make significant financial contributions to support such research. (4) Our AMA continues to encourage medical schools a) to support clinical research; b) to train and develop clinical researchers; c) to recognize the contribution of clinical researchers to academic medicine; d) to assure the highest quality of clinical research; and e) to explore innovative ways in which clinical researchers in academic health centers can actively involve practicing physicians in clinical research. (5) Our AMA encourages and supports development of community and practice-based clinical research networks. (CSA Rep. 2, I-96; Reaffirmed: CSA Rep. 13, I-99; Reaffirmation A-00; Reaffirmed: CME Rep. 4, I-08; Modified: CSAPH Rep. 01, A-18) H-460.971, "Support for Training of Biomedical Scientists and Health Care Researchers" Our AMA: (1) continues its strong support for the Medical Scientists Training Program's stated mission goals; (2) supports taking immediate steps to enhance the continuation and adequate funding for stipends in federal research training programs in the biomedical sciences and health care research, including training of combined MD and PhD, biomedical PhD, and post-doctoral (post MD and post PhD) research trainees; (3) supports monitoring federal funding levels in this area and being prepared to provide testimony in support of these and other programs to enhance the training of biomedical scientists and health care research; (4) supports a comprehensive strategy to increase the number of physician-scientists by: (a) emphasizing the importance of biomedical research for the health of our population; (b) supporting the need for career opportunities in biomedical research early during medical school and in residency training; (c) advocating National Institutes of Health support for the career development of physician-scientists; and (d) encouraging academic medical institutions to develop faculty paths supportive of successful careers in medical research; and (5) supports strategies for federal government-sponsored programs, including reduction of education-acquired debt, to encourage training of physician-scientists for biomedical research. (Res. 93, I-88; Reaffirmed: Sunset Report, I-98; Amended: Sub. Res. 302, I-99; Appended: Res. 515 and Reaffirmation A-00; Reaffirmed: CME

			Rep. 14, A-09; Reaffirmed: CSAPH Rep. 01, A-19)
H-480.950	Diagnostic Ultrasound Utilization and Education	Our AMA affirms that ultrasound imaging is a safe, effective, and efficient tool when utilized by, or under the direction of, appropriately trained physicians and supports the educational efforts and widespread integration of ultrasound throughout the continuum of medical education. (Res. 507, A-12)	Retain; still relevant.
D-630.972	AMA Race/ Ethnicity Data	Our American Medical Association will continue to work with the Association of American Medical Colleges to collect race/ethnicity information through the student matriculation file and the GME census including automating the integration of this information into the Masterfile. (BOT Rep. 24, I-06; Modified: CCB/CLRPD Rep. 3, A-12)	Retain; still relevant.

2. AN UPDATE ON CONTINUING BOARD CERTIFICATION

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS
REMAINDER OF REPORT FILED
See Policy D-275.954

Policy D-275.954(1), "Continuing Board Certification," asks that the American Medical Association (AMA) "continue to monitor the evolution of Continuing Board Certification (CBC), continue its active engagement in discussions regarding their implementation, encourage specialty boards to investigate and/or establish alternative approaches for CBC, and prepare a yearly report to the HOD regarding the CBC process."

Council on Medical Education Report 1, "An Update on Continuing Board Certification," adopted at the Special November 2020 Meeting, recommended that our AMA, "through its Council on Medical Education, continue to work with the American Board of Medical Specialties (ABMS) and ABMS member boards to implement key recommendations outlined by the Continuing Board Certification: Vision for the Future Commission in its final report, including the development of new, integrated standards for continuing certification programs by 2020 that will address the Commission's recommendations for flexibility in knowledge assessment and advancing practice, feedback to diplomates, and consistency." This recommendation was appended to Policy D-275.954, becoming the 38th clause.

This report is submitted for the information of the House of Delegates in response to these policies.

BACKGROUND

The years 2020-2021 saw the emergence and spread of the novel coronavirus (COVID-19), first identified outside of the U.S. in late 2019 and quickly evolving into a global pandemic. Due to the impact of COVID-19, the traditional in-person Annual and Interim Meetings of the AMA House of Delegates (HOD) were not feasible. Special Meetings of the HOD were conducted in a virtual format in June and November 2020 and 2021. The streamlined June 2020 Meeting contained only essential business of the HOD; therefore, it did not address resolutions or reports which had been originally intended for that Meeting. As such, this annual report was moved to the November 2020 Meeting. This change reset the annual clock for the report, which is now submitted each year to the Interim Meeting. However, reports were again streamlined for the November 2021 meeting, which resulted in this report being deferred to Annual 2022.

The ramifications of COVID-19 were also felt by the ABMS and its member boards. Various meetings and conferences scheduled in 2020-2021 were cancelled, delayed, or moved to a virtual format. Many initiatives and programs were altered or put on hold. The ABMS released several statements throughout 2020 and 2021 to provide guidance to member boards and physicians. This report provides an overview of the CBC landscape and advancements during this unsettling period despite the challenges posed by a public health crisis.

CONTINUING BOARD CERTIFICATION: VISION FOR THE FUTURE COMMISSION

In 2018, the Continuing Board Certification: Vision for the Future Commission, an independent body of 27 individuals representing diverse stakeholders, was established by the ABMS and charged with reviewing continuing certification within the current context of the medical profession. Later that year, the AMA Council on Medical Education ("Council") provided comments to strengthen the draft recommendations of the Commission. The Commission's final report, released in 2019, contained research, testimony, and public feedback from stakeholders throughout the member boards and health care communities. The report comprised of 14 recommendations intended to modernize CBC so that it is meaningful, contemporary, and a relevant professional development activity for diplomates who are striving to be up to date in their specialty of medicine. The ABMS and its member boards, in collaboration with professional organizations and other stakeholders, agreed and prioritized these recommendations and developed strategies and task forces to implement them (as described in the last report, CME 1-N-20).[1] The Commission's report included a commitment by the ABMS to develop new, integrated Standards for continuing certification programs by 2020. The final set of recommendations marked the end of the Commission's work. Due to COVID-19, the release of these draft Standards was delayed to 2021.

Updates on ABMS Task Forces

The "Achieving the Vision" task forces continued their work, with many of the physician volunteer members making an extraordinary effort to actively contribute, while also meeting the demands of being on the front line battling COVID-19. On May 1, 2020, the Chairs of the Improving Health and Health Care, Professionalism, Remediation, and Information and Data Sharing Task Forces met virtually with the Council to share updates on their progress and received feedback from Council members to help inform and guide their work.

The Improving Health and Health Care (IHHC) Task Force, formerly the Advancing Practice Task Force, was asked to engage specialty societies, the continuing medical education/continuing professional development community, and other expert stakeholders to identify practice environment changes necessary to support learning and improvement activities to produce data-driven advances in clinical practice. The task force promoted a "wide door" approach to a broader range of potential improvement options for diplomates, recommending that the member boards support improvement at any level—personal, team, system, or community—that is relevant to any role in which a diplomate serves. The task force emphasized the use of clear, non-technical language in the belief that many diplomates are alienated by and unfamiliar with tools of quality improvement. Recognizing that this unfamiliarity may be in part what keeps diplomates disengaged, the task force encouraged further learning about health systems science, improvement science, and safety science, and incorporating knowledge of those methods into member board assessment programs. Through its work, the task force heard about successful strategies that some member boards use and about the impressive array of tools and services available from the specialty societies, particularly with respect to data resources, quality tools, and coaching/practice facilitation services. Members discussed promoting teamwork and team-based improvement and leveraging the sponsors of the ABMS Portfolio Program to create locally available, practice-relevant opportunities aligned with institutional quality priorities. To support small and independent practices, the group was impressed by the AMA's STEPS Forward™ resources, which help physicians make their practices more efficient, increase practice satisfaction and reduce burnout. The task force recommended partnering with the specialty and medical societies to make tools and resources available to diplomates. It also examined how improvement methods could be used by diplomates to work on important priorities, such as equity and professionalism, and how they could support related learning, assessment, and improvement. Importantly, the task force has recommended that ABMS transform ongoing efforts to support improvement work into a "Community of Learning," focused on a strategic approach incorporating internal and external stakeholders, expertise, and resources.

The Information and Data Sharing Task Force (IDSTF) was assigned the task of examining the development of processes and infrastructure to facilitate research and data collaboration between member boards and key stakeholders to inform future continuing certification assessments, requirements, and standards that will facilitate the prioritization of specialty learning and improvement goals. The goals of these collaborations include studying the impact of

continuing certification on diplomate professional development, changes in diplomate practice, and changes in patient outcomes. Initially, the IDSTF focused on identifying data that member boards collect currently on their diplomates as well as data that are most important to support collaboration with other organizations. The group's milestones emphasized the importance of identifying necessary enhancements to the existing ABMS Boards' data warehouse structure in support of potential research-based data needs. Transparency and governance of data usage remain critical considerations, and the task force believes that the ABMS Boards Community must continue to ensure the privacy of diplomates as it engages in research evaluating the value of continuing certification. The task force also discussed the timely issue of the collection of data related to diversity, equity, and inclusion (DEI) within the ABMS Boards community. The group recognized the importance of DEI data sets and their essential role in certification research going forward.

The Professionalism Task Force was established to address the recommendation of the Commission calling for the ABMS and ABMS member boards to seek input from other stakeholder organizations to develop approaches to evaluate professionalism and professional standing while ensuring due process for the diplomate when questions of professionalism arise. The task force emphasized the importance of promoting positive professionalism through policies and programs. It also supported behavioral approaches to enhancing professionalism by encouraging formative assessment, learning, and improvement focused on interpersonal and social relationship skills vital to good health care. Task force members felt that diplomates would benefit from formative feedback on workplace performance accompanied by learning and improvement activities and encouraged the ABMS to work collaboratively with specialty societies to develop high-quality assessment tools and resources that can be used to support the development of professionalism skills. The task force also encouraged the ABMS to advocate for professional values, including issues of health equity and scientific integrity.

The Remediation Task Force was tasked with defining aspects of and suggesting a set of pathways for longitudinal assessment programs (LAP) and non-LAP for remediation of gaps prior to certificate loss, balancing specialty-specific practice differences with the avoidance of non-value-added variation in processes. In addition, this task force was asked to differentiate between pathways for re-entry and regaining certification after diplomate loss of certificate, based on the reason for certificate revocation. To inform and facilitate its work, the group established a peer-reviewed literature resource center of scholarly work on diplomate remediation and assessment research and established the development of a central repository of remediation programs that can effectively serve diplomates and improve the delivery of quality patient care.

The Standards Task Force was tasked with developing new continuing certification standards consistent with the Commission's recommendations, with appropriate input from stakeholders (including practicing physicians and diplomates) that would be implemented by the ABMS member boards. The final set of new standards was presented to and adopted by the ABMS Board of Directors in October 2021. The new Standards represent the culmination of three years of consultation with diplomates, professional and state medical societies, consumers, and other public stakeholders from across the health care spectrum to reconceive the way specialty physician recertification is conducted. They have been designed to guide the ABMS member boards in establishing continuing certification programs that help diplomates stay current in their specialty while providing hospitals, health systems, patients, and communities with a credential upon which they can continue to rely and depend.

The development of the new Standards was inclusive and transparent by design. Nearly 100 volunteers were involved in the process, representing important stakeholder groups, including professional and state medical societies, individual practicing diplomates, member boards, and public constituents such as credentialers and health care consumer advocates. Additionally, thousands of individuals and organizations provided feedback on the draft Standards during an 80-day public comment period. The feedback collected was highly valued, and each draft Standard was revised in some manner to address the comments received. This resulted in a final set of Standards that meets the needs of the stakeholders who possess, use, or rely upon the board certification credential as an indicator of a diplomate's skills, knowledge, judgment, and professionalism. The new Standards reinforce the transition to innovative assessment programs that support and direct learning. These new assessment models represent an intentional shift from conventional high-stakes exams every 10 years to frequent, flexible, online testing that offers immediate feedback and directs participants to resources for further study. The new systems support learning and retention and complement the continuing education that that all physicians undertake to improve their skills. The new Standards also support greater opportunities for recognition of quality and safety improvement activities in which diplomates are engaged and provide member boards the flexibility to address specialty-specific requirements. A

phased-in transition will be used to implement the standards, and member boards will continue to assess, update, and modify their programs based on diplomate and public feedback.

Standards for Continuing Certification

The Draft Standards for Continuing Certification were intended to address the Commission's recommendations for consistency yet flexibility in knowledge assessment and advancing practice and guidance for feedback. The Standards were developed after a year of deliberation with key stakeholders in response to the recommendations of the Vision Commission as well as of the wider stakeholder community. The ABMS had been prepared to release a Call for Comments on the Draft Standards in early December 2020 in accordance with the timeframes established in the Commission's final report. However, the surge in new COVID-19 cases placed an additional burden on the already stressed health care system, which prompted the ABMS to postpone the opening of the public comment period to April-July 2021. The ABMS Board of Directors reviewed the feedback at their October 2021 meeting, and the new Standards were released on November 1, 2021.

These 19 Standards were structured to support and provide diplomates with the tools they need to stay current in medical knowledge, prepare them to address emerging medical and public health issues, and help them identify and address opportunities for practice improvement within the systems in which they work—all in a manner that enhances relevance and reduces burden. They have been organized into the following groups: General Standards, Professional Standing, Lifelong Learning, and Improvement in Health and Health Care. Each member board must meet each requirement in a manner consistent with the spirit of the Standards and in a fashion consistent with its specialty. Each Standard has associated commentary which provides rationale and context and addresses important considerations. The Standards read as follows:

#	NEW STANDARD	COMMENTARY
	General Standards	
1	Program Goals: Member boards must define goals for their continuing certification program that address the overarching themes in the Introduction* and each of the subsequent standards in this document.	Program elements should be designed to achieve the goals of the program, highlight the boards' unique role as an assessment organization, lessen diplomate burden, and support diplomates in their professional obligation to keep up to date with advances in medical knowledge and continually improve themselves, their colleagues, and the systems in which they work. The goals and components of continuing certification programs should be clearly communicated and available on member board websites for stakeholders, which includes the public, diplomates, and credentialers.
2	Requirements for Continuing Certification: Member boards must define the requirements and deadlines for each component of their integrated continuing certification program.	Both participation and performance requirements for each component must be clearly specified along with the intervals at which they must be completed. Any decision on the certificate status of a diplomate by a member board must be based on each component of their integrated continuing certification program. Member boards may make allowances for diplomates with extenuating circumstances who cannot complete requirements to stay certified according to established timelines. Appropriate procedures to ensure due process regarding member board decisions must be in place and clearly communicated to diplomates as part of diplomate engagement. Member boards should have a process to verify attestation for participation standards.
3	Assessment of Certification Status: Member boards must determine at intervals no longer than five years whether a diplomate is meeting continuing certification requirements to retain each certificate.	Assessment of certification status on a frequent interval provides the public and credentialers trusted information about the diplomate; therefore, member boards may make certification decisions on a more frequent interval

		than five years. Policies that specify the requirements for certification and the relevant periodicity will be established by each member board. These policies require a decision to determine a diplomate's certificate status (e.g., certified, not certified) at the established interval. The components utilized to make a certification decision in the board-determined interval may vary (e.g., knowledge assessment, case logs, peer review, improving health and health care activity). Member boards may have some components of their continuing certification process that extend beyond five years.
4	Transparent Display of Certification History: Member boards must publicly display and clearly report a diplomate's certification status and certification history for each certificate held. Member boards must change a diplomate's certificate(s) status if any requirements (either a performance or participation requirement) in their continuing certification program are not met. Changes in the status of a certificate must be publicly displayed, including any disciplinary status. Member boards must use common categories for reporting the status of certificates, with such categories being defined, used, and publicly displayed in the same way.	Member boards have an obligation to the medical community and the public to display on their respective websites and/or the ABMS Certification Matters website, the certification status and history for each diplomate including the date of initial certification, whether the diplomate is certified, and whether the diplomate is participating in continuing certification.
5	Opportunities to Address Performance or Participation Deficits: Member boards must provide diplomates with opportunities to address performance or participation deficits prior to the loss of a certificate. Fair and sufficient warning, determined by each member board, must be communicated that a certificate might be at risk.	Diplomates should receive early notice about the need to complete any component of the continuing certification program. Diplomates at risk for not meeting a performance standard should be notified of their deficit along with information about approaches to meet the requirements. Member boards should collaborate with specialty societies and other organizations to encourage the development of resources to address performance deficits. The timeline to address deficits should not extend the time a diplomate has to complete requirements (i.e., deficits must be addressed within the cycle they are due). If a diplomate chooses not to address their deficits or is unsuccessful in doing so, the diplomate should be notified of the potential for the loss of certification.
6	Regaining Certification: Member boards must define a process for regaining certification if the loss of certification resulted from not meeting a participation or performance standard.	A pathway should be available for physicians and medical specialists to regain certification following loss of certification after a lack of participation in a continuing certification program or not meeting the performance standard.
7	Program Evaluation: Member boards must continually evaluate and improve their continuing certification program using appropriate data that include feedback from diplomates and other stakeholders.	It is crucial for member boards to evaluate their continuing certification program on an ongoing basis using a variety of metrics to guide enhancements to their program. Aspects of program evaluation should include assessing diplomate experience, the value of the program to diplomates, and whether diplomates are meeting the member board's objectives. Feedback from other certification stakeholders — professional societies,

		credentialers, hospitals and health systems, patients, and the public — should also be considered.
8	Holders of Multiple Certificates: Member boards must streamline requirements for diplomates who hold multiple certificates, to minimize duplication of effort and cost.	Diplomates who hold multiple specialty and/or subspecialty certificates from one or more member boards could have duplicative requirements to maintain all certificates. member boards should avoid redundancy of requirements of programs for their diplomates maintaining multiple certificates from their board (e.g., Lifelong Learning credit for participation in longitudinal assessment and improving health and health care credit for quality improvement efforts). Similar processes should be incorporated to offer reciprocity of credit for diplomates with multiple certificates held across member boards (e.g., Lifelong Learning credit for participation in longitudinal assessment and improving health and health care credit for quality improvement efforts).
9	Diplomates Holding Non-time-limited Certificate: Member boards must have a process by which non-time-limited certificate holders can participate in continuing certification without jeopardizing their certification status.	Member boards must have a process for diplomates with non-time-limited certificates to apply for and participate in their continuing certification programs. Certificates for non-time-limited certificate holders should not be at risk for failure to meet continuing certification requirements if the diplomate participates in continuing certification; however, member board professional standing and conduct standards must be upheld by all certificate holders in order to remain certified.
	Professional Standing and Conduct	
10	Review of Professional Standing: Primary Source Verification of unrestricted licensure must occur annually. In addition, member boards must have a mechanism to identify and review information regarding licensure in every state in which the diplomate holds a medical license. Any actions by other authorities that signal a violation of the member board's professionalism policies that become known by a board must also be reviewed.	Credentialers and the public rely on ABMS and its member boards to ensure that diplomates meet high standards of professionalism. Member boards rely on state medical licensing boards for primary evidence that diplomates maintain good standards of professional conduct and expect medical licenses held by diplomates to be unrestricted. On a timely basis, member boards are expected to review available information, including restrictions forwarded to the member board, and take appropriate action to protect patient safety and the trustworthiness of ABMS board certification. Member boards are expected to distinguish between material actions and actions that are administrative rule violations that do not threaten patient care or that are being appropriately monitored and resolved by the regulatory authority. • To ensure diplomates are in good standing with their licensing board(s), ABMS will facilitate Primary Source Verification of unrestricted licensure with a seamless and efficient mechanism through which member boards can easily identify restrictions on a diplomate's medical license. • Mechanisms such as the ABMS Disciplinary Action Notification Service reports may assist member boards in continually monitoring any actions taking place between annual Primary Source Verification of licensure. • Member boards may choose to use additional methods to evaluate professional standing.

		• Member boards must effectively communicate the expectations and process for diplomate self-reporting of any changes in professional standing and the implications for failing to do so.
11	Responding to Issues Related to Professional Standing and Conduct: Member boards must have policies on professional standing and conduct that define the process for reviewing and taking action on the information that reflects a violation of professional norms. Policies should be communicated to diplomates and available on member board websites.	Member board policies on professional standing and conduct are to be made readily accessible to diplomates and the public. These policies ensure that: • Material actions that may imperil a diplomate's certificate status are clearly defined (e.g., disciplinary actions against a license, criminal convictions, incidents of sexual misconduct); • The facts and context of each action are considered before making any change in a diplomate's certification status; • Appropriate procedures to ensure due process are in place and clearly articulated to diplomates; and • There is a clearly outlined process for diplomates to regain a revoked certificate if they are eligible to do so. When disciplinary actions are reported, member boards should review each instance in which an action has been taken against a diplomate's license (e.g., revoked, suspended, surrendered, or had limitations placed) to determine if there has been a material breach of professional norms that may threaten patient safety or undermine trust in the profession and the trustworthiness of certification. Actions against a medical license should not automatically lead to actions against a certificate without reviewing the individual facts and circumstances of the situation. A change in certificate status should occur when the diplomate poses a risk to patients or has engaged in conduct that could undermine the public's trust in the diplomate, profession, and/or certification. This standard for professional standing and conduct means that the loss of a certificate can result from issues that fall short of a licensure action. Conversely, some licensure actions may not warrant a change in certificate status. For example, there are instances where restrictions placed on a diplomate's license do not reflect professionalism concerns or threaten patient safety (e.g., restrictions due to physical limitations or administrative rule violations). Some restrictions are self-imposed while some relate to administrative infractions that, while serious, may not be viewed as a breach of professional norms. Member boards are not investigatory bodies, but they are expected to weigh available evidence and render an informed judgment with due process. Member boards should consider permitting a diplomate to retain a certificate when the diplomate has been successfully participating in physician health programs or other treatment programs recognized by the state medical board.

		Finally, when a member board takes action on the certification status of a diplomate who holds certificates from multiple member boards, the member board must work with ABMS to notify other member boards of the action taken.
	Lifelong Learning	
12	Program Content and Relevance: Member boards' continuing certification programs must balance core content in the specialty with practice-specific content relevant to diplomates.	A continuing certification program should reflect the general scope of practice encompassed by a certificate as defined in collaboration with specialty societies, as well as the specific scope of diplomate's practice. To a reasonable degree, customization of required content should occur to enhance clinical relevance of certification.
13	Assessments of Knowledge, Judgment, and Skills: Member boards must assess whether diplomates have the knowledge, clinical judgment, and skills to practice safely and effectively in the specialty. Member boards must offer assessment options that have a formative emphasis and that assist diplomates in learning key clinical advances in the specialty.	Assessments should integrate learning opportunities and provide feedback that enhances learning. Member boards may choose to offer point-in-time, secure assessments for diplomates who prefer this approach, provided that the member board can give useful feedback to guide diplomate learning.
14	Use of Assessment Results in Certification Decisions: Member boards' continuing certification assessments must meet psychometric and security standards to support making consequential, summative decisions regarding certification status.	Performance on continuing certification assessments should contribute to making certification decisions when assessment is a component of the decision matrix. Continuing certification programs must provide sufficient information upon which to base a decision about a diplomate's certification status. Member boards should ensure that subject matter experts engaging in assessment development are clinically active. In order for users to have confidence in the value of the certificate, sufficient psychometric standards must be met for reliable, fair, and valid assessments to make a consequential (summative) decision. Security methods must be used to determine the identity of the certificate holder while preserving assessment material without creating unnecessary burden for participating diplomates.
15	Diplomate Feedback from Assessments: Member board assessments must provide personalized feedback that enhances learning for diplomates.	A member board should provide specific, instructive feedback to each diplomate that identifies their knowledge gaps on assessments. Feedback should also inform any risk to loss of certification. Member boards should work with specialty societies and other stakeholders to identify educational resources that address knowledge and skills gaps and to inform diplomates about these. Member boards should also work with specialty societies to allow diplomates to share member board assessment data to support personalized learning plans implemented by specialty societies.
16	Sharing Aggregated Data to Address Specialty-based Gaps: Member boards must analyze performance data from their continuing certification program to identify any specialty-based gaps. Aggregated identified gaps should be shared with essential	An analysis of performance data allows identification of specialty-specific knowledge gaps. By sharing these data, educational organizations can create targeted learning resources for the benefit of the specialty. Summary data should only be shared with essential stakeholders, such as specialty societies, that require the

	stakeholders, including diplomates, for the development of learning opportunities.	information for nonprofit service to the profession. Member boards should collaborate with specialty societies in a continual and timely manner to address major public health needs and frequently occurring deficits, engaging specialty societies in the bidirectional communication necessary for further identification and prioritization of gaps.
17	Lifelong Professional Development: Member boards' continuing certification programs must reflect principles of Continuing Professional Development (CPD) with an emphasis on clinically oriented, highly relevant content.	Continuing certification should increase a diplomates' knowledge, skills, and abilities that result in the provision of safe, high-quality care to patients. CPD activities must be of high quality and free of commercial bias. Member boards should work with stakeholders to help diplomates identify relevant, high-quality activities and report completion with minimal administrative burden.
	Improving Health and Health Care	
18	Quality Agenda: In collaboration with stakeholder organizations, member boards must facilitate the process for developing an agenda for improving the quality of care in their specialties. One area of emphasis must involve eliminating health care inequities.	Member boards are expected to support a quality agenda in alignment with their specialty-at-large. Member boards must collaborate with key organizations, including specialty societies and other quality organizations, to identify areas in which patient care can be improved, review the areas, and define strategies to improve care. To support a quality agenda, member boards should use the common framework developed by the Institute of Medicine for safe, timely, effective, efficient, equitable, and patient-centered care.
19	Engagement in Improving Health and Health Care: Member board continuing certification programs must commit to helping the medical profession improve health and health care by: a. Setting goals and meeting progressive participation metrics that demonstrate an ever-increasing commitment toward having all diplomates engaged in activities that improve care; b. Recognizing the quality improvement expertise of partner organizations and seeking collaborative opportunities for diplomate engagement with efforts to improve care through a variety of existing efforts; c. Working with partner organizations, including medical specialty societies, to create systems (e.g., data transfer process), for diplomates engaged in the organizations' quality improvement activities to seamlessly receive credit from the member boards; and d. Modeling continuous quality improvement by evaluating methods and sharing best practices for program implementation and diplomate engagement.	Wherever possible, member boards should align their expectations to existing performance measurement, quality reporting, and quality improvement efforts. Member boards should work with specialty societies and other stakeholders to ensure that opportunities exist for diplomates in all practice settings and in non-clinical roles (e.g., educator, researcher, executive, or advocate). Progressive participation goals may be appropriate for those member boards that are developing new programs or revising current programs.

In May 2021, the ABMS hosted a webinar on the Draft Standards for AMA leadership, including those representing AMA sections and councils. The Council responded to the Call for Comments to the Draft Standards to guide and inform the ABMS board of directors in the development of the final Standards.

CONTINUING BOARD CERTIFICATION: AN UPDATE

The Council and the HOD have carried out extensive and sustained work in developing policy on CBC. This includes working with the ABMS and the American Osteopathic Association (AOA) to provide physician feedback to improve CBC processes, informing our members about progress on CBC through annual reports to the HOD, and developing strategies to address concerns about the CBC processes raised by physicians. The Council has prepared reports covering CBC (formerly titled "Update on Maintenance of Certification and Osteopathic Continuous Certification") for the past 12 years.[1-12] Council members, AMA trustees, and AMA staff have participated in the following meetings with the ABMS and its member boards:

- ABMS Committee on Continuing Certification
- ABMS Stakeholder Council
- ABMS Accountability and Resolution Committee
- ABMS 2020 Annual Conference
- AMA Council on Medical Education 2020-2021 meetings

ABMS Committee on Continuing Certification

The ABMS Committee on Continuing Certification (known as "3C") is charged with overseeing the review process to CBC programs of the 24 member boards as well as the policies and procedures followed by the boards. Through 3C activities, the member boards share best practices in designing, implementing, and promoting continuing certification as individual member boards continue to receive input from subject matter experts researching physician competence, performance standards, continuing professional development, security considerations, and psychometric characteristics of longitudinal assessment programs.

During 2020 and 2021, the 3C continued to approve substantive program changes implemented among the ABMS member boards and announced additional pilot programs intended to enhance relevance to practice and improve diplomate satisfaction, while maintaining the rigor of assessment, education, and improvement components. This committee sought to improve the level of detail and analysis regarding the approval processes for assessment of new pilots and for adoption of substantive changes by aligning these review processes. This includes utilization of a third reviewer as a technical expert for assessment of new pilots. This third reviewer is designated as a member board staff volunteer (psychometrician or other staff with expertise in assessment design or administration) who provides additional technical expertise in the realm of assessment in recommended areas of analysis.

The 3C also participated in the review of the Draft Standards for Continuing Certification during the Call for Comments period. The committee continues to include AMA representation for monitoring issues of importance to multiple certificate holders, holders of cosponsored certificates, and physicians trained through non-Accreditation Council for Graduate Medical Education-approved pathways.

ABMS Stakeholder Council

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

During 2020-21 meetings, the Stakeholder Council reviewed and provided feedback to the ABMS regarding the Draft Standards for Continuing Certification, the ABMS Certification Matters display research project and its goals, and this Council's workgroup product regarding diversity and equity. Ongoing work within the Stakeholder Council discusses how the ABMS and its member boards can effectively communicate the evolving process of continuing certification that better balances the value of learning and assessment for physicians, while meeting the needs of the public for a meaningful credential. Issues identified as an important part of this Council's charge include sharing research, promoting best practices for new/emerging technologies, developing novel assessment techniques, aligning continuing certification activities with national reporting and licensure requirements, strengthening relationships between boards and specialty societies, and engaging in patient advocacy.

ABMS Accountability and Resolution Committee

The ABMS Accountability and Resolution Committee (ARC) is continuing its review of how the ABMS member boards engage with ABMS' eight organizational standards. These standards, which address issues related to member board governance, financial and organizational management, and stakeholder engagement, among others, are being reviewed with the intent of identifying best practices among the member boards that can be shared and scaled.

ABMS 2020-2021 Annual Conferences

Amidst the rapidly changing COVID-19 environment, the ABMS and its member boards continue to focus on delivering the value of board certification by convening virtually during the pandemic. For example, during the 2020 Annual Conference, held September 23-24, 2020, educational tracks featured current priorities and enduring principles related to the value of board certification, innovative assessments, and professionalism. This meeting also explored the impact of COVID-19 as well as topics on diversity, equity, and inclusion. AMA's past president, Patrice A. Harris, MD, MA, was featured in a plenary panel session entitled "Improving Public Health Through Diversity, Equity, and Inclusion."

The 2021 Annual Conference, "Transforming Certification for Better Care," was held virtually September 28-29, 2021. AMA staff leadership played key roles in the presenting of information. Jodi Abbott, MD, MSc, MHCM, Medical Director of Curriculum and Outreach for the AMA Ed Hub™, led a panel discussion on the elements and perspectives required in the design, development, editing, and publishing of foundational health equity education. This session illuminated how COVID-19, and other determinants of health, uniquely impact historically marginalized and minoritized communities. Also, AMA leaders Marie T. Brown, MD, MACP, Director of Practice Redesign, and Christine Sinsky, MD, MACP, Vice President, Professional Satisfaction, spoke in the plenary sessions "Addressing Health Care Disparities and the Role of the ABMS Community" and "Addressing Physician Well-being and Burnout: The Present and Future Role of Continuing Certification," respectively.

AMA Council on Medical Education 2020-2021 meetings

At the August 2020 as well as the March and November 2021 meetings of the Council, Richard Hawkins, MD, CEO of the ABMS, presented updates to the Council related to the Vision Commission and Standards. These meetings provided the Council with opportunities to ask questions and give real-time feedback.

