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328* Increasing Transparency of the Resident Physician Application Process

329* Use of the Terms "Residency" and "Fellowship" by Health Professionals Outside of Medicine

* *contained in the Handbook Addendum*

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 1-A-22

Subject: Council on Medical Education Sunset Review of 2012 House Policies

Presented by: Niranjan V. Rao, MD, Chair

Referred to: Reference Committee C

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to the HOD or resolution to sunset a policy earlier than its 10-year horizon if it is no longer relevant, has been superseded by a more current policy, or has been accomplished.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. (Directive to Take Action)

Fiscal Note: $1,000.

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 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)	Retain; still relevant.
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	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:

		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)	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 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)	Rescind and incorporate into D-275.984, "Licensure and Liability for Senior Physician Volunteers," as shown below.
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	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.

		those who wish to volunteer their services to the uninsured or indigent. (BOT Rep. 17, A-04; Reaffirmed: CCB/CLRPD Rep. 1, A-14)	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; (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	Retain; still relevant, with editorial revisions as shown to reflect the full (and current) names of the organizations in clause 6.

		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. 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)	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 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.	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

		(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)	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	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."

		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.~~ 3. Our AMA will: (a) promote equal acceptance of the USMLE and COMLEX at all United States residency programs; (b) work with appropriate stakeholders including but not limited to the National Board of Medical Examiners, Association of American Medical Colleges, National Board of Osteopathic Medical Examiners, Accreditation Council for Graduate Medical Education and American Osteopathic Association to educate	

		Residency Program Directors on how to interpret and use COMLEX scores; and (c) work with Residency Program Directors to promote higher COMLEX utilization with residency program matches in light of the new single accreditation system. 4~~5~~. 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	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

		(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)	(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	Rescind; superseded by H-275.970, "Licensure Confidentiality," which reads:

		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)	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 medical licensure applications. (Res. 308, I-01; Reaffirmed:	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.

		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	Rescind; superseded by H-295.864, "Systems-Based Practice Education for Medical Students and Resident/Fellow Physicians."

		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. (Res. 801, I-07; Appended: Res. 320, A-12)	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.
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	Rescind; superseded by D-160.981 (1), "Promotion of Better Pain Care:"

		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)	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 Colleges to request that its member institutions promote equitable access to clinical electives for allopathic and osteopathic medical students and charge equitable	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."

		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	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.

		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 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 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	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). Clause 4: Rescind; the NRMP has published two articles in this regard, on applicant non-compliance and program non-compliance, respectively. 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

		consequences for both programs and applicants while maintaining the integrity of the match and protecting the identities of both programs and participants; (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 (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.	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." 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

		(CME Rep. 15, A-06; Appended: Res. 918, I-11; Appended: CME Rep. 12, A-12)	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. (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	Retain; still relevant.

		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 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	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 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

		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)	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.

REPORT 02 OF THE COUNCIL ON MEDICAL EDUCATION (A-22)
An Update on Continuing Board Certification
(Reference Committee C)

EXECUTIVE SUMMARY

The Council on Medical Education has monitored continuing board certification (CBC), formerly referred to as maintenance of certification (MOC), during the last year. This annual report, per American Medical Association (AMA) Policy D-275.954, "Continuing Board Certification," provides an update on some of the changes that have occurred as a result of collaboration among multiple stakeholder groups with active input from the AMA to improve the CBC process. Due to the impact of the COVID-19 pandemic and reprioritization of business put forth to the AMA House of Delegates (HOD), submission of this Council report was moved to the 2022 Annual Meeting.

The Continuing Board Certification: Vision for the Future Commission was established in 2018 by the American Board of Medical Specialties (ABMS) and charged with reviewing continuing certification within the current context of the medical profession. In 2019, the Commission completed its final report, which contained 14 recommendations intended to modernize CBC, with input from the AMA Council on Medical Education ("Council"). The ABMS and its member boards, in collaboration with professional organizations and other stakeholders, agreed upon and prioritized these recommendations and developed strategies to implement them. A summary of these strategies was provided in the previous annual Council report.[1] In April 2021, the ABMS released Draft Standards for Continuing Certification. These Standards reflect foundational changes to the manner in which ABMS and its member boards deliver on their mission, bringing value to both the profession and the public at large. A Call for Comments period from April-July 2021 allowed for stakeholder feedback. The ABMS Board of Directors reviewed the feedback at their October 2021 meeting and released the final standards shortly thereafter.

All ABMS member boards now offer alternatives to the historical high-stakes, 10-year examination or are administering longitudinal assessment pilots, enabling delivery of assessments that promote continual learning and are less burdensome. Appendix A in this report provides updates on these models. The ABMS member boards continue to expand the range of acceptable activities that meet the Improvement in Medical Practice (IMP) requirements in response to physician concerns about the relevance, cost, and time associated with fulfilling the IMP requirements. Appendix A also includes an update of these initiatives.

Given the consequences of the COVID-19 pandemic, several boards offered temporary changes to continuing as well as initial certification requirements, as listed in Appendix B.

The Council is committed to ensuring that CBC supports physicians' ongoing learning and practice improvement and remains actively engaged in the implementation of the Commission's recommendations and the development and release of Standards for Continuing Certification.

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 2-A-22

Subject: An Update on Continuing Board Certification

Presented by: Niranjan V. Rao, MD, Chair

Referred to: Reference Committee C

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	It is crucial for member boards to evaluate their continuing certification program on an

	their continuing certification program using appropriate data that include feedback from diplomates and other stakeholders.	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	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.

	authorities that signal a violation of the member board's professionalism policies that become known by a board must also be reviewed.	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 stakeholders, including diplomates, for the development of learning opportunities.	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 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 when necessary as determined 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." (Modify Current HOD Policy)

Fiscal Note: $3,000

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

Dermatology (ABD) abderm.org	**Part III:** Computer-based secure modular exam still administered at a proctored test center twice a year or by remote proctoring technology. Diplomates must pass the exam once every 10 years. Test preparation material available 6 months before the exam at no cost. The material includes diagnoses from which the general dermatology clinical images will be drawn and questions that will be used to generate the subspecialty modular exams. Examinees are required to take the general dermatology module, consisting of 100 clinical images to assess diagnostic skills, and can then choose among 50-item subspecialty modules.	**Part III[1]:** ABD completed trials employing remote proctoring technology to monitor exam administration in the diplomates' homes or offices. On January 6, 2020, diplomates can participate in CertLink®: • Diplomates must complete 13 questions per quarter for a total of 52 questions; • Diplomates will receive a mix of visual recognition questions, specialty area questions, and article-based questions; • Written references and online resources are allowed while answering questions; and • Diplomates are permitted to take one quarter off per year without advanced permission or penalty, using the "Time Off" feature (if diplomate opts not to take a quarter off, 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. Partnering with specialty society to transfer any MOC-related credit directly to Board.	**Part IV[2]:** ABD developed more than 40 focused practice improvement modules that are simpler to complete and cover a wide range of topics to accommodate different practice types. Peer and patient communication surveys are now optional.
Emergency Medicine (ABEM) abem.org	**Part III:** ABEM's ConCert™, computer-based, secure exam administered at a proctored test center twice a year. Diplomates must pass the exam once every 10 years. *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 IV²: 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 IV²:** 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 IV²: IMP Projects include: • Collaborative Projects: Structured projects that involve physician teams collaborating across practice sites and/or institutions to implement strategies designed to improve care. • Projects Initiated in the Workplace: These projects are based on identified gaps in quality in a local or small group setting.	**Part IV²:** ABFM developed and launched the national primary care registry (PRIME) to reduce time and reporting requirements.

	• 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 IV²: 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 IV²:** 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 individual will participate in an on-line training session and "certify" the exam computers. *The secure exam is no longer offered.*	**Part III:** In 2018, Core Neurosurgical Knowledge, an annual adaptive cognitive learning tool and modules, replaced the 10-year secure exam: • Open book exam focusing on 30 or so evidence-based practice principles critical to emergency, urgent, or critical care; • Shorter, relevant, and more focused questions than the prior exam; • Diplomates receive immediate feedback for each question and references with links and/or articles are provided; and • Web-based format with 24/7 access from the 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	**Part IV:** ABNM recognizes QI activities in which physicians participate in their clinical practice.

	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.	
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 • Participate in the ABMS multi-specialty portfolio program pathway.	**Part IV[2]:** Diplomates can choose to: • Select 3 QI journal articles from ABO's reading list and answer two questions about each article (this activity option may be used only once during each 10-year cycle). • Design a registry-based IMP Project using their AAO IRIS® Registry Data; • Create a customized, self-directed IMP activity; or • Participate in the ABMS multi-specialty portfolio program through their institution.
Orthopaedic Surgery (ABOS) abos.org	**Part III:** Computer-based secure modular exam administered at a proctored test center. Diplomates must pass the exam once every 10 years. The optional oral exam is given in Chicago in July. Diplomates without subspecialty certifications can take practice-profiled exams in orthopaedic sports medicine and surgery of the hand.	**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

	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.	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 • Online modules (PIMS)	**Part IV[2]:** ABP is enabling new pathways for pediatricians to claim Part IV QI credit for work they are already doing. These pathways are available to physicians who are engaged in QI projects alone or in groups and include a pathway for institutional leaders in quality to claim credit for their leadership. ABP is also allowing trainees (residents and fellows) to "bank" MOC credit for QI activities in which they participate. The pediatricians supervising these trainees also may claim MOC credit for qualifying projects.
Physical Medicine and Rehabilitation (ABPMR) abpmr.org	**Part III:** Computer-based secure exam administered at a proctored test center. Diplomates must pass the exam once every 10 years. Released MOC 100, a set of free practice questions pulled directly from the ABPMR exam question banks to help physicians prepare for the exam. There is a separate computer-based secure exam administered at a proctored test center that is required to maintain subspecialty certification. *After the last administration of secure exam in 2020, the exam will be replaced with the Longitudinal Assessment for PM&R (LA-PM&R).*	**Part III[1]:** 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 cases from any single index procedure every 3 years, and ABPS provides feedback on diplomate data across five index procedures in four subspecialty areas.	**Part IV:** Allowing MOC credit for IMP activities that a diplomate is engaged in through their hospital or institution. Physician participation in one of four options can satisfy the diplomate's Practice Improvement Activity: • Quality Improvement Publication • Quality Improvement Project • Registry Participation • Tracer Procedure Log
Preventive Medicine (ABPM) theabpm.org	**Part III:** In-person, pencil-and-paper, secure exam administered at 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,*	**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;

	Addiction Medicine subspecialty certification exam was administered to diplomates of any of the 24 ABMS member boards who meet the eligibility requirements.	• 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.	**Part III:** In 2018, ABS began offering shorter, more frequent, open-book, modular, lower-stakes assessments required every 2 years in place of the high-stakes exam: • Diplomates will select from four practice-related topics: general surgery, abdomen, alimentary tract, or breast; • More topics based on feedback from diplomates and surgical societies are being planned;

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

Urology (ABU) abu.org	**Part III:** Computer-based secure exam administered at a proctored test center once a year (October). Diplomates must pass the exam once every 10 years. Clinical management emphasized on the exam. Questions are derived from the American Urological Association (AUA) Self-Assessment Study Program booklets from the past five years, AUA Guidelines, and AUA Updates. Diplomates required to take the 40-question core module on general urology and choose one of four 35-question content specific modules. ABU provides increased feedback to reinforce areas of knowledge deficiency.	**Part III:** 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 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.	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.
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	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.

	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.	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 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.	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 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). • 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	▪ 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. ▪ 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.

	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 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 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	CC diplomates who expired in June 2020 – Diplomates given option to defer to May 2021 exam and certification extended until that time.

	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 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	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. 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.

	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.	
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	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.

	leave time and will not result in a mandated increase to training time.	
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. 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.	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 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)	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.

	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 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 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	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.

	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

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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

REPORT 03 OF THE COUNCIL ON MEDICAL EDUCATION (A-22)
Onsite and Subsidized Childcare for Medical Students, Residents and Fellows
(Resolution 304-J-21, Resolve 3)
(Reference Committee C)

EXECUTIVE SUMMARY

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 resident physicians 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. Annual costs of childcare range from approximately $6,000 to $33,000, depending upon the state, age of the child, and type of provider. The U.S. Department of Health and Human Services 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. The salaries of residents are low, particularly considering the number of hours they typically work and their job responsibilities; the median first year salary in 2021 was $58,650. Residents who are parents affirm that resources that would be most helpful to assist with childcare are onsite childcare with extended hours and childcare subsidies.

The struggle of juggling childcare and medical education can further increase stress for individuals who are in an environment shown to increase levels of depression and burnout. Affordable, onsite childcare with extended hours could address many of the concerns of all health care workers who are parents, and substantial subsidization of childcare expenses in locations where onsite childcare is impractical would provide additional and much needed support to families who face financial restrictions in obtaining affordable, flexible childcare. Meeting this need may place a significant financial burden on medical schools and graduate medical education institutions that may be operating on already small margins, but enabling families to provide a nurturing environment for young children is an essential goal for society.

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 3-A-22

Subject: Onsite and Subsidized Childcare for Medical Students, Residents and Fellows (Resolution 304-J-21, Resolve 3)

Presented by: Niranjan V. Rao, MD, Chair

Referred to: Reference Committee C

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. (New HOD Policy)

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. (New HOD Policy)

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

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. (Directive to Take Action)

Fiscal Note: $2,500

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

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REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 4-A-22

Subject: Protection of Terms Describing Physician Education and Practice (Resolution 305-J-21, Alternate Resolve 2)

Presented by: Niranjan V. Rao, MD, Chair

Referred to: Reference Committee C

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 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 with the public. (Directive to Take Action)

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. (Modify Current HOD Policy)

Fiscal Note: $5,000

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REPORT 5 OF THE COUNCIL ON MEDICAL EDUCATION (A-22)
Education, Training, and Credentialing of Non-Physician Health Care Providers and Their Impact on Physician Education and Training (Resolution 305-J-21, Resolve 8)
(Reference Committee C)

EXECUTIVE SUMMARY

This report is written in response to two resolves from Resolution 305-J-21, "Non-Physician Postgraduate Medical Training," which 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. One resolve, now AMA Policy D-275.949, asked:

> 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.

A second resolve was referred which asked:

> 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.

The accrediting bodies of undergraduate and graduate medical education address interprofessional education, collaboration, and supervision in their accreditation requirements. The differences in education and training between physicians and non-physicians, particularly nurse practitioners and physician assistants, is reviewed in greater detail in this report as well as support for and concerns regarding such interprofessional efforts.

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 health care providers. This may pose a conflict of interest for those non-physician health care providers who seek to practice independently of physicians. However, 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.

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 5-A-22

Subject: Education, Training, and Credentialing of Non-Physician Health Care Providers and Their Impact on Physician Education and Training (Resolution 305-J-21, Resolve 8)

Presented by: Niranjan V. Rao, MD, Chair

Referred to: Reference Committee C

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. (New HOD Policy)

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. (New HOD Policy)

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. (Reaffirm HOD Policy)

4. That our AMA encourage medical education regulatory bodies to 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. (Directive to Take Action)

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.~~ (Rescind HOD Policy)

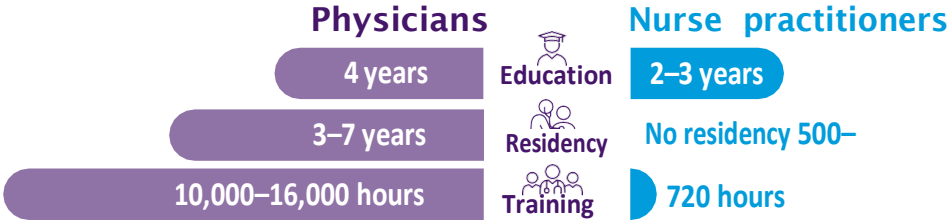
Fiscal note: $500

APPENDIX A: Physician vs Nurse Practitioner education and training

Physicians are trained to lead

AMA AMERICAN MEDICAL ASSOCIATION

With the highest level of education and 20x the clinical training



Physician education

Physician education is ...

Comprehensive: Studying all aspects of the human condition—biological, chemical, pharmacological and behavioral—in the classroom, laboratory and through direct patient care

Hands-on: Rotating through different specialties during medical school, assisting licensed physicians

Established and proven: Developing clinical judgment and medical decision-making skills through direct experience managing patients in all aspects of medicine

Physician residency is ...

Selective and specialized: Newly graduated physicians match into residency programs for 3–7 years of training in a select surgical or medical specialty

Reinforcing: Newly graduated physicians move from direct supervision to progressively increased responsibility in guided preparation for independently practicing medicine

Accredited: All residency programs are highly standardized and must be accredited by ACGME, with graded and progressive responsibility atthe core of American graduate medical education

Physician assessment and certification are ...

Thorough: Students must pass a series of exams during and following graduation from medical school, with MDs taking the USMLE and DOs taking the COMLEX

Validating: After completing an accredited residency and establishing licensed practice, physicians may obtain board certification in various specialties to further demonstrate their mastery of knowledge in a specific field of medicine

Nurse practitioner education

Nurse practitioner education is ...

Abbreviated: NPs can complete a master's (MSN) or doctorate degree (DNP), with the majority completing a master's degree in 2–3 years

Limited hands-on training: 60% of NP programs are completely or partially online

Not standardized: Unlike physician education and training there is **no** standardization for obtaining practical experience in patient care

Nurse practitioner residency is ...

Not required for graduation or licensure

Nurse practitioner assessment and certification are ...

Inconsistent: NPs must pass a national certifying exam in a specific area of focus (based on the type of program from which the NP graduated) but they are not required to practice in that area—meaning an NP certified in primary care can practice in cardiology, dermatology, neurology, orthopedics, and other specialties without any additional formal education or training

Every health care professional has an important role to play in the high-stakes field of medicine. But these high stakes demand education, experience, acumen, coordination and the robust management of care found only with physician-led teams.

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:

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

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

B. Appropriate supervision by qualified 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.

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REPORT 6 OF THE COUNCIL ON MEDICAL EDUCATION (A-22)
Clinical Applications of Pathology and Laboratory Medicine for Medical Students, Residents, and Fellows
(Reference Committee C)

EXECUTIVE SUMMARY

Essential to becoming a competent physician is the ability to continually improve one's diagnostic acumen and the understanding of optimal treatment alternatives through lifelong learning. A current area of concern in medical education is whether medical school curricula and graduate medical education programs provide sufficient training in how to order complex laboratory tests and interpret the test results. Improper application of principles of clinical pathology and laboratory medicine can result in ordering incorrect or redundant lab tests and contributes to excessive costs for care.

While there is extensive inclusion of pathology in medical school curricula, the content historically has focused on anatomic pathology, with much less emphasis on clinical pathology. This pedagogy does not align with current medical practice, in which most physicians engage more in clinical pathologic applications. Many medical schools do offer elective courses in clinical pathology, but few students participate. Thus, medical schools have the appearance of teaching pathology and meeting the standards set by both the Liaison Committee on Medical Education (LCME) and Commission on Osteopathic College Accreditation (COCA), but the reality is that in most medical schools, the balance of content in the required curriculum has not been updated to align with current practice. Similarly, graduate medical education programs are recognizing the need to enhance training for residents in appropriate and cost-effective applications of laboratory medicine.

Various stakeholders have implemented initiatives to increase the knowledge of clinical pathology among medical students and residents. In 2014, The National Standards in Pathology highlighted the proposed minimum standards for all medical students to understand for practicing medicine and remaining current with medical practice. These standards evolved in 2017 into the Pathology Competencies for Medical Education (PCME), which 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 that could easily be adapted into any curriculum. The Vanderbilt School of Medicine Diagnostics and Therapeutics course and Dell Medical School Department of Diagnostic Medicine are two examples of clinical pathology integration into medical education curriculum. Additionally, innovative programs like "Choosing Wisely" can be applied in medical school and graduate medical education to bolster learning in clinical pathology and laboratory medicine.

Improving the use of clinical pathology diagnostic tools in health care will require multiple interventions across the health system, including but not limited to innovations in medical education.

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 6-A-22

Subject: Clinical Applications of Pathology and Laboratory Medicine for Medical Students, Residents, and Fellows

Presented by: Niranjan V. Rao, MD, Chair

Referred to: Reference Committee C

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) Our AMA will promote awareness of the Choosing Wisely initiative and encourage medical schools and their teaching hospitals to incorporate concepts from the campaign into their educational offerings. (Modify Current HOD Policy)

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. (Rescind HOD Policy)

Fiscal note: $5,000.

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.

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 301
(A-22)

Introduced by: New York

Subject: Medical Education Debt Cancellation in the Face of a Physician Shortage During the COVID-19 Pandemic

Referred to: Reference Committee C

Whereas, There is a physician shortage facing our nation; and[i]

Whereas, The shortage is going to worsen since 2 of 5 current physicians will be 65 years or older and in retirement age this year; and[i]

Whereas, The shortage is amplified now during the COVID-19 pandemic, demonstrating now more than ever the need for a sufficient and robust physician workforce; and[i]

Whereas, An unprecedented number of physicians now plan to retire in the next year and many of whom are under 45 years old and therefore would be retiring earlier than expected by workforce shortage predictors due to COVID-19; and[ii]

Whereas, 8% of physicians surveyed across the United States have closed their practices during the pandemic, amounting to approximately 16,000 closed practices further exacerbating the shortage of healthcare providers; and[iii]

Whereas, The COVID-19 pandemic has placed immense financial strain on physicians across specialties who have reported loss of staff, lack of reimbursement, and closure of independent physician practices during the COVID-19 pandemic; and[iii,iv]

Whereas, Young physicians are expected to be part of the workforce for many years to come, yet the majority of healthcare workers (HCW) who died during the COVID-19 pandemic were under 60 years old with primary care physicians (PCPs) accounting for a disproportionate number of these HCW deaths; and[v,vi]

Whereas, Before the pandemic, the physician shortage in New York State (NYS) was already predicted to be between 2,500 and 17,000 by 2030; and[vii]

Whereas, During the pandemic, the shortage has been amplified in that New York City has had the highest COVID-19 death rate in the country with NYS accounting for the greatest number of HCW deaths in the USA; and[v,viii]

Whereas, 73% of medical students graduated with debt in 2020; and[ix]

Whereas, The cost of medical school has increased 129% in the past 20 years after adjusting for inflation, affecting newer generations of students and physicians substantially more than past ones; and[x]

Whereas, The average medical student debt is $207,003--an approximately 28% increase in the past 10 years--however, the average physician ultimately pays $365,000-$440,000 for an educational loan with interest; and[ix,x,xi]

Whereas, In the United States, 50% of low-income medical school graduates have educational debt that exceeds $100,000; and[x]

Whereas, The financial barrier to entry into medical school is significant in that over half of medical students belong to the top quintile of US household income, with 20-30% of students belonging to the top 5% of income; however, only less than 5% of students come from the lowest quintile of US household income; and[x]

Whereas, A recent study found that higher debt levels among medical students is more likely to motivate them to choose higher paying specialties than primary care specialties; and[xii]

Whereas, Higher burdens of educational debt has been demonstrated to cause residents to place greater emphasis on financial considerations when choosing a specialty; and[xiii]

Whereas, The COVID-19 pandemic is producing a secondary surge in primary care need that has been studied previously in natural disasters and has been shown to persist for years; and[xiv,xv]

Whereas, It is well-established that health inequities existed before the pandemic in that individuals with low socioeconomic status are more likely to also be from minority populations, and are more likely to have worse health outcomes; and[xvi]

Whereas, These inequities have now been exacerbated by the pandemic, with the heaviest burden of COVID-19 disease falling upon Black, Latinx, and immigrant communities; and[xvii]

Whereas, Over 27 million Americans have lost their employer-sponsored health insurance during the pandemic; thus, we will need more physicians now than ever before to address these disparities and rising needs in health care; and[xviii]

Whereas, 72% of physicians surveyed across specialties reported loss of income during the pandemic, with over half of these respondents reporting losses of 26% or more; and[iii]

Whereas, Policies modeled to include provisions for debt relief or increase in incomes were found by one study to be more likely to incentivize students to choose primary care physician specialties; and[xix]

Whereas, Current AMA policies support methods to alleviate debt burden but do not address debt cancellation specifically; and

Whereas, $50 billion of the initial CARES Act Provider Relief Fund were allocated to support the current healthcare system by giving hospitals and providers funding “to support health care-related expenses or lost revenue attributable to COVID-19...”; however, funding formulas based on market shares of Medicare costs and total patient revenue are most likely to bankrupt independent physicians, specifically primary care providers; and[xx,xxi]

Whereas, One study found that primary care internists whose medical education were funded through Public Service Loan Forgiveness and Federally Granted Loans were predicted to have

significantly less net present value than primary care internists who received military or private funding; and[xxii]

Whereas, Medical education debt has been shown to be a significant barrier for underrepresented minorities and low/middle income strata students to choose medicine for a career; and[xxii]

Whereas, A key strategy to address health needs of underserved communities involves recruiting students from these communities as they may be more likely to return to address local health needs; and[xxiii]

Whereas, One medical school has created a debt-free program for matriculated students and saw (1) an increase in applicants to supply the future physician workforce and (2) an increase in applicants from groups underrepresented in medicine to help address socioeconomic and racial/ethnic disparities in the medical workforce and in healthcare; and[xxiv]

Whereas, There is currently a student debt forgiveness resolution in the United States Senate to cancel $50,000 of student debt which will also apply to all medical students, training physicians, and early career physicians; and[xxv]

Whereas, Data suggests women and people of color will benefit most from such debt cancellation because they are most in need; therefore be it[xxv]

RESOLVED, That our American Medical Association study the issue of medical education debt cancellation and consider the opportunities for integration of this into a broader solution addressing debt for all medical students, physicians in training, and early career physicians. (Directive to Take Action)

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

Received: 03/22/22

RELEVANT AMA POLICY

Cares Act Equity and Loan Forgiveness in the Medicare Accelerated Payment Program D-305.953
In the setting of the COVID-19 pandemic, our AMA will advocate for additional financial relief for physicians to reduce medical school educational debt.
Citation: Res. 202, I-20

Principles of and Actions to Address Medical Education Costs and Student Debt H-305.925
The costs of medical education should never be a barrier to the pursuit of a career in medicine nor to the decision to practice in a given specialty. To help address this issue, our American Medical Association (AMA) will:
1. Collaborate with members of the Federation and the medical education community, and with other interested organizations, to address the cost of medical education and medical student debt through public- and private-sector advocacy.
2. Vigorously advocate for and support expansion of and adequate funding for federal scholarship and loan repayment programs--such as those from the National Health Service Corps, Indian Health Service, Armed Forces, and Department of Veterans Affairs, and for comparable programs from states and the private sector--to promote practice in underserved areas, the military, and academic medicine or clinical research.
3. Encourage the expansion of National Institutes of Health programs that provide loan repayment in exchange for a commitment to conduct targeted research.
4. Advocate for increased funding for the National Health Service Corps Loan Repayment Program to assure adequate funding of primary care within the National Health Service Corps, as well as to permit:

(a) inclusion of all medical specialties in need, and (b) service in clinical settings that care for the underserved but are not necessarily located in health professions shortage areas.
5. Encourage the National Health Service Corps to have repayment policies that are consistent with other federal loan forgiveness programs, thereby decreasing the amount of loans in default and increasing the number of physicians practicing in underserved areas.
6. Work to reinstate the economic hardship deferment qualification criterion known as the “20/220 pathway,” and support alternate mechanisms that better address the financial needs of trainees with educational debt.
7. Advocate for federal legislation to support the creation of student loan savings accounts that allow for pre-tax dollars to be used to pay for student loans.
8. Work with other concerned organizations to advocate for legislation and regulation that would result in favorable terms and conditions for borrowing and for loan repayment, and would permit 100% tax deductibility of interest on student loans and elimination of taxes on aid from service-based programs.
9. Encourage the creation of private-sector financial aid programs with favorable interest rates or service obligations (such as community- or institution-based loan repayment programs or state medical society loan programs).
10. Support stable funding for medical education programs to limit excessive tuition increases, and collect and disseminate information on medical school programs that cap medical education debt, including the types of debt management education that are provided.
11. Work with state medical societies to advocate for the creation of either tuition caps or, if caps are not feasible, pre-defined tuition increases, so that medical students will be aware of their tuition and fee costs for the total period of their enrollment.
12. Encourage medical schools to (a) Study the costs and benefits associated with non-traditional instructional formats (such as online and distance learning, and combined baccalaureate/MD or DO programs) to determine if cost savings to medical schools and to medical students could be realized without jeopardizing the quality of medical education; (b) Engage in fundraising activities to increase the availability of scholarship support, with the support of the Federation, medical schools, and state and specialty medical societies, and develop or enhance financial aid opportunities for medical students, such as self-managed, low-interest loan programs; (c) Cooperate with postsecondary institutions to establish collaborative debt counseling for entering first-year medical students; (d) Allow for flexible scheduling for medical students who encounter financial difficulties that can be remedied only by employment, and consider creating opportunities for paid employment for medical students; (e) Counsel individual medical student borrowers on the status of their indebtedness and payment schedules prior to their graduation; (f) Inform students of all government loan opportunities and disclose the reasons that preferred lenders were chosen; (g) Ensure that all medical student fees are earmarked for specific and well-defined purposes, and avoid charging any overly broad and ill-defined fees, such as but not limited to professional fees; (h) Use their collective purchasing power to obtain discounts for their students on necessary medical equipment, textbooks, and other educational supplies; (i) Work to ensure stable funding, to eliminate the need for increases in tuition and fees to compensate for unanticipated decreases in other sources of revenue; mid-year and retroactive tuition increases should be opposed.
13. Support and encourage state medical societies to support further expansion of state loan repayment programs, particularly those that encompass physicians in non-primary care specialties.
14. Take an active advocacy role during reauthorization of the Higher Education Act and similar legislation, to achieve the following goals: (a) Eliminating the single holder rule; (b) Making the availability of loan deferment more flexible, including broadening the definition of economic hardship and expanding the period for loan deferment to include the entire length of residency and fellowship training; (c) Retaining the option of loan forbearance for residents ineligible for loan deferment; (d) Including, explicitly, dependent care expenses in the definition of the “cost of attendance”; (e) Including room and board expenses in the definition of tax-exempt scholarship income; (f) Continuing the federal Direct Loan Consolidation program, including the ability to “lock in” a fixed interest rate, and giving consideration to grace periods in renewals of federal loan programs; (g) Adding the ability to refinance Federal Consolidation Loans; (h) Eliminating the cap on the student loan interest deduction; (i) Increasing the income limits for taking the interest deduction; (j) Making permanent the education tax incentives that our AMA successfully lobbied for as part of Economic Growth and Tax Relief Reconciliation Act of 2001; (k) Ensuring that loan repayment programs do not place greater burdens upon married couples than for similarly situated couples who are cohabitating; (l) Increasing efforts to collect overdue debts from the present medical student loan programs in a manner that would not interfere with the provision of future loan funds to medical students.

