

HOD ACTION: Council on Medical Education Report 4 adopted and the remainder of the report filed.

REPORT 4 OF THE COUNCIL ON MEDICAL EDUCATION (November 2020)
Preparedness for Pandemics Across the Medical Education Continuum
(Informational)

EXECUTIVE SUMMARY

As the coronavirus (COVID-19) spread throughout the United States, the nation's medical education community was forced to prepare for a variety of issues across the medical education continuum. While the 2017 Department of Health and Human Services Pandemic Influenza Plan offered guidance on how to respond to a pandemic, education, including medical education at all levels, was not included as a distinct domain that needed to be supported with planning. At the March 15, 2020, meeting of the Council of Medical Education, members decided to develop an informational report on preparedness for pandemics across the medical education continuum in the context of COVID-19 for the November 2020 House of Delegates meeting. This informational report provides a framework for preparedness for pandemics and other large-scale public health emergencies across medical education based on lessons learned from the COVID-19 pandemic.

This report provides an overview of COVID-19 in the United States and discusses the following:

- The impact of COVID-19 on U.S. undergraduate medical education (UME),
- The impact of COVID-19 on U.S. graduate medical education (GME),
- The impact on international medical graduates entering GME programs in the U.S.,
- The impact of COVID-19 on continuing medical education (CME) in the U.S.,
- The impact of COVID-19 on mental health of students, residents, and physicians, and
- Efforts by key stakeholders to address issues in medical education, training, licensure, and credentialing.

The Council on Medical Education is committed to best equipping individuals for success at various points in their medical career while ensuring patient safety. As such, the Council on Medical Education anticipates there will be evolving issues related to COVID-19 and will continue to monitor the evolution of these issues.

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REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 4, November 2020

Subject: Preparedness for Pandemics Across the Medical Education Continuum

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1 INTRODUCTION

2
3 The first confirmed coronavirus (COVID-19) case in the United States was reported on January 21,
4 2020. As COVID-19 increasingly spread throughout the United States, the nation’s medical
5 education community was forced to prepare for a variety of issues across the medical education
6 continuum, including, but not limited to:

- 7
8
 - 9 • Conscientious oversight of the deployment of medical students;
 - 10 • Recommended trajectory for medical students transitioning from graduation to residency;
 - 11 • Student and trainee movement across geographic areas for interviews and clinical
12 rotations;
 - 13 • Field promotion of fellows to attending roles;
 - 14 • Access to, and instruction in, the use of adequate personal protective equipment;
 - 15 • Accreditation, licensure, examination, and certification requirements;
 - 16 • Flexibility in graduate medical education reimbursements;
 - 17 • Guidelines for volunteer clinical work;
 - 18 • Maintaining standards for credentialing and competencies during this time of emergency;
 - 19 • Continuing education offerings for practicing physicians.

20 Based on lessons learned from the COVID-19 pandemic, the Council on Medical Education offers
21 this informational report to provide a framework for preparedness for pandemics and other large-
22 scale public health emergencies across the medical education continuum.

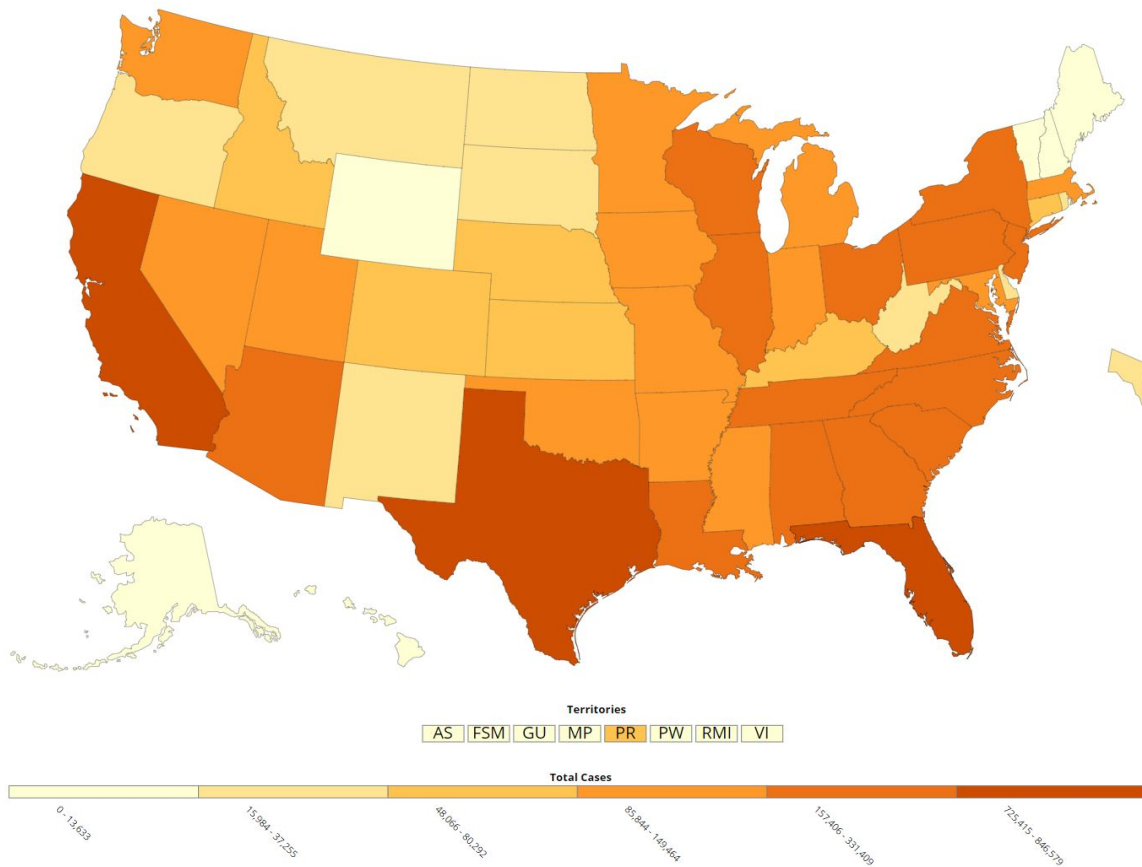
23
24 OVERVIEW OF COVID-19 IN THE UNITED STATES

25
26 In late December 2019, officials in Wuhan, the capital of China’s central Hubei province,
27 confirmed dozens of cases of pneumonia from an unknown cause in the region.¹ In January 2020,
28 the outbreak was confirmed as a new coronavirus, and on March 11, the World Health
29 Organization declared the outbreak of coronavirus (COVID-19) to “be characterized as a
30 pandemic.”² The first confirmed COVID-19 case in the United States was reported on January 21,
31 2020.³ The outbreak initially appeared contained through February; however, by mid-March,
32 transmission of SARS-CoV-2, the virus that causes COVID-19, had accelerated, with rapidly
33 increasing case counts indicating established transmission in the United States. Factors that
34 contributed to the rapid acceleration of the spread of COVID-19 included continued importation of
35 the virus by travelers infected elsewhere; attendance at professional and social events, which
36 amplified the transmission of COVID-19 in the host locations and multistate spread; introduction

1 of the virus into facilities or settings prone to amplification such as long-term care facilities and
2 high-density urban areas; and challenges in virus detection, including limited testing, emergence
3 during the peak months of influenza circulation and influenza and pneumonia hospitalizations, and
4 other cryptic transmission including from persons who were asymptomatic or presymptomatic.³

5
6 As of October 12, 2020, a total of 7,740,934 cases and 214,108 deaths in the United States were
7 reported to the Centers for Disease Control and Prevention (CDC) since January 21, 2020. The
8 states with the highest number of cases include California (846,579); Texas (792,478); Florida
9 (725,415); New York (475,540) and Georgia (331,409). New York City leads the country in the
10 number of total cases (251,618) in a city.⁴ The map in Figure 1 highlights the total number of
11 COVID-19 cases in the U.S. reported to the CDC by state/territory.

Figure 1 Total number of COVID-19 Cases in the US by state/territory reported to the CDC as of September 15, 2020



Source: CDC COVID Data Tracker, 2020

12 As the number of confirmed cases in the United States continued to grow, so did concern for the
13 hospitals and health care facilities' capacity to respond to the pandemic. In 2005, the U.S.
14 Department of Health and Human Services (HHS) developed the inaugural Pandemic Influenza
15 Plan, which was most recently updated in 2017 to model the potential health care impact of
16 moderate and severe influenza pandemics.⁵ It suggested that a moderate pandemic would infect
17 about 64 million Americans, with about 800,000 (1.25%) requiring hospitalization and 160,000
18 (0.25%) requiring beds in the intensive care unit (ICU). The plan also suggested that a severe

1 pandemic would dramatically increase these demands. The 2017 Plan identified the following
2 seven domains to support planning for the next decade:

- 3
- 4 • Surveillance, epidemiology, and laboratory activities;
- 5 • Community mitigation measures;
- 6 • Medical countermeasures: diagnostic devices, vaccines, therapeutics, and respiratory
7 devices;
- 8 • Health care system preparedness and response activities;
- 9 • Communications and public outreach;
- 10 • Scientific infrastructure and preparedness; and
- 11 • Domestic and international response policy, incident management, and global
12 partnerships and capacity building.
- 13

14 These domains expanded upon the original four key pandemic response elements of the original
15 2005 plan to reflect an end-to-end systems approach to improving the way preparedness and
16 response are integrated across sectors and disciplines, while remaining flexible for the conditions
17 surrounding a specific pandemic.⁶ Of note, education, including medical education at all levels, was
18 not included as a distinct domain that needed to be supported with planning, which complicated the
19 development of a strategic response.

20
21 According to the American Hospital Association, there were 5,198 community hospitals and 209
22 federal hospitals in the United States in 2018. In community hospitals, there were 792,417 beds,
23 with 3,532 emergency departments and 96,500 ICU beds, of which 23,000 were neonatal and 5,100
24 pediatric, leaving just under 68,400 ICU beds of all types for the adult population.⁶ The
25 extraordinary and sustained demands of responding to patients affected by COVID-19 on public
26 health, health systems, and providers of essential community services created the need to ration
27 medical equipment and interventions.⁷ The earliest example was the near-immediate recognition
28 that there were not enough high-filtration N-95 masks for health care workers, prompting
29 contingency guidance on how to reuse masks designed for single use.⁸ In addition, acute care
30 hospitals in the United States currently have about 62,000 full-function ventilators and about
31 98,000 basic ventilators, with an additional 8,900 in the Office of the Assistant Secretary for
32 Preparedness and Response Strategic National Stockpile.⁹ While all hospitals have some lifesaving
33 ventilators, that number of available ventilators is proportional to the number of hospital beds in
34 the institution. As a surge of need develops in a particular community, all hospitals in the area then
35 compete for a finite number of resources, which could lead to difficult decisions regarding who
36 gets access to a ventilator and who does not.¹⁰

37
38 To prevent overburdening U.S. hospitals and health care facilities, immediate efforts were
39 implemented to slow the spread of COVID-19. This was known as “flattening the curve.” These
40 efforts included strict social distancing practices and stay-at-home orders. Social distancing has
41 been identified as the most effective preventive strategy since the emergence of COVID-19
42 pending development of a vaccine, treatment, or both.¹¹ California Governor Gavin Newsom was
43 the first governor to issue a stay-at-home order on March 19, and by early April many states had
44 restrictions in place to mitigate the spread of the disease.¹²

45 46 THE IMPACT OF COVID-19 ON U.S. UNDERGRADUATE MEDICAL EDUCATION

47

48 Prior to COVID-19, most medical schools convened students in physical settings during the first 12
49 to 18 months of classes for interactive problem-solving or discussions in small groups, the
50 students’ physical presence in both inpatient and outpatient settings being an accepted tenet of

1 early clinical immersion experiences and the clerkship curriculum. The last 18 months of medical
2 school may be individualized, with students participating in advanced clinical rotations,
3 subinternships prior to residency, or scholarly projects. While efforts to provide individualized
4 instruction for asynchronous learning existed prior to COVID-19, students still convened in-person
5 for small-group interactions, laboratory sessions, simulations, and technology sessions, as well as
6 for clinical instruction with standardized patients and in authentic patient care environments.¹³ The
7 advent of strict social distancing altered undergraduate medical education in a multitude of ways.
8 The traditional classroom experience shifted to virtual instruction, which severely limited on-
9 campus activities and interactions, to minimize gathering in large groups and spending prolonged
10 time in close proximity with faculty, staff, and students in spaces such as classrooms, learning
11 studios, lecture halls, or small-group rooms. These changes also required faculty to rethink how
12 they teach.

13
14 On March 17, 2020, the Association of American Medical Colleges (AAMC) issued a guidance
15 document recommending that member schools suspend medical student participation in activities
16 that involve patient contact.¹⁴ The high probability that medical students in the hospital would be
17 exposed to COVID-19 and the need to conserve personal protective equipment (PPE) seemed to
18 outweigh the educational benefits of students' participation. By decreasing non-essential personnel
19 in health care settings, including medical students, medical schools contributed to national and
20 global efforts to "flatten the curve."¹⁵

21
22 With the removal of students from clinical sites, medical schools quickly developed curricula for
23 their clinical students who were unable to see patients in person. For example, a teaching hospital
24 affiliate of the University of Minnesota Medical School created a database of about 1,400 patients
25 at risk of SARS-CoV-2 infection. The hospital implemented a system to send daily emails to these
26 patients asking about COVID-19 relevant symptoms, such as fever, cough, and shortness of breath.
27 Any patient who reported one or more of the symptoms would then receive a call from a third- or
28 fourth-year medical student. The student would take a history and staff the patient with a
29 supervising resident. Similarly, the Boonshoft School of Medicine in Ohio created an elective in
30 which students worked through online modules on psychological first aid and behavioral
31 activation. Each student was then paired with an isolated older adult in the community with whom
32 they made weekly virtual social visits to ensure patient access to food, water, shelter, and
33 medications, as well as the ability to pay bills. In another example, the Association of Professors of
34 Gynecology and Obstetrics (APGO) at the University of Vermont Larner School of Medicine
35 developed a two-week elective using APGO's medical student educational objectives and vast
36 library of basic science videos. Students completed about six video cases per day in obstetrics and
37 gynecology, sexuality, intimate partner violence, and sexual assault; with each requiring critical
38 thinking and the development of differential diagnoses. An assessment of the student's knowledge
39 was done through APGO-developed quizzes.¹⁶ The AMA Medical Education Department curated a
40 crowdsourced list of potential resources—both free and paid—for virtual or remote clinical and
41 non-clinical learning ([https://www.ama-assn.org/delivering-care/public-health/covid-19-resources-
42 medical-educators](https://www.ama-assn.org/delivering-care/public-health/covid-19-resources-medical-educators)). The AMA did not review or endorse any of the listings, aside from those
43 created directly by the AMA. Rather, they were provided as a resource to help medical
44 educators determine the best ways to teach remote learners during the coronavirus pandemic.