ABMS Continuing Certification Directory

The ABMS Continuing Certification Directory provides ABMS board-certified physicians access to an online repository of practice-relevant, competency-based, accredited continuing medical education (CME) activities for continuing certification by participating member boards. During the past year, the Directory has increased its inventory and now indexes more than 4,000 open-access CME activities from more than 65 accredited CME providers. The inventory includes Opioid Prescriber Education Programs and other national health and quality priorities to help diplomates address national health priorities through continuing certification requirements for Lifelong Learning and Self-Assessment (Part II). Working in collaboration with the JAMA Network, the Continuing Certification Directory currently indexes individual journal-based and enduring CME activities across the JAMA Network. This collaboration has improved access to practice-relevant education opportunities as well as the representation of these learning formats across the CME enterprise.

With the Directory, diplomates can strategically align CME with member boards' Continuing Certification Programs. The competency-based activities are routinely added following the review and approval by one or more of the ABMS member boards. All activities are accredited for CME by the Accreditation Council for Continuing Medical Education (ACCME).

In addition, the ABMS offers a Continuing Certification Reference Center, a searchable resource on its website that highlights literature relevant to member board certification and continuing certification. This reference center, provided by the Research and Education Foundation, is a dynamic database which grows as new studies, reviews, and commentaries are published.

ACCME updates and resources

The ACCME continues to support the continuing certification of physicians. CME Finder is a free search tool that helps physicians find accredited CME activities that meet their needs. In the last year, the ACCME has added more activities and enhancements to this tool to reduce burdens on learners and better serve accredited CME providers as well as to meet the needs of credentialing, certifying, and licensing authorities. These enhancements include the following:

- Ability to display any current or future activities that the accredited CME provider chooses to include as activities that are registered for Improvement in Medical Practice (IMP/Part IV) as well as Merit-Based Incentive Payment System (MIPS) or Risk Evaluation and Mitigation Strategies (REMS);
- Enabling physicians to create a personalized account to view their reported CME and IMP credits and generate transcripts for their state medical board, certifying board, employer, or other regulatory authority; and
- Searchability by activity format, date, types of credit offered, topic, location, keyword, specialty, and other filters.

In late summer 2021, the ACCME launched a new and improved Program and Activity Reporting System (PARS), the system used by accredited CME providers to report their activities and participate in the reaccreditation progress. The new PARS gives accredited CME providers the option to enter, track, and manage physician-learner data for all accredited activities, including activities for IMP. These enhancements support the value of accredited CME and lifelong learning.

The ACCME released its 2020-2021 Highlights Report, "Learning to Thrive Together," which outlines the key initiatives aimed to respond to the CME community's recommendations, fulfill strategic goals, and support a shared mission to improve care for patients and communities. Key takeaways are that the ACCME in 2020-2021:

- Continued to offer new accommodations and resources to help the accredited education community adapt to new circumstances.
- Provided an expedited pathway for planning activities related to COVID-19, a searchable database for vaccine-related education, and guidance for transitioning to virtual learning formats.
- Released the Standards for Integrity and Independence in Accredited Continuing Education, delivering on a promise to health care professionals that they can trust accredited continuing education to provide accurate, balanced, evidence-based information that supports high-quality patient care.
- Launched CME Passport, a free, all-in-one web application that enables physicians to find, track, and manage their CME.
- Expanded collaborations with colleague regulatory bodies, with the goal of reducing CME-reporting burdens for physicians, giving them more time to focus on their education and patient care, rather than on compliance.
- Convened a special task force of the ACCME Board of Directors to explore the fostering of learning environments that promote diversity, health equity, and inclusiveness, as well as the facilitation of meaningful change in accredited education.

Update on Alternatives to the Secure, High-Stakes Examination/ Part III

All 24 ABMS member boards have moved away from the secure, high-stakes exam, to offer assessment options that combine adult learning principles with state-of-the-art technology, enabling delivery of assessments that promote ongoing learning and are less stressful. Fourteen member boards have implemented and/or are piloting a longitudinal assessment approach, which involves repeatedly administering shorter assessments of specific content, such as medical knowledge, over a period of time. Seven of these boards are using CertLink®, a technology platform developed by the ABMS to support the boards in delivering more frequent, practice-relevant, and user-friendly competence assessments to physicians. Sixteen member boards have retained the traditional secure exam option for reentry purposes and for diplomates who prefer this exam method.

Several boards leveraged their longitudinal assessment platforms to create and distribute up-to-date assessment items on COVID-19. The disruptions of COVID-19 prompted some member boards to make temporary changes to requirements for certification; according to the ABMS, per information obtained from 23 of the member boards regarding these changes, eight offered certificate extensions (three automatically; five by request). In addition, several boards offered extensions (six automatically; five by request) or modifications (three automatically; one by request)

to Part III. Given the fluidity of the pandemic, other adjustments may have been or are being made that are not fully reflected in this report.

In April 2021, the American Board of Surgery (ABS) announced that it launched a pilot program in video-based assessment (VBA), taking place from June to December 2021, to help the ABS investigate the use of VBA as a component of its Continuous Certification Program and assess the feasibility of full implementation in the future. In this pilot, surgeons will upload videos of their operations from a predefined list of procedures and will be asked to review videos of their peers. They will provide feedback on their experience with the platform and overall experience with VBA. Videos will be de-identified for surgeon and patient anonymity. Pilot participants will receive quantitative and qualitative feedback on their technique. The ABS will have access to identified information only with respect to who completed uploads and reviews and to de-identified information on ratings, engagement, performance data, and other key performance indicators as defined prior to the pilot.

Progress with Refining IMP/ Part IV

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

As described in the previous report,[1] several ABMS member boards have continued to innovate in the CBC space by developing online practice assessment protocols and tools that allow physicians to assess patient care using evidence-based quality indicators. Boards are also partnering with specialty societies to design population-based activities, integrating patient experience and peer review into IMP requirements, including simulation options, and allowing for personalized activities using data from a physician's own practice. The American Board of Family Medicine (ABFM) worked with four institutions to successfully create registries of measures that matter, despite the challenges of bringing consistency to the measures across the different institutions.

Amidst the challenges of COVID-19, the ABMS member boards continued to align CBC activities with other organizations' quality improvement (QI) efforts to reduce redundancy and physician burden while promoting meaningful participation. Many of the boards encouraged participation in organizational QI initiatives through the ABMS Multi-Specialty Portfolio Program™. According to the ABMS, per information obtained from 23 of the member boards regarding temporary changes to continuing certification due to COVID-19, several boards offered extensions (four automatically; five by request) or modifications (two automatically) to IMP/Part IV. Given the fluidity of the pandemic, other adjustments may have been or are being made that are not fully reflected in this report. Appendix B offers detailed information per board as to the temporary changes offered for continuing as well as initial certification.

ABMS Multi-Specialty Portfolio Program

The ABMS Portfolio Program (Portfolio Program™) supports health care organizations' quality and safety goals, encourages physician and physician assistant involvement in QI activities, and offers continuing certification credit for the improvement work being done in practice. Through the Portfolio Program™ community, individuals and organizations share resources and camaraderie, make strategic connections, and provide advice and feedback to other sponsor organizations. The Portfolio Program™ community includes hospitals, academic medical centers, integrated delivery systems, interstate collaboratives, specialty societies, state medical societies, and other types of organizations in the physician QI/education space. More than 4,500 QI projects have been approved by the Portfolio Program in which 18 ABMS member boards participate, focusing on such areas as COVID-19, health care inequities, advanced care planning, cancer screening, cardiovascular disease prevention, depression screening and treatment, provision of immunizations, obesity counseling, patient-physician communication, transitions of care, and patient-safety-related topics including sepsis and central line infection reduction. Many of these projects have had a positive impact on patient care and outcomes. To date, there have been nearly 47,000 instances of physicians receiving continuing certification credit through participation in the Portfolio Program™.

Specific to COVID-19, nearly 700 individual activities have been submitted by sponsor organizations participating in the Portfolio Program. These projects were related to or included the implementation of telehealth, process redesign,

medication, intubation, contact tracing, vaccinations, and more. Through these activities, roughly 3,000 physicians and physician assistants have received credit.

Recent additions among the nearly 100 current Portfolio Program sponsors include the Perelman School of Medicine at the University of Pennsylvania, the Professional Renewal Center, and Rainbow Babies & Children's Hospital at Case Western University. The full list of sponsors is available on the ABMS Portfolio Program website.

The AMA is also a sponsor in the Portfolio Program, having published several Performance Improvement CME activities which also offered IMP credit. Two activities launched in May 2021, "Screening for Abnormal Blood Glucose" and "Intervention for Abnormal Blood Glucose in Prediabetes Range," provide a streamlined learner experience. In October 2021, two additional activities were launched, "Retesting of Abnormal Blood Glucose in Patients with Prediabetes" and "Improving BMI Documentation and Follow-Ups." These activities support the AMA's ongoing efforts to improve health outcomes, particularly the prevention of diabetes; they can be found on the AMA's Ed Hub™.

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

The Council has continued to review published literature and emerging data as part of its ongoing efforts to critically review CBC. The annotated bibliography in Appendix C provides a list of recent studies, editorials, and announcements. Such information addresses ABMS member board history, initiatives, and advancements as well as concerns, challenges, and considerations for the future. The appendix also provides information on CBC in Canada and Europe.

OSTEOPATHIC CONTINUOUS CERTIFICATION: AN UPDATE

The American Osteopathic Association (AOA) offers board certification in 27 primary specialties and 48 subspecialties (including certifications of added qualifications). Nine of the 48 subspecialties are conjoint certifications managed by multiple AOA specialty boards. As of December 31, 2021, a total of 38,355 physicians held 45,128 active certifications issued by the AOA's specialty certifying boards.

The AOA Certifying Board Services Department works in collaboration with the 16 osteopathic medical specialty certifying boards on the development and implementation of certification programs and assessments. Under the guidance of the AOA Bureau of Osteopathic Specialists, specialty certifying boards commit to enhancing board certification services that better serve candidates and diplomates pursuing and maintaining AOA board certification.

AOA specialty certifying boards provide a modernized, expedited approach to the delivery of relevant and meaningful competency assessment for board certified diplomates. Through innovation and leveraging technology opportunities, all AOA specialty boards have developed longitudinal assessment programs that replaced the high stakes recertification exams previously required. Several AOA specialty certifying boards, including Anesthesiology, Emergency Medicine, Family Medicine, General Surgery, Internal Medicine, Neurology & Psychiatry, Obstetrics & Gynecology, and Radiology have successfully launched their longitudinal assessment programs. The remaining primary specialty certifying boards remain on schedule to launch longitudinal assessment programs by the end of 2022.

To provide added convenience for AOA diplomates and in service of a long-range goal to improve user experience, every AOA specialty certifying board now offers its candidates and diplomates online remote proctored delivery of its certification and Osteopathic Continuous Certification (OCC) exams. Operational improvements were made within the department, which has resulted in reduced processing time for exam score reporting and enhanced psychometric exam validation.

CURRENT AMA POLICIES RELATED TO CBC

The AMA maintains robust policy related to CBC and lifelong learning, which can be accessed in the AMA PolicyFinder database. Specifically, Policies H-275.924 and D-275.954, both entitled "Continuing Board Certification," and H-275.926, "Medical Specialty Board Certification Standards," can be found in Appendix D.

DISCUSSION

The Council is actively engaged in the implementation of the Vision for the Future Commission's recommendations and standards to improve the process for the more than 640,000 diplomates participating in continuing certification (unpublished data, ABMS Diplomate Database, accessed July 1, 2021, with permission from ABMS). This report highlights the progress the ABMS and ABMS member boards have continued to make to ease burdens and improve the CBC process for physicians.

Council on Medical Education Report (CME 1-N-20), "An Update on Continuing Board Certification," considered at the Special November 2020 Meeting, recommended that our AMA, "through its Council on Medical Education, continue to work with the ABMS and its member boards to implement key recommendations outlined by the Vision Commission's final report, including the development of new, integrated standards for continuing certification programs by 2020 that will address the Commission's recommendations for flexibility in knowledge assessment and advancing practice, feedback to diplomates, and consistency." The recommendation was appended to AMA Policy D-275.954 as the 38th clause. However, the impact of COVID-19 led to the delay in the release of the new Draft Standards until 2021. The ABMS Board of Directors considered the feedback on the Draft Standards at their October 2021 meeting, and the final Standards were released shortly thereafter. Therefore, this report proposes to amend the policy to strike "2020" as well as to include language supporting the new Standards. Upon further review of this policy, another inaccuracy was noted. The 22nd clause of this policy refers to the AMA's continued participation in the National Alliance for Physician Competence; this Alliance was renamed the Coalition for Physician Accountability, and policy should reflect the current name.

Policy adopted at the June 2021 Special Meeting, now appended to AMA Policy D-275.954, "Continuing Board Certification," asks that our AMA "work with the ABMS and its member boards to reduce financial burdens for physicians holding multiple certificates who are actively participating in continuing certification through an ABMS member board, by developing opportunities for reciprocity for certification requirements as well as consideration of reduced or waived fee structures." The impetus for this policy is that many physicians are certified by more than one ABMS Board but may participate in CBC with only one of those boards. As one example, the American Board of Internal Medicine (ABIM) charges such physicians a fee and does not accurately reflect such physicians' status as participating in CBC in the ABIM Directory unless they pay that fee. The Council is in regular communication with the ABMS regarding these concerns raised.

Existing AMA policy is supportive of cost transparency as well as reduced financial burdens on physicians in their achievement of continuing certification. Policy H-275.924(19) states that "the CBC process should be reflective of and consistent with the cost of development and administration of the CBC components, ensure a fair fee structure, and not present a barrier to patient care." Also, Policy D-275.954 states that our AMA will "encourage the ABMS to ensure that all ABMS member boards provide full transparency related to the costs of preparing, administering, scoring, and reporting CBC and certifying examinations" and "encourage the ABMS to ensure that CBC and certifying examinations do not result in substantial financial gain to ABMS member boards, and advocate that the ABMS develop fiduciary standards for its member boards that are consistent with this principle."

Since 2007, the Council has provided an annual report on CBC per AMA Policy D-275.954. Given advancements and improvements made in the field of CBC, the Council believes it is no longer imperative to provide a report every year. The Council continues to monitor the CBC process and will submit a report to the HOD when deemed necessary.

SUMMARY AND RECOMMENDATIONS

The AMA has been actively engaged in the implementation of the Continuing Board Certification: Vision for the Future Commission's recommendations as well as the development of the Draft Standards to contribute to the improvement of the continuing board certification process. The Council continues to monitor the development of continuing board certification programs and to work with the ABMS, ABMS member boards, AOA, and state and specialty medical societies to identify and suggest improvements to these programs.

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

That our American Medical Association (AMA) amend Policy D-275.954 clauses 1, 22, and 38 by addition and deletion to read as follows:

1. (1), "Continue to monitor the evolution of Continuing Board Certification (CBC), continue its active engagement in discussions regarding their implementation, encourage specialty boards to investigate and/or establish alternative approaches for CBC, and prepare a ~~yearly~~ report ~~to the House of Delegates~~ regarding the CBC process at the request of the House of Delegates or when deemed necessary by the Council on Medical Education."

2. (22), "Continue to participate in the Coalition for Physician Accountability, formerly known as the National Alliance for Physician Competence forums."

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

APPENDIX A - Improvements to Assessment of Knowledge, Judgment, and Skills (Part III) and Improvement in Medical Practice (Part IV)*

American Board of:	Original Format	New Models/Innovations
Allergy and Immunology (ABAI) abai.org	Part III: Computer-based, secure exam was administered at a proctored test center once a year. Diplomates were required to pass the exam once every 10 years. *Traditional secure exam only offered for re-entry.*	Part III: In 2018, ABAI-Continuous Assessment Program was implemented in place of 10-year secure exam: • A 10-year program with two 5-year cycles; • Open-book with approximately 80 questions annually; • Customized to practice; • Diplomates must answer three questions for each of 10 journal articles in each cycle posted in February and August; • 10 core questions during each 6-month cycle; • Questions can be answered independently for each article; • Diplomate feedback required on each question; • Opportunity to drop the two lowest 6-month cycle scores during each 5-year period to allow for unexpected life events; and • Diplomates can take exam where and when it is convenient and have the ability to complete questions on PCs, laptops, MACs, tablets, and smart phones by using the new diplomate dashboard accessed via the existing ABAI Web Portal page.
	Part IV: ABAI diplomates receive credit for participation in registries.	Part IV: In 2018, new Part IV qualifying activities provided credit for a greater range of Improvement in Medical Practice (IMP) activities that physicians complete at their institutions and/or individual practices. A practice assessment/quality improvement (QI) module must be completed once every 5 years.
Anesthesiology (ABA) theaba.org	Part III: MOCA 2.0 introduced in 2014 to provide a tool for ongoing low-stakes assessment with more extensive,	Part III: MOCA Minute® replaced the MOCA exam:

	question-specific feedback. Also provides focused content that could be reviewed periodically to refresh knowledge and document cognitive expertise.	• Customized to practice; • Diplomates must answer 30 questions per calendar quarter (120 per year), no matter how many certifications they are maintaining; and • Knowledge Assessment Report shows details on the MOCA Minute questions answered incorrectly, peer performance, and links to related CME.
	Part IV[2]: Traditional MOCA requirements include completion of case evaluation and simulation course during the 10-year MOCA cycle. One activity must be completed between Years 1 to 5 and the second between Years 6 to 10. An attestation is due in Year 9.	Part IV[2]: ABA added and expanded multiple activities for diplomates to demonstrate that they are participating in evaluations of their clinical practice and are engaging in practice improvement. Diplomates may choose activities that are most relevant to their practice; reporting templates no longer required for self-report activities; and simulation activity not required. An attestation is due in Year 9.
Colon and Rectal Surgery (ABCRS) abcrs.org	Part III: Computer-based secure exam administered at a proctored test center once a year (in May). Diplomates must pass the exam once every 10 years. *The secure exam is no longer offered.*	Part III[1]: New Continuous Certification Longitudinal Assessment Program (CertLink®) replaced the high-stakes Part III Cognitive Written Exam which was required every 10 years: • Diplomates must complete 12 to 15 questions per quarter through the CertLink® platform. • The fifth year of the cycle can be a year free of questions or used to extend the cycle if life events intervene.
	Part IV: Requires ongoing participation in a local, regional, or national outcomes registry or quality assessment program.	Part IV: If there are no hospital-based or other programs available, diplomates can maintain a log of their own cases and morbidity outcomes utilizing the ACS Surgeon Specific Case Log System (with tracking of 30-day complications). Resources are provided to enable completion of QI activities based on the results.
Dermatology (ABD) abderm.org	Part III: Computer-based secure modular exam still administered at a proctored test center twice a year or by remote proctoring technology. Diplomates must pass the exam once every 10 years. Test preparation material available 6 months before the exam at no cost. The material includes diagnoses from which the general dermatology clinical images will be drawn and questions that will be used to generate the subspecialty modular exams. Examinees are required to take the general dermatology module, consisting of 100 clinical images to assess diagnostic skills, and can then choose among 50-item subspecialty modules.	Part III[1]: ABD completed trials employing remote proctoring technology to monitor exam administration in the diplomates' homes or offices. On January 6, 2020, diplomates can participate in CertLink®: • Diplomates must complete 13 questions per quarter for a total of 52 questions; • Diplomates will receive a mix of visual recognition questions, specialty area questions, and article-based questions; • Written references and online resources are allowed while answering questions; and • Diplomates are permitted to take one quarter off per year without advanced permission or penalty, using the "Time Off" feature (if diplomate opts not to take a quarter off, their lowest scoring quarter during that year will be eliminated from scoring).
	Part IV[2]: Tools diplomates can use for Part IV include: • Focused practice improvement modules. • ABD's basal cell carcinoma registry tool.	Part IV[2]: ABD developed more than 40 focused practice improvement modules that are simpler to

	Partnering with specialty society to transfer any MOC-related credit directly to Board.	complete and cover a wide range of topics to accommodate different practice types. Peer and patient communication surveys are now optional.
Emergency Medicine (ABEM) abem.org	Part III: ABEM's ConCert™, computer-based, secure exam administered at a proctored test center twice a year. Diplomates must pass the exam once every 10 years. *ConCert will be phased out after 2022*	Part III: ABEM launched an alternative assessment, MyEMCert, that consists of: • Short assessment modules, consisting of up to 50 questions each; • Each module addresses a category of common patient presentations in the emergency department; • Eight modules are required in each 10-year certification. (ABEM-diplomates who have less than 10 years remaining on their current certification and who choose to participate in MyEMCert will have less time to complete eight modules before their certification expires); • Each module includes recent advances in emergency medicine (that may or may not be related to the category of patient presentation). Participants in MyEMCert do not also have to take LLSAs; • Three attempts are available for each registration; • MyEMCert modules will be available 24/7/365; and • Diplomates can look up information—for example, textbooks or online resources to which they subscribe—while completing a module.
	Part IV^2: Physicians may complete practice improvement efforts related to any of the measures or activities listed on the ABEM website. Others that are not listed, may be acceptable if they follow the four steps ABEM requirements.	Part IV^2: ABEM is developing a pilot program to grant credit for participation in a clinical data registry. ABEM diplomates receive credit for improvements they are making in their practice setting. Must complete and attest to two performance improvement activities, one in years one through five of certification and one in years six through ten.
Family Medicine (ABFM) theabfm.org	Part III: One-day Family Medicine Certification Exam. Traditional computer-based secure exam administered at a proctored test center twice a year or by remote proctoring technology. Diplomates must pass the exam once every 10 years. The exam day schedule consists of four 95-minute sections (75 questions each) and 100 minutes of pooled break time available between sections.	Part III: In 2018, ABFM launched Family Medicine Certification Longitudinal Assessment (FMCLA), • Diplomates must complete 25 questions per quarter; 300 questions over a 4-year time period; • Diplomates receive immediate feedback after each response; • Clinical references similar to those used in practice allowed during the assessment; and • Questions can be completed at the place and time of the diplomate's choice.
	Part IV^2: IMP Projects include: • Collaborative Projects: Structured projects that involve physician teams collaborating across	Part IV^2: ABFM developed and launched the national primary care registry (PRIME) to reduce time and reporting requirements.

	practice sites and/or institutions to implement strategies designed to improve care. • Projects Initiated in the Workplace: These projects are based on identified gaps in quality in a local or small group setting. • Web-based Activities: Self-paced activities that physicians complete within their practice setting (these activities are for physicians, who do not have access to other practice improvement initiatives).	
Internal Medicine (ABIM) abim.org	Part III: Computer-based secure exam administered at a proctored test center. Diplomates must pass the exam once every 10 years. This option includes open-book access (to UpToDate®) that physicians requested. *ABIM introduced grace period for physicians to retry assessments for additional study and preparation if initially unsuccessful.*	Part III: ABIM will be piloting a longitudinal assessment option in 2022. *ABIM has developed collaborative pathways with the American College of Cardiology and American Society of Clinical Oncology for physicians to maintain board certification in several subspecialties. ABIM is working with other specialty societies to explore the development of pathways.*
	Part IV[2]: Practice assessment/QI activities include identifying an improvement opportunity in practice, implementing a change to address that opportunity, and measuring the impact of the change. Diplomates can earn MOC points for many practice assessment/QI projects through their medical specialty societies, hospitals, medical groups, clinics, or other health-related organizations.	Part IV[2]: Optional; incentive for participation in approved activities. Increasing number of specialty-specific IMP activities recognized for credit (activities that physicians are participating in within local practice and institutions).
Medical Genetics and Genomics (ABMGG) abmgg.org	Part III: Computer-based secure exam administered at a proctored test center once a year (August). Diplomates must pass the exam once every 10 years. *The secure exam is no longer offered.*	Part III[1]: ABMGG offers a longitudinal assessment program (CertLink®) • Diplomates receive 24 questions every 6 months, regardless of number of specialties in which a diplomate is certified; • Diplomates must answer all questions by the end of each 6-month timeframe (5 minutes allotted per question); • Resources allowed, collaboration with colleagues not allowed; • Realtime feedback and performance provided for each question; and • "Clones" of missed questions will appear in later timeframes to help reinforce learning.
	Part IV[2]: Diplomates can choose from the list of options to complete practice improvement modules in areas consistent with the scope of their practice.	Part IV[2]: ABMGG is developing opportunities to allow diplomates to use activities already completed at their workplace to fulfill certain requirements. *Expanding accepted practice improvement activities for laboratorians.*
Neurological Surgery (ABNS) abns.org	Part III: The 10-year secure exam can be taken from any computer, e.g., in the diplomate's office or home. Access to reference materials is not restricted; it is an open book exam. On applying to take the exam, a diplomate must assign a person to be their proctor. Prior to the exam, that	Part III: In 2018, Core Neurosurgical Knowledge, an annual adaptive cognitive learning tool and modules, replaced the 10-year secure exam: • Open book exam focusing on 30 or so evidence-based practice principles critical to emergency, urgent, or critical care; • Shorter, relevant, and more focused questions than the prior exam;

	individual will participate in an on-line training session and "certify" the exam computers. *The secure exam is no longer offered.*	• Diplomates receive immediate feedback for each question and references with links and/or articles are provided; and • Web-based format with 24/7 access from the diplomate's home or office.
	Part IV: Diplomates receive credit for documented participation in an institutional QI project.	Part IV: Diplomates are required to participate in a meaningful way in morbidity and mortality conferences (local, regional, and/or national). For those diplomates participating in the Pediatric Neurosurgery, CNS-ES, NeuCC focused practice programs, a streamlined case log is required to confirm that their practice continues to be focused and the diplomate is required to complete a learning tool that includes core neurosurgery topics and an additional eight evidence-based concepts critical to providing emergency, urgent, or critical care in their area of focus.
Nuclear Medicine (ABNM) abnm.org	Part III: Computer-based secure exam administered at a proctored test center once a year (October). Diplomates must pass the exam once every 10 years.	Part III[1]: Diplomates can choose between the 10-year exam or a longitudinal assessment program (CertLink®). • Diplomates receive nine questions per quarter and up to four additional questions that are identical or very similar to questions previously answered (called "clones") and many will have images; • Educational resources can be used; • Diplomates receive immediate feedback with critiques and references; and • Allows for emergencies and qualifying life events.
	Part IV: Diplomates must complete one of the three following requirements each year. 1. Attestation that the diplomate has participated in QI activities as part of routine clinical practice, such as participation in a peer review process, attendance at tumor boards, or membership on a radiation safety committee. 2. Participation in an annual practice survey related to approved clinical guidelines released by the ABNM. The survey has several questions based on review of actual cases. Diplomates receive a summary of the answers provided by other physicians that allows them to compare their practice to peers. 3. Improvement in Medical Practice projects designed by diplomates or provided by professional groups such as the SNMMI. Project areas may include medical care provided for common/major health conditions; physician behaviors, such as communication and professionalism, as they relate to patient care; and many others. The projects typically follow the model of Plan, Do, Study, Act. The ABNM has developed a few IMP modules for the SNMMI, Alternatively, diplomates may design their own project.	Part IV: ABNM recognizes QI activities in which physicians participate in their clinical practice.

Obstetrics and Gynecology (ABOG) abog.org	Part III: The secure, external assessment is offered in the last year of each ABOG diplomate's 6-year cycle in a modular test format; diplomates can choose two selections that are the most relevant to their current practice. The exam administered at a proctored test center.	Part III: ABOG integrated the article-based self-assessment (Part II) and external assessment (Part III) requirements, allowing diplomates to continuously demonstrate their knowledge of the specialty. Diplomates can earn an exemption from the current computer-based exam in the sixth year of the program if they reach a threshold of performance during the first 5 years of the self-assessment program. Since 2019, diplomates can choose to take the 6-year exam or participate in Performance Pathway, an article-based self-assessment (with corresponding questions) which showcases new research studies, practice guidelines, recommendations, and up-to-date reviews. Diplomates who participate in Performance Pathway are required to read a total of 180 selected articles and answer 720 questions about the articles over the 6-year MOC cycle.
	Part IV[2]: Diplomates required to participate in one of the available IMP activities yearly in MOC Years 1-5. ABOG will consider structured QI projects (IMP modules, QI efforts, simulation courses) in obstetrics and gynecology for Part IV credit. These projects must demonstrate improvement in care and be based on accepted improvement science and methodology. Newly developed QI projects from organizations with a history of successful QI projects are also eligible for approval.	Part IV[2]: ABOG recognizes work with QI registries for credit. ABOG continues to expand the list of approved activities which can be used to complete the Part IV.
Ophthalmology (ABO) abop.org	Part III: The Demonstration of Ophthalmic Cognitive Knowledge (DOCK) high-stakes, 10-year exam administered through 2018. *The secure exam is no longer offered.*	Part III: In 2019, Quarterly Questions™ replaced the DOCK Examination for all diplomates: • Diplomates receive 50 questions (40 knowledge-based and 10 article-based); • The questions should not require preparation in advance, but a content outline for the questions will be available; • The journal portion will require reading five articles from a list of key ophthalmic journal articles with questions focused on the application of this information to patient care; • Diplomates receive immediate feedback and recommendations for resources related to gaps in knowledge; and • Questions can be completed remotely at home or office through computer, tablet, or mobile apps.
	Part IV[2]: Diplomates whose certificates expire on or before December 31, 2020, must complete one of the following options; all other diplomates complete two activities: • Read QI articles through Quarterly Questions; • Choose a QI CME activity; • Create an individual IMP activity; or	Part IV[2]: Diplomates can choose to: • Select 3 QI journal articles from ABO's reading list and answer two questions about each article (this activity option may be used only once during each 10-year cycle).