15. Continue to work with state and county medical societies to advocate for adequate levels of medical school funding and to oppose legislative or regulatory provisions that would result in significant or unplanned tuition increases.
16. Continue to study medical education financing, so as to identify long-term strategies to mitigate the debt burden of medical students, and monitor the short-and long-term impact of the economic environment on the availability of institutional and external sources of financial aid for medical students, as well as on choice of specialty and practice location.
17. Collect and disseminate information on successful strategies used by medical schools to cap or reduce tuition.
18. Continue to monitor the availability of and encourage medical schools and residency/fellowship programs to (a) provide financial aid opportunities and financial planning/debt management counseling to medical students and resident/fellow physicians; (b) work with key stakeholders to develop and disseminate standardized information on these topics for use by medical students, resident/fellow physicians, and young physicians; and (c) share innovative approaches with the medical education community.
19. Seek federal legislation or rule changes that would stop Medicare and Medicaid decertification of physicians due to unpaid student loan debt. The AMA believes that it is improper for physicians not to repay their educational loans, but assistance should be available to those physicians who are experiencing hardship in meeting their obligations.
20. Related to the Public Service Loan Forgiveness (PSLF) Program, our AMA supports increased medical student and physician participation in the program, and will: (a) Advocate that all resident/fellow physicians have access to PSLF during their training years; (b) Advocate against a monetary cap on PSLF and other federal loan forgiveness programs; (c) Work with the United States Department of Education to ensure that any cap on loan forgiveness under PSLF be at least equal to the principal amount borrowed; (d) Ask the United States Department of Education to include all terms of PSLF in the contractual obligations of the Master Promissory Note; (e) Encourage the Accreditation Council for Graduate Medical Education (ACGME) to require residency/fellowship programs to include within the terms, conditions, and benefits of program appointment information on the employer's PSLF program qualifying status; (f) Advocate that the profit status of a physician's training institution not be a factor for PSLF eligibility; (g) Encourage medical school financial advisors to counsel wise borrowing by medical students, in the event that the PSLF program is eliminated or severely curtailed; (h) Encourage medical school financial advisors to increase medical student engagement in service-based loan repayment options, and other federal and military programs, as an attractive alternative to the PSLF in terms of financial prospects as well as providing the opportunity to provide care in medically underserved areas; (i) Strongly advocate that the terms of the PSLF that existed at the time of the agreement remain unchanged for any program participant in the event of any future restrictive changes; (j) Monitor the denial rates for physician applicants to the PSLF; (k) Undertake expanded federal advocacy, in the event denial rates for physician applicants are unexpectedly high, to encourage release of information on the basis for the high denial rates, increased transparency and streamlining of program requirements, consistent and accurate communication between loan servicers and borrowers, and clear expectations regarding oversight and accountability of the loan servicers responsible for the program; (l) Work with the United States Department of Education to ensure that applicants to the PSLF and its supplemental extensions, such as Temporary Expanded Public Service Loan Forgiveness (TEPSLF), are provided with the necessary information to successfully complete the program(s) in a timely manner; and (m) Work with the United States Department of Education to ensure that individuals who would otherwise qualify for PSLF and its supplemental extensions, such as TEPSLF, are not disqualified from the program(s).
21. Advocate for continued funding of programs including Income-Driven Repayment plans for the benefit of reducing medical student load burden.
22. Strongly advocate for the passage of legislation to allow medical students, residents and fellows who have education loans to qualify for interest-free deferment on their student loans while serving in a medical internship, residency, or fellowship program, as well as permitting the conversion of currently unsubsidized Stafford and Graduate Plus loans to interest free status for the duration of undergraduate and graduate medical education.
Citation: CME Report 05, I-18; Appended: Res. 953, I-18; Reaffirmation: A-19; Appended: Res. 316, A-19; Appended: Res. 226, A-21; Reaffirmed in lieu of: Res. 311, A-21; Modified: CME Rep. 4, I-21

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 302
(A-22)

Introduced by: Resident and Fellow Section

Subject: Resident and Fellow Access to Fertility Preservation

Referred to: Reference Committee C

Whereas, The average age at completion of medical training in the United States is approximately 31.6 years overall[1] and 36.8 years for surgical trainees[2]; and

Whereas, Female fertility is known to decrease substantially after age 35,[3,4] with a nearly 50% drop from the early 20s to late 30s[5]; and

Whereas, Female physicians have a chance of infertility that is twice that of the general population (24.1% vs. 10.9%), with an average age at diagnosis of 33.7 years[1]; and

Whereas, The demands of residency increase the risk of pregnancy complications, with a higher rate of gestational hypertension, placental abruption, preterm labor, and intrauterine growth restriction among female residents[6–8]; and

Whereas, A majority of recent trainees perceive a stigma associated with pregnancy during training[9] and have concerns about workplace support,[10] which may deter medical students from choosing a career in a surgical or other field with longer and demanding training; and

Whereas, Approximately one third of program directors have reported discouraging pregnancy among residents in surgical training programs[10]; and

Whereas, Oocyte cryopreservation is an established method of preserving fertility[11] that can cost $10,000 per cycle, often with multiple cycles required, and $500 per year for storage,[12] in addition to requiring timely injection of ovarian stimulation medications and numerous outpatient visits for cycle monitoring and egg retrieval[13]; and

Whereas, Companies such as Google, Apple, and Facebook have been offering oocyte cryopreservation benefits to their workforce, who are similarly largely of reproductive age, for several years[14]; therefore be it

RESOLVED, That our American Medical Association support education for residents and fellows regarding the natural course of female fertility in relation to the timing of medical education, and the option of fertility preservation and infertility treatment (New HOD Policy); and be it further

RESOLVED, That our AMA advocate inclusion of insurance coverage for fertility preservation and infertility treatment within health insurance benefits for residents and fellows offered through graduate medical education programs (Directive to Take Action); and be it further

RESOLVED, That our AMA support the accommodation of residents and fellows who elect to pursue fertility preservation and infertility treatment, including the need to attend medical visits to complete the oocyte preservation process and to administer medications in a time-sensitive fashion. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

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RELEVANT AMA POLICY

Disclosure of Risk to Fertility with Gonadotoxic Treatment H-425.967

Our AMA: (1) supports as best practice the disclosure to cancer and other patients of risks to fertility when gonadotoxic treatment is used; and (2) supports ongoing education for providers who counsel patients who may benefit from fertility preservation.
Citation: Res. 512, A-19

Infertility and Fertility Preservation Insurance Coverage H-185.990

1. Our AMA encourages third party payer health insurance carriers to make available insurance benefits for the diagnosis and treatment of recognized male and female infertility.
2. Our AMA supports payment for fertility preservation therapy services by all payers when iatrogenic infertility may be caused directly or indirectly by necessary medical treatments as determined by a licensed physician and will lobby for appropriate federal legislation requiring payment for fertility preservation therapy services by all payers when iatrogenic infertility may be caused directly or indirectly by necessary medical treatments as determined by a licensed physician.
Citation: Res. 150, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CMS Rep. 4, A-08; Appended: Res. 114, A-13; Modified: Res. 809, I-14

Infertility Benefits for Veterans H-510.984

1. Our AMA supports lifting the congressional ban on the Department of Veterans Affairs (VA) from covering in vitro fertilization (IVF) costs for veterans who have become infertile due to service-related injuries.

2. Our AMA encourages interested stakeholders to collaborate in lifting the congressional ban on the VA from covering IVF costs for veterans who have become infertile due to service-related injuries.
3. Our AMA encourages the Department of Defense (DOD) to offer service members fertility counseling and information on relevant health care benefits provided through TRICARE and the VA at pre-deployment and during the medical discharge process.
4. Our AMA supports efforts by the DOD and VA to offer service members comprehensive health care services to preserve their ability to conceive a child and provide treatment within the standard of care to address infertility due to service-related injuries. Citation: CMS Rep. 01, I-16Appended: Res. 513, A-19

Right for Gamete Preservation Therapies H-65.956
1. Fertility preservation services are recognized by our AMA as an option for the members of the transgender and non-binary community who wish to preserve future fertility through gamete preservation prior to undergoing gender affirming medical or surgical therapies.
2. Our AMA supports the right of transgender or non-binary individuals to seek gamete preservation therapies. Citation: Res. 005, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 303
(A-22)

Introduced by: Women Physicians Section

Subject: Fatigue Mitigation Respite for Faculty and Residents

Referred to: Reference Committee C

Whereas, During the COVID-19 pandemic, physicians have been on the front lines, and have experienced increased duress and extreme fatigue during the case surges as hospitals are overrun with patients; and

Whereas, Longer shifts, disruptions to sleep and to work-life balance, and occupational hazards associated with exposure to COVID-19 have contributed to physical and mental fatigue; and

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

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

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

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

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

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

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

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

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

RESOLVED, That our American Medical Association make available resources to institutions and physicians that support self-care and fatigue mitigation, help protect physician health and well-being, and model appropriate health promoting behaviors (Directive to Take Action); and be it further

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

Fiscal Note: Minimal - less than $1,000

Received: 03/31/22

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RELEVANT AMA POLICY

Resident/Fellow Clinical and Educational Work Hours H-310.907
Our AMA adopts the following Principles of Resident/Fellow Clinical and Educational Work Hours, Patient Safety, and Quality of Physician Training:
1. Our AMA supports the 2017 Accreditation Council for Graduate Medical Education (ACGME) standards for clinical and educational work hours (previously referred to as "duty hours").
2. Our AMA will continue to monitor the enforcement and impact of clinical and educational work hour standards, in the context of the larger issues of patient safety and the optimal learning environment for residents.
3. Our AMA encourages publication and supports dissemination of studies in peer-reviewed publications and educational sessions about all aspects of clinical and educational work hours, to include such topics as extended work shifts, handoffs, in-house call and at-home call, level of supervision by attending physicians, workload and growing service demands, moonlighting, protected sleep periods, sleep deprivation and fatigue, patient safety, medical error, continuity of care, resident well-being and burnout, development of professionalism, resident learning outcomes, and preparation for independent practice.
4. Our AMA endorses the study of innovative models of clinical and educational work hour requirements and, pending the outcomes of ongoing and future research, should consider the evolution of specialty- and rotation-

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

m) Program directors should establish guidelines for scheduled work outside of the residency program, such as moonlighting, and must approve and monitor that work such that it does not interfere with the ability of the resident to achieve the goals and objectives of the educational program.
n) The costs of clinical and educational work hour limits should be borne by all health care payers. Individual resident compensation and benefits must not be compromised or decreased as a result of changes in the graduate medical education system.
o) The general public should be made aware of the many contributions of resident/fellow physicians to high-quality patient care and the importance of trainees' realizing their limits (under proper supervision) so that they will be able to competently and independently practice under real-world medical situations.
8. Our AMA is in full support of the collaborative partnership between allopathic and osteopathic professional and accrediting bodies in developing a unified system of residency/fellowship accreditation for all residents and fellows, with the overall goal of ensuring patient safety.
9. Our AMA will actively participate in ongoing efforts to monitor the impact of clinical and educational work hour limitations to ensure that patient safety and physician well-being are not jeopardized by excessive demands on post-residency physicians, including program directors and attending physicians.
Citation: CME Rep. 5, A-14; Modified: CME Rep. 06, I-18

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

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 304
(A-22)

Introduced by: Resident and Fellow Section

Subject: Organizational Accountability to Resident and Fellow Trainees

Referred to: Reference Committee C

Whereas, The stated mission of the Accreditation Council for Graduate Medical Education (ACGME) is to, "improve healthcare and population health by assessing and advancing the quality of resident physicians' education through accreditation"[1]; and

Whereas, To achieve its mission the ACGME has determined that it has two main purposes: "(1) to establish and maintain accreditation standards that promote the educational quality of residency and subspecialty training programs; and (2) to promote conduct of the residency educational mission with sensitivity to the safety of care rendered to patients and in a humane environment that fosters the welfare, learning, and professionalism of residents,"[1]; and

Whereas, While the ACGME has taken steps to advocate for residents, its ability to effectively and timely work on their behalf is limited by "blunt tools" related to removal of accreditation and delay in providing feedback to programs[3]; and

Whereas, Our AMA Residents and Fellows' Bill of Rights (H-310.912) establishes that residents and fellows have rights to: (1) have a safe workspace that enables them to fulfill their clinical duties and educational obligations; (2) defend themselves against any allegations presented by a patient, health professional, or training program in accordance with due process guidelines established by the AMA; (3) 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 (4) confidentially evaluate faculty and programs and expect that the training program will address deficiencies by these evaluations in a timely fashion[4]; and

Whereas, Resident and fellow trainees still endure suboptimal training conditions, with recourse to address these issues limited by multiple factors including a high debt burden and fear of their program losing accreditation thus affecting future career prospects, which ultimately makes reporting even gross ACGME guideline infractions difficult to encourage[5,6]; and

Whereas, During the COVID-19 pandemic, residents and fellow trainees have been particularly susceptible to poor conditions including limited availability of personal protective equipment (PPE), longer work hours, lack of hazard pay or similar programs, redeployment into other specialties which may or may not be relevant to education in their own specialty, and difficulty in securing workers' compensation in the event of severe illness, with many programs revoking promised stipend increases[6]; and

Whereas, The rate of closure of family medicine residency programs is increasing, and the Federation of State Medical Boards (FSMB) has records of over 50 hospitals with accredited training programs that have closed, with indications that more closures can be expected across the country in multiple specialties[7,8]; and

Whereas, As exemplified by the Hahnemann University Hospital closure, residents and fellow trainees are vulnerable to the negative effects of hospital closures that threaten the quality and completion of their graduate medical education, financial wellbeing, and legal status within the United States,[9,10]; and

Whereas, Numerous organizations such as the ACGME, AMA, American Osteopathic Association (AOA), American Board of Medical Specialties (ABMS), Association of American Medical Colleges (AAMC), Council of Medical Specialty Societies, National Board of Medical Examiners (NBME), Pennsylvania Medical Society (PAMED), Philadelphia County Medical Society (PCMS), and Educational Commission for Foreign Medical Graduates (ECFMG) responded to the Hahnemann closure as well as other residency closures with offers of legal assistance, grants, visa assistance, tail-insurance coverage, and other forms of support[11]; and

Whereas, The majority of funding for Graduate Medical Education (GME) is through Medicare and Medicaid, with additional funding through the U.S. Department of Veteran Affairs (VA) and Health Resources and Services Administration (HRSA), as well as private hospital funding[12]; and

Whereas, The Centers for Medicare & Medicaid Services (CMS) is tasked with distributing the majority of GME funding, but is not responsible for overseeing the quality of training programs nor the wellness or treatment of trainees[12]; and

Whereas, None of the organizations that responded to the Hahnemann residency closures were required to by law, nor was the response coordinated, regulated, or monitored by any type of oversight organization with regards to resident and fellow interests, and an ACGME investigation of the closure of the Hahnemann University Hospital found that no existing organizations represented resident and fellow interests to the exclusion of other stakeholder interests.[3,11]; therefore be it

RESOLVED, That our American Medical Association work with relevant stakeholders to: (1) determine which organizations or governmental entities are best suited for being permanently responsible for resident and fellow interests without conflicts of interests; (2) determine how organizations can be held accountable for fulfilling their duties to protect the rights and wellbeing of resident and fellow trainees as detailed in the Residents and Fellows' Bill of Rights; (3) determine methods of advocating for residents and fellows that are timely and effective without jeopardizing trainees' current and future employability; (4) study and report back by the 2023 Annual Meeting on how such an organization may be created, in the event that no organizations or entities are identified that meet the above criteria; and (5) determine transparent methods to communicate available residency positions to displaced residents. (Directive to Take Action)

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

Received: 04/04/22

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RELEVANT AMA POLICY

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:

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

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

B. Appropriate supervision by qualified 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.
Citation: CME Rep. 8, A-11; Appended: Res. 303, A-14; Reaffirmed: Res. 915, I-15; Appended: CME Rep. 04, A-16; Modified: CME Rep. 06, I-18; Appended: Res. 324, A-19; Modified: Res. 304, A-21; Modified: Res. 305, A-21; Modified: BOT Rep. 18, I-21

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 305
(A-22)

Introduced by: Resident and Fellow Section

Subject: Reducing Overall Fees and Making Costs for Licensing, Exam Fees, Application Fees, etc., Equitable for IMGS

Referred to: Reference Committee C

Whereas, United States Medical Licensing Examination (USMLE) fees are steep as a US medical student: Step 1 $645, Step 2 $6451,2; and

Whereas, USMLE fees are even higher for International Medical Graduates (IMGs): Step 1 $975, Step 2 $975[3]; and

Whereas, If a medical student takes the USMLE Step 1 or 2 exams outside the US, there is an additional delivery fee of the electronic test of $180 for Step 1 and $200 for Step 2[4]; and

Whereas, In 2020, over 52,000 US MD/DO and IMG applicants applied to residencies (over $38M for US MD/DO med students and over $40M for IMGs in USMLE Step 1 and 2 fees)[5]; and

Whereas, In 2018, 21,393 graduates applied for Educational Commission for Foreign Medical Graduates (ECFMG) certification and only 9,431 were certified[6]; and

Whereas, ECFMG certification ($60 in 2013; $150 in 2021) is required to take USMLE Step 3 for IMGs: primary source of verification of credentials ($60) + passing USMLE exams[3,7]; and

Whereas, In 2019, IMGs constituted 22% of physicians in training in residency, yet their costs to apply to become physicians in the US is much greater than their US counterparts[8]; and

Whereas, During the COVID-19 pandemic and suspension of USMLE Step 2 CS, ECFMG required IMGs to pass an Occupational English Test (OET) ($444) (online courses available for purchase from official OET sites), if students fit within 5 defined pathways ($900)[9,10]; and

Whereas, Prior to the cancellation of the USMLE Step 2 CS exam, examination fees rose year after year, but even more so for IMGs (~ $1600 in 2020, up from ~$1420 in 2013) compared to US counterparts (~ $1280 in 2020, up from ~$1200 in 2013)[11]; and

Whereas, ECFMG also provides an alternative way to verify credentials through Electronic Portfolio of International Credentials (EPIC) that costs $130 ($125 in 2020) and $100 ($90 in 2020) to confirm each credential and costs $50 to deliver each subsequent EPIC report[12]; and

Whereas, The ECFMG net assets in 2018 were $151,818,498[13]; therefore be it

RESOLVED, That our American Medical Association work with all relevant stakeholders to reduce application, exam, licensing fees and related financial burdens for international medical graduates (IMGs) to ensure cost equity with US MD and DO trainees (Directive to Take Action); and be it further

RESOLVED, That our AMA amend current policy H-255.966, "Abolish Discrimination in Licensure of IMGs," by addition to read as follows:

2. Our AMA will continue to work with the FSMB to encourage parity in licensure requirements, and associated costs, for all physicians, whether U.S. medical school graduates or international medical graduates. (Modify Current HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 04/04/22

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RELEVANT AMA POLICY

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 D-275.950
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.
Citation: Res. 306, I-20

AMA Principles on International Medical Graduates H-255.988
Our AMA supports:
1. Current U.S. visa and immigration requirements applicable to foreign national physicians who are graduates of medical schools other than those in the United States and Canada.
2. Current regulations governing the issuance of exchange visitor visas to foreign national IMGs, including the requirements for successful completion of the USMLE.
3. The AMA reaffirms its policy that the U.S. and Canada medical schools be accredited by a nongovernmental accrediting body.
4. Cooperation in the collection and analysis of information on medical schools in nations other than the U.S. and Canada.
5. Continued cooperation with the ECFMG and other appropriate organizations to disseminate information to prospective and current students in foreign medical schools. An AMA member, who is an IMG, should be appointed regularly as one of the AMA's representatives to the ECFMG Board of Trustees.

6. Working with the Accreditation Council for Graduate Medical Education (ACGME) and the Federation of State Medical Boards (FSMB) to assure that institutions offering accredited residencies, residency program directors, and U.S. licensing authorities do not deviate from established standards when evaluating graduates of foreign medical schools.
7. In cooperation with the ACGME and the FSMB, supports only those modifications in established graduate medical education or licensing standards designed to enhance the quality of medical education and patient care.
8. The AMA continues to support the activities of the ECFMG related to verification of education credentials and testing of IMGs.
9. That special consideration be given to the limited number of IMGs who are refugees from foreign governments that refuse to provide pertinent information usually required to establish eligibility for residency training or licensure.
10. That accreditation standards enhance the quality of patient care and medical education and not be used for purposes of regulating physician manpower.
11. That AMA representatives to the ACGME, residency review committees and to the ECFMG should support AMA policy opposing discrimination. Medical school admissions officers and directors of residency programs should select applicants on the basis of merit, without considering status as an IMG or an ethnic name as a negative factor.
12. The requirement that all medical school graduates complete at least one year of graduate medical education in an accredited U.S. program in order to qualify for full and unrestricted licensure. State medical licensing boards are encouraged to allow an alternate set of criteria for granting licensure in lieu of this requirement: (a) completion of medical school and residency training outside the U.S.; (b) extensive U.S. medical practice; and (c) evidence of good standing within the local medical community.
13. Publicizing existing policy concerning the granting of staff and clinical privileges in hospitals and other health facilities.
14. The participation of all physicians, including graduates of foreign as well as U.S. and Canadian medical schools, in organized medicine. The AMA offers encouragement and assistance to state, county, and specialty medical societies in fostering greater membership among IMGs and their participation in leadership positions at all levels of organized medicine, including AMA committees and councils and state boards of medicine, by providing guidelines and non-financial incentives, such as recognition for outstanding achievements by either individuals or organizations in promoting leadership among IMGs.
15. Support studying the feasibility of conducting peer-to-peer membership recruitment efforts aimed at IMGs who are not AMA members.
16. AMA membership outreach to IMGs, to include a) using its existing publications to highlight policies and activities of interest to IMGs, stressing the common concerns of all physicians; b) publicizing its many relevant resources to all physicians, especially to nonmember IMGs; c) identifying and publicizing AMA resources to respond to inquiries from IMGs; and d) expansion of its efforts to prepare and disseminate information about requirements for admission to accredited residency programs, the availability of positions, and the problems of becoming licensed and entering full and unrestricted medical practice in the U.S. that face IMGs. This information should be addressed to college students, high school and college advisors, and students in foreign medical schools.
17. Recognition of the common aims and goals of all physicians, particularly those practicing in the U.S., and support for including all physicians who are permanent residents of the U.S. in the mainstream of American medicine.
18. Its leadership role to promote the international exchange of medical knowledge as well as cultural understanding between the U.S. and other nations.
19. Institutions that sponsor exchange visitor programs in medical education, clinical medicine and public health to tailor programs for the individual visiting scholar that will meet the needs of the scholar, the institution, and the nation to which he will return.
20. Informing foreign national IMGs that the availability of training and practice opportunities in the U.S. is limited by the availability of fiscal and human resources to maintain the quality of medical education and patient care in the U.S., and that those IMGs who plan to return to their country of origin have the opportunity to obtain GME in the United States.
21. U.S. medical schools offering admission with advanced standing, within the capabilities determined by each institution, to international medical students who satisfy the requirements of the institution for matriculation.

22. The Federation of State Medical Boards, its member boards, and the ECFMG in their willingness to adjust their administrative procedures in processing IMG applications so that original documents do not have to be recertified in home countries when physicians apply for licenses in a second state.
Citation: BOT Rep. Z, A-86; Reaffirmed: Res. 312, I-93; Modified: CME Rep. 2, A-03; Reaffirmation I-11; Reaffirmed: CME Rep. 1, I-13; Modified: BOT Rep. 25, A-15; Modified: CME Rep. 01, A-16; Appended: Res. 304, A-17; Modified: CME Rep. 01, I-17; Reaffirmation: A-19; Modified: CME Rep. 2, A-21

Abolish Discrimination in Licensure of IMGs H-255.966
1. Our AMA supports the following principles related to medical licensure of international medical graduates (IMGs):
A. State medical boards should ensure uniformity of licensure requirements for IMGs and graduates of U.S. and Canadian medical schools, including eliminating any disparity in the years of graduate medical education (GME) required for licensure and a uniform standard for the allowed number of administrations of licensure examinations.
B. All physicians seeking licensure should be evaluated on the basis of their individual education, training, qualifications, skills, character, ethics, experience and past practice.
C. Discrimination against physicians solely on the basis of national origin and/or the country in which they completed their medical education is inappropriate.
D. U.S. states and territories retain the right and responsibility to determine the qualifications of individuals applying for licensure to practice medicine within their respective jurisdictions.
E. State medical boards should be discouraged from a) using arbitrary and non-criteria-based lists of approved or unapproved foreign medical schools for licensure decisions and b) requiring an interview or oral examination prior to licensure endorsement. More effective methods for evaluating the quality of IMGs' undergraduate medical education should be pursued with the Federation of State Medical Boards (FSMB) and other relevant organizations. When available, the results should be a part of the determination of eligibility for licensure.
2. Our AMA will continue to work with the FSMB to encourage parity in licensure requirements for all physicians, whether U.S. medical school graduates or international medical graduates.
3. Our AMA will continue to work with the Educational Commission for Foreign Medical Graduates and other appropriate organizations in developing effective methods to evaluate the clinical skills of IMGs.
4. Our AMA will work with state medical societies in states with discriminatory licensure requirements between IMGs and graduates of U.S. and Canadian medical schools to advocate for parity in licensure requirements, using the AMA International Medical Graduate Section licensure parity model resolution as a resource.
5. Our AMA will: (a) encourage states to study existing strategies to improve policies and processes to assist IMGs with credentialing and licensure to enable them to care for patients in underserved areas; and (b) encourage the FSMB and state medical boards to evaluate the progress of programs aimed at reducing barriers to licensure--including successes, failures, and barriers to implementation.
Citation: BOT Rep. 25, A-15; Appended: CME Rep. 4, A-21

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 306
(A-22)

Introduced by: Illinois, American Society of Anesthesiologists

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

Referred to: Reference Committee C

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

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

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

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

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

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

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

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

Received: 04/07/22

RELEVANT AMA POLICY

D-305.984 - Reduction in Student Loan Interest Rates

…

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

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

5. Our AMA will work with appropriate organizations, such as the Accreditation Council for Graduate Medical Education and the Association of American Medical Colleges, to collect data and report on student indebtedness that includes total loan costs at completion of graduate medical education training.

Res. 316, A-03 Reaffirmed: BOT Rep. 28, A-13 Appended: Res. 302, A-13 Modified and Appended: 301, A-16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 307
(A-22)

Introduced by: Illinois

Subject: Parental Leave and Planning Resources for Medical Students

Referred to: Reference Committee C

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Fiscal Note: Minimal - less than $1,000

Received: 04/07/22

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RELEVANT AMA POLICY

Policies for Parental, Family and Medical Necessity Leave H-405.960

AMA adopts as policy the following guidelines for, and encourages the implementation of, Parental, Family and Medical Necessity Leave for Medical Students and Physicians:

1. Our AMA urges medical schools, residency training programs, medical specialty boards, the Accreditation Council for Graduate Medical Education, and medical group practices to incorporate and/or encourage development of leave policies, including parental, family, and medical leave policies, as part of the physician's standard benefit agreement.

2. Recommended components of parental leave policies for medical students and physicians include: (a) duration of leave allowed before and after delivery; (b) category of leave credited; (c) whether leave is paid or unpaid; (d) whether provision is made for continuation of insurance benefits during leave, and who pays the premium; (e) whether sick leave and vacation time may be accrued from year to year or used in advance; (f) how much time must be made up in order to be considered board eligible; (g) whether make-up time will be paid; (h) whether schedule accommodations are allowed; and (i) leave policy for adoption.

3. AMA policy is expanded to include physicians in practice, reading as follows: (a) residency program directors and group practice administrators should review federal law concerning maternity leave for guidance in developing policies to assure that pregnant physicians are allowed the same sick leave or disability benefits as those physicians who are ill or disabled; (b) staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in other physicians' workloads, particularly in residency programs; and (c) physicians should be able to return to their practices or training programs after taking parental leave without the loss of status.

4. Our AMA encourages residency programs, specialty boards, and medical group practices to incorporate into their parental leave policies a six-week minimum leave allowance, with the understanding that no parent should be required to take a minimum leave.

5. Residency program directors should review federal and state law for guidance in developing policies for parental, family, and medical leave.

6. Medical students and physicians who are unable to work because of pregnancy, childbirth, and other related medical conditions should be entitled to such leave and other benefits on the same basis as other physicians who are temporarily unable to work for other medical reasons.

7. Residency programs should develop written policies on parental leave, family leave, and medical leave for physicians. Such written policies should include the following elements: (a) leave policy for birth or adoption; (b) duration of leave allowed before and after delivery; (c) category of leave credited (e.g., sick, vacation, parental, unpaid leave, short term disability); (d) whether leave is paid or unpaid; (e) whether provision is made for continuation of insurance benefits during leave and who pays for premiums; (f) whether sick leave and vacation time may

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

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

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

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

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

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

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

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

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

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 308
(A-22)

Introduced by: Medical Student Section

Subject: University Land Grant Status in Medical School Admissions

Referred to: Reference Committee C

Whereas, American Indian and Alaska Natives (AI-AN) are defined as “people having origins in any of the original peoples of North America, South America, and Central America, who maintain tribal affiliation or community attachment”[1]; and

Whereas, The United States Department of Interior Bureau of Indian Affairs recognizes 574 American Indian and Alaska Native tribes and villages in the United States, with many more recognized at the state level or in the process of seeking recognition[2]; and

Whereas, AI-AN communities in the U.S. continue to have lower health status and disproportionate disease burden compared with other Americans, secondary to inadequate education, disproportionate poverty, discrimination in the delivery of health services, and cultural differences with healthcare providers[3]; and

Whereas, AI-AN individuals born today have a life expectancy that is 5.5 years less than the U.S. all races population (73.0 years to 78.5 years, respectively)[3]; and

Whereas, The Government Accountability Office reports that 29% of the Indian Health Services’ physician positions are vacant, with some regions operating with up to 46% of their physician positions vacant[4]; and

Whereas, The Association of American Medical Colleges (AAMC) recognizes that the continued underrepresentation of AI-AN physicians should be viewed as a national crisis faced by all medical schools[5]; and

Whereas, Only 0.56% of active physicians identify as AI-AN alone or in combination with another race, far below their national representation of 2%[1,5]; and

Whereas, From 2013-2018, greater than 95% of AI-AN tribes (547 / 574) had fewer than 10 AI-AN applicants to medical school and 99% of AI-AN tribes (567 / 574) had fewer than 10 matriculants to medical school[5]; and

Whereas, AI-AN medical students are more likely to practice medicine in tribal communities, and are more likely than their peers to practice in underserved areas[5]; and

Whereas, In a 2016-2017 Curriculum Inventory, the AAMC reported that only 11% of U.S. MD-granting institutions (14 of 131 participating) had AI-AN health content[5]; and

Whereas, Including AI-AN health content in medical school curricula provides visibility to and acknowledges the importance of the health of [AI-AN] communities and prepares all trainees to work with AI-AN communities[5]; and

Whereas, The AAMC recommends the development of focused AI-AN medical education curricula and medical school admissions policies that consider the political identity, rather than solely the race or ethnicity, of American Indians and Alaska Natives from tribal nations[5-6]; and

Whereas, The U.S. Supreme Court has recognized that membership status in a tribe does not violate laws related to non-discrimination or equal protection under the law (i.e., anti-affirmative action laws), iterating that tribal status is distinct from race[6-7]; and

Whereas, The AAMC has recognized that anti-affirmative action laws have impacted AI-AN application and matriculation rates to medical school despite rulings from the U.S. Supreme Court[8]; and

Whereas, There are professional programs that preferentially consider tribal membership in admissions and funding awards, such as UCLA School of Law, UC San Diego, and UC Davis School of Medicine[6,9-10]; and

Whereas, 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 to meet the needs of AI-AN communities (H-350.981); and

Whereas, Our AMA opposes legislation and other related efforts that undermine the ability of institutions to employ affirmative action to promote a diverse student population (D-200.985); and

Whereas, As tribal membership is legally distinct from race, then it follows that tribal membership can be affirmatively considered outside of holistic admissions processes, including those that have race-blind admissions (e.g., California, Washington)[5]; and

Whereas, The federal government has a unique legal and political relationship with Tribal governments established through and confirmed by the United States Constitution, treaties, federal statutes, executive orders, and judicial decisions[11]; and

Whereas, Central to this relationship is the Federal Government's trust responsibility to protect the interests of Indian Tribes and communities[11]; and

Whereas, The federal trust responsibility is a legal obligation under which the federal government "has charged itself with moral obligations of the highest responsibility and trust" toward AI-AN tribes, which include healthcare and education[12-13]; and

Whereas, The federal trust responsibility establishes the basis for a variety of federal services provided to federally recognized tribes and villages, including healthcare delivery and the provision of physicians, on the basis of tribal membership, not racial identification[14]; and

Whereas, Land-grant universities are universities built on land transferred to states from the federal government with the enactment of the Morrill Act of 1862[15-16]; and

Whereas, Land-grant universities, many of which house associated medical schools, continue to derive benefit from 10.7 million acres of land expropriated from nearly 250 tribal nations, while being federal and state government-funded entities[15-16]; and

Whereas, As a creation of the federal government and recipient of federal funding, land-grant universities therefore play a role in the fulfillment of the federal trust responsibility; and

Whereas, The rationale for this policy is supported by the following 29 health and policy-related organizations and AI-AN tribes: American Indian Studies Department, CSUSM, San Marcos, CA, American Indian Studies Department, SDSU, San Diego, CA, Association of American Indian Physicians, Oklahoma City, OK, California Consortium for Urban Indian Health, Sacramento, CA, California Democratic Party Native American Caucus, Sacramento, CA, California Indian Culture and Sovereignty Center, San Marcos, CA, California Rural Indian Health Board, Roseville, CA, Center for Native American Youth, Washington, DC, Coyote Valley Band of Pomo Indians, Redwood Valley, CA, Federated Indians of Graton Rancheria, Rohnert Park, CA, Indian Health Center of Santa Clara Valley, San Jose, CA, Indian Health Council, Valley Center, CA, La Jolla Band of Luiseño Indians, Pauma Valley, CA, Latino Medical Student Association, Chicago, IL, Mesa Grande Band of Mission Indians, Santa Ysabel, CA, National Indian Health Board, Washington, DC, Native American Health Center, Oakland, CA, Pala Band of Mission Indians, Pala, CA, Pauma Band of Luiseño Indians, Pauma Valley, CA, Rincon Band of Luiseño Indians, Valley Center, CA, Sacramento Native American Health Center, Sacramento, CA, San Diego American Indian Health Center, San Diego, CA, San Manuel Band of Mission Indians, Highland, CA, San Pasqual Band of Mission Indians, Valley Center, CA Santa Ynez Band of Chumash Indians, Santa Ynez, CA, Student National Medical Association, Washington, DC Sycuan Band of the Kumeyaay Nation, El Cajon, CA, Tolowa Dee-ni' Nation, Smith River, CA, Wilton Rancheria, Elk Grove, CA[17]; and

Whereas, Medical schools are chiefly responsible for the composition of the physician workforce and set their own admissions criteria[5]; therefore be it

RESOLVED, That our American Medical Association work with the Association of American Medical Colleges, Liaison Committee on Medical Education, Association of American Indian Physicians, and Association of Native American Medical Students to design and promulgate medical school admissions recommendations in line with the federal trust responsibility (Directive to Take Action); and be it further