45
46 Medical students also identified numerous ways to volunteer their time and efforts to support
47 health care teams and patients during COVID-19. For example, medical students at the University
48 of Texas Southwestern launched a wave of volunteerism as campus educational programs and
49 research activities scaled back amid concerns over COVID-19. These students collaborated with
50 institutional leadership to identify immediate as well as long-term needs to support and supplement
51 the efforts of front-line clinical teams and staff; these efforts, which aligned with national

1 guidelines for medical student volunteerism, allowed learners to provide maximum support while
2 minimizing their own risk. Volunteer activities included helping to screen hospital visitors,
3 answering phones, moving furniture, and delivering supplies.¹⁷ In Chicago, students from
4 Northwestern University, Rosalind Franklin University of Medicine and Science, University of
5 Chicago, Rush Medical College, Loyola University, Midwestern University, and University of
6 Illinois at Chicago recruited more than 500 volunteers for the COVID Rapid Response Team
7 Chicago to secure PPE and distribute them to the front lines of the epidemic, in addition to working
8 to boost support for blood drives, performing laboratory tests, and organizing food drives for health
9 care workers who did not have time to buy groceries.¹⁸ Additionally, the AAMC established
10 *iCollaborative* (<https://icollaborative.aamc.org/collection/covid-19-student-service-projects>) a
11 compendium of student volunteer and relief initiatives
12

13 COVID-19 also prompted the creation of a process for early graduation of final-year medical
14 students. On March 24, 2020, the Grossman School of Medicine at New York University (NYU)
15 became the first medical school in the United States to announce an offer of early graduation to
16 eligible students. The school's decision came as its hospitals were overwhelmed with an increasing
17 number of COVID-19 patient cases, including in critical care.¹⁹ Similar actions were taken by the
18 medical schools at Tufts University, Boston University, and the University of Massachusetts
19 following a request from the state of Massachusetts to help expand the medical work force.
20 Massachusetts also provided 90-day provisional licenses for early graduates, allowing almost
21 automatic entry into clinical work and making approximately 700 medical students in the state
22 eligible to offer patient care at least eight weeks earlier than expected.²⁰
23

24 While innovative efforts to respond to the health care demands of COVID-19 were rapidly and
25 successfully implemented in some areas, uncertainty in other aspects of medical education proved
26 problematic for medical students including administration of medical college admission and
27 licensing examinations as well as the impact of testing center closures.

28 Aspiring premed college students were also impacted by disruptions to medical education. For
29 example, the Medical College Admission Test (MCAT) is required by the AAMC to be taken in
30 person. Due to COVID-19, the AAMC cancelled MCATs scheduled for March, April, and most of
31 May, and the lack of communication regarding the cancellation of tests proved to be problematic.
32 On May 7, the AAMC opened its MCAT scheduling system for applicants who needed to
33 reschedule or make their initial testing appointment. However, the system was not prepared to
34 handle the volume of individuals trying to schedule their exams, and it crashed. Additionally, those
35 who needed special testing accommodations found the process to secure the necessary
36 accommodations to be difficult. Additionally, MCAT test-taking stations were to be set up in
37 accordance with social and physical distancing guidelines: Eight people can take the test together at
38 one time and masks are required, among other changes. However, students expressed concern that
39 the changes were insufficient to ensure safety or equality in taking the test and, in July, it was
40 reported that three students had tested positive for COVID-19 from 2 to 7 days after taking the in-
41 person MCAT exam.²⁰
42

43 On March 18, 2020, Prometric, the private company that administers the United States Medical
44 Licensure Examinations® (USMLE®) Step 1, Step 2 Clinical Knowledge (CK), and Step 3 exams
45 closed its test centers in the U.S. and Canada through May 1, 2020. On May 1, 2020, Prometric
46 resumed testing in a limited capacity in the U.S. and Canada for essential services programs and
47 opened some of its locations for USMLE testing at 50% capacity. To accommodate this change, the
48 company randomly selected thousands of appointments for cancellation.²¹ On June 1, 2020,
49 Prometric resumed testing, where possible, for all programs in numerous states and regions across
50 North America. It is estimated that cancellations affected 17,000 medical students and residents

1 through mid-May. Criticisms of Prometric’s administration of the exams describe the process as
2 “chaotic, poorly communicated, discriminatory, and outright harmful.”²² Inconsistent and often
3 conflicting information from Prometric and the USMLE resulted in confusion and frustration for
4 test-takers. Last-minute cancellations of these exams continued through early June, sometimes just
5 hours before exams were to start. Students also reported arriving at testing centers for exams, only
6 to find them closed. In response to demand for increased testing capacity, USMLE developed a
7 phased approach to expand testing centers. Phase one established a small number of testing sites
8 in medical schools using Prometric equipment for different geographical regions across the U.S.
9 Phase two sought to determine the school’s level of interest and ability to participate in event-based
10 testing to administer Step 1 and Step 2 CK among Liaison Committee on Medical Education
11 (LCME)-accredited medical schools and American Osteopathic (AOA)-accredited medical
12 schools.²²

13
14 The situation also exposed inherent inequities in the system. Those who required testing
15 accommodations were even further disadvantaged as they could not use the online system. People
16 with learning disabilities, mobility impairments, type 1 diabetes, and anyone who was pregnant or
17 breastfeeding was required to reschedule their exam by phone during business hours and often
18 encountered hours-long waits. Additionally, equity concerns were raised when the National Board
19 of Medical Examiners (NBME) announced that an abbreviated version of the examinations would
20 be made available to those participating in event-based testing held at medical schools in July and
21 August. The proposed changes would have cut approximately two hours from the total eight-hour
22 test time. The shorter version also included the elimination of experimental questions, which are
23 not scored but are used to determine whether they are valid indicators of a test-taker’s performance.
24 This plan met with an immediate backlash, and the USMLE announced on June 9, 2020, that a
25 reduced-length test would not be offered to students taking Step 1 and Step 2 CK exams.²³

26
27 Additionally, on May 26, 2020, the USMLE announced that Step 2 Clinical Skills (CS) exams
28 would be suspended for a period of 12 to 18 months.²³ Step 2 CS aims to examine clinical skills in
29 a performance-based setting; its primary purpose is medical licensure. Additionally, Step 2 CS is
30 an important metric for international medical graduates looking to match into a U.S. residency
31 program. Successful completion of Step 2 CS is a graduation requirement to begin the first year of
32 residency. Suspension of the exam made meeting that requirement impossible for some medical
33 students in the upcoming residency application cycle. A variety of factors influenced the
34 suspension of Step 2 CS, including discouragement of non-essential travel as well as health and
35 safety risks associated with using standardized patients.²⁴

36
37 Similar to Prometric, the National Board of Osteopathic Medical Examiners’ (NBOME) National
38 Center for Clinical Skills Testing (NCCST), which administers the COMLEX-USA Level 2-
39 Performance Evaluation, also temporarily closed its testing center due to COVID-19. On June 3,
40 2020, the NBOME announced its decision to postpone resumption of COMLEX-USA Level 2-PE
41 testing until September 1, 2020. The scheduling change has complicated the ability of some
42 students with 2021 graduation dates to complete examinations by the end of the 2020-21 academic
43 year and has impacted DO students differently than their MD student counterparts. Following that
44 decision, the Commission on Osteopathic College Accreditation (COCA) announced its decision to
45 allow deans at colleges of osteopathic medicine to waive the requirement to pass the COMLEX
46 Level 2-PE clinical skills exam for 2021 graduates.²⁵ Concerns have been raised by both DO and
47 MD students regarding the differences in NBME & NBOME policies regarding testing during
48 COVID-19.

49
50 The process for residency interview and selection was also impacted by COVID-19. The Coalition
51 for Physician Accountability (CPA)—a national group of organizations concerned with the

1 oversight, education, and assessment of medical students and physicians throughout their medical
2 careers and of which the AMA is a member—issued recommendations concerning three major
3 issues facing applicants and training programs as they prepare for the 2020-2021 residency
4 application cycle: away rotations, in-person interviews for residency, and the ERAS[®] (Electronic
5 Residency Application Service) timeline. Specifically, the CPA recommended discouraging away
6 rotations with limited exceptions; committing to online interviews and virtual visits for all
7 applicants rather than in-person interviews for the entire cycle; and delaying both the opening of
8 ERAS[®] for residency programs and the release of the medical student performance evaluation.²⁶
9

10 These recommendations were not without consequences. For example, participation in away
11 rotations is especially common within the competitive surgical subspecialties. In many of these
12 fields, 50 percent or more of students completing away rotations match at a program where they
13 rotated so suspension of these rotations could weaken students' applications.²⁷ Furthermore, as
14 regions of the United States lift social distancing measures at different times throughout the coming
15 year, a potential inequity could be created if some institutions accept external students for clinical
16 rotations while other programs do not. Additionally, students attending school in an area where
17 they must remain quarantined may be disadvantaged if students in other geographic areas are able
18 return more quickly to clinical activities and travel to externship rotations.²⁷ Additional concerns
19 were raised regarding the removal of financial constraints from in-person interviews, leading to a
20 rise in qualified applicants over-applying for the limited number of available residency slots. Prior
21 to COVID-19, the number of interviews an applicant could attend was limited by time and travel
22 expense, but these constraints will be less relevant with virtual interviews. Students who are fearful
23 of how their applications will be evaluated may respond by applying to even more programs and
24 accepting more interview invitations which could lead to an increase in both the number of
25 unmatched applicants and unfilled programs.²⁸

26 To support and protect medical students during this time of uncertainty, the AMA Council on
27 Medical Education developed guiding principles for conscientious oversight of the deployment of
28 medical students. (see Appendix 2).
29

30 THE IMPACT OF COVID-19 ON U.S. GRADUATE MEDICAL EDUCATION

31

32 The process for onboarding early graduation medical students into residency programs was an
33 evolving one beginning in April 2020. At NYU Langone Health, early graduates were initially
34 anticipated to be supplemental to the teams caring for non-COVID-19 patients. However, due to
35 the demand, these graduates were integrated into the health system's internal medicine and
36 emergency medicine departments regardless of their match specialty. While both the current
37 residents and early graduates expressed concerns about the transition from medical school to the
38 wards during a national pandemic, NYU created a boot camp for them to address circumstances
39 specifically related to COVID-19. The curriculum focused on the proper use of PPE, treatment
40 protocols related to the virus, physician and patient isolation, and the moral distress physicians may
41 feel treating COVID-19 patients. NYU also paired early graduates with residents who were not on
42 service during the boot camp as part of the orientation.²⁹ To conform with their Match agreements,
43 early graduates were not part of any specific residency program at NYU. Under an executive order
44 from New York Governor Andrew Cuomo, graduates of medical schools accredited by the LCME
45 and AOA, and matched into an Accreditation Council for Graduate Medical Education (ACGME)-
46 accredited residency program in or outside New York, were eligible to temporarily practice
47 medicine in New York under the supervision of a licensed physician prior to reporting to their
48 matched program and did not have to apply for a license to do so.
49

1 Residents have been on the front lines during the COVID-19 response and like other health care
2 workers, experienced some of the highest exposure risk situations and have the same need for PPE.
3 Unfortunately, health care systems across the United States have reported substantial PPE
4 shortages since the start of COVID-19 pandemic, compromising their ability to keep health care
5 professionals (including residents) safe while treating increasing numbers of patients.³⁰ The
6 situation became so dire that some providers utilized social media with tags like #GetMePPE to
7 raise public awareness. The Society for Healthcare Epidemiology of America (SHEA) conducted a
8 survey in April 2020, among epidemiologists and infectious disease specialists at health care
9 facilities in the United States, Canada, and abroad regarding how their facilities were adapting their
10 PPE policies as shortages and knowledge about the coronavirus evolved. SHEA found that 52
11 percent of respondents said they had to ask health care workers in certain hospital units to use the
12 same disposable N95 respirator for a whole day, 71 percent who reported PPE at “limited” or
13 “crisis” levels practiced extended respirator use or reuse, and 48 percent said they reprocessed
14 respirators. Some health care workers used surgical or cloth masks over their respirators and stored
15 them in a paper bag to preserve them for reuse. Moreover, 59 percent of respondents who said their
16 hospitals’ supply of gowns was “limited” or “crisis-level” were having to wear gowns for an
17 extended time or reuse them, and 13 percent said they were making their own PPE, including face
18 shields, eye shields, coveralls, gowns, and surgical masks.³¹

19
20 Involvement of residents and fellows in COVID-19 care has varied by specialty and rapidly
21 evolved. Some of these residents may have cared for patients with COVID-19 during assigned
22 rotations. Others were asked to assume roles that were not a prescribed part of their specialty
23 training, being deployed to medical units and emergency departments away from their roles in
24 operating rooms and outpatient clinics. Residents may have been compelled to acquire skills on the
25 job that were not an expectation when they began residency. Furthermore, time spent providing
26 these services may not meet the requirements for graduation and certification in their discipline,
27 leading to concerns that their training may need to be extended when routine clinical duties resume.
28 Additionally, some subspecialty fellows were asked to serve in attending physician roles in their
29 core disciplines (e.g., gastroenterology fellows serving as general internal medicine attending
30 physicians). While they may have been board-certified in these specialties, their compensation and
31 malpractice coverage were not guaranteed to be commensurate with the role. This is important,
32 since resident salaries are low compared to those of other health care workers, particularly on an
33 hourly basis. Given average resident salaries and an 80-hour work week, resident salaries equate to
34 approximately \$15 to \$20 per hour. In addition, residents carry significant debt loads related to
35 their undergraduate medical education. The average student loan burden at medical school
36 graduation exceeds \$200,000.

