DISCLAIMER

The following is a preliminary report of actions taken by the House of Delegates at its 2022 Interim Meeting and should not be considered final. Only the Official Proceedings of the House of Delegates reflect official policy of the Association.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (I-22)

Report of Reference Committee C

Ramin Manshadi, MD, Chair

Your Reference Committee recommends the following consent calendar for acceptance:

RECOMMENDED FOR ADOPTION

1. Council on Medical Education Report 1 – The Impact of Private Equity on Medical Training

2. Resolution 304 – Protecting State Medical Licensing Boards from External Political Influence

RECOMMENDED FOR ADOPTION AS AMENDED

3. Council on Medical Education Report 2 – Mitigating Demographic and Socioeconomic Inequities in the Residency and Fellowship Selection Process

4. Resolution 302 – Expanding Employee Leave to Include Miscarriage and Stillbirth

   Resolution 303 – Medical Student Leave Policy

   Resolution 308 – Paid Family/Medical Leave in Medicine

5. Resolution 305 – Encouraging Medical Schools to Sponsor Pipeline Programs to Medicine for Underrepresented Groups

6. Resolution 306 – Increased Credit for Continuing Medical Education Preparation

7. Resolution 309 – Bereavement Leave for Medical Students and Physicians

8. Resolution 310 – Enforce AMA Principles on Continuing Board Certification

9. Resolution 312 - Reporting of Residency Demographic Data

10. Resolution 313 – Request a two-year delay in ACCME Changes to State Medical Society Recognition Program

11. Resolution 316 – Recognizing Specialty Certifications for Physicians

12. Resolution 317 – Support for GME Training in Reproductive Services

RECOMMENDED FOR REAFFIRMATION IN LIEU OF

13. Resolution 307 – Fair Compensation of Residents and Fellows

RECOMMENDED FOR ADOPTION IN LIEU OF

14. Resolution 311 – Supporting a Hybrid Residency and Fellowship Interview Process

Amendments: If you wish to propose an amendment to an item of business, click here: Submit New Amendment

Existing policy was reaffirmed in lieu of the following resolutions via the Reaffirmation Consent Calendar:

Resolution 314 – Balancing Supply and Demand for Physicians by 2030
Resolution 315 – Bedside Nursing and Health Care Staff Shortages

RECOMMENDED FOR ADOPTION

(1) COUNCIL ON MEDICAL EDUCATION REPORT 1 – THE IMPACT OF PRIVATE EQUITY ON MEDICAL TRAINING

RECOMMENDATION:

Recommendations in Council on Medical Education Report 1 be adopted and the remainder of the report be filed.

HOD ACTION: Recommendations in Council on Medical Education Report 1 adopted and the remainder of the report filed

That our AMA:

1. Affirm that an institution or medical education training program academic mission should not be compromised by a clinical training site's fiduciary responsibilities to an external corporate or for-profit entity. (New HOD Policy)

2. Encourage GME training institutions, programs, and relevant stakeholders to: a. demonstrate transparency on mergers and closures, especially as it relates to private equity acquisition of GME programs and institutions, and demonstrate institutional accountability to their trainees by making this information available to current and prospective trainees;
b. uphold comprehensive policies which protect trainees, including those who are not funded by Medicare dollars, to ensure the obligatory transfer of funds after institution closure;
c. empower designated institutional officials (DIOs) to be involved in institutional decision-making to advance such transparency and accountability in protection of their residents, fellows, and physician faculty;
d. develop educational materials that can help trainees better understand the business of medicine, especially at the practice, institution, and corporate levels;
e. develop policies highlighting the procedures and responsibilities of sponsoring institutions regarding the unanticipated catastrophic loss of faculty or clinical training sites and make these policies available to current and prospective GME learners. (Directive to Take Action)

3. Encourage necessary changes in Public Service Loan Forgiveness Program (PSLF) to allow medical students and physicians to enroll in the program even if they receive some or all of their training at a for-profit or governmental institution. (Directive to Take Action)

4. Support publicly funded independent research on the impact that private equity has on graduate medical education. (New HOD Policy)

5. Encourage physician associations, boards, and societies to draft policy or release their own issue statements on private equity to heighten awareness among the physician community. (Directive to Take Action)

6. Encourage physicians who are contemplating corporate investor partnerships to consider the ongoing education and welfare for trainee physicians who train under physicians in that practice, including the financial implications of existing funding that is used to support that training. (Directive to Take Action)