	• Participate in the ABMS multi-specialty portfolio program pathway.	• Design a registry-based IMP Project using their AAO IRIS® Registry Data; • Create a customized, self-directed IMP activity; or • Participate in the ABMS multi-specialty portfolio program through their institution.
Orthopaedic Surgery (ABOS) abos.org	Part III: Computer-based secure modular exam administered at a proctored test center. Diplomates must pass the exam once every 10 years. The optional oral exam is given in Chicago in July. Diplomates without subspecialty certifications can take practice-profiled exams in orthopaedic sports medicine and surgery of the hand. General orthopaedic questions were eliminated from the practice-profiled exams, so diplomates are only tested in areas relevant to their practice. Detailed blueprints are being produced for all exams to provide additional information for candidates to prepare for and complete the exams. Eight different practice-profiled exams offered to allow assessment in the diplomate's practice area.	Part III: ABOS offers a longitudinal assessment program (ABOS WLA) the Knowledge Assessment. This pathway may be chosen instead of an ABOS computer-based or oral recertification 10-year exam: • Diplomates must answer 30 questions (from each Knowledge Source chosen by the diplomate); • The assessment is open-book and diplomates can use the Knowledge Sources, if the questions are answered within the 3-minute window and that the answer represents the diplomate's own work; and • Questions can be answered remotely at home or office through computer, tablet, or mobile apps.
	Part IV: Case lists allow diplomates to review their practice including adhering to accepted standards, patient outcomes, and rate and type of complications. Case list collection begins on January 1st of the calendar year that the diplomate plans to submit their recertification application and is due by December 1. The ABOS recommends that this be done in Year 7 of the 10-year MOC Cycle, but it can be done in Year 8 or 9. A minimum of 35 cases is required for the recertification candidate to sit for the recertification exam of their choice. Diplomates receive a feedback report based on their submitted case list.	Part IV: ABOS is streamlining the case list entry process to make it easier to enter cases and classify complications.
Otolaryngology – Head and Neck Surgery (ABOHNS) aboto.org	Part III: Computer-based secure modular exam administered at a proctored test center. Diplomates must pass the exam once every 10 years.	Part III[1]: CertLink®-based longitudinal assessment: • Diplomates receive 10 to 15 questions per quarter; • Immediate, personalized feedback provided regarding the percentage of questions answered correctly; • Questions can be answered at a diplomate's convenience so long as all questions are answered by the end of each quarter; and • Remote access via desktop or laptop computer (some items will contain visuals).
	Part IV[2]: The three components of Part IV include: • A patient survey; • A peer survey; and • A registry that will be the basis for QI activities.	Part IV[2]: ABOHNS is partnering with the American Academy of Otolaryngology-Head and Neck Surgery in their development of a RegentSM registry. Selected data will be extracted from RegentSM for use in practice improvement modules that diplomates can use to meet IMP requirements. ABOHNS is working to identify

		and accept improvement activities that diplomates engage in as part of their practice. ABOHNS will roll out the last section of MOC, Part IV, which is still under development. Part IV will consist of three components, a patient survey, a professional survey, and a Performance Improvement Module (PIM).
Pathology (ABPath) abpath.org	Part III: Computer-based secure modular exam administered at the ABP Exam Center in Tampa, Florida twice a year (March and August). Remote computer exams can be taken anytime 24/7 that the physician chooses during the assigned 2-week period (spring and fall) from their home or office. Physicians can choose from more than 90 modules, covering numerous practice areas for a practice-relevant assessment. Diplomates must pass the exam once every 10 years.	Part III[1]: The ABPath CertLink® program is available for all diplomates: • Customization allows diplomates to select questions from practice (content) areas relevant to their practice. • Diplomates can log in anytime to answer 15 to 25 questions per quarter; • Each question must be answered within 5 minutes; • Resources (e.g. internet, textbooks, journals) can be used; and • Diplomates receive immediate feedback on whether each question is answered correctly or incorrectly, with a short narrative about the topic (critique), and references.
	Part IV[2]: Diplomates must participate in at least one inter-laboratory performance improvement and quality assurance program per year appropriate for the spectrum of anatomic and clinical laboratory procedures performed in that laboratory.	Part IV[2]: IMP requirements must be reported as part of a reporting period every 2 years via PATHway. There are three aspects to IMP: • Laboratory Accreditation; • Laboratory Performance Improvement and Quality Assurance; and • Individual Performance Improvement and Quality Assurance.
Pediatrics (ABP) abp.org	Part III: Computer-based secure exam administered at a proctored test center. Diplomates must pass the exam once every 10 years.	Part III: In 2019, a new testing platform with shorter and more frequent assessments, Maintenance of Certification Assessment for Pediatrics (MOCA-Peds), was implemented: • Allows for questions to be tailored to the pediatrician's practice profile; • A series of questions released through mobile devices or a web browser at regular intervals; • Diplomates receive 20 questions per quarter (may be answered at any time during the quarter); • Diplomates receive immediate feedback and references; • Resources (e.g., internet, books) can be used. *Those who wish to continue taking the exam once every 5 years in a secure testing facility will be able to do so.*
	Part IV[2]: Diplomates must earn at least 40 points every 5 years in one of the following activities: • Local or national QI projects • Diplomates' own project • National Committee for Quality Assurance Patient-Centered Medical Home or Specialty Practice • Institutional QI leadership	Part IV[2]: ABP is enabling new pathways for pediatricians to claim Part IV QI credit for work they are already doing. These pathways are available to physicians who are engaged in QI projects alone or in groups and include a pathway for institutional leaders in quality to claim credit for their leadership.

	• Online modules (PIMS)	ABP is also allowing trainees (residents and fellows) to "bank" MOC credit for QI activities in which they participate. The pediatricians supervising these trainees also may claim MOC credit for qualifying projects.
Physical Medicine and Rehabilitation (ABPMR) abpmr.org	Part III: Computer-based secure exam administered at a proctored test center. Diplomates must pass the exam once every 10 years. Released MOC 100, a set of free practice questions pulled directly from the ABPMR exam question banks to help physicians prepare for the exam. There is a separate computer-based secure exam administered at a proctored test center that is required to maintain subspecialty certification. *After the last administration of secure exam in 2020, the exam will be replaced with the Longitudinal Assessment for PM&R (LA-PM&R).*	Part III[1]: The Longitudinal Assessment for PM&R (LA-PM&R) is available for all diplomates: • Diplomates receive 20 questions per quarter; after that: between 15 and 18 questions depending on performance (higher performance = fewer questions); • Maximum of 2 minutes to answer each question; • Diplomates can customize their question content; • Diplomates receive immediate feedback indicating whether the answer was correct or incorrect, followed by a critique; and • Available from a desktop or tablet (some features may not work on a phone's web browser). The ABPMR is exploring the use of longitudinal assessment for its subspecialty assessment requirement, but these plans, IT infrastructure, customer service support, and item banks take time to develop. More information on longitudinal assessment for subspecialties will be available in the next few years.
	Part IV[2]: Guided practice improvement projects are available through ABPMR. Diplomates must complete: • Clinical module (review of one's own patient charts on a specific topic), or • Feedback module (personal feedback from peers or patients regarding the diplomates clinical performance using questionnaires or surveys). Each module consists of three steps to complete within a 24-month period: initial assessment, identify and implement improvement, and reassessment.	Part IV[2]: ABPMR introduced several free tools to complete an IMP project, including a simplified and flexible template to document small improvements and educational videos, infographics, and enhanced web pages. ABPMR is seeking approval from the National Committee for Quality Assurance Patient-Centered Specialty Practice Recognition for Part IV IMP credit. ABPMR is also working with its specialty society to develop relevant registry-based QI activities.
Plastic Surgery (ABPS) abplasticsurgery.org	Part III: Computer-based secure exam administered at a proctored test center once a year (October). Diplomates must pass the exam once every 10 years. Modular exam to ensure relevance to practice. ABPS offers a Part III Study Guide with multiple choice question items derived from the same sources used for the exam. *Following 2021, the computer-based secure exam will be replaced with the internet-based format.*	Part III: In April 2020, the continuous certification exam will move to an internet-based testing format: • Diplomate receives 30 questions per year; • Diplomates receive immediate feedback on answers with links to references and educational resources. These are offered with an opportunity to respond again; and • Available on any computer with an internet connection;
	Part IV: ABPS provides Part IV credit for registry participation. ABPS also allows Part IV credit for IMP activities that a diplomate is engaged in through their hospital or institution. Diplomates are asked to input data from 10	Part IV: Allowing MOC credit for IMP activities that a diplomate is engaged in through their hospital or institution.

	cases from any single index procedure every 3 years, and ABPS provides feedback on diplomate data across five index procedures in four subspecialty areas.	Physician participation in one of four options can satisfy the diplomate's Practice Improvement Activity: · Quality Improvement Publication · Quality Improvement Project · Registry Participation · Tracer Procedure Log
Preventive Medicine (ABPM) theabpm.org	Part III: In-person, pencil-and-paper, secure exam administered at a secure test facility. MOC exams follow the same content outline as the initial certification exam (without the core portion). *In 2016, new multispecialty subspecialty of Addiction Medicine was established. In 2017, Addiction Medicine subspecialty certification exam was administered to diplomates of any of the 24 ABMS member boards who meet the eligibility requirements.*	Part III: In 2019, the ABPM began offering all diplomates remotely proctored MOC exams: • Must be completed by the examinee in a single sitting; • Given in two 50-question sections with an optional 15-minute break between sections; • Diplomates are not allowed to consult outside resources or notes; • Results available on diplomate's dashboard in the physician portal 4 weeks after the completion of the exam; and • Available on smart phone or computer. In 2021, ABPM began piloting a longitudinal assessment program for the Clinical Informatics subspecialty certificate.
	Part IV[2]: Diplomates must complete two IMP activities during each 10-year cycle. One of the activities must be completed through a Preventive Medicine specialty or subspecialty society (ACOEM, ACPM, AMIA, AsMA, or UHMS).	Part IV[2]: Partnering with specialty societies to design quality and performance improvement activities for diplomates with population-based clinical focus (e.g., public health).
Psychiatry and Neurology (ABPN) abpn.com	Part III: Computer-based secure exam administered at a proctored test center. Diplomates must pass the exam once every 10 years. ABPN is developing MOC exams with committees of clinically active diplomates to ensure relevance to practice. ABPN is also enabling diplomates with multiple certificates to take all of their MOC exams at once and for a reduced fee. Grace period so that diplomates can retake the exam.	Part III: ABPN implemented a new assessment that allows physicians to select 30-40 lifelong learning articles and demonstrate learning by high performance on the questions accompanying the article in order to earn exemption from the 10-year MOC high-stakes exam.
	Part IV[2]: Diplomates satisfy the IMP requirement by completing one of the following: 1. Clinical Module: Review of one's own patient charts on a specific topic (diagnosis, types of treatment, etc.). 2. Feedback Module: Obtain personal feedback from either peers or patients regarding your own clinical performance using questionnaires or surveys.	Part IV[2]: ABPN is allowing Part IV credit for IMP and patient safety activities diplomates complete in their own institutions and professional societies, and those completed to fulfill state licensure requirements. Diplomates participating in registries, such as those being developed by the American Academy of Neurology and the American Psychiatric Association, can have 8 hours of required self-assessment CME waived.
Radiology (ABR) theabr.org	Part III: Computer-based secure modular exam administered at a proctored test center. Diplomates must pass the exam once every 10 years. *The secure exam is needed only in limited situations.*	Part III: An Online Longitudinal Assessment (OLA) model was implemented in place of the 10-year traditional exam. OLA includes modern and more relevant adult learning concepts to provide psychometrically valid sampling of the diplomate's knowledge.

		• Diplomates must create a practice profile of the subspecialty areas that most closely fit what they do in practice, as they do now for the modular exams; • Diplomates will receive weekly emails with links to questions relevant to their registered practice profile. • Questions may be answered singly or, for a reasonable time, in small batches, in a limited amount of time. • Diplomates receive immediate feedback about questions answered correctly or incorrectly and will be presented with a rationale, critique of the answers, and brief educational material. *Those who answer questions incorrectly will receive future questions on the same topic to gauge whether they have learned the material.*
	Part IV[2]: Diplomates must complete at least one practice QI project or participatory QI activity in the previous 3 years at each MOC annual review. A project or activity may be conducted repeatedly or continuously to meet Part IV requirements.	Part IV[2]: ABR is automating data feeds from verified sources to minimize physician data reporting. ABR is also providing a template and education about QI to diplomates with solo or group projects.
Surgery (ABS) absurgery.org	Part III: Computer-based secure exam administered at a proctored test center. Diplomates must pass the exam once every 10 years. Transparent exam content, with outlines, available on the ABS website and regularly updated. ABS is coordinating with the American College of Surgeons and other organizations to ensure available study materials align with exam content. *The secure exam is no longer offered for general surgery, vascular surgery, pediatric surgery, surgical critical care, or complex general surgical oncology.*	Part III: In 2018, ABS began offering shorter, more frequent, open-book, modular, lower-stakes assessments required every 2 years in place of the high-stakes exam: • Diplomates will select from four practice-related topics: general surgery, abdomen, alimentary tract, or breast; • More topics based on feedback from diplomates and surgical societies are being planned; • Diplomates must answer 40 questions total (20 core surgery, 20 practice-related; • Open book with topics and references provided in advance; • Individual questions are untimed (with 2 weeks to complete); • Diplomate receives immediate feedback and results (two opportunities to answer a question correctly); and • Diplomates can use their own computer at a time and place of their choosing within the assessment window. The new assessment is available for general surgery, vascular surgery, pediatric surgery, or surgical critical care with other ABS specialties launching over the next few years.
	Part IV[2]: ABS allows ongoing participation in a local, regional, or national outcomes registry or quality assessment program, either individually or through the Diplomate's institution. Diplomates must describe how they are meeting this requirement—no patient data is collected. The ABS audits a percentage of submitted forms each year.	Part IV[2]: ABS allows multiple options for registry participation, including individualized registries, to meet IMP requirements.

Thoracic Surgery (ABTS) abts.org	Part III: Remote, secure, computer-based exams can be taken any time (24/7) that the physician chooses during the assigned 2-month period (September-October) from their home or office. Diplomates must pass the exam once every 10 years. Modular exam, based on specialty, and presented in a self-assessment format with critiques and resources made available to diplomates.	Part III: ABTS developed a web-based self-assessment tool (SESATS) that includes all exam material, instant access to questions, critiques, abstracts, and references.
	Part IV[2]: ABTS diplomates must complete at least one practice QI project within 2 years, prior to their 5-year and 10-year milestones. There are several pathways by which diplomates may meet these requirements: individual, group or institutional. A case summary and patient safety module must also be completed.	Part IV[2]: *No changes to report at this time.*
Urology (ABU) abu.org	Part III: Computer-based secure exam administered at a proctored test center once a year (October). Diplomates must pass the exam once every 10 years. Clinical management emphasized on the exam. Questions are derived from the American Urological Association (AUA) Self-Assessment Study Program booklets from the past five years, AUA Guidelines, and AUA Updates. Diplomates required to take the 40-question core module on general urology and choose one of four 35-question content specific modules. ABU provides increased feedback to reinforce areas of knowledge deficiency.	Part III: In 2021, ABU began piloting a new assessment format that combines shorter more frequent assessments with article-based assessments over a 5-year cycle. Diplomates achieving a score of > 60% correct during the Knowledge Reinforcement (years 1 and 3), and ≥ 80% correct during the Knowledge Exposure (years 2 and 4) are not required to take the year 5 Knowledge Assessment but may participate if desired. If the Knowledge Assessment is not taken, learning in year 5 would be self-directed. The existing computer-based secure knowledge assessment is based on Criterion referencing, thus allowing the identification of two groups, those who unconditionally pass the knowledge assessment and those who are given a conditional pass. The group getting a conditional pass will consist of those individuals who score in the band of one standard error of measurement above the pass point down to the lowest score. That group would be required to complete additional CME in the areas where they demonstrate low scores. After completion of the designated CME activity, they would continue in the Lifelong Learning process and the condition of their pass would be lifted.
	Part IV[2]: Completion of Practice Assessment Protocols. ABU uses diplomate practice logs and diplomate billing code information to identify areas for potential performance or QI.	Part IV[2]: ABU allows credit for registry participation (e.g., participation in the MUSIC registry in Michigan and the AUA AQUA registry). Another avenue to receive credit is participation in the ABMS multi-specialty portfolio program (this is more likely to be used by Diplomates who are part of a large health system, e.g. Kaiser, or those in academic practices).

* The information in this table is sourced from ABMS member board websites and is current as of January 20, 2022.
1. Utilizing CertLink®, an ABMS web-based platform that leverages smart mobile technology to support the design, delivery, and evaluation of longitudinal assessment programs, some of which launched in 2017-2018. More information is available at: https://www.abms.org/initiatives/certlink/member-board-certlink-programs/ (accessed 1-13-20).
2. Participates in the ABMS Portfolio Program™ which offers an option for organizations to support physician involvement in quality, performance and process improvement (QI/PI) initiatives at their institution and award physician IMP credit for continuing certification.

APPENDIX B - Member Board Temporary Changes Due to Covid-19**

American Board of	Initial Certification	Continuing Certification
Allergy and Immunology	1. ABAI will give initial certification exam candidates the option to take the exam in 2021 without the need to reapply or pay additional fees. 2. ABAI will enable a one-time increase from 8 to 10 weeks for maximum time away from training requirement without a formal exception to policy request from the program director for 2020 and 2021 graduates. 3. ABAI will support the inclusion of COVID-19 education and clinical activities in fellowship curricula as determined by the ACGME Allergy-Immunology Review Committee. 4. Extending the board eligibility window by one year from 7 to 8 for all allergist-immunologists meeting eligibility requirements for the 2020 initial certification exam regardless of whether a candidate is registered for the exam.	1. Extending the expiration date for certificates expiring in 2020 to 12/31/2021. No diplomate will lose their certification this year or next as a result of the COVID-19 crisis. 2. Extending the deadline for all individual MOC requirements (parts I, II, III, and IV due in 2020 to 12/31/2021. 3. Extending 2020 MOC fee deadline to 12/31/2021 allowing for combined 2020/2021 fee submission without penalty or impact continuing certification status. 4. ABAI will provide expedited certification status confirmation to credentialing bodies as diplomates adapt in person and telemedicine practices.
Anesthesiology	1. All applied exams have been cancelled. Trainees will not be adversely affected. The ABA is working to create a virtual exam. 2. Time spent by residents in quarantine will be counted as clinical hours. 3. Residents who miss training due to contracting COVID-19 may request an additional absence from training. 4. ABA executing ADVANCED Exam as scheduled in July. 5. ABA has voted to move forward with a virtual administration of the APPLIED Examination in the spring of 2021. While it remains the intention to assess all 2020 and 2021 candidates by the end of 2021, 2020 APPLIED Exam candidates will be given priority and will receive their exam appointment for the first half of the year no later than November. Time zones will be taken into consideration and accommodated. The Board will decide in early 2021 if the APPLIED Exams will continue virtually during the second half of 2021 based upon the state of the pandemic. In order to assess as many candidates as possible in 2021, candidates will not be able to select their exam appointment.	The ABA have already begun to add COVID-19 questions to MOCA Minute and are working to rapidly add more questions that speak to the unique needs of this pandemic. As with all MOCA Minute questions, the new COVID-19 related items include links to learning resources that physicians may find useful.
Colon and Rectal Surgery	1. It is up to the program director with input from the CCC to assess procedural competence of an individual trainee as one part of the determination of whether that individual is prepared to enter autonomous practice. 2. Case log minima will not be waived by the RRC, but case logs will be judiciously considered in light of the impact of the pandemic on that program. 3. Regarding certification by the ABCRS, all application deadlines remain in place. The board utilizes a number of criteria to admit a candidate for the written examination. The program director attestation and case logs will be reviewed with consideration given to the issues we are facing. The oral examination scheduled for September. 4. With a decrease in elective surgeries during	1. Due to the unprecedented pandemic creating obstacles for Diplomates, there is an option built into the Continuing Certification program. If the Diplomate has successfully answered 70% of the questions over four years, Diplomates can take the fifth year off from answering any question. Diplomates may request off a quarter or more without penalty and those quarters will be added to the fifth year. 2. Requests to take a quarter off may be made during that quarter for a maximum of four quarters.

	this time, residencies/fellowships may be extended. The ACGME accredits programs. It does not certify individuals. What an extension of residency/fellowship would mean for a given individual in terms of the board certification process can only be answered by the appropriate certifying board. 5. The oral exam has been deferred to March 2021.	
Dermatology	1. The ABD will grant an extra year of eligibility for board certification to residents graduating in 2020. Instead of the normal 5 years of eligibility, residents will have 6 years to pass the exam. 2. Any board-eligible candidate currently in the traditional certification pathway may switch to the new certification pathway. This involves passing 4 CORE Exam modules, which can be taken via online proctoring, then passing the APPLIED Exam, which can be taken at a local Pearson VUE test center. The first possible date to complete all portions of this new exam is July 2021. Once in the new pathway, there is no option to switch back to the traditional pathway. 3. The traditional certification pathway exam is planned for administration via Pearson VUE in both 2021 and 2022. After 2022, everyone in the traditional certification pathway who has not passed the Certification Exam must transfer to the new pathway and pass the CORE and the APPLIED Exams.	1. ABD offering diplomates in the last year of their cycle the option to enroll in CertLink® in lieu of taking the traditional MOC Exam. 2. ABD reduced the question load from four segments to two and extended the period for completion for diplomates participating in CertLink®. Diplomates will have the option of designating one of these segments as a "time off" period. 3. Diplomates scheduled to take the MOC exam before the end of 2020 had two options: either participate in CertLink® or take the traditional exam with a deadline of June 2021. 4. The self-assessment requirement for 2020 is deferred until the end of 2021. 5. Practice improvement exercises due in 2020 can be deferred until the end of 2021.
Emergency Medicine	1. ABEM cancelled the May ConCert exam. It will now be available in an online-open book format for two three-week periods during 2021 and 2022. 2. ABEM will accommodate a 2-week quarantine period for residents without affecting board eligibility. 3. ABEM does not define what constitutes 44-week training programs. Program directors and the ACGME define those requirements. ABEM does not define, police, or regulate clinical hours or other forms of educational activity. ABEM strongly supports asynchronous learning as part of training during any time at which a candidate might be quarantined. 4. ABEM has relaxed deadlines and simplified logistics for recent residency graduates who are pursuing initial certification in Emergency Medicine and a subspecialty. The new deadline for completing certification requirements is June 30, 2021. Subspecialty certification deadline is now December 31, 2021 for: Anesthesiology Critical Care Medicine, Hospice and Palliative Medicine, Internal Medicine-Critical Care Medicine, Pain Medicine, and Sports Medicine. 5. The virtual Oral Exam will be piloted and then fully implemented in 2021. Candidates who were scheduled for the Oral Exam in 2020 will be the first to be scheduled for the virtual Oral Exam.	1. ABEM extended the grace period for certification by six months for those physicians whose certificates expire in 2020. The new deadline for meeting certification requirements is July 2021. 2. Beginning in spring 2021, ABEM-certified physicians will be able to meet continuing certification requirements by completing four MyEMCert modules (online and open book, approximately 50 questions each) instead of taking the ConCert Exam. The switch to MyEMCert will emphasize relevant content, save emergency physicians time and money, and better accommodate their busy schedules. ABEM will no longer offer ConCert after 2022. Starting in 2021, ABEM will move to a 5-year certification period for physicians when they next recertify. Specifically, any certificate awarded or renewed in 2021 and after will be for a 5-year duration. It is important to note the move from a 10-year to 5-year certification length will not increase total requirements or increase the cost to stay certified. This change is in response to physician requests to use MyEMCert to recertify sooner. By moving to a 5-year certification period, physicians will now be able to use MyEMCert to recertify starting in 2021. As physicians move to a 5-year certification period, ABEM will also move to an annual fee structure. We recognize this change affects physicians differently based on where they are in their current continuing certification process. ABEM has set a cap on fees paid by physicians so no physician will pay more than $1,400 to renew their certification. This approach levels the costs associated with certification. ABEM has identified

		physicians who have exceeded this fee cap and will issue a refund.
Family Medicine	1. ABP cancelled initial certification exams, which includes the Adolescent Medicine initial certification exam necessary for candidates for Adolescent Family Medicine. ABFM reached out to those physicians and is monitoring what ABP does before making any decisions. 2. ABFM relies on Program Director attestation that the resident has completed all ACGME requirements for training and that the program's CCC agrees that the resident is ready for autonomous practice. Specifically important for board eligibility are that the resident has completed 1,650 in person patient encounters and has had 40 weeks of continuity practice in each year of training. For COVID accommodations, ABFM is allowing for the 1,650 visits to be either in person or virtual and accepting Program Director attestation on any modifications of rotation requirements based on ACGME's direction. Additionally, ABFM has stated that any time away from residency related to a resident requiring quarantine for COVID exposure or personal treatment for COVID will not count against the time away from training/family leave policy.	1. ABFM extended the 2020 FMCLA quarterly deadlines by 3 months each. 2. ABIM cancelled their Spring exam, which includes the Geriatric Medicine continuing certification exam necessary for diplomates specializing in Geriatric Family Medicine. There was a 2nd administration of that exam in the Fall. 3. Diplomates with a stage ending in 2020 will have a one-year extension to complete stage requirements. 4. Physicians due to take their examination in 12/31/2020 will have the option for an additional year to complete the examination requirement while remaining certified. 5. Diplomates who participate in certification activities this year will have the option to defer paying certification fees due to financial hardship until next year. 6. Diplomates in the 2021 cohort of FMCLA had their meaningful participation requirement in the first year reduced from 80 completed items to 50 items. 7. A new COVID-19 Self-Directed PI activity provides a mechanism for meeting the Performance Improvement (PI) requirement by reporting on the unprecedented and rapid changes they had to make as a result of the pandemic. 8. Any board-eligible family physician with an eligibility end date in 2020, or anyone participating in the re-entry process with an end date in 2020, will have an additional year to obtain their certification. 9. Any Diplomate who also holds a Certificate of Added Qualification with an examination deadline in 2020 will have the option for an additional year to complete the examination requirement.
Internal Medicine	1. Any absence related to COVID-19 will not affect board eligibility for residents. 2. ABIM has decided to cancel all Spring assessments, including the Critical Care Medicine Knowledge Check-in. ABIM will extend the assessment deadline so that rescheduling does not reduce the number of opportunities to pass the exam prior to the deadline. 3. ABIM unable to print Specialty certificates for physicians due to the Philadelphia stay at home order. ABIM encourages physicians to find their digital badge on the Physician Portal. No proof or documentation is needed if you schedule for a future date. 4. The IM Certification exam has been cancelled. Candidates will receive a $150 credit and can reschedule their exam for the following dates:	1. ABIM is extending deadlines for all Maintenance of Certification (MOC) requirements to 12/31/22. 2. Diplomates can reschedule their exam at no additional cost. 3. There will be no negative impact to certification status due to cancellation of Spring assessments. No one will lose their certification status if they are not able to complete a requirement this year. Any physician who is currently certified and has a Maintenance of Certification (MOC) requirement due in 2020—including an assessment, point requirement, or attestation—will now have until the end of 2021 to complete it. Physicians currently in their grace year will also be afforded an additional grace year in 2021. 4. ABIM is working with ACCME to ensure their virtual education offerings that earn CME also count for MOC points.
Medical Genetics and Genomics	1. Time spent in quarantine can count as clinical hours for residents as long as the program director defines continued learning and training activities that can be accomplished and documented. 2. Extended absences for those who contract COVID-19 will be considered on a case-by-case basis. 3. Any required rotation experiences may require an extension of training which will be	1. The total number of required CME is reduced from 25 to 15 hours. 2. LGG Alternative Pathway Logbook Requirements: The ABMGG continues to monitor the impact of COVID-19 pandemic and urges you to prioritize your safety and that of your colleagues. To accommodate the potential impact of the pandemic on the LGG Alternative Certification Pathway, the ABMGG will allow the following adjustments to

	determined by the program director. 4. Telemedicine sessions may be included in logbooks for both clinical and laboratory trainees as long as appropriate learning objectives have been fulfilled. 5. Laboratory Fellows: The number of cases per time period may be modified such that up to 35 cases may be collected in a given month for clinical biochemical genetics and up to 40 cases may be collected in a given month for laboratory genetics and genomics. 6. LGG Mentored Cases: The ACMG is working with the faculty mentors in each pathway on a detailed schedule. Registered participants sent link via Zoom meeting and assigned to breakout groups. The groups rotate with the mentors to go through the cases. 7. The requirement for the ACMG hands-on short course has been modified for the 2021 Examination cycle. If you could not participate in the 2020 virtual course, you will be able to take the course offered in April 2021 at the ACMG annual meeting to meet requirements for the 2021 Certification Examination. You will have to submit to the ABMGG proof of course registration before the March 10, 2021, deadline and your certificate of attendance after the course is completed.	logbook requirements for the 2021 examination only: • The deadline for logbook submission is now May 10, 2021. • Up to 30 cases may be collected in a given week. • If a diplomate is unable to complete all logbook requirements by May 10, 2021, up to 15% fewer total cases may be submitted. However, the logbook must still reflect substantive experience in ALL required categories and be reviewed by the supervising geneticist. In such instances, a letter of explanation from the diplomate and the supervising geneticist must be included with the logbook submission. 3. ABMGG Board of Directors has extended the alternative pathway through 2025 to allow diplomates more time to gain their required training and be able to sit the exam in 2025. Note that all requirements for training remain the same.
Neurological Surgery	1. The ABNS Primary exam for self-assessment is not considered mandatory. Those who schedule to take the 2020 self-assessment may choose to wait until next year to take the exam.	
Nuclear Medicine	1. ABNM modified their leave policy to include 2 weeks of quarantine. 2. If a resident exceeds an 8-week absence, program directors will need to have a plan approved by ABNM to compensate for lost educational time. 3. Candidates for the ABNM certification examination are also required to be certified in advanced cardiac life support (ACLS). The American Heart Association is allowing a 60-day extension of ACLS instructor cards beyond the renewal date and recommends that employers and regulatory bodies extend provider cards 60 days beyond renewal date. The ABNM is adopting this recommendation: ACLS certification – 60-day extension beyond renewal date of current provider cards. 4. If trainees do not meet these modified requirements, program directors will be required to provide the ABNM with an educational plan and request for exemption that will be considered on a case-by-case basis.	
Obstetrics and Gynecology	2021 Specialty CE: • Application Fee: Candidate can request a refund if request is based on inability to take exam due to COVID-19. Or candidate can choose to roll this fee into 2022 exam year. • Application Deadline: Application deadline is extended to June 21, 2021 (instead of May 21). Late fee deadlines are extended out by one month (1st late fee applies 5/4 instead of 4/2; 2nd applies 6/4 instead of 5/4).	▪ All articles released within ABOG's MOC Part II Lifelong Learning and Self -Assessment in January and May this 2021 MOC year will be designated as incentivized. ▪ Each incentivized article has eight questions to complete (instead of the usual four). ▪ ABOG Diplomates will read half the number of required articles (15 instead of the usual 30) but still answer a total of 120 questions to complete the requirement for 2021 MOC year.