RESOLVED, That our AMA amend Policy H-350.981, "AMA Support of American Indian Health Career Opportunities," by addition to read as follows:

AMA Support of American Indian Health Career Opportunities H-350.981

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.
(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. These efforts should include, but are not limited to, priority consideration of applicants who self-identify as American Indian or Alaska Native and can provide some form of affiliation with an American Indian or Alaska Native tribe in the United States, and robust mentorship programs that support the successful advancement of these trainees.
(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 stronger clinical exposure and a greater number of 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.
(5) Our AMA acknowledges long-standing federal precedent that membership or lineal descent from an enrolled member in a federally recognized tribe is distinct from racial identification as American Indian or Alaska Native and should be considered in medical school admissions even when restrictions on race-conscious admissions policies are in effect.
(6) Our AMA will engage with the Association of Native American Medical Students and Association of American Indian Physicians to design and disseminate American Indian and Alaska Native medical education curricula that prepares trainees to serve AI-AN communities. (Modify Current HOD Policy)

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

Date Received: 04/08/22

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RELEVANT AMA POLICY

AMA Support of American Indian Health Career Opportunities H-350.981

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.
(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

Indian Health Service H-350.977

The policy of the AMA is to support efforts in Congress to enable the Indian Health Service to meet its obligation to bring American Indian health up to the general population level. The AMA specifically recommends: (1) Indian Population: (a) In current education programs, and in the expansion of educational activities suggested below, special consideration be given to involving the American Indian and Alaska native population in training for the various health professions, in the expectation that such professionals, if provided with adequate professional resources, facilities, and income, will be more likely to serve the tribal areas permanently; (b) Exploration with American Indian leaders of the possibility of increased numbers of nonfederal American Indian health centers, under tribal sponsorship, to expand the American Indian role in its own health care; (c) Increased involvement of private practitioners and facilities in American Indian care, through such mechanisms as agreements with tribal leaders or Indian Health Service contracts, as well as normal private practice relationships; and (d) Improvement in transportation to make access to existing private care easier for the American Indian population.
(2) Federal Facilities: Based on the distribution of the eligible population, transportation facilities and roads, and the availability of alternative non-federal resources, the AMA recommends that those Indian Health Service facilities currently necessary for American Indian care be identified and that an immediate construction and modernization program be initiated to bring these facilities up to current standards of practice and accreditation.
(3) Manpower: (a) Compensation for Indian Health Service physicians be increased to a level competitive with other Federal agencies and nongovernmental service; (b) Consideration should be given to increased compensation for service in remote areas; (c) In conjunction with improvement of Service facilities, efforts should be made to establish closer ties with teaching centers, thus increasing both the available manpower and the level of professional expertise available for consultation; (d) Allied health professional staffing of Service facilities should be maintained at a level appropriate to the special needs

of the population served; (e) Continuing education opportunities should be provided for those health professionals serving these communities, and especially those in remote areas, and, increased peer contact, both to maintain the quality of care and to avert professional isolation; and (f) Consideration should be given to a federal statement of policy supporting continuation of the Public Health Service to reduce the great uncertainty now felt by many career officers of the corps.
(4) Medical Societies: In those states where Indian Health Service facilities are located, and in counties containing or adjacent to Service facilities, that the appropriate medical societies should explore the possibility of increased formal liaison with local Indian Health Service physicians. Increased support from organized medicine for improvement of health care provided under their direction, including professional consultation and involvement in society activities should be pursued.
(5) Our AMA also support the removal of any requirement for competitive bidding in the Indian Health Service that compromises proper care for the American Indian population.
CLRPD Rep. 3, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmation: A-12; Reaffirmed: Res. 233, A-13

Improving Health Care of American Indians H-350.976
Our AMA recommends that: (1) All individuals, special interest groups, and levels of government recognize the American Indian people as full citizens of the U.S., entitled to the same equal rights and privileges as other U.S. citizens.
(2) The federal government provide sufficient funds to support needed health services for American Indians.
(3) State and local governments give special attention to the health and health-related needs of non-reservation American Indians in an effort to improve their quality of life.
(4) American Indian religions and cultural beliefs be recognized and respected by those responsible for planning and providing services in Indian health programs.
(5) Our AMA recognize the "medicine man" as an integral and culturally necessary individual in delivering health care to American Indians.
(6) Strong emphasis be given to mental health programs for American Indians in an effort to reduce the high incidence of alcoholism, homicide, suicide, and accidents.
(7) A team approach drawing from traditional health providers supplemented by psychiatric social workers, health aides, visiting nurses, and health educators be utilized in solving these problems.
(8) Our AMA continue its liaison with the Indian Health Service and the National Indian Health Board and establish a liaison with the Association of American Indian Physicians.
(9) State and county medical associations establish liaisons with intertribal health councils in those states where American Indians reside.
(10) Our AMA supports and encourages further development and use of innovative delivery systems and staffing configurations to meet American Indian health needs but opposes overemphasis on research for the sake of research, particularly if needed federal funds are diverted from direct services for American Indians.
(11) Our AMA strongly supports those bills before Congressional committees that aim to improve the health of and health-related services provided to American Indians and further recommends that members of appropriate AMA councils and committees provide testimony in favor of effective legislation and proposed regulations.
CLRPD Rep. 2, I-98; Reaffirmed: Res. 22, A-07; Reaffirmation: A-12; Reaffirmed: Res. 233, A-13

Desired Qualifications for Indian Health Service Director H-440.816
Our AMA supports the following qualifications for the Director of the Indian Health Service:
1. Health profession, preferably an MD or DO, degree and at least five years of clinical experience at an Indian Health Service medical site or facility.
2. Demonstrated long-term interest, commitment, and activity within the field of Indian Health.
3. Lived on tribal lands or rural American Indian or Alaska Native community or has interacted closely with an urban Indian community.
4. Leadership position in American Indian/Alaska Native health care or a leadership position in an academic setting with activity in American Indian/ Alaska Native health care.
5. Experience in the Indian Health Service or has worked extensively with Indian Health Service, Tribal, or Urban Indian health programs.

6. Knowledge and understanding of social and cultural issues affecting the health of American Indian and Alaska Native people.
7. Knowledge of health disparities among Native Americans / Alaska Natives, including the pathophysiological basis of the disease process and the social determinants of health that affect disparities.
8. Experience working with Indian Tribes and Nations and an understanding of the Trust Responsibility of the Federal Government for American Indian and Alaska Natives as well as an understanding of the sovereignty of American Indian and Alaska Native Nations.
9. Experience with management, budget, and federal programs.
Res. 603, I-18

Strong Opposition to Cuts in Federal Funding for the Indian Health Service D-350.987
1. Our AMA will strongly advocate that all of the facilities that serve Native Americans under the Indian Health Service be adequately funded to fulfill their mission and their obligations to patients and providers.
2. Our AMA will ask Congress to take all necessary action to immediately restore full and adequate funding to the Indian Health Service.
3. Our AMA adopts as new policy that the Indian Health Service not be treated more adversely than other health plans in the application of any across the board federal funding reduction.
4. In the event of federal inaction to restore full and adequate funding to the Indian Health Service, our AMA will consider the option of joining in legal action seeking to require the federal government to honor existing treaties, obligations, and previously established laws regarding funding of the Indian Health Service.
5. Our AMA will request that Congress: (A) amend the Indian Health Care Improvement Act to authorize Advanced Appropriations; (B) include our recommendation for the Indian Health Service (HIS) Advanced Appropriations in the Budget Resolution; and (C) include in the enacted appropriations bill IHS Advanced Appropriations.
Res. 233, A-13; Appended: Res. 229, A-14

Plan for Continued Progress Toward Health Equity H-180.944
Health equity, defined as optimal health for all, is a goal toward which our AMA will work by advocating for health care access, research, and data collection; promoting equity in care; increasing health workforce diversity; influencing determinants of health; and voicing and modeling commitment to health equity.
Citation: BOT Rep. 33, A-18; Reaffirmed: CMS Rep. 5, I-21;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 309
(A-22)

Introduced by: Medical Student Section

Subject: Decreasing Bias in Evaluations of Medical Student Performance

Referred to: Reference Committee C

Whereas, Racism, xenophobia, sexism, homophobia, transphobia, ableism, and other discrimination within medical education manifests through structural, institutional, and interpersonal means, which necessitates a multilevel approach in order to be addressed[1-6]; and

Whereas, The Liaison Committee on Medical Education (LCME) defines a "fair and formal process for taking any action that may affect the status of a medical student" such that a "...student will be assessed by individuals who have not previously formed an opinion of the student's abilities, professionalism, and/or suitability to become a physician"[7]; and

Whereas, Differences by race and ethnicity have been documented in receipt of Honors in various clerkships, Alpha Omega Alpha membership, Medical Student Performance Evaluation (MSPE) comments, and the residency application process[8-13]; and

Whereas, Latinx and Black physicians received a disproportionate number of complaints to the Medical Board of California and had greater odds of complaints escalating to investigations, and Latinx physicians had a greater probability of having an investigation result in disciplinary action in a study of 32,978 complaints to the Medical Board of California between 2003 and 2013[14]; and

Whereas, A study in which fabricated prospective students with names indicative of their gender and race sent emails to professors to discuss research opportunities demonstrated that professors were most responsive to students whose names indicated that they were Caucasian and male, especially professors at private universities and those in more lucrative fields[15]; and

Whereas, A study of medical students in the Netherlands revealed that non-Dutch students were referred to the professional behavior board at a rate 2.86 times that of Dutch students, and noted that "(cultural) differences in communication styles may be a possible explanation for these students' underperformance" and "more subjective grading in clinical training can lead to what is called 'examiner bias', which means that examiners have a more positive view on people who are similar to themselves"[16]; and

Whereas, Blinded peer review of scientific abstracts has been found to resolve statistically-significant bias against non-English speaking authors, international institutions, and less prestigious institutions[17]; and

Whereas, All component groups of the admissions committee of the Ohio State University College of Medicine showed implicit white preference on the Black-White Implicit Association Test, with men and faculty members displaying greater levels of unconscious bias than women and students[18]; and

Whereas, It has been shown implicit bias in grading can be mitigated through the recruitment of diverse disciplinary and grade review committees and through implicit bias awareness training[18-23]; and

Whereas, There is existing literature on the benefits of a two-interval grading system from a wellbeing standpoint, but there are limited published studies delineating the specific impact of this grading schema for minoritized trainees in terms of residency applications and career opportunities[24-26]; and

Whereas, The tiered grading system, often using grades of honors, high pass, pass, fail, or similar, is the most commonly used system for clerkship grading in allopathic US medical schools, while the two-interval, or pass/fail, system is most often used for clerkship grading in osteopathic US medical schools although a number of US allopathic medical schools such as Harvard, University of San Francisco, the David Geffen School of Medicine at UCLA, and the Perelman School of Medicine at the University of Pennsylvania have transitioned to two-tiered systems for at least some of their required clerkships[27-29]; and

Whereas, Inequities present in the tiered grading system have been shown to cascade to subsequent levels of training, leading to the persistent underrepresentation of Black, Latinx/Hispanic, American Indian, Alaska Native, and certain Asian subgroups in medicine[30]; and

Whereas, Two-interval grading and hybrid systems that incorporate pass/fail grades may minimize the disparities in the quantitative aspects of performance evaluations; however, this does not protect from the racial biases codified in the language of medical student performance evaluations as well as other aspects of residency applications, and as such, there is not enough evidence to support or oppose two-interval grading systems for clinical clerkships at this time[31-38]; therefore be it

RESOLVED, That our American Medical Association work with appropriate stakeholders, such as the Liaison Committee on Medical Education and the Commission on Osteopathic College Accreditation to support: 1) increased diversity and implementation of implicit bias training to individuals responsible for assessing medical students' performance, including the evaluation of professionalism and investigating and ruling upon disciplinary matters involving medical students; and 2) that all reviews of medical student professionalism and academic performance be conducted in a blinded manner when doing such does not interfere with appropriate scoring (Directive to Take Action); and be it further

RESOLVED, That our AMA study the impact of two-interval clinical clerkship grading systems on residency application outcomes and clinical performance during residency. (Directive to Take Action)

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

Date Received: 04/08/22

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RELEVANT AMA POLICY

E-8.5 Disparities in Health Care

Stereotypes, prejudice, or bias based on gender expectations and other arbitrary evaluations of any individual can manifest in a variety of subtle ways. Differences in treatment that are not directly related to differences in individual patients' clinical needs or preferences constitute inappropriate variations in health care. Such variations may contribute to health outcomes that are considerably worse in members of some populations than those of members of majority populations.

This represents a significant challenge for physicians, who ethically are called on to provide the same quality of care to all patients without regard to medically irrelevant personal characteristics.

To fulfill this professional obligation in their individual practices physicians should:

(a) Provide care that meets patient needs and respects patient preferences.

(b) Avoid stereotyping patients.

(c) Examine their own practices to ensure that inappropriate considerations about race, gender identify, sexual orientation, sociodemographic factors, or other nonclinical factors, do not affect clinical judgment.

(d) Work to eliminate biased behavior toward patients by other health care professionals and staff who come into contact with patients.

(e) Encourage shared decision making.

(f) Cultivate effective communication and trust by seeking to better understand factors that can influence patients' health care decisions, such as cultural traditions, health beliefs and health literacy, language or other barriers to communication and fears or misperceptions about the health care system.

The medical profession has an ethical responsibility to:

(g) Help increase awareness of health care disparities.

(h) Strive to increase the diversity of the physician workforce as a step toward reducing health care disparities.

(i) Support research that examines health care disparities, including research on the unique health needs of all genders, ethnic groups, and medically disadvantaged populations, and the development of quality measures and resources to help reduce disparities.

Issued: 2016

Fostering Professionalism During Medical School and Residency Training D-295.983

(1) Our AMA, in consultation with other relevant medical organizations and associations, will work to develop a framework for fostering professionalism during medical school and residency training. This planning effort should include the following elements: (a) Synthesize existing goals and outcomes for professionalism into a practice-based educational framework, such as provided by the AMA's Principles of Medical Ethics.

(b) Examine and suggest revisions to the content of the medical curriculum, based on the desired goals and outcomes for teaching professionalism.

(c) Identify methods for teaching professionalism and those changes in the educational environment, including the use of role models and mentoring, which would support trainees' acquisition of professionalism.
(d) Create means to incorporate ongoing collection of feedback from trainees about factors that support and inhibit their development of professionalism.
(2) Our AMA, along with other interested groups, will continue to study the clinical training environment to identify the best methods and practices used by medical schools and residency programs to fostering the development of professionalism.
CME Rep. 3, A-01; Reaffirmation: I-09; Reaffirmed: CME Rep. 01, A-19; Modified: CME Rep. 01, A-20

11.2.1 Professionalism in Health Care Systems
Containing costs, promoting high-quality care for all patients, and sustaining physician professionalism are important goals. Models for financing and organizing the delivery of health care services often aim to promote patient safety and to improve quality and efficiency. However, they can also pose ethical challenges for physicians that could undermine the trust essential to patient-physician relationships.
Payment models and financial incentives can create conflicts of interest among patients, health care organizations, and physicians. They can encourage undertreatment and overtreatment, as well as dictate goals that are not individualized for the particular patient.
Structures that influence where and by whom care is delivered—such as accountable care organizations, group practices, health maintenance organizations, and other entities that may emerge in the future—can affect patients' choices, the patient-physician relationship, and physicians' relationships with fellow health care professionals.
Formularies, clinical practice guidelines, and other tools intended to influence decision making, may impinge on physicians' exercise of professional judgment and ability to advocate effectively for their patients, depending on how they are designed and implemented.
Physicians in leadership positions within health care organizations should ensure that practices for financing and organizing the delivery of care:
(a) Are transparent.
(b) Reflect input from key stakeholders, including physicians and patients.
(c) Recognize that over reliance on financial incentives may undermine physician professionalism.
(d) Ensure ethically acceptable incentives that:
(i) are designed in keeping with sound principles and solid scientific evidence. Financial incentives should be based on appropriate comparison groups and cost data and adjusted to reflect complexity, case mix, and other factors that affect physician practice profiles. Practice guidelines, formularies, and other tools should be based on best available evidence and developed in keeping with ethics guidance;
(ii) are implemented fairly and do not disadvantage identifiable populations of patients or physicians or exacerbate health care disparities;
(iii) are implemented in conjunction with the infrastructure and resources needed to support high-value care and physician professionalism;
(iv) mitigate possible conflicts between physicians' financial interests and patient interests by minimizing the financial impact of patient care decisions and the overall financial risk for individual physicians.
(e) Encourage, rather than discourage, physicians (and others) to:
(i) provide care for patients with difficult to manage medical conditions;
(ii) practice at their full capacity, but not beyond.
(f) Recognize physicians' primary obligation to their patients by enabling physicians to respond to the unique needs of individual patients and providing avenues for meaningful appeal and advocacy on behalf of patients.

(g) Are routinely monitored to:
(i) identify and address adverse consequences;
(ii) identify and encourage dissemination of positive outcomes.
All physicians should:
(h) Hold physician-leaders accountable to meeting conditions for professionalism in health care systems.
(i) Advocate for changes in health care payment and delivery models to promote access to high-quality care for all patients.
Issued: 2016

Reducing Racial and Ethnic Disparities in Health Care D-350.995
Our AMA's initiative on reducing racial and ethnic disparities in health care will include the following recommendations:
(1) Studying health system opportunities and barriers to eliminating racial and ethnic disparities in health care.
(2) Working with public health and other appropriate agencies to increase medical student, resident physician, and practicing physician awareness of racial and ethnic disparities in health care and the role of professionalism and professional obligations in efforts to reduce health care disparities.
(3) Promoting diversity within the profession by encouraging publication of successful outreach programs that increase minority applicants to medical schools, and take appropriate action to support such programs, for example, by expanding the "Doctors Back to School" program into secondary schools in minority communities.
BOT Rep. 4, A-03; Reaffirmation: A-11; Reaffirmation: A-16; Reaffirmed: CMS Rep. 10, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 310
(A-22)

Introduced by: Medical Student Section

Subject: Support for Standardized Interpreter Training

Referred to: Reference Committee C

Whereas, There are more than 6,900 known living languages spoken in the world[1]; and

Whereas, More than 66 million Americans speak at least one of over 350 languages other than English at home and more than 25 million Americans speak English "less than very well"[2-4]; and

Whereas, Language barriers can have major adverse effects on health such as suboptimal health status; lower likelihood of having regular care providers; lower rates of mammograms, pap smears, and other preventative services; greater likelihood of diagnosis of more severe psychopathology; leaving the hospital against medical advice; and increased risk of drug complications[1,3,5]; and

Whereas, Ad hoc interpreters have been shown to engage in "false fluency", where substandard interpretation skills leads to inadequate translation, thereby compromising the integrity of the patient-provider interaction[6-8]; and

Whereas, Errors in medical interpretation are not uncommon, and translation errors made by ad hoc interpreters are more likely to result in clinical consequences than errors made by professionally trained medical interpreters[9]; and

Whereas, Underuse of a valuable health care resource, professional medical interpretation, can result in these adverse effects and inappropriate care[4]; and

Whereas, Professional medical interpreter services can facilitate effective communication across language differences and increase the delivery of health care to Limited English Proficiency (LEP) patients, yet remain underutilized in health care[3,10]; and

Whereas, Language assistance is a legal right of patients under Title VI of the 1964 Civil Rights Act, therefore hospitals have policies and processes in place, but how they are communicated to front-line staff is variable[5,11]; and

Whereas, One potential contributor is the lack of a designated place within medical training curricula to address language barriers, which calls for a more recognizable and accessible resource for training[5,11]; and

Whereas, In recent studies, only 19% of emergency department (ED) staff had reported prior training on working with interpreters, regardless of the source of training[7], and most ED providers and staff who have little training in the use of language assistance were unaware of hospital policy in this area[11,12]; and

Whereas, Only 28% of medical schools offer students on clerkships training involving a language interpreter[13]; and

Whereas, Dissemination of best practices for the provision of language assistance and the clinical use of non-English language skills has the potential to improve communication with LEP patients[11]; and

Whereas, Healthcare organizations should ensure that medical professionals across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery or have access to training[14]; and

Whereas, Providing training to physicians and medical students about the proper use of medical interpreter services increases the correct use of those services[15-18]; and

Whereas, Teaching medical professionals to emphasize the appropriate use of an interpreter is warranted to improve cross-language clinical encounters, and could be executed through a Continuing Medical Education (CME) module[12]; and

Whereas, It has been recommended that healthcare organizations should either verify that staff at all levels and in all disciplines participate in ongoing CME-accredited education or other training in Culturally and Linguistically Appropriate Services delivery, or arrange for such education and training to be made available to staff[14]; and

Whereas, CME is a cornerstone of improving competencies and ensuring high-quality patient care by nurses and physicians[19]; and

Whereas, Although the AMA Education Hub (EdHub) has produced a series of modules related to Health Disparities and the Health Care Workforce, such as Disparities in Research and Health Equity to Bias in Artificial Intelligence, it does not currently have any modules covering the correct use of interpreter services; and

Whereas, The American Association of Medical Colleges (AAMC) has published “Guidelines on the Use of Medical Interpreter Services,” which describe best practices for assessing English proficiency, use of an interpreter, additional considerations for ad hoc interpreters, conflicts of interest and privacy, and considerations for telephonic interpreter services[20]; and

Whereas, Though AMA policy reimbursement for and calls for further research regarding interpreter services (D-385.957, H-160.924, H-385.928, H-382.929, D-385.978), it does not recognize the importance of interpreter services for providing appropriate care or call upon physicians to use them with patients with LEP, and the AMA Ed Hub does not currently provide any resources addressing how to correctly use interpreter services; therefore be it

RESOLVED, That our American Medical Association recognize the importance of using medical interpreters as a means of improving quality of care provided to patients with Limited English Proficiency (LEP) including patients with sensory impairments (New HOD Policy); and

RESOLVED, That our AMA encourage physicians and physicians in training to improve interpreter-use skills and increase education through publicly available resources such as the American Association of Medical College’s “Guidelines for Use of Medical Interpreter Services” (New HOD Policy); and be it further

RESOLVED, That our AMA work with the Commission for Medical Interpreter Education, National Hispanic Medical Association, National Council of Asian Pacific Islander Physicians, National Medical Association, Association of American Indian Physicians, and other relevant stakeholders to develop a cohesive Continuing Medical Education module offered through the AMA Ed Hub for physicians to effectively and appropriately use interpreter services to ensure optimal patient care. (Directive to Take Action)

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

Date Received: 04/08/22

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RELEVANT AMA POLICY

Certified Translation and Interpreter Services D-385.957

Our AMA will: (1) work to relieve the burden of the costs associated with translation services implemented under Section 1557 of the Affordable Care Act; and (2) advocate for legislative and/or regulatory changes to require that payers including Medicaid programs and Medicaid managed care plans cover interpreter services and directly pay interpreters for such services, with a progress report at the 2017 Interim Meeting of the AMA House of Delegates.
Res. 703, A-17; Reaffirmed: CMS Rep. 7, A-21

Use of Language Interpreters in the Context of the Patient-Physician Relationship H-160.924
AMA policy is that: (1) further research is necessary on how the use of interpreters--both those who are trained and those who are not--impacts patient care; (2) treating physicians shall respect and assist the patients' choices whether to involve capable family members or friends to provide language assistance that is culturally sensitive and competent, with or without an interpreter who is competent and culturally sensitive; (3) physicians continue to be resourceful in their use of other appropriate means that can help facilitate communication--including print materials, digital and other electronic or telecommunication services with the understanding, however, of these tools' limitations--to aid LEP patients' involvement in meaningful decisions about their care; and (4) physicians cannot be expected to provide and fund these translation services for their patients, as the Department of Health and Human Services' policy guidance currently requires; when trained medical interpreters are needed, the costs of their services shall be paid directly to the interpreters by patients and/or third party payers and physicians shall not be required to participate in payment arrangements.
BOT Rep. 8, I-02; Reaffirmation: I-03; Reaffirmed in lieu of Res. 722, A-07; Reaffirmation: A-09; Reaffirmed: CMS Rep. 5, A-11; Reaffirmed in lieu of Res. 110, A-13; Reaffirmation: A-17

Patient Interpreters H-385.928
Our AMA supports sufficient federal appropriations for patient interpreter services and will take other necessary steps to assure physicians are not directly or indirectly required to pay for interpreter services mandated by the federal government.
Res. 219, I-01; Reaffirmed: BOT Rep. 8, I-02; Reaffirmation: I-03; Reaffirmed in lieu of Res .722, A-07; Reaffirmation: A-09; Reaffirmation: A-10; Reaffirmation A-14

Availability and Payment for Medical Interpreters Services in Medical Practices H-385.929
It is the policy of our AMA to: (1) the fullest extent appropriate, to actively oppose the inappropriate extension of the OCR LEP guidelines to physicians in private practice; and (2) continue our proactive, ongoing efforts to correct the problems imposed on physicians in private practice by the OCR language interpretation requirements.
BOT Rep. 25, I-01; Reaffirmation: I-03; Reaffirmed: Res. 907, I-03; Reaffirmation: A-09; Reaffirmation: A-17

Language Interpreters D-385.978
Our AMA will: (1) continue to work to obtain federal funding for medical interpretive services;(2) redouble its efforts to remove the financial burden of medical interpretive services from physicians;(3) urge the Administration to reconsider its interpretation of Title VI of the Civil Rights Act of 1964 as requiring medical interpretive services without reimbursement;(4) consider the feasibility of a legal solution to the problem of funding medical interpretive services; and(5) work with governmental officials and other organizations to make language interpretive services a covered benefit for all health plans inasmuch as health plans are in a superior position to pass on the cost of these federally mandated services as a business expense.
Res. 907, I-03; Reaffirmed in lieu of Res. 722, A-07; Reaffirmation: A-09; Reaffirmation: A-10; Reaffirmed: CMS Rep. 5, A-11; Reaffirmed in lieu of Res. 110, A-13; Reaffirmation: A-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 311
(A-22)

Introduced by: Illinois

Subject: Discontinue State Licensure Requirement for COMLEX Level 2 PE

Referred to: Reference Committee C

Whereas, The National Board of Medical Examiners (NBME) announced in late January the cancellation of the USMLE Step 2 Clinical Skills examination, soon after the AMA had adopted a resolution encouraging USMLE Step 2 Clinical Skills and COMLEX Level 2 PE to be eliminated and replaced by examinations administered by accredited medical schools[1]; and

Whereas, The usefulness of these examinations for graduates of U.S. and Canadian medical schools is questionable, given that North American medical students passed the USMLE Step 2 examination with a rate of 98% whereas by contrast medical students attending school outside North America have a pass rate of 79%[2]; therefore be it

RESOLVED, That our American Medical Association advocate to remove COMLEX Level 2 PE as a requirement for state medical licensure for graduates of accredited U.S. and Canadian osteopathic medical schools, and encourage state medical societies to do the same for their state licensure bodies. (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000

Received: 04/08/22

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1. Murphy B. USMLE Step 2 CS canceled: What it means for medical students. American Medical Association. https://www.ama-assn.org/residents-students/usmle/usmle-step-2-cs-canceled-what-it-means-medical-students. Published February 4, 2021.
2. Lehman EP 4th, Guercio JR. The Step 2 Clinical Skills exam--a poor value proposition. N Engl J Med. 2013;368(10):889-891. doi:10.1056/NEJMp1213760
3. Gesundheit, Neil MD, MPH A Crisis of Trust Between U.S. Medical Education and the National Board of Medical Examiners, Academic Medicine: September 2020 - Volume 95 - Issue 9 - p 1300-1304 doi: 10.1097/ACM.0000000000003131

RELEVANT AMA POLICY

Potential Impact of the USMLE Step 2 CS and COMLEX-PE on Undergraduate and Graduate Medical Education D-275.981
Our AMA will: (1) continue to closely monitor the USMLE Step 2 CS and the COMLEX-USA Level 2-PE, collecting data on initial and final pass rates, delays in students starting residency training due to scheduling of examinations, economic impact on students, and the potential impact of ethnicity on passing rates; and (2) encourage residency program directors to proactively evaluate their access to resources needed to assist resident physicians who have not passed these examinations to remediate.
Citation: (CME Rep. 4, A-04; Modified: CME Rep. 2, A-14)

Clinical Skills Assessment During Medical School D-295.988

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.

Citation: CME Rep. 7, I-99; Reaffirmed: CME Rep. 2, A-09; Appended: Alt. Res. 311, A-16; Appended: CME Rep. 9, A-17; Reaffirmation: I-19; Reaffirmed: Res. 306, I-20; Reaffirmed in lieu of: Res. 308, A-21

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 312
(A-22)

Introduced by: Illinois

Subject: Reduce Financial Burden to Medical Students of Medical Licensure Examinations

Referred to: Reference Committee C

Whereas, The National Board of Medical Examiners (NBME) and Federation of State Medical Boards (FSMB) require medical students and residents to purchase four examinations in order to complete their training; and

Whereas, The purchase of these examinations with loan money substantially increases the amount paid by trainees; and

Whereas, The cost of the Step 2 Clinical Skills examination alone costs medical students in the United States and Canada $20.4 million per annum, which increases to $56.4 million at compounded interest at a rate of 6.8%; and

Whereas, The standard inflation discount rate of 3% adjusts the 15-year cost of the Step 2 Clinical Skills examination to $36.2 million annually in 2012; and

Whereas, The median student debt accrued at graduation has increased by 220% from 1992 to 2017 after accounting for inflation for medical students in the United States from $50,000 in 1992 and rising to $192,000 in 2017; and

Whereas, Increasing level of medical student debt level is associated with poor academic performance and mental health, as well as alcohol abuse and dependence; therefore be it

RESOLVED, That our American Medical Association advocate for medical licensure examinations and related study, practice examinations, and examination preparatory materials released by the National Board of Medical Examiners and the National Board of Osteopathic Medical Examiners to be available at a cost that does not exceed the reasonable cost of providing the examination and examination preparatory materials. (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000

Received: 04/08/22

References:
1. Lehman EP 4th, Guercio JR. The Step 2 Clinical Skills exam--a poor value proposition. *N Engl J Med*. 2013;368(10):889-891. doi:10.1056/NEJMp1213760
2. Pisaniello MS, Asahina AT, Bacchi S, et al. Effect of medical student debt on mental health, academic performance and specialty choice: a systematic review. *BMJ Open*. 2019;9(7):e029980. Published 2019 Jul 2. doi:10.1136/bmjopen-2019-029980
3. Gesundheit N. A Crisis of Trust Between U.S. Medical Education and the National Board of Medical Examiners [published online ahead of print, 2019 Dec 17]. *Acad Med*. 2019;10.1097/ACM.0000000000003131.