37
38 COVID-19 also highlighted the need for flexibility in GME reimbursement. Medicare GME
39 affiliated group agreements are often in place at the beginning of the academic year (i.e., prior to
40 July 1) to transfer cap slots between institutions and allow the host institution to claim the inbound
41 rotator for reimbursement. If a rotation is canceled, the home hospital may find itself claiming
42 more resident full-time equivalents (FTEs) than its cap allows, and the host hospital may find itself
43 with more cap slots than resident FTEs it has to claim, impacting the GME reimbursement for both.
44 It should be noted, however, that it is possible to amend a Medicare GME affiliated group
45 agreement during the ongoing academic year (i.e., prior to June 30), provided that any changes are
46 made only to the original parties to the agreement. Additionally, financial issues may arise if
47 residents become “off cycle” and require additional time to complete their training. Residents are
48 only eligible for funding for the accredited length of their program, and additional time is not
49 reimbursed by the Centers for Medicare & Medicaid Services (CMS).

50

1 On top of the issues already presented, some residents who became ill and/or required quarantine
2 while caring for COVID-19 patients learned that their residency program leave policies did not
3 adequately account for these unplanned absences during the pandemic response. In response to the
4 concerns of residents and fellows, the AMA developed guidance for residency programs to
5 adequately address the personal, physical, and economic stresses that trainees face. Some key
6 points of the guidance include:

- 7
- 8 • Residents who become ill as a result of their participation in the COVID-19 response
9 must not be required to use vacation or personal time off while ill or quarantined.
- 10 • Residents who require leave under these circumstances must continue to receive their
11 salary and benefits.
- 12 • Residents deployed to clinical areas unfamiliar to them must receive appropriate
13 training and supervision for the tasks they will be asked to perform.
- 14 • Clinical work that residents perform during the pandemic response should be
15 considered in assessments of a trainee's qualifications for program completion. Where
16 possible, credit should be given for the work residents are doing during this time.
- 17 • Bodies overseeing certification requirements should allow flexibility in assessments of
18 the competence of trainees, in light of the pandemic. Where possible, these
19 assessments should not delay program completion nor eligibility for certification.
- 20 • Fellows who assume attending physician roles in core disciplines in which they are
21 licensed and certified should receive pay and benefits commensurate with these roles.
22 The impact of this activity on progress toward completion of the training program must
23 be openly discussed with fellows prior to them assuming these responsibilities.
- 24

25 The guiding principles to protect resident and fellow physicians responding to COVID-19 are
26 featured in Appendix 3.

27 THE IMPACT OF COVID-19 ON INTERNATIONAL MEDICAL GRADUATES ENTERING 28 GME PROGRAMS IN THE U.S.

29

30 As states called for more doctors to help meet the demand of the growing number of COVID-19
31 cases, non-U.S. citizen international medical graduates (IMGs) faced unique challenges that
32 prevented them from responding due to visa limitations. Currently, non-U.S. citizen IMGs with
33 H-1B visas and J-1 waivers face restrictions on where they can work.³² Furthermore, the U.S.
34 Citizenship and Immigration Services (USCIS) announced on March 20, 2020, its suspension of
35 premium processing for all Form I-129, Petition for a Nonimmigrant Worker and I-140, Immigrant
36 Petition for Alien Workers due to the coronavirus (COVID-19) pandemic.³³ This suspension was
37 anticipated to exacerbate physician shortages, particularly in rural areas, and at the leading
38 academic and research organizations that depend on health care provided by non-U.S. citizen
39 IMGs. On April 9, 2020, U.S. Senators Dick Durbin (D-IL), Tammy Duckworth (D-IL), Amy
40 Klobuchar (D-MN) along with colleagues in both the House and the Senate wrote a bipartisan,
41 bicameral [letter](#) urging the Administration to resume premium processing for physicians seeking
42 employment-based visas.³⁴ On May 29, 2020, USCIS announced it would resume premium
43 processing for Form I-129 and Form I-140 in phases beginning June 1, 2020.³⁵ Moreover, USCIS
44 announced that non-U.S. citizen IMGs can deliver telehealth services during the public health
45 emergency without having to apply for a new or amended Labor Condition Application and that it
46 is temporarily waiving certain immigration consequences for failing to meet the full-time work
47 requirement.

48

49 On June 22, 2020, the President of the United States issued a Presidential Proclamation. As it
50 pertains to physicians, the Proclamation states that there are exemptions for:

- 1
- 2 • Sec. 4(a)(i)... [individuals who] are involved with the provision of medical care to
- 3 individuals who have contracted COVID-19 and are currently hospitalized; are
- 4 involved with the provision of medical research at United States facilities to help the
- 5 United States combat COVID-19...
- 6 • Or Sec. 3(b)(iv) any alien whose entry would be in the national interest as determined
- 7 by the Secretary of State, the Secretary of Homeland Security, or their respective
- 8 designees.
- 9

10 J-1 physicians have been given an exemption from the June 22, 2020 Proclamation. However, the
11 Proclamation still applies to most H-1B physicians. Per the AMA [letter](#) to Vice President Pence
12 sent on May 4, 2020, urging the Administration to allow J-1, H-1B, and O-1 International Medical
13 Graduates (IMGs) to be exempt from any future immigration bans or limitations, AMA has been
14 aware of, and advocating against, any physician immigration bans since before this Proclamation
15 was issued.

16
17 In response to the Proclamation, the Department of State (DOS) issued a statement that “as
18 resources allow, embassies and consulates may continue to provide emergency and mission-critical
19 visa services. Mission-critical immigrant visa categories include applicants who may be eligible for
20 an exception under these presidential proclamations, such as...certain medical professionals.” As
21 such, on June 26, 2020, the AMA sent a [letter](#) to the Department of Homeland Security (DHS) and
22 the Department of State strongly urging the Administration to consider J-1 and H-1B IMGs and
23 their families’ entry into the U.S. to be in the national interest of the country so that families can
24 remain together and non-U.S. citizen IMG physicians can immediately begin to provide health care
25 to U.S. patients. The AMA understands that every physician is mission critical, especially at this
26 time. Moreover, the AMA spearheaded a sign-on letter for specialty societies. The [letter](#) urges the
27 DOS and DHS to issue clarifying guidance pertaining to the Proclamation by directing Consular
28 Affairs to advise embassies and consulates that H-1B physicians and their dependent family
29 members’ entry into the U.S. is in the national interest of the country.

30
31 On July 6, 2020, the Student and Exchange Visitor Program (SEVP) announced that nonimmigrant
32 F-1 and M-1 students attending schools operating entirely online could not take a full online course
33 load and enter or remain in the United States. In response, on July 9, 2020, the AMA sent a [letter](#)
34 urging the Administration to withdraw its modifications to the temporary exemptions for
35 nonimmigrant students taking online classes due to the pandemic for the Fall 2020 semester, so that
36 medical students seeking to study in the U.S. on an F-1 visa could enter or remain in the country. In
37 part due to the advocacy efforts of the AMA, on July 14, 2020, the Trump Administration
38 rescinded the directive.

39
40 In addition to advocating for non-U.S. citizen IMGs, the AMA developed guidance to help ensure
41 that visa-related issues do not prevent non-U.S. citizen IMGs from continuing to care for patients
42 during COVID-19; this document is featured in Appendix 4.

43 44 THE IMPACT OF COVID-19 ON EFFORTS TO INCREASE DIVERSITY AMONG MEDICAL 45 STUDENTS AND RESIDENTS

46
47 As medical school enrollment doubled over the past two decades, the percentage of entering under-
48 represented students actually fell by 16%.³⁶ Even prior to COVID-19, national data suggested
49 medical education was already losing ground with respect to racial and ethnic parity. Diversity
50 efforts are particularly vulnerable during times of disruption; hence institutions must heighten their
51 commitment of attention and resources. Current disruptions related to COVID-19 may amplify

1 underlying inequities in our educational system, similar to the pandemic's role in exacerbating
2 health inequities. Broader initiatives to foster long-term change in medicine and address inequities
3 in the entire United States educational system are imperative and are underway. To support these
4 efforts, the AMA developed guidance to protect underrepresented students and residents during
5 COVID-19; this document is featured in Appendix 5.

6 THE IMPACT OF COVID-19 ON CONTINUING MEDICAL EDUCATION IN THE U.S.

7
8
9 With the increased demand for physicians to respond to COVID-19 cases, many physicians who
10 had left practice had a desire to return. Like many professionals, physicians take time off to raise
11 children, care for sick family members, or recover from their own illnesses. Some also switch to
12 non-clinical jobs. But efforts to return to medicine are more difficult than in most careers, as
13 clinical change occurs quickly. Drugs, devices, and surgical techniques that were standard a decade
14 ago may now be obsolete, and a returning doctor's skills may simply be outdated. The AMA
15 defines physician re-entry as "a return to clinical practice in the discipline in which one has been
16 trained or certified following an extended period of clinical inactivity not resulting from discipline
17 or impairment." Re-entry is a complicated, time-consuming, and expensive process. While inactive
18 physicians may not lose their licenses, they must complete a physician reentry program if they stop
19 practicing for a certain length of time (it varies by state but averages about three years).

20 Unfortunately, there is a dearth of training programs for physicians who have already completed
21 residency training and need retraining.³⁷ Reentry programs also cost most returning physicians
22 between \$3,000 and \$10,000 per month, not including travel and relocation costs for the duration
23 of the training. While each program has different features, they all require some type of assessment
24 to determine the physician's skill set and clinical competence. After completing a reentry program,
25 physicians who have let their license lapse have to petition their state board to reactivate it. Once
26 licensure is granted, reentering physicians can then obtain hospital privileges and insurance
27 coverage.

28 Likewise, many senior and retired physicians may have either wanted to return to work or were
29 called upon to do so during the COVID-19 outbreak, which raised additional considerations. For
30 example, the licensure status of retired physicians varies by state. In some states retired physicians
31 maintain their regular license, while others create a separate category for retired or inactive
32 physicians, and still others have no license category for retired physicians. The path to reentry from
33 a licensing perspective also varies. For senior and retired physicians who maintain active licenses,
34 there are no licensure restrictions on re-entry to practice. For physicians who maintain an inactive,
35 retired physician, or similar license, their state may have temporarily waived any barriers to re-
36 entry due to COVID-19.

37
38 The issue of whether senior physicians should be providing direct patient care for COVID-19
39 patients is a complex one that must balance a number of factors, such as whether the age of the
40 physician and their family members puts them in a high risk group, whether PPE is readily
41 available, and whether they can contribute meaningfully in a non-direct patient care role.

42
43 The Federation of State Medical Boards (FSMB) has developed a repository of state-issued
44 guidelines for expediting licensure for health care workers whose licenses are inactive or expired.
45 As of June 9, 2020, 39 states issued guidelines waiving some of the requirements for physician
46 reentry in response to COVID-19, though most require that physicians be recently retired (within
47 the last two to five years).³⁸ Forty-nine state medical boards have policies or regulations that dictate
48 what physicians need to do to reenter medicine after "an extended period of clinical inactivity."
49 That period differs for each state but ranges from 1 to 10 years. After the designated time
50 allotment, the board usually requires an evaluation before granting a license to practice medicine.

1 Additional factors that need to be considered for senior physicians looking to go back to work
2 include professional and medical liability, clarification of roles, and the effect of income on
3 retirement status. The AMA developed a resource guide, featured in Appendix 6, to assist senior
4 physicians as they consider these important issues.

5
6 THE IMPACT OF COVID-19 ON THE MENTAL HEALTH OF STUDENTS, RESIDENTS,
7 AND PHYSICIANS

8
9 Critical stressors for medical students, residents, and physicians during COVID-19 are the
10 uncertainty surrounding the pandemic; trauma associated with knowing there is a risk to one's own
11 health; and concern for the safety and well-being of one's patients, as well as one's family and
12 friends.³⁹ Many students reported moral distress associated with watching patients in isolation from
13 loved ones and described feeling distant from patients while wearing PPE as well as
14 disappointment and frustration about not being able to help. Safety concerns among residents and
15 fellows are complicated by the recognition that their decisions had implications for their loved ones
16 and others outside the hospital. Some worried about transmitting infection to others in their homes.
17 Feelings of vulnerability were exacerbated by rapidly changing conditions and recommendations.
18 The fear of potential PPE shortages was prominent. Trainees not providing COVID-19 care
19 because of personal health issues expressed guilt that colleagues had to step in. These feelings of
20 anxiety and vulnerability among students and trainees compete internally with a desire and
21 commitment to serve the sick.³⁹ A recent study reported in *JAMA* found that front-line health care
22 workers who have been exposed to COVID-19 have a high risk of developing unfavorable mental
23 health outcomes and may need psychological support or interventions.⁴¹ However, many students,
24 residents, and physicians continue to do more than has been required of them for patient care and
25 within the community, despite the risks and challenges of COVID-19.

26 The AMA developed a guide, "Caring for our caregivers during COVID-19," for health system
27 leadership to consider when supporting their physicians and care teams during COVID-19. The
28 guide provides practical examples and strategies to encourage well-being and improve physician
29 satisfaction as well as valuable strategies that address workload redistribution, institutional policies,
30 meals, childcare, attention to emotional and mental well-being, and connecting with others. This
31 guide is featured in Appendix 7.

32
33 EFFORTS BY KEY STAKEHOLDERS TO ADDRESS ISSUES ACROSS THE CONTINUUM
34 OF EDUCATION, TRAINING, LICENSURE, CERTIFICATION, AND CREDENTIALING

35
36 The LCME is officially recognized by the U.S. Department of Education to accredit medical school
37 programs leading to the MD degree in the United States and Canada. It is jointly overseen by the
38 AAMC and AMA but is an independent organization. To achieve and maintain accreditation, a
39 medical education program must meet the LCME accreditation standards and is required to
40 demonstrate that their graduates exhibit general professional competencies appropriate for entry to
41 the next stage of their training and that serve as the foundation for lifelong learning and proficient
42 medical care. The LCME developed and disseminated numerous resources to offer guidance to
43 medical schools during COVID-19. The LCME guiding principles are featured in Appendix 8.