	• Case List and Exam Fee Deadlines: Deadlines are extended to August 31, 2021 (instead of August 16) and late fee deadline is extended to August 16, 2021 (instead of August 2). Case lists requirements have been reduced. Increasing the amount of leave time allowed during case collection from 12 to 24 weeks. 2022 Subspecialty CE: • Application fee: Candidate can request a refund if request is based on inability to take exam due to COVID-19. Or candidate can choose to roll this fee into 2022 exam year. • Application deadline: Application deadline is extended to July 31, 2021 (rather than June 30). Late fee deadlines are extended out by one month (1st late fee applies 7/7 instead of 6/4; 2nd applies 7/20 instead of 6/18). 2021 Specialty and Subspecialty QEs: • Applications and processes already completed for the 2021 QEs. No changes. NOTE regarding FLS Certification: Requirement to complete by Qualifying Exam date is lifted. Completion and submission of documentation (FLS certificate) required to be eligible to submit application for Certifying Examination. Subspecialty Training • Completion of Research/Thesis: Fellows can finalize research and theses after completion of training, provided Program Director (PD) contacts ABOG to request the extension. The PD must include how long they are requesting the research be extended and a new estimated completion date for review by the Credentials Subcommittee. Typically, research and theses to be presented during the Certifying Examinations are required to be completed by the end of fellowship training.1. As an alternative to the May 11 date, ABOG is offering affected candidates (lost seats, other issues) the option of taking a proctored paper examination. Additional Notes: • Time spent in quarantine will count as clinical experience. Residents can coordinate with their program directors to arrange academic, research, and study activities. • Time spent taking care of a family member, partner, or dependent in COVID-19 quarantine will count as clinical experience. This is a local decision based on local program requirements. • Eligibility period for certification will be extended by one year for any resident, fellow, residency graduate, or active candidate who requests such an extension due to the COVID-19 crisis. • ABOG is increasing the allowed weeks of leave from 12 to 24 weeks. This includes medical leave, maternity leave, caregiver leave, vacation, furloughs, and other situations. • Candidates may list COVID-19 patients if they were primarily responsible for their inpatient or	▪ There will be no articles released in August as Diplomates will be able to complete their article requirements using the incentivized process. ▪ This incentivization applies to both OB GYN specialists and subspecialists. ▪ Diplomates who participate in the 2021 MOC year will be automatically granted Part IV IMP credit in recognition for the COVID-19 practice improvement that they will continue to do this year during the evolving pandemic. ▪ If Diplomates have completed the IMP requirement prior to this ABOG action, ABOG will apply the credit towards their 2022 MOC year. ▪ The deadline to take and pass the ABOG MOC Re-Entry Exam will be extended through June 30, 2021, to allow physicians to have more time to take and pass the exam. ▪ There will be additional COVID-19 articles included in the 2021 MOC year, especially regarding COVID-19 vaccines.

	outpatient care. • As part of its COVID-19 response, ABOG has established a policy extending eligibility by two years for all candidates currently eligible for initial OB GYN and subspecialty certification. This policy applies to physicians who have graduated from residency and/or fellowship and whose eligibility for certification has not previously expired or whose eligibility was previously reestablished.	
Ophthalmology	1. Oral exams have been cancelled. After surveying the 650 candidates scheduled to take the oral exam, ABOp has decided to move to a virtual oral exam. ABOp intends to preserve the original case-based format of the face-to-face oral examination when they shift to a virtual administration (VOE20). Beta testing is going well. 2. All exam fees are transferable to the next exam administration and each candidate's board eligibility window will be extended accordingly. 3. Seven-year board eligibility window following graduation from residency will be extended by one year if you are unable to sit for the VOE20. 4. ABOp has an informational video for candidates concerning what to expect from the Virtual Oral Examination.	1. ABOp diplomates are actively looking for ABOp MOC content and resources to use during this period of time when many of them are unable to see non-emergency patients. 2. Many of our colleagues requested that we release Quarterly Questions content ahead of schedule so that they can use unanticipated downtime productively. The second quarter's installment, originally slated for release on April 1st, was distributed by email on March 24th. 3. With the help of many dedicated ophthalmologist volunteers, we released new COVID-19-related article-based material for Quarterly Questions on March 31st. 4. Several dozen diplomates have embraced a new option for creating Improvement in Medical Practice projects that are designed to improve the care of patients with COVID-19 and to protect the health of ophthalmologists and their staff. Completion earns credit for one Improvement in Medical Practice activity. 5. Newly approved CME activities focused on the COVID-19 pandemic are available on the CME Finder Menu. These activities may be counted toward the ABO's requirement for lifelong learning and self-assessment. 6. Extensions may be requested by those whose certificates expire on December 31, 2020, to allow additional time to complete Maintenance of Certification (MOC) activities.
Orthopaedic Surgery	1. ABOS rules and procedures changed to allow for 6 weeks of time away from education per year of residency. 2. Candidates for the 2021 ABOS Part II Oral Examination must collect and submit all consecutive surgical cases that they perform as primary surgeon beginning January 1, 2020, for a minimum of six consecutive months. On July 1, 2020, if the Candidate has reached 250 surgical cases, they can cease collecting. If not, the Candidate will continue to collect cases until they have entered 250 consecutive surgical cases, or until September 30th, whichever comes first. 3. The ABOS is transitioning their oral exam to an online, case-based exam. Details about the exam are in the "other" column.	ABOS will make ABOS WLA available to diplomates who did not start the program last year. Diplomates who have ABOS Board Certification expiration dates between 2019 and 2020 and who did not participate in the 2019 ABOS WLA, may now participate beginning this year.
Otolaryngology - Head and Neck Surgery	1. The October in-person exam administrations have been cancelled. ABOHNS is working to develop a virtual exam format for all exams, including the first virtual oral examination. They plan to administer these exams in October or November to Neurotology subspecialty candidates. ABOHNS will use that same format to administer the Otolaryngology-Head and Neck	CC diplomates who expired in June 2020 – Diplomates given option to defer to May 2021 exam and certification extended until that time.

	Surgery oral certifying exam and are currently working toward a January 2021 tentative date. 2. For the PGY-1 residents for the 2019-2020 academic year, the ABOHNS expects a minimum of 3 months of otolaryngology rotations and 3 months of non-otolaryngology rotations chosen from amongst the options described in the Booklet-of-Information dated June 2019. For the remaining 6 months, the ABOHNS will allow flexibility for the rotations at the discretion of the residency program director if necessary to ensure best care for patients with COVID-19. If changes need to be made to a resident's rotations that result in the usual requirements not being met, the Residency Program Director needs to inform the Board at the conclusion of the resident's PGY-1 year. No rotations will need to be made up as long as the minimum requirements described above are met. 3. Clinical time caring for patients with COVID-19 will be counted toward the training requirements for Board Eligibility. At the conclusion of the academic year, the residency program director with input from the CCC will still be required to decide whether a resident has acquired/demonstrated the knowledge, skills, and behaviors necessary to advance to the subsequent PGY-year or graduate from residency and enter autonomous practice if in the ultimate year. If a determination is made that a resident's training needs to be extended based on effects of the COVID pandemic on their Otolaryngology-Head and Neck Surgery training/experience, then the ABOHNS requests being proactively informed by the program director of this decision as soon as feasible. 4. If an Otolaryngology-Head and Neck Surgery resident requires a 2-week self-isolation/quarantine, this time will not count toward the 6-weeks allowed leave time for the PGY-year if the program arranges for the resident to complete academic/study activity during that time. The Residency Program Director will need to provide a written description of the academic/study activity to the ABOHNS. Extended absences (> 2 weeks) for residents that contract and require care for COVID-19 will be considered on a case-by-case basis. 5. Oral Certifying Exam – Spring 2020 postponed, moving to virtual exam in Feb 2021 6. Board Eligibility extended by 1 year for all WQE candidates – Candidates were given the option to defer or to take the exam.	
Pathology	The American Board of Pathology will allow the following reasons for absence 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 should keep a daily log of time spent and a brief description of the activities. The Program Director must attest that the overall competency of the resident/fellow at the completion of training was not adversely	1. At this time, ABPath Continuing Certification requirements, except for ABPCL, have not changed. 2. The 2021 Subspecialty and Fall Primary Exams (AP and CP) will be administered using Pearson VUE Professional test centers 3. The American Board of Pathology (ABPath) is announcing two changes to the Continuing Certification (CC) Program that have been approved by the American Board of Medical Specialties.

	affected by the absence. • COVID-19 illness or exposure • Mandated quarantine • Shelter in place/shelter at home directives • Self-imposed isolation because of significant underlying health issues • Care for a sick or quarantined immediate family member • Providing childcare due to school/childcare closures • Volunteering or being assigned to other institutional or clinical duties The ABPath 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. Due to the ongoing health risks of COVID-19, the ABPath has been working diligently to administer this year's certification exams remotely. ABPath is making a one-time exception to policy that will allow candidates who have completed ACGME subspecialty fellowship training to apply for and take 2020 Subspecialty exams prior to passing the primary exam. Candidate subspecialty examination results will be placed in a Withhold Results status. The results of their subspecialty exam will not be released to you until you achieve primary certification. Candidates will have until 2022 (2 years) to become certified in AP and/or CP. If they do not achieve primary certification before the end of 2022, the subspecialty examination results will be declared null and void. Candidates will be required to retake the subspecialty exam again and only after you have achieved primary certification. If their period of board eligibility for primary certification ends prior to 2022, their subspecialty examination results will become null and void at that time. 2020 candidates for certification have already completed their 50 autopsies. The ABPath recognizes that some 2021 candidates may have difficulty achieving 50 autopsy cases. We will address this when applications become available for them in the fall.	Beginning in 2021, the ABPath will no longer require: • Self-Assessment Modules (SAMs) for Part II Lifelong Learning of the CC program • a Patient Safety Course. The "SAMs" requirement was developed by ABPath to ensure that at least 20 of the required 70 CME credits had a self- assessment activity. Since ACCME accreditation requires that the CME provider analyzes changes in learners (competence, performance, or patient outcomes) achieved as a result of the overall program's activities/educational interventions, having a SAMs requirement is no longer necessary and is burdensome for diplomates and CME providers. ABPath's CertLink® longitudinal assessment has been approved by ABMS as a permanent change to our CC program in 2021 and this provides diplomates with self-assessment of medical knowledge as well. Diplomates will still be required to complete and report a minimum of 70 AMA PRA Category 1 CME credits for each two-year CC reporting period. Participation in Patient Safety CME will be encouraged, but no longer required. 4. The American Medical Association (AMA) has recently announced added enhancements to their online education portal AMA Ed Hub™ aimed at offering physicians a centralized location for finding, earning, tracking, and reporting continuing medical education (CME) and other education on a wide range of clinical and professional topics. The platform now allows physicians who are board-certified with the American Board of Pathology (ABPath) to have their credits automatically reported to ABPath.
Pediatrics	1. Residents should address training absences with their program director. 2. If candidates are unable to reschedule their exam, they can request a refund of the exam fees. If a candidate chooses not to take the exam this year, their eligibility will not be extended. 3. There will be a one-year extension for general pediatrics candidates who cancel their certification exam due to COVID-19. The same extension applies to all candidates taking the subspecialty exam. 4. Prometric has rescheduled a small number of subspecialty exam candidates from test centers due to COVID-19 social distancing guidelines.	1. Prometric has suspended their proctored MOC exams, and they are reaching out to individuals with testing appointments in order to reschedule. 2. No pediatrician will lose their ABP certification because of the extraordinary patient care pressures associated with this pandemic. 3. The ABP will recognize board certified pediatricians for their COVID-19 related contributions to the MOC program. 4. Diplomates unable to participate in MOC activities or MOCA-Peds because of the pandemic; it will not jeopardize their certificate or ability to re-enroll in MOC. 5. ABPeds is actively working on ways to accommodate pediatricians due to enroll in 2021 who continue to face significant financial hardship through the end of the year. In the meantime, all pediatricians should be aware of the smaller ($280

		for those with one certification) annual payment option for MOC. 6. For those pediatricians who have already completed their Part 2 and Part 4 activity requirements for their MOC cycle ending in 2020, thank you! We will award 25 Part 2 points and 25 Part 4 points for COVID-19-related learning and improvement in January 2021 to count toward your next cycle.
Physical Medicine and Rehabilitation	1. Exam applications for Brain Injury Medicine, Neuromuscular Medicine, Pediatric Rehabilitation Medicine, Spinal Cord Injury Medicine, and Sports Medicine have been extended. 2. ABPMR understands that changing the date of the exam may introduce scheduling conflicts, but it is extremely important that candidates make every attempt to take the exam in September. If too many 2020 candidates delay taking the exam until next year, it is likely that the ABPMR will need to place a cap on 2021 Part II Examination applications, potentially turning applicants away for the first time in our history. 3. ABMPR urges candidates to continue exam preparation efforts. We will be releasing additional vignette and roleplay videos over the next few weeks to help candidates prepare. 4. Candidates need to wait for announcements about subspecialties. If they had plans to take the Part II Examination and a subspecialty examination consecutively in 2020, we realize postponing Part II presents timing issues for some of these exams. We are currently evaluating options and will make announcements when more information is available. In some cases, it may be necessary to defer taking the subspecialty exam to the next administration. 5. ABPMR will administer a virtual certification oral exam in the fall. 6. After hearing reports that candidates were unable to find seats at a testing center near them, the American Board of Anesthesiology (ABA, the administering board for the Pain Medicine Examination), offered to extend the Pain Medicine Examination date to a 2-week window for ABPMR candidates. We quickly agreed; all ABPMR candidates can now schedule on any day in that two-week window. Candidates should reach out to the ABA for more information. 7. Through June 30, 2021 — Up to 30 additional working days spent away from training due to mandated quarantine, institutional restriction, or illness directly related to COVID-19 will be permitted provided the trainee is otherwise competent, per the Program Director, at the conclusion of training. These 30 working days are in addition to overall leave time and will not result in a mandated increase to training time.	1. No ABPMR diplomate will lose certification or experience a status change due to not being able to complete an MOC requirement in 2020. Any outstanding MOC requirements on primary certificate at the end of 2020 will carry over into the first 5-year continuing certification cycle, giving an extended timeline of 2025. 2. ABPMR will give full carryovers for all 2020 ABPMR computer-based exams. 3. In order to maintain a reduced burden on diplomates during the pandemic, the next LA-PM&R ‘quarter’ will extend from August through December, with only 20 questions for participants to answer for the remainder of the year. All diplomates’ quotas and scoring will be adjusted automatically.

Plastic Surgery	1. Candidates taking WE in 2020 were allowed to shift to 2021 w/o penalty. 2. Alternate dates for scheduling the WE were offered, 3. Required number of cases for candidate case logs were reduced, 4. Certain documentation requirements for case lists were eliminated, 5. OE exam was switched to a virtual exam for 2020 and 2021, 6. Eligibility will be extended for any candidate who could not schedule for the WE in 2020.	1. ABPS has given every Diplomate who needed to report CME in 2020 an extension to 2021. 2. The self-assessment exam and the practice improvement activities remain the same. The practice improvement activity can use cases from as far as three years back. 3. All self-assessment exams including prior years that still need to be completed are available online.
Preventive Medicine	ABPM will make accommodations for early graduations or truncated residency and/or fellowship training for physicians who would otherwise qualify to sit for this year's ABPM initial Certification Exam.	1. Effective as of April 1, 2020, and continuing through December 31, 2022, Diplomates who meet the qualifications below will not be required to complete the Transitional MOC Part 2 (CME), Part 4 (Improvement in Medical Practice) or the Patient Safety Course (PSC) requirements. ABPM will recognize these qualified Diplomates as fully participating in MOC through the remainder of the ABPM's Transitional MOC Period. To qualify for this waiver of Part 2, Part 4 and PSC requirements, Diplomates must possess current, unexpired Certification in at least one ABPM Specialty or Subspecialty and must by December 31, 2020. 2. Diplomates with ABPM Certificates expiring between August 1, 2020, and January 31, 2023, and who have; (I) taken and passed the MOC Exam prior to the expiration date on the Diplomate's Certificate and, (ii) by the December 31, 2020, deadline, have registered their Diplomate account on the ABPM's Physician Portal, will be deemed to be fully compliant with the Transitional MOC requirements. 3. Diplomates with ABPM Certificates expiring on or after February 1, 2023, and who have, by the December 31, 2020, deadline, registered their Diplomate account on the ABPM's online Physician Portal, need take no further action and shall be deemed to be fully compliant with all Transitional MOC requirements. 4. While not required, Diplomates who complete a Part 4 activity between February 1, 2020, and December 31, 2022, will receive credit toward the first Improvement in Medical Practice requirement (or its equivalent) of ABPM's Continuing Certification Program which is currently scheduled to launch in April of 2023. 5. Diplomates who do not qualify for the waiver by registering their Diplomate account on the ABPM's Physician Portal by the December 31, 2020, deadline will be required to complete all Transitional MOC requirements as set forth on the ABPM website. 6. Additionally, the ABPM has partnered with its specialty societies to provide a list of free online courses on COVID-19. Diplomates who complete these courses may request credit towards the ABPM's Transitional MOC Part 2 requirements using the online attestation found in the Physician Portal.
Psychiatry and Neurology	1. All late payment fees have been waived. 2. If any candidate cannot make it to a Pearson Vue testing center within 50 miles of their location, ABPN will assist them in scheduling their exam date.	1. The ABPN and the American Academy of Neurology (AAN) have collaborated to provide ABPN diplomates complimentary access to American Academy of Neurology (AAN) 2019 meeting programming. Through an educational grant

	3. ABPN has decided to extend its current board eligibility policy through June 30, 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. 4. 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.	from the ABPN to the AAN, ABPN diplomates now have free access to both the AAN Annual Meeting on Demand 2019 program and the NeuroSAE 2019 Annual Meeting Edition. 2. For diplomates whose specialty or subspecialty certificates would have expired in 2020, we will defer the 2020 CC/MOC exam requirement for 1 year until December 31, 2021. Certificates expiring in 2020 will be extended to the end of 2021. This extension does not include certificates that lapsed prior to February 1, 2020. 3. For diplomates currently in the CC program, ABPN will not change a certification status negatively even if there are insufficient or incomplete activities (CME, Self-Assessment or PIP) recorded in Physician Folios at the end of 2020. Incomplete CC program activities will be deferred until the end of 2021. 4. Extending deadlines for all current 2020 and 2021 Continuing Certification Program examination and activity requirements until Dec. 31, 2022. 5. The APA and ABPN have collaborated to provide diplomates with complimentary programming to satisfy ABPN CME and self-assessment CME activity requirements. ABPN diplomates have access to the APA's Spring Highlights meeting 2020, held virtually on April 25-26, 2020. 6. The APA is also providing CME credit and access to select articles included in ABPN's MOC Part III journal-based pilot project.
Radiology	1. ABR canceled the RISE administration scheduled for April 6, 2020, in Tucson. The next available RISE administration is scheduled for October 4, 2021, at the ABR Exam Centers in Tucson and Chicago. 2. The ABR will continue to rely on program directors, supported by their Clinical Competency Committees, to provide attestation to the completion of individual training. Details regarding rescheduling of delayed ABR Core, Qualifying and Certifying exams will be provided to the stakeholder community as soon as information is available. Additionally, we are working with the Commission on Accreditation of Medical Physics Education Programs (CAMPEP) regarding the impact on medical physics residency training. 3. The current exam schedule is as follows: • DR RISE: postponed until 2021 (Chicago and Tucson) • DR Subspecialty: postponed until 2021(Chicago and Tucson) • DR Certifying: postponed until 2021 (Chicago and Tucson) • RO Oral: postponed until 2021 (Tucson) • MP Part 3 (Oral): Postponed until 2021 (Tucson) • DR, IR/DR Core: postponed until 2021 (Chicago and Tucson) 4. In response to the growing health situation posed by the coronavirus (COVID-19) pandemic, for candidates whose application to take the medical physics Part 1 Exam was set to expire on December 31, 2020, we are extending the	Reduction in SA-CME requirement from 15 every three years to 10 for those completing their previous year's Online Longitudinal Assessment annual progress requirement.

	deadline until December 31, 2021. 5. The ABR has committed to a remote exam platform starting in 2021. The decision was made after weeks of consultation with key stakeholders, including candidates, programs, associations, and societies. We are continuing those discussions as we move forward in our exam development process. 6. ABR computer-based initial certification exams will take place in a remote location of the candidate's choosing, provided that place meets a few basic requirements. Remote computer-based exams are not likely to be given at commercial testing centers (e.g., Pearson VUE) or ABR centers. The exams will use an ABR-developed exam interface similar to what has previously been used for computer-based exams. In addition, we will likely use a third-party vendor to handle exam-day security and remote monitoring. We will provide additional details about the requirements when we know more. The oral exam will use an ABR-developed platform that will combine remote proctoring with video conferencing. As with the computer-based exams, candidates will have the freedom to select a location, but it must meet a few basic requirements. The details about exam-day location and other logistics are still in development and will be communicated when we have more information. 7. The ABR Board of Governors this week determined remote exam dates for the first half of 2021. Dates for the second half of the year will be established shortly and posted on their website.	
Surgery	1. ABS family leave policies allow for an additional 2 weeks of non-clinical time beyond 4 weeks. The existing family leave policy may be applied to quarantine/COVID-19. This does not require special permission from ABS. 2. Non-voluntary offsite time that is used for clinical or educational purposes can be counted as clinical time. The types of activities done in this time should be documented by the program. 3. The ABS will accept 44 weeks of clinical time (including the non-voluntary time) for the 2019-20 academic year, without the need for pre-approval, permission, or explanation. This represents approximately a 10% decrease in time requirements. 4. For those specialties with case requirements, the ABS will accept a similar 10% decrease in total cases without the need for further documentation. 5. Program directors are entrusted, as they always are, to make a decision about the readiness of the resident for independent practice. If a resident falls below the 90% mark for cases or the 44-week mark for time in training, and the PD nevertheless endorses them as ready for independent practice, the ABS will seek a more detailed supporting statement. This might include information from the CCC, milestones achievements, entrustment through	ABS encourages anyone who has a grace year available to them and feels they are unable or unprepared to take this year's assessment to take their grace year.

	EPAs, ITE scores, evidence of leadership during this crisis, or other information. 6. Residents should assess their own progress toward the standard requirements in terms of rotations, cases, and specialty specific requirements. Residents should make a remediation proposal for gaps and share with their PDs. 7. The QE applications (and CE application for SCC) are being modified to be all online, and to allow for these variances. 8. ABS will consider on a case-by-case basis those situations in which a resident missed training for an extended period due to severe COVID-19 illness. 9. The virtual General Surgery Qualifying Exam administration failed. ABS will issue refunds. The exam will not take place in July. FAQ page can be found here http://www.absurgery.org/default.jsp?faq_virtualgsqe2020 10. The 2020 General Surgery Qualifying Exam (QE) has been rescheduled for Thursday, April 15, 2021, and will be held at Pearson VUE exam centers across the country. 11. In recognition of the negative impact of participating in the administration of the July exam, candidates who had registered for the 2020 QE will receive a $400 discount on the next exam, bringing the new price to $950. 12. ABS will extend Board Eligibility for one year for those candidates whose eligibility would expire in 2020.	
Thoracic Surgery	1. The Oral Exam that was tentatively scheduled for October 16-17, 2020, will be postponed until winter/spring of 2021. 2. Programs or candidates who anticipate a problem in achieving the ABTS case requirements for a particular pathway should contact the ABTS to request a ruling as to whether or not their case-list would be acceptable for entry into the certification process.	1. ABTS also plans to work with the doctors if they are short on CMEs since so many Annual Meetings have been postponed this spring. At this time, it will be handled on a case-by-case basis. 2. The newest edition of SESATS, XIII, is now available. SESATS is a comprehensive online tool used to study and review the essential aspects of cardiac and thoracic surgery. This latest version features 400 brand new questions with instant access to the items, in-depth critiques, real-time abstracts, and linked references. Completion of this online activity permits one to claim up to 70 AMA PRA Category 1 CME credits.
Urology	ABU will be working with the RRC to make efforts not to punish candidates who miss training due to circumstances out of their control.	1. ABU tried to offer CMEs that did not require travel to the AUA Annual Meeting. If Annual Meeting was the only option for diplomates to achieve CMEs, AUA will remain flexible about other options. 2. ABU will work with physicians to meet the deadline to submit surgical logs. It is recommended for people who are recertifying to consider waiting until 2021. 3. For those diplomates recertifying this year and unable to delay a year, log submission timeline has been extended.
**Used with permission from the ABMS. The information in this table was sourced from the ABMS on July 12, 2021, per the member board websites; some items may have expired given the fluidity of the pandemic.		

APPENDIX C - Annotated Bibliography

ABMS Member Board History, Initiatives, and Advancements

Abraham GL, Saravolatz LD. The American Board of Internal Medicine's New Longitudinal Assessment Option and What It Means for Infectious Disease Specialists. *Clinical Infectious Diseases.* 2021;72(10):1854–1857. doi: 10.1093/cid/ciaa1493

Anzia JM. Lifelong Learning in Psychiatry and the Role of Certification. *Psychiatr Clin North Am*. 2021;44(2):309-316. doi: 10.1016/j.psc.2021.03.001

Iyer MS, Bachur R, Wang, V, et al. Maintenance of Certification Pediatrics: Pediatric Emergency Medicine (PEM), *Pediatric Emergency Care.* 2021;(37)6:329-333. doi: 10.1097/PEC.0000000000002451

Johnson RL. The American Board of Pathology's 2020 Continuing Certification Program. *Arch Pathol Lab Med*. 2021. doi: 10.5858/arpa.2020-0385-RA

Myhre E, Graves K, White S, et al. MyABFM Portfolio: Improving Communication on Certification Activities and Progress, Designed by Family Physicians, for Family Physicians. *J Am Board Fam Med*. 2021;34:673–674. doi: 10.3122/jabfm.2021.03.210156

Newton WP, Baxley L, Williamson A, et al. Improving Performance Improvement. *J Am Board Fam Med.* 2020;33:819–821. doi: 10.3122/jabfm.2020.05.200418

Pradarelli J, Pavuluri S, Yee A, et al. Surgical coaching to achieve the ABMS vision for the future of continuing board certification. *Am J Surg*. 2021 Jan;221(1):4-10. doi: 10.1016/j.amjsurg.2020.06.014. Epub 2020 Jun 19.

Wallner PE, Kachnic LA, Alektiar KM. Maintenance and Assessment of Skills and Knowledge Over the Career Continuum. In: Chandra RA, Vapiwala N, Thomas Jr. CR. (eds). *Career Development in Academic Radiation Oncology*. 2021. Springer, Cham. doi: 10.1007/978-3-030-71855-8_19

Warner DO. ABA Go: What We've Learned on the Road Beyond MOCA 2.0. *ASA Monitor*. 2021;85:13. doi: 10.1097/01.ASM.0000754200.69013.8b

CBC in Canada and Europe

Karantanas, AH, Maas, M. Strategy required: "Maintenance of certification for European radiologists". *Insights Imaging*. 2021;(12)15. doi: 10.1186/s13244-020-00953-9

Levinson W, Wong BM. Aligning continuing professional development with quality improvement. *CMAJ*. 2021;(3)193:E647-8. doi: 10.1503/cmaj.202797

Concerns, Challenges, and Considerations

Alyesh D, Gambhir A, Waase M, et al. A Blueprint for Productive Maintenance of Certification, But Is the American Board of Internal Medicine up to the Challenge? *Circ Cardiovasc Qual Outcomes*. 2020;13(12). doi: 10.1161/CIRCOUTCOMES.120.006696
Kempen PM. The Curse and Corporate Cult of Certification in America. *Journal of American Physicians and Surgeons.* 2021;(26)2

LaVigne C, Foulkes G, Kane S. The Estimated Cost of Maintenance of Certification. J Bone Joint Surg Am. 2021 Aug 4;103(15):e58. doi: 10.2106/JBJS.20.00632

McAdams C, McNally M. Continuing Medical Education and Lifelong Learning. *Surg Clin North Am*. 2021 Aug;101(4):703-715. doi: 10.1016/j.suc.2021.05.015.

Nasrallah, HA. Revamp the MOC. *Current Psychiatry*. 2020;(19)9:7-10. doi:10.12788/cp.0038

APPENDIX D - Current HOD Policies Related to CBC

H-275.924, "Continuing Board Certification"
AMA Principles on Continuing Board Certification
1. Changes in specialty-board certification requirements for CBC programs should be longitudinally stable in structure, although flexible in content.

2. Implementation of changes in CBC must be reasonable and take into consideration the time needed to develop the proper CBC structures as well as to educate physician diplomates about the requirements for participation.
3. Any changes to the CBC process for a given medical specialty board should occur no more frequently than the intervals used by that specialty board for CBC.
4. Any changes in the CBC process should not result in significantly increased cost or burden to physician participants (such as systems that mandate continuous documentation or require annual milestones).
5. CBC requirements should not reduce the capacity of the overall physician workforce. It is important to retain a structure of CBC programs that permits physicians to complete modules with temporal flexibility, compatible with their practice responsibilities.
6. Patient satisfaction programs such as The Consumer Assessment of Healthcare Providers and Systems (CAHPS) patient survey are neither appropriate nor effective survey tools to assess physician competence in many specialties.
7. Careful consideration should be given to the importance of retaining flexibility in pathways for CBC for physicians with careers that combine clinical patient care with significant leadership, administrative, research and teaching responsibilities.
8. Legal ramifications must be examined, and conflicts resolved, prior to data collection and/or displaying any information collected in the process of CBC. Specifically, careful consideration must be given to the types and format of physician-specific data to be publicly released in conjunction with CBC participation.
9. Our AMA affirms the current language regarding continuing medical education (CME): Each Member board will document that diplomates are meeting the CME and Self-Assessment requirements for CBC Part II. The content of CME and self-assessment programs receiving credit for CBC will be relevant to advances within the diplomate s scope of practice, and free of commercial bias and direct support from pharmaceutical and device industries. Each diplomate will be required to complete CME credits (AMA PRA Category 1 Credit, American Academy of Family Physicians Prescribed, American College of Obstetricians and Gynecologists, and/or American Osteopathic Association Category 1A).
10. In relation to CBC Part II, our AMA continues to support and promote the AMA Physician s Recognition Award (PRA) Credit system as one of the three major credit systems that comprise the foundation for continuing medical education in the U.S., including the Performance Improvement CME (PICME) format; and continues to develop relationships and agreements that may lead to standards accepted by all U.S. licensing boards, specialty boards, hospital credentialing bodies and other entities requiring evidence of physician CME.
11. CBC is but one component to promote patient safety and quality. Health care is a team effort, and changes to CBC should not create an unrealistic expectation that lapses in patient safety are primarily failures of individual physicians.
12. CBC should be based on evidence and designed to identify performance gaps and unmet needs, providing direction and guidance for improvement in physician performance and delivery of care.
13. The CBC process should be evaluated periodically to measure physician satisfaction, knowledge uptake and intent to maintain or change practice.
14. CBC should be used as a tool for continuous improvement.
15. The CBC program should not be a mandated requirement for licensure, credentialing, recredentialing, privileging, reimbursement, network participation, employment, or insurance panel participation.
16. Actively practicing physicians should be well-represented on specialty boards developing CBC.
17. Our AMA will include early career physicians when nominating individuals to the Boards of Directors for ABMS member boards.
18. CBC activities and measurement should be relevant to clinical practice.
19. The CBC process should be reflective of and consistent with the cost of development and administration of the CBC components, ensure a fair fee structure, and not present a barrier to patient care.
20. Any assessment should be used to guide physicians' self-directed study.
21. Specific content-based feedback after any assessment tests should be provided to physicians in a timely manner.
22. There should be multiple options for how an assessment could be structured to accommodate different learning styles.
23. Physicians with lifetime board certification should not be required to seek recertification.
24. No qualifiers or restrictions should be placed on diplomates with lifetime board certification recognized by the ABMS related to their participation in CBC.
25. Members of our House of Delegates are encouraged to increase their awareness of and participation in the proposed changes to physician self-regulation through their specialty organizations and other professional membership groups.
26. The initial certification status of time-limited diplomates shall be listed and publicly available on all American Board of Medical Specialties (ABMS) and ABMS Member boards websites and physician certification databases. The names and initial certification status of time-limited diplomates shall not be removed from ABMS and ABMS Member boards websites or physician certification databases even if the diplomate chooses not to participate in CBC.
27. Our AMA will continue to work with the national medical specialty societies to advocate for the physicians of America to receive value in the services they purchase for Continuing Board Certification from their specialty boards. Value in CBC should include cost effectiveness with full financial transparency, respect for physicians' time and their patient care commitments, alignment of CBC requirements with other regulator and payer requirements, and adherence to an evidence basis for both CBC content and processes.
(Policy Timeline: CME Rep. 16, A-09 Reaffirmed: CME Rep. 11, A-12 Reaffirmed: CME Rep. 10, A-12 Reaffirmed in lieu of Res. 313, A-12 Reaffirmed: CME Rep. 4, A-13 Reaffirmed in lieu of Res. 919, I-13 Appended: Sub. Res. 920, I-14 Reaffirmed: CME Rep. 2, A-15 Appended: Res. 314, A-15 Modified: CME Rep. 2, I-15 Reaffirmation A-16 Reaffirmed: Res. 309, A-16 Modified: Res. 307, I-16 Reaffirmed: BOT Rep. 05, I-16 Appended: Res. 319, A-17 Reaffirmed in lieu of: Res. 322, A-17 Modified: Res. 953, I-17 Reaffirmation: A-19 Modified: CME Rep. 02, A-19)

D-275.954, “Continuing Board Certification”
Our AMA will:
1. Continue to monitor the evolution of Continuing Board Certification (CBC), continue its active engagement in discussions regarding their implementation, encourage specialty boards to investigate and/or establish alternative approaches for CBC, and prepare a yearly report to the House of Delegates regarding the CBC process.
2. Continue to review, through its Council on Medical Education, published literature and emerging data as part of the Council s ongoing efforts to critically review CBC issues.
3. Continue to monitor the progress by the American Board of Medical Specialties (ABMS) and its member boards on implementation of CBC, and encourage the ABMS to report its research findings on the issues surrounding certification and CBC on a periodic basis.
4. Encourage the ABMS and its member boards to continue to explore other ways to measure the ability of physicians to access and apply knowledge to care for patients, and to continue to examine the evidence supporting the value of specialty board certification and CBC.
5. Work with the ABMS to streamline and improve the Cognitive Expertise (Part III) component of CBC, including the exploration of alternative formats, in ways that effectively evaluate acquisition of new knowledge while reducing or eliminating the burden of a high-stakes examination.
6. Work with interested parties to ensure that CBC uses more than one pathway to assess accurately the competence of practicing physicians, to monitor for exam relevance and to ensure that CBC does not lead to unintended economic hardship such as hospital de-credentialing of practicing physicians.
7. Recommend that the ABMS not introduce additional assessment modalities that have not been validated to show improvement in physician performance and/or patient safety.
8. Work with the ABMS to eliminate practice performance assessment modules, as currently written, from CBC requirements.
9. Encourage the ABMS to ensure that all ABMS member boards provide full transparency related to the costs of preparing, administering, scoring and reporting CBC and certifying examinations.
10. Encourage the ABMS to ensure that CBC and certifying examinations do not result in substantial financial gain to ABMS member boards, and advocate that the ABMS develop fiduciary standards for its member boards that are consistent with this principle.
11. Work with the ABMS to lessen the burden of CBC on physicians with multiple board certifications, particularly to ensure that CBC is specifically relevant to the physician s current practice.
12. Work with key stakeholders to (a) support ongoing ABMS member board efforts to allow multiple and diverse physician educational and quality improvement activities to qualify for CBC; (b) support ABMS member board activities in facilitating the use of CBC quality improvement activities to count for other accountability requirements or programs, such as pay for quality/performance or PQRS reimbursement; (c) encourage ABMS member boards to enhance the consistency of quality improvement programs across all boards; and (d) work with specialty societies and ABMS member boards to develop tools and services that help physicians meet CBC requirements.
13. Work with the ABMS and its member boards to collect data on why physicians choose to maintain or discontinue their board certification.
14. Work with the ABMS to study whether CBC is an important factor in a physician s decision to retire and to determine its impact on the US physician workforce.
15. Encourage the ABMS to use data from CBC to track whether physicians are maintaining certification and share this data with the AMA.
16. Encourage AMA members to be proactive in shaping CBC by seeking leadership positions on the ABMS member boards, American Osteopathic Association (AOA) specialty certifying boards, and CBC Committees.
17. Continue to monitor the actions of professional societies regarding recommendations for modification of CBC.
18. Encourage medical specialty societies leadership to work with the ABMS, and its member boards, to identify those specialty organizations that have developed an appropriate and relevant CBC process for its members.
19. Continue to work with the ABMS to ensure that physicians are clearly informed of the CBC requirements for their specific board and the timelines for accomplishing those requirements.
20. Encourage the ABMS and its member boards to develop a system to actively alert physicians of the due dates of the multi-stage requirements of continuous professional development and performance in practice, thereby assisting them with maintaining their board certification.
21. Recommend to the ABMS that all physician members of those boards governing the CBC process be required to participate in CBC.
22. Continue to participate in the National Alliance for Physician Competence forums.
23. Encourage the PCPI Foundation, the ABMS, and the Council of Medical Specialty Societies to work together toward utilizing Consortium performance measures in Part IV of CBC.
24. Continue to assist physicians in practice performance improvement.
25. Encourage all specialty societies to grant certified CME credit for activities that they offer to fulfill requirements of their respective specialty board s CBC and associated processes.
26. Support the American College of Physicians as well as other professional societies in their efforts to work with the American Board of Internal Medicine (ABIM) to improve the CBC program.
27. Oppose those maintenance of certification programs administered by the specialty boards of the ABMS, or of any other similar physician certifying organization, which do not appropriately adhere to the principles codified as AMA Policy on Continuing Board Certification.