RELEVANT AMA POLICY

Clinical Skills Training in Medical Schools D-295.960
Our AMA: (1) encourages medical schools to reevaluate their educational programs to ensure appropriate emphasis of clinical skills training in medical schools; (2) encourages medical schools to include longitudinal clinical experiences for students during the "preclinical" years of medical education; (3) will evaluate the cost/value equation, benefits, and consequences of the implementation of standardized clinical exams as a step for licensure, along with the barriers to more meaningful examination feedback for both examinees and US medical schools, and provide recommendations based on these findings; and (4) will evaluate the consequences of the January 2013 changes to the USMLE Step II Clinical Skills exam and their implications for US medical students and international medical graduates.
Citation: (Res. 324, A-03; Appended: Res. 309, A-11; Appended: Res. 904, I-13)

Alternatives to the Federation of State Medical Boards Recommendations on Licensure H-275.934
Our AMA adopts the following principles:
(1) Ideally, all medical students should successfully complete Steps 1 and 2 of the United States Medical Licensing Examination (USMLE) or Levels 1 and 2 of the Comprehensive Osteopathic Medical Licensing Examination (COMLEX USA) prior to entry into residency training. At a minimum, individuals entering residency training must have successfully completed Step 1 of the USMLE or Level 1 of COMLEX USA. There should be provision made for students who have not completed Step 2 of the USMLE or Level 2 of the COMLEX USA to do so during the first year of residency training.
(2) All applicants for full and unrestricted licensure, whether graduates of U.S. medical schools or international medical graduates, must have completed one year of accredited graduate medical education (GME) in the U.S., have passed all state-required licensing examinations (USMLE or COMLEX USA), and must be certified by their residency program director as ready to advance to the next year of GME and to obtain a full and unrestricted license to practice medicine. State medical licensing boards are encouraged to allow an alternate set of criteria for granting licensure in lieu of this requirement for completing one year of accredited GME in the U.S.: (a) completion of medical school and residency training outside the U.S.; (b) extensive U.S. medical practice; and (c) evidence of good standing within the local medical community.
(3) There should be a training permit/educational license for all resident physicians who do not yet have a full and unrestricted license to practice medicine. To be eligible for an initial training permit/educational license, the resident must have completed Step 1 of the USMLE or Level 1 of COMLEX USA.
(4) Residency program directors shall report only those actions to state medical licensing boards that are reported for all licensed physicians.
(5) Residency program directors should receive training to ensure that they understand the process for taking disciplinary action against resident physicians, and are aware of procedures for dismissal of residents and for due process. This requirement for residency program directors should be enforced through Accreditation Council for Graduate Medical Education accreditation requirements.
(6) There should be no reporting of actions against medical students to state medical licensing boards.
(7) Medical schools are responsible for identifying and remediating and/or disciplining medical student unprofessional behavior, problems with substance abuse, and other behavioral problems. as well as gaps in student knowledge and skills.
(8) The Dean's Letter of Evaluation should be strengthened and standardized, to serve as a better source of information to residency programs about applicants.
Citation: CME Rep. 8, A-99; Reaffirmed: CME Rep. 4, I-01; Reaffirmed: CME Rep. 2, A-11; Modified: CME Rep. 2, A-12; Modified: CME Rep. 2, A-21

Independent Regulation of Physician Licensing Exams D-295.939
Our AMA will: (1) continue to work with the National Board of Medical Examiners to ensure that the AMA is given appropriate advance notice of any major potential changes in the examination system; (2) continue to collaborate with the organizations who create, validate, monitor, and administer the United States Medical Licensing Examination; (3) continue to promote and disseminate the rules governing USMLE in its publications; (4) continue its dialog with and be supportive of the process of the Committee to Evaluate the USMLE Program (CEUP); and (5) work with American Osteopathic Association and National Board of Osteopathic Medical Examiners to stay apprised of any major potential changes in the Comprehensive Osteopathic Medical Licensing Examination (COMLEX).
Citation: CME Rep. 10, A-08; Modified: CME Rep. 01, A-18

Principles of and Actions to Address Medical Education Costs and Student Debt H-305.925
The costs of medical education should never be a barrier to the pursuit of a career in medicine nor to the decision to practice in a given specialty. To help address this issue, our American Medical Association (AMA) will:
1. Collaborate with members of the Federation and the medical education community, and with other interested organizations, to address the cost of medical education and medical student debt through public- and private-sector advocacy.
2. Vigorously advocate for and support expansion of and adequate funding for federal scholarship and loan repayment programs--such as those from the National Health Service Corps, Indian Health Service, Armed Forces, and Department of Veterans Affairs, and for comparable programs from states and the private sector--to promote practice in underserved areas, the military, and academic medicine or clinical research.
3. Encourage the expansion of National Institutes of Health programs that provide loan repayment in exchange for a commitment to conduct targeted research.
4. Advocate for increased funding for the National Health Service Corps Loan Repayment Program to assure adequate funding of primary care within the National Health Service Corps, as well as to permit: (a) inclusion of all medical specialties in need, and (b) service in clinical settings that care for the underserved but are not necessarily located in health professions shortage areas.
5. Encourage the National Health Service Corps to have repayment policies that are consistent with other federal loan forgiveness programs, thereby decreasing the amount of loans in default and increasing the number of physicians practicing in underserved areas.
6. Work to reinstate the economic hardship deferment qualification criterion known as the “20/220 pathway,” and support alternate mechanisms that better address the financial needs of trainees with educational debt.
7. Advocate for federal legislation to support the creation of student loan savings accounts that allow for pre-tax dollars to be used to pay for student loans.
8. Work with other concerned organizations to advocate for legislation and regulation that would result in favorable terms and conditions for borrowing and for loan repayment, and would permit 100% tax deductibility of interest on student loans and elimination of taxes on aid from service-based programs.
9. Encourage the creation of private-sector financial aid programs with favorable interest rates or service obligations (such as community- or institution-based loan repayment programs or state medical society loan programs).
10. Support stable funding for medical education programs to limit excessive tuition increases, and collect and disseminate information on medical school programs that cap medical education debt, including the types of debt management education that are provided.
11. Work with state medical societies to advocate for the creation of either tuition caps or, if caps are not feasible, pre-defined tuition increases, so that medical students will be aware of

their tuition and fee costs for the total period of their enrollment.
12. Encourage medical schools to (a) Study the costs and benefits associated with non-traditional instructional formats (such as online and distance learning, and combined baccalaureate/MD or DO programs) to determine if cost savings to medical schools and to medical students could be realized without jeopardizing the quality of medical education; (b) Engage in fundraising activities to increase the availability of scholarship support, with the support of the Federation, medical schools, and state and specialty medical societies, and develop or enhance financial aid opportunities for medical students, such as self-managed, low-interest loan programs; (c) Cooperate with postsecondary institutions to establish collaborative debt counseling for entering first-year medical students; (d) Allow for flexible scheduling for medical students who encounter financial difficulties that can be remedied only by employment, and consider creating opportunities for paid employment for medical students; (e) Counsel individual medical student borrowers on the status of their indebtedness and payment schedules prior to their graduation; (f) Inform students of all government loan opportunities and disclose the reasons that preferred lenders were chosen; (g) Ensure that all medical student fees are earmarked for specific and well-defined purposes, and avoid charging any overly broad and ill-defined fees, such as but not limited to professional fees; (h) Use their collective purchasing power to obtain discounts for their students on necessary medical equipment, textbooks, and other educational supplies; (i) Work to ensure stable funding, to eliminate the need for increases in tuition and fees to compensate for unanticipated decreases in other sources of revenue; mid-year and retroactive tuition increases should be opposed.
13. Support and encourage state medical societies to support further expansion of state loan repayment programs, particularly those that encompass physicians in non-primary care specialties.
14. Take an active advocacy role during reauthorization of the Higher Education Act and similar legislation, to achieve the following goals: (a) Eliminating the single holder rule; (b) Making the availability of loan deferment more flexible, including broadening the definition of economic hardship and expanding the period for loan deferment to include the entire length of residency and fellowship training; (c) Retaining the option of loan forbearance for residents ineligible for loan deferment; (d) Including, explicitly, dependent care expenses in the definition of the “cost of attendance”; (e) Including room and board expenses in the definition of tax-exempt scholarship income; (f) Continuing the federal Direct Loan Consolidation program, including the ability to “lock in” a fixed interest rate, and giving consideration to grace periods in renewals of federal loan programs; (g) Adding the ability to refinance Federal Consolidation Loans; (h) Eliminating the cap on the student loan interest deduction; (i) Increasing the income limits for taking the interest deduction; (j) Making permanent the education tax incentives that our AMA successfully lobbied for as part of Economic Growth and Tax Relief Reconciliation Act of 2001; (k) Ensuring that loan repayment programs do not place greater burdens upon married couples than for similarly situated couples who are cohabitating; (l) Increasing efforts to collect overdue debts from the present medical student loan programs in a manner that would not interfere with the provision of future loan funds to medical students.
15. Continue to work with state and county medical societies to advocate for adequate levels of medical school funding and to oppose legislative or regulatory provisions that would result in significant or unplanned tuition increases.
16. Continue to study medical education financing, so as to identify long-term strategies to mitigate the debt burden of medical students, and monitor the short-and long-term impact of the economic environment on the availability of institutional and external sources of financial aid for medical students, as well as on choice of specialty and practice location.
17. Collect and disseminate information on successful strategies used by medical schools to cap or reduce tuition.
18. Continue to monitor the availability of and encourage medical schools and residency/fellowship programs to (a) provide financial aid opportunities and financial

planning/debt management counseling to medical students and resident/fellow physicians; (b) work with key stakeholders to develop and disseminate standardized information on these topics for use by medical students, resident/fellow physicians, and young physicians; and (c) share innovative approaches with the medical education community.
19. Seek federal legislation or rule changes that would stop Medicare and Medicaid decertification of physicians due to unpaid student loan debt. The AMA believes that it is improper for physicians not to repay their educational loans, but assistance should be available to those physicians who are experiencing hardship in meeting their obligations.
20. Related to the Public Service Loan Forgiveness (PSLF) Program, our AMA supports increased medical student and physician participation in the program, and will: (a) Advocate that all resident/fellow physicians have access to PSLF during their training years; (b) Advocate against a monetary cap on PSLF and other federal loan forgiveness programs; (c) Work with the United States Department of Education to ensure that any cap on loan forgiveness under PSLF be at least equal to the principal amount borrowed; (d) Ask the United States Department of Education to include all terms of PSLF in the contractual obligations of the Master Promissory Note; (e) Encourage the Accreditation Council for Graduate Medical Education (ACGME) to require residency/fellowship programs to include within the terms, conditions, and benefits of program appointment information on the employer's PSLF program qualifying status; (f) Advocate that the profit status of a physician's training institution not be a factor for PSLF eligibility; (g) Encourage medical school financial advisors to counsel wise borrowing by medical students, in the event that the PSLF program is eliminated or severely curtailed; (h) Encourage medical school financial advisors to increase medical student engagement in service-based loan repayment options, and other federal and military programs, as an attractive alternative to the PSLF in terms of financial prospects as well as providing the opportunity to provide care in medically underserved areas; (i) Strongly advocate that the terms of the PSLF that existed at the time of the agreement remain unchanged for any program participant in the event of any future restrictive changes; (j) Monitor the denial rates for physician applicants to the PSLF; (k) Undertake expanded federal advocacy, in the event denial rates for physician applicants are unexpectedly high, to encourage release of information on the basis for the high denial rates, increased transparency and streamlining of program requirements, consistent and accurate communication between loan servicers and borrowers, and clear expectations regarding oversight and accountability of the loan servicers responsible for the program; (l) Work with the United States Department of Education to ensure that applicants to the PSLF and its supplemental extensions, such as Temporary Expanded Public Service Loan Forgiveness (TEPSLF), are provided with the necessary information to successfully complete the program(s) in a timely manner; and (m) Work with the United States Department of Education to ensure that individuals who would otherwise qualify for PSLF and its supplemental extensions, such as TEPSLF, are not disqualified from the program(s).
21. Advocate for continued funding of programs including Income-Driven Repayment plans for the benefit of reducing medical student load burden.
22. Strongly advocate for the passage of legislation to allow medical students, residents and fellows who have education loans to qualify for interest-free deferment on their student loans while serving in a medical internship, residency, or fellowship program, as well as permitting the conversion of currently unsubsidized Stafford and Graduate Plus loans to interest free status for the duration of undergraduate and graduate medical education.
Citation: CME Report 05, I-18; Appended: Res. 953, I-18; Reaffirmation: A-19; Appended: Res. 316, A-19; Appended: Res. 226, A-21; Reaffirmed in lieu of: Res. 311, A-21; Modified: CME Rep. 4, I-21

Clinical Skills Assessment During Medical School D-295.988
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.
Citation: CME Rep. 7, I-99; Reaffirmed: CME Rep. 2, A-09; Appended: Alt. Res. 311, A-16; Appended: CME Rep. 9, A-17; Reaffirmation: I-19; Reaffirmed: Res. 306, I-20; Reaffirmed in lieu of: Res. 308, A-21

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 313
(A-22)

Introduced by: Illinois, American Society of Anesthesiologists

Subject: Decreasing Medical Student Debt and Increasing Transparency in Cost of Medical School Attendance

Referred to: Reference Committee C

Whereas, 73% of 2019 medical school graduates reported having educational debt, with a median reported debt being $200,000[1]; and

Whereas, Education debt levels have been increasing at a rate higher than inflation over the past decade, and grants and scholarships rarely cover the entire cost of medical school attendance[1]; and

Whereas, Texas medical schools have decreased the costs of education through establishing a state-wide tuition cap law for state residents[2], and NYU Langone School of Medicine has been able to eliminate student tuition through donor funds[3]; therefore be it

RESOLVED, That our American Medical Association work with Congress and related bodies to make it a priority to reduce the costs of medical school tuition incurred by graduates of U.S. medical schools, without sacrificing current educational quality (Directive to Take Action); and be it further

RESOLVED, That our AMA encourage the written transparent disclosure by U.S. medical schools of the overall cost of attendance, including but not limited to, cost of living; educational materials not provided by the school, such as exam preparatory materials from outside companies; examination fees; interview and residency application costs; and other related costs incurred by students over the duration of their education (New HOD Policy); and be it further

RESOLVED, That our AMA encourage the written transparent disclosure of all scholarships provided by an institution, including disclosure of allocation criteria and duration (New HOD Policy); and be it further

RESOLVED, That our AMA encourage U.S. medical schools to provide written, transparent information about how medical school tuition dollars are allocated across the medical school budget. (New HOD Policy)

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

Received: 04/08/22

References:
1. Youngclaus J & Fresne JA. Physician Education Debt and the Cost to Attend Medical School: 2020 Update. AAMC. 2020.
2. Texas Education Code § 54
3. NYU School of Medicine offers full-tuition scholarships to all new & current medical students [news release]. New York: NYU Langone Health; August 16, 2018. https://nyulangone.org/press-releases/nyu-school-of-medicine-offers-full-tuition- scholarships-to-all-new-current-medical-students. Accessed October 22, 2020.

RELEVANT AMA POLICY

Principles of and Actions to Address Medical Education Costs and Student Debt H-305.925

The costs of medical education should never be a barrier to the pursuit of a career in medicine nor to the decision to practice in a given specialty. To help address this issue, our American Medical Association (AMA) will:

1. Collaborate with members of the Federation and the medical education community, and with other interested organizations, to address the cost of medical education and medical student debt through public- and private-sector advocacy.
2. Vigorously advocate for and support expansion of and adequate funding for federal scholarship and loan repayment programs--such as those from the National Health Service Corps, Indian Health Service, Armed Forces, and Department of Veterans Affairs, and for comparable programs from states and the private sector--to promote practice in underserved areas, the military, and academic medicine or clinical research.
3. Encourage the expansion of National Institutes of Health programs that provide loan repayment in exchange for a commitment to conduct targeted research.
4. Advocate for increased funding for the National Health Service Corps Loan Repayment Program to assure adequate funding of primary care within the National Health Service Corps, as well as to permit: (a) inclusion of all medical specialties in need, and (b) service in clinical settings that care for the underserved but are not necessarily located in health professions shortage areas.
5. Encourage the National Health Service Corps to have repayment policies that are consistent with other federal loan forgiveness programs, thereby decreasing the amount of loans in default and increasing the number of physicians practicing in underserved areas.
6. Work to reinstate the economic hardship deferment qualification criterion known as the “20/220 pathway,” and support alternate mechanisms that better address the financial needs of trainees with educational debt.
7. Advocate for federal legislation to support the creation of student loan savings accounts that allow for pre-tax dollars to be used to pay for student loans.
8. Work with other concerned organizations to advocate for legislation and regulation that would result in favorable terms and conditions for borrowing and for loan repayment, and would permit 100% tax deductibility of interest on student loans and elimination of taxes on aid from service-based programs.
9. Encourage the creation of private-sector financial aid programs with favorable interest rates or service obligations (such as community- or institution-based loan repayment programs or state medical society loan programs).
10. Support stable funding for medical education programs to limit excessive tuition increases, and collect and disseminate information on medical school programs that cap medical education debt, including the types of debt management education that are provided.
11. Work with state medical societies to advocate for the creation of either tuition caps or, if caps are not feasible, pre-defined tuition increases, so that medical students will be aware of their tuition and fee costs for the total period of their enrollment.
12. Encourage medical schools to (a) Study the costs and benefits associated with non-traditional instructional formats (such as online and distance learning, and combined baccalaureate/MD or DO programs) to determine if cost savings to medical schools and to medical students could be realized without jeopardizing the quality of medical education; (b) Engage in fundraising activities to increase the availability of scholarship support, with the support of the Federation, medical schools, and state and specialty medical societies, and develop or enhance financial aid opportunities for medical students, such as self-managed, low-interest loan programs; (c) Cooperate with postsecondary institutions to establish collaborative debt counseling for entering first-year medical students; (d) Allow for flexible scheduling for

medical students who encounter financial difficulties that can be remedied only by employment, and consider creating opportunities for paid employment for medical students; (e) Counsel individual medical student borrowers on the status of their indebtedness and payment schedules prior to their graduation; (f) Inform students of all government loan opportunities and disclose the reasons that preferred lenders were chosen; (g) Ensure that all medical student fees are earmarked for specific and well-defined purposes, and avoid charging any overly broad and ill-defined fees, such as but not limited to professional fees; (h) Use their collective purchasing power to obtain discounts for their students on necessary medical equipment, textbooks, and other educational supplies; (i) Work to ensure stable funding, to eliminate the need for increases in tuition and fees to compensate for unanticipated decreases in other sources of revenue; mid-year and retroactive tuition increases should be opposed.

13. Support and encourage state medical societies to support further expansion of state loan repayment programs, particularly those that encompass physicians in non-primary care specialties.

14. Take an active advocacy role during reauthorization of the Higher Education Act and similar legislation, to achieve the following goals: (a) Eliminating the single holder rule; (b) Making the availability of loan deferment more flexible, including broadening the definition of economic hardship and expanding the period for loan deferment to include the entire length of residency and fellowship training; (c) Retaining the option of loan forbearance for residents ineligible for loan deferment; (d) Including, explicitly, dependent care expenses in the definition of the “cost of attendance”; (e) Including room and board expenses in the definition of tax-exempt scholarship income; (f) Continuing the federal Direct Loan Consolidation program, including the ability to “lock in” a fixed interest rate, and giving consideration to grace periods in renewals of federal loan programs; (g) Adding the ability to refinance Federal Consolidation Loans; (h) Eliminating the cap on the student loan interest deduction; (i) Increasing the income limits for taking the interest deduction; (j) Making permanent the education tax incentives that our AMA successfully lobbied for as part of Economic Growth and Tax Relief Reconciliation Act of 2001; (k) Ensuring that loan repayment programs do not place greater burdens upon married couples than for similarly situated couples who are cohabitating; (l) Increasing efforts to collect overdue debts from the present medical student loan programs in a manner that would not interfere with the provision of future loan funds to medical students.

15. Continue to work with state and county medical societies to advocate for adequate levels of medical school funding and to oppose legislative or regulatory provisions that would result in significant or unplanned tuition increases.

16. Continue to study medical education financing, so as to identify long-term strategies to mitigate the debt burden of medical students, and monitor the short-and long-term impact of the economic environment on the availability of institutional and external sources of financial aid for medical students, as well as on choice of specialty and practice location.

17. Collect and disseminate information on successful strategies used by medical schools to cap or reduce tuition.

18. Continue to monitor the availability of and encourage medical schools and residency/fellowship programs to (a) provide financial aid opportunities and financial planning/debt management counseling to medical students and resident/fellow physicians; (b) work with key stakeholders to develop and disseminate standardized information on these topics for use by medical students, resident/fellow physicians, and young physicians; and (c) share innovative approaches with the medical education community.

19. Seek federal legislation or rule changes that would stop Medicare and Medicaid decertification of physicians due to unpaid student loan debt. The AMA believes that it is improper for physicians not to repay their educational loans, but assistance should be available to those physicians who are experiencing hardship in meeting their obligations.

20. Related to the Public Service Loan Forgiveness (PSLF) Program, our AMA supports increased medical student and physician participation in the program, and will: (a) Advocate that

all resident/fellow physicians have access to PSLF during their training years; (b) Advocate against a monetary cap on PSLF and other federal loan forgiveness programs; (c) Work with the United States Department of Education to ensure that any cap on loan forgiveness under PSLF be at least equal to the principal amount borrowed; (d) Ask the United States Department of Education to include all terms of PSLF in the contractual obligations of the Master Promissory Note; (e) Encourage the Accreditation Council for Graduate Medical Education (ACGME) to require residency/fellowship programs to include within the terms, conditions, and benefits of program appointment information on the employer's PSLF program qualifying status; (f) Advocate that the profit status of a physician's training institution not be a factor for PSLF eligibility; (g) Encourage medical school financial advisors to counsel wise borrowing by medical students, in the event that the PSLF program is eliminated or severely curtailed; (h) Encourage medical school financial advisors to increase medical student engagement in service-based loan repayment options, and other federal and military programs, as an attractive alternative to the PSLF in terms of financial prospects as well as providing the opportunity to provide care in medically underserved areas; (i) Strongly advocate that the terms of the PSLF that existed at the time of the agreement remain unchanged for any program participant in the event of any future restrictive changes; (j) Monitor the denial rates for physician applicants to the PSLF; (k) Undertake expanded federal advocacy, in the event denial rates for physician applicants are unexpectedly high, to encourage release of information on the basis for the high denial rates, increased transparency and streamlining of program requirements, consistent and accurate communication between loan servicers and borrowers, and clear expectations regarding oversight and accountability of the loan servicers responsible for the program; (l) Work with the United States Department of Education to ensure that applicants to the PSLF and its supplemental extensions, such as Temporary Expanded Public Service Loan Forgiveness (TEPSLF), are provided with the necessary information to successfully complete the program(s) in a timely manner; and (m) Work with the United States Department of Education to ensure that individuals who would otherwise qualify for PSLF and its supplemental extensions, such as TEPSLF, are not disqualified from the program(s).

21. Advocate for continued funding of programs including Income-Driven Repayment plans for the benefit of reducing medical student load burden.

22. Strongly advocate for the passage of legislation to allow medical students, residents and fellows who have education loans to qualify for interest-free deferment on their student loans while serving in a medical internship, residency, or fellowship program, as well as permitting the conversion of currently unsubsidized Stafford and Graduate Plus loans to interest free status for the duration of undergraduate and graduate medical education.

Citation: CME Report 05, I-18; Appended: Res. 953, I-18; Reaffirmation: A-19; Appended: Res. 316, A-19; Appended: Res. 226, A-21; Reaffirmed in lieu of: Res. 311, A-21; Modified: CME Rep. 4, I-21

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

1. Our AMA will actively collaborate with appropriate stakeholder organizations, (including Association of American Medical Colleges, American Hospital Association, state medical societies, medical specialty societies/associations) to advocate for the preservation, stability and expansion of full funding for the direct and indirect costs of graduate medical education (GME) positions from all existing sources (e.g. Medicare, Medicaid, Veterans Administration, CDC and others).

2. Our AMA will actively advocate for the stable provision of matching federal funds for state Medicaid programs that fund GME positions.

3. Our AMA will actively seek congressional action to remove the caps on Medicare funding of GME positions for resident physicians that were imposed by the Balanced Budget Amendment of 1997 (BBA-1997).

4. Our AMA will strenuously advocate for increasing the number of GME positions to address the future physician workforce needs of the nation.
5. Our AMA will oppose efforts to move federal funding of GME positions to the annual appropriations process that is subject to instability and uncertainty.
6. Our AMA will oppose regulatory and legislative efforts that reduce funding for GME from the full scope of resident educational activities that are designated by residency programs for accreditation and the board certification of their graduates (e.g. didactic teaching, community service, off-site ambulatory rotations, etc.).
7. Our AMA will actively explore additional sources of GME funding and their potential impact on the quality of residency training and on patient care.
8. Our AMA will vigorously advocate for the continued and expanded contribution by all payers for health care (including the federal government, the states, and local and private sources) to fund both the direct and indirect costs of GME.
9. Our AMA will work, in collaboration with other stakeholders, to improve the awareness of the general public that GME is a public good that provides essential services as part of the training process and serves as a necessary component of physician preparation to provide patient care that is safe, effective and of high quality.
10. Our AMA staff and governance will continuously monitor federal, state and private proposals for health care reform for their potential impact on the preservation, stability and expansion of full funding for the direct and indirect costs of GME.
11. Our AMA: (a) recognizes that funding for and distribution of positions for GME are in crisis in the United States and that meaningful and comprehensive reform is urgently needed; (b) will immediately work with Congress to expand medical residencies in a balanced fashion based on expected specialty needs throughout our nation to produce a geographically distributed and appropriately sized physician workforce; and to make increasing support and funding for GME programs and residencies a top priority of the AMA in its national political agenda; and (c) will continue to work closely with the Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, American Osteopathic Association, and other key stakeholders to raise awareness among policymakers and the public about the importance of expanded GME funding to meet the nation's current and anticipated medical workforce needs.
12. Our AMA will collaborate with other organizations to explore evidence-based approaches to quality and accountability in residency education to support enhanced funding of GME.
13. Our AMA will continue to strongly advocate that Congress fund additional graduate medical education (GME) positions for the most critical workforce needs, especially considering the current and worsening maldistribution of physicians.
14. Our AMA will advocate that the Centers for Medicare and Medicaid Services allow for rural and other underserved rotations in Accreditation Council for Graduate Medical Education (ACGME)-accredited residency programs, in disciplines of particular local/regional need, to occur in the offices of physicians who meet the qualifications for adjunct faculty of the residency program's sponsoring institution.
15. Our AMA encourages the ACGME to reduce barriers to rural and other underserved community experiences for graduate medical education programs that choose to provide such training, by adjusting as needed its program requirements, such as continuity requirements or limitations on time spent away from the primary residency site.
16. Our AMA encourages the ACGME and the American Osteopathic Association (AOA) to continue to develop and disseminate innovative methods of training physicians efficiently that foster the skills and inclinations to practice in a health care system that rewards team-based care and social accountability.
17. Our AMA will work with interested state and national medical specialty societies and other appropriate stakeholders to share and support legislation to increase GME funding, enabling a state to accomplish one or more of the following: (a) train more physicians to meet state and regional workforce needs; (b) train physicians who will practice in physician

shortage/underserved areas; or (c) train physicians in undersupplied specialties and subspecialties in the state/region.
18. Our AMA supports the ongoing efforts by states to identify and address changing physician workforce needs within the GME landscape and continue to broadly advocate for innovative pilot programs that will increase the number of positions and create enhanced accountability of GME programs for quality outcomes.
19. Our AMA will continue to work with stakeholders such as Association of American Medical Colleges (AAMC), ACGME, AOA, American Academy of Family Physicians, American College of Physicians, and other specialty organizations to analyze the changing landscape of future physician workforce needs as well as the number and variety of GME positions necessary to provide that workforce.
20. Our AMA will explore innovative funding models for incremental increases in funded residency positions related to quality of resident education and provision of patient care as evaluated by appropriate medical education organizations such as the Accreditation Council for Graduate Medical Education.
21. Our AMA will utilize its resources to share its content expertise with policymakers and the public to ensure greater awareness of the significant societal value of graduate medical education (GME) in terms of patient care, particularly for underserved and at-risk populations, as well as global health, research and education.
22. Our AMA will advocate for the appropriation of Congressional funding in support of the National Healthcare Workforce Commission, established under section 5101 of the Affordable Care Act, to provide data and healthcare workforce policy and advice to the nation and provide data that support the value of GME to the nation.
23. Our AMA supports recommendations to increase the accountability for and transparency of GME funding and continue to monitor data and peer-reviewed studies that contribute to further assess the value of GME.
24. Our AMA will explore various models of all-payer funding for GME, especially as the Institute of Medicine (now a program unit of the National Academy of Medicine) did not examine those options in its 2014 report on GME governance and financing.
25. Our AMA encourages organizations with successful existing models to publicize and share strategies, outcomes and costs.
26. Our AMA encourages insurance payers and foundations to enter into partnerships with state and local agencies as well as academic medical centers and community hospitals seeking to expand GME.
27. Our AMA will develop, along with other interested stakeholders, a national campaign to educate the public on the definition and importance of graduate medical education, student debt and the state of the medical profession today and in the future.
28. Our AMA will collaborate with other stakeholder organizations to evaluate and work to establish consensus regarding the appropriate economic value of resident and fellow services.
29. Our AMA will monitor ongoing pilots and demonstration projects, and explore the feasibility of broader implementation of proposals that show promise as alternative means for funding physician education and training while providing appropriate compensation for residents and fellows.
30. Our AMA will monitor the status of the House Energy and Commerce Committee's response to public comments solicited regarding the 2014 IOM report, Graduate Medical Education That Meets the Nation's Health Needs, as well as results of ongoing studies, including that requested of the GAO, in order to formulate new advocacy strategy for GME funding, and will report back to the House of Delegates regularly on important changes in the landscape of GME funding.
31. Our AMA will advocate to the Centers for Medicare & Medicaid Services to adopt the concept of “Cap-Flexibility” and allow new and current Graduate Medical Education teaching institutions to extend their cap-building window for up to an additional five years beyond the

current window (for a total of up to ten years), giving priority to new residency programs in underserved areas and/or economically depressed areas.
32. Our AMA will: (a) encourage all existing and planned allopathic and osteopathic medical schools to thoroughly research match statistics and other career placement metrics when developing career guidance plans; (b) strongly advocate for and work with legislators, private sector partnerships, and existing and planned osteopathic and allopathic medical schools to create and fund graduate medical education (GME) programs that can accommodate the equivalent number of additional medical school graduates consistent with the workforce needs of our nation; and (c) encourage the Liaison Committee on Medical Education (LCME), the Commission on Osteopathic College Accreditation (COCA), and other accrediting bodies, as part of accreditation of allopathic and osteopathic medical schools, to prospectively and retrospectively monitor medical school graduates' rates of placement into GME as well as GME completion.
33. Our AMA encourages the Secretary of the U.S. Department of Health and Human Services to coordinate with federal agencies that fund GME training to identify and collect information needed to effectively evaluate how hospitals, health systems, and health centers with residency programs are utilizing these financial resources to meet the nation's health care workforce needs. This includes information on payment amounts by the type of training programs supported, resident training costs and revenue generation, output or outcomes related to health workforce planning (i.e., percentage of primary care residents that went on to practice in rural or medically underserved areas), and measures related to resident competency and educational quality offered by GME training programs.
Citation: Sub. Res. 314, A-07; Reaffirmation I-07; Reaffirmed: CME Rep. 4, I-08; Reaffirmed: Sub. Res. 314, A-09; Reaffirmed: CME Rep. 3, I-09; Reaffirmation A-11; Appended: Res. 910, I-11; Reaffirmed in lieu of Res. 303, A-12; Reaffirmed in lieu of Res. 324, A-12; Reaffirmation: I-12; Reaffirmation A-13; Appended: Res. 320, A-13; Appended: CME Rep. 5, A-13; Appended: CME Rep. 7, A-14; Appended: Res. 304, A-14; Modified: CME Rep. 9, A-15; Appended: CME Rep, 1, I-15; Appended: Res. 902, I-15; Reaffirmed: CME Rep. 3, A-16; Appended: Res. 320, A-16; Appended: CME Rep. 04, A-16; Appended: CME Rep. 05, A-16; Reaffirmation A-16; Appended: Res. 323, A-17; Appended: CME Rep. 03, A-18; Appended: Res. 319, A-18; Reaffirmed in lieu of: Res. 960, I-18; Modified: Res. 233, A-19; Modified: BOT Rep. 25, A-19; Reaffirmed: CME Rep. 3, A-21

Residency Interview Costs H-310.966
1. It is the policy of the AMA to pursue changes to federal legislation or regulation, specifically to the Higher Education Act, to include an allowance for residency interview costs for fourth-year medical students in the cost of attendance definition for medical education.
2. Our AMA will work with appropriate stakeholders, such as the Association of American Medical Colleges and the Accreditation Council for Graduate Medical Education, in consideration of the following strategies to address the high cost of interviewing for residency/fellowship: a) establish a method of collecting data on interviewing costs for medical students and resident physicians of all specialties for study, and b) support further study of residency/fellowship interview strategies aimed at mitigating costs associated with such interviews.
Citation: (Res. 265, A-90; Reaffirmed: Sunset Report, I-00; Modified: CME Rep. 2, A-10; Appended: Res. 308, A-15)

Minorities in the Health Professions H-350.978
The policy of our AMA is that (1) Each educational institution should accept responsibility for increasing its enrollment of members of underrepresented groups.
(2) Programs of education for health professions should devise means of improving retention rates for students from underrepresented groups.