44
45 The COCA accredits medical school programs granting the DO degree in the United States. COCA
46 is recognized by the U.S. Department of Education as the accreditor of colleges of osteopathic
47 medicine. COCA accreditation signifies that a college has met or exceeded the Commission's
48 standards for educational quality. COCA developed and disseminated numerous resources to offer
49 guidance to colleges of osteopathic medicine related to COVID-19. The guidance developed by
50 COCA can be found on its website (<https://osteopathic.org/accreditation/coca-covid-19/>).

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The National Resident Matching Program[®] (NRMP[®]), or The Match[®], is a private, non-profit organization established to provide an orderly and fair mechanism for matching the preferences of applicants for U.S. residency positions with the preferences of residency program directors. NRMP created Frequently Asked Questions (FAQs) to address questions regarding the applicant transition to GME during the COVID-19 crisis. FAQs developed by NRMP can be found on its website (<http://www.nrmp.org/covid-faqs-2-2/>)

The ACGME is an independent, not-for-profit, physician-led organization that sets and monitors the professional educational standards essential to preparing physicians who deliver safe, high-quality medical care to all Americans and monitors compliance with those standards. During COVID-19, the ACGME has monitored the needs of the GME community and provided guidance, clarification, and resources. ACGME resources specific to COVID can be found on its website (<https://acgme.org/COVID-19/ACGME-Guidance-Statements>).

The Educational Commission for Foreign Medical Graduates (ECFMG) assesses the readiness of IMGs to enter residency or fellowship programs in the United States that are accredited by the ACGME. The ECFMG also acts as the registration and score-reporting agency for the USMLE for IMGs. It conducts three examinations: Step 1, Step 2CK, and Step 2CS. The ECFMG certificate is issued to physicians who pass the three exams within seven years. The ECFMG developed resources and launched a COVID-19 specific newsletter during the pandemic. These resources are available on the ECFMG website (<https://www.ecfm.org/annc/covid-19-coronavirus.html>).

The NBME is an independent, not-for-profit organization that serves the public through its high-quality assessments of health care professionals. The NBME is also a co-sponsor of the USMLE[®]. The NBME provided updates related to assessments during COVID-19 which can be found on its website (<https://www.nbme.org/news/coronavirus-covid-19-assessment-information-and-updates>)

The American Board of Medical Specialties (ABMS) is an independent, not-for-profit organization founded to set professional standards for physician practice and board certification. The ABMS and its 24 Member Boards aim to improve the quality of health care by elevating the discipline of specialty medicine through board certification. The ABMS developed numerous resources for diplomates and their fellow health care professionals which can be found on its website (<https://www.abms.org/initiatives/covid-19-information/>).

The FSMB is a national, non-profit organization that represents the state medical and osteopathic boards of the United States and its territories. FSMB also co-sponsors the USMLE[®]. The FSMB developed recommendations for medical license portability during COVID-19 and other resources which can be found on its website (<https://www.fsmb.org/advocacy/covid-19/>).

The CPA is a cross-organizational group of national medical education organizations, including the AMA, concerned with the oversight, education, and assessment of medical students and physicians throughout their medical careers. During COVID-19, the CPA created several work groups to develop common recommendations to address urgent issues related to the COVID-19 pandemic and physician education. “Maintaining Quality and Safety Standards Amid COVID-19” is a product of one of the work groups and offers guidance for health care administrators and credentialing staff members supporting the contributions of new or volunteer physicians during the COVID-19 pandemic. This product is featured in Appendix 9.

RELEVANT AMA POLICY

1 The AMA has developed several policies in response to addressing pandemics. These policies are
2 featured in Appendix 1.

3

4 SUMMARY

5

6 The rapid spread of COVID-19 disrupted life, including medical education. Fortunately, the
7 response of key stakeholders was equally rapid and multifactorial. Strategic planning for future
8 pandemics needs to focus on equipping individuals at various points in their medical careers to
9 redeploy while ensuring patient safety. As many of the issues presented in this report are
10 interrelated, it will also be necessary for key stakeholders to collaborate to minimize negative
11 unintended consequences for students, residents, physicians, and most importantly patients. The
12 Council on Medical Education expects there to be evolving issues related to COVID-19 and will
13 continue to monitor the evolution.

APPENDIX 1: RELEVANT AMA POLICY

9.2.1, “Medical Student Involvement in Patient Care”

Having contact with patients is essential for training medical students, and both patients and the public benefit from the integrated care that is provided by health care teams that include medical students. However, the obligation to develop the next generation of physicians must be balanced against patients’ freedom to choose from whom they receive treatment.

All physicians share an obligation to ensure that patients are aware that medical students may participate in their care and have the opportunity to decline care from students. Attending physicians may be best suited to fulfill this obligation. Before involving medical students in a patient’s care, physicians should:

- (a) Convey to the patient the benefits of having medical students participate in their care.
- (b) Inform the patients about the identity and training status of individuals involved in care. Students, their supervisors, and all health care professionals should avoid confusing terms and properly identify themselves to patients.
- (c) Inform the patient that trainees will participate before a procedure is undertaken when the patient will be temporarily incapacitated.
- (d) Discuss student involvement in care with the patient’s surrogate when the patient lacks decision-making capacity.
- (e) Confirm that the patient is willing to permit medical students to participate in care.

9.2.2, “Resident & Fellow Physicians' Involvement in Patient Care”

Residents and fellows have dual roles as trainees and caregivers. Residents and fellows share responsibility with physicians involved in their training to facilitate educational and patient care goals.

Residents and fellows are physicians first and foremost and should always regard the interests of patients as paramount. When they are involved in patient care, residents and fellows should:

- (a) Interact honestly with patients, including clearly identifying themselves as members of a team that is supervised by the attending physician and clarifying the role they will play in patient care. They should notify the attending physician if a patient refuses care from a resident or fellow.
- (b) Participate fully in established mechanisms in their training programs and hospital systems for reporting and analyzing errors. They should cooperate with attending physicians in communicating errors to patients.
- (c) Monitor their own health and level of alertness so that these factors do not compromise their ability to care for patients safely. Residents and fellows should recognize that providing patient care beyond time permitted by their programs (for example, “moonlighting” or other activities that interfere with adequate rest during off hours) might be harmful to themselves and patients.

Physicians involved in training residents and fellows should:

- (d) Take steps to help ensure that training programs are structured to be conducive to the learning process as well as to promote the patient’s welfare and dignity.

(e) Address patient refusal of care from a resident or fellow. If after discussion, a patient does not want to participate in training, the physician may exclude residents or fellows from the patient's care. If appropriate, the physician may transfer the patient's care to another physician or nonteaching service or another health care facility.

(f) Provide residents and fellows with appropriate faculty supervision and availability of faculty consultants, and with graduated responsibility relative to level of training and expertise.

(g) Observe pertinent regulations and seek consultation with appropriate institutional resources, such as an ethics committee, to resolve educational or patient care conflicts that arise in the course of training. All parties involved in such conflicts must continue to regard patient welfare as the first priority. Conflict resolution should not be punitive, but should aim at assisting residents and fellows to complete their training successfully.

11.1.3, "Allocating Limited Health Care Resources"

Physicians' primary ethical obligation is to promote the well-being of their patients. Policies for allocating scarce health care resources can impede their ability to fulfill that obligation, whether those policies address situations of chronically limited resources, such as ICU (intensive care unit) beds, medications, or solid organs for transplantation, or "triage" situations in times of scarcity, such as access to ventilators during an influenza pandemic.

As professionals dedicated to protecting the interests of their patients, physicians thus have a responsibility to contribute their expertise to developing allocation policies that are fair and safeguard the welfare of patients.

Individually and collectively through the profession, physicians should advocate for policies and procedures that allocate scarce health care resources fairly among patients, in keeping with the following criteria:

(a) Base allocation policies on criteria relating to medical need, including urgency of need, likelihood and anticipated duration of benefit, and change in quality of life. In limited circumstances, it may be appropriate to take into consideration the amount of resources required for successful treatment. It is not appropriate to base allocation policies on social worth, perceived obstacles to treatment, patient contribution to illness, past use of resources, or other non-medical characteristics.

(b) Give first priority to those patients for whom treatment will avoid premature death or extremely poor outcomes, then to patients who will experience the greatest change in quality of life, when there are very substantial differences among patients who need access to the scarce resource(s).

(c) Use an objective, flexible, transparent mechanism to determine which patients will receive the resource(s) when there are not substantial differences among patients who need access to the scarce resource(s).

(d) Explain the applicable allocation policies or procedures to patients who are denied access to the scarce resource(s) and to the public.

H-140.900, "A Declaration of Professional Responsibility"

Our AMA adopts the Declaration of Professional Responsibility

DECLARATION OF PROFESSIONAL RESPONSIBILITY: MEDICINE'S SOCIAL CONTRACT WITH HUMANITY

Preamble

Never in the history of human civilization has the well being of each individual been so inextricably linked to that of every other. Plagues and pandemics respect no national borders in a world of global commerce and travel. Wars and acts of terrorism enlist innocents as combatants and mark civilians as targets. Advances in medical science and genetics, while promising to do great good, may also be harnessed as agents of evil. The unprecedented scope and immediacy of these universal challenges demand concerted action and response by all.

As physicians, we are bound in our response by a common heritage of caring for the sick and the suffering. Through the centuries, individual physicians have fulfilled this obligation by applying their skills and knowledge competently, selflessly and at times heroically. Today, our profession must reaffirm its historical commitment to combat natural and man-made assaults on the health and well being of humankind. Only by acting together across geographic and ideological divides can we overcome such powerful threats. Humanity is our patient.

Declaration

We, the members of the world community of physicians, solemnly commit ourselves to: (1) Respect human life and the dignity of every individual. (2) Refrain from supporting or committing crimes against humanity and condemn any such acts. (3) Treat the sick and injured with competence and compassion and without prejudice. (4) Apply our knowledge and skills when needed, though doing so may put us at risk. (5) Protect the privacy and confidentiality of those for whom we care and breach that confidence only when keeping it would seriously threaten their health and safety or that of others. (6) Work freely with colleagues to discover, develop, and promote advances in medicine and public health that ameliorate suffering and contribute to human well-being. (7) Educate the public and polity about present and future threats to the health of humanity. (8) Advocate for social, economic, educational, and political changes that ameliorate suffering and contribute to human well-being. (9) Teach and mentor those who follow us for they are the future of our caring profession. We make these promises solemnly, freely, and upon our personal and professional honor.

H-295.860, "Promoting Transparency in Medical Education and Access to Training"

Our American Medical Association: (1) strongly encourages medical schools and graduate medical education training programs to communicate with current and prospective medical students, residents and fellows how affiliations and mergers among health care organizations may impact health care delivery, medical education and training opportunities at their respective institutions; and (2) will work with the Accreditation Council for Graduate Medical Education and other appropriate stakeholders to support transparency within medical education, recommending that medical schools and graduate medical education training programs communicate with current and prospective medical students, residents and fellows how affiliations and mergers among health care organizations may impact health care delivery, medical education and training opportunities.

H-295.868, Education in Disaster Medicine and Public Health Preparedness During Medical School and Residency Training

1. Our AMA recommends that formal education and training in disaster medicine and public health preparedness be incorporated into the curriculum at all medical schools and residency programs.
2. Our AMA encourages medical schools and residency programs to utilize multiple methods, including simulation, disaster drills, interprofessional team-based learning, and other interactive formats for teaching disaster medicine and public health preparedness.
3. Our AMA encourages public and private funders to support the development and implementation of education and training opportunities in disaster medicine and public health preparedness for medical students and resident physicians.

4. Our AMA supports the National Disaster Life Support (NDLS) Program Office's work to revise and enhance the NDLS courses and supporting course materials, in both didactic and electronic formats, for use in medical schools and residency programs.
5. Our AMA encourages involvement of the National Disaster Life Support Education Consortium's adoption of training and education standards and guidelines established by the newly created Federal Education and Training Interagency Group (FETIG).
6. Our AMA will continue to work with other specialties and stakeholders to coordinate and encourage provision of disaster preparedness education and training in medical schools and in graduate and continuing medical education.
7. Our AMA encourages all medical specialties, in collaboration with the National Disaster Life Support Educational Consortium (NDLSEC), to develop interdisciplinary and inter-professional training venues and curricula, including essential elements for national disaster preparedness for use by medical schools and residency programs to prepare physicians and other health professionals to respond in coordinated teams using the tools available to effectively manage disasters and public health emergencies.
8. Our AMA encourages medical schools and residency programs to use community-based disaster training and drills as appropriate to the region and community they serve as opportunities for medical students and residents to develop team skills outside the usual venues of teaching hospitals, ambulatory clinics, and physician offices.
9. Our AMA will make medical students and residents aware of the context (including relevant legal issues) in which they could serve with appropriate training, credentialing, and supervision during a national disaster or emergency, e.g., non-governmental organizations, American Red Cross, Medical Reserve Corps, and other entities that could provide requisite supervision.
10. Our AMA will work with the Federation of State Medical Boards to encourage state licensing authorities to include medical students and residents who are properly trained and credentialed to be able to participate under appropriate supervision in a national disaster or emergency.
11. Our AMA encourages physicians, residents, and medical students to participate in disaster response activities through organized groups, such as the Medical Response Corps and American Red Cross, and not as spontaneous volunteers.
12. Our AMA encourages teaching hospitals to develop and maintain a relocation plan to ensure that educational activities for faculty, medical students, and residents can be continued in times of national disaster and emergency.