28. Ask the ABMS to encourage its member boards to review their maintenance of certification policies regarding the requirements for maintaining underlying primary or initial specialty board certification in addition to subspecialty board certification, if they have not yet done so, to allow physicians the option to focus on continuing board certification activities relevant to their practice.
29. Call for the immediate end of any mandatory, secured recertifying examination by the ABMS or other certifying organizations as part of the recertification process for all those specialties that still require a secure, high-stakes recertification examination.
30. Support a recertification process based on high quality, appropriate Continuing Medical Education (CME) material directed by the AMA recognized specialty societies covering the physician s practice area, in cooperation with other willing stakeholders, that would be completed on a regular basis as determined by the individual medical specialty, to ensure lifelong learning.
31. Continue to work with the ABMS to encourage the development by and the sharing between specialty boards of alternative ways to assess medical knowledge other than by a secure high stakes exam.
32. Continue to support the requirement of CME and ongoing, quality assessments of physicians, where such CME is proven to be cost-effective and shown by evidence to improve quality of care for patients.
33. Through legislative, regulatory, or collaborative efforts, will work with interested state medical societies and other interested parties by creating model state legislation and model medical staff bylaws while advocating that Continuing Board Certification not be a requirement for: (a) medical staff membership, privileging, credentialing, or recredentialing; (b) insurance panel participation; or (c) state medical licensure.
34. Increase its efforts to work with the insurance industry to ensure that continuing board certification does not become a requirement for insurance panel participation.
35. Advocate that physicians who participate in programs related to quality improvement and/or patient safety receive credit for CBC Part IV.
36. Continue to work with the medical societies and the American Board of Medical Specialties (ABMS) member boards that have not yet moved to a process to improve the Part III secure, high-stakes examination to encourage them to do so.
37. Our AMA will, through its Council on Medical Education, continue to work with the American Board of Medical Specialties (ABMS), ABMS Committee on Continuing Certification (3C), and ABMS Stakeholder Council to pursue opportunities to implement the recommendations of the Continuing Board Certification: Vision for the Future Commission and AMA policies related to continuing board certification.
38. Our AMA, through its Council on Medical Education, will continue to work with the American Board of Medical Specialties (ABMS) and ABMS member boards to implement key recommendations outlined by the Continuing Board Certification: Vision for the Future Commission in its final report, including the development of new, integrated standards for continuing certification programs by 2020 that will address the Commission's recommendations for flexibility in knowledge assessment and advancing practice, feedback to diplomates, and consistency.
(Policy Timeline: CME Rep. 2, I-15 Appended: Res. 911, I-15 Appended: Res. 309, A-16 Appended: CME Rep. 02, A-16 Appended: Res. 307, I-16 Appended: Res. 310, I-16 Modified: CME Rep. 02, A-17 Reaffirmed: Res. 316, A-17 Reaffirmed in lieu of: Res. 322, A-17 Appended: CME Rep. 02, A-18 Appended: Res. 320, A-18 Appended: Res. 957, I-18 Reaffirmation: A-19 Modified: CME Rep. 02, A-19, Appended: CME Rep. 1, I-20)

H-275.926, "Medical Specialty Board Certification Standards"
Our AMA:
(1) Opposes any action, regardless of intent, that appears likely to confuse the public about the unique credentials of American Board of Medical Specialties (ABMS) or American Osteopathic Association Bureau of Osteopathic Specialists (AOA-BOS) board certified physicians in any medical specialty, or take advantage of the prestige of any medical specialty for purposes contrary to the public good and safety.
(2) Opposes any action, regardless of intent, by organizations providing board certification for non-physicians that appears likely to confuse the public about the unique credentials of medical specialty board certification or take advantage of the prestige of medical specialty board certification for purposes contrary to the public good and safety.
(3) Continues to work with other medical organizations to educate the profession and the public about the ABMS and AOA-BOS board certification process. It is AMA policy that when the equivalency of board certification must be determined, accepted standards, such as those adopted by state medical boards or the Essentials for Approval of Examining Boards in Medical Specialties, be utilized for that determination.
(4) Opposes discrimination against physicians based solely on lack of ABMS or equivalent AOA-BOS board certification, or where board certification is one of the criteria considered for purposes of measuring quality of care, determining eligibility to contract with managed care entities, eligibility to receive hospital staff or other clinical privileges, ascertaining competence to practice medicine, or for other purposes. Our AMA also opposes discrimination that may occur against physicians involved in the board certification process, including those who are in a clinical practice period for the specified minimum period of time that must be completed prior to taking the board certifying examination.
(5) Advocates for nomenclature to better distinguish those physicians who are in the board certification pathway from those who are not.
(6) Encourages member boards of the ABMS to adopt measures aimed at mitigating the financial burden on residents related to specialty board fees and fee procedures, including shorter preregistration periods, lower fees and easier payment terms.
(Policy Timeline: Res. 318, A-07 Reaffirmation A-11 Modified: CME Rep. 2, I-15 Modified: Res. 215, I-19)

REFERENCES

1. Report 1-N-20, Update on Maintenance of Certification and Osteopathic Continuous Certification.
2. Report 2-A-19, Update on Maintenance of Certification and Osteopathic Continuous Certification.
3. Report 2-A-18, Update on Maintenance of Certification and Osteopathic Continuous Certification.
4. Report 2-A-17, Update on Maintenance of Certification and Osteopathic Continuous Certification.
5. Report 2-A-16, Update on Maintenance of Certification and Osteopathic Continuous Certification.
6. Report 2-A-15, Update on Maintenance of Certification and Osteopathic Continuous Certification.
7. Report 6-A-14, Update on Maintenance of Certification, Osteopathic Continuous Certification, and Maintenance of Licensure.
8. Report 4-A-13, An Update on Maintenance of Certification, Osteopathic Continuous Certification, and Maintenance of Licensure.
9. Report 10-A-12, An Update on Maintenance of Certification, Osteopathic Continuous Certification, and Maintenance of Licensure.
10. Report 11-A-12, Impact of Maintenance of Certification, Osteopathic Continuous Certification, Maintenance of Licensure on the Physician Workforce.
11. Report 3-A-10, Specialty Board Certification and Maintenance of Licensure.
12. Report 16-A-09, Maintenance of Certification/Maintenance of Licensure.

Past reports of the AMA Council on Medical Education related to CBC can be found at: https://www.ama-assn.org/councils/council-medical-education/certification-licensure-council-medical-education-reports

3. ONSITE AND SUBSIDIZED CHILDCARE FOR MEDICAL STUDENTS, RESIDENTS AND FELLOWS (RESOLUTION 304-JUN-21, RESOLVE 3)

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: RECOMMENDATIONS ADOPTED
IN LIEU OF RESOLVE 3 OF RESOLUTION 304-JUN-21
REMAINDER OF REPORT FILED
See Policies H-200.948 and D-200.974

INTRODUCTION

Resolution 304-J-21, "Decreasing Financial Burdens on Residents and Fellows," introduced by the Resident and Fellow Section (RFS), asked that the American Medical Association (AMA) work with several stakeholders to reduce some of the expenses residents and fellows experience that are a result of their training status, including assistance with managing educational debt and ensuring healthy food options in hospitals for staff and patients. Resolve 3, "That our AMA work with relevant stakeholders to ensure that medical trainees have access to on-site and subsidized child care," was referred by the House of Delegates to explore the topic further and develop recommendations to reduce financial burdens on trainees while also maintaining equity, both among trainees and among all health care workers. This report is in response to the referral.

BACKGROUND

High-quality care of young children has undisputed benefits, for the child, families, and society at large.[1] The United States, however, is an outlier in comparison to other rich nations in expectations of who provides childcare and how it is funded.

Parents in the U.S. are guaranteed (with some exceptions) 12 weeks of leave to take care of a new child without fear of losing their job—the result of the Family and Medical Leave Act (FMLA) passed in 1993—but the FMLA guarantees only unpaid leave.[2] Some states have passed laws guaranteeing some form of paid leave, and many employers provide paid leave as well.

Organizations that oversee the education, training, and eventual certification of resident/fellow physicians and medical students have specific regulations as well. In July 2021, for example, the American Board of Medical Specialties (ABMS) created policy requesting that "Member Board eligibility requirements must allow for a minimum of 6 weeks of time away from training for purposes of parental, caregiver and medical leave at least once during training, without exhausting all other allowed time away from training and without extending training. Member boards must allow all

new parents, including birthing and non-birthing parents, adoptive/foster parents, and surrogates to take parental leave."[3]

Similarly, beginning in July 2022, training programs accredited by the Accreditation Council for Graduate Medical Education (ACGME) are required to provide to residents at least one paid leave of a minimum six-weeks duration for "approved medical, parental, and caregiver leave(s) of absence."[4]

Medical schools are not required to have a parental leave policy for medical students to be accredited by the Liaison Committee on Medical Education (LCME) or Commission on Osteopathic College Accreditation (COCA). In addition, although medical schools may have parental leave policy that includes medical students, a recent study found that this policy is not easily accessible for students at two-thirds of medical schools, both MD-granting and DO-granting.[5]

AVAILABILITY AND EXPENSE OF CHILDCARE IN THE UNITED STATES

While there are now established regulations regarding family leave for the U.S. population, easily accessible and affordable childcare remains elusive for the general public, although the need is great. In 2016, 40 percent of children younger than six years old were cared for solely by their parents; the remaining 60 percent—nearly 13 million children—received on average 30 hours of care per week from a non-parent. For children younger than three, non-parental care includes home-based childcare (65 percent of children—including 42 percent cared by a relative); 35 percent of children younger than three are in center-based care. Preschool-aged children are more likely to be cared for outside of the home, with 31 percent of three- to five-year-olds in home-based childcare, and 69 percent in center-based care.[1]

In 2019, 5.2 million childcare providers cared for 12.3 million children under the age of 13 in their homes.[1] Family childcare homes are typically less expensive compared to center-based childcare, often because of lower wages for family childcare providers. In 2017, the national average yearly cost of childcare for infants to four-year-olds was approximately $10,000 for center-based care and $8,000 for family home-based care.[6] In 2015, depending on the state in which the care took place, in-home-based childcare costs ranged from $25,000 to $33,000, and center-based care ranged from $5,700 to close to $16,000.[7]

Average childcare expenses for children under five in 2017 consumed 13 percent of the income of families who pay for childcare. The U.S. Department of Health and Human Services (HHS) considers childcare affordable if it costs families no more than seven percent of their income. Most working families (over 60 percent) exceed this level of expenditures for center-based childcare, regardless of parents' marital status, race, age, or education level, and across a broad range of income levels.[1]

More than half of the childcare centers serving three- to five-year-olds were open less than 30 hours per week in 2012. About half of center-based care only serves children in certain age ranges; for example, one-third of programs accept children ages three through five only. This can make it difficult for parents of younger children, or those with more than one young child, to find an acceptable childcare solution for their children. Center-based care also varies in other dimensions, including enrollment size, affiliation, and organizational structure.[1]

The lack of providers creates hard choices for families even if they can afford childcare. In a recent study, the Center for American Progress used U.S. census tracts to identify areas where there are more than three young children for every licensed childcare slot, categorizing these areas as "childcare deserts." Over half of Americans live in such deserts, with low-income and rural families more likely to live in areas that are underserved.[8]

Aside from the availability of childcare and the cost of such care, proximity to a parent's workplace, hours of operation, services for children with different abilities, cultural and language fit, and other dimensions also influence parents' childcare options. One study found that location and minimizing travel time is very important to families' decisions in that over 75 percent choose a provider within five miles of their home, although that distance varied by whether the family lived in an urban, suburban, or rural area. Furthermore, parents were willing to pay substantially more for a provider that is one mile closer. Distance was the strongest predictor of whether a family selected a particular childcare provider, even more important than quality, cost, and other important factors for childcare decision making.[9]

Medical students and residents are at a particular disadvantage considering many of the aforementioned difficulties with finding suitable childcare. Medical students face several considerations during their preclerkship years that increase the burdens associated with childcare, including high student loan burden, schedules that often preclude income-generating work, and mandatory class attendance that affects students' ability to care for sick children (who may be excluded from childcare during illness). Once students advance to their clinical rotations, they face the added challenge of longer work hours that may begin prior to the opening of or extend past closing time of childcare facilities in addition to a general lack of control of their work schedule. Students on rotations with overnight call face additional barriers.

Residents, though salaried employees, have circumstances that make them unique in the workforce. Resident physicians have dual roles, pursuing their education while providing clinical service. Once matched into a training program by way of the National Resident Matching Program (NRMP) or other matching program, residents are obligated to matriculate into that program, with very few exceptions. Residents do not have the liberty to choose a job based upon a schedule or consider part-time or non-traditional hours to balance home responsibilities and their career. Part-time residency positions are a rarity, and the reduction in hours impacts the ability to meet educational requirements necessary for completion of training. Resident work hours are "limited" to 80 hours per week and commonly start earlier in the day and end later than typical jobs. Weekend shifts and overnight call, which can be up to a 32-hour continuous shift, further differentiate their "work hours" from others in the workforce. Part of the rigidity of residents' work schedules results from the necessary scheduling of all residents in the program to make sure the service is staffed in compliance with ACGME work hour regulations. It is imperative to contrast this with other careers, where opting for a particular schedule (e.g., part time hours, evening shifts, or weekends) may be an inconvenience or undesired, but not an impossibility. As with students, residents have little to no control over their work schedule.

REQUIREMENTS FOR CHILDCARE FOR MEDICAL STUDENTS AND RESIDENTS

There are no requirements or standards from the LCME, COCA, or ACGME regarding childcare for medical students or residents. The American Hospital Association (AHA) does not have requirements either; however, the AHA recognizes that employee stress concerning childcare is one issue that can affect employee well-being and retention and suggests that reducing these stresses may require hospitals to rethink and expand available support.[10]

CHILDCARE OPTIONS FOR MEDICAL STUDENTS AND RESIDENTS

Two articles published in the *Journal of the American Medical Association* in the 1980s promoted the need for and advantages of hospital-based childcare options. In 1989, it was reported that 40 percent of hospitals provided or helped provide some form of childcare for employees. Eleven percent had onsite childcare, and 7.3 percent had facilities located near the hospital. Larger hospitals were more likely to provide childcare benefits.[11,12] The childcare experiences of health care personnel during the COVID-19 pandemic, when many childcare providers closed, led many workers to stay home and not report to work at a time when their presence and expertise were vital.[13] In response, the leaders of the AHA, the American Nurses Association, and the AMA sent a letter to the U.S. Congress, asking that Congress prioritize COVID-19 emergency funding, including funding for "quality child care for front line health care personnel in need through direct funding to front line health care personnel and facilities, or, like some states have done, partnering with schools and daycare centers to provide funding to ensure there is quality child care."[14] The negative effects of reduced childcare options on health care workers during the pandemic have been well documented.[15,16,17]

A 2020 survey of Association of American Medical Colleges (AAMC) member institutions found that, of the responding organizations, 49 percent provided childcare assistance before COVID-19. Of those, 62 percent (18/29) expanded childcare options during the pandemic. Of the 27 organizations (46 percent) that provided no childcare assistance before COVID-19, only two expanded their support as a result of the pandemic.[18] Early career female physicians who are parents were more likely, compared to their male counterparts, to lose childcare during the pandemic and to become the primary provider of childcare or schooling. In addition, these same mothers suffered more symptoms of depression compared to fathers during the pandemic, possibly a result of the increased work/family conflict.[19]

Before the COVID-19 pandemic, many hospitals and health care systems affiliated with graduate medical education (GME) offered forms of childcare assistance, some in the form of onsite childcare, financial subsidies, priority-status

on childcare waitlists, and referral networks.[20,21,22,23] As an example, the Wellstar Health System has 11 hospitals and several clinics and facilities in Georgia, with onsite childcare centers at its two largest hospitals. The total annual budget for the two onsite centers is over $3 million. Over 240 employees typically utilize the childcare centers, including residents, fellows, and attending physicians. (Personal communication, Michele Harris, Wellstar Health System.)

Some medical schools, such as Yale School of Medicine,[24] Rush University,[25] Michigan State University,[26] University of North Texas Health Science Center,[27] and Harvard Medical School,[28] also provide childcare options and childcare subsidies for medical students. The University of Cincinnati (UC) Medical Center implemented a program at the outset of the COVID-19 pandemic through local YMCAs that allowed employees, including residents and fellows, to leave their children (six weeks and older) at a participating YMCA daycare center from 6 am to 6 pm. The medical center subsidized 50% of the daily costs for its employees. The program was discontinued, in part because the YMCA resumed its pre-COVID-19 programming. (Personal communication, Christine Ann Buczek, UC Medical Center in Cincinnati, OH.)

MEDICAL STUDENTS' AND RESIDENTS' EXPERIENCES WITH CHILDCARE

Even though most medical students and residents are in their peak childbearing years, there is relatively little known about how many will need childcare during this time and how this has changed over time. It is unknown how many students enter medical school as parents with childcare responsibilities or become parents while in medical school. The most recent Graduation Questionnaire administered by the AAMC finds that 7.3 percent of graduating seniors of MD-granting schools have a dependent who is not a partner or spouse (the type of dependent is not defined, e.g., could be a sibling, child, or parent).[29] The lack of knowledge regarding the number of students who may require childcare services prevents adequate preparation and guidance for medical schools and students.[30]

There are various estimates of the number of residents who enter GME as parents or become parents while in training. A recent six-institution survey of female residents found that 16 percent had children, and another three percent were currently pregnant.[31] In 2013, a survey of male and female residents training at three sites of the Mayo School of Graduate Medical Education found that 41 percent of responding residents were parents (and of those, 45 percent had more than one child), and nearly 12 percent planned on having a child during their current residency.[32]

Most residents who are parents will likely have to find some form of childcare. A survey of residents in 2008 at one institution (302 respondents) found that 47 percent of parents used a childcare facility. Other options used included a stay-at-home spouse (37 percent), a nanny (25 percent), and extended family members (10 percent). A number of families relocated to take advantage of family members for childcare, after difficulties finding suitable local childcare. The monthly cost per child for facility-based childcare varied, but nearly two-thirds reported costs between $500 and $1,500 (in 2008). Most respondents with children would enroll, or strongly consider enrolling their child in hospital-based childcare, especially if extended hours or drop-in emergency childcare were available. Asked if hospital-based childcare options would influence the choice between two otherwise equal residency programs, 71 percent of all respondents—non-parents and parents—said they would rank the program with hospital-based childcare higher.[33]

A survey in 2017 of residents at six teaching hospitals (578 respondents) found that 63 percent of respondents with children had difficulty arranging childcare and relied on multiple sources for childcare. Only 10 percent reported using a daycare facility affiliated with their hospital; nonuse was typically the result of a long waitlist and inconvenience. Most residents with children desired a daycare with extended and weekend daycare hours, which were not available locally. The costs of daycare were considerable; the reported median proportion of pretax salary paid for childcare used by PGY1 and PGY2 parents was 43 percent (interquartile range 41 percent to 71 percent) and decreased modestly with increasing training.[34]

Twenty percent of 184 respondents of a 2019 survey at one GME institution had their first child during residency, and an additional 18 percent were parents when they entered residency. When asked about the experience of childcare, 60 percent of parents rated it as quite or extremely stressful, made worse when partners were working fulltime or no family members were nearby to help. Nearly 19 percent had family members relocate to help with childcare. Childcare expenses were significant; 44.3 percent of parents spent between 11 percent and 25 percent, and 37.1 percent of parents spent 26 percent or more of their family income on childcare. Childcare was used by 35.7 percent of parents, while 27.1 percent had a partner who stayed home to provide care. Parents were asked what resources would be most helpful

to assist with childcare; the most preferred options were on-site day care with extended hours (51.6 percent) and childcare subsidies (25.8 percent).[35]

THE NEEDS OF THE HEALTH CARE WORKFORCE IN GENERAL

It is estimated, based on the U.S. Current Population Survey, that nearly 29 percent of the U.S. health care workforce needs to provide care for children aged 3 to 12 years.[15] Many health care workers, including residents and students, work nonstandard work hours, outside the standard business schedule of Monday through Friday, 8 am to 5 pm. The number of childcare centers that provide some form of care during nonstandard hours is small; two percent offer childcare during the evening, six percent offer overnight care, and three percent offer weekend care.[36]

Due to the relatively low salaries of most health care workers, including residents—and typically medical students are not wage earners—childcare expenses are well over the seven percent of income that HHS considers affordable. According to the Bureau of Labor Statistics, in May 2020 the median annual wage for health care practitioners and technical occupations (e.g., registered nurses, physicians, and dental hygienists) was $69,870. Health care support occupations (e.g., home health aides, occupational therapy assistants, and medical transcriptionists) had a median annual wage of $29,960.[37] The median salary in 2021 for first year residents was $58,650, ranging from $55,115 for first year residents training in the South, to $62,534 in the Northeast.[38]

RELEVANT AMA POLICY

D-200.974, "Supporting Childcare for Health Care Professionals"
Our AMA will work with interested stakeholders to investigate solutions for innovative childcare policies and flexible working environments for all health care professionals (in particular, medical students and physician trainees).

H-310.912, "Residents and Fellows' Bill of Rights"
(5) Our AMA will partner with ACGME and other relevant stakeholders to encourage training programs to reduce financial burdens on residents and fellows by providing employee benefits including, but not limited to, on-call meal allowances, transportation support, relocation stipends, and childcare services.

H-215.985, "Child Care in Hospitals"
Our AMA: (1) strongly encourages hospitals to establish and support child care facilities; (2) encourages that priority be given to children of those in training and that services be structured to take their needs into consideration; (3) supports informing the AHA, hospital medical staffs, and residency program directors of these policies; and (4) supports studying the elements of quality child care and availability of child care on a 24-hour basis.

SUMMARY AND RECOMMENDATIONS

There is a nationwide lack of options for affordable, accessible, quality childcare for the U.S. public in general, but in particular for individuals of lower income and with work schedules that are non-traditional, varied, or inflexible. Medical students and residents who are parents face childcare challenges that include low or even non-existent income, rigid academic schedules, and training and service requirements that extend the workday well beyond what can be easily accommodated by most childcare providers. The struggle of juggling childcare and medical education can further increase stress for individuals who are in an environment that has been documented to increase levels of depression and burnout.[39]

The Build Back Better Act was passed by the U.S. House of Representatives in November 2021. The bill included universal free preschool for 3- and 4-year-olds and ensured that families earning up to 1.5 times their state's median income would not pay more than seven percent of their income for childcare of young children. Also included were four weeks of federal paid parental, sick, or caregiver leave.[40] This level of assistance, if enacted, would provide medical students and residents with children some financial support, and some support in the form of childcare (preschool for 3- and 4- year-olds) but would not address the needs of parents with younger children and school-aged children as well as parents with non-traditional work schedules. Opposition in the Senate to the Build Back Better Act has led to consideration of smaller legislative action that would provide support to make childcare more affordable.

Convenience and cost are the most important factors for parents in selecting childcare arrangements. Affordable, onsite childcare with extended hours could address many of those concerns, and substantial subsidization of childcare

expenses in locations where onsite childcare is impractical would provide additional, much needed support to families who face financial restrictions in obtaining affordable, flexible childcare. Enabling families to provide a nurturing environment for young children is an essential goal for society. Doing so, however, may place a significant financial burden on medical schools and graduate medical education institutions that may be operating on already small margins. If institutions are mandated to provide such services, they may attempt to recoup costs with higher tuition or lowered salaries.

The Council on Medical Education therefore recommends that the following recommendations be adopted in lieu of Resolution 304-J-21, Resolve 3, and the remainder of this report be filed:

1. That our AMA recognize the unique childcare challenges faced by medical students, residents and fellows, which result from a combination of limited negotiating ability (given the matching process into residency), non-traditional work hours, extended or unpredictable shifts, and minimal autonomy in selecting their work schedules.

2. That our AMA recognize the fiscal challenges faced by medical schools and graduate medical education institutions in providing onsite and/or subsidized childcare to students and employees, including residents and fellows.

3. That our AMA encourage provision of onsite and/or subsidized childcare for medical students, residents, and fellows.

4. That our AMA work with the Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, and American Association of Colleges of Osteopathic Medicine to identify barriers to childcare for medical trainees and innovative methods and best practices for instituting on-site and/or subsidized childcare that meets the unique needs of medical students, residents, and fellows.