(3) Health profession organizations should support the entry of disabled persons to programs of education for the health professions, and programs of health profession education should have established standards concerning the entry of disabled persons.
(4) Financial support and advisory services and other support services should be provided to disabled persons in health profession education programs. Assistance to the disabled during the educational process should be provided through special programs funded from public and private sources.
(5) Programs of health profession education should join in outreach programs directed at providing information to prospective students and enriching educational programs in secondary and undergraduate schools.
(6) Health profession organizations, especially the organizations of professional schools, should establish regular communication with counselors at both the high school and college level as a means of providing accurate and timely information to students about health profession education.
(7) The AMA reaffirms its support of: (a) efforts to increase the number of black Americans and other minority Americans entering and graduating from U.S. medical schools; and (b) increased financial aid from public and private sources for students from low income, minority and socioeconomically disadvantaged backgrounds.
(8) The AMA supports counseling and intervention designed to increase enrollment, retention, and graduation of minority medical students, and supports legislation for increased funding for the HHS Health Careers Opportunities Program.
Citation: CLRPD Rep. 3, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmed: CEJA Rep. 06, A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 314
(A-22)

Introduced by: Medical Student Section

Subject: Support for Institutional Policies for Personal Days for Undergraduate Medical Students

Referred to: Reference Committee C

Whereas, Burnout is a multifactorial occupational syndrome characterized by emotional exhaustion, depersonalization, and cynicism or professional dissatisfaction as a result of prolonged stress[1,2]; and

Whereas, Burnout can not only undermine professional development, but also contribute to mental health disorders including suicidal ideation and substance use[2]; and

Whereas, Over half of U.S. medical students report experiencing burnout at some point in their medical education, along with greater prevalence of depressive symptoms (27.2%) and suicidal ideation (11.1%) compared to the general population (7.1% and 4%, respectively)[2-4]; and

Whereas, A lack of protected time remains the prominent barrier preventing medical students from accessing mental health treatment[5]; and

Whereas, Institutional policies and initiatives to address burnout and improve mental wellness vary widely, including the implementation of “sick days” which may require proof of illness or be restricted in how they can be utilized[6,7]; and

Whereas, Students may not feel comfortable sharing mental health concerns due to professional stigma, shame, or fear or repercussions on professional development[8]; and

Whereas, Personal days are defined as excused absences that may require advance notice but without an explanation for the absence, and may also be utilized for mental wellness, physical wellness, and self-care[9]; and

Whereas, Personal days have been increasingly prevalent in workplace or corporate policies, and are now offered in over one third of workplaces and in companies such as Netflix, Best Buy, and Virgin America[10,11]; and

Whereas, The implementation of personal days in medical schools would allow students to address their health needs--including mental health and routine appointments--without compromising their privacy to clerkship directors or administrators; and

Whereas, A number of medical schools have started providing personal days, though policies continue to vary widely due to lack of standardization[12-31]; and

Whereas, Our AMA has policy supporting existing programs in identification and management of stress (H-405.957), prioritizing self-care among medical students and the maintenance of a healthy lifestyle (H-405.957), and promoting the recognition of burnout in students by

institutional officials, program directors, resident physicians, and attending faculty (H-295.858); therefore be it

RESOLVED, That our American Medical Association encourage medical schools to accept flexible uses for excused absences from clinical clerkships (New HOD Policy); and be it further

RESOLVED, That our AMA support a clearly defined number of easily accessible personal days for medical students per academic year, which should be explained to students at the beginning of each academic year and a subset of which should be granted without requiring an explanation on the part of the students. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 04/08/22

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RELEVANT AMA POLICY

Access to Confidential Health Services for Medical Students and Physicians H-295.858

1. Our AMA will ask the Liaison Committee on Medical Education, Commission on Osteopathic College Accreditation, American Osteopathic Association, and Accreditation Council for Graduate Medical Education to encourage medical schools and residency/fellowship programs, respectively, to:
A. Provide or facilitate the immediate availability of urgent and emergent access to low-cost, confidential health care, including mental health and substance use disorder counseling services, that: (1) include appropriate follow-up; (2) are outside the trainees' grading and evaluation pathways; and (3) are available (based on patient preference and need for assurance of confidentiality) in reasonable proximity to the education/training site, at an external site, or through telemedicine or other virtual, online means;
B. Ensure that residency/fellowship programs are abiding by all duty hour restrictions, as these regulations exist in part to ensure the mental and physical health of trainees;
C. Encourage and promote routine health screening among medical students and resident/fellow physicians, and consider designating some segment of already-allocated personal time off (if necessary, during scheduled work hours) specifically for routine health screening and preventive services, including physical, mental, and dental care; and
D. Remind trainees and practicing physicians to avail themselves of any needed resources, both within and external to their institution, to provide for their mental and physical health and well-being, as a component of their professional obligation to ensure their own fitness for duty and the need to prioritize patient safety and quality of care by ensuring appropriate self-care, not working when sick, and following generally accepted guidelines for a healthy lifestyle.
2. Our AMA will urge state medical boards to refrain from asking applicants about past history of mental health or substance use disorder diagnosis or treatment, and only focus on current impairment by mental illness or addiction, and to accept "safe haven" non-reporting for physicians seeking licensure or relicensure who are undergoing treatment for mental health or addiction issues, to help ensure confidentiality of such treatment for the individual physician while providing assurance of patient safety.
3. Our AMA encourages medical schools to create mental health and substance abuse awareness and suicide prevention screening programs that would:
A. be available to all medical students on an opt-out basis;
B. ensure anonymity, confidentiality, and protection from administrative action;
C. provide proactive intervention for identified at-risk students by mental health and addiction professionals; and
D. inform students and faculty about personal mental health, substance use and addiction, and other risk factors that may contribute to suicidal ideation.

4. Our AMA: (a) encourages state medical boards to consider physical and mental conditions similarly; (b) encourages state medical boards to recognize that the presence of a mental health condition does not necessarily equate with an impaired ability to practice medicine; and (c) encourages state medical societies to advocate that state medical boards not sanction physicians based solely on the presence of a psychiatric disease, irrespective of treatment or behavior.
5. Our AMA: (a) encourages study of medical student mental health, including but not limited to rates and risk factors of depression and suicide; (b) encourages medical schools to confidentially gather and release information regarding reporting rates of depression/suicide on an opt-out basis from its students; and (c) will work with other interested parties to encourage research into identifying and addressing modifiable risk factors for burnout, depression and suicide across the continuum of medical education.
6.Our AMA encourages the development of alternative methods for dealing with the problems of student-physician mental health among medical schools, such as: (a) introduction to the concepts of physician impairment at orientation; (b) ongoing support groups, consisting of students and house staff in various stages of their education; (c) journal clubs; (d) fraternities; (e) support of the concepts of physical and mental well-being by heads of departments, as well as other faculty members; and/or (f) the opportunity for interested students and house staff to work with students who are having difficulty. Our AMA supports making these alternatives available to students at the earliest possible point in their medical education.
7.Our AMA will engage with the appropriate organizations to facilitate the development of educational resources and training related to suicide risk of patients, medical students, residents/fellows, practicing physicians, and other health care professionals, using an evidence-based multidisciplinary approach.
Citation: CME Rep. 01, I-16; Appended: Res. 301, A-17; Appended: Res. 303, A-17; Modified: CME Rep. 01, A-18; Appended: Res. 312, A-18; Reaffirmed: BOT Rep. 15, A-19

Programs on Managing Physician Stress and Burnout H-405.957
1. Our American Medical Association supports existing programs to assist physicians in early identification and management of stress and the programs supported by the AMA to assist physicians in early identification and management of stress will concentrate on the physical, emotional and psychological aspects of responding to and handling stress in physicians' professional and personal lives, and when to seek professional assistance for stress-related difficulties.
2. Our AMA will review relevant modules of the STEPs Forward Program and also identify validated student-focused, high quality resources for professional well-being, and will encourage the Medical Student Section and Academic Physicians Section to promote these resources to medical students.
Citation: Res. 15, A-15; Appended: Res. 608, A-16; Reaffirmed: BOT Rep. 15, A-19

Study of Medical Student, Resident, and Physician Suicide D-345.983
Our AMA will: (1) explore the viability and cost-effectiveness of regularly collecting National Death Index (NDI) data and confidentially maintaining manner of death information for physicians, residents, and medical students listed as deceased in the AMA Physician Masterfile for long-term studies; (2) monitor progress by the Association of American Medical Colleges and the Accreditation Council for Graduate Medical Education (ACGME) to collect data on medical student and resident/fellow suicides to identify patterns that could predict such events; (3) support the education of faculty members, residents and medical students in the recognition of the signs and symptoms of burnout and depression and supports access to free, confidential, and immediately available stigma-free mental health and substance use disorder services; and (4) collaborate with other stakeholders to study the incidence of and risk factors for depression,

substance misuse and addiction, and suicide among physicians, residents, and medical students.
Citation: CME Rep. 06, A-19

Physician and Medical Student Burnout D-310.968
1. Our AMA recognizes that burnout, defined as emotional exhaustion, depersonalization, and a reduced sense of personal accomplishment or effectiveness, is a problem among residents, fellows, and medical students.
2. Our AMA will work with other interested groups to regularly inform the appropriate designated institutional officials, program directors, resident physicians, and attending faculty about resident, fellow, and medical student burnout (including recognition, treatment, and prevention of burnout) through appropriate media outlets.
3. Our AMA will encourage partnerships and collaborations with accrediting bodies (e.g., the Accreditation Council for Graduate Medical Education and the Liaison Committee on Medical Education) and other major medical organizations to address the recognition, treatment, and prevention of burnout among residents, fellows, and medical students and faculty.
4. Our AMA will encourage further studies and disseminate the results of studies on physician and medical student burnout to the medical education and physician community.
5. Our AMA will continue to monitor this issue and track its progress, including publication of peer-reviewed research and changes in accreditation requirements.
6. Our AMA encourages the utilization of mindfulness education as an effective intervention to address the problem of medical student and physician burnout.
7. Our AMA will encourage medical staffs and/or organizational leadership to anonymously survey physicians to identify local factors that may lead to physician demoralization.
8. Our AMA will continue to offer burnout assessment resources and develop guidance to help organizations and medical staffs implement organizational strategies that will help reduce the sources of physician demoralization and promote overall medical staff well-being.
9. Our AMA will continue to: (a) address the institutional causes of physician demoralization and burnout, such as the burden of documentation requirements, inefficient work flows and regulatory oversight; and (b) develop and promote mechanisms by which physicians in all practices settings can reduce the risk and effects of demoralization and burnout, including implementing targeted practice transformation interventions, validated assessment tools and promoting a culture of well-being.
Citation: CME Rep. 8, A-07; Modified: Res. 919, I-11; Modified: BOT Rep. 15, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 315
(A-22)

Introduced by: Medical Student Section

Subject: Modifying Eligibility Criteria for the Association of American Medical Colleges' Financial Assistance Program

Referred to: Reference Committee C

Whereas, The American College Application Service (AMCAS) is the American Association of Medical College's (AAMC) centralized medical school application processing service and is used by most US medical schools as the primary application method for their entering class[1]; and

Whereas, The 2019 medical school application fee through AMCAS is $170 for the first application and an additional $40 for each application after[2]; and

Whereas, It is estimated that the average cost of secondary applications is $80 per application, and pre-medical applicants apply to an average of 16 medical schools per cycle[3,4]; and

Whereas, Pre-medical students without AAMC Fee Assistance Program (FAP) benefits spend at least $2,800 on application fees alone, not including travel costs for interviews[5]; and

Whereas, Spending $2,800 on application fees alone would be four times greater than the amount the median US household saves for miscellaneous fees in their budget[6]; and

Whereas, The Medical College Admission Test (MCAT), developed and administered by the AAMC, is a standardized, multiple-choice examination created to help medical school admissions offices assess students[7]; and

Whereas, The cost of MCAT registration is $315, with additional fees for late registration and changing test dates, not including test-prep materials recommended to most students which are offered by the AAMC and other test-prep companies[9]; and

Whereas, The University of California Berkeley Career Center estimates a total cost of approximately $7,520 total for the medical school application process as of 2014, and notes that the cost is higher for those applying to both allopathic and osteopathic programs[10]; and

Whereas, The AAMC generated over $70 million dollars in revenue by administering the MCAT and AMCAS alone in 2016[8]; and

Whereas, The Fee Assistance Program (FAP), offered by AAMC, exists to assist those who, without financial assistance, would not be able to apply to medical schools who use the AMCAS application and would not be able to afford the MCAT registration fee[9]; and

Whereas, In order to qualify for the 2019 FAP, the applicants' total family income in 2018 must be 300% or less than the 2018 national poverty level for that family size[11]; and

Whereas, In contrast to other federally funded programs, the FAP does not distinguish between independent or dependent tax statuses, and therefore, parental financial information and tax documents are required and must also fall within eligibility guidelines; this requirement is not waived based on marital status, age or tax filing status[11]; and

Whereas, An applicant having an income that meets the eligibility requirements for fee assistance will still be denied assistance based on parental income[11]; and

Whereas, The Free Application for Federal Student Aid (FAFSA) provided for by the U.S. Department of Education does not require an applicant to report parental income if they file taxes as an independent[12]; and

Whereas, The Expected Family Contribution (EFC) is an index number used by the FAFSA based on family's taxed and untaxed income, assets, and benefits to generate a sliding-scale model in which a lower EFC indicates eligibility for more financial aid[13]; and

Whereas, Offering additional need-based aid to students increases the odds of obtaining their degree, thus helping to reduce inequality in higher education[14]; and

Whereas, In 2017, less than 5% of entering medical students came from the lowest quintile of family income while 51% came from the highest quintile[15]; and

Whereas, Despite several efforts to make medical education attainable to low-income students, the cost of attending medical school continues to rise, making it even more difficult for low-income students and families to afford in the future[16]; and

Whereas, Our AMA has pledged to take action on the rising cost of medical education and its contribution to student debt (H-305.925); and

Whereas, Our AMA has established support for increasing the representation of minority and economically disadvantaged populations in the medical profession (H-350.979) and has committed to working with the AAMC to achieve this goal (D-200.985); therefore be it

RESOLVED, That our American Medical Association encourage the Association of American Medical Colleges to conduct a study of the financial impact of the current Fee Assistance Program policy to medical school applicants. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 04/08/22

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RELEVANT AMA POLICY

Increase the Representation of Minority and Economically Disadvantaged Populations in the Medical Profession H-350.979

Our AMA supports increasing the representation of minorities in the physician population by: (1) Supporting efforts to increase the applicant pool of qualified minority students by: (a) Encouraging state and local governments to make quality elementary and secondary education opportunities available to all; (b) Urging medical schools to strengthen or initiate programs that offer special premedical and precollegiate experiences to underrepresented minority students; (c) urging medical schools and other health training institutions to develop new and innovative measures to recruit underrepresented minority students, and (d) Supporting legislation that provides targeted financial aid to financially disadvantaged students at both the collegiate and medical school levels.
(2) Encouraging all medical schools to reaffirm the goal of increasing representation of underrepresented minorities in their student bodies and faculties.
(3) Urging medical school admission committees to consider minority representation as one factor in reaching their decisions.
(4) Increasing the supply of minority health professionals.
(5) Continuing its efforts to increase the proportion of minorities in medical schools and medical school faculty.
(6) Facilitating communication between medical school admission committees and premedical counselors concerning the relative importance of requirements, including grade point average and Medical College Aptitude Test scores.
(7) Continuing to urge for state legislation that will provide funds for medical education both directly to medical schools and indirectly through financial support to students.
(8) Continuing to provide strong support for federal legislation that provides financial assistance for able students whose financial need is such that otherwise they would be unable to attend medical school.
Citation: CLRPD Rep. 3, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmed: CME Rep. 01, A-18

Strategies for Enhancing Diversity in the Physician Workforce D-200.985

1. Our AMA, independently and in collaboration with other groups such as the Association of American Medical Colleges (AAMC), will actively work and advocate for funding at the federal and state levels and in the private sector to support the following: (a) Pipeline programs to prepare and motivate members of underrepresented groups to enter medical school; (b) Diversity or minority affairs offices at medical schools; (c) Financial aid programs for students from groups that are underrepresented in medicine; and (d) Financial support programs to recruit and develop faculty

members from underrepresented groups.
2. Our AMA will work to obtain full restoration and protection of federal Title VII funding, and similar state funding programs, for the Centers of Excellence Program, Health Careers Opportunity Program, Area Health Education Centers, and other programs that support physician training, recruitment, and retention in geographically-underserved areas.
3. Our AMA will take a leadership role in efforts to enhance diversity in the physician workforce, including engaging in broad-based efforts that involve partners within and beyond the medical profession and medical education community.
4. Our AMA will encourage the Liaison Committee on Medical Education to assure that medical schools demonstrate compliance with its requirements for a diverse student body and faculty.
5. Our AMA will develop an internal education program for its members on the issues and possibilities involved in creating a diverse physician population.
6. Our AMA will provide on-line educational materials for its membership that address diversity issues in patient care including, but not limited to, culture, religion, race and ethnicity.
7. Our AMA will create and support programs that introduce elementary through high school students, especially those from groups that are underrepresented in medicine (URM), to healthcare careers.
8. Our AMA will create and support pipeline programs and encourage support services for URM college students that will support them as they move through college, medical school and residency programs.
9. Our AMA will recommend that medical school admissions committees use holistic assessments of admission applicants that take into account the diversity of preparation and the variety of talents that applicants bring to their education.
10. Our AMA will advocate for the tracking and reporting to interested stakeholders of demographic information pertaining to URM status collected from Electronic Residency Application Service (ERAS) applications through the National Resident Matching Program (NRMP).
11. Our AMA will continue the research, advocacy, collaborative partnerships and other work that was initiated by the Commission to End Health Care Disparities.
12. Our AMA opposes legislation that would undermine institutions' ability to properly employ affirmative action to promote a diverse student population.
13. Our AMA will work with the AAMC and other stakeholders to create a question for the AAMC electronic medical school application to identify previous pipeline program (also known as pathway program) participation and create a plan to analyze the data in order to determine the effectiveness of pipeline programs.
Citation: CME Rep. 1, I-06; Reaffirmation I-10; Reaffirmation A-13; Modified: CCB/CLRPD Rep. 2, A-14; Reaffirmation: A-16; Appended: Res. 313, A-17; Appended: Res. 314, A-17; Modified: CME Rep. 01, A-18; Appended: Res. 207, I-18; Reaffirmation: A-19; Appended: Res. 304, A-19; Appended: Res. 319, A-19; Modified: CME Rep. 5, A-21

Principles of and Actions to Address Medical Education Costs and Student Debt H-305.925
The costs of medical education should never be a barrier to the pursuit of a career in medicine nor to the decision to practice in a given specialty. To help address this issue, our American Medical Association (AMA) will:
1. Collaborate with members of the Federation and the medical education community, and with other interested organizations, to address the cost of medical education and medical student debt through public- and private-sector advocacy.
2. Vigorously advocate for and support expansion of and adequate funding for federal scholarship and loan repayment programs--such as those from the National Health Service Corps, Indian Health Service, Armed Forces, and Department of Veterans Affairs, and for comparable programs from states and the private sector--to promote practice in underserved areas, the military, and academic medicine or clinical research.
3. Encourage the expansion of National Institutes of Health programs that provide loan repayment in exchange for a commitment to conduct targeted research.
4. Advocate for increased funding for the National Health Service Corps Loan Repayment Program to assure adequate funding of primary care within the National Health Service Corps, as well as to

permit: (a) inclusion of all medical specialties in need, and (b) service in clinical settings that care for the underserved but are not necessarily located in health professions shortage areas.
5. Encourage the National Health Service Corps to have repayment policies that are consistent with other federal loan forgiveness programs, thereby decreasing the amount of loans in default and increasing the number of physicians practicing in underserved areas.
6. Work to reinstate the economic hardship deferment qualification criterion known as the “20/220 pathway,” and support alternate mechanisms that better address the financial needs of trainees with educational debt.
7. Advocate for federal legislation to support the creation of student loan savings accounts that allow for pre-tax dollars to be used to pay for student loans.
8. Work with other concerned organizations to advocate for legislation and regulation that would result in favorable terms and conditions for borrowing and for loan repayment, and would permit 100% tax deductibility of interest on student loans and elimination of taxes on aid from service-based programs.
9. Encourage the creation of private-sector financial aid programs with favorable interest rates or service obligations (such as community- or institution-based loan repayment programs or state medical society loan programs).
10. Support stable funding for medical education programs to limit excessive tuition increases, and collect and disseminate information on medical school programs that cap medical education debt, including the types of debt management education that are provided.
11. Work with state medical societies to advocate for the creation of either tuition caps or, if caps are not feasible, pre-defined tuition increases, so that medical students will be aware of their tuition and fee costs for the total period of their enrollment.
12. Encourage medical schools to (a) Study the costs and benefits associated with non-traditional instructional formats (such as online and distance learning, and combined baccalaureate/MD or DO programs) to determine if cost savings to medical schools and to medical students could be realized without jeopardizing the quality of medical education; (b) Engage in fundraising activities to increase the availability of scholarship support, with the support of the Federation, medical schools, and state and specialty medical societies, and develop or enhance financial aid opportunities for medical students, such as self-managed, low-interest loan programs; (c) Cooperate with postsecondary institutions to establish collaborative debt counseling for entering first-year medical students; (d) Allow for flexible scheduling for medical students who encounter financial difficulties that can be remedied only by employment, and consider creating opportunities for paid employment for medical students; (e) Counsel individual medical student borrowers on the status of their indebtedness and payment schedules prior to their graduation; (f) Inform students of all government loan opportunities and disclose the reasons that preferred lenders were chosen; (g) Ensure that all medical student fees are earmarked for specific and well-defined purposes, and avoid charging any overly broad and ill-defined fees, such as but not limited to professional fees; (h) Use their collective purchasing power to obtain discounts for their students on necessary medical equipment, textbooks, and other educational supplies; (i) Work to ensure stable funding, to eliminate the need for increases in tuition and fees to compensate for unanticipated decreases in other sources of revenue; mid-year and retroactive tuition increases should be opposed.
13. Support and encourage state medical societies to support further expansion of state loan repayment programs, particularly those that encompass physicians in non-primary care specialties.
14. Take an active advocacy role during reauthorization of the Higher Education Act and similar legislation, to achieve the following goals: (a) Eliminating the single holder rule; (b) Making the availability of loan deferment more flexible, including broadening the definition of economic hardship and expanding the period for loan deferment to include the entire length of residency and fellowship training; (c) Retaining the option of loan forbearance for residents ineligible for loan deferment; (d) Including, explicitly, dependent care expenses in the definition of the “cost of attendance”; (e) Including room and board expenses in the definition of tax-exempt scholarship income; (f) Continuing the federal Direct Loan Consolidation program, including the ability to “lock in” a fixed interest rate, and giving consideration to grace periods in renewals of federal loan programs; (g) Adding the ability to refinance Federal Consolidation Loans; (h) Eliminating the cap on the student loan interest deduction; (i) Increasing the income limits for taking the interest deduction; (j) Making

permanent the education tax incentives that our AMA successfully lobbied for as part of Economic Growth and Tax Relief Reconciliation Act of 2001; (k) Ensuring that loan repayment programs do not place greater burdens upon married couples than for similarly situated couples who are cohabitating; (l) Increasing efforts to collect overdue debts from the present medical student loan programs in a manner that would not interfere with the provision of future loan funds to medical students.
15. Continue to work with state and county medical societies to advocate for adequate levels of medical school funding and to oppose legislative or regulatory provisions that would result in significant or unplanned tuition increases.
16. Continue to study medical education financing, so as to identify long-term strategies to mitigate the debt burden of medical students, and monitor the short-and long-term impact of the economic environment on the availability of institutional and external sources of financial aid for medical students, as well as on choice of specialty and practice location.
17. Collect and disseminate information on successful strategies used by medical schools to cap or reduce tuition.
18. Continue to monitor the availability of and encourage medical schools and residency/fellowship programs to (a) provide financial aid opportunities and financial planning/debt management counseling to medical students and resident/fellow physicians; (b) work with key stakeholders to develop and disseminate standardized information on these topics for use by medical students, resident/fellow physicians, and young physicians; and (c) share innovative approaches with the medical education community.
19. Seek federal legislation or rule changes that would stop Medicare and Medicaid decertification of physicians due to unpaid student loan debt. The AMA believes that it is improper for physicians not to repay their educational loans, but assistance should be available to those physicians who are experiencing hardship in meeting their obligations.
20. Related to the Public Service Loan Forgiveness (PSLF) Program, our AMA supports increased medical student and physician participation in the program, and will: (a) Advocate that all resident/fellow physicians have access to PSLF during their training years; (b) Advocate against a monetary cap on PSLF and other federal loan forgiveness programs; (c) Work with the United States Department of Education to ensure that any cap on loan forgiveness under PSLF be at least equal to the principal amount borrowed; (d) Ask the United States Department of Education to include all terms of PSLF in the contractual obligations of the Master Promissory Note; (e) Encourage the Accreditation Council for Graduate Medical Education (ACGME) to require residency/fellowship programs to include within the terms, conditions, and benefits of program appointment information on the employer's PSLF program qualifying status; (f) Advocate that the profit status of a physician's training institution not be a factor for PSLF eligibility; (g) Encourage medical school financial advisors to counsel wise borrowing by medical students, in the event that the PSLF program is eliminated or severely curtailed; (h) Encourage medical school financial advisors to increase medical student engagement in service-based loan repayment options, and other federal and military programs, as an attractive alternative to the PSLF in terms of financial prospects as well as providing the opportunity to provide care in medically underserved areas; (i) Strongly advocate that the terms of the PSLF that existed at the time of the agreement remain unchanged for any program participant in the event of any future restrictive changes; (j) Monitor the denial rates for physician applicants to the PSLF; (k) Undertake expanded federal advocacy, in the event denial rates for physician applicants are unexpectedly high, to encourage release of information on the basis for the high denial rates, increased transparency and streamlining of program requirements, consistent and accurate communication between loan servicers and borrowers, and clear expectations regarding oversight and accountability of the loan servicers responsible for the program; (l) Work with the United States Department of Education to ensure that applicants to the PSLF and its supplemental extensions, such as Temporary Expanded Public Service Loan Forgiveness (TEPSLF), are provided with the necessary information to successfully complete the program(s) in a timely manner; and (m) Work with the United States Department of Education to ensure that individuals who would otherwise qualify for PSLF and its supplemental extensions, such as TEPSLF, are not disqualified from the program(s).
21. Advocate for continued funding of programs including Income-Driven Repayment plans for the benefit of reducing medical student load burden.

22. Strongly advocate for the passage of legislation to allow medical students, residents and fellows who have education loans to qualify for interest-free deferment on their student loans while serving in a medical internship, residency, or fellowship program, as well as permitting the conversion of currently unsubsidized Stafford and Graduate Plus loans to interest free status for the duration of undergraduate and graduate medical education.
Citation: CME Report 05, I-18; Appended: Res. 953, I-18; Reaffirmation: A-19; Appended: Res. 316, A-19; Appended: Res. 226, A-21; Reaffirmed in lieu of: Res. 311, A-21; Modified: CME Rep. 4, I-21

Cost and Financing of Medical Education and Availability of First-Year Residency Positions H-305.988
Our AMA:
1. believes that medical schools should further develop an information system based on common definitions to display the costs associated with undergraduate medical education;
2. in studying the financing of medical schools, supports identification of those elements that have implications for the supply of physicians in the future;
3. believes that the primary goal of medical school is to educate students to become physicians and that despite the economies necessary to survive in an era of decreased funding, teaching functions must be maintained even if other commitments need to be reduced;
4. believes that a decrease in student enrollment in medical schools may not result in proportionate reduction of expenditures by the school if quality of education is to be maintained;
5. supports continued improvement of the AMA information system on expenditures of medical students to determine which items are included, and what the ranges of costs are;
6. supports continued study of the relationship between medical student indebtedness and career choice;
7. believes medical schools should avoid counterbalancing reductions in revenues from other sources through tuition and student fee increases that compromise their ability to attract students from diverse backgrounds;
8. supports expansion of the number of affiliations with appropriate hospitals by institutions with accredited residency programs;
9. encourages for profit-hospitals to participate in medical education and training;
10. supports AMA monitoring of trends that may lead to a reduction in compensation and benefits provided to resident physicians;
11. encourages all sponsoring institutions to make financial information available to help residents manage their educational indebtedness; and
12. will advocate that resident and fellow trainees should not be financially responsible for their training.
Citation: CME Rep. A, I-83; Reaffirmed: CLRPD Rep. 1, I-93; Res. 313, I-95; Reaffirmed by CME Rep. 13, A-97; Modified: CME Rep. 7, A-05; Modified: CME Rep. 13, A-06; Appended: Res. 321, A-15; Reaffirmed: CME Rep. 05, A-16; Modified: CME Rep. 04, A-16;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 316
(A-22)

Introduced by: Illinois

Subject: Providing Transparent and Accurate Data Regarding Students and Faculty at Medical Schools

Referred to: Reference Committee C

Whereas, The racial and ethnic data for matriculants of United States medical schools shows that Black, Hispanic, and American Indian or Alaska Native populations are underrepresented in medical schools when compared to the general population, despite the implementation of Liaison Committee on Medical Education (LCME) diversity accreditation guidelines in 2009; and

Whereas, A study comparing Association of American Medical Colleges (AAMC) faculty data between 1990 and 2016 found that Blacks and Hispanics are more underrepresented in the faculty for sixteen medical specialties in 2016 than they were in 1990 with the exception of Black females in obstetrics and gynecology; and

Whereas, Racial and ethnic population differences between medical students and physicians and the populations that they serve lead to health disparities in underrepresented minorities (URM); and

Whereas, Results of a systematic review on implicit bias among healthcare providers suggests that implicit bias against African Americans, Hispanics and other people of color is present among many health care providers of different specialties, levels of training, and levels of experience; and

Whereas, Recruitment and retention of URM faculty members, mentors, and teachers have shown to improve the educational experiences of all medical students and residents, and by extension the quality of patient care in diverse populations; and

Whereas, A study looking at successful strategies of URM faculty recruitment and retention showed that institutional support for underrepresented minorities and awareness of diversity climate is a successful strategy; and

Whereas, The most common reason for underrepresentation of minorities in medicine is lack of a welcoming environment and role models with whom they can identify, and transparent data will allow applicants to evaluate the diversity climate of the institution; and

Whereas, AAMC provides racial and ethnic data of applicants and matriculants to medical schools by year and state, however does not break this data down for individual medical schools; and

Whereas, AAMC provides transparent medical school faculty data including rank, sex, department, and race, however this is not broken down for individual medical schools; therefore be it

RESOLVED, That our American Medical Association work with the Liaison Committee on Medical Education and Commission on Osteopathic College Accreditation to encourage their respective accredited medical schools to make publicly available without charge transparent and accurately reported race and ethnicity demographic data regarding students and faculty. (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000

Received: 05/02/22

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RELEVANT AMA POLICY

Strategies for Enhancing Diversity in the Physician Workforce D-200.985

1. Our AMA, independently and in collaboration with other groups such as the Association of American Medical Colleges (AAMC), will actively work and advocate for funding at the federal and state levels and in the private sector to support the following: (a) Pipeline programs to prepare and motivate members of underrepresented groups to enter medical school; (b) Diversity or minority affairs offices at medical schools; (c) Financial aid programs for students from groups that are underrepresented in medicine; and (d) Financial support programs to recruit and develop faculty members from underrepresented groups.
2. Our AMA will work to obtain full restoration and protection of federal Title VII funding, and similar state funding programs, for the Centers of Excellence Program, Health Careers Opportunity Program, Area Health Education Centers, and other programs that support physician training, recruitment, and retention in geographically-underserved areas.
3. Our AMA will take a leadership role in efforts to enhance diversity in the physician workforce, including engaging in broad-based efforts that involve partners within and beyond the medical profession and medical education community.
4. Our AMA will encourage the Liaison Committee on Medical Education to assure that medical schools demonstrate compliance with its requirements for a diverse student body and faculty.
5. Our AMA will develop an internal education program for its members on the issues and possibilities involved in creating a diverse physician population.
6. Our AMA will provide on-line educational materials for its membership that address diversity issues in patient care including, but not limited to, culture, religion, race and ethnicity.
7. Our AMA will create and support programs that introduce elementary through high school students, especially those from groups that are underrepresented in medicine (URM), to healthcare careers.
8. Our AMA will create and support pipeline programs and encourage support services for URM college students that will support them as they move through college, medical school and residency programs.