H-295.939, Protecting Medical Trainees from Hazardous Exposure

1. Our AMA will encourage all health care-related educational institutions to apply the Occupational Safety and Health Administration (OSHA) Blood Borne Pathogen standard and OSHA hazardous exposure regulations, including communication requirements, equally to employees, students, and residents/fellows.
2. Our AMA recommends: (a) that the Accreditation Council for Graduate Medical Education revise the common program requirements to require education and subsequent demonstration of competence regarding potential exposure to hazardous agents relevant to specific specialties, including but not limited to: appropriate handling of hazardous agents, potential risks of exposure to hazardous agents, situational avoidance of hazardous agents, and appropriate responses when exposure to hazardous material may have occurred in the workplace/training site; (b) (i) that medical school policies on hazardous exposure include options to limit hazardous agent exposure in a manner that does not impact students' ability to successfully complete their training, and (ii) that medical school policies on continuity of educational requirements toward degree

completion address leaves of absence or temporary reassignments when a pregnant trainee wishes to minimize the risks of hazardous exposures that may affect the trainee's and/or fetus' personal health status; (c) that medical schools and health care settings with medical learners be vigilant in updating educational material and protective measures regarding hazardous agent exposure of its learners and make this information readily available to students, faculty, and staff; and (d) medical schools and other sponsors of health professions education programs ensure that their students and trainees meet the same requirements for education regarding hazardous materials and potential exposures as faculty and staff.

H-310.912, Residents and Fellows' Bill of Rights

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 encourages teaching institutions to explore benefits to residents and fellows that will reduce personal cost of living expenditures, such as allowances for housing, childcare, and transportation.
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 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 faculty with progressive resident responsibility toward independent practice.

With regard to supervision, residents and fellows should expect supervision by physicians and non-physicians who are adequately qualified and which allows them to assume progressive responsibility appropriate to their level of education, competence, and experience. It is neither feasible nor desirable to develop universally applicable and precise requirements for supervision of residents.

C. Regular and timely feedback and evaluation based on valid assessments of resident performance.

With regard to evaluation and assessment processes, residents and fellows should expect: (1) Timely and substantive evaluations during each rotation in which their competence is objectively assessed by faculty who have directly supervised their work; (2) To evaluate the faculty and the program confidentially and in writing at least once annually and expect that the training program will address deficiencies revealed by these evaluations in a timely fashion; (3) Access to their training file and to be made aware of the contents of their file on an annual basis; and (4) Training programs to complete primary verification/credentialing forms and recredentialing forms, apply all required signatures to the forms, and then have the forms permanently secured in their educational files at the completion of training or a period of training and, when requested by any organization involved in credentialing process, ensure the submission of those documents to the requesting organization within thirty days of the request.

D. A safe and supportive workplace with appropriate facilities.

With regard to the workplace, residents and fellows should have access to: (1) A safe workplace that enables them to fulfill their clinical duties and educational obligations; (2) Secure, clean, and comfortable on-call rooms and parking facilities which are secure and well-lit; (3) Opportunities to participate on committees whose actions may affect their education, patient care, workplace, or contract.

E. Adequate compensation and benefits that provide for resident well-being and health.

(1) With regard to contracts, residents and fellows should receive: a. Information about the interviewing residency or fellowship program including a copy of the currently used contract clearly outlining the conditions for (re)appointment, details of remuneration, specific responsibilities including call obligations, and a detailed protocol for handling any grievance; and b. At least four months advance notice of contract non-renewal and the reason for non-renewal.

(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 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.

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-440.835, "AMA Role in Addressing Epidemics and Pandemics"

1. Our AMA strongly supports U.S. and global efforts to fight epidemics and pandemics, including Ebola, and the need for improved public health infrastructure and surveillance in affected countries.
2. Our AMA strongly supports those responding to the Ebola epidemic and other epidemics and pandemics in affected countries, including all health care workers and volunteers, U.S. Public Health Service and U.S. military members.
3. Our AMA reaffirms Ethics Policy E-2.25, The Use of Quarantine and Isolation as Public Health Interventions, which states that the medical profession should collaborate with public health colleagues

to take an active role in ensuring that quarantine and isolation interventions are based on science. 4. Our AMA will collaborate in the development of recommendations and guidelines for medical professionals on appropriate treatment of patients infected with or potentially infected with Ebola, and widely disseminate such guidelines through its communication channels. 5. Our AMA will continue to be a trusted source of information and education for physicians, health professionals and the public on urgent epidemics or pandemics affecting the U.S. population, such as Ebola. 6. Our AMA encourages relevant specialty societies to educate their members on specialty-specific issues relevant to new and emerging epidemics and pandemics.

H-440.847, Pandemic Preparedness for Influenza

In order to prepare for a potential influenza pandemic, our AMA: (1) urges the Department of Health and Human Services Emergency Care Coordination Center, in collaboration with the leadership of the Centers for Disease Control and Prevention (CDC), state and local health departments, and the national organizations representing them, to urgently assess the shortfall in funding, staffing, vaccine, drug, and data management capacity to prepare for and respond to an influenza pandemic or other serious public health emergency; (2) urges Congress and the Administration to work to ensure adequate funding and other resources: (a) for the CDC, the National Institutes of Health (NIH) and other appropriate federal agencies, to support implementation of an expanded capacity to produce the necessary vaccines and anti-viral drugs and to continue development of the nation's capacity to rapidly vaccinate the entire population and care for large numbers of seriously ill people; and (b) to bolster the infrastructure and capacity of state and local health department to effectively prepare for, respond to, and protect the population from illness and death in an influenza pandemic or other serious public health emergency; (3) urges the CDC to develop and disseminate electronic instructional resources on procedures to follow in an influenza epidemic, pandemic, or other serious public health emergency, which are tailored to the needs of physicians and medical office staff in ambulatory care settings; (4) supports the position that: (a) relevant national and state agencies (such as the CDC, NIH, and the state departments of health) take immediate action to assure that physicians, nurses, other health care professionals, and first responders having direct patient contact, receive any appropriate vaccination in a timely and efficient manner, in order to reassure them that they will have first priority in the event of such a pandemic; and (b) such agencies should publicize now, in advance of any such pandemic, what the plan will be to provide immunization to health care providers; (6) will monitor progress in developing a contingency plan that addresses future influenza vaccine production or distribution problems and in developing a plan to respond to an influenza pandemic in the United States.

APPENDIX 2: AMA GUIDING PRINCIPLES TO PROTECT LEARNERS RESPONDING TO COVID-19

Updated May 1, 2020

This article is part of a series of COVID-19 articles and resources on medical education.

In their efforts to meet workforce demands in response to COVID-19, medical schools and health systems must make responsible decisions about engaging medical students. There are many opportunities for students to contribute to the clinical care of patients without engaging in direct physical contact with patients. However, in some institutions the workforce demands may be great enough that it is appropriate to consider including medical students in direct patient care.

Some students may be permitted to graduate early from medical school and may subsequently contribute as employed members of medical staffs prior to entering their planned residency training. Some students may be enlisted while retaining the status of student, on a voluntary basis, with appropriate supervision and with attention to infection control.

It is the responsibility of the AMA to support and protect medical students as we rely on them during this time. We stand with key stakeholders across the continuum of medical education, including but not limited to the [Association of American Medical Colleges](#), [Liaison Committee on Medical Education](#) (LCME), [Accreditation Council for Graduate Medical Education](#), [American Osteopathic Association](#), [American Association of Colleges of Osteopathic Medicine](#) and the [Educational Commission for Foreign Medical Graduates](#) in support of conscientious oversight of the deployment of medical students. The [AMA Council on Medical Education](#) recommends observance of the following principles:

For all institutions engaging medical students in physical contact with patients:

1. Thoughtful planning will allow the safe re-engagement of students in the direct care of patients and thus support the continuation of student training. For required coursework involving direct patient contact, schools should provide reasonable accommodations to learners who are unable to participate.
2. Medical students should be included in conversations as direct patient interaction activities are being explored, developed and implemented.
3. Medical students must be provided proper training and oversight in the use and reuse of personal protective equipment (PPE). This includes fit testing for N95 or other respirators, donning and doffing of enhanced PPE, and institutional policies related to the use of one's own PPE to augment hospital-supplied PPE.
4. Appropriate COVID-19 testing protocols for students and health care workers should be in place to reduce risk of transmission and to monitor trends in disease burden among students.
5. Each clinical environment in which students will come into direct contact with patients should be assessed for safety and educational readiness, including:
 - o Burden of COVID-19 exposure
 - o Stability of care protocols and clarity of roles
 - o Appropriate patient mix to support learning goals
 - o Faculty capacity to provide supervision, teaching and feedback
6. Health systems and medical schools should support the wellbeing of all providers and recognize that learners face an added stressor of uncertainty about their educational pathways.
7. Medical students should not be financially responsible for diagnosis and treatment of their own disease should they become ill due to care of COVID-19 patients through school-approved activities.
8. Medical schools should use a competency-based approach to redesign educational and assessment activities, considering alternatives to direct patient contact to meet desired learning outcomes.
9. Medical schools should work with the LCME to identify viable options to assess students' competency and meet curricular requirements in order to avoid, to the extent possible, any delay in medical students' graduation or progression in medical school.

Additionally, for institutions implementing early graduation to allow students to join the physician workforce:

10. Early graduation should be enacted on a voluntary basis and founded upon attainment of core competencies.
11. To the extent possible, early graduates should serve under the supervision of an approved graduate medical education program.
12. Medical school graduates should not be compelled to work for their matched residency institution prior to the intended date of employment.
13. Institutions deploying early graduates should grant these providers full status as health care employees with appropriate salary and benefits, while continuing efforts to mitigate their personal risk.
14. Institutions and medical school graduates should remain mindful of graduates' contractual obligations to their matched residencies, including consideration of the potential for quarantine and/or illness due to care of COVID-19 patients.
15. Financial institutions overseeing all loans, public and private, for medical school graduates deployed into the workforce between graduation and beginning residency should exercise forbearance and/or forgiveness of debt service during this time.

APPENDIX 3: GUIDING PRINCIPLES TO PROTECT RESIDENT & FELLOW PHYSICIANS RESPONDING TO COVID-19

Updated April 13, 2020

This article is part of a series of COVID-19 articles and resources on medical education.

Background

There are over 135,000 residents and fellows (“residents”) working in graduate medical education (GME) programs in the United States. They are participating in supervised clinical experiences that will qualify them for certification and independent practice in a wide array of medical specialties. While acquiring this experience, residents are the frontline physician workforce in the health systems that employ them.

During the response to the COVID-19 pandemic, residents are experiencing personal, physical and economic stresses. Many of these stresses are common to all health care workers affected by the pandemic; some are unique to their status as employed trainees. These include the following:

- Residents are on the front lines during the COVID-19 response and like other health care workers, such as first responders and ED nurses, experience some of the highest risk situations for exposure and have the same need for personal protective equipment (PPE). They are at personal risk, and their work creates a risk to family members. Residents themselves may become ill and/or require quarantine while caring for COVID-19 patients, and residency program leave policies may not adequately account for these unplanned absences during the pandemic response.
- During the response to COVID-19, many residents are being asked to assume roles that are not a prescribed part of their specialty training, being deployed to medical units and emergency departments from their roles in operating rooms and outpatient clinics. Their preparation for these roles is variable, and residents may be compelled to acquire skills on the job that were not an expectation when they began residency. Furthermore, time spent providing these services may not meet the requirements for graduation and certification in their discipline, leading to concerns that their training may need to be extended when routine clinical duties resume.
- Some subspecialty fellows are being asked to serve in attending physician roles in their core disciplines (e.g., gastroenterology fellows serving as general internal medicine attending physicians). While they may be board certified in these specialties, their compensation and malpractice coverage may not be commensurate with the role.
- Resident salaries are low compared to those of other health care workers, particularly on an hourly basis. Given average resident salaries and an 80-hour work week, resident salaries equate to approximately \$15 to \$20/hour. In addition, residents carry significant debt loads related to their undergraduate medical education. The average student loan burden at medical school graduation exceeds \$200,000.
- Residents are particularly vulnerable in their negotiating ability as a labor force. Although they are employed health care workers, their status as trainees makes them dependent upon their employer for their professional development. As such, their influence over the environment in which they work is limited.

Guiding principles

In managing the engagement of residents during the response to COVID-19, the AMA Council on Medical Education strongly supports observance of the following principles by programs, sponsoring institutions and national organizations:

1. Residents must be actively engaged in COVID-19 response planning regarding deployment of health care workers, including field promotion of fellows to attending roles, in order for the specific interests of trainees to be considered.
2. Residents must be free to raise concerns about their personal safety and the safety of those around them without recrimination or consequence to their employment and training.

3. Residents must have access to, and instruction in, the use of adequate personal protective equipment (PPE), as should all health care workers.
4. Residents deployed to clinical areas with which they are unfamiliar must receive appropriate training and supervision for the tasks they will be asked to perform.
5. Residents who become ill as a result of their participation in the COVID-19 response must not be required to use vacation and/or personal time off while ill and/or quarantined. Residents who require leave under these circumstances must continue to receive their salary and benefits.
6. Sponsoring institutions and residency programs must continue to comply with the Accreditation Council for Graduate Medical Education (ACGME) requirement to provide access to confidential, affordable mental health assessment, counseling and treatment, including access to urgent and emergency care 24 hours a day, seven days a week.
7. The clinical work that residents perform during the pandemic response must be considered in assessments of a trainee's qualifications for program completion. Where possible, credit should be given for the work residents are doing during this time.
8. The ACGME review committees (RCs), the American Board of Medical Specialties (ABMS) specialty boards and the American Osteopathic Association (AOA) specialty boards should consider their program and certification requirements, in light of the pandemic, to allow flexibility in assessments of the competence of trainees. Where possible, these assessments should not delay program completion nor eligibility for certification.
9. Residents must be permitted to remain in their programs to complete necessary requirements that qualify them for board certification. They must continue to receive salary and benefits and have access to necessary clinical experiences.
10. Residents should be candidates for hazard pay in a way that is equitable to other health care workers.
11. Residents should be granted forgiveness and/or forbearance for all or portions of their student loan debt to ease the financial stress they may experience in caring for themselves and their families. This is particularly important during this time of compromised access to opportunities to supplement their income, such as moonlighting.
12. Fellows who assume attending physician roles in core disciplines in which they are licensed and certified should receive pay and benefits commensurate with these roles. The impact of this activity on progress toward completion of the training program must be openly discussed with fellows prior to them assuming these responsibilities.
13. The Centers for Medicare & Medicaid Services (CMS) should ensure flexibility in GME reimbursements to hospitals to accommodate variations in training due to the COVID-19 response. This flexibility should lengthen the initial residency period (IRP) for residents to allow them to extend their training, if necessary, to meet program and board certification requirements. In addition, CMS should expand the residency funding cap at institutions where residents must extend their training, in order to support an increased number of residents, as new trainees begin, while existing trainees remain to complete their programs.
14. As hospitals and health systems confront the economic impact of the pandemic response, we urge early consideration of effects on the training environment and the sustainability of GME programs. Health systems should also proactively manage opportunities for residents to continue their professional development.
15. In the event of program contraction or closure that may result from the pandemic response, disruptions to resident education may be mitigated through active planning for resident relocation. In the event of closures, the AMA stands with other organizations ready to assist should the need arise.