REFERENCES

1. U.S. Department of Treasury. *The Economics of Child Care Supply in the United States. 2021*. Accessed February 3, 2022. https://home.treasury.gov/system/files/136/The-Economics-of-Childcare-Supply-09-14-final.pdf
2. Francis E, Cheung H, Berger M. How does the U.S. compare to other countries on paid parental leave? Americans get 0 weeks. Estonians get more than 80. Washington Post. Nov 11, 2021. Accessed February 3, 2022.https://www.washingtonpost.com/world/2021/11/11/global-paid-parental-leave-us/
3. American Board of Medical Specialties. *American Board of Medical Specialties Policy on Parental, Caregiver and Medical Leave During Training*. Accessed February 3, 2022. https://www.abms.org/policies/parental-leave/
4. Accreditation Council for Graduate Medical Education. *Institutional Requirements*, effective July 1, 2022. Accessed February 3, 2022. https://www.acgme.org/globalassets/pfassets/programrequirements/800_institutionalrequirements_2022.pdf
5. Kraus MB, Talbott JMV, Melikian R et al. Current parental leave policies for medical students at U.S. medical schools: A comparative study. *Acad Med*. 2021;96:1315–1318. doi: 10.1097/ACM.0000000000004074
6. Child Care Aware® of America. *The US and the High Cost of Child Care*. 2018. Accessed February 3, 2022. https://www.childcareaware.org/wp-content/uploads/2015/10/costofcare2018.pdf
7 Schulte B, Durana A. *The New America Care Report*, September 2016. Accessed February 3, 2022. https://d1y8sb8igg2f8e.cloudfront.net/documents/FINAL_Care_Report.pdf
8. Malik R, Hamm K, Schochet L, Novoa C, Workman S, Jessen-Howard S. *America's Child Care Deserts in 2018*. Center for American Progress, December 6, 2018. Accessed February 3, 2022. https://www.americanprogress.org/issues/early-childhood/reports/2018/12/06/461643/americas-child-caredeserts-2018/.
9. Borowsky J, Davis E, Sojourner A. How far will they go? Choice and distance in subsidized child care. Working paper. Found in Hardy E, Joshi P, Leonardos M, Acevedo-Garcia D. *Advancing Racial Equity Through Neighborhood-Informed Early Childhood Policies: A Research and Policy Review*. September 2021. Accessed February 3, 2022. https://www.diversitydatakids.org/sites/default/files/file/neighborhood-informed-early-childhood-policies_final_2021-09-27.pdf.
10. American Hospital Association. *2022 Health Care Talent Scan*. Accessed February 3, 2022. https://www.aha.org/aha-talent-scan
11. Ricks AE, Ricks S. Hospitals should provide day-care for children of employees. *JAMA*. 1983;249(15):2090-2091. doi:10.1001/jama.1983.03330390082042
12. Silverman S. When it comes to child care, hospitals may be setting the pace for much of the nation. *JAMA*. 1989;261(13):1857-1861. doi:10.1001/jama.1989.03420130015005
13. Bipartisan Policy Center (2020). Nationwide survey: Child care in the time of coronavirus. https://bipartisanpolicy.org/blog/nationwide-survey-child-care-in-the-time-of-coronavirus/ and

https://bipartisanpolicy.org/download/?file=/wp-content/uploads/2020/04/4-5-Updated-Crosstabs-Parents_with_children_under_5_v3_LM.pdf
14. AHA, AMA and ANA Send Letter to Congress on COVID-19 Funding. Accessed February 3, 2022. https://www.aha.org/lettercomment/2020-03-19-aha-ama-and-ana-send-letter-congress-covid-19-funding
15. Bayham J, Fenichel EP. Impact of school closures for COVID-19 on the US health-care workforce and net mortality: a modelling study. *Lancet Public Health 2020* May;5(5):e271-e278. doi: 10.1016/S2468-2667(20)30082-7. Epub 2020 Apr 3.
16. Robinson LJ, Engelson BJ, Hayes SN. Who is caring for health care workers' families amid COVID-19? *Acad Med*. 2021 Sep 1;96(9):1254-1258. doi: 10.1097/ACM.0000000000004022
17. Mensik H. How hospitals leveraged on-site child care during the pandemic in a bid to drive retention. *Healthcare Dive* Nov 3, 2021. Accessed February 3, 2022. https://www.healthcaredive.com/news/hospitals-on-site-child-care-covid-19-pandemic-retention/607895/
18. Group on Business Affairs and Group on Women in Medicine and Science. GBAnalytics #11: Childcare Offerings During COVID-19. Accessed February 3, 2022. https://www.aamc.org/media/47646/download
19. Frank E, Zhao Z, Fang Y. Experiences of work-family conflict and mental health symptoms by gender among physician parents during the COVID-19 pandemic. *JAMA Network Open.* 2021;4(11):e2134315. doi:10.1001/jamanetworkopen.2021.34315
20. Tampa General Hospital. Child Care Center. Accessed February 3, 2022. https://www.tgh.org/careers-at-tgh/team-member-total-rewards/child-care-center
21. Mass General Brigham. Childcare and Youth Activities. Accessed February 3, 2022. https://eap.partners.org/caregiving-family/childcare-and-youth-activities/#childcare-BWH
22. Yale New Haven Hospital. Yale New Haven Hospital Day Care Center. Accessed February 3, 2022. https://your.yale.edu/yale-new-haven-hospital-day-care-center
23. BayCare Health System. St. Joseph's Hospital Child Care Center. Accessed February 3, 2022. https://baycare.org/careers/benefits/st-josephs-child-care-center
24. Cho S, Feibel A. Med school enhances childcare support. *Yale News.* Feb 20, 2018. Accessed February 3, 2022. https://yaledailynews.com/blog/2018/02/20/med-school-enhances-childcare-support/
25. Rush University. Student Resources. Accessed February 3, 2022. https://www.rushu.rush.edu/rush-experience/student-services/student-resources
26. Michigan State University. MSU Child Care Grant. Accessed February 3, 2022. https://finaid.msu.edu/ccgrant.asp
27. The University of North Texas Health Science Center at Fort Worth. Early Learning Center. Accessed February 3, 2022. https://www.unthsc.edu/culture-and-experience/early-learning-center/
28. Harvard Division of Medical Sciences. DMS Childcare Scholarship. Accessed February 3, 2022. https://www.hms.harvard.edu/dms/resources/parents.html
29. Association of American Medical Colleges. Medical School Graduation Questionnaire 2021 All Schools Summary Report. Accessed December 24, 2021. https://www.aamc.org/media/55736/download.
30. Durfey SNM, White J, Adashi EY. Pregnancy and parenting in medical school: Highlighting the need for data and support. *Acad Med*. 2021;96:1259-1262.doi: 10.1097/ACM.0000000000003988
31. Stack SW, Jagsi R, Biermann JS et al. Maternity leave in residency: A multicenter study of determinants and wellness outcomes. *Acad Med*.2019;94: 1738-1745 doi: 10.1097/ACM.0000000000002780
32. Blair JE, Mayer AP, Caubet SL, Norby SM, O'Connor MI, Hayes SN. Pregnancy and parental leave during graduate medical education. *Acad Med*.2016;91:972-978 doi: 10.1097/ACM.0000000000001006
33. Snyder RA, Tarpley MJ, Phillips SE, Terhune KP. The case for on-site child care in residency training and afterward. *JGME*. 2013;5:365-367. https://doi.org/10.4300/JGME-D-12-00294.1

34 Magudia K, Ng TSC, Bick AG et al. Parenting while training: A comprehensive needs assessment of residents and fellows. *JGME*. 2020;12:162-167. https://doi.org/10.4300/JGME-D-19-00563.1

35. Spruce MW, Gingrich AA, Phares A et al. Child-rearing during postgraduate medical training and its relation to stress and burnout: Results from a single-institution multi-specialty survey. *Military Medicine*. 2021;, usab029, https://doi.org/10.1093/milmed/usab029
36. Dobbins D, Lange K, Gardey C, Bump J, Stewart J. *It's About Time! Parents Who Work Nonstandard Hours Face Child Care Challenges.* Child Care Aware® of America. 2019. Accessed February 3, 2022. https://cdn2.hubspot.net/hubfs/3957809/NSH%20Report%202019.pdf
37. Bureau of Labor Statistics, U.S. Department of Labor. *Occupational Outlook Handbook*, Healthcare Occupations. Sept 8, 2021. Accessed February 3, 2022.https://www.bls.gov/ooh/healthcare/mobile/home.htm.
38. Association of American Medical Colleges. *Survey of Resident/Fellow Stipends and Benefits Report*. November 2021. Accessed February 3, 2022. https://www.aamc.org/data-reports/students-residents/report/aamc-survey-resident/fellow-stipends-and-benefits
39. Pereira-Lima K, Gupta, RR, Guille C, Sen S. Residency program factors associated with depressive symptoms in internal medicine interns: A prospective cohort study. *Acad Med*. 2019;94:869-875. doi: 10.1097/ACM.0000000000002567
40. Wilkie C. House passes $1.75 trillion Biden plan that funds universal pre-K, Medicare expansion and renewable energy credits. CNBC. Updated, November 19, 2021 Accessed February 3, 2022. https://www.cnbc.com/2021/11/19/biden-build-back-better-bill-house-passes-social-safety-net-and-climate-plan.html

4. PROTECTION OF TERMS DESCRIBING PHYSICIAN EDUCATION AND PRACTICE (RESOLUTION 305-JUN-21, ALTERNATE RESOLVE 2)

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS IN LIEU OF RESOLUTION 305-JUN-21 AND RESOLUTION 329 REMAINDER OF REPORT FILED
See Policy D-405.973

INTRODUCTION

Resolution 305-J-21, "Non-Physician Postgraduate Medical Training," introduced by the American Medical Association (AMA) Resident and Fellow Section (RFS), asked that our AMA amend Policy H-275.925, "Protection of the Titles 'Doctor,' 'Resident' and 'Residency.'" Testimony on this item during the June 2021 Special Meeting led to proposed revisions to the original resolution's second resolve:

> That our AMA amend Policy H-275.925 "Protection of the Titles "Doctor," "Resident" and "Residency"," by addition and deletion to read as follows:
>
> Our AMA: (1) recognizes that when used in the healthcare setting, specific terms describing various levels of allopathic and osteopathic physician training and practice (including the terms "medical student," "resident," "residency," "fellow," "fellowship," "physician," and "attending") represent the completion of structured, rigorous, medical education undertaken by physicians (as defined by the American Medical Association in H-405.951, "Definition and Use of the Term Physician"), and must be reserved for describing only physician roles; (2) will advocate that professionals in a clinical health care setting clearly and accurately identify to patients their qualifications and degree(s) attained and develop model state legislation for implementation; and (3) supports and develops model state legislation that would penalize misrepresentation of one's role in the physician-led healthcare team, up to and including the level of ~~make it a~~ felony ~~to~~ for misrepresenting oneself as a physician (MD/DO); and (4) support and develop model state legislation that calls for statutory restrictions for non-physician postgraduate diagnostic and clinical training programs using the terms "medical student," "resident," "residency," "fellow," "fellowship," "physician," or "attending" in a healthcare setting except by physicians.

This alternate resolve was referred by the AMA House of Delegates. This report is in response to the referral.

BACKGROUND

Recognizing that there is confusion among the public as to the education, training, and skills of different health care professionals, which can lead to patients seeking and obtaining inappropriate and potentially unsafe medical care, the AMA has partnered with 105 national, state and specialty medical associations to form the Scope of Practice Partnership (SOPP). To inform SOPP's "Truth in Advertising Campaign," SOPP has conducted several surveys to gauge public knowledge of titles, qualifications, practices and licensure status of various health care professionals.

The first SOPP survey in 2008 found that while patients strongly support a physician-led health care team, many were confused about the level of education and training of their health care provider. Follow-up surveys conducted in 2010, 2012 and 2014 confirmed that patients were confused as to who is and who is not a physician, e.g., 80 percent believed a dermatologist was a physician, and 19 percent and 17 percent thought nurse practitioners and physician assistants, respectively, were physicians.[1] The surveys did not ask about educational or training roles, such as resident or fellow.

The AMA has addressed this issue in the past; in 2008 the Illinois Delegation introduced a resolution related to the titles "Doctor," "Resident" and "Residency." The resolution asked that the title doctor (in a medical setting) "apply only to physicians licensed to practice medicine in all its branches, dentists and podiatrists"; that the AMA "adopt policy that the title 'Resident' apply only to individuals enrolled in physician, dentist or podiatrist training programs"; that the AMA "adopt policy that the title 'Residency' apply only to physician, dentist or podiatrist training programs;" and that the AMA "serve to protect, through legislation," these titles. The action that was adopted by the HOD became

Policy H-275.925, asking that all health professionals clearly identify their qualifications and training and supporting state legislation that would make it a felony to misrepresent oneself as a physician.

HEALTH CARE PROFESSIONAL TITLES AND EDUCATIONAL PROGRAMS

A brief history in medicine

It can be assumed that the general public is reasonably familiar with terms such as "medical student" and "physician," but other terms, such as resident, residency, fellow, fellowship and attending, may not be as well understood. In the health care field, the founders of Johns Hopkins Medical School in the 1890s are credited with first using the terms resident and residency to describe medical school graduates furthering their education in a clinical setting and the educational program in which that education occurs. The programs at Johns Hopkins were designed to be an intensive experience for physicians to study a specific field of medicine—so intensive, the physicians lived at the hospital.[2]

"Fellow" and "fellowship" have a long history within education, designating a senior scholar and the formal or informal organization of those scholars. Within medicine, the term fellowship as part of graduate medical education was used at least as early as the mid-1930s.[3] The term attending, when used in the hospital setting, appears to have its origins describing when private physicians would leave their clinics to "attend" to "their" patients who had been admitted to a hospital. The term has evolved to generally define a physician on the staff of a hospital with the primary responsibility over the treatment of a patient and who often supervises treatment given by interns, residents and fellows.

In other health care fields

The nursing profession has created educational modules and pilots using the term "attending," with literature describing implementation of these pilots dating back to the early 1990s.[4,5,6,7] The literature, however, does not always advocate for a "change of title or regulation" but a recognition of a stature earned.[8] Nonetheless, it is possible to find advertisements for positions called "attending nurse,"[9] and the province of Ontario has an Attending Nurse Practitioner in Long-term Care Homes Initiative.[10]

The American Nurses Credentialing Center (ANCC) is a subsidiary of the American Nurses Association. The ANCC Practice Transition Accreditation Program® (PTAP) is recognized by the U.S. Department of Labor as a Standards Recognition Entity for Industry-Recognized Apprenticeship Programs (IRAP) and sets the global standard for residency or fellowship programs that prepare registered nurses (RNs) and advanced practice registered nurses (APRNs) to transition into new practice settings. ANCC accredits the following types of transition programs:

RN Residencies	For nurses with less than 12 months' experience
RN Fellowships	For experienced nurses to master new clinical settings
APRN Fellowships	For newly certified advanced practice nurses

There are currently 221 programs accredited by the ANCC.[11] Another organization, the National Nurse Practitioner Residency & Fellowship Training Consortium, which has just received recognition by the U.S. Department of Education, has accredited nine programs.[12] For example, Northwell Health requires all nurses with 6 months or less experience to enroll in their nurse residency and offers nursing fellowships in five clinical areas.[13] The Medical College of Wisconsin has a pediatric critical care nurse practitioner 12-month fellowship program for pediatric critical care nurse practitioners to further their training.[14]

The Association of Postgraduate PA Programs provides a list of 70 training programs, many called residency or fellowship programs,[15] while the Physician Assistant Program Directory provides a list of 85 programs.[16]

Outside of health care

As mentioned above, the terms "fellow" and "fellowship" have a long history outside of medicine. The terms "resident" and "residency" are used widely in fields outside of health care, such as in the arts,[17] engineering,[18] and journalism[19] to name only a few. Attending does not appear to be in use for modifying a position (e.g., attending physician) outside of health care.

REGULATIONS/GUIDANCE REGARDING USE OF THE TERMS IN HEALTH CARE

At this time, there appear to be no regulations by state medical boards on who can use the terms resident, residency, fellow, fellowship or attending. Medical licensure requirements reflect what someone can do under various licenses, e.g., practice medicine, but do not stipulate what an educational program is named or the titles that one can use in describing a position.

The AMA's model bill, "Health Care Professional Transparency Act," has been successfully adopted in many states and describes how health professionals should properly identify their type of license but does not include roles. Section 4.(b).1, for example, requires health care practitioners to wear a photo identification tag that includes, among other information, the person's type of license, e.g., medical doctor or nurse practitioner. The model bill does not include the roles in the health care setting that practitioners likely use when introducing themselves to patients, such as attending physician, resident, etc. Further adoption of this model legislation by additional states may help address the issue of appropriate identification of physicians (whether resident physician or fully licensed physician) versus other health professionals.

RELEVANT AMA POLICY

D-275.979, "Non-Physician 'Fellowship' Programs"
Our AMA will (1) in collaboration with state and specialty societies, develop and disseminate informational materials directed at the public, state licensing boards, policymakers at the state and national levels, and payers about the educational preparation of physicians, including the meaning of fellowship training, as compared with the preparation of other health professionals; and (2) continue to work collaboratively with the Federation to ensure that decisions made at the state and national levels on scope of practice issues are informed by accurate information and reflect the best interests of patients.

H-270.958 (2), "Need for Active Medical Board Oversight of Medical Scope-of-Practice Activities by Mid Level Practitioners"
Our AMA will work with interested Federation partners: (a) in pursuing legislation that requires all health care practitioners to disclose the license under which they are practicing and, therefore, prevent deceptive practices such as nonphysician healthcare practitioners presenting themselves as physicians or "doctors"; (b) on a campaign to identify and have elected or appointed to state medical boards physicians (MDs or DOs) who are committed to asserting and exercising the state medical board's full authority to regulate the practice of medicine by all persons within a state notwithstanding efforts by nonphysician practitioner state regulatory boards or other such entities that seek to unilaterally redefine their scope of practice into areas that are true medical practice.

D-35.996, "Scope of Practice Model Legislation"
Our AMA Advocacy Resource Center will continue to work with state and specialty societies to draft model legislation that deals with non-physician independent practitioners' scope of practice, reflecting the goal of ensuring that non-physician scope of practice is determined by training, experience, and demonstrated competence; and our AMA will distribute to state medical and specialty societies the model legislation as a framework to deal with questions regarding non-physician independent practitioners' scope of practice.

H-405.951, "Definition and Use of the Term Physician"
Affirms that the term physician be limited to those people who have a Doctor of Medicine, Doctor of Osteopathic Medicine, or a recognized equivalent physician degree and who would be eligible for an Accreditation Council for Graduate Medical Education (ACGME) residency.

D-405.991 (1) (2), "Clarification of the Title 'Doctor' in the Hospital Environment"
1. Our AMA Commissioners will, for the purpose of patient safety, request that The Joint Commission develop and implement standards for an identification system for all hospital facility staff who have direct contact with patients which would require that an identification badge be worn which indicates the individual's name and credentials as appropriate (i.e., MD, DO, RN, LPN, DC, DPM, DDS, etc), to differentiate between those who have achieved a Doctorate, and those with other types of credentials.
2. Our AMA Commissioners will, for the purpose of patient safety, request that The Joint Commission develop and implement new standards that require anyone in a hospital environment who has direct contact with a patient who presents himself or herself to the patient as a "doctor," and who is not a "physician" according to the AMA definition

(H-405.969) that a physician is an individual who has received a "Doctor of Medicine" or a "Doctor of Osteopathic Medicine" degree or an equivalent degree following successful completion of a prescribed course of study from a school of medicine or osteopathic medicine) must specifically and simultaneously declare themselves a "non-physician" and define the nature of their doctorate degree.

H-405.992, "'Doctor' as a Title"
The AMA encourages state medical societies to oppose any state legislation or regulation that might alter or limit the title "Doctor," which persons holding the academic degrees of Doctor of Medicine or Doctor of Osteopathy are entitled to employ.

H-405.968 (1), "Clarification of the Term 'Provider' in Advertising, Contracts and other Communications"
Our AMA supports requiring that health care entities, when using the term "provider" in contracts, advertising and other communications, specify the type of provider being referred to by using the provider's recognized title which details education, training, license status and other recognized qualifications; and supports this concept in state and federal health system reform.

SUMMARY AND RECOMMENDATIONS

There is potential confusion for the public in the use of terms describing the training program and level of training that health care professionals enroll in or complete; data are needed to assess the extent of that confusion. A standardization and understanding of terms for physicians and non-physicians will be beneficial to the public and health care professionals and could inform future proposed legislation.

The Council on Medical Education therefore recommends that the following recommendations be adopted in lieu of Resolution 305-J-21, Alternate Resolve 2, and the remainder of this report be filed:

1. That our AMA engage with academic institutions across the nation that develop educational programs for training of non-physicians in health care careers, and their associated professional organizations, to create alternative, clarifying nomenclature in place of "resident," "residency," "fellow," "fellowship" and "attending" and other related terms to reduce confusion among the public.

2. That AMA Policy H-275.925, "Protection of the Titles 'Doctor,' 'Resident' and 'Residency'" be amended by insertion and deletion as follows:

   Our AMA: (1) will advocate that all health professionals in a clinical health care setting clearly and accurately ~~identify~~ communicate to patients and relevant others their qualifications, ~~and~~ degree(s) attained, and current training status within their training program; (2) ~~and~~ develop model state legislation for implementation to this effect; ~~and (2)~~ (3) supports state legislation that would make it a felony to misrepresent oneself as a physician (MD/DO)~~.~~; and (4) will expand efforts in educational campaigns that: a) address the differential education, training and licensure/certification requirements for non-physician health professionals versus physicians (MD/DO) and b) provide clarity regarding the role that physicians (MD/DO) play in providing patient care relative to other health professionals as it relates to nomenclature, qualifications, degrees attained and current training status.

REFERENCES

1. American Medical Association. "Truth in Advertising" Campaign. https://www.ama-assn.org/system/files/2020-10/truth-in-advertising-campaign-booklet.pdf. Accessed January 25, 2022.
2. Ludmerer KM. Let Me Heal: *The Opportunity to Preserve Excellence in American Medicine*. New York, NY: Oxford University Press; 2015.
3. "Medical Education in the United States and Canada for the Session of 1934-1935." Reprinted from the Educational Number of the Journal of the American Medical Association, August 31, 1935.
4. Niemela K, Poster EC, Moreau D. The attending nurse: a new role for the advanced clinician. *J Child Adol Psych Nurs*. 1992;5(3):5Y12.
5. Moreau D, Poster EC, Niemela K. Implementing and evaluating an attending nurse model. *Nurs Manage*. 1993;24(6):56Y58, 60,64.
6. Watson J, Forster R. The attending nurse caring model: integrating theory, evidence and advanced caring-healing therapeutics for transforming professional practice. *J Clin Nurs*. 2003;12:360Y365.

7. Cyrus R, Weaver C, Kulkarni N, Astik G, Hanrahan K, O'Sullivan P. Getting discharges off the back burner: The role of the attending nurse. Society of Hospital Medicine Meeting 2018; April 8-11; Orlando, Fla.
8. Minarik PA, Sparacino PSA Re: Editorial Entitled "Clinical Nurse Specialist as Attending Nurse" *Clinical Nurse Specialist*. 2008;22(4): 166.doi: 10.1097/01.NUR.0000311712.63060.07
9. https://www.healthecareers.com/job/attending-nurse-practitioner/2100690. Accessed January 15, 2022.
10. Ministry of Health and Long Term Care. Ontario, Canada. Attending Nurse Practitioners in Long-Term Care Homes: Recruitment and Integration Toolkit. https://www.health.gov.on.ca/en/pro/programs/hhrsd/nursing/docs/2017_NP_LTCH_Rec_int_toolkit.pdf. Accessed January 25, 2022.
11. Practice Transition Accreditation Program® (PTAP) https://www.nursingworld.org/organizational-programs/accreditation/ptap/ Accessed January 25, 2022.
12. National Nurse Practitioner Residency & Fellowship Training Consortium. https://www.nppostgradtraining.com/postgraduate-training/locations/ Accessed February 8, 2022.
13. https://jobs.northwell.edu/career-specialties/nursing/nursing-externship-fellowship/#tab-id-4. Accessed January 25, 2022.
14. https://www.mcw.edu/departments/pediatrics/divisions/critical-care/education/nurse-practitioner-fellowship-program Accessed January 25, 2022.
15. Association of Postgraduate Physician Assistant Programs https://appap.org/programs/postgraduate-pa-np-programs-listings/ Accessed January 25, 2022.
16. https://www.paschoolfinder.com/cat/postgraduate-pa-residency-program/ Accessed January 25, 2022.
17. https://resartis.org/ Accessed January 25, 2022.
18. https://www.niu.edu/ceet/outreach/corporate-partnerships/engineers-in-residence.shtml Accessed January 25, 2022.
19. https://www.chicagobooth.edu/research/stigler/education/journalists-in-residence-program Accessed January 25, 2022.

5. EDUCATION, TRAINING, AND CREDENTIALING OF NON-PHYSICIAN HEALTH CARE PROFESSIONALS AND THEIR IMPACT ON PHYSICIAN EDUCATION AND TRAINING (RESOLUTION 305-J-21, RESOLVE 8)

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS
IN LIEU OF RESOLVE 8 OF RESOLUTION 305-JUN-21
TITLE CHANGED
REMAINDER OF REPORT FILED
See Policies D-275.948, D-275.979, and D-295.934

INTRODUCTION

Resolution 305-J-21, "Non-Physician Postgraduate Medical Training" was authored by the American Medical Association (AMA) Resident and Fellow Section and submitted to the Special Meeting of the House of Delegates in June 2021. Its third resolved statement was adopted as amended, resulting in AMA Policy D-275.949, which asks that our AMA "study and report back to the House of Delegates on curriculum, accreditation requirements, accrediting bodies, and supervising boards for undergraduate, graduate, and postgraduate clinical training programs for non-physicians and the impact on undergraduate and graduate medical education."

In addition, the following resolve of Resolution 305-J-21 was referred:

> That our AMA oppose non-physician healthcare providers from holding a seat on the board of an organization that regulates and/or provides oversight of physician undergraduate and graduate medical education, accreditation, certification, and credentialing when these types of non-physician healthcare providers either possess or seek to possess the ability to practice without physician supervision as it represents a conflict of interest.

This report is written in response to the adopted policy and the referral. To clarify, this report is not about non-physician scope of practice, nor funding of physician vs. non-physician clinical training programs. The Council on Medical Education acknowledges the concerns articulated by the authors of these resolutions. This report seeks to investigate and discuss the issues raised in the resolutions in order to advance these learning environments.

BACKGROUND

The accrediting bodies of undergraduate and graduate medical education address interprofessional collaborations and supervision in their accreditation requirements.

Allopathic and osteopathic requirements

In evaluating non-physician educational programs and requirements, it is imperative to understand the rigors of medical training inclusive of the requirements set forth by the Liaison Committee on Medical Education (LCME) and Commission on Osteopathic College Accreditation (COCA) for undergraduate medical education as well as the Accreditation Council for Graduate Medical Education (ACGME) for graduate medical education.

Undergraduate medical education

To achieve and maintain accreditation, a medical education program leading to the MD degree in the U.S. must demonstrate appropriate performance in the standards and elements of the LCME. According to its updated Functions and Structure of a Medical School standards released in 2021, Standard 9: Teaching, Supervision, Assessment, and Student and Patient Safety states, "A medical school ensures that its medical education program includes a comprehensive, fair, and uniform system of formative and summative medical student assessment and protects medical students' and patients' safety by ensuring that all persons who teach, supervise, and/or assess medical students are adequately prepared for those responsibilities."[1] Likewise, Standard 5: Learning Environments of the American Osteopathic Association's COCA states, "A College of Osteopathic Medicine (COM) must ensure that its educational program occurs in professional, respectful, nondiscriminatory, and intellectually stimulating academic and clinical environments. The school also promotes students' attainment of the osteopathic core competencies required of future osteopathic physicians." Further, COCA Standard 7 states, "The faculty members at a COM must be qualified through their education, training, experience, and continuing professional development and provide the leadership and support necessary to attain the institution's educational, research, and service goals. A COM must ensure that its medical education program includes a comprehensive, fair, and uniform system of formative and summative medical student assessment and protects medical students' and patients' safety by ensuring that all persons who teach, supervise, and/or assess medical students are adequately prepared for those responsibilities."[2]

Graduate medical education

The ACGME offers a single GME accreditation system that allows graduates of allopathic and osteopathic medical schools to complete their residency and/or fellowship education in ACGME-accredited programs and demonstrate achievement of common milestones and competencies. The ACGME Common Program Requirements are a basic set of standards in training and preparing resident and fellow physicians. These requirements address non-physicians' roles in resident education, both from the perspective of teaching faculty as well as the impact of non-physician learners on resident education:

- I.E. The presence of other learners and other care providers, including, but not limited to, residents from other programs, subspecialty fellows, and advanced practice providers, must enrich the appointed residents' education. (Core)
- I.E.1. The program must report circumstances when the presence of other learners has interfered with the residents' education to the DIO and Graduate Medical Education Committee (GMEC). (Core)
- II.A.4. Program Director Responsibilities: The program director must have responsibility, authority, and accountability for: administration and operations; teaching and scholarly activity; resident recruitment and selection, evaluation, and promotion of residents, and disciplinary action; supervision of residents; and resident education in the context of patient care.
    a). (3) Background and intent: The program director may establish a leadership team to assist in the accomplishment of program goals. Residency programs can be highly complex. In a complex organization, the leader typically has the ability to delegate authority to others yet remains accountable. The leadership team may include physician and non-physician personnel with varying levels of education, training, and experience.
- II.B.3.c) Any non-physician faculty members who participate in residency program education must be approved by the program director. (Core) Background and Intent: The provision of optimal and safe patient care requires a team approach. The education of residents by non-physician educators enables the resident to better manage

patient care and provides valuable advancement of the residents' knowledge. Furthermore, other individuals contribute to the education of the resident in the basic science of the specialty or in research methodology. If the program director determines that the contribution of a non-physician individual is significant to the education of the residents, the program director may designate the individual as a program faculty member or a program core faculty member.[3]

Non-physician requirements

The AMA Advocacy Resource Center (ARC) produced a Scope of Practice Data Series[4,5] to serve as a resource to state medical associations, national specialty societies, and state lawmakers on the difference in the education, training, and licensure requirements of non-physicians as compared to physicians. Two of the informational modules address nurse practitioners (NPs) and physician assistants (PAs).

The NP must hold a valid registered nurse (RN) license, have completed a graduate-level degree, and pass a state licensure examination. The educational pathways leading to a diploma and becoming a RN include an associate degree (ADN), a baccalaureate degree (BSN), or a master's degree in nursing (MSN). Moreover, some nurses who graduate with a diploma or associate degree continue to enroll in baccalaureate programs, and increasingly, some nurses with baccalaureate degrees in other fields begin their nursing education in "direct entry" master's degree programs.[6]

The Scope of Practice Data Series on the NP[5] explains in detail the journey of a physician, using a family physician as an example, through medical school, licensure exams (the United States Medical Licensing Examination, or USMLE, and Comprehensive Osteopathic Medical Licensing Examination of the United States, or COMLEX-USA), residency training, and board certification. Comparatively, it walks though the NP journey, starting with the licensure as a RN per the curriculum standards for nursing schools of the American Association of Colleges of Nursing (AACN) as well as the RN licensure exam. It explains the three types of NP programs: a masters of nursing practice (MSN), practice-focused doctor of nursing practice (DNP), or doctoral (DNP) degree program, with most NPs completing a MSN. Both MSN and DNP programs are accredited by the Commission on Collegiate Nursing Education (CCNE) or the Accreditation Commission for Education in Nursing (ACEN). The standards for NP programs, based on guidelines from the AACN ("MSN Essentials") and National Task Force on Quality Nurse Practitioner Education, Criteria for Evaluation of Nurse Practitioner Programs ("NTF Criteria"), outline the core content, skills, and knowledge a graduate of a NP program should possess. While some NP programs offer postgraduate training after attainment of the degree, similar to medical residencies, completion of a postgraduate clinical practicum is not required for licensure or certification. Further, the data series reviews NP licensure and certification and maintenance of certification. Appendix A contains an infographic from the ARC comparing the education and training of physicians and NPs.

PAs are also members of the interprofessional team under the guidance and supervision of a physician. PA education must be completed through an accredited PA program. Upon completion, students must pass the PA National Certifying Exam (PANCE) and obtain licensure in the state in which they wish to practice. Some PA schools may require completion of science courses and hands-on experience prior to admission. While accreditation standards require PA programs to provide a generalist education, the length of the program, type of degree, and specific course requirements vary by institution and state.[7]

The Scope of Practice Data Series on the PA[4] describes the same physician journey as compared to the PA. It reviews the Phase I (classroom/didactic phase) and Phase II (clinical phase) education standards of a PA set forth by the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA), as well as the optional postgraduate clinical practicum, licensure, certification, optional specialty certification(s), and maintenance of certification. The ARC-PA standards, which are used for the development, evaluation, and self-analysis of PA programs, maintain that PAs are "academically and clinically prepared to practice medicine on collaborative medical teams," given that "the collaborative medical team is fundamental to the PA profession and enhances the delivery of high-quality health care."[8] See Appendix B, which contains a table from the ARC comparing the education and training of physicians and PAs. The ARC can provide more information on this series as requested.

Non-physician board membership requirements

Some boards of organizations that regulate and/or provide oversight of physicians (e.g., undergraduate and graduate medical education, accreditation, certification, and credentialing) have seats for non-physician providers. Whether or not these types of non-physician providers possess or seek to possess the ability to practice without physician

supervision is often not addressed in the description of the seat. Further, there is little information in the literature about boards promoting designated seats specifically to non-physician providers, other than that of a "public member" seat.

For the AMA Board of Trustees, the non-physician/public member seat is defined in its Constitution and Bylaws B-3.2.6, "Public Trustee. The public trustee shall be an individual who does not possess the United States degree of doctor of medicine (MD) or doctor of osteopathic medicine (DO), or a recognized international equivalent, and who is not a medical student."

The Federation of State Medical Boards (FSMB) provides guidance for state medical boards on the makeup of their board seats. They recommend that at least 25 percent be public members and that such members "reside in the state and be persons of recognized ability and integrity; not be licensed physicians, providers of health care, or retired physicians or health care providers; have no past or current substantial personal or financial interests in the practice of medicine or with any organization regulated by the board (except as a patient or caregiver of a patient); and have no immediate familial relationships with any licensees or any organization regulated by the Board, unless otherwise required by law. Public members should represent a wide range of careers."[9] Often, such seats are determined by a state's governor and/or legislature. While all state medical boards are linked by the FSMB, it is not as apparent how non-physician state boards are connected to each other.

Regarding physician certification and accreditation, organizations such as the American Board of Medical Specialties (ABMS) and ACGME have not disclosed the criteria for the composition of their own boards of directors, which include non-physicians, nor is it apparent if ABMS offers recommendations on the structure and function of the boards of directors for their member boards.