9. Our AMA will recommend that medical school admissions committees use holistic assessments of admission applicants that take into account the diversity of preparation and the variety of talents that applicants bring to their education.
10. Our AMA will advocate for the tracking and reporting to interested stakeholders of demographic information pertaining to URM status collected from Electronic Residency Application Service (ERAS) applications through the National Resident Matching Program (NRMP).
11. Our AMA will continue the research, advocacy, collaborative partnerships and other work that was initiated by the Commission to End Health Care Disparities.
12. Our AMA opposes legislation that would undermine institutions' ability to properly employ affirmative action to promote a diverse student population.
13. Our AMA will work with the AAMC and other stakeholders to create a question for the AAMC electronic medical school application to identify previous pipeline program (also known as pathway program) participation and create a plan to analyze the data in order to determine the effectiveness of pipeline programs.
Citation: CME Rep. 1, I-06; Reaffirmation I-10; Reaffirmation A-13; Modified: CCB/CLRPD Rep. 2, A-14; Reaffirmation: A-16; Appended: Res. 313, A-17; Appended: Res. 314, A-17; Modified: CME Rep. 01, A-18; Appended: Res. 207, I-18; Reaffirmation: A-19; Appended: Res. 304, A-19; Appended: Res. 319, A-19; Modified: CME Rep. 5, A-21

Increase the Representation of Minority and Economically Disadvantaged Populations in the Medical Profession H-350.979
Our AMA supports increasing the representation of minorities in the physician population by: (1) Supporting efforts to increase the applicant pool of qualified minority students by: (a) Encouraging state and local governments to make quality elementary and secondary education opportunities available to all; (b) Urging medical schools to strengthen or initiate programs that offer special premedical and precollegiate experiences to underrepresented minority students; (c) urging medical schools and other health training institutions to develop new and innovative measures to recruit underrepresented minority students, and (d) Supporting legislation that provides targeted financial aid to financially disadvantaged students at both the collegiate and medical school levels.
(2) Encouraging all medical schools to reaffirm the goal of increasing representation of underrepresented minorities in their student bodies and faculties.
(3) Urging medical school admission committees to consider minority representation as one factor in reaching their decisions.
(4) Increasing the supply of minority health professionals.
(5) Continuing its efforts to increase the proportion of minorities in medical schools and medical school faculty.
(6) Facilitating communication between medical school admission committees and premedical counselors concerning the relative importance of requirements, including grade point average and Medical College Aptitude Test scores.
(7) Continuing to urge for state legislation that will provide funds for medical education both directly to medical schools and indirectly through financial support to students.
(8) Continuing to provide strong support for federal legislation that provides financial assistance for able students whose financial need is such that otherwise they would be unable to attend medical school.
Citation: CLRPD Rep. 3, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmed: CME Rep. 01, A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 317
(A-22)

Introduced by: Illinois

Subject: Medical Student, Resident and Fellow Suicide Reporting

Referred to: Reference Committee C

Whereas, Depression is a known risk factor for suicide; and

Whereas, 27% of medical students screen positive for depression, a rate 2.2-5.2 times higher than the age-matched general population; and

Whereas, A meta-analysis reported that 29% of residents screen positive for depression, a rate higher than the general population; and

Whereas, There are no studies assessing fellow depressive symptoms across multiple specialties, though a single survey assessing United States (U.S.) pulmonary and critical care medicine fellows reports that 41% show depressive symptoms; and

Whereas, A relationship that meets causal criteria exists between burnout and suicidal ideation in medical trainees; and

Whereas, Burnout is defined in the *11th Revision of the International Classification of Diseases (ICD-11)* as a syndrome resulting from chronic workplace stress, that has not been successfully managed, and is characterized by feelings of exhaustion, increased cynicism related to the profession, and reduced professional efficacy; and

Whereas, Medical students, residents and fellows report higher rates of burnout than the general population; and

Whereas, The presence of an anxiety disorder is an independent risk factor for suicidal ideation; and

Whereas, Medical students have significantly higher rates of anxiety than the general population; and

Whereas, Residents and fellows are 800% more likely to screen positive for generalized anxiety than the general population; and

Whereas, Over 11% of medical students report experiencing suicidal ideation, yet only three research articles have been published exclusively surveying and collecting data on national medical student suicide rates; and

Whereas, The only published study investigating suicide rates among trainees in Accreditation Council for Graduate Medical Education (ACGME)-Accredited Residency Programs states that the second leading cause of death among residents is suicide; and

Whereas, There are currently no studies reporting suicide rates among U.S. fellowship programs; and

Whereas, There is a general lack of published data on medical student, resident and fellow suicide rates; and

Whereas, AMA Policy D-345.983 urges the Association of American Medical Colleges (AAMC) and ACGME to privately collect data for research on the prevention of future medical trainee suicides; and

Whereas, Council on Medical Education Report 6, A-19, recognizes the limitations of National Death Index (NDI) retrospective data collection, stating, “Studies have shown that suicide is likely under-reported due to a lack of systematic approaches to reporting and assessing the statistics,” and further states the AMA is exploring potential new mechanisms for data collection; and

Whereas, Response bias, listed as a common study design limitation, resulted in underreporting of suicides in the two most recent national medical student suicide survey reports conducted from 1989-1994 and 2006-2011; and

Whereas, Data published attempting to quantify medical student, resident, and fellow suicide is inconsistent because there is no reliable, systematic reporting mechanism for medical trainee suicide; and

Whereas, Lack of consistent published data on medical trainee suicide necessitates a national standardized reporting mechanism and protocol; and

Whereas, Centralized data registries have been found to be beneficial for epidemiologic research initiatives due to the ability to collect prospective, tailorable data that can be stratified to aid with pattern recognition, and a similar system could be beneficial for medical trainee suicides; and

Whereas, Laitman et al (2019) call for reporting of “... numbers of deaths by school, [that] should be publicly available on the AAMC and ACGME websites”; and

Whereas, The AMA has no policy regarding standardized reporting of medical student, resident and fellow suicide information to a publicly accessible database; therefore be it

RESOLVED, That our American Medical Association amend Policy D-345.983 by addition to read as follows:

Study of Medical Student, Resident, and Physician Suicide D-345.983

Our AMA will: (1) explore the viability and cost-effectiveness of regularly collecting National Death Index (NDI) data and confidentially maintaining manner of death information for physicians, residents, and medical students listed as deceased in the AMA Physician Masterfile for long-term studies; (2) monitor progress by the Association of American Medical Colleges, the American Association of Colleges of Osteopathic Medicine, and the Accreditation Council for Graduate Medical Education (ACGME) to collect data on medical student and resident/fellow suicides to identify patterns that could predict such events; (3) support the education of faculty members, residents and medical students in the recognition of the signs and symptoms of burnout and depression and supports access to free, confidential, and immediately available stigma-free mental health and substance use disorder services; ~~and~~ (4) collaborate with other stakeholders to study the incidence of and risk factors for depression, substance misuse and addiction, and suicide among physicians, residents, and medical students~~.~~ ; (5) work with appropriate stakeholders to develop a standardized reporting mechanism for the confidential collection of pertinent suicide information of trainees in medical schools, residency, and fellowship programs, along with current wellness initiatives, to inform and promote meaningful interventions at these institutions; and (6) create a publicly accessible database that stratifies medical institutions based on relative rate of trainee suicide over a period of time, in order to raise awareness and promote the implementation of initiatives to prevent medical trainee suicide, while maintaining confidentiality of the deceased. (Modify Current HOD Policy)

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

Received: 05/02/22

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RELEVANT AMA POLICY

Study of Medical Student, Resident, and Physician Suicide D-345.983
Our AMA will: (1) explore the viability and cost-effectiveness of regularly collecting National Death Index (NDI) data and confidentially maintaining manner of death information for physicians, residents, and medical students listed as deceased in the AMA Physician Masterfile for long-term studies; (2) monitor progress by the Association of American Medical Colleges and the Accreditation Council for Graduate Medical Education (ACGME) to collect data on medical student and resident/fellow suicides to identify patterns that could predict such events; (3) support the education of faculty members, residents and medical students in the recognition of the signs and symptoms of burnout and depression and supports access to free, confidential, and immediately available stigma-free mental health and substance use disorder services; and (4) collaborate with other stakeholders to study the incidence of and risk factors for depression, substance misuse and addiction, and suicide among physicians, residents, and medical students.
Citation: CME Rep. 06, A-19

Access to Confidential Health Services for Medical Students and Physicians H-295.858
1. Our AMA will ask the Liaison Committee on Medical Education, Commission on Osteopathic College Accreditation, American Osteopathic Association, and Accreditation Council for Graduate Medical Education to encourage medical schools and residency/fellowship programs, respectively, to:
A. Provide or facilitate the immediate availability of urgent and emergent access to low-cost, confidential health care, including mental health and substance use disorder counseling services, that: (1) include appropriate follow-up; (2) are outside the trainees' grading and evaluation pathways; and (3) are available (based on patient preference and need for assurance of confidentiality) in reasonable proximity to the education/training site, at an external site, or through telemedicine or other virtual, online means;
B. Ensure that residency/fellowship programs are abiding by all duty hour restrictions, as these regulations exist in part to ensure the mental and physical health of trainees;
C. Encourage and promote routine health screening among medical students and resident/fellow physicians, and consider designating some segment of already-allocated personal time off (if necessary, during scheduled work hours) specifically for routine health screening and preventive services, including physical, mental, and dental care; and
D. Remind trainees and practicing physicians to avail themselves of any needed resources, both within and external to their institution, to provide for their mental and physical health and well-being, as a component of their professional obligation to ensure their own fitness for duty and the need to prioritize patient safety and quality of care by ensuring appropriate self-care, not working when sick, and following generally accepted guidelines for a healthy lifestyle.
2. Our AMA will urge state medical boards to refrain from asking applicants about past history of mental health or substance use disorder diagnosis or treatment, and only focus on current impairment by mental illness or addiction, and to accept "safe haven" non-reporting for physicians seeking licensure or

relicensure who are undergoing treatment for mental health or addiction issues, to help ensure confidentiality of such treatment for the individual physician while providing assurance of patient safety.
3. Our AMA encourages medical schools to create mental health and substance abuse awareness and suicide prevention screening programs that would:
A. be available to all medical students on an opt-out basis;
B. ensure anonymity, confidentiality, and protection from administrative action;
C. provide proactive intervention for identified at-risk students by mental health and addiction professionals; and
D. inform students and faculty about personal mental health, substance use and addiction, and other risk factors that may contribute to suicidal ideation.
4. Our AMA: (a) encourages state medical boards to consider physical and mental conditions similarly; (b) encourages state medical boards to recognize that the presence of a mental health condition does not necessarily equate with an impaired ability to practice medicine; and (c) encourages state medical societies to advocate that state medical boards not sanction physicians based solely on the presence of a psychiatric disease, irrespective of treatment or behavior.
5. Our AMA: (a) encourages study of medical student mental health, including but not limited to rates and risk factors of depression and suicide; (b) encourages medical schools to confidentially gather and release information regarding reporting rates of depression/suicide on an opt-out basis from its students; and (c) will work with other interested parties to encourage research into identifying and addressing modifiable risk factors for burnout, depression and suicide across the continuum of medical education.
6.Our AMA encourages the development of alternative methods for dealing with the problems of student-physician mental health among medical schools, such as: (a) introduction to the concepts of physician impairment at orientation; (b) ongoing support groups, consisting of students and house staff in various stages of their education; (c) journal clubs; (d) fraternities; (e) support of the concepts of physical and mental well-being by heads of departments, as well as other faculty members; and/or (f) the opportunity for interested students and house staff to work with students who are having difficulty. Our AMA supports making these alternatives available to students at the earliest possible point in their medical education.
7.Our AMA will engage with the appropriate organizations to facilitate the development of educational resources and training related to suicide risk of patients, medical students, residents/fellows, practicing physicians, and other health care professionals, using an evidence-based multidisciplinary approach.
Citation: CME Rep. 01, I-16; Appended: Res. 301, A-17; Appended: Res. 303, A-17; Modified: CME Rep. 01, A-18; Appended: Res. 312, A-18; Reaffirmed: BOT Rep. 15, A-19

Medical and Mental Health Services for Medical Students and Resident and Fellow Physicians H-345.973
Our AMA promotes the availability of timely, confidential, accessible, and affordable medical and mental health services for medical students and resident and fellow physicians, to include needed diagnostic, preventive, and therapeutic services. Information on where and how to access these services should be readily available at all education/training sites, and these services should be provided at sites in reasonable proximity to the sites where the education/training takes place.
Citation: Res. 915, I-15; Revised: CME Rep. 01, I-16

Educating Physicians About Physician Health Programs and Advocating for Standards D-405.990
Our AMA will:
(1) work closely with the Federation of State Physician Health Programs (FSPHP) to educate our members as to the availability and services of state physician health programs to continue to create opportunities to help ensure physicians and medical students are fully knowledgeable about the purpose of physician health programs and the relationship that exists between the physician health program and the licensing authority in their state or territory;
(2) continue to collaborate with relevant organizations on activities that address physician health and wellness;
(3) in conjunction with the FSPHP, develop state legislative guidelines addressing the design and implementation of physician health programs;
(4) work with FSPHP to develop messaging for all Federation members to consider regarding elimination of stigmatization of mental illness and illness in general in physicians and physicians in training;
(5) continue to work with and support FSPHP efforts already underway to design and implement the physician health program review process, Performance Enhancement and Effectiveness Review

(PEER™), to improve accountability, consistency and excellence among its state member PHPs. The AMA will partner with the FSPHP to help advocate for additional national sponsors for this project; and (6) continue to work with the FSPHP and other appropriate stakeholders on issues of affordability, cost effectiveness, and diversity of treatment options.
Citation: Res. 402, A-09; Modified: CSAPH Rep. 2, A-11; Reaffirmed in lieu of Res. 412, A-12; Appended: BOT action in response to referred for decision Res. 403, A-12; Reaffirmed: BOT Rep. 15, A-19; Modified: Res. 321, A-19

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

B. Appropriate supervision by qualified 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.

Citation: CME Rep. 8, A-11; Appended: Res. 303, A-14; Reaffirmed: Res. 915, I-15; Appended: CME Rep. 04, A-16; Modified: CME Rep. 06, I-18; Appended: Res. 324, A-19; Modified: Res. 304, A-21; Modified: Res. 305, A-21; Modified: BOT Rep. 18, I-21

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 318
(A-22)

Introduced by: Oklahoma

Subject: CME for Preceptorship

Referred to: Reference Committee C

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

Whereas, Being a “preceptor” for medical students, residents, fellows, and other allied health professional students requires countless hours of preparation; and

Whereas, The American Osteopathic Association (AOA) offers category 1B credit to its members for participation in the AOA Didactic and Preceptor Program; and

Whereas, 60 AOA category 1B credits may be applied to the required 120 hours of CME for AOA physicians; and

Whereas, The American Academy of Family Physicians offers CME credits to its members for teaching of medical students, residents, and other allied health professional students; and

Whereas, The AMA does not recognize the AOA credits awarded for teaching and being a preceptor; and

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

RESOLVED, That our American Medical Association study formulating a plan, in collaboration with other interested bodies, to award AMA Category 1 credits to physicians who serve as preceptors and teach medical students, residents, fellows, and other allied health professional students training in Liaison Committee on Medical Education/Accreditation Council for Graduate Medical Education accredited institutions (Directive to Take Action); and be it further

RESOLVED, That our AMA devise a method of converting those credits awarded by other organizations into AMA recognized credits for the purpose of CME. (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000

Received: 05/04/22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 319
(A-22)

Introduced by: AMDA – The Society for Post-Acute and Long-Term Care Medicine

Subject: Senior Living Community Training for Medical Students And Residents

Referred to: Reference Committee C

Whereas, Skilled nursing facilities (SNFs) and nursing facilities (NFs), assisted living facilities (ALFs), and continuing care retirement communities (CCRCs) that incorporate a combination of NFs, SNFs and ALFs with independent living communities (ILFs), are the senior living communities (SLCs) where our nation's most vulnerable older and disabled people reside; and

Whereas, Residents of SLCs are frail and functionally impaired, and often find it difficult to access clinical care at traditional venues such as outpatient clinics and ambulatory centers, and this lack of access to care results in unnecessary utilization of urgent care, emergency departments and hospitals, where older persons are prone to developing adverse outcomes; and

Whereas, SLCs, especially NFs, SNFs and ALFs are highly regulated by federal and state governments, and the average primary care physician (PCP) does not venture to practice in these care settings in part due to lack of familiarity with such regulations and difficulty in complying with them; and

Whereas, Primary care training for medical students and residents requires exposure to various care settings, including outpatient clinics, emergency rooms and hospitals, exposure to SLCs has not been required by the Accreditation Council for Graduate Medical Education (ACGME), thereby deepening the disconnect between PCPs and our vulnerable elderly patients; and

Whereas, Specialty training in geriatric medicine is a part of medical school and primary care residency programs, clinical care of our most vulnerable and frail patients in the SLC setting is not required by ACGME during such training; and

Whereas, The COVID-19 pandemic and other healthcare crises and natural disasters have proven it valuable for all clinicians to be familiar with all common healthcare settings, and especially PALTC due to the unique nature of the care setting and our frail older and disabled residents; therefore be it

RESOLVED, That our American Medical Association advocate to require training of medical students and residents in senior living communities (to include nursing homes and assisted living facilities) during their primary care rotations (internal medicine, family medicine and geriatric medicine). (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000

Received: 05/10/22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 320
(A-22)

Introduced by: Michigan

Subject: Tuition Cost Transparency

Referred to: Reference Committee C

Whereas, In 2018, the Association of American Medical Colleges (AAMC) reported that 76 percent of medical students graduated with a median loan debt of $200,000. Compared to the median medical student debt of $50,000 in 1992, there is an approximate 220 percent increase in medical school debt, even after accounting for the rate of inflation; and

Whereas, The capitalizing interest rates of Stafford Subsidized loans increased from 1.87 percent prior to 2006, to a current fixed rate of 6.87 percent, thereby exacerbating the rising debt of medical students; and

Whereas, Higher levels of medical school debt are associated with worse academic outcomes in undergraduate medical education, negative effects on mental well-being, and higher levels of stress; and

Whereas, Higher medical school debt influences the way medical students approach major life choices; students with higher aggregate amounts of debt were more likely to delay marriage or having children and disagree that they would choose to become a physician again; and

Whereas, Medical students with higher debt compared to their peers were more likely to choose a specialty with a higher annual income, were less likely to choose primary care, and less likely to plan to practice in underserved locations; and

Whereas, The number of graduate medical students exceeds the number of available post graduate year positions. The increasing number of students not matching, and the increase in medical student debt can make medical school seem more of a financial risk; and

Whereas, The American Medical Association (AMA) supports continued assessment of the value of graduate medical education (GME) and transparency of federal funding, which is received by GME institutions; and

Whereas, Undergraduate medical students are not provided specific breakdowns of tuition costs or reasons for tuition increases; and

Whereas, The AMA supports improving the systematic reporting of undergraduate medical student expenditures to determine which items are included and the ranges of costs; therefore be it

RESOLVED, That our American Medical Association collaborate with organizations such as the Association of American Medical Colleges in creating transparency in tuition costs of undergraduate medical education institutions (Directive to Take Action); and be it further

RESOLVED, That our AMA work with other national organizations to improve the affordability of medical education. (Directive to Take Action)

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

Received: 05/11/22

Sources:
1. AAMC. An Exploration of the Recent Decline in the Percentage of U.S. Medical School Graduates With Education Debt. https://www.aamc.org/download/296002/data/aibvol12_no2.pdf. Accessed January 13, 2020.
2. Pisaniello MS, Asahina AT, Bacchi S, et al. Effect of medical student debt on mental health, academic performance and specialty choice: A systematic review. BMJ Open. 2019;9(7). doi:10.1136/bmjopen-2019-029980
3. Craft III J, Craft T. Rising Medical Education Debt a Mounting Concern. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6179784/pdf/ms109_p0266.pdf. Accessed January 13, 2020.
4. Hill MR, Goicochea S, Merlo LJ. In their own words: stressors facing medical students in the millennial generation. Med Educ Online. 2018;23(1). doi:10.1080/10872981.2018.1530558
5. Rohlfing J, Navarro R, Maniya OZ, Hughes BD, Rogalsky DK. Medical student debt and major life choices other than specialty. Med Educ Online. 2014;19(1). doi:10.3402/meo.v19.25603
6. Grayson MS, Newton DA, Thompson LF. Payback time: the associations of debt and income with medical student career choice. Med Educ. 2012;46(10):983-991. doi:10.1111/j.1365-2923.2012.04340.x

RELEVANT AMA POLICY

Cost and Financing of Medical Education and Availability of First-Year Residency Positions H-305.988
Our AMA:
1. believes that medical schools should further develop an information system based on common definitions to display the costs associated with undergraduate medical education;
2. in studying the financing of medical schools, supports identification of those elements that have implications for the supply of physicians in the future;
3. believes that the primary goal of medical school is to educate students to become physicians and that despite the economies necessary to survive in an era of decreased funding, teaching functions must be maintained even if other commitments need to be reduced;
4. believes that a decrease in student enrollment in medical schools may not result in proportionate reduction of expenditures by the school if quality of education is to be maintained;
5. supports continued improvement of the AMA information system on expenditures of medical students to determine which items are included, and what the ranges of costs are;
6. supports continued study of the relationship between medical student indebtedness and career choice;
7. believes medical schools should avoid counterbalancing reductions in revenues from other sources through tuition and student fee increases that compromise their ability to attract students from diverse backgrounds;
8. supports expansion of the number of affiliations with appropriate hospitals by institutions with accredited residency programs;
9. encourages for profit-hospitals to participate in medical education and training;
10. supports AMA monitoring of trends that may lead to a reduction in compensation and benefits provided to resident physicians;
11. encourages all sponsoring institutions to make financial information available to help residents manage their educational indebtedness; and
12. will advocate that resident and fellow trainees should not be financially responsible for their training.
Citation: CME Rep. A, I-83; Reaffirmed: CLRPD Rep. 1, I-93; Res. 313, I-95; Reaffirmed by CME Rep. 13, A-97; Modified: CME Rep. 7, A-05; Modified: CME Rep. 13, A-06; Appended: Res. 321, A-15; Reaffirmed: CME Rep. 05, A-16; Modified: CME Rep. 04, A-16

The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education D-305.967
1. Our AMA will actively collaborate with appropriate stakeholder organizations, (including Association of American Medical Colleges, American Hospital Association, state medical societies, medical specialty societies/associations) to advocate for the preservation, stability and expansion of full funding for the direct and indirect costs of graduate medical education (GME) positions from all existing sources (e.g. Medicare, Medicaid, Veterans Administration, CDC and others).

2. Our AMA will actively advocate for the stable provision of matching federal funds for state Medicaid programs that fund GME positions.
3. Our AMA will actively seek congressional action to remove the caps on Medicare funding of GME positions for resident physicians that were imposed by the Balanced Budget Amendment of 1997 (BBA-1997).
4. Our AMA will strenuously advocate for increasing the number of GME positions to address the future physician workforce needs of the nation.
5. Our AMA will oppose efforts to move federal funding of GME positions to the annual appropriations process that is subject to instability and uncertainty.
6. Our AMA will oppose regulatory and legislative efforts that reduce funding for GME from the full scope of resident educational activities that are designated by residency programs for accreditation and the board certification of their graduates (e.g. didactic teaching, community service, off-site ambulatory rotations, etc.).
7. Our AMA will actively explore additional sources of GME funding and their potential impact on the quality of residency training and on patient care.
8. Our AMA will vigorously advocate for the continued and expanded contribution by all payers for health care (including the federal government, the states, and local and private sources) to fund both the direct and indirect costs of GME.
9. Our AMA will work, in collaboration with other stakeholders, to improve the awareness of the general public that GME is a public good that provides essential services as part of the training process and serves as a necessary component of physician preparation to provide patient care that is safe, effective and of high quality.
10. Our AMA staff and governance will continuously monitor federal, state and private proposals for health care reform for their potential impact on the preservation, stability and expansion of full funding for the direct and indirect costs of GME.
11. Our AMA: (a) recognizes that funding for and distribution of positions for GME are in crisis in the United States and that meaningful and comprehensive reform is urgently needed; (b) will immediately work with Congress to expand medical residencies in a balanced fashion based on expected specialty needs throughout our nation to produce a geographically distributed and appropriately sized physician workforce; and to make increasing support and funding for GME programs and residencies a top priority of the AMA in its national political agenda; and (c) will continue to work closely with the Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, American Osteopathic Association, and other key stakeholders to raise awareness among policymakers and the public about the importance of expanded GME funding to meet the nation's current and anticipated medical workforce needs.
12. Our AMA will collaborate with other organizations to explore evidence-based approaches to quality and accountability in residency education to support enhanced funding of GME.
13. Our AMA will continue to strongly advocate that Congress fund additional graduate medical education (GME) positions for the most critical workforce needs, especially considering the current and worsening maldistribution of physicians.
14. Our AMA will advocate that the Centers for Medicare and Medicaid Services allow for rural and other underserved rotations in Accreditation Council for Graduate Medical Education (ACGME)-accredited residency programs, in disciplines of particular local/regional need, to occur in the offices of physicians who meet the qualifications for adjunct faculty of the residency program's sponsoring institution.
15. Our AMA encourages the ACGME to reduce barriers to rural and other underserved community experiences for graduate medical education programs that choose to provide such training, by adjusting as needed its program requirements, such as continuity requirements or limitations on time spent away from the primary residency site.
16. Our AMA encourages the ACGME and the American Osteopathic Association (AOA) to continue to develop and disseminate innovative methods of training physicians efficiently that foster the skills and inclinations to practice in a health care system that rewards team-based care and social accountability.
17. Our AMA will work with interested state and national medical specialty societies and other appropriate stakeholders to share and support legislation to increase GME funding, enabling a state to accomplish one or more of the following: (a) train more physicians to meet state and regional workforce needs; (b) train physicians who will practice in physician shortage/underserved areas; or (c) train physicians in undersupplied specialties and subspecialties in the state/region.
18. Our AMA supports the ongoing efforts by states to identify and address changing physician workforce needs within the GME landscape and continue to broadly advocate for innovative pilot programs that will

increase the number of positions and create enhanced accountability of GME programs for quality outcomes.
19. Our AMA will continue to work with stakeholders such as Association of American Medical Colleges (AAMC), ACGME, AOA, American Academy of Family Physicians, American College of Physicians, and other specialty organizations to analyze the changing landscape of future physician workforce needs as well as the number and variety of GME positions necessary to provide that workforce.
20. Our AMA will explore innovative funding models for incremental increases in funded residency positions related to quality of resident education and provision of patient care as evaluated by appropriate medical education organizations such as the Accreditation Council for Graduate Medical Education.
21. Our AMA will utilize its resources to share its content expertise with policymakers and the public to ensure greater awareness of the significant societal value of graduate medical education (GME) in terms of patient care, particularly for underserved and at-risk populations, as well as global health, research and education.
22. Our AMA will advocate for the appropriation of Congressional funding in support of the National Healthcare Workforce Commission, established under section 5101 of the Affordable Care Act, to provide data and healthcare workforce policy and advice to the nation and provide data that support the value of GME to the nation.
23. Our AMA supports recommendations to increase the accountability for and transparency of GME funding and continue to monitor data and peer-reviewed studies that contribute to further assess the value of GME.
24. Our AMA will explore various models of all-payer funding for GME, especially as the Institute of Medicine (now a program unit of the National Academy of Medicine) did not examine those options in its 2014 report on GME governance and financing.
25. Our AMA encourages organizations with successful existing models to publicize and share strategies, outcomes and costs.
26. Our AMA encourages insurance payers and foundations to enter into partnerships with state and local agencies as well as academic medical centers and community hospitals seeking to expand GME.
27. Our AMA will develop, along with other interested stakeholders, a national campaign to educate the public on the definition and importance of graduate medical education, student debt and the state of the medical profession today and in the future.
28. Our AMA will collaborate with other stakeholder organizations to evaluate and work to establish consensus regarding the appropriate economic value of resident and fellow services.
29. Our AMA will monitor ongoing pilots and demonstration projects, and explore the feasibility of broader implementation of proposals that show promise as alternative means for funding physician education and training while providing appropriate compensation for residents and fellows.
30. Our AMA will monitor the status of the House Energy and Commerce Committee's response to public comments solicited regarding the 2014 IOM report, Graduate Medical Education That Meets the Nation's Health Needs, as well as results of ongoing studies, including that requested of the GAO, in order to formulate new advocacy strategy for GME funding, and will report back to the House of Delegates regularly on important changes in the landscape of GME funding.
31. Our AMA will advocate to the Centers for Medicare & Medicaid Services to adopt the concept of “Cap-Flexibility” and allow new and current Graduate Medical Education teaching institutions to extend their cap-building window for up to an additional five years beyond the current window (for a total of up to ten years), giving priority to new residency programs in underserved areas and/or economically depressed areas.
32. Our AMA will: (a) encourage all existing and planned allopathic and osteopathic medical schools to thoroughly research match statistics and other career placement metrics when developing career guidance plans; (b) strongly advocate for and work with legislators, private sector partnerships, and existing and planned osteopathic and allopathic medical schools to create and fund graduate medical education (GME) programs that can accommodate the equivalent number of additional medical school graduates consistent with the workforce needs of our nation; and (c) encourage the Liaison Committee on Medical Education (LCME), the Commission on Osteopathic College Accreditation (COCA), and other accrediting bodies, as part of accreditation of allopathic and osteopathic medical schools, to prospectively and retrospectively monitor medical school graduates’ rates of placement into GME as well as GME completion.
33. Our AMA encourages the Secretary of the U.S. Department of Health and Human Services to coordinate with federal agencies that fund GME training to identify and collect information needed to effectively evaluate how hospitals, health systems, and health centers with residency programs are

utilizing these financial resources to meet the nation's health care workforce needs. This includes information on payment amounts by the type of training programs supported, resident training costs and revenue generation, output or outcomes related to health workforce planning (i.e., percentage of primary care residents that went on to practice in rural or medically underserved areas), and measures related to resident competency and educational quality offered by GME training programs.
Citation: Sub. Res. 314, A-07; Reaffirmation I-07; Reaffirmed: CME Rep. 4, I-08; Reaffirmed: Sub. Res. 314, A-09; Reaffirmed: CME Rep. 3, I-09; Reaffirmation A-11; Appended: Res. 910, I-11; Reaffirmed in lieu of Res. 303, A-12; Reaffirmed in lieu of Res. 324, A-12; Reaffirmation: I-12; Reaffirmation A-13; Appended: Res. 320, A-13; Appended: CME Rep. 5, A-13; Appended: CME Rep. 7, A-14; Appended: Res. 304, A-14; Modified: CME Rep. 9, A-15; Appended: CME Rep, 1, I-15; Appended: Res. 902, I-15; Reaffirmed: CME Rep. 3, A-16; Appended: Res. 320, A-16; Appended: CME Rep. 04, A-16; Appended: CME Rep. 05, A-16; Reaffirmation A-16; Appended: Res. 323, A-17; Appended: CME Rep. 03, A-18; Appended: Res. 319, A-18; Reaffirmed in lieu of: Res. 960, I-18; Modified: Res. 233, A-19; Modified: BOT Rep. 25, A-19; Reaffirmed: CME Rep. 3, A-21

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 321
(A-22)

Introduced by: Michigan

Subject: Improving and Standardizing Pregnancy and Lactation Accommodations for Medical Board Examinations

Referred to: Reference Committee C

Whereas, There are known complications of pregnancy, including but not limited to, carpal tunnel syndrome, gestational diabetes, gastroesophageal reflux, morning sickness including hyperemesis gravidarum, urinary tract or bladder infections, chronic migraines, and pelvic and back pain, that can be disruptive to women's ability to complete workplace responsibilities; and

Whereas, Complications of pregnancy qualify as disabilities under the American Disability Act, which requires employers to provide appropriate accommodations; and

Whereas, 53 percent of pregnant, working women felt the need to modify job requirements; and

Whereas, 70 percent of women report morning sickness in the first trimester; and

Whereas, In 2019, women accounted for 50.5% of all matriculating medical students; and

Whereas, Medical student parents face unique barriers to coordinating medical school graduation requirements; and

Whereas, The majority of medical schools have scheduled licensing exam study periods and deadlines by which students must complete testing with relative inflexibility in timing; and

Whereas, The Prometric testing sites for the USMLE exam provide minimal pregnancy accommodations, limited to a trackball computer mouse, pillows for physical comfort, and private testing rooms; and

Whereas, The Prometric testing sites for the USMLE exam provide minimal lactation accommodations, limited to curtains or a pop-up tent for privacy during nursing or pumping; and

Whereas, The Personal Item Exceptions (PIEs) list of pre-approved items allowed within the secure testing area provides limited pregnancy comfort aids, including glucose tablets, non-electric heating pads, ice packs, pillow/lumbar support, and stools for limb elevation; and

Whereas, Neither the National Board of Medical Education (NBME) nor the contracted Prometric Testing sites have a public, unified list of common pregnancy accommodations for the USMLE exams, leaving candidates to find and cite multiple webpages to identify previously approved accommodations for the USMLE; and

Whereas, The state of California provides graduate students in their public institutions the same accommodations and support services to pregnant students and those recovering from childbirth-related conditions as it would to other students with temporary medical conditions; and

Whereas, The American Board of Internal Medicine considers pregnancy and breastfeeding to be medical conditions worthy of accommodation for board exams and offers a core set of accommodations offered to all pregnant or nursing examinees, including extra break time and the opportunity to take the exam over two days; and

Whereas, Basic guidelines for lactation support at standardized testing centers have already been recognized by academic journals, including a private space for milk expression and storage of breastmilk ("lactation station") that is close to the testing site with furniture to support lactation including a chair to sit on while pumping, a power outlet, a sink for washing hands and/or cleaning pump parts, and a refrigerator and freezer to store expressed milk; therefore be it

RESOLVED, That our American Medical Association support and advocate for the implementation of 60 minutes of additional, scheduled break time for medical students and residents who have pregnancy complications and/or lactation needs for all NBME administered examinations, consistent with American Board of Internal Medicine accommodations (New HOD Policy); and be it further

RESOLVED, That our AMA support and advocate for the addition of pregnancy comfort aids, including but not limited to, ginger teas, saltines, wastebaskets, and antiemetics, to the USMLE pre-approved list of Personal Item Exemptions (PIEs) permitted in the secure testing area for pregnant individuals. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 05/11/22

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RELEVANT AMA POLICY

AMA Support for Breastfeeding H-245.982

1. Our AMA: (a) recognizes that breastfeeding is the optimal form of nutrition for most infants; (b) endorses the 2012 policy statement of American Academy of Pediatrics on Breastfeeding and the use of Human Milk, which delineates various ways in which physicians and hospitals can promote, protect, and support breastfeeding practices; (c) supports working with other interested organizations in actively seeking to promote increased breastfeeding by Supplemental Nutrition Program for Women, Infants, and Children (WIC Program) recipients, without reduction in other benefits; (d) supports the availability and appropriate use of breast pumps as a cost-effective tool to promote breast feeding; and (e) encourages public facilities to provide designated areas for breastfeeding and breast pumping; mothers nursing babies should not be singled out and discouraged from nursing their infants in public places.
2. Our AMA: (a) promotes education on breastfeeding in undergraduate, graduate, and continuing medical education curricula; (b) encourages all medical schools and graduate medical education programs to support all residents, medical students and faculty who provide breast milk for their infants, including appropriate time and facilities to express and store breast milk during the working day; (c) encourages the education of patients during prenatal care on the benefits of breastfeeding; (d) supports breastfeeding in the health care system by encouraging hospitals to provide written breastfeeding policy that is communicated to health care staff; (e) encourages hospitals to train staff in the skills needed to implement written breastfeeding policy, to educate pregnant women about the benefits and management of breastfeeding, to attempt early initiation of breastfeeding, to practice "rooming-in," to educate mothers on how to breastfeed and maintain lactation, and to foster breastfeeding support groups and services; (f) supports curtailing formula promotional practices by encouraging perinatal care providers and hospitals to ensure that physicians or other appropriately trained medical personnel authorize distribution of infant formula as a medical sample only after appropriate infant feeding education, to specifically include education of parents about the medical benefits of breastfeeding and encouragement of its practice, and education of parents about formula and bottle-feeding options; and (g) supports the concept that the parent's decision to use infant formula, as well as the choice of which formula, should be preceded by consultation with a physician.
3. Our AMA: (a) supports the implementation of the WHO/UNICEF Ten Steps to Successful Breastfeeding at all birthing facilities; (b) endorses implementation of the Joint Commission Perinatal Care Core Measures Set for Exclusive Breast Milk Feeding for all maternity care facilities in the US as measures of breastfeeding initiation, exclusivity and continuation which should be continuously tracked by the nation, and social and demographic disparities should be addressed and eliminated; (c) recommends exclusive breastfeeding for about six months, followed by continued breastfeeding as complementary food are introduced, with continuation of breastfeeding for 1 year or longer as mutually desired by mother and infant; (d) recommends the adoption of employer programs which support breastfeeding mothers so that they may safely and privately express breast milk at work or take time to feed their infants; and (e) encourages employers in all fields of healthcare to serve as role models to improve the public health by supporting mothers providing breast milk to their infants beyond the postpartum period.
4. Our AMA supports the evaluation and grading of primary care interventions to support breastfeeding, as developed by the United States Preventive Services Task Force (USPSTF).
5. Our AMA's Opioid Task Force promotes educational resources for mothers who are breastfeeding on the benefits and risks of using opioids or medication-assisted therapy for opioid use disorder, based on the most recent guidelines.
Citation: CSA Rep. 2, A-05; Res. 325, A-05; Reaffirmation A-07; Reaffirmation A-12; Modified in lieu of Res. 409, A-12 and Res. 410, A-12; Appended: Res. 410, A-16; Appended: Res. 906, I-17; Reaffirmation: I-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 322
(A-22)

Introduced by: Michigan

Subject: Standards in Cultural Humility Training within Medical Education

Referred to: Reference Committee C

Whereas, Cultural humility within medicine is defined as “the lifelong commitment to self-evaluation and self-critique to redressing the power imbalances in patient-physician dynamic;” and

Whereas, Cultural humility is a skill that is beneficial for students and physicians to understand how their culture and identity influences patient encounters to become more culturally sensitive doctors, minimizing the risk of subconscious bias of personal beliefs onto a patient; and

Whereas, Cultural humility is distinct from cultural competence, as competency implies achievement of proficiency, while humility includes constant self-reflection and learning, focuses on the clinicians ability to connect on multiple levels to patients, and fosters cultural respect; and

Whereas, The Liaison Committee on Medical Education (LCME) introduced standards for cultural competency for all medical students upon graduation, yet medical schools are not explicitly required to have standards for cultural humility education within their curriculum; and

Whereas, There is existing literature outlining techniques to implement tools and coaching of cultural humility in the healthcare field, such as simulated teaching interventions, the 5R’s approach of developing humility (reflection, respect, regard, relevance, and resiliency), and self-reflective courses; and

Whereas, Several cultural minority groups experience barriers in receiving quality health care and have worse mortality and morbidity outcomes across various chronic diseases; and

Whereas, Training health care professionals in cultural humility is associated with higher scores on accountability, improved health care experiences, and increased empathy towards patients; therefore be it

RESOLVED, That our AMA amend policy H-295.897, “Enhancing the Cultural Competence of Physicians,” by addition to read as follows:

Enhancing the Cultural Competence of Physicians H-295.897
1. Our AMA continues to inform medical schools and residency program directors about activities and resources related to assisting physicians in providing culturally competent care to patients throughout their life span and encourage them to include the topic of culturally effective health care in their curricula.
2. Our AMA continues to support research into the need for and effectiveness of training in cultural competence and cultural humility, using existing mechanisms such as the annual medical education surveys.