APPENDIX 4: COVID-19 FAQs: GUIDANCE FOR INTERNATIONAL MEDICAL GRADUATES

Updated June 26, 2020

International Medical Graduate (IMG) physicians are a critical part of the U.S. health care workforce. During the COVID-19 pandemic, the AMA is advocating for IMG physicians, whether currently licensed to practice in the U.S. or seeking such licensure, and helping to ensure that visa-related issues do not stop their ability to continue to care for patients during this challenging time.

FAQs about the work the AMA is doing to support IMGs

How is the AMA working to ensure that I am supported after the COVID-19 pandemic subsides?

Ensuring that underserved and under-resourced communities have ample access to physicians is a chronic challenge in normal times, and the COVID-19 pandemic is expected to exacerbate this issue. Physicians practicing in underserved communities either via an H-1B visa or as part of the Conrad State 30 program play a key role in providing much needed health care to vulnerable populations. As such, we are supporting and working with [U.S. Senator Amy Klobuchar](#), [U.S. Representative Bradley Schneider](#), and the other bipartisan, bicameral Congressional members to pass legislation that will increase the number of doctors in rural and other medically underserved areas. Additionally, we are continuing to fight against a proposal by U.S. Immigration and Customs Enforcement (ICE) to modify the period of authorized stay for certain categories of nonimmigrants traveling to the United States by eliminating the availability of “duration of status” and by providing a maximum period of authorized stay with options for extensions for each applicable visa category. The AMA joined with other leading organizations in medical education and health care, to urge the Administration to [not change duration of status](#), or to at the very least, exempt medical residents from such a proposal.

FAQs about visa processing

How will COVID-19 impact the processing of my visa?

Originally the U.S. had stopped processing visas. However, the U.S. Department of State (DoS) agreed to begin processing visa applications for foreign-born medical professionals after the [AMA urged the DoS to expedite visa processing](#) at U.S. embassies and consulates around the world.

The DoS encourages individuals with an approved U.S. non-immigrant or immigrant visa petition (I-129, I-140 or similar), or a certificate of eligibility in an approved exchange visitor program (DS-2019), to review the website of their nearest embassy or consulate for procedures to request a visa appointment. For any applicants who had an appointment scheduled with an Application Service Center (ASC) after their closure on March 18 or who have filed a Form I-765, Application for Employment Authorization, they will have their application processed using previously submitted biometrics. This announcement is consistent with U.S. Citizenship and Immigration Services' (USCIS) existing ability to reuse previously submitted biometrics. This will remain in effect until ASC resumes normal operations.

Is there premium processing for visas right now?

No. On March 20, 2020, USCIS announced that it will not accept any new requests for [premium processing](#). This temporary suspension includes petitions filed for H-1B visas. The AMA is strongly urging USCIS to [reconsider this suspension](#) and to temporarily expand and expediate the premium processing option for H-1B physicians so they can provide health care to U.S. patients during this pandemic.

FAQs for IMG examinees and students

How will my medical licensing examination be affected?

The United States Medical Licensing Examination (USMLE) program is extending eligibility periods for all examinees who currently have a scheduling permit. The eligibility period ending in 2020 will be extended to have an end date of December 2020, regardless of the country in which examinees are testing. Extensions will be processed in order of expiration date, with all extension processing expected to be completed by the week of

April 13. Examinees will receive a notification and new scheduling permit when their eligibility extension has been processed. Examinees will need to use the new permit once received. Extending the eligibility period for your Step 1, Step 2 CK, or Step 3 examination will not impact already scheduled appointments. No fees will be charged for these eligibility extensions. Eligibility periods will be extended automatically, requiring no action from examinees. For more information, [visit the USMLE program website](#) which has published a COVID-19 page that includes information and FAQs about its responses to the pandemic.

Can special exceptions be made to allow exchange visitors to renew their J-1 visas without traveling back to their home country?

[Exchange visitors currently on an exchange program](#) whose visas have expired and who do not plan to travel outside of the U.S. do not need to renew their visa. If the exchange visitor does travel outside of the United States during their current exchange visitor program and after their J-1 visa has expired, they must apply for a new J-1 visa in their home country in order to re-enter the United States to continue their program. In addition, in accordance with [AMA's letter](#), the State Department [announced](#) that J-1 physicians (medical residents) may consult with their program sponsor, to extend their programs in the United States, and confirmed that J-1 physicians can engage in revised clinical training rotations/assignments in keeping with the ACGME's "[Response to Pandemic Crisis.](#)"

FAQs for IMGs currently practicing in the United States

As a physician on a H-1B visa, can I move to a different location to practice during the COVID-19 pandemic?

A physician on a H-1B visa must obtain a certified [Labor Condition Application](#) (LCA) covering each location where the physician will perform services as required under Department of Labor (DOL) regulations. The term "[place of employment](#)" means the worksite or physical location where an H-1B nonimmigrant worker actually performs his or her work.

The LCA will apply to any worksites within this "area of employment" meaning the area within normal commuting distance of the place (address) of employment, or worksite, where the H-1B nonimmigrant is, or will be, employed. However, in certain circumstances, an H-1B visa holder can temporarily work in a different geographic location without [requiring a new LCA](#) for up to 60 days in a one-year period. Moreover, the [AMA is urging the Administration to permit H-1B physicians](#) that are currently practicing in the U.S. with an active license and an approved immigrant petition, to apply and quickly receive authorization, to [work at multiple locations](#) and facilities with a broader range of medical services for the duration of the COVID-19 pandemic.

I am a foreign doctor not licensed in the U.S. but with practice experience in another country. How can I assist with the COVID-19 pandemic in my state?

The licensure requirements and steps to practice medicine in the U.S. remain the same. The licensure requirements and steps to practice medicine in the U. S. would require you to have additional years of residency training, pass the USMLE exams, become ECFMG certified and apply for licensure within the state that you want to practice medicine.

I'm an H-1B visa holder. What happens if I lose my job during the COVID-19 pandemic? How will this affect my H-4 visa family members?

An H-1B visa holder must remain employed for their visa to continue to be valid. If an H-1B visa holder loses their job they have a 60-day grace period within which they can remain in the U.S. and try to find a new job and sponsoring employer. If they are unsuccessful in finding a new position, then they must leave the country. The AMA understands how difficult losing a job is especially during this time, as such we are advocating to temporarily extend the 60-day grace period to 180 days to try and better accommodate IMGs during this time.

An H-1B visa holder's spouse and unmarried children under 21 years of age may seek admission to the U.S. as H-4 nonimmigrants. However, the H-4 visa is completely dependent on the [H-1B visa holder's status](#). As such, the H-1B visa holder must remain in compliance with all visa requirements, including [meeting relevant employment requirements](#). If the H-1B visa holder loses their job due to COVID-19 and cannot find new employment within the grace period, the H-4 visa is no longer valid and the H-4 visa holder must leave the country.

Can I be removed from the United States if I overstay my H-1B visa due to COVID-19?

Yes. Deportation or removal is the same for H-1B visa holders as it is for all visa holders. In order to stay in status, an H-1B employee must continue working for the H-1B employer while in the United States. Generally, an H-1B employee must be in status in order to [change, extend or adjust status](#). If an H-1B visa holder is terminated before the end of the period of authorized stay, the [employer is liable for reasonable costs](#) of the visa holder's return transportation unless the visa holder voluntarily resigns. As a matter of prosecutorial discretion, DHS may permit an H-1B visa holder who is present in the United States unlawfully, but who has pending an application that stops the accrual of unlawful presence, to remain in the United States while that application remains pending. In this sense, the H-1B visa holder's remaining can be said to be "authorized."

However, the fact that the H-1B visa holder does not accrue unlawful presence does not mean that their presence in the United States is lawful. If an H-1B visa holder [accrues unlawful presence](#) in the United States, they may be barred from reentering the U.S. for three years, ten years, or permanently depending on how long they [overstayed the visa](#). For example, an H-1B professional who has been legally employed in the U.S. in H-1B status is permitted by federal regulation to continue living in the U.S. and working for the sponsoring employer for up to 240 days while an extension petition is pending – as long as the extension petition is filed prior to the expiration of the prior H-1B petition. However, due to significant processing backlogs, USCIS very often takes six months or longer to adjudicate H-1B extension petitions. During that time the previous H-1B petition may expire, leaving the H-1B professional solely dependent on the 240 days of work authorization permitted under the regulation – and without any underlying H-1B status unless/until the H-1B extension petition is approved. If the petition is ultimately denied, then such a person would be deemed unlawfully present as of the date of the denial and, a [Notice To Appear](#) would be issued. Petitions for nonimmigrant (temporary) visas may be filed up to six months in advance of the anticipated work start date. Extensions may be filed up to six months in advance of the expiration date of the current petition. Employers should plan to file petitions at the earliest possible moment.

AMA advocacy efforts supporting IMGs

- [AMA June 26 letter](#): Urging the Administration to consider J-1 and H-1B IMGs and their families' entry into the U.S. to be in the national interest of the country so that families can remain together and IMG physicians can immediately begin to provide health care to U.S. patients.
- [AMA May 8 letter](#): Supporting the Healthcare Workforce Resilience Act and to urging the [Senate](#) and [House](#) to quickly pass the legislation so that we could recapture 15,000 unused employment-based physician immigrant visas from prior fiscal years which would help enable our U.S. physicians to have the support they need and our U.S. patients to have the care they deserve.
- [AMA May 4 letter](#): Urging Vice President Michael Pence to allow J-1, H-1B and O-1 IMGs to be exempt from any future immigration bans or limitations so IMGs can maintain their lawful non-immigrant status while responding to the COVID-19 pandemic.
- [AMA April 14 letter](#): Urging U.S. Citizenship and Immigration Services (USCIS) to temporarily extend visas automatically for one year and expedite approvals of extensions and changes of status for IMGs.
- [AMA April 3 letter](#): Asking Vice President Pence and USCIS to address the situation of thousands of IMGs in temporary status.
- [AMA March 24 letter](#): Urging U.S. Department of State to let IMGs either continue, or begin, to serve a vital role in caring for patients during the COVID-19 pandemic.
- [AMA March 24 letter](#): Petitioning USCIS to temporarily expedite extensions and changes of status for foreign national doctors currently in the U.S.

Additional federal guidance

- [USCIS: Special situations](#)
- [Department of Homeland Security \(COVID-19\)](#)
- Department of State:
 - [Coronavirus disease 2019 \(COVID-19\)](#)
 - [Update on visas for medical professionals](#)

APPENDIX 5: PROTECTING UNDERREPRESENTED STUDENTS AND RESIDENTS DURING COVID-19

Updated July 6, 2020

The current pandemic is impacting all segments of society—but not equally—and it has created significant disruptions in medical education. Even prior to the pandemic, national data suggested medical education was already losing ground with respect to racial and ethnic parity.¹

Recent weeks have brought additional stressors to the fore as our society continues to grapple with [structural racism](#). The medical education community must remain vigilant for potential inequities in educational outcomes across the medical education continuum. Diversity efforts are particularly vulnerable during times of disruption, hence institutions must heighten their commitment of attention and resources.

It is the responsibility of the AMA to advocate for medical students, to act to [reverse the historic active exclusion](#) of racially marginalized groups (specifically, Blacks, Latinx and Native Americans) from the practice of medicine and to drive advancement of multiple dimensions of diversity in the medical profession. Broader initiatives to foster long-term change in medicine and address inequities in the entire United States educational system are imperative and are underway.

Current disruptions related to COVID-19, however, may amplify underlying inequities in our educational system, similar to the pandemic's role in exacerbating health inequities. Recent societal unrest in response to ongoing public racist acts of violence further compounds immediate concerns. Detailed examples of pressing risks for inequity in educational outcomes are provided here.

Concerns span the continuum of pre-medical education, transition to medical school, performance during medical school, residency selection and performance in graduate medical education. Although this highlights immediate risks posed by current circumstances, these recommendations should be applied as long-term interventions.

Recommendations

Colleges, medical schools and residency programs should:

- Increase attention to structural determinants of academic success and provide a clear process by which students can report challenges and seek assistance.
- Engage students, residents and faculty from underrepresented backgrounds (particularly racial and socioeconomic) in the process of planning adjustments to curriculum, assessment and application processes in order to better consider the diverse circumstances of students.
- Amplify efforts to create inclusive learning and working environments across the continuum of pre-medical education, medical school, graduate medical education and practice.
- Heighten monitoring of learner well-being at all levels of medical education and minimize barriers to mental health care.
- Implement a systems approach to promoting well-being that serves to complement the resilience of individuals. Organizational-level efforts should be undertaken to provide:
 - Consistent and inclusive communication.
 - Clarity regarding changes in curriculum, performance expectations or administrative processes.
 - Allyship to address microaggressions in clinical and learning environments.
 - Responsiveness to student and resident concerns.
 - Processes for addressing student and resident grievances.
- Adjust medical school admissions and residency selection processes to:
 - Mitigate bias (e.g. review of applications blinded to academic metrics bias training for admissions committees and interviewers).
 - Apply novel screening practices (e.g. situational judgment tests).
 - Incorporate more holistic, inclusive selection criteria (e.g. distance traveled score).
 - Monitor outcomes for potential bias related to any newly implemented or modified approaches in admissions and selection.

- Improve communication in medical school admissions and residency selection processes by:
 - Implementing robust outreach to students from disadvantaged and underrepresented backgrounds.
 - Developing targeted platforms to foster bilateral exchange of information between applicants and medical schools or residency programs respectively.
 - Reducing complexity and improving transparency in application and selection processes.
 - Minimizing the disparities in candidates' access to coaching in selection processes, such as by providing tips for success at the level of the receiving medical school or graduate medical education (GME) program.
- Increase commitment to, and investment in, pathway and retention programs and other initiatives that intentionally promote equity, diversity and inclusion.