DISCUSSION

Interprofessional education and collaboration: support and concerns

Interprofessional education (IPE), when students from two or more health professions learn together during all or part of their training, and collaborative practices are intended to optimize patient outcome. The AMA recognizes their value as stated in Policy D-295.934, "1. Our AMA: (A) recognizes that interprofessional education and partnerships are a priority of the American medical education system; 2. Our AMA supports the concept that medical education should prepare students for practice in physician-led interprofessional teams. 3. Our AMA will encourage health care organizations that engage in a collaborative care model to provide access to an appropriate mix of role models and learners."

Accrediting bodies support interprofessional education and collaborative practice. LCME Standard 7.9 addresses interprofessional collaborative skills, stating, "The faculty of a medical school ensure that the core curriculum of the medical education program prepares medical students to function collaboratively on health care teams that include health professionals from other disciplines as they provide coordinated services to patients. These curricular experiences include practitioners and/or students from the other health professions." The ACGME's Common Program Requirement VI.E.2. states, "Teamwork: Residents must care for patients in an environment that maximizes communication. This must include the opportunity to work as a member of effective interprofessional teams that are appropriate to the delivery of care in the specialty and larger health system. (Core)"[1] Similarly, COCA Element 6.8: Interprofessional Education for Collaborative Practice (CORE) states, "In each year of the curriculum, a COM must ensure that the core curriculum prepares osteopathic medical students to function collaboratively on health care teams, adhering to the IPEC core competencies, by providing learning experiences in academic and/or clinical environments that permit interaction with students enrolled in other health professions degree programs or other health professionals."[2]

Despite the value of IPE, clinical learning environments often include learners from multiple professions and from various training programs without coordinated accountability for management of the clinical setting. Physician training can be adversely affected if the presence of multiple learners results in decreased opportunities for patient or procedural exposures.

Further, there is concern that enrolling advanced practice providers into "resident" positions can lead to reduction in the number of MD/DO graduate positions available. Differences in training and qualifications need to be carefully

considered. Some medical specialty groups have spoken out about the concern of advanced practice providers in "resident" positions. The American Academy of Emergency Medicine released a statement, updated in September 2020, on Emergency Medicine Training Programs for Non-Physician Practitioners (NPP) which states that such postgraduate programs:

- Must be clear to the public by prohibiting the use of the following terms: doctor, intern, internship, resident, residency, fellow, and fellowship. The recommended term is postgraduate training program.
- Must be structured, intended, and advertised as to prepare its participants to practice only as members of a physician-led team.
- Must not interfere with the educational opportunities of emergency medicine residents and medical students. Potential detriment to resident and student education must be monitored in a comprehensive and meaningful way throughout the existence of the NPP program.
- Must be initiated with the consultation and approval of the emergency medicine residents and physician faculty.[10]

Regarding accreditation of nursing postgraduate clinical practicums, the ANCC's Practice Transition Accreditation Program® (PTAP) is recognized by the U.S. Department of Labor as a Standards Recognition Entity for Industry-Recognized Apprenticeship Programs (IRAP). It sets the global standard for postgraduate clinical practicums that prepare RNs and advanced practice RNs to transition into new practice settings. In January 2022, the National Nurse Practitioner Residency & Fellowship Training Consortium announced its federal recognition as an accrediting agency by the U.S. Department of Education. These two organizations can play a key role in fostering interprofessional team learning environments. Should these practicums interfere with GME, the GMEC office may not have the authority necessary to make an impact, resulting in a negative consequence to the GME training program. Appropriate institutional leaders should address these concerns and foster action.

NP and PA "residents" can bill for patient care. This raises concern that systems favor these advanced practice provider practicums as a mechanism to deliver care at a reduced cost compared to staffing clinical services by resident physicians. Substituting providers with differing qualifications may harm the educational mission. Disparities in pay are also a concern as resident pay is capped due to the availability of federal support for GME funding. The same is not true for advanced practice providers in postgraduate clinical practicums, which may lead to disparity in salaries for trainees with varying entering levels of education. AMA Policy H-310.912, Resident and Fellows Bill of Rights, states, "10. Our AMA believes that healthcare trainee salary, benefits, and overall compensation should, at minimum, reflect length of pre-training education, hours worked, and level of independence and complexity of care allowed by an individual's training program (for example when comparing physicians in training and midlevel providers at equal postgraduate training levels)." The use of the term "resident" to describe these postgraduate clinical practicums is another concern; this terminology is being addressed in a concurrent Council on Medical Education report, "Protection of Terms Describing Physician Education and Practice."

Interprofessional board members: support and concern

Testimony on the eighth resolve of Resolution 305 at the June 2021 Special Meeting expressed concern for non-physician health care providers holding a seat on a board with oversight of physicians, noting that this may pose a conflict of interest for those non-physician providers who seek to practice independently of physicians. On the other hand, Reference Committee C, in its report to the HOD, noted that there can be value in having a non-physician representative on a board in order to provide additional perspective and ensure the best interests of patients. Such mixed representation is already in practice on some boards (e.g., institutional review boards, hospital medical quality boards, medical specialty boards).

One example of such mixed representation is the California Medical Board, which is composed of 15 board members, 8 physician members, and 7 public members. The governor appoints 13 members, and two are appointed by the legislature.[11] A 2021 senate bill proposed adding two members from the general public to the board, giving non-physicians a slim majority; however, the author of the bill removed the proposed change before it was voted upon.[12]

In 2017, the Iowa Board of Medicine seated the first non-physician to chair the board that has overseen the licensure and regulation of the state's physicians for 130 years. At that time, only four of the nation's 70 state and territory medical boards had public members serving as chairs. Historically, Iowa governors were required to appoint members of licensing boards from lists of nominees submitted by their state trade and professional groups. However, state legislation was changed to alleviate suspicions that some licensing boards functioned more to protect members of the profession than to protect the public.[13]

Aside from the public member seat, consideration should be given to the risks as well as benefits of boards that promote seats specific to a non-physician provider as a designated seat. Some may say that non-physician health care providers can pose a conflict of interest on a board that oversees physicians, particularly for those who seek to practice independently of physicians. Others may say that not having non-physician providers on a physician oversight board may also pose a conflict, as an all-physician board may be inherently biased in its self-governance. One potential benefit of a non-physician majority is that it could boost public confidence that the board is focused on protecting patients.

Understanding the composition of the boards that monitor non-physicians is also important. The National Council of State Boards of Nursing (NCSBN) is a not-for-profit organization whose U.S. members include the nursing regulatory bodies in the 50 states, the District of Columbia and four U.S. territories. The leadership of NCSBN consists of a board of directors and a delegate assembly. This board of directors comprises nurses as well as other professionals. The National Commission of Certification of Physician Assistants (NCCPA) is the only certifying organization for PAs in the United States. The NCCPA Board of Directors is made up of PAs as well as other professionals, and currently includes four physicians.

RELEVANT AMA POLICY

AMA policy addresses interprofessional education among health care professions students; educational preparation of physicians, including the meaning of fellowship training, as compared with the preparation of other health professionals; and the difference in education of physicians and non-physician health care workers. These and other related policies are shown in Appendix C.

Regarding non-physician seats on physician oversight boards as raised in the eighth resolve of Resolution 305 and the issue of conflict of interest (COI), the AMA does not have specific policy on COI but does have policy on COI in other situations. For example, H-235.970, "Conflict of Interest Issues and Medical Staff Leaders," states that:

> Our AMA encourages medical staffs to adopt and incorporate into their bylaws medical staff conflict of interest policies that reflect the following principles:
>
> 1. Disclosure of potential conflicts. Candidates for election or appointment to medical staff leadership positions should disclose in writing to the medical staff, prior to the date of election or appointment, any personal, professional or financial affiliations or relationships of which they are reasonably aware, including employment or contractual relationships, which could foreseeably result in a conflict of interest with their acting on behalf of the medical staff. Elected or appointed medical staff leaders should disclose potential conflicts in writing to the medical staff whenever they arise.
>
> 2. Management of conflicts. When conflicts of interest exist, elected or appointed medical staff leaders should, as appropriate, recuse themselves from the deliberative process and/or abstain from voting on the matter to which the conflict relates. The medical staff should establish a process for disqualification from the deliberative process and/or from voting on the matter at hand for any elected or appointed medical staff leader with an identified conflict who fails to disclose the interest or who fails to recuse himself or herself from the deliberative process and/or from voting on the matter to which the conflict relates, as appropriate.

Neither Council on Ethical and Judicial Affairs (CEJA) opinions nor AMA Bylaws cite an explicit definition of COI. The AMA PolicyFinder database offers more information.

SUMMARY AND RECOMMENDATIONS

The AMA believes that all qualified health care professionals play an integral role in the delivery of health care in this country—a role that should be clearly defined by one's education and training. Reaffirmation of Policies D-295.934, "Encouragement of Interprofessional Education Among Health Care Professions Students," and D-275.979, "Non-Physician 'Fellowship' Programs," would signify this support. Such education and training of non-physicians should not inhibit in any way the education and training of physicians, thus those responsible for interprofessional education and collaborations should appropriately manage the resources for such trainings. To promote transparency, interprofessional students and trainees may benefit from training on the differences that exist among them in the amount and depth of training as well as supervision and testing of that training. Non-physician roles and seats on a

board that provides oversight to physicians should be clearly defined and transparent and these boards should not take actions that inhibit in any way the education, training, or practice of physicians. Careful consideration should be given to the management of COI.

The Council on Medical Education therefore recommends that the following recommendations be adopted in lieu of Resolve 8 of Resolution 305-J-21 and the remainder of this report be filed:

1. That our AMA support the concept that interprofessional education include a mechanism by which members of interdisciplinary teams learn about, with, and from each other; and that this education include learning about differences in the depth and breadth of their educational backgrounds, experiences, and knowledge and the impact these differences may have on patient care.

2. That our AMA support a clear mechanism for medical school and appropriate institutional leaders to intervene when undergraduate and graduate medical education is being adversely impacted by undergraduate, graduate, and postgraduate clinical training programs of non-physicians.

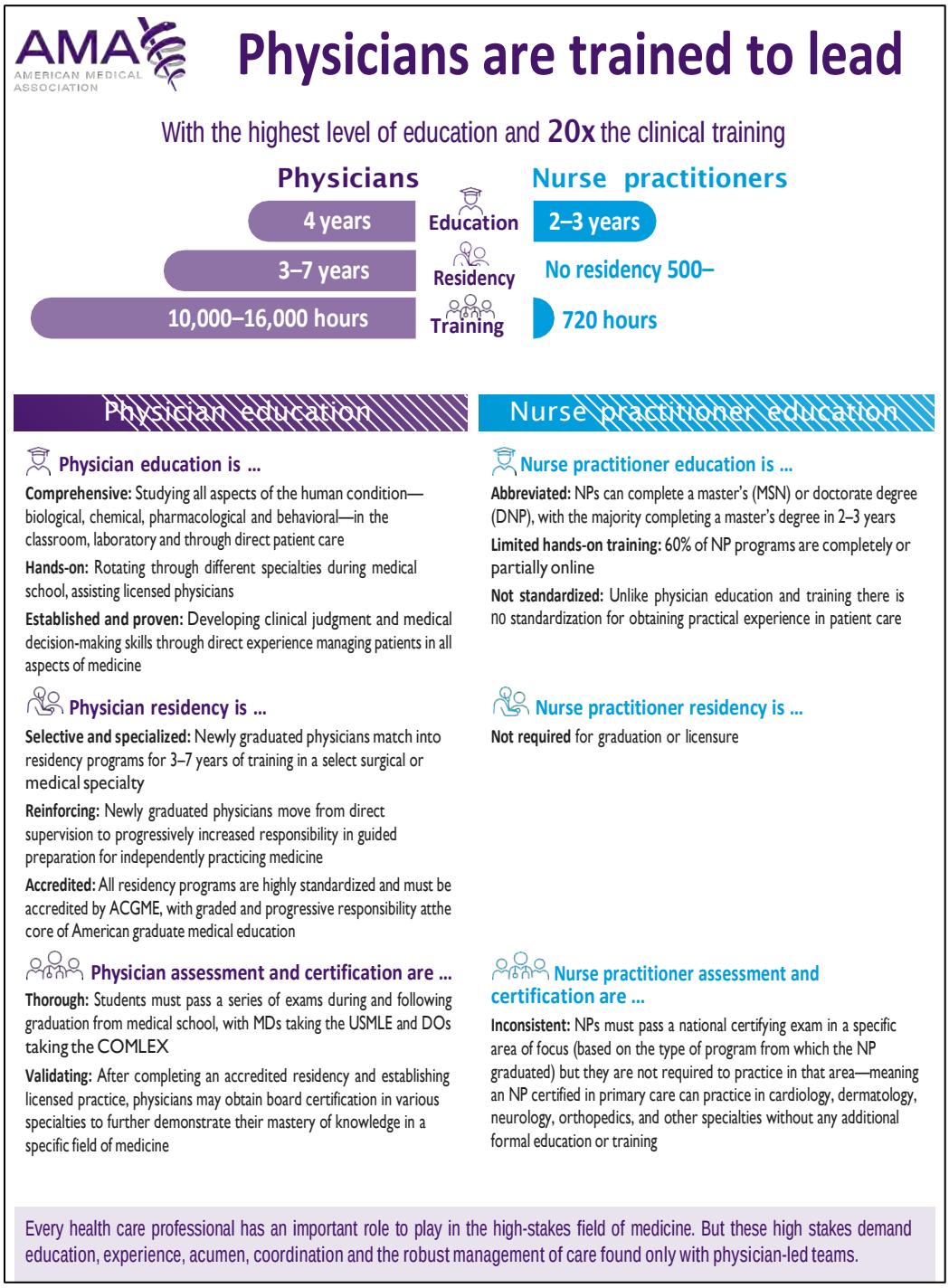
3. That Policies D-295.934, "Encouragement of Interprofessional Education Among Health Care Professions Students," and D-275.979, "Non-Physician "Fellowship" Programs," be reaffirmed.

4. That our AMA work with key regulatory bodies involved with physician education, accreditation, certification, licensing, and credentialing to a) increase transparency of the process by encouraging them to openly disclose how their board is composed and members are selected and b) review their conflict of interest and other policies related to non-physician health care professionals holding formal leadership positions (e.g., board, committee) when that non-physician professional represents a field that either possesses or seeks to possess the ability to practice without physician supervision.

5. That Policy D-275.949, "Non-Physician Postgraduate Medical Training," be rescinded, as having been accomplished by the writing of this report.

~~Our AMA will study and report back to the House of Delegates on curriculum, accreditation requirements, accrediting bodies, and supervising boards for undergraduate, graduate and postgraduate clinical training programs for non-physicians and the impact on undergraduate and graduate medical education.~~

APPENDIX A - Physician vs Nurse Practitioner education and training



APPENDIX B - Physician education and training vs Physician Assistant[4]

	Undergraduate degree	Entrance exam	Postgraduate schooling	Residency and duration	Total time for completion	Total patient care hours required through training
Family Physician	Standards 4-year BA/BS	Medical College Admission Test (MCAT)	4-year doctoral program (MD or DO)	3-year family medicine residency	12-14 years	12,000-16,000 hours
Physician Assistant	Standard 4-year BA/BS (Not uniformly required)	Graduate Record Examination (GRE) (Not uniformly required)	2-2.5-year master's program (some award a bachelor's certificate or associate's)	None required	6-6.5 years	2,000 hours

APPENDIX C - Relevant AMA Policy

Interprofessional education

Encouragement of Interprofessional Education Among Health Care Professions Students, D-295.934
1. Our AMA: (A) recognizes that interprofessional education and partnerships are a priority of the American medical education system; and (B) will explore the feasibility of the implementation of Liaison Committee on Medical Education and American Osteopathic Association accreditation standards requiring interprofessional training in medical schools.
2. Our AMA supports the concept that medical education should prepare students for practice in physician-led interprofessional teams.
3. Our AMA will encourage health care organizations that engage in a collaborative care model to provide access to an appropriate mix of role models and learners.
4. Our AMA will encourage the Liaison Committee on Medical Education, Commission on Osteopathic College Accreditation, American Osteopathic Association, and Accreditation Council for Graduate Medical Education to facilitate the incorporation of physician-led interprofessional education into the educational programs for medical students and residents in ways that support high quality medical education and patient care.
5. Our AMA will encourage the development of skills for interprofessional education that are applicable to and appropriate for each group of learners.

Non-Physician "Fellowship" Programs, D-275.979
Our AMA will (1) in collaboration with state and specialty societies, develop and disseminate informational materials directed at the public, state licensing boards, policymakers at the state and national levels, and payers about the educational preparation of physicians, including the meaning of fellowship training, as compared with the preparation of other health professionals; and (2) continue to work collaboratively with the Federation to ensure that decisions made at the state and national levels on scope of practice issues are informed by accurate information and reflect the best interests of patients.

Physician and Nonphysician Licensure and Scope of Practice, D-160.995
1. Our AMA will: (a) continue to support the activities of the Advocacy Resource Center in providing advice and assistance to specialty and state medical societies concerning scope of practice issues to include the collection, summarization and wide dissemination of data on the training and the scope of practice of physicians (MDs and DOs) and nonphysician groups and that our AMA make these issues a legislative/advocacy priority; (b) endorse current and future funding of research to identify the most cost effective, high-quality methods to deliver care to patients, including methods of multidisciplinary care; and (c) review and report to the House of Delegates on a periodic basis on such data that may become available in the future on the quality of care provided by physician and nonphysician groups.
2. Our AMA will: (a) continue to work with relevant stakeholders to recognize physician training and education and patient safety concerns, and produce advocacy tools and materials for state level advocates to use in scope of practice discussions with legislatures, including but not limited to infographics, interactive maps, scientific overviews, geographic comparisons, and educational experience; (b) advocate for the inclusion of non-physician scope of practice characteristics in various analyses of practice location attributes and desirability; (c) advocate for the inclusion of scope of practice expansion into measurements of physician well-being; and (d) study the impact of scope of practice expansion on medical student choice of specialty.
3. Our AMA will consider all available legal, regulatory, and legislative options to oppose state board decisions that increase non-physician health care provider scope of practice beyond legislative statute or regulation.

Practicing Medicine by Non-Physicians, H-160.949
Our AMA: (1) urges all people, including physicians and patients, to consider the consequences of any health care plan that places any patient care at risk by substitution of a non-physician in the diagnosis, treatment, education, direction, and medical procedures where clear-cut documentation of assured quality has not been carried out, and where such alters the traditional pattern of practice in which the physician directs and supervises the care given;

(2) continues to work with constituent societies to educate the public regarding the differences in the scopes of practice and education of physicians and non-physician health care workers;
(3) continues to actively oppose legislation allowing non-physician groups to engage in the practice of medicine without physician (MD, DO) training or appropriate physician (MD, DO) supervision;
(4) continues to encourage state medical societies to oppose state legislation allowing non-physician groups to engage in the practice of medicine without physician (MD, DO) training or appropriate physician (MD, DO) supervision;
(5) through legislative and regulatory efforts, vigorously support and advocate for the requirement of appropriate physician supervision of non-physician clinical staff in all areas of medicine; and
(6) opposes special licensing pathways for "assistant physicians" (i.e., those who are not currently enrolled in an Accreditation Council for Graduate Medical Education training program or have not completed at least one year of accredited graduate medical education in the U.S.).

The Structure and Function of Interprofessional Health Care Teams, H-160.912
1. Our AMA defines 'team-based health care' as the provision of health care services by a physician-led team of at least two health care professionals who work collaboratively with each other and the patient and family to accomplish shared goals within and across settings to achieve coordinated, high-quality, patient-centered care.
2. Our AMA will advocate that the physician leader of a physician-led interprofessional health care team be empowered to perform the full range of medical interventions that she or he is trained to perform.
3. Our AMA will advocate that all members of a physician-led interprofessional health care team be enabled to perform medical interventions that they are capable of performing according to their education, training and licensure and the discretion of the physician team leader in order to most effectively provide quality patient care.
4. Our AMA adopts the following principles to guide physician leaders of health care teams:
a. Focus the team on patient and family-centered care.
b. Make clear the team's mission, vision and values.
c. Direct and/or engage in collaboration with team members on patient care.
d. Be accountable for clinical care, quality improvement, efficiency of care, and continuing education.
e. Foster a respectful team culture and encourage team members to contribute the full extent of their professional insights, information and resources.
f. Encourage adherence to best practice protocols that team members are expected to follow.
g. Manage care transitions by the team so that they are efficient and effective, and transparent to the patient and family.
h. Promote clinical collaboration, coordination, and communication within the team to ensure efficient, quality care is provided to the patient and that knowledge and expertise from team members is shared and utilized.
i. Support open communication among and between the patient and family and the team members to enhance quality patient care and to define the roles and responsibilities of the team members that they encounter within the specific team, group or network.
j. Facilitate the work of the team and be responsible for reviewing team members' clinical work and documentation.
k. Review measures of 'population health' periodically when the team is responsible for the care of a defined group.
5. Our AMA encourages independent physician practices and small group practices to consider opportunities to form health care teams such as through independent practice associations, virtual networks or other networks of independent providers.
6. Our AMA will advocate that the structure, governance and compensation of the team should be aligned to optimize the performance of the team leader and team members.

Residents and Fellows' Bill of Rights, H-310.912
1. Our AMA continues to advocate for improvements in the ACGME Institutional and Common Program Requirements that support AMA policies as follows: a) adequate financial support for and guaranteed leave to attend professional meetings; b) submission of training verification information to requesting agencies within 30 days of the request; c) adequate compensation with consideration to local cost-of-living factors and years of training, and to include the orientation period; d) health insurance benefits to include dental and vision services; e) paid leave for all purposes (family, educational, vacation, sick) to be no less than six weeks per year; and f) stronger due process guidelines.
2. Our AMA encourages the ACGME to ensure access to educational programs and curricula as necessary to facilitate a deeper understanding by resident physicians of the US health care system and to increase their communication skills.
3. Our AMA regularly communicates to residency and fellowship programs and other GME stakeholders this Resident/Fellows Physicians' Bill of Rights.
4. Our AMA: a) will promote residency and fellowship training programs to evaluate their own institution's process for repayment and develop a leaner approach. This includes disbursement of funds by direct deposit as opposed to a paper check and an online system of applying for funds; b) encourages a system of expedited repayment for purchases of $200 or less (or an equivalent institutional threshold), for example through payment directly from their residency and fellowship programs (in contrast to following traditional workflow for reimbursement); and c) encourages training programs to develop a budget and strategy for planned expenses versus unplanned expenses, where planned expenses should be estimated using historical data, and should include trainee reimbursements for items such as educational materials, attendance at conferences, and entertaining applicants. Payment in advance or within one month of document submission is strongly recommended.
5. Our AMA will partner with ACGME and other relevant stakeholders to encourage training programs to reduce financial burdens on residents and fellows by providing employee benefits including, but not limited to, on-call meal allowances, transportation support, relocation stipends, and childcare services.

6. Our AMA will work with the Accreditation Council for Graduate Medical Education (ACGME) and other relevant stakeholders to amend the ACGME Common Program Requirements to allow flexibility in the specialty-specific ACGME program requirements enabling specialties to require salary reimbursement or "protected time" for resident and fellow education by "core faculty," program directors, and assistant/associate program directors.
7. Our AMA encourages teaching institutions to offer retirement plan options, retirement plan matching, financial advising and personal finance education.
8. Our AMA adopts the following "Residents and Fellows' Bill of Rights" as applicable to all resident and fellow physicians in ACGME-accredited training programs:

RESIDENT/FELLOW PHYSICIANS' BILL OF RIGHTS
Residents and fellows have a right to:

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

With regard to education, residents and fellows should expect: (1) A graduate medical education experience that facilitates their professional and ethical development, to include regularly scheduled didactics for which they are released from clinical duties. Service obligations should not interfere with educational opportunities and clinical education should be given priority over service obligations; (2) Faculty who devote sufficient time to the educational program to fulfill their teaching and supervisory responsibilities; (3) Adequate clerical and clinical support services that minimize the extraneous, time-consuming work that draws attention from patient care issues and offers no educational value; (4) 24-hour per day access to information resources to educate themselves further about appropriate patient care; and (5) Resources that will allow them to pursue scholarly activities to include financial support and education leave to attend professional meetings.
B. Appropriate supervision by qualified physician faculty with progressive resident responsibility toward independent practice.
With regard to supervision, residents and fellows must be ultimately supervised by physicians who are adequately qualified and allow them to assume progressive responsibility appropriate to their level of education, competence, and experience. In instances where clinical education is provided by non-physicians, there must be an identified physician supervisor providing indirect supervision, along with mechanisms for reporting inappropriate, non-physician supervision to the training program, sponsoring institution or ACGME as appropriate.
C. Regular and timely feedback and evaluation based on valid assessments of resident performance.
With regard to evaluation and assessment processes, residents and fellows should expect: (1) Timely and substantive evaluations during each rotation in which their competence is objectively assessed by faculty who have directly supervised their work; (2) To evaluate the faculty and the program confidentially and in writing at least once annually and expect that the training program will address deficiencies revealed by these evaluations in a timely fashion; (3) Access to their training file and to be made aware of the contents of their file on an annual basis; and (4) Training programs to complete primary verification/credentialing forms and recredentialing forms, apply all required signatures to the forms, and then have the forms permanently secured in their educational files at the completion of training or a period of training and, when requested by any organization involved in credentialing process, ensure the submission of those documents to the requesting organization within thirty days of the request.
D. A safe and supportive workplace with appropriate facilities.
With regard to the workplace, residents and fellows should have access to: (1) A safe workplace that enables them to fulfill their clinical duties and educational obligations; (2) Secure, clean, and comfortable on-call rooms and parking facilities which are secure and well-lit; (3) Opportunities to participate on committees whose actions may affect their education, patient care, workplace, or contract.
E. Adequate compensation and benefits that provide for resident well-being and health.
(1) With regard to contracts, residents and fellows should receive: a. Information about the interviewing residency or fellowship program including a copy of the currently used contract clearly outlining the conditions for (re)appointment, details of remuneration, specific responsibilities including call obligations, and a detailed protocol for handling any grievance; and b. At least four months advance notice of contract non-renewal and the reason for non-renewal.
(2) With regard to compensation, residents and fellows should receive: a. Compensation for time at orientation; and b. Salaries commensurate with their level of training and experience. Compensation should reflect cost of living differences based on local economic factors, such as housing, transportation, and energy costs (which affect the purchasing power of wages), and include appropriate adjustments for changes in the cost of living.
(3) With regard to benefits, residents and fellows must be fully informed of and should receive: a. Quality and affordable comprehensive medical, mental health, dental, and vision care for residents and their families, as well as retirement plan options, professional liability insurance and disability insurance to all residents for disabilities resulting from activities that are part of the educational program; b. An institutional written policy on and education in the signs of excessive fatigue, clinical depression, substance abuse and dependence, and other physician impairment issues; c. Confidential access to mental health and substance abuse services; d. A guaranteed, predetermined amount of paid vacation leave, sick leave, family and medical leave and educational/professional leave during each year in their training program, the total amount of which should not be less than six weeks; e. Leave in compliance with the Family and Medical Leave Act; and f. The conditions under which sleeping quarters, meals and laundry or their equivalent are to be provided.
F. Clinical and educational work hours that protect patient safety and facilitate resident well-being and education.
With regard to clinical and educational work hours, residents and fellows should experience: (1) A reasonable work schedule that is in compliance with clinical and educational work hour requirements set forth by the ACGME; and (2) At-home call that is not so frequent or demanding such that rest periods are significantly diminished or that clinical and educational work hour requirements are effectively circumvented. Refer to AMA Policy H-310.907, "Resident/Fellow Clinical and Educational Work Hours," for more information.

G. Due process in cases of allegations of misconduct or poor performance.
With regard to the complaints and appeals process, residents and fellows should have the opportunity to defend themselves against any allegations presented against them by a patient, health professional, or training program in accordance with the due process guidelines established by the AMA.
H. Access to and protection by institutional and accreditation authorities when reporting violations.
With regard to reporting violations to the ACGME, residents and fellows should: (1) Be informed by their program at the beginning of their training and again at each semi-annual review of the resources and processes available within the residency program for addressing resident concerns or complaints, including the program director, Residency Training Committee, and the designated institutional official; (2) Be able to file a formal complaint with the ACGME to address program violations of residency training requirements without fear of recrimination and with the guarantee of due process; and (3) Have the opportunity to address their concerns about the training program through confidential channels, including the ACGME concern process and/or the annual ACGME Resident Survey.
9. Our AMA will work with the ACGME and other relevant stakeholders to advocate for ways to defray additional costs related to residency and fellowship training, including essential amenities and/or high cost specialty-specific equipment required to perform clinical duties.
10. Our AMA believes that healthcare trainee salary, benefits, and overall compensation should, at minimum, reflect length of pre-training education, hours worked, and level of independence and complexity of care allowed by an individual's training program (for example when comparing physicians in training and midlevel providers at equal postgraduate training levels).
11.The Residents and Fellows' Bill of Rights will be prominently published online on the AMA website and disseminated to residency and fellowship programs.
12. Our AMA will distribute and promote the Residents and Fellows' Bill of Rights online and individually to residency and fellowship training programs and encourage changes to institutional processes that embody these principles.

REFERENCES

1. Functions and Structure of a Medical School: Standards for Accreditation of Medical Education Programs Leading to the MD Degree. October 2021. Liaison Committee on Medical Education. https://lcme.org/publications/ Accessed December 15, 2021.
2. Accreditation of Colleges of Osteopathic Medicine: COM Continuing Accreditation Standards. July 2019. Commission on Osteopathic College Accreditation. https://osteopathic.org/wp-content/uploads/2018/02/com-continuing-accreditation-standards.pdf Accessed December 15, 2021.
3. ACGME Common Program Requirements (Residency). July 1, 2020. Accreditation Council for Graduate Medical Education. https://www.acgme.org/globalassets/PFAssets/ProgramRequirements/CPRResidency2021.pdf Accessed December 15, 2021.
4. American Medical Association (AMA) Scope of Practice Data Series: Physician Assistants. 2021. AMA Advocacy Resource Center.
5. American Medical Association (AMA) Scope of Practice Data Series: Nurse Practitioners. 2021. AMA Advocacy Resource Center.
6. American Association of Colleges of Nursing (AACN) Accelerated Baccalaureate and Master's Degrees in Nursing. https://www.aacnnursing.org/Nursing-Education-Programs/Accelerated-Programs. Accessed on November 24, 2020
7. A. Dunker, E. Krofah, F. Isasi. *The Role of Physician Assistants in Health Care Delivery*. (Washington, D.C.: National Governor's Association Center for Best Practices, September 22, 2014).
8. Accreditation Standards for Physician Assistant Education. September 1, 2020. Accreditation Review Commission on Education for the Physician Assistant, Inc. http://www.arc-pa.org/wp-content/uploads/2021/03/Standards-5th-Ed-March-2021.pdf Accessed January 5, 2022.
9. Guidelines for the Structure and Function of a State Medical and Osteopathic Board. May 2021. Federation of State Medical Boards. https://www.fsmb.org/siteassets/advocacy/policies/guidelines-for-the-structure-and-function-of-a-state-medical-and-osteopathic-board.pdf Accessed December 20, 2021.
10. AAEM and AAEM/RSA Position Statement on Emergency Medicine Training Programs for Non-Physician Practitioners. February 26, 2020. American Academy of Emergency Medicine. https://www.aaem.org/resources/statements/position/em-training-programs-for--pas-and-nps Accessed January 10, 2022.
11. Sunset Review Oversight Report. December 31, 2020. Medical Board of California. https://www.mbc.ca.gov/Download/Reports/sunset-report-2020.pdf Accessed December 20, 2021.
12. Times Editorial Board. Editorial: Put non-physicians in charge of the state medical board. Los Angeles Times. July 6, 2021. https://www.latimes.com/opinion/story/2021-07-06/california-medical-board-reform Accessed December 20, 2021.
13. Bowden M. First non-physician leads medical board. *Des Moines Register*. June 30, 2016. https://www.desmoinesregister.com/story/opinion/columnists/iowa-view/2016/06/30/first-non-physician-leads-medical-board/86451562/ Accessed December 15, 2021.