3. Our AMA will assist physicians in obtaining information about and/or training in culturally effective health care through dissemination of currently available resources from the AMA and other relevant organizations.
4. Our AMA encourages training opportunities for students and residents, as members of the physician-led team, to learn cultural competency from community health workers, when this exposure can be integrated into existing rotation and service assignments.
5. Our AMA supports initiatives for medical schools to incorporate diversity in their Standardized Patient programs as a means of combining knowledge of health disparities and practice of cultural competence with clinical skills.
6. Our AMA will encourage the inclusion of peer-facilitated intergroup dialogue in medical education programs nationwide.
7. Our AMA supports the development of national standards for cultural humility training in the medical school curricula. (Modify Current HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 05/11/22

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RELEVANT AMA POLICY

Enhancing the Cultural Competence of Physicians H-295.897
1. Our AMA continues to inform medical schools and residency program directors about activities and resources related to assisting physicians in providing culturally competent care to patients throughout their life span and encourage them to include the topic of culturally effective health care in their curricula.
2. Our AMA continues to support research into the need for and effectiveness of training in cultural competence, using existing mechanisms such as the annual medical education surveys.
3. Our AMA will assist physicians in obtaining information about and/or training in culturally effective health care through dissemination of currently available resources from the AMA and other relevant organizations.
4. Our AMA encourages training opportunities for students and residents, as members of the physician-led team, to learn cultural competency from community health workers, when this exposure can be integrated into existing rotation and service assignments.
5.Our AMA supports initiatives for medical schools to incorporate diversity in their Standardized Patient programs as a means of combining knowledge of health disparities and practice of cultural competence with clinical skills.
6.Our AMA will encourage the inclusion of peer-facilitated intergroup dialogue in medical education programs nationwide.
Citation: CME Rep. 5, A-98; Reaffirmed: Res. 221, A-07; Reaffirmation A-11; Appended: Res. 304, I-16; Modified: CME Rep. 01, A-17; Appended: Res. 320, A-17; Reaffirmed: CMS Rep. 02, I-17; Appended: Res. 315, A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 323
(A-22)

Introduced by: Medical Student Section

Subject: Cultural Leave for American Indian Trainees

Referred to: Reference Committee C

Whereas, American Indian and Alaska Native students have disparately lower four-year medical school graduation rates compared to their non-Hispanic white peers (71% vs. 87%)[1]; and

Whereas, The Association of American Medical Colleges and Association of American Indian Physicians recognize that perception of one's school/workplace environment influences medical student retention and success and that a positive psychological climate can be fostered when student programming and student affairs offices are responsive to American Indian and Alaska Native culture and history[1]; and

Whereas, A 2021 survey conducted by the Association of Native American Medical Students found that 20% of respondents cited loss of culture and distance from family as significant challenges to their progression in medical training;[2] and

Whereas, The American Indian Religious Freedom Act of 1978 requires protection and preservation of American Indians' inherent right of freedom to believe, express, and exercise the traditional religions of the American Indian, Eskimo, Aleut, and Native Hawaiians, including but not limited to access to sites, use and possession of sacred objects, and the freedom to worship through ceremonial and traditional rites[3]; and

Whereas, Despite this law, American Indian and Alaska Native K-12 students are more likely to face disciplinary action in education systems, including suspension and expulsion, than their peers due to a lack of cultural responsiveness[4]; and

Whereas, Cultural responsiveness enables individuals and organizations to respond respectfully and effectively to people of all cultures, languages, classes, races, ethnic backgrounds, disabilities, religions, genders, sexual orientations, and other diversity factors in a manner that recognizes, affirms, and values their worth[5]; and

Whereas, Culturally-responsive practices involve recognizing and incorporating the assets and strengths all students bring into the classroom, and ensuring that learning experiences, from curriculum through assessment, are relevant to all students, and are grounded in evidence-based community practice[6]; and

Whereas, Existing AMA policy focused on equity, diversity and, inclusion (H-200.951, D-200.985) is not specific to or inclusive of cultural leave practices; and

Whereas, American Indian and Alaska Native cultural responsiveness must be an ongoing and deliberate effort, taking root across the school spectrum—curriculum, pedagogy, engagement with students and their families, and overall policies and practices;[7-8] and

Whereas, There is strong evidence that institutions must accommodate American Indian and Alaska Native cultural practices instead of relying on the student to navigate non-specific policies allowing for leave;[9] therefore be it

RESOLVED, That our American Medical Association amend policy H-310.923, Eliminating Religious Discrimination from Residency Programs, by addition and deletion to read as follows:

> Eliminating Religious and Cultural Discrimination from Residency and Fellowship Programs and Medical Schools H-310.923
>
> Our AMA encourages residency programs, fellowship programs, and medical schools to: (1) ~~make an effort to accommodate~~ Allow ~~residents'~~ trainees to take leave and attend religious and cultural holidays and observances, including those practiced by American Indians and Alaskan Natives, provided that patient care and the rights of other ~~residents~~ trainees are not compromised; and (2) explicitly inform applicants and entrants about their policies and procedures related to accommodation for religious and cultural holidays and observances; (Modify Current HOD Policy) and be it further

RESOLVED, That our AMA work with the Association of American Indian Physicians, Association of Native American Medical Students, and other appropriate stakeholders to design model cultural leave policies for undergraduate and graduate medical education programs and healthcare employers. (Directive to Take Action)

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

Received: 05/11/22

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RELEVANT AMA POLICY

Policies for Parental, Family and Medical Necessity Leave H-405.960
AMA adopts as policy the following guidelines for, and encourages the implementation of, Parental, Family and Medical Necessity Leave for Medical Students and Physicians:
1. Our AMA urges medical schools, residency training programs, medical specialty boards, the Accreditation Council for Graduate Medical Education, and medical group practices to incorporate and/or encourage development of leave policies, including parental, family, and medical leave policies, as part of the physician's standard benefit agreement.
2. Recommended components of parental leave policies for medical students and physicians include: (a)

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

Eliminating Religious Discrimination from Residency Programs H-310.923
Our AMA encourages residency programs to: (1) make an effort to accommodate residents' religious holidays and observances, provided that patient care and the rights of other residents are not compromised; and (2) explicitly inform applicants and entrants about their policies and procedures related to accommodation for religious holidays and observances. CME Rep. 10, A-06; Reaffirmed: CME Rep. 01, A-16.

Strategies for Enhancing Diversity in the Physician Workforce H-200.951
Our AMA: (1) supports increased diversity across all specialties in the physician workforce in the categories of race, ethnicity, disability status, sexual orientation, gender identity, socioeconomic origin, and rurality; (2) commends the Institute of Medicine (now known as the National Academies of Sciences, Engineering, and Medicine) for its report, "In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce," and supports the concept that a racially and ethnically diverse educational experience results in better educational outcomes; (3) encourages the development of evidence-informed programs to build role models among academic leadership and faculty for the mentorship of students, residents, and fellows underrepresented in medicine and in specific specialties; (4) encourages physicians to engage in their communities to guide, support, and mentor high school and undergraduate students with a calling to medicine; (5) encourages medical schools, health care institutions, managed care and other appropriate groups to adopt and utilize activities that bolster efforts to include and support individuals who are underrepresented in medicine by developing policies that articulate the value and importance of diversity as a goal that benefits all participants, cultivating and funding programs that nurture a culture of diversity on campus, and recruiting faculty and staff who share this goal; and (6) continue to study and provide recommendations to improve the future of health equity and racial justice in medical education, the diversity of the health workforce, and the outcomes of marginalized patient populations.
CME Rep. 1, I-06; Reaffirmed: CME Rep. 7, A-08; Reaffirmed: CCB/CLRPD Rep. 4, A-13; Modified: CME Rep. 01, A-16; Reaffirmation A-16; Modified: Res. 009, A-21; Modified: CME Rep. 5, A-21

Strategies for Enhancing Diversity in the Physician Workforce D-200.985
1. Our AMA, independently and in collaboration with other groups such as the Association of American Medical Colleges (AAMC), will actively work and advocate for funding at the federal and state levels and in the private sector to support the following: (a) Pipeline programs to prepare and motivate members of underrepresented groups to enter medical school; (b) Diversity or minority affairs offices at medical schools; (c) Financial aid programs for students from groups that are underrepresented in medicine; and (d) Financial support programs to recruit and develop faculty members from underrepresented groups.
2. Our AMA will work to obtain full restoration and protection of federal Title VII funding, and similar state funding programs, for the Centers of Excellence Program, Health Careers Opportunity Program, Area Health Education Centers, and other programs that support physician training, recruitment, and retention in geographically-underserved areas.
3. Our AMA will take a leadership role in efforts to enhance diversity in the physician workforce, including engaging in broad-based efforts that involve partners within and beyond the medical profession and medical education community.
4. Our AMA will encourage the Liaison Committee on Medical Education to assure that medical schools demonstrate compliance with its requirements for a diverse student body and faculty.
5. Our AMA will develop an internal education program for its members on the issues and possibilities involved in creating a diverse physician population.
6. Our AMA will provide on-line educational materials for its membership that address diversity issues in patient care including, but not limited to, culture, religion, race and ethnicity.
7. Our AMA will create and support programs that introduce elementary through high school students, especially those from groups that are underrepresented in medicine (URM), to healthcare careers.
8. Our AMA will create and support pipeline programs and encourage support services for URM college students that will support them as they move through college, medical school and residency programs.
9. Our AMA will recommend that medical school admissions committees use holistic assessments of admission applicants that take into account the diversity of preparation and the variety of talents that applicants bring to their education.
10. Our AMA will advocate for the tracking and reporting to interested stakeholders of demographic information pertaining to URM status collected from Electronic Residency Application Service (ERAS)

applications through the National Resident Matching Program (NRMP).
11. Our AMA will continue the research, advocacy, collaborative partnerships and other work that was initiated by the Commission to End Health Care Disparities.
12. Our AMA opposes legislation that would undermine institutions' ability to properly employ affirmative action to promote a diverse student population.
13. Our AMA will work with the AAMC and other stakeholders to create a question for the AAMC electronic medical school application to identify previous pipeline program (also known as pathway program) participation and create a plan to analyze the data in order to determine the effectiveness of pipeline programs.
CME Rep. 1, I-06; Reaffirmation I-10; Reaffirmation A-13; Modified: CCB/CLRPD Rep. 2, A-14; Reaffirmation: A-16; Appended: Res. 313, A-17; Appended: Res. 314, A-17; Modified: CME Rep. 01, A-18; Appended: Res. 207, I-18; Reaffirmation: A-19; Appended: Res. 304, A-19; Appended: Res. 319, A-19; Modified: CME Rep. 5, A-21

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 324
(A-22)

Introduced by: Medical Student Section

Subject: Sexual Harassment Accreditation Standards for Medical Training Programs

Referred to: Reference Committee C

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

Whereas, According to the 2018 report from the National Academies of Sciences, Engineering, and Medicine, 49.6% of female students in medical school or in graduate school for a healthcare field have reported having experienced sexual harassment during their training[2]; and

Whereas, Female medical students are 220% more likely to experience unwanted crude behavior from faculty or staff compared to female students studying non-scientific fields[2]; and

Whereas, At one medical program, female medical students were more likely than their male colleagues to be physically sexually harassed and to be harassed by a person of higher professional status, resulting in 79% of female survivors and 45% of male survivors saying that the experience of sexual harassment created a "hostile environment" or interfered with work performance[3]; and

Whereas, Sexual harassment during training has been shown to have a significant impact on the specialty and residency program choices of female trainees[4]; and

Whereas, Female residents are more likely to experience sexual harassment during graduate medical education in fields such as surgery and emergency medicine compared to other specialties, with one study finding that 70.8% of female general surgery residents reported experiencing sexual harassment during training[2,5]; and

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

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

through psychological consequences such as anxiety and depression compared to general job stressors such as workload and meeting deadlines[2,10]; and

Whereas, Sexual harassment continues to be a problem in medicine despite federal protection such as Title VII, Title IX, and the Clery Act, which intend to protect victims of sexual harassment from gender discrimination and unwanted sexual attention[11-14]; and

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

Whereas, Legal protections do not adequately protect trainees from covert retaliation, and fear of retaliation accounts for 28% of the approximately 79% of cases of sexual harassment that go unreported[11]; and

Whereas, In the absence of an institutional culture that promotes sexual harassment training at all levels and the importance of incident reporting as part of the solution to mitigate sexual harassment, sexual harassment training and reporting methods are not effective at reducing sexual harassment of medical trainees[16-18]; and

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

Whereas, The Liaison Committee on Medical Education (LCME) serves as the accrediting body that holds all medical schools to 12 standards which ensure graduates have been adequately trained to begin graduate medical education[20]; and

Whereas, The LCME does not explicitly address sexual harassment in the written standards for Anti-Discrimination and Student Mistreatment[21]; and

Whereas, LCME Standard 12 does explicitly address the need for medical schools to provide "effective student services to all medical students to assist them in achieving the program's goals for its students"[21]; and

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

Whereas, The Accreditation Council for Graduate Medical Education (ACGME) serves as the accrediting body that evaluates all residency and fellowship programs to ensure programs meet the established quality standards for each specialty and subspecialty[22]; and

Whereas, The ACGME requires residency and fellowship programs to maintain a professional environment free from sexual harassment, but does not explicitly state how that standard is evaluated[23,24]; therefore be it

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

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

Fiscal Note: Minimal - less than $1,000

Received: 05/11/22

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RELEVANT AMA POLICY

9.1.3 Sexual Harassment in the Practice of Medicine
Sexual harassment can be defined as unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature.
Sexual harassment in the practice of medicine is unethical. Sexual harassment exploits inequalities in status and power, abuses the rights and trust of those who are subjected to such conduct; interferes with an individual's work performance, and may influence or be perceived as influencing professional advancement in a manner unrelated to clinical or academic performance harm professional working relationships, and create an intimidating or hostile work environment; and is likely to jeopardize patient care. Sexual relationships between medical supervisors and trainees are not acceptable, even if consensual. The supervisory role should be eliminated if the parties wish to pursue their relationship.
Physicians should promote and adhere to strict sexual harassment policies in medical workplaces.
Physicians who participate in grievance committees should be broadly representative with respect to gender identity or sexual orientation, profession, and employment status, have the power to enforce harassment policies, and be accessible to the persons they are meant to serve.
AMA Principles of Medical Ethics: II,IV,VII
The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law.
Issued: 2016

Principles for Advancing Gender Equity in Medicine H-65.961
Principles for Advancing Gender Equity in Medicine:
Our AMA:
1. declares it is opposed to any exploitation and discrimination in the workplace based on personal characteristics (i.e., gender);
2. affirms the concept of equal rights for all physicians and that the concept of equality of rights under the law shall not be denied or abridged by the U.S. Government or by any state on account of gender;
3. endorses the principle of equal opportunity of employment and practice in the medical field;
4. affirms its commitment to the full involvement of women in leadership roles throughout the federation, and encourages all components of the federation to vigorously continue their efforts to recruit women members into organized medicine;
5. acknowledges that mentorship and sponsorship are integral components of one's career advancement, and encourages physicians to engage in such activities;
6. declares that compensation should be equitable and based on demonstrated competencies/expertise and not based on personal characteristics;
7. recognizes the importance of part-time work options, job sharing, flexible scheduling, re-entry, and contract negotiations as options for physicians to support work-life balance;
8. affirms that transparency in pay scale and promotion criteria is necessary to promote gender equity, and as such academic medical centers, medical schools, hospitals, group practices and other physician employers should conduct periodic reviews of compensation and promotion rates by gender and evaluate protocols for advancement to determine whether the criteria are discriminatory; and
9. affirms that medical schools, institutions and professional associations should provide training on leadership development, contract and salary negotiations and career advancement strategies that include an analysis of the influence of gender in these skill areas.

Our AMA encourages: (1) state and specialty societies, academic medical centers, medical schools, hospitals, group practices and other physician employers to adopt the AMA Principles for Advancing Gender Equity in Medicine; and (2) academic medical centers, medical schools, hospitals, group practices and other physician employers to: (a) adopt policies that prohibit harassment, discrimination and retaliation; (b) provide anti-harassment training; and (c) prescribe disciplinary and/or corrective action should violation of such policies occur.
BOT Rep. 27, A-19

Policy on Conduct at AMA Meetings and Events H-140.837
It is the policy of the American Medical Association that all attendees of AMA hosted meetings, events and other activities are expected to exhibit respectful, professional, and collegial behavior during such meetings, events and activities, including but not limited to dinners, receptions and social gatherings held

in conjunction with such AMA hosted meetings, events and other activities. Attendees should exercise consideration and respect in their speech and actions, including while making formal presentations to other attendees, and should be mindful of their surroundings and fellow participants.

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

Definition

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

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

Sexual Harassment

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

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

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

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

Operational Guidelines

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

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

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

The AMA shall establish and maintain a Committee on Conduct at AMA Meetings and Events (CCAM), to be comprised of 5-7 AMA members who are nominated by the Office of General Counsel (or through a nomination process facilitated by the Office of General Counsel) and approved by the Board of Trustees.

The CCAM should include one member of the Council on Ethical and Judicial Affairs (CEJA); provided, however, that such CEJA member on the CCAM shall be recused from discussion and vote concerning referral by the CCAM of a matter to CEJA for further review and action. The remaining members may be appointed from AMA membership generally, with emphasis on maximizing the diversity of membership. Appointments to the CCAM shall ensure appropriate independence and neutrality, and avoid even the appearance of conflict of interest, in decisions on consequences for policy violations. Appointments to the CCAM should be multi-year, with staggered terms.

2. Reporting Violations of the Policy

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

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

These reporting mechanisms will be publicized to ensure awareness.

3. Investigations

All reported violations of Policy H-140.837, "Policy on Conduct at AMA Meetings and Events," pursuant to Section 2 above (irrespective of the reporting mechanism used) will be investigated by the Conduct Liaison. Each reported violation will be promptly and thoroughly investigated. Whenever possible, the Conduct Liaison should conduct incident investigations on-site during the event. This allows for immediate action at the event to protect the safety of event participants. When this is not possible, the Conduct Liaison may continue to investigate incidents following the event to provide recommendations for action to the CCAM. Investigations should consist of structured interviews with the person reporting the incident (the reporter), the person targeted (if they are not the reporter), any witnesses that the reporter or target identify, and the alleged violator.

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

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

4. Disciplinary Action

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

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

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

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

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

5. Confidentiality

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

6. Assent to Policy

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

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

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

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

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

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

Teacher-Learner Relationship In Medical Education H-295.955

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

CODE OF BEHAVIOR

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

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

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

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

to evaluate objective performance; assigning tasks for punishment rather than educational purposes; requiring the performance of personal services; taking credit for another individual's work; intentional neglect or intentional lack of communication.
On the institutional level, abuse may be defined as policies, regulations, or procedures that are socially disapproved as a violation of individuals' rights. Examples of institutional abuse are: policies, regulations, or procedures that are discriminatory based on race, religion, ethnicity, sex, age, sexual orientation, gender identity, and physical disabilities; and requiring individuals to perform unpleasant tasks that are entirely irrelevant to their education as physicians.
While criticism is part of the learning process, in order to be effective and constructive, it should be handled in a way to promote learning. Negative feedback is generally more useful when delivered in a private setting that fosters discussion and behavior modification. Feedback should focus on behavior rather than personal characteristics and should avoid pejorative labeling.
Because people's opinions will differ on whether specific behavior is acceptable, teaching programs should encourage discussion and exchange among teacher and learner to promote effective educational strategies. People in the teaching role (including faculty, residents, and students) need guidance to carry out their educational responsibilities effectively.
Medical schools are urged to develop innovative ways of preparing students for their roles as educators of other students as well as patients.
BOT Rep. ZZ, I-90 Reaffirmed by CME Rep. 9, A-98 Reaffirmed: CME Rep. 2, I-99 Modified: BOT Rep. 11, A-07 Reaffirmed: CME Rep. 9, A-13; Reaffirmed: BOT Rep. 9, I-20

Recommendations for Future Directions for Medical Education H-295.995
Our AMA supports the following recommendations relating to the future directions for medical education:
(1) The medical profession and those responsible for medical education should strengthen the general or broad components of both undergraduate and graduate medical education. All medical students and resident physicians should have general knowledge of the whole field of medicine regardless of their projected choice of specialty.
(2) Schools of medicine should accept the principle and should state in their requirements for admission that a broad cultural education in the arts, humanities, and social sciences, as well as in the biological and physical sciences, is desirable.
(3) Medical schools should make their goals and objectives known to prospective students and premedical counselors in order that applicants may apply to medical schools whose programs are most in accord with their career goals.
(4) Medical schools should state explicitly in publications their admission requirements and the methods they employ in the selection of students.
(5) Medical schools should require their admissions committees to make every effort to determine that the students admitted possess integrity as well as the ability to acquire the knowledge and skills required of a physician.
(6) Although the results of standardized admission testing may be an important predictor of the ability of students to complete courses in the preclinical sciences successfully, medical schools should utilize such tests as only one of several criteria for the selection of students. Continuing review of admission tests is encouraged because the subject content of such examinations has an influence on premedical education and counseling.
(7) Medical schools should improve their liaison with college counselors so that potential medical students can be given early and effective advice. The resources of regional and national organizations can be useful in developing this communication.
(8) Medical schools are chartered for the unique purpose of educating students to become physicians and should not assume obligations that would significantly compromise this purpose.
(9) Medical schools should inform the public that, although they have a unique capability to identify the changing medical needs of society and to propose responses to them, they are only one of the elements of society that may be involved in responding. Medical schools should continue to identify social problems related to health and should continue to recommend solutions.
(10) Medical school faculties should continue to exercise prudent judgment in adjusting educational programs in response to social change and societal needs.
(11) Faculties should continue to evaluate curricula periodically as a means of insuring that graduates will have the capability to recognize the diverse nature of disease, and the potential to provide preventive and comprehensive medical care. Medical schools, within the framework of their respective institutional goals

and regardless of the organizational structure of the faculty, should provide a broad general education in both basic sciences and the art and science of clinical medicine.
(12) The curriculum of a medical school should be designed to provide students with experience in clinical medicine ranging from primary to tertiary care in a variety of inpatient and outpatient settings, such as university hospitals, community hospitals, and other health care facilities. Medical schools should establish standards and apply them to all components of the clinical educational program regardless of where they are conducted. Regular evaluation of the quality of each experience and its contribution to the total program should be conducted.
(13) Faculties of medical schools have the responsibility to evaluate the cognitive abilities of their students. Extramural examinations may be used for this purpose, but never as the sole criterion for promotion or graduation of a student.
(14) As part of the responsibility for granting the MD degree, faculties of medical schools have the obligation to evaluate as thoroughly as possible the non-cognitive abilities of their medical students.
(15) Medical schools and residency programs should continue to recognize that the instruction provided by volunteer and part-time members of the faculty and the use of facilities in which they practice make important contributions to the education of medical students and resident physicians. Development of means by which the volunteer and part-time faculty can express their professional viewpoints regarding the educational environment and curriculum should be encouraged.
(16) Each medical school should establish, or review already established, criteria for the initial appointment, continuation of appointment, and promotion of all categories of faculty. Regular evaluation of the contribution of all faculty members should be conducted in accordance with institutional policy and practice.
(17a) Faculties of medical schools should reevaluate the current elements of their fourth or final year with the intent of increasing the breadth of clinical experience through a more formal structure and improved faculty counseling. An appropriate number of electives or selected options should be included. (17b) Counseling of medical students by faculty and others should be directed toward increasing the breadth of clinical experience. Students should be encouraged to choose experience in disciplines that will not be an integral part of their projected graduate medical education.
(18) Directors of residency programs should not permit medical students to make commitments to a residency program prior to the final year of medical school.
(19) The first year of postdoctoral medical education for all graduates should consist of a broad year of general training. (a) For physicians entering residencies in internal medicine, pediatrics, and general surgery, postdoctoral medical education should include at least four months of training in a specialty or specialties other than the one in which the resident has been appointed. (A residency in family practice provides a broad education in medicine because it includes training in several fields.) (b) For physicians entering residencies in specialties other than internal medicine, pediatrics, general surgery, and family practice, the first postdoctoral year of medical education should be devoted to one of the four above-named specialties or to a program following the general requirements of a transitional year stipulated in the "General Requirements" section of the "Essentials of Accredited Residencies." (c) A program for the transitional year should be planned, designed, administered, conducted, and evaluated as an entity by the sponsoring institution rather than one or more departments. Responsibility for the executive direction of the program should be assigned to one physician whose responsibility is the administration of the program. Educational programs for a transitional year should be subjected to thorough surveillance by the appropriate accrediting body as a means of assuring that the content, conduct, and internal evaluation of the educational program conform to national standards. The impact of the transitional year should not be deleterious to the educational programs of the specialty disciplines.
(20) The ACGME, individual specialty boards, and respective residency review committees should improve communication with directors of residency programs because of their shared responsibility for programs in graduate medical education.
(21) Specialty boards should be aware of and concerned with the impact that the requirements for certification and the content of the examination have upon the content and structure of graduate medical education. Requirements for certification should not be so specific that they inhibit program directors from exercising judgment and flexibility in the design and operation of their programs.
(22) An essential goal of a specialty board should be to determine that the standards that it has set for certification continue to assure that successful candidates possess the knowledge, skills, and the commitment to upgrade continually the quality of medical care.

(23) Specialty boards should endeavor to develop a consensus concerning the significance of certification by specialty and publicize it so that the purposes and limitations of certification can be clearly understood by the profession and the public.
(24) The importance of certification by specialty boards requires that communication be improved between the specialty boards and the medical profession as a whole, particularly between the boards and their sponsoring, nominating, or constituent organizations and also between the boards and their diplomates.
(25) Specialty boards should consider having members of the public participate in appropriate board activities.
(26) Specialty boards should consider having physicians and other professionals from related disciplines participate in board activities.
(27) The AMA recommends to state licensing authorities that they require individual applicants, to be eligible to be licensed to practice medicine, to possess the degree of Doctor of Medicine or its equivalent from a school or program that meets the standards of the LCME or accredited by the American Osteopathic Association, or to demonstrate as individuals, comparable academic and personal achievements. All applicants for full and unrestricted licensure should provide evidence of the satisfactory completion of at least one year of an accredited program of graduate medical education in the US. Satisfactory completion should be based upon an assessment of the applicant's knowledge, problem-solving ability, and clinical skills in the general field of medicine. The AMA recommends to legislatures and governmental regulatory authorities that they not impose requirements for licensure that are so specific that they restrict the responsibility of medical educators to determine the content of undergraduate and graduate medical education.
(28) The medical profession should continue to encourage participation in continuing medical education related to the physician's professional needs and activities. Efforts to evaluate the effectiveness of such education should be continued.
(29) The medical profession and the public should recognize the difficulties related to an objective and valid assessment of clinical performance. Research efforts to improve existing methods of evaluation and to develop new methods having an acceptable degree of reliability and validity should be supported.
(30) Methods currently being used to evaluate the readiness of graduates of foreign medical schools to enter accredited programs in graduate medical education in this country should be critically reviewed and modified as necessary. No graduate of any medical school should be admitted to or continued in a residency program if his or her participation can reasonably be expected to affect adversely the quality of patient care or to jeopardize the quality of the educational experiences of other residents or of students in educational programs within the hospital.
(31) The Educational Commission for Foreign Medical Graduates should be encouraged to study the feasibility of including in its procedures for certification of graduates of foreign medical schools a period of observation adequate for the evaluation of clinical skills and the application of knowledge to clinical problems.
(32) The AMA, in cooperation with others, supports continued efforts to review and define standards for medical education at all levels. The AMA supports continued participation in the evaluation and accreditation of medical education at all levels.
(33) The AMA, when appropriate, supports the use of selected consultants from the public and from the professions for consideration of special issues related to medical education.
(34) The AMA encourages entities that profile physicians to provide them with feedback on their performance and with access to education to assist them in meeting norms of practice; and supports the creation of experiences across the continuum of medical education designed to teach about the process of physician profiling and about the principles of utilization review/quality assurance.
(35) Our AMA encourages the accrediting bodies for MD- and DO-granting medical schools to review, on an ongoing basis, their accreditation standards to assure that they protect the quality and integrity of medical education in the context of the emergence of new models of medical school organization and governance.
(36) Our AMA will strongly advocate for the rights of medical students, residents, and fellows to have physician-led (MD or DO as defined by the AMA) clinical training, supervision, and evaluation while recognizing the contribution of non-physicians to medical education.
(37) Our AMA will publicize to medical students, residents, and fellows their rights, as per Liaison Committee on Medical Education and Accreditation Council for Graduate Medical Education guidelines, to physician-led education and a means to report violations without fear of retaliation.