Examples of inequity in educational outcomes due to recent disruptions

Similar themes apply across the continuum of pre-medical education, transition to medical school, performance during medical school, residency selection and performance in GME.

- The shift to virtual platforms of educational delivery has revealed inequities that may further limit the academic achievement of students from under-resourced urban and rural communities, such as in:
 - Access to technology, including internet access and appropriate devices.
 - Home circumstances, including dedicated space and a quiet environment in which to work.
- Students are losing enrichment activities that carry particular importance to candidates who are from backgrounds underrepresented in medicine or who have perceived weaknesses in other aspects of their portfolios. Activities such as research, shadowing, global health experiences and clinical electives serve to instill confidence in pursuing a medical career, support exploration among medical disciplines, spur mentoring, and provide opportunities for distinction that contribute to successful advancement.
- Geographic inconsistency in administration of Medical Colleges Admissions Test (MCAT) and United States Medical Licensing Examination (USMLE) Step examinations has induced some students to consider travel for testing, which will amplify existing disparity in access and in completeness of application portfolios.
- Geographic variations in COVID-19 impact and response—such as physical distancing requirements, testing availability, and availability of personal protective equipment—will create inconsistency in recovery of medical student clinical activities among schools and may disproportionately impact under-resourced schools.
- Limited clinical activities may reduce medical students' access to advocacy in the residency application process (as in the form of letters of recommendation or other communication) which is particularly valuable to disadvantaged candidates.
- Limitations on medical student participation in away rotations, of particular importance for students to demonstrate their abilities to prospective GME programs and to assess the culture of those programs, may disproportionately disadvantage candidates who are underrepresented or who have perceived weaknesses in other aspects of their portfolios.
- The shift to virtual interviews for both medical school and residency selection may have disproportionately negative impacts on students from underrepresented groups or under-resourced communities, due to limitations in technology and appropriate dedicated space as well as less time and personal presence to overcome bias.
- Because people of color are experiencing COVID-19 disproportionately, there may be a corresponding emotional toll on students and residents who lose family and friends to the disease.
- The families of students and residents of color or those who are from lower socioeconomic status may be experiencing greater economic burden from COVID-19, perhaps due to losing employment or increased costs of essential goods. Students may prioritize the need to help support their families over school-related obligations.
- The current environment of racial and societal unrest may have disproportionately negative impacts on the well-being of students and residents from minority communities, impairing their ability to succeed in course work and to navigate application processes.

- Pathway and recruitment programs may suffer from disrupted opportunities to interact with students; and financial strain on many academic centers may result in decreased support to such programs, both in financial resources and in the engagement of participating faculty.

Additional resources

ACGME News: [Increasing Graduate Medical Education Diversity and Inclusion](#), McDade

AAMC: [Holistic Review in Medical School Admissions](#)

¹Talamantes, et al. Closing the Gap - Making Medical School Admissions More Equitable. *NEJM* 2019. (As medical school enrollment doubled over the past two decades, the percentage of entering under-represented students actually fell by 16%)

APPENDIX 6: SENIOR PHYSICIAN COVID-19 RESOURCE GUIDE

Updated March 28, 2020

The AMA has curated a selection of resources to provide guidance to senior and retired physicians who may wish to return to work or are called upon to do so during the coronavirus (COVID-19) outbreak.

1. License considerations

The licensure status of retired physicians varies by state. In some states retired physicians maintain their regular license while others create a separate category for retired or inactive physicians, and still others have no license category for retired physicians. In response to COVID-19, many states have taken action to allow retired physicians to temporarily return to practice through an Executive Order, Department of Health Order or Board of Medicine directive. Often these actions specify the physician's license must have been in good standing at the time of retirement. Many states have also indicated the physician must have been in active practice within the last 2-5 years.

The path to reentry from a licensing perspective varies. For senior and retired physicians who maintain an active license, there are no licensure restrictions on re-entry to practice. For physicians who maintain an inactive, retired physician, or similar license, your state may have temporarily waived any barriers to re-entry. We encourage you to check the [Federation of State Medical Boards' COVID-19 resource on state actions on license status](#) for inactive/retired physicians for guidance: As this landscape continues to evolve, we strongly encourage physicians to check with their respective state medical boards for the latest information.

2. Providing assistance that does not involve direct patient care

Whether senior physicians should be providing direct patient care for COVID 19 patients is a complex issue that must balance a number of factors, such as whether the age of the physician and their family members puts them in a high risk group, whether personal protective equipment (PPE) is readily available, and whether they could contribute meaningfully in a non-direct patient care role. Below is a list of important contributions to consider:

- Many health systems are assigning senior physicians to telehealth and administrative activities, which may free up others to be on the front line.
- Contact your local or state health department. Many are keeping listings of needed roles for volunteer physicians and health care workers.
- Medical schools are using senior physicians for online teaching and mentoring of medical students. Contact your medical school's dean's office to find out how you can participate.
- Consider making an appointment at your local Red Cross to donate blood.
- Provide online outreach to residents of nursing homes or senior residential communities to combat isolation

Assist local practices in creating patient education materials and information sheets with local/regional resources.

3. Re-entering practice

Explore opportunities to provide mentoring or training in your practice location. Many institutions have developed algorithms for telephone triage and/or assessment of symptomatic patients.

4. Professional liability

Explore coverage with your local health system. If you are licensed and volunteer, the third federal economic COVID-19 stimulus package (H.R. 748) includes liability protections for volunteer health care professionals during COVID-19 emergency response. In addition, if you are authorized to prescribe and administer certain countermeasures to treat COVID-19, you may be immune from liability under the [Public Readiness and Emergency Preparedness Act \(PREP Act\)](#). Also check with your state medical association; you may have additional liability protections under state law, a recent Gubernatorial Executive Order, or other emergency response programs, such as the [Uniform Emergency Volunteer Health Practitioners Act \(UEVHPA\)](#) or the [Emergency Management Assistance Compact \(EMAC\)](#).

5. Retirement status

Some physicians are receiving retirement income that may be affected by a return to paid employment. Check the status of your retirement income according to the role you are being asked to perform.

6. Role clarification

Clarity on the following questions may be helpful if you are planning to volunteer your assistance.

- What are the activities I'm being asked to do?
- Do those activities align with my skill set?
- What types of training/refreshers/mentoring will be provided?
- Will I be provided with PPE?

7. COVID-19 resources

- [JAMA Network Coronavirus disease 2019 resource center](#)
- [AMA COVID-19 resource center](#)
- [AMA licensure chart](#) (PDF)

APPENDIX 7: CARING FOR OUR CAREGIVERS DURING COVID-19

Updated June 5, 2020

Resources for health care leadership

Amid the COVID-19 global outbreak, it's likely to be a stressful time for those who work on the front lines of health care.

Now more than ever, it's important for health systems and health care organizations to create and ensure an infrastructure and resources to support physicians, nurses and care team members.

The following lists provide practical strategies for health system leadership to consider in support of their physicians and care teams during COVID-19.

Note that any activities involving medical students or other health professions students should be part of a voluntary, student-led program overseen by their school in compliance with guidance from the LCME or other accreditor. No direct solicitation of individual students should occur.

Some items in the list are suggestions, while others have already been implemented by health systems.

Assess physician stress and identify specific drivers

- Surveys can be used to track trends in stress levels, identify specific drivers of stress, and develop supportive infrastructures based on these drivers. The American Medical Association is [offering two no-cost surveys](#) to help health care organizations monitor the impact COVID-19 has on their workforce during this pandemic.

Building a resilient organization

- The AMA's [caregiver resource, Creating a Resilient Organization](#), provides 17 steps that health care organizations can take in order to effectively care for health care workers during times of crises. Successful organizations will take a systems approach and focus on becoming a resilient organization prior to times of crises, rather than limiting their efforts to a focus on individual resilience. Resilient organizations will need to rapidly reconfigure their well-being priorities to meet the biggest new drivers of stress in a crisis setting.

Workload redistribution

- Physicians/APPs who are at home (on quarantine or for childcare) manage the inboxes and phone calls of those who are at work and provide telemedicine care. Organizations have the ability to redirect or create physician work (wRVU) credit for this work.
 - Atlantic Medical Group has shifted their ambulatory practice care model to telephonic and telemedicine and has reduced office visits significantly. They are considering splitting their offices into teams of staff and physicians and rotating the teams in/out of the office. Rotating shifts would reduce staffing in the office such that everyone isn't in the same very close spaces together. Clinicians not in the office can do phone visits, telemedicine, answer patient questions or be deployed to call centers and testing centers.
- Retraining and/or enhancing the skills of who have not recently worked in the intensive care unit to increase workforce. AMA has [curated guidance and resources](#) for those who may wish to return to work or are called upon to do so during the coronavirus (COVID-19) outbreak.
- [COVID Staffing provides and online resource](#) to help hospitals understand and manage their staffing needs during the COVID-19 pandemic.
- Administrators and clinicians with extra time due to decreased regular services have offered assist with insurance needs (finding old claims, updating bad addresses, etc.).
- Set up triage hotline. Medical students at multiple states are providing extra staffing for the medical school call center. The purpose of this triage hotline is to provide students/staff/faculty who have traveled or have symptoms of COVID-19 with real-time information on protocol and next steps.
- Allow medical assistants and nurses to make contributions according to their ability, with physician or APP oversight and discretion. This may include nurses or MAs taking verbal orders, performing

computerized order entry, doing medication reconciliation or assisting further with visit note documentation. This will alleviate some of the workload on physicians and APPs.

Institutional policies

- Ensure that paid time off and sick days remain unaffected for all employees for COVID-19 related illnesses.
- Ensure no out-of-pocket expenses for employees with COVID-19 related illnesses.
- [CMS](#), [Surgeon General](#), [CDC](#) and [American College of Surgeons](#) have called for cancellation of all elective surgeries and the rescheduling all non-urgent outpatient visits.
- CMS has [implemented several blanket waivers](#) (PDF) for COVID-19. This includes additional flexibility for verbal orders. View additional [CMS policies and regulatory flexibilities](#).
- [Six ways to address physician stress](#) during COVID-19
- The Center for the Study of Traumatic Stress [offers information for how health care teams notify families](#) (PDF) after a COVID-19 death.

Meals

- [SweetGreen will deliver free salads and bowls](#) to hospitals in the cities they serve: DC, Philadelphia, Boston, New York City, San Francisco, Los Angeles, Chicago and Houston. To request free salads, please [visit their site to order](#).
- [GrubHub](#) and [DoorDash](#) are now offering contact-free deliveries. Both companies have reduced or eliminated commission fees for local restaurants to support restaurants that are mandated to only have carry-out/delivery only service.
- Medical students at multiple states have volunteered to deliver supplies/meals and run errands on behalf of individuals in quarantine.
- A Denver community has reported the development of “Lunches for Clinicians” in which clinicians can order meals from local restaurants for delivery during shifts. Community members are raising funds to help pay for these meals. Many communities across the country have launched similar efforts.

Childcare and pet care

- Medical students in [Minnesota](#), [St. Louis \(Washington University in St. Louis\)](#) and [Chicago \(Northwestern University\)](#) are offering childcare and pet care services for physicians and care teams. To facilitate logistics, both students and families register for services and students volunteer for shifts. Students are then matched with families based on need and availability. Students have reported that the need is overwhelming, with some systems reporting more than 100 families signed up for childcare or pet care services. Mount Sinai offers similar services through their [Sinai Kids](#) and [Sinai Together](#) initiatives. UW Health has partnered with Epic and Meriter to [transform Epic’s old headquarters](#) into a 24/7 childcare center for children of clinicians that are working at local hospitals during COVID-19.
- Several organizations have partnered with their local YMCA to provide additional childcare for their health care workers.
- One system reported a program in which staff members who must stay home to care for their children are still paid their regular rate if they agree to care for children of two other staff members.

Personal protective equipment (PPE)

- American Dental Association and state dental associations are encouraging dentists to donate their PPE to local hospitals.
- Consider the use of [Mask Match](#) in order to request masks (if you are a health care professional) or to donate masks if you have extra. Masks are not for purchase or for sale. Those who are matched with a health care worker are expected to cover the cost shipping and handling.
- Mount Sinai has developed [guidelines](#) for health care workers to consider for keeping their family and friends safe when returning home from work.

Attention to emotional and mental well-being

- [Headspace](#) is a meditation and sleep app that can have a positive impact on health professionals' personal and professional lives.
- Organizations like [Mount Sinai](#) and [UNC](#) provide online toolkits where all well-being resources are centralized and easy for clinicians to access.
- Consider assigning therapists to strategic locations (e.g., cafeteria, staff lounges, emergency department) to provide easy access for staff. Several health systems offer drop-in hours with a psychologist onsite for their physicians and care teams. Several organizations are offering 24/7 emotional support through their behavioral health teams. In many cases, this includes emotional support for family members of clinicians as well.
- Continue to monitor the ability of the Employee Health and Well-Being Unit to meet workload demands, personnel health and safety, resource needs and documentation practices.
- Supervisors can conduct a 5-minute debrief at the end of every shift with their care team. Make debriefing a routine part of the day.
- Several wellness committees and Chief Wellness Officers have shared that intensive in-person rounding to frontline health care workers has proven enormously helpful. Rounding may include:
 - Supplying basic wellbeing needs (food, drinks, hygiene items)
 - Provide in the moment support, direct pathway for more intensive support needs through behavioral health teams, peer support, etc.
 - Elicit concerns/needs that require escalation and advocacy (has led to countless system changes, including prepaying of childcare, scrub service, transparency efforts, creation of a caregiver relief fund, etc)
 - Increase awareness of available support resources
- Consider making [mental health resources available to families of clinicians](#) (PDF), as traumatic experiences from COVID-19 will affect them as well.
- The Department of Psychiatry at SUNY Downstate Health Sciences Center has created a COVID-Stress Hotline that can be accessed by everyone at the medical center. The hotline can be accessed by SMS text, email, or call in and was set up using Updox. A second line was established for leadership to communicate about groups that might need help sessions or immediate group interventions.
- AMA offers strategies and resources to [manage mental well-being](#) while also caring for patients during the pandemic or any other crisis.
- With the goals of ensuring physicians and advanced practitioners receive the psychological support they need and of paving the way for them to successfully access existing resources through their Physician Assistance Program, the Washington State Medical Association called on Employee Assistance Programs/Physician Assistance Programs with clients in the health care industry to consider the following actions:
 - Change the pre-recorded greeting message on the 1-800 number to clearly communicate that all calls are confidential and HIPAA compliant.
 - Establish a triage system at entry that allows people to identify themselves as clinicians at the frontline of the COVID-19 response. Deploy your most highly trained and skilled staff to support this population, including the provision of cognitive behavioral therapy.
 - Develop custom communication materials targeted to clinicians at the frontline of the COVID-19 response that clearly explain that your mental health care professionals are equipped to help them navigate the COVID-19 crisis and that the services are completely confidential.
 - Work with each of your clients to provide just-in-time group and 1:1 sessions to frontline clinicians while protecting the health of your staff. For example, use telehealth technology to plant multiple virtual mental health professionals inside the most impacted hospitals and/or at health care provider quarantine facilities for easy on-demand access.
 - Ensure your organizations' emergency response plan includes strategies to adequately handle a surge in requests for services.