6. CLINICAL APPLICATIONS OF PATHOLOGY AND LABORATORY MEDICINE FOR MEDICAL STUDENTS, RESIDENTS, AND FELLOWS

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS
REMAINDER OF REPORT FILED
See Policy D-155.988

INTRODUCTION

American Medical Association (AMA) Policy D-295.930, "Clinical Applications of Pathology and Laboratory Medicine for Medical Students, Residents, and Fellows," asks that our AMA study current practices within medical education regarding the clinical use of pathology and laboratory medicine information to identify potential gaps in training in the principles of decision-making and the utilization of quantitative evidence.

The policy stems from concern that inappropriate use and interpretation of laboratory and other diagnostic tests can lead to shortfalls in patient safety, harm to patients, and malpractice claims. The need for students and trainees to learn effective stewardship of health care resources is important as well.

This report focuses on existing and planned educational initiatives that are intended to help physicians and medical students develop knowledge and skills in the principles of decision-making and the utilization of quantitative evidence. The report: 1) summarizes current Liaison Committee on Medical Education (LCME) and Commission on Osteopathic College Accreditation (COCA) educational standards within medical education regarding pathology and laboratory medicine; 2) provides examples of integration of clinical pathology in medical education, 3) outlines relevant AMA policy; and 4) makes recommendations to the HOD.

BACKGROUND

Medical School Accreditation Standards Regarding Pathology and Laboratory Medicine

The LCME accredits medical education programs leading to the MD degree in the United States. Requirements related to pathology and laboratory medicine are addressed in LCME Standard 7: Curricular Content. This standard dictates that the faculty of a medical school ensure that the medical curriculum provides content of sufficient breadth and depth to prepare medical students for entry into any residency program and for the subsequent contemporary practice of medicine. For the purpose of this report, discussion of Standard 7 is limited solely to elements 7.2 and 7.4, which are outlined in further detail below:

Element 7.2: Organ Systems/Life Cycle/Prevention/Symptoms/Signs/Differential Diagnosis, Treatment Planning: The faculty of a medical school ensure that the medical curriculum includes content and clinical experiences related to each organ system; each phase of the human life cycle; continuity of care; and preventive, acute, chronic, rehabilitative, and end-of-life care.

Element 7.4: Critical Judgment/Problem-Solving Skills: The faculty of a medical school ensure that the medical curriculum incorporates the fundamental principles of medicine, provides opportunities for medical students to acquire skills of critical judgment based on evidence and experience, and develops medical students' ability to use those principles and skills effectively in solving problems of health and disease.

In assessing compliance with Standard 7.2 and 7.4, during the site visit (typically occurring every eight years), the LCME survey team asks the school to provide the following information relevant to pathology and laboratory medicine:

Standard 7.2:

1. School and national data from the AAMC Medical School Graduation Questionnaire (AAMC GQ) on the percentage of respondents who rated preparation for clinical clerkships and electives in pathology as excellent or good.

2. Data from the Independent Student Analysis (ISA) on the percentage of respondents in each class who were satisfied with the adequacy of their education in the following content areas: education to diagnose disease; education to manage disease; education in disease prevention; and education in health maintenance.

Standard 7.4:
1. Indicate whether skills of critical judgment based on evidence and skills of medical problem-solving are taught separately as an independent required course and/or as part of a required integrated course.
2. Indicate the year(s) in which the learning objectives related to skills of critical judgment based on evidence and skills of medical problem-solving are taught and assessed.

The American Osteopathic Association's COCA accredits osteopathic medical education programs leading to the Doctor of Osteopathic Medicine (DO) degree in the United States (programmatic accreditation). Requirements related to pathology and laboratory medicine are addressed in COCA Element 6.2: Osteopathic Core Competencies, which requires colleges of medicine to "teach and educate students in order to ensure the development of the seven osteopathic core competencies of medical knowledge, patient care, communication, professionalism, practice-based learning, systems-based practice, and osteopathic principles and practice/osteopathic manipulative treatment."[1] Further, Element 6.4: Clinical Education requires institutions to define the skills to be performed by the students, the appropriate clinical setting for these experiences, and the expected levels of student responsibilities.

However, these measures of how prepared students feel for their clerkships do not fully address this issue since students are unaware of their knowledge gap, and many of their clinical role models likely do not recognize this gap in their own training as evidenced by the overutilization of laboratory tests. Additionally, critical judgment and medical problem-solving courses are heavily focused on clinical presentation without the depth of understanding about laboratory tests. Education of medical students in the United States by experts on the selection of clinical laboratory tests and interpretation of the test results remains limited. Additionally, highly complex genetic testing began to emerge in the clinical laboratory shortly after the year 2000, and changes in the medical school curriculum have been occurring at a time when the clinical laboratory tests available have dramatically increased in number, complexity, and cost. The general medical student population at large has not been effectively taught when to order such complex testing and how to interpret the genetic test results. Medical students graduate with little to no education on how to order the correct tests, and only the correct tests, from the thousands of expensive assays available. A common estimate is that one out of every five tests performed is unnecessary.[2] Causes for inappropriate test ordering include personal, organizational, and technical factors. A physician's lack of knowledge on specific laboratory tests, potential insecurities regarding differential diagnosis, and lack of awareness about optimal ordering of tests contribute to the personal factors that impact overutilization. Lack of adequate supervision and feedback from supervisors on ordering behavior, a culture of not questioning which tests a supervisor suggests, and a lack of formal education in laboratory medicine contribute to organizational factors. Ease of laboratory testing and the inconvenient process of cancelling laboratory orders deemed unnecessary, contribute to the technical factors impacting test ordering.[3]

Concerns about Medical Student and Resident Knowledge of Pathology and Laboratory Medicine

Essential to becoming a competent physician is the understanding of the normal and pathological physiology of each organ system, the ability to apply knowledge of disease mechanisms to recognize pathophysiology, and the ability to continually improve one's diagnostic acumen and understanding of optimal treatment alternatives through lifelong learning. The teaching of pathology in medical education has traditionally been assigned to the preclinical years as a component of the basic science curriculum, with an emphasis on principles of pathogenesis and morphology. Historically, students have had little formal experience with the practice of anatomic and clinical pathology and their practical applications to patient care within the medical school curriculum.[4] As noted in a white paper on this topic from the College of American Pathologists (CAP) and the Association of Pathology Chairs (APC), "the lack of formal pathology education [is] an important deficit that could lead to inappropriate use of anatomic pathology and laboratory services by future clinicians in the care of their patients."[5]

Concerns regarding sufficient integration of pathology and laboratory medicine into and across the medical education continuum are warranted. Three of every four medical decisions derive from lab test evaluation, and the dramatic increase in the number of tests underscores the need for at least minimal training in the medical education continuum as well as a better understanding of evidence-based medicine across the continuum.[6] Additionally, research from the Centers for Disease Control and Prevention and others has found that poor knowledge and inappropriate use of laboratory tests by physicians are in part due to a lack of formal training during medical school.[1]

It is necessary to mention that other factors beyond medical education play a vital role toward improving diagnosis and reducing diagnostic error. For example, the National Academies of Sciences, Engineering, and Medicine (NASEM) outlined the following steps to achieve this goal:[7]

1. Facilitate more effective teamwork in the diagnostic process among health care professionals, patients, and their families.
2. Enhance health care professional education and training in the diagnostic process.
3. Ensure that health information technologies support patients and health care professionals in the diagnostic process.
4. Develop and deploy approaches to identify, learn from, and reduce diagnostic errors and near misses in clinical practice.
5. Establish a work system and culture that supports the diagnostic process and improvements in diagnostic performance.
6. Develop a reporting environment and medical liability system that facilitates improved diagnosis by learning from diagnostic errors and near misses.
7. Design a payment and care delivery environment that supports the diagnostic process.
8. Provide dedicated funding for research on the diagnostic process and diagnostic errors.

There has been a significant effort in medical education to integrate instruction in laboratory medicine into the curriculum; however, few students are participating in these courses. To quantify the deficits in teaching laboratory medicine, a 2014 study of LCME-accredited U.S. medical school programs found that 82 schools (84 percent) offered some course work in laboratory medicine incorporated within the existing curriculum and 76 schools (78 percent) required this course in laboratory medicine during the first two years. Coursework could include lectures, laboratory sessions, small-group learning, clinical consultations, and/or electronic/digital exercises. The median number of hours of instruction at the 76 schools was 12.5, with 8.0 hours devoted to lecture and 4.5 hours devoted to small-group problem-based learning and/or laboratory sessions. All the required coursework included a lecture component. Pathologists were involved in the teaching and played a leadership role at 81 schools (99 percent of the 82 schools with any laboratory medicine coursework).[8] The study also found that, in terms of lecture time, anatomic pathology ranged from 61 to 302 hours in the medical school curriculum, in contrast to time devoted to clinical pathology (laboratory medicine), which was about eight hours.[9] While there are many courses available in clinical pathology in medical institutions, these appear to be elective courses listed in the course directory, which are taken by very few students. This was evidenced in the same study which also found that 63% of respondents reported lack of student interest as a major barrier to optimizing laboratory medicine education. Thus, medical institutions have the appearance of teaching laboratory medicine, but the reality is that few students actually spend any time learning it.

Pathology Competencies for Undergraduate Medical Education

In 2014, the National Standards in Pathology were established by a national committee of experts, including anatomic pathology/laboratory medicine practitioners and experts in medical education, as well as members of the Undergraduate Medical Educators Sections (UMEDS) of the APC and/or the Group for Research in Pathology Education (GRIPE). The committee was organized into subcommittees to frame competencies into three major general domains and their subcategories: (1) interactions with the departments of pathology and laboratory medicine; (2) anatomic pathology, to include surgical pathology/cytopathology and end of life issues (autopsy, death certificates, and forensic considerations); and (3) laboratory medicine, to include basic principles of laboratory testing, transfusion medicine, clinical chemistry and immunology, hematology, microbiology, and molecular diagnostics.[1] The National Standards in Pathology were published on the APC website to highlight the proposed minimum standards for all medical students to understand for practicing medicine and remaining current with medical practice. These standards were extensively revised and peer reviewed.

These standards evolved in 2017 into the Pathology Competencies for Medical Education (PCME), an effort that was initiated by the Undergraduate Medical Education Committee of the APC. In addition to updating the 2014 National Standards in Pathology, PCME sought to (1) create a revisable document that would be able to keep pace with current medical practice and understanding; (2) emphasize laboratory medicine; and (3) develop a shared resource of pathology competencies and educational cases highlighting the competencies for pathology faculty, educators, and students, which are developed by or with pathologists, peer reviewed, and represent foundational understanding of pathobiology essential for clinical practice that could easily be adapted into any curriculum.[10]

In addition to these standards, the PCME developed current, peer-reviewed educational cases that highlight pathology competencies. The learning cases can be easily adapted to multiple educational modalities. The cases demonstrate the application of medical reasoning to clinical scenarios, allowing the learner to understand and apply diagnostic principles, incorporating morphologic findings and laboratory values with discussion of the laboratory medicine essentials for accurate diagnosis and treatment.

Integrating Pathology into Clinical Education: Vanderbilt School of Medicine "Diagnosis and Therapeutics" course

Vanderbilt School of Medicine currently offers a longitudinal experience throughout the core clerkship phase via their "Diagnosis and Therapeutics" course. Course sessions align with each clinical discipline and highlight core principles of laboratory medicine and case-based review of common testing as applied in that particular field. The course prepares students by having them review high-yield information from radiology, pharmacy, and the clinical laboratories. Students build competencies in effectively using clinical laboratory testing to diagnose patients, understanding the role of radiological imaging in differential diagnosis, determining the strengths and weaknesses of the different available therapeutic options, improving selection of tests and interpretation of test results and managing situations where additional help is needed.

Accreditation Council for Graduate Medical Education Standards

The Accreditation Council for Graduate Medical Education (ACGME) sets standards for U.S. graduate medical education (GME) residency and fellowship programs and the institutions that sponsor them and renders accreditation decisions based on compliance with these standards. The ACGME recognizes that knowledge of pathology is necessary to the practice of medicine, regardless of specialty, and mandates pathology education across many of its accredited residency and fellowship programs. Common program requirements related to the principles of decision-making and the utilization of quantitative evidence are addressed in Section IV.B. ACGME Competencies, as highlighted below:

> Section IV.B.1.b). (2): Residents must be able to perform all medical, diagnostic, and surgical procedures considered essential for the area of practice.
>
> Section IV.B.1.c): Residents must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological, and social-behavioral sciences, as well as the application of this knowledge to patient care.
>
> Section IV.B.1.d): Residents must demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and lifelong learning.
>
> Section IV.B.1.d). (1).(g): Residents must demonstrate competence in using information technology to optimize learning.
>
> Section IV.B.1.e). (1).(c): Residents must demonstrate competence in working effectively as a member or leader of a health care team or other professional group.
>
> Section IV.B.1.f): Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care, including the social determinants of health, as well as the ability to call effectively on other resources to provide optimal health care.

ACGME Review Committees may further specify additional requirements for competencies in pathology and laboratory medicine based on the medical specialty or subspecialty.

Integrating Pathology into Graduate Medical Education: Dell Medical School Department of Diagnostic Medicine

As evidence of the growing trend of medical schools integrating pathology and laboratory medicine into the curriculum, Dell Medical School at The University of Texas at Austin (Dell Med) established a Department of Diagnostic Medicine in 2017 which includes divisions of radiology and pathology. The Department of Diagnostic Medicine integrated the traditional departments of pathology, radiology, and laboratory medicine to improve accuracy in diagnoses, make testing more convenient and efficient, lower costs, and broadly integrate patient health data with

electronic health records. Dell Med earned its full accreditation by LCME and graduated its first class in 2020. The school also features a Diagnostic Radiology Residency program which earned its accreditation by the by the Accreditation Council for Graduate Medical Education in February 2021. Their inaugural residency class will begin July 2022.

Using an innovative approach to team-based care, Dell Med has activated an existing network of medical experts in the community to work collaboratively to organize diagnostic care in a way that streamlines and improves the patient experience before, during, and after testing. This unique approach also aligns with Dell Med's commitment to health informatics, broadly defined as how information technology and health data are used to improve patient care and health outcomes. To support this effort Dell Med created a Biomedical Data Science Hub in 2018. The Biomedical Data Science Hub's team of computer, information, and statistical scientists will collaborate with those at other University of Texas System entities, including the Cockrell School of Engineering, College of Natural Sciences, College of Liberal Arts, Texas Advanced Computing Center, Lyndon B. Johnson School of Public Affairs, University of Texas Health School of Public Health, and others to develop new ways to analyze complex clinical and nonclinical health-related data.

One opportunity to improve the process for educating residents on how to effectively order tests was found in the "Choose Wisely" program. To promote the effective use of health care resources, the American Board of Internal Medicine Foundation and Consumer Reports launched the "Choose Wisely" campaign in April 2012 to raise national awareness of the "Top Five" lists of tests and treatments that were overused in their specialty and did not provide meaningful benefit for patients. Following the inaugural year of the campaign, eight resident physician groups in the Department of Medicine at Vanderbilt University Medical Center were able to eliminate 1,572 redundant lab tests and help patients avoid $194,954 in medical bills.

DISCUSSION

Pathology is one of the major diagnostic disciplines with essential contributions to patient management. Magid argues that students must be educated in proper interactions with physicians/ clinical laboratory scientists in anatomic pathology and laboratory medicine to understand practical implications for patient assessment and management.[1] Nonpathology departments and GME programs often request that pathology faculty provide educational experiences to meet ACGME requirements for nonpathology trainees. Thus, pathology departments become responsible, at least in part, for the education of the majority of graduate medical trainees at a given institution.[11]

Having a national peer-reviewed repository of pathology-related competencies facilitates the use of learning objectives and educational cases in individual curricula, potentially relieving some of the load on pathology course directors to continually update curricula to keep current with the exponential expanse of knowledge, laboratory testing, and treatment options. A national repository of learning objectives and cases can be used to support pathology exposure in integrated curricula to ensure exposure to an acceptable minimum amount of pathology for all students.[6]

Inappropriate use and interpretation of laboratory and other diagnostic tests can lead to shortfalls in the quality of patient care, harm to patients, malpractice claims, and increased costs of care. Improving diagnosis in health care will require multiple interventions across the health system, including but not limited to innovations in medical education. Opportunities to improve the diagnostic process include cultivating a culture of efficient and effective intra- and interprofessional collaboration, including integration of a "diagnostic management team (DMT) model which features collaborations among pathologists, radiologists, and the treating health care professionals in order to ensure that the correct diagnostic tests are ordered and that the results are correctly interpreted and acted upon."[12] Innovative educational programs have included students and residents in DMT sessions to help learners appreciate the impact of diagnostic ordering.

As medical education prepares students and trainees on how to care for patients most effectively and efficiently, there is value in providing educational opportunities to fiscal stewardship. Physicians have an ethical obligation to be prudent stewards of the shared societal resources with which they are entrusted (*Code of Medical Ethics* 11.1.2). Programs like "Choosing Wisely" and clinical decision support systems help physicians and patients make decisions about care that are supported by evidence, not duplicative of other tests or procedures already received, free from harm, and truly necessary.

RELEVANT AMA POLICY

Among other policies that are germane to this topic, Policy H-295.995, "Recommendations for Future Directions for Medical Education," notes that "....(11) Faculties should continue to evaluate curricula periodically as a means of ensuring 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." This and other relevant AMA policies are shown in the appendix.

SUMMARY AND RECOMMENDATIONS

Accreditation entities within medical education have established competencies related to the principles of decision-making and the utilization of quantitative evidence which are available for schools to use in developing curriculum. There is a need to enhance training focus on laboratory medicine. The opportunity lies in educating and equipping students, trainees, and physicians with the effective understanding of what tests should be ordered and when the support of an expert, such as a clinical pathologist, is most beneficial. As curriculum for laboratory medicine exists but is underutilized, the AMA may be able to influence current physicians, medical students and trainees to pursue this knowledge throughout the medical education continuum.

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

1. That our AMA modify Policy D-155.988, "Support for the Concepts of the Choosing Wisely Program," by addition to read as follows:

   (1) Our AMA supports the concepts of the American Board of Internal Medicine Foundation's Choosing Wisely program.
   (2) That our AMA work with relevant stakeholders, including specialty societies in the Federation of Medicine, such as the American Society for Clinical Pathology and College of American Pathologists, to promote educational resources regarding appropriate test ordering and interpretation.

2. That our AMA rescind Policy D-295.930, "Clinical Applications of Pathology and Laboratory Medicine for Medical Students, Residents and Fellows," as having been fulfilled by this report.

APPENDIX - Relevant AMA Policy

D-295.317, "Competency Based Medical Education Across the Continuum of Education and Practice"
1. Our AMA Council on Medical Education will continue to study and identify challenges and opportunities and critical stakeholders in achieving a competency-based curriculum across the medical education continuum and other health professions that provides significant value to those participating in these curricula and their patients.
2. Our AMA Council on Medical Education will work to establish a framework of consistent vocabulary and definitions across the continuum of health sciences education that will facilitate competency-based curriculum, andragogy and assessment implementation.
3. Our AMA will continue to explore, with the Accelerating Change in Medical Education initiative and with other stakeholder organizations, the implications of shifting from time-based to competency-based medical education on residents' compensation and lifetime earnings.

H-155.998, "Voluntary Health Care Cost Containment"
(1) All physicians, including physicians in training, should become knowledgeable in all aspects of patient-related medical expenses, including hospital charges of both a service and professional nature. (2) Physicians should be cost conscious and should exercise discretion, consistent with good medical care, in determining the medical necessity for hospitalization and the specific treatment, tests and ancillary medical services to be provided a patient. (3) Medical staffs, in cooperation with hospital administrators, should embark now upon a concerted effort to educate physicians, including house staff officers, on all aspects of hospital charges, including specific medical tests, procedures, and all ancillary services. (4) Medical educators should be urged to include similar education for future physicians in the required medical school curriculum. (5) All physicians and medical staffs should join with hospital administrators and hospital governing boards nationwide in a conjoint and across-the-board effort to voluntarily contain and control the escalation of health care costs, individually and collectively, to the greatest extent possible consistent with good medical care. (6) All physicians, practicing solo or in groups, independently or in professional association,

should review their professional charges and operating overhead with the objective of providing quality medical care at optimum reasonable patient cost through appropriateness of fees and efficient office management, thus favorably moderating the rate of escalation of health care costs. (7) The AMA should widely publicize and disseminate information on activities of the AMA and state, county and national medical specialty societies which are designed to control or reduce the costs of health care.

H-295.864, "Systems-Based Practice Education for Medical Students and Resident/Fellow Physicians"
Our AMA: (1) supports the availability of educational resources and elective rotations for medical students and resident/fellow physicians on all aspects of systems-based practice, to improve awareness of and responsiveness to the larger context and system of health care and to aid in developing our next generation of physician leaders; (2) encourages development of model guidelines and curricular goals for elective courses and rotations and fellowships in systems-based practice, to be used by state and specialty societies, and explore developing an educational module on this topic as part of its Introduction to the Practice of Medicine (IPM) product; and (3) will request that undergraduate and graduate medical education accrediting bodies consider incorporation into their requirements for systems-based practice education such topics as health care policy and patient care advocacy; insurance, especially pertaining to policy coverage, claim processes, reimbursement, basic private insurance packages, Medicare, and Medicaid; the physician's role in obtaining affordable care for patients; cost awareness and risk benefit analysis in patient care; inter-professional teamwork in a physician-led team to enhance patient safety and improve patient care quality; and identification of system errors and implementation of potential systems solutions for enhanced patient safety and improved patient outcomes.

H-295.921, "Federal Intervention in the Setting of Educational Standards"
The AMA strongly opposes federal intervention, through legislative restrictions, that would limit the authority of professional accrediting bodies to design and implement appropriate educational standards for the training of physicians. The AMA strongly opposes infringements and mandates on medical school curricular requirements through state and federal legislative efforts, and also recommends that state medical societies should carefully monitor such activities and notify the AMA when such intrusions take place.

H-295.995, "Recommendations for Future Directions for Medical Education"
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.

H-310.929, “Principles for Graduate Medical Education”
Our AMA urges the Accreditation Council for Graduate Medical Education (ACGME) to incorporate these principles in its Institutional Requirements, if they are not already present. (1) PURPOSE OF GRADUATE MEDICAL EDUCATION AND ITS RELATIONSHIP TO PATIENT CARE. There must be objectives for residency education in each specialty that promote the development of the knowledge, skills, attitudes, and behavior necessary to become a competent practitioner in a recognized medical specialty. Exemplary patient care is a vital component for any residency/fellowship program. Graduate medical education enhances the quality of patient care in the institution sponsoring an accredited program. Graduate medical education must never compromise the quality of patient care. Institutions sponsoring residency programs and the director of each program must assure the highest quality of care for patients and the attainment of the program s educational objectives for the residents. (2) RELATION OF ACCREDITATION TO THE PURPOSE OF RESIDENCY TRAINING. Accreditation requirements should relate to the stated purpose of a residency program and to the knowledge, skills, attitudes, and behaviors that a resident physician should have on completing residency education. (3) EDUCATION IN THE BROAD FIELD OF MEDICINE. GME should provide a resident physician with broad clinical experiences that address the general competencies and professionalism expected of all physicians, adding depth as well as breadth to the competencies introduced in medical school. (4) SCHOLARLY ACTIVITIES FOR RESIDENTS. Graduate medical education should always occur in a milieu that includes scholarship. Resident physicians should learn to appreciate the importance of scholarly activities and should be knowledgeable about scientific method. However, the accreditation requirements, the structure, and the content of graduate medical education should be directed toward preparing physicians to practice in a medical specialty. Individual educational opportunities beyond the residency program should be provided for resident physicians who have an interest in, and show an aptitude for, academic and research pursuits. The continued development of evidence-based medicine in the graduate medical education curriculum reinforces the integrity of the scientific method in the everyday practice of clinical medicine. (5) FACULTY SCHOLARSHIP. All residency faculty members must engage in scholarly activities and/or scientific inquiry. Suitable examples of this work must not be limited to basic biomedical research. Faculty can comply with this principle through participation in scholarly meetings, journal club, lectures, and similar academic pursuits. (6) INSTITUTIONAL RESPONSIBILITY FOR PROGRAMS. Specialty-specific GME must operate under a system of institutional governance responsible for the development and implementation of policies regarding the following; the initial authorization of programs, the appointment of program directors, compliance with the accreditation requirements of the ACGME, the advancement of resident physicians, the disciplining of resident physicians when this is appropriate, the maintenance of permanent records, and the credentialing of resident physicians who successfully complete the program. If an institution closes or has to reduce the size of a residency program, the institution must inform the residents as soon as possible. Institutions must make every effort to allow residents already in the program to complete their education in the affected program. When this is not possible, institutions must assist residents to enroll in another program in which they can continue their education. Programs must also make arrangements, when necessary, for the disposition of program files so that future confirmation of the completion of residency education is possible. Institutions should allow residents to form housestaff organizations, or similar organizations, to address patient care and resident work environment concerns. Institutional committees should include resident members. (7) COMPENSATION OF RESIDENT PHYSICIANS. All residents should be compensated. Residents should receive fringe benefits, including, but not limited to, health, disability, and professional liability insurance and parental leave and should have access to other benefits offered by the institution. Residents must be informed of employment policies and fringe benefits, and their access to them. Restrictive covenants must not be required of residents or applicants for residency education. (8) LENGTH OF TRAINING. The usual duration of an accredited residency in a specialty should be defined in the Program Requirements. The required minimum duration should be the same for all programs in a specialty and should be sufficient to meet the stated objectives of residency education for the specialty and to cover the course content specified in the Program Requirements. The time required for an individual resident physician s education might be modified depending on the aptitude of the resident physician and the availability of required clinical experiences. (9) PROVISION OF FORMAL EDUCATIONAL EXPERIENCES. Graduate medical education must include a formal educational component in addition to supervised clinical experience. This component should assist resident physicians in acquiring the knowledge and skill base required for practice in the specialty. The assignment of clinical responsibility to resident physicians must permit time for study of the basic sciences and clinical pathophysiology related to the specialty. (10) INNOVATION OF GRADUATE MEDICAL EDUCATION. The requirements for accreditation of residency training should encourage educational innovation and continual improvement. New topic areas such as continuous quality improvement (CQI), outcome management, informatics and information systems, and population-based medicine should be included as appropriate to the specialty. (11) THE ENVIRONMENT OF GRADUATE MEDICAL EDUCATION. Sponsoring organizations and other GME programs must create an environment that is conducive to learning. There must be an appropriate balance between education and service. Resident physicians must be treated as colleagues. (12) SUPERVISION OF RESIDENT PHYSICIANS. Program directors must supervise and evaluate the clinical performance of resident physicians. The policies of the sponsoring institution, as enforced by the program director, and specified in the ACGME Institutional Requirements and related accreditation documents, must ensure that the clinical activities of each resident physician are supervised to a degree that reflects the ability of the resident physician and the level of responsibility for the care of patients that may be safely delegated to the resident. The sponsoring institution s GME Committee must monitor programs supervision of residents and ensure that supervision is consistent with: (A) Provision of safe and effective patient care; (B) Educational needs of residents; (C) Progressive responsibility appropriate to residents’ level of education, competence, and experience; and (D) Other applicable Common and specialty/subspecialty specific Program Requirements. The program director, in cooperation with the institution, is responsible for maintaining work schedules for each resident based on the intensity and variability of assignments in conformity with ACGME

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

H-310.960, "Resident Education in Laboratory Utilization"
Our AMA endorses the concept of practicing physicians devoting time with medical students and resident physicians for chart reviews focusing on appropriate test ordering in patient care.

H-310.968, "Opposition to Centralized Postgraduate Medical Education"
Our AMA (1) continues to support a pluralistic system of postgraduate medical education for house officer training; and (2) opposes the mandatory centralization of postgraduate medical training under the auspices of the nation's medical schools.

H-480.944, "Improving Genetic Testing and Counseling Services"
Our AMA supports: (1) appropriate utilization of genetic testing, pre- and post-test counseling for patients undergoing genetic testing, and physician preparedness in counseling patients or referring them to qualified genetics specialists; (2) the development and dissemination of guidelines for best practice standards concerning pre- and post-test genetic counseling; and (3) research and open discourse concerning issues in medical genetics, including genetic specialist workforce levels, physician preparedness in the provision of genetic testing and counseling services, and impact of genetic testing and counseling on patient care and outcomes.

REFERENCES

1. Commission on Osteopathic College Accreditation. (2019). Accreditation of Colleges of Osteopathic Medicine: COM Continuing Accreditation Standards. https://osteopathic.org/wp-content/uploads/2018/02/com-continuing-accreditation-standards.pdf. Accessed December 13, 2021.
2. M. Zhi, E.L. Ding, et al., The landscape of inappropriate laboratory testing: a 15-year meta-analysis, PloS One 8 (11) (2013) e78962, , https://doi.org/10.1371/journal.pone. 0078962.
3. Vrijsen, B. E. L., Naaktgeboren, C. A., Vos, L. M., van Solinge, W. W., Kaasjager, H. A. H., & Ten Berg, M. J. (2020). Inappropriate laboratory testing in internal medicine inpatients: prevalence, causes and interventions. *Annals of Medicine and Surgery*, *51*, 48-53.
4. Magid, M. S., Shah, D. T., Cambor, C. L., Conran, R. M., Lin, A. Y., Peerschke, E. I., ... & Harris, I. B. (2015). Consensus guidelines for practical competencies in anatomic pathology and laboratory medicine for the undifferentiated graduating medical student. *Academic pathology*, *2*(4), 2374289515605336.
5. Talbert, M. L., Ashwood, E. R., Brownlee, N. A., Clark, J. R., Horowitz, R. E., Lepoff, R. B., ... & Sodeman, T. M. (2009). Resident preparation for practice: a white paper from the College of American Pathologists and Association of Pathology Chairs. Archives of pathology & laboratory medicine, 133(7), 1139-1147.
6. Freedman, D. B. (2015). Towards better test utilization–strategies to improve physician ordering and their impact on patient outcomes. *EJIFCC*, *26*(1), 15.
7. National Academies of Sciences, Engineering, and Medicine 2015. Improving Diagnosis in Health Care. Washington, DC: The National Academies Press. https://doi.org/10.17226/21794.
8. Smith, B. R., Kamoun, M., & Hickner, J. (2016). Laboratory medicine education at US medical schools: a 2014 status report. Academic medicine: journal of the Association of American Medical Colleges, 91(1), 107.
9. Laposata M. (2016). Insufficient Teaching of Laboratory Medicine in US Medical Schools. *Academic pathology*, *3*, 2374289516634108. https://doi.org/10.1177/2374289516634108
10. Knollmann-Ritschel, B. E., Regula, D. P., Borowitz, M. J., Conran, R., & Prystowsky, M. B. (2017). Pathology competencies for medical education and educational cases. Academic pathology, 4, 2374289517715040.

11. Bean, S. M., Nagler, A., & Buckley, P. J. (2012). What are the pathology education requirements for all nonpathology ACGME-accredited programs in an academic center? American Journal of Clinical Pathology, 138(3), 327-331.
12. Govern, P. (2013). Diagnostic management efforts thrive on teamwork. http://news.vumc.org/2013/03/07/diagnostic-management-efforts-thrive-on-teamwork/. Accessed January 25, 2020.