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

Alignment of Accreditation Across the Medical Education Continuum H-295.862
1. Our AMA supports the concept that accreditation standards for undergraduate and graduate medical education should adopt a common competency framework that is based in the Accreditation Council for Graduate Medical Education (ACGME) competency domains.
2. Our AMA recommends that the relevant associations, including the AMA, Association of American Medical Colleges (AAMC), American Osteopathic Association (AOA), and American Association of Colleges of Osteopathic Medicine (AACOM), along with the relevant accreditation bodies for undergraduate medical education (Liaison Committee on Medical Education, Commission on Osteopathic College Accreditation) and graduate medical education (ACGME, AOA) develop strategies to:
a. Identify guidelines for the expected general levels of learners' competencies as they leave medical school and enter residency training.
b. Create a standardized method for feedback from medical school to premedical institutions and from the residency training system to medical schools about their graduates' preparedness for entry.
c. Identify areas where accreditation standards overlap between undergraduate and graduate medical education (e.g., standards related to the clinical learning environment) so as to facilitate coordination of data gathering and decision-making related to compliance.
All of these activities should be codified in the standards or processes of accrediting bodies.
3. Our AMA encourages development and implementation of accreditation standards or processes that support utilization of tools (e.g., longitudinal learner portfolios) to track learners' progress in achieving the defined competencies across the continuum.
4. Our AMA supports the concept that evaluation of physicians as they progress along the medical education continuum should include the following: (a) assessments of each of the six competency domains of patient care, medical knowledge, interpersonal and communication skills, professionalism, practice-based learning and improvement, and systems-based practice; and (b) use of assessment instruments and tools that are valid and reliable and appropriate for each competency domain and stage of the medical education continuum.
5. Our AMA encourages study of competency-based progression within and between medical school and residency.
a. Through its Accelerating Change in Medical Education initiative, our AMA should study models of competency-based progression within the medical school.
b. Our AMA should work with the Accreditation Council for Graduate Medical Education (ACGME) to study how the Milestones of the Next Accreditation System support competency-based progression in residency.
6. Our AMA encourages research on innovative methods of assessment related to the six competency domains of the ACGME/American Board of Medical Specialties that would allow monitoring of performance across the stages of the educational continuum.
7. Our AMA encourages ongoing research to identify best practices for workplace-based assessment that allow performance data related to each of the six competency domains to be aggregated and to serve as feedback to physicians in training and in practice.
CME Rep. 4, A-14 Appended: CME Rep. 10, A-15

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 325
(A-22)

Introduced by: Medical Student Section

Subject: Single Licensing Exam Series for Osteopathic and Allopathic Medical Students

Referred to: Reference Committee C

Whereas, The Comprehensive Osteopathic Medical Licensing Examination (COMLEX) USA is a licensing exam series that is currently required by the Commission on Osteopathic College Accreditation (COCA) to be taken by all osteopathic medical students in order to graduate from a COCA-accredited medical school[1]; and

Whereas, The United States Medical Licensing Examination (USMLE) is a licensing exam series that is currently taken by all allopathic medical students and some osteopathic medical students[2]; and

Whereas, In 1997, 363 osteopathic medical student first-time test takers completed USMLE Step 1 and Step 2 Clinical Knowledge (CK) and by 2020, that number had increased more than 23-fold, significantly outpacing the 3-fold growth in osteopathic medical school enrollment, so that in 2020 70% of the first-time test-taking osteopathic students who took COMLEX Level 1 also took USMLE Step 1[2,3,4]; and

Whereas, The growing trend of osteopathic students choosing to take the USMLE series in addition to the COMLEX USA series further exacerbates the osteopathic medical student debt burden, adding an approximate total of $6,131,840 in additional examination fees for osteopathic test takers during 2019-2020[2,5]; and

Whereas, An increasing number of osteopathic medical schools have mandated students to complete the USMLE and COMLEX USA series prior to graduation, despite evidence that a minimal number of licensing examinations already significantly increase rates of stress, anxiety, and depression amongst medical students[6]; and

Whereas, Two high-stakes licensing examinations establishing the same competency create redundancy, as evident by strong correlation between USMLE Step 1 and Step 2 and respective COMLEX Level 1 and 2 scores for residency applicants[7,8,9]; and

Whereas, Although USMLE Step 1 and the COMLEX USA Level 1 will change to a pass/fail scoring system by 2022, the USMLE Step 2 CK will remain a scored exam[10]; and

Whereas, In 2014, the American Osteopathic Association (AOA), American Association of Colleges of Osteopathic Medicine (AACOM), and the Accreditation Council of Graduate Medical Education (ACGME) agreed to transition to a single accreditation system to increase collaboration among the medical education community, reduce costs and increase efficiency, and provide consistency[11]; and

Whereas, The AOA has recognized the importance of modernizing board certification exams, and are offering a new pathway of board certification that does not include and/or require Osteopathic Manipulative Treatment (OMT), emphasizing the similarities between the allopathic and osteopathic professions[12]; and

Whereas, Although the AMA has adopted policy H-295.876, *Equal Fees for Osteopathic and Allopathic Medical Students,* which is currently being enacted by the AMA Council of Medical Education, there is evidence that ACGME programs have and continue to discriminate against osteopathic medical students who did not to take the USMLE series when selecting candidates for away rotations and residencies[13,14]; and

Whereas, Nearly 20% of ACGME program directors do not utilize the COMLEX USA series and require the USMLE series as part of the residency selection process, putting osteopathic medical students who elect not take USMLE series at a significant disadvantage[11,13]; and

Whereas, Many ACGME program directors, and a majority of program directors in certain specialties such as emergency medicine, consider it to be important for osteopathic students to apply with USMLE series scores, and that in these specialties, osteopathic students who take the USMLE series have a 20% better match rate[13,15]; and

Whereas, Despite previously-enacted advocacy efforts regarding AMA resolution H-275.013, *The Grading Policy for Medical Licensure Examination*, calling for equal recognition of the COMLEX USA and USMLE series as licensing exams, recent data shows that 54% of VSAS participating institutions require USMLE Step 1 scores for away rotations[13]; and

Whereas, The National Student Osteopathic Medical Association (SOMA) adopted resolution S-20-30, *Single Licensing Exam*, encouraging the National Board of Osteopathic Medical Examiners (NBOME), National Board of Medical Examiners (NBME), and Federation of State Medical Boards (FSMB) to develop a single licensing examination series for all medical students with an additional osteopathic specific subject test for osteopathic medical students[16,17]; and

Whereas, Although the Coalition for Physician Accountability's Undergraduate Medical Education-Graduate Medical Education Review Committee offered the solutions of standardized score conversion between USMLE and the COMLEX-USA series, historically program directors have required USMLE scores despite the long standing availability of COMLEX percentile converters by the NBOME[18,19]; and

Whereas, SOMA has advocated to the COCA to adjust their continuing accreditation standards such that Element 6.12 no longer requires the COMLEX USA series to be passed prior to graduation from an Osteopathic medical school, rather Osteopathic medical students must pass a new single licensing exam developed by the NBOME, FSMB, and NBME[20]; therefore be it,

RESOLVED, That our American Medical Association encourage the development of a single licensing examination series for all medical students attending a medical school accredited by the Liaison Committee on Medical Education (LCME) or the Commission on Osteopathic College Accreditation (COCA), with a separate, additional osteopathic-specific subject test for osteopathic medical students. (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000

Received: 05/11/22

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RELEVANT AMA POLICY

Proposed Single Examination for Licensure H-275.962

Our AMA: (1) endorses the concept of a single examination for medical licensure;
(2) urges the NBME and the FSMB to place responsibility for developing Steps I and II of the new single examination for licensure with the faculty of U.S. medical schools working through the NBME;
(3) continues its vigorous support of the LCME and its accreditation of medical schools and supports monitoring the impact of a single examination on the effectiveness of the LCME;
(4) urges the NBME and the FSMB to establish a high standard for passing the examination;
(5) strongly recommends and supports actively pursuing efforts to assure that the standard for passing be criterion-based; that is, that passing the examination indicate a degree of knowledge acceptable for practicing medicine; and
(6) will work with the appropriate stakeholders to study the advantages, disadvantages, and practicality of combining the USMLE Step 1 and Step 2 CK exams into a single licensure exam measuring both foundational science and clinical knowledge competencies.
CME Rep. B, I-89; Reaffirmed: Sunset Report, A-00; Modified: CME Rep. 2, A-10; Reaffirmed: BOT Rep. 3, I-14; Appended: Res. 309, A-17

Equal Fees for Osteopathic and Allopathic Medical Students H-295.876
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.
4. Our AMA: (a) encourages the Association of American Medical 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

National Resident Matching Program Reform D-310.977
Our AMA:
(1) will work with the National Resident Matching Program to develop and distribute educational programs to better inform applicants about the NRMP matching process;
(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;
(5) will work with the Accreditation Council for Graduate Medical Education 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 applicant;
(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 National Resident Matching Program (NRMP) and Accreditation Council for Graduate Medical Education (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; and
(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.
CME Rep. 4, A-05; Appended: Res. 330, A-11; Appended: Res. 920, I-11; Appended: Res. 311, A-14; Appended: Res. 312, A-14; Appended: Res. 304, A-15; Appended: CME Rep. 03, A-16; Reaffirmation: A-16; Appended: CME Rep. 06, A-17; Appended: Res. 306, A-17; Modified: Speakers Rep. 01, A-17; Appended: CME Rep. 3, A-21

Alternatives to the Federation of State Medical Boards Recommendations on Licensure H-275.934
Our AMA adopts the following principles:(1) Ideally, all medical students should successfully complete Steps 1 and 2 of the United States Medical Licensing Examination (USMLE) or Levels 1 and 2 of the Comprehensive Osteopathic Medical Licensing Examination (COMLEX USA) prior to entry into residency training. At a minimum, individuals entering residency training must have successfully completed Step 1 of the USMLE or Level 1 of COMLEX USA. There should be provision made for students who have not completed Step 2 of the USMLE or Level 2 of the COMLEX USA to do so during the first year of residency training. (2) All applicants for full and unrestricted licensure, whether graduates of U.S. medical schools or international medical graduates, must have completed one year of accredited graduate medical education (GME) in the U.S., have passed all licensing examinations (USMLE or COMLEX USA), and must be certified by their residency program director as ready to advance to the next year of GME and to obtain a full and unrestricted license to practice medicine. The candidate for licensure should have had education that provided exposure to general medical content. (3) There should be a training permit/educational license for all resident physicians who do not yet have a full and unrestricted license to practice medicine. To be eligible for an initial training permit/educational license, the resident must have completed Step 1 of the USMLE or Level 1 of COMLEX USA. (4) Residency program directors shall report only those actions to state medical licensing boards that are reported for all licensed physicians. (5) Residency program directors should receive training to ensure that they understand the process for taking disciplinary action against resident physicians, and are aware of procedures for dismissal of residents and for due process. This requirement for residency program directors should be enforced through Accreditation Council for Graduate Medical Education accreditation requirements. (6) There should be no reporting of actions against medical students to state medical licensing boards. (7) Medical schools are responsible for identifying and remediating and/or disciplining medical student unprofessional behavior, problems with substance abuse, and other behavioral problems. as well as gaps in student knowledge and skills. (8) The Dean's Letter of Evaluation should be strengthened and standardized, to serve as a better source of information to residency programs about applicants.
CME Rep. 8, A-99; Reaffirmed: CME Rep. 4, I-01; Reaffirmed: CME Rep. 2, A-11; Modified: CME Rep. 2, A-12; Modified: CME Rep. 2, A-21

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 D-275.950
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 credentialing 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.
Res. 306, I-20

The Grading Policy for Medical Licensure Examinations H-275.953
1. Our AMA's representatives to the ACGME are instructed to promote the principle that selection of residents should be based on a broad variety of evaluative criteria, and to propose that the ACGME General Requirements state clearly that residency program directors must not use NBME or USMLE ranked passing scores as a screening criterion for residency selection.
2. Our AMA adopts the following policy on NBME or USMLE examination scoring: (a) Students receive "pass/fail" scores as soon as they are available. (If students fail the examinations, they may request their numerical scores immediately.) (b) Numerical scores are reported to the state licensing authorities upon request by the applicant for licensure. At this time, the applicant may request a copy of his or her numerical scores. (c) Scores are reported in pass/fail format for each student to the medical school. The school also receives a frequency distribution of numerical scores for the aggregate of their students.

3. Our AMA will co-convene the appropriate stakeholders to study possible mechanisms for transitioning scoring of the USMLE and COMLEX exams to a Pass/Fail system in order to avoid the inappropriate use of USMLE and COMLEX scores for screening residency applicants while still affording program directors adequate information to meaningfully and efficiently assess medical student applications, and that the recommendations of this study be made available by the 2019 Interim Meeting of the AMA House of Delegates.
4. Our AMA will: (a) promote equal acceptance of the USMLE and COMLEX at all United States residency programs; (b) work with appropriate stakeholders including but not limited to the National Board of Medical Examiners, Association of American Medical Colleges, National Board of Osteopathic Medical Examiners, Accreditation Council for Graduate Medical Education and American Osteopathic Association to educate Residency Program Directors on how to interpret and use COMLEX scores; and (c) work with Residency Program Directors to promote higher COMLEX utilization with residency program matches in light of the new single accreditation system.
5. 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

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 326
(A-22)

Introduced by: Medical Student Section

Subject: Standardized Wellness Initiative Reporting

Referred to: Reference Committee C

Whereas, Existing studies of medical trainees have shown high rates of depression and anxiety, both of which are known risk factors for suicide[1-4]; and

Whereas, In one meta-analysis, the prevalence of depression or depressive symptoms among medical students was 27%, with only 16% of those who screened positive seeking psychiatric treatment; residents report depression at rates of 21-43%, with rates increasing over time[3,5]; and

Whereas, Matriculating medical students have lower rates of depression and burnout compared to the general population, a trend that quickly reverses when they begin medical school; similarly, the first year of residency is associated with a 16% increase in depressive symptoms, highlighting a need for additional support during that transition[5-7]; and

Whereas, Rates of burnout - a contributor to depression, relationship problems, and substance use - are higher in all medical trainees compared to the general population[8,9]; and

Whereas, Suicide rates in medical trainees are difficult to estimate due to lack of high-quality data, particularly in the medical student population[7,8,10]; and

Whereas, A study on causes of death in residents revealed suicide to be the second leading cause (second only to cancer), and the leading cause of death for male residents[11]; and

Whereas, There is limited data on depression, anxiety, and suicide in post-graduate physicians, much of which comes from older data and small-scale studies, although a 2020 meta-analysis subsequently found that suicide remains a leading cause of mortality for physicians when compared to other causes (i.e., cardiovascular disease, cancer), despite a general decrease in physician suicide rates since 1980; more recently, the Medscape Physician Burnout and Suicide Report has become a powerful tool to track mental health trends anonymously within our profession in real time[12-15]; and

Whereas, Overall, there are limited robust studies about medical student, resident, and physician suicide, as noted in a 2015 *JAMA Psychiatry* viewpoint calling for a national response regarding studies of depression and suicide in medical trainees[16]; and

Whereas, Increasing professional demands and worsening burnout related to the COVID-19 pandemic highlight the importance of collecting accurate, real-time data on our profession's mental health to inform efforts on mitigating risks and preventing suicide[17]; and

Whereas, For allopathic medical school accreditation, the LCME requires that institutions "include programs that promote student wellbeing;" for osteopathic medical school accreditation, COCA requires that the institution "must develop and implement policies and procedures as well

as provide the human and physical resources required to support and promote health and wellness;" for residency, ACGME requires "Institution, must ensure healthy and safe learning and working environments that promote resident well-being"[18-20]; and

Whereas, Wellness initiatives in medical schools and residency programs can vary widely in format—usually with preventative, reactive, and cultural programming, and rarely with structural programming—and effectiveness, and often face barriers such as insufficient financial or administrative support[21-23]; and

Whereas, A public database of wellness initiatives of each medical school and residency would allow programs to display their own initiatives as well as gather ideas and contact information to more rapidly and effectively implement new ones; therefore be it

RESOLVED, That our American Medical Association amend D-345.983, "Study of Medical Student, Resident, and Physician Suicide," by addition to read as follows:

D-345.983 – STUDY OF MEDICAL STUDENT, RESIDENT, AND PHYSICIAN SUICIDE
Our AMA will: (1) explore the viability and cost-effectiveness of regularly collecting National Death Index (NDI) data and confidentially maintaining manner of death information for physicians, residents, and medical students listed as deceased in the AMA Physician Masterfile for long-term studies; (2) monitor progress by the Association of American Medical Colleges, the American Association of Colleges of Osteopathic Medicine, and the Accreditation Council for Graduate Medical Education (ACGME) to collect data on medical student and resident/fellow suicides to identify patterns that could predict such events; (3) support the education of faculty members, residents and medical students in the recognition of the signs and symptoms of burnout and depression and supports access to free, confidential, and immediately available stigma-free mental health and substance use disorder services; ~~and~~ (4) collaborate with other stakeholders to study the incidence of and risk factors for depression, substance misuse and addiction, and suicide among physicians, residents, and medical students~~.~~; and (5) work with appropriate stakeholders to explore the viability of developing a standardized reporting mechanism for the collection of current wellness initiatives that institutions have in place, to inform and promote meaningful mental health and wellness interventions in these populations. (Modify Current HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 05/11/22

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RELEVANT AMA POLICY

Study of Medical Student, Resident, and Physician Suicide D-345.983
Our AMA will: (1) explore the viability and cost-effectiveness of regularly collecting National Death Index (NDI) data and confidentially maintaining manner of death information for physicians, residents, and medical students listed as deceased in the AMA Physician Masterfile for long-term studies; (2) monitor progress by the Association of American Medical Colleges and the Accreditation Council for Graduate Medical Education (ACGME) to collect data on medical student and resident/fellow suicides to identify patterns that could predict such events; (3) support the education of faculty members, residents and medical students in the recognition of the signs and symptoms of burnout and depression and supports access to free, confidential, and immediately available stigma-free mental health and substance use disorder services; ~~and~~ (4) collaborate with other stakeholders to study the incidence of and risk factors for depression, substance misuse and addiction, and suicide among physicians, residents, and medical students.
CME Rep. 06, A-19

Access to Confidential Health Services for Medical Students and Physicians H-295.858
1. Our AMA will ask the Liaison Committee on Medical Education, Commission on Osteopathic College Accreditation, American Osteopathic Association, and Accreditation Council for Graduate Medical Education to encourage medical schools and residency/fellowship programs, respectively, to:
A. Provide or facilitate the immediate availability of urgent and emergent access to low-cost, confidential health care, including mental health and substance use disorder counseling services, that: (1) include appropriate follow-up; (2) are outside the trainees' grading and evaluation pathways; and (3) are available (based on patient preference and need for assurance of confidentiality) in reasonable proximity to the education/training site, at an external site, or through telemedicine or other virtual, online means;
B. Ensure that residency/fellowship programs are abiding by all duty hour restrictions, as these regulations exist in part to ensure the mental and physical health of trainees;
C. Encourage and promote routine health screening among medical students and resident/fellow physicians, and consider designating some segment of already-allocated personal time off (if necessary, during scheduled work hours) specifically for routine health screening and preventive services, including physical, mental, and dental care; and

D. Remind trainees and practicing physicians to avail themselves of any needed resources, both within and external to their institution, to provide for their mental and physical health and well-being, as a component of their professional obligation to ensure their own fitness for duty and the need to prioritize patient safety and quality of care by ensuring appropriate self-care, not working when sick, and following generally accepted guidelines for a healthy lifestyle.
2. Our AMA will urge state medical boards to refrain from asking applicants about past history of mental health or substance use disorder diagnosis or treatment, and only focus on current impairment by mental illness or addiction, and to accept "safe haven" non-reporting for physicians seeking licensure or relicensure who are undergoing treatment for mental health or addiction issues, to help ensure confidentiality of such treatment for the individual physician while providing assurance of patient safety.
3. Our AMA encourages medical schools to create mental health and substance abuse awareness and suicide prevention screening programs that would:
A. be available to all medical students on an opt-out basis;
B. ensure anonymity, confidentiality, and protection from administrative action;
C. provide proactive intervention for identified at-risk students by mental health and addiction professionals; and
D. inform students and faculty about personal mental health, substance use and addiction, and other risk factors that may contribute to suicidal ideation.
4. Our AMA: (a) encourages state medical boards to consider physical and mental conditions similarly; (b) encourages state medical boards to recognize that the presence of a mental health condition does not necessarily equate with an impaired ability to practice medicine; and (c) encourages state medical societies to advocate that state medical boards not sanction physicians based solely on the presence of a psychiatric disease, irrespective of treatment or behavior.
5. Our AMA: (a) encourages study of medical student mental health, including but not limited to rates and risk factors of depression and suicide; (b) encourages medical schools to confidentially gather and release information regarding reporting rates of depression/suicide on an opt-out basis from its students; and (c) will work with other interested parties to encourage research into identifying and addressing modifiable risk factors for burnout, depression and suicide across the continuum of medical education.
6. Our AMA encourages the development of alternative methods for dealing with the problems of student-physician mental health among medical schools, such as: (a) introduction to the concepts of physician impairment at orientation; (b) ongoing support groups, consisting of students and house staff in various stages of their education; (c) journal clubs; (d) fraternities; (e) support of the concepts of physical and mental well-being by heads of departments, as well as other faculty members; and/or (f) the opportunity for interested students and house staff to work with students who are having difficulty. Our AMA supports making these alternatives available to students at the earliest possible point in their medical education.
7. Our AMA will engage with the appropriate organizations to facilitate the development of educational resources and training related to suicide risk of patients, medical students, residents/fellows, practicing physicians, and other health care professionals, using an evidence-based multidisciplinary approach.
CME Rep. 01, I-16; Appended: Res. 301, A-17; Appended: Res. 303, A-17; Modified: CME Rep. 01, A-18; Appended: Res. 312, A-18; Reaffirmed: BOT Rep. 15, A-19

9.3.1 Physician Health & Wellness
When physician health or wellness is compromised, so may the safety and effectiveness of the medical care provided. To preserve the quality of their performance, physicians have a responsibility to maintain their health and wellness, broadly construed as preventing or treating acute or chronic diseases, including mental illness, disabilities, and occupational stress.
To fulfill this responsibility individually, physicians should:
(a) Maintain their own health and wellness by:
(i) following healthy lifestyle habits;
(ii) ensuring that they have a personal physician whose objectivity is not compromised.
(b) Take appropriate action when their health or wellness is compromised, including:
(i) engaging in honest assessment of their ability to continue practicing safely;
(ii) taking measures to mitigate the problem;
(iii) taking appropriate measures to protect patients, including measures to minimize the risk of transmitting infectious disease commensurate with the seriousness of the disease;
(iv) seeking appropriate help as needed, including help in addressing substance abuse. Physicians should not practice if their ability to do so safely is impaired by use of a controlled substance, alcohol, other chemical agent or a health condition.
Collectively, physicians have an obligation to ensure that colleagues are able to provide safe and effective care, which includes promoting health and wellness among physicians.
AMA Principles of Medical Ethics: I,II,IV

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 327
(A-22)

Introduced by: New Jersey

Subject: Leadership Training Must Become an Integral Part of Medical Education

Referred to: Reference Committee C

“No one other than physicians can do what physicians do. They have a unique skill set in healing and "fixing" people. If doctors aren’t willing to contribute their professional expertise in these areas, they will essentially leave the health of their profession to those outside of the profession” - General Mark Hertling

Whereas, Physicians play a leading role in the healthcare team and are considered to be ultimately responsible for the overall outcome of patient care (1); and

Whereas, Medical graduates are expected to “provide leadership skills that enhance team functioning, the learning environment, and/or the healthcare delivery system” (1); and

Whereas, A physician’s role as a leader of medicine is currently underestimated within the current medical curriculum (6); and

Whereas, Medical students report that they do not feel that they have received an adequate level of leadership training required to be an effective leader (5); and

Whereas, The number of medical programs implementing some form of leadership training into their curriculum is growing, experiences are rare and inconsistent (6); and

Whereas, There is an essential need for a clearly developed and standardized form of training that can be implemented throughout the graduate and postgraduate medical curriculum (4); and

Whereas, Many schools lack formal leadership programs, which may reflect the time constraints of existing curricula, limited resources, beliefs that leadership cannot be taught, lack of consensus on leadership content, and other factors (2); and

Whereas, Students report a lack of support structure for practicing leadership skills, a lack of opportunity to serve in a leadership position, and the number of time-related pressures present for medical students during their training (4); and

Whereas, Addressing leadership training opportunities for physicians has been in the AMA policy radar since at least 2018 per D-295.316, the urgency for implementation of concrete steps cannot be overstated (9); therefore be it

RESOLVED, That our American Medical Association study the extent of the impact of AMA Policy D-295.316, “Management and Leadership for Physicians,” on elective curriculum and provide a report at the interim meeting (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate for the implementation of concrete steps to incorporate leadership training as an integral part of the core curriculum of medical school education, post-graduate training, and for practicing physicians.

Fiscal Note: Minimal - less than $1,000

Received: 05/10/22

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RELEVANT AMA POLICY

Management and Leadership for Physicians D-295.316

1. Our AMA will study advantages and disadvantages of various educational options on management and leadership for physicians with a report back to the House of Delegates; and develop an online report and guide aimed at physicians interested in management and leadership that would include the advantages and disadvantages of various educational options.
2. Our AMA will work with key stakeholders to advocate for collaborative programs among medical schools, residency programs, and related schools of business and management to better prepare physicians for administrative, financial and leadership responsibilities in medical management.
3. Our AMA: (a) will advocate for and support the creation of leadership programs and curricula that emphasize experiential and active learning models to include knowledge, skills and management techniques integral to achieving personal and professional financial literacy and leading interprofessional team care, in the spirit of the AMA's Accelerating Change in Medical Education initiative; and (b) will advocate with the Liaison Committee for Medical Education, Association of American Medical Colleges and other governing bodies responsible for the education of future physicians to implement programs early in medical training to promote the development of leadership and personal and professional financial literacy capabilities.
Citation: Sub. Res. 918, I-14; Appended: Res. 306, I-16; Reaffirmed in lieu of: Res. 307, A-17; Modified: Res. 313, A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 328
(A-22)

Introduced by: Ohio

Subject: Increasing Transparency of the Resident Physician Application Process

Referred to: Reference Committee C

Whereas, The mean number of residency applications medical students send has increased dramatically the last two decades, in some specialties more than 100% [1–3]; and

Whereas, This trend of increased applications results in increased expense for medical students [4,5]; and

Whereas, This trend of increased applications also increases administrative burden for residency programs [1,6]; and

Whereas, Many residency programs use filters to pare down the number of residency applications they must consider [7,8]; and

Whereas, Many residency programs do not disclose the use of these filters to applicants, leading medical students to spend money on applications that will never be considered [7]; and

Whereas, Increasing numbers of applications have made it difficult for residency directors to determine genuine interest from an applicant, leading to the proliferation of post-interview communication and third-party services as informal workarounds [9,10]; and

Whereas, Increasing transparency in residency applications has been proposed as a way to combat the increases in applications[11–14]; and

Whereas, Resolving uncertainty in the area of career development is recognized as one way of decreasing medical student and resident burnout [16]; therefore be it

RESOLVED, That our American Medical Association, and interested stakeholders, study options for improving transparency in the resident application process. (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000

Received: 05/10/22

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RELEVANT AMA POLICY

Policy Suggestions to Improve the National Resident Matching Program D-310.974
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 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; (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 **(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.**
Citation: (CME Rep. 15, A-06; Appended: Res. 918, I-11; Appended: CME Rep. 12, A-12)

National Resident Matching Program Reform D-310.977
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;
(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;
(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 applicant;
(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.
Citation: CME Rep. 4, A-05; Appended: Res. 330, A-11; Appended: Res. 920, I-11; Appended: Res. 311, A-14; Appended: Res. 312, A-14; Appended: Res. 304, A-15; Appended: CME Rep. 03, A-16; Reaffirmation: A-16; Appended: CME Rep. 06, A-17; Appended: Res. 306, A-17; Modified: Speakers Rep. 01, A-17; Appended: CME Rep. 3, A-21

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 329
(A-22)

Introduced by: Texas

Subject: Use of the Terms “Residency” and “Fellowship” by Health Professions Outside of Medicine

Referred to: Reference Committee C

Whereas, The terms “residency” and “fellowship” have historical and valued meaning within American medicine, dating back more than 100 years. In 1889 at Johns Hopkins Hospital, William Osler, MD, established America's first formal residency program with interns and residents residing in the hospital. Fellows stayed for additional years of training, and these roles and references remain relevant; and

Whereas, Physicians pursuing specialty board certification are required to complete standardized and accredited training referred to as residency, with the possibility for further sub-specialized training referred to as fellowship; and

Whereas, Some postgraduate training programs for nonphysician clinicians, including podiatrists, pharmacists, advanced practice registered nurses, and psychologists have started using the same nomenclature, labeling their programs as residencies and fellowships; and

Whereas, The curricula for postgraduate medical training programs are well-defined and standardized through a national accreditation process and informed by board-certification requirements. The postgraduate training pathways for other health professionals do not require the same rigor as medicine. They often are not standardized, and the content is vastly more limited than medicine in depth, scope, and duration. The broad application of these terms to a diversity of programs without the same complexity of training creates the potential for misconceptions among the general public; and

Whereas, Using these terms to blur the lines between the training of physicians and other health professions do not accurately reflect the distinctions between the training models and can demean the definition of the field of medicine. These misconceptions also are used to support scope-of-practice expansions in health professions outside medicine; and

Whereas, A survey of the public revealed confusion about which clinicians have medical degrees or degrees of osteopathic medicine, and favored transparency of training; and

Whereas, The American Academy of Dermatology has stated that labeling nonphysician training programs as residencies or fellowships is misleading and this terminology should apply only to physician training programs; and

Whereas, In the patient care setting, the role of individual health care practitioners should be clearly identified to patients and other health care practitioners. Name tags that identify residents or fellows as physicians distinguishes them from other health care practitioners and clarifies their role on the health care team; and

Whereas, The American Academy of Emergency Medicine has stated that training programs for physician assistants and advanced practice registered nurses should avoid use of the terms resident and fellow; and

Whereas, A national discussion by the American Medical Association is needed to prevent the continued distortion of these terms by nonphysician groups; therefore be it

RESOLVED, That our American Medical Association hold a national discussion about the historical value and current nature of the terms “residency” and “fellowship” to describe physician postgraduate training and address the ramifications of nonphysician clinician groups using similar nomenclature that can confuse the general public. (Directive to Take Action)

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

Received: 05/09/22

The topic of this resolution is currently under study by the Council on Medical Education.

References:

1. A History of Medical Residency
2. Truth in Advertising survey results
3. AAEM and AAEM/RSA Position Statement on Emergency Medicine Training Programs for Non-Physician Practitioners
4. Position Statement on Dermatology Residency and Fellowship Training Nomenclature Exclusivity for U.S. Based Dermatology Residents and/or Fellows

RELEVANT AMA POLICY

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.
Citation: (CME Rep. 4, I-04; Reaffirmed: CME Rep. 2, A-14)

Guidelines for Integrated Practice of Physician and Nurse Practitioner H-160.950
Our AMA endorses the following guidelines and recommends that these guidelines be considered and quoted only in their entirety when referenced in any discussion of the roles and responsibilities of nurse practitioners: (1) The physician is responsible for the supervision of nurse practitioners and other advanced practice nurses in all settings.
(2) The physician is responsible for managing the health care of patients in all practice settings.
(3) Health care services delivered in an integrated practice must be within the scope of each practitioner's professional license, as defined by state law.
(4) In an integrated practice with a nurse practitioner, the physician is responsible for supervising and coordinating care and, with the appropriate input of the nurse practitioner, ensuring the quality of health care provided to patients.
(5) The extent of involvement by the nurse practitioner in initial assessment, and implementation of treatment will depend on the complexity and acuity of the patients' condition, as determined by the supervising/collaborating physician.
(6) The role of the nurse practitioner in the delivery of care in an integrated practice should be defined through mutually agreed upon written practice protocols, job descriptions, and written contracts.

(7) These practice protocols should delineate the appropriate involvement of the two professionals in the care of patients, based on the complexity and acuity of the patients' condition.
(8) At least one physician in the integrated practice must be immediately available at all times for supervision and consultation when needed by the nurse practitioner.
(9) Patients are to be made clearly aware at all times whether they are being cared for by a physician or a nurse practitioner.
(10) In an integrated practice, there should be a professional and courteous relationship between physician and nurse practitioner, with mutual acknowledgment of, and respect for each other's contributions to patient care.
(11) Physicians and nurse practitioners should review and document, on a regular basis, the care of all patients with whom the nurse practitioner is involved. Physicians and nurse practitioners must work closely enough together to become fully conversant with each other's practice patterns.
Citation: (CMS Rep. 15 - I-94; BOT Rep. 6, A-95; Reaffirmed: Res. 240, A-00; Reaffirmation A-00; Reaffirmed: BOT Rep. 28, A-09; Reaffirmed: BOT Rep. 9, I-11; Reaffirmed: Joint CME-CMS Rep., I-12; Reaffirmed: BOT Rep. 16, A-13)