Social support

- Several organizations, including Methodist Hospital, UCSF and [Mount Sinai](#), are using video conferencing tools to set up peer support “connection groups” in which physicians and care teams can

support one another and discuss ongoing challenges. UCSF's anesthesia department provides virtual support sessions via Zoom for faculty and trainees. These sessions are held once per week—one for faculty and one for trainees. Discussion questions for these sessions includes: What worries you? How are you feeling and what are you experiencing now? How are you processing all of this? Here are some Zoom and moderator tips provided by UCSF.

- **Virtual session tips:**

1. Have everyone turn on their cameras (if possible)
2. Open Zoom chat function so participants can bring up items and moderators can discuss with the group
3. If more than 15 people consider using Zoom breakout rooms
4. Acknowledge each person as they join the Zoom meeting

- **Moderator tips:**

1. Psychological safety is key
2. It may take time for participants to open up, resist the urge to “fill the silence” if there are lulls
3. Let conversations unfold naturally
4. Try to focus more on emotions vs. clinical details or how to fix the problem

Christiana Care is offering “[COVID Conversations](#),” topic-driven group support sessions. These sessions allow caregivers to connect with another and share thoughts, feelings and ideas about life during the pandemic.

[PeerRxMed](#) is a free, peer-to-peer program for physicians and others working in health care designed to provide support, connection, encouragement, resources and skill-building in order to help participants advance along the Burnout to Thriving Index toward optimal well-being, however you would define that state for yourself. This program provides regular reminders for weekly, monthly and quarterly check-ins with a peer. Reminders include exercises that provide structure for you to [connect with a colleague or friend](#).

Jo Shapiro, MD (Harvard Medical School) discusses the importance of peer support, the fundamentals for operationalizing a peer-support system in health systems and practices and how it can [potentially change organizational culture](#) especially during the COVID-19 pandemic.

Nebraska Medicine offers 1:1 peer support through their Peers in Need of Support (PiNS) program. More than 120 volunteers were specifically trained for COVID-19 response [using just-in-time training](#) (PDF).

A new Slack channel, “Medical Students vs. COVID-19,” allows medical students from across the country to connect and share helpful strategies for how students can continue to support physicians and care teams. [Join the Slack channel](#).

An ambulatory care clinic in Arizona has set up games for clinicians and patients to play throughout the day to keep morale high.

AMA COVID-19 news coverage

Through interviews with health system leaders, the AMA highlights programs and initiatives from around the country that are supporting the health care workforce during the COVID-19 outbreak.

- [COVID-19 front line: Mount Sinai keeps physician well-being in focus](#)
- [6 ways to address physician stress during COVID-19 pandemic](#)
- [Peer support program strives to ease distress during pandemic](#)
- [COVID-19 physician well-being initiatives embrace family needs](#)
- [5 wellness task force tactics designed to prioritize physician health](#)
- [6 ways a health system attacks stress during the COVID-19 crisis](#)

APPENDIX 8: LCME GUIDING PRINCIPLES

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Medical Students, Patients, and COVID-19: A Community Conversation about Education and Safety

March 12, 2020

LCME Guidance Principles

1. Your faculty has defined your school's educational program objectives (EPOs) and graduation requirements and the assessments you will use to ensure that those objectives and requirements are met. It is likely that you will need to change the mechanisms through which medical student learning occurs (e.g., online content delivery and/or interactive work) and is assessed (e.g., paper cases, simulation exercises when onsite clinical interactions might be limited). The LCME completely understands that, and while the LCME Secretariat is always happy to speak with, provide a sounding board to, or guide you, you do not need to notify the LCME of these adjustments in instructional and assessment methods.
2. The goal of accreditation is to assure all stakeholders (i.e., the public, medical students, medical schools, graduate medical education programs, health systems, licensing bodies, Department of Education) of educational program quality. This means that, together, our goal is to provide that by ensuring that our graduates meet their school's EPOs, course and clerkship learning objectives, and required clinical experiences in this most challenging of times. It is likely that the schools will face the greatest challenges in accomplishing this for students' required clinical experiences. From national data that you have shared, the LCME knows that most of our medical schools have several elective weeks/months in the last year or phase of the curriculum. Should you need to interrupt or postpone clerkships or other required clinical experiences because of the real and important pressures and stresses of the clinical environment, these elective weeks are available to adjust your students' clinical training schedules without having to delay completion of these required experiences before graduation. In other words, in looking at your own graduation requirements, you can and should be flexible with the elective weeks built into your curriculum; the LCME understands the need to repurpose elective time to achieve the required clinical experiences. The LCME also recommends that all changes in the required clerkships pass through the school's curriculum governance committee (e.g., Curriculum Committee) prior to implementation.
3. The LCME is you. Fifteen of its 19 members are deans and associate deans, perhaps at your school and at other LCME-accredited schools; there are two public and two medical student members. It completely understands and is experiencing the exceptional pressures you are under, as a result of both the national and local environment.
4. If you are contemplating significant changes in the structure (e.g., major shift in clinical training sites from the inpatient to outpatient setting); timing (e.g., delay in student progression to graduation); duration (e.g., below the 130-week expectation); or location (e.g., due to local variation in the spread of COVID-19), please email the Secretariat (lcme@aamc.org), and we will speak with and work with you to think through your particular situation and approach before you

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notify the LCME of the major curriculum changes you are anticipating/making. Remember that any and all conversations you have with the Secretariat are completely confidential and are never shared with the LCME.

Know that we are being challenged along with you, learning from you, and thinking about this with you, every step of the way. We will be creating and updating a page on the LCME website for additional accreditation-related resources and information as they become available. This document, as well as the March 5, 2020 memo from Alison Whelan, Geoffrey Young, and Veronica Catanese will be posted there, and the AAMC COVID-19 resource site will contain links to this LCME resource collection.

APPENDIX 9: “MAINTAINING QUALITY AND SAFETY STANDARDS AMID COVID-19”

Coalition for Physician Accountability

**Maintaining Quality and Safety Standards Amid
COVID-19**

May 11, 2020

The member organizations of the Coalition for Physician Accountability (www.physicianaccountability.org) have released the following statement and table of resources to provide guidance and support to healthcare administrators and credentialing staff who are supporting the contributions of new or volunteer physicians to patient care during the COVID-19 pandemic.

The Coalition for Physician Accountability (Coalition), a cross-organizational group including AACOM, AAMC, ABMS, ACCME, ACGME, AMA, AOA, CMSS (OPDA), ECFMG, FSMB, LCME, NBME, and NBOME, was established in 2009 to promote professional accountability by improving the quality, efficiency, and continuity of the education, training, and assessment of physicians. Its membership includes the national organizations responsible for the accreditation of medical education and training and the assessment, licensure and certification of physicians throughout their medical career, from medical school through practice. Our membership also includes members of the public and the profession. We share a strong commitment to protecting the public’s health and safety through the delivery of quality health care.

The pandemic has created a public health emergency that is rapidly altering the provision of health care services across the country. Physicians and other clinicians have responded with offers to provide care outside of their previously licensed jurisdiction and beyond their typical scope of practice.

The Coalition members overseeing physician workforce and training have developed the following guidance and resources for the deployment of physicians, physicians in training (interns, residents and fellows), and retired or inactive physicians, to ensure the safe delivery of quality clinical care during this unprecedented emergency.

The Coalition’s Guidance for Maintaining Quality and Safety Standards Amid COVID-19 Pandemic include:

- **Planning:** The pandemic poses a direct threat of over-burdening the health system. The stress to health systems is variable, but all health care facilities should be developing strategies for the optimal use of physician resources as the disease spreads and resource demands fluctuate.
- **Verification:** Acknowledging the additional flexibility that regulators have provided, administrators should access readily available licensing, credentialing, and certification data to verify the attestations of volunteers and new recruits.
- **Provision of Care:** The American Medical Association’s *Code of Medical Ethics: Guidance in a Pandemic* states that physicians have an ethical obligation to “provide urgent medical care during disasters,” an obligation that holds “even in the face of

greater than usual risk to physicians' own safety, health or life.” In a crisis, “(t)he risks of providing care to individual patients today should be evaluated against the ability to provide care in the future.”

- **Protection:** Healthcare professionals must be equipped with appropriate Personal Protective Equipment (PPE) to safeguard their health and that of their patients, families, and the general public, and physicians must use this protection. The more transmissible the disease, and the higher the risk of occupational exposure, the more urgent the need for protection.
- **Training, Education, and Support:** Healthcare professionals who may be asked to practice outside their areas of training and expertise must have access to training and educational resources for the type(s) of care they are asked to provide during the COVID-19 pandemic to assure safe patient care. Appropriate mentorship, support, training, and supervision must also be available for healthcare professionals who are asked to provide care to which they are unaccustomed.
- **Maintenance of Safety Standards:** Health care facilities should have contingency plans to maintain customary safety standards in the face of a demand surge. Guidance for the adoption of crisis standards of care is available to help leaders make informed decisions that optimize resources while mitigating the risk of harm.

The following are some steps that can be taken to prepare for the arrival of a new volunteer:

	Action Step	Resource	Additional questions/resources
1	Check what licenses the physician has (and/or ECFMG certification if an international medical graduate)	www.Docinfo.org (free service) Physician Data Center www.fsmb.org/PDC/ ECFMG Certification Verification	Email: pdc@fsmb.org Email: cvsonline@ecfm.org or call ECFMG at 215-386-5900
2	Determine applicable licensing waivers or exceptions (if licensed elsewhere)	FSMB COVID-19 Page for a summary of changes Please check applicable state or territorial medical board website	
3	Check Information on a volunteer’s education and training	Physician Data Center www.fsmb.org/PDC/ ECFMG (for IMGS)	Email: pdc@fsmb.org Email: cvsonline@ecfm.org or call ECFMG at 215-386-5900
4	Determine if the volunteer has a valid controlled substance license	Obtain copy of existing license and see: https://apps.deadiversion.usdoj.gov/webforms2/spring/dupe	https://deanumber.com/default.aspx?relID=33637

		CertLogin?execution=e1s1	
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5	Check a volunteer's board certification status	ABMS certification AOA certification https://certification.osteopathic.org/validate/	<p>Call: ABMS Solutions at (800) 733-2267 with questions.</p> <p>Call: AOA at (888)-626-9262</p>
6	<p>Confirm:</p> <p>a) vaccination record</p> <p>b) malpractice insurance</p> <p>c) Review any history of malpractice</p>	<p>Recommended vaccinations for healthcare workers: https://www.cdc.gov/vaccines/adults/rec-vac/hcw.html</p> <p>Guidance on medical liability insurance during the COVID- 19 crisis available from the Medical Professional Liability Association</p> <p>National Practitioner Data Bank*: https://www.npdb.hrsa.gov/hcorg/howToSubmitAQuery.jsp</p>	<p>Call: CDC at (800)-232-4636</p> <p>See also: The Coronavirus Aid, Relief, and Economic Security Act (CARES Act, H.R. 748), Section 3215: Limitation on Liability for Volunteer Health Care Professionals During COVID- 19 Emergency Response</p> <p>Email: help@npdb.hrsa.gov</p>
7	Other Important Credentialing Resources	NAMSS COVID-19 Resources	Email: info@namss.org

**Only Accessible by Eligible Entities*

If the volunteer is a recently graduated physician, refer to the following resources:

8	Refer to guidance from AAMC, AACOM, ACGME and FSMB	AAMC guidance AACOM Coronavirus Resources ACGME guidance FSMB COVID-19 Page (for training license information)	
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To support the volunteer as they start providing care:

9	Provide guidance to the physician	AMA volunteer guide AMA Code of Medical Ethics: Guidance in a Pandemic FSMB COVID-19 Page (for emergency licensure information) AOA COVID-19 Resources	
10	Provide training resources to the physician	ACCME training resources CDC guidance HHS COVID-19 Workforce Virtual Toolkit	Email: info@accme.org
11	Provide information on PPE	CDC guidance for PPE	
12	Share resources on managing telehealth	ACCME telehealth resources AMA Telehealth playbook HRSA Telehealth Website (hhs.telehealth.gov)	Email: info@accme.org

For more information on how to prepare for an anticipated surge in demand for scarce resources during an epidemic:

13	Expand contingency plans to include a process for adopting crisis standards of care to manage scarce physician and other resources	National Academy of Medicine - Discussion Paper on Crisis Standards of Care in response to SARS-CoV-2 National Academy of Medicine - Systems framework for crisis standards of care	
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Workgroup Members:

American Board of Medical Specialties (ABMS)

Accreditation Council for Continuing Medical Education (ACCME) Accreditation Council for

Graduate Medical Education (ACGME) Council of Medical Specialty Societies (CMSS)

Educational Commission for Foreign Medical Graduates (ECFMG) Federation of State Medical

Boards (FSMB) National Resident Matching Program (NRMP) Public Member

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