7. Amend Policy D-310.948 “Protection of Resident and Fellow Training in the Case of Hospital or Training Program Closure” by addition to read as follows:
Our AMA: (6) will continue to work with ACGME, interested specialty societies, and others to monitor issues, collect data, and share information related to training programs run by corporate and nonprofit entities and their effect on medical education. (Modify HOD Policy)

8. Reaffirm the following policies:

• H-310.904 “Graduate Medical Education and the Corporate Practice of Medicine”
• H-310.943 “Closing of Residency Programs”
• H-310.929 “Principles for Graduate Medical Education"
• H-215.981 “Corporate Practice of Medicine” (Reaffirm HOD policy)

9. Rescind AMA Policy D-310.947 as having been accomplished by this report. (Rescind HOD policy)

Your Reference Committee reviewed live and online testimony regarding this item. Testimony was received suggesting a title change, in that the report encompasses entities that are beyond private equity, to include United Healthcare, HCA, and Summa. Your Reference Committee considered this point but felt that a title change would have been beyond the intent and the scope of the report. Other testimony expressed strong support for the report, noting how the influence of private equity is far from benign and may cause significant disruptions to the education and training of future physicians as well as harm to underserved communities that rely on safety net hospitals. Therefore, your Reference Committee recommends that CME Report 1 be adopted.

(2) RESOLUTION 304 – PROTECTING STATE MEDICAL LICENSING BOARDS FROM EXTERNAL POLITICAL INFLUENCE

RECOMMENDATION:

Resolution 304 be adopted.

HOD ACTION: Resolution 304 adopted

RESOLVED, That our American Medical Association work with the Federation of State Medical Boards and other interested parties to minimize external interference with the independent functioning of state medical disciplinary and licensing boards. (Directive to Take Action)

Your Reference Committee reviewed live and online testimony regarding this item. Testimony for this item was largely supportive of the intent yet was mixed between adoption and reaffirmation. Testimony in support of reaffirmation expressed that current policy is broad and already encourages collaboration with other stakeholders. However, there were concerns that current policy does not go far enough to adequately address the present polarized political climate and interference by legislators to limit the ability of the boards to enact their primary mission—that is, protection of the public. References were made regarding current efforts to place licenses in jeopardy for meeting expected standards of care. Therefore, your Reference Committee recommends that Resolution 304 be adopted.

RECOMMENDED FOR ADOPTION AS AMENDED

(3) COUNCIL ON MEDICAL EDUCATION REPORT 2 – MITIGATING DEMOGRAPHIC AND SOCIOECONOMIC INEQUITIES IN THE RESIDENCY AND FELLOWSHIP SELECTION PROCESS

RECOMMENDATION A:

Recommendation 5 in Council on Medical Education Report 2 be amended by addition, to read as follows:

5. That our AMA advocate for and support innovation in the undergraduate medical education to graduate medical education transition, especially focusing on the efforts of the Accelerating Change in Medical Education initiative, to include pilot efforts to optimize the residency/fellowship application and matching process and study of the impact of using filters in the Electronic Residency Application Service (ERAS) by program directors on the diversity of entrants into residency. (New HOD Policy)

RECOMMENDATION B:

Recommendation 6 in Council on Medical Education Report 2 be amended by addition and deletion, to read as follows:

6. That our AMA encourage caution among medical schools and residency/fellowship programs when utilizing ~~monitor use of~~ novel online assessments for sampling personal characteristics for the purpose of ~~medical school~~ admissions or ~~residency/fellowship~~ selection and monitor use and validity of these tools ~~and consider their impact on equity and diversity of the physician workforce~~. (New HOD Policy)

RECOMMENDATION C:

Recommendations in Council on Medical Education Report 2 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Recommendations in Council on Medical Education Report 2 adopted as amended and the remainder of the report filed

Recommendation 5 of Council on Medical Education Report 2 be <u>amended by addition</u>, to read as follows:

5. That our AMA advocate for and support innovation in the undergraduate medical education to graduate medical education transition, especially focusing on the efforts of the Accelerating Change in Medical Education initiative, to include pilot efforts to optimize the residency/fellowship application and matching process <u>and encourage the study of the impact of using filters in the Electronic Residency Application Service (ERAS) by program directors on the diversity of entrants into residency</u>. (New HOD Policy)

1. That our AMA encourage medical schools, medical honor societies, and residency/fellowship programs to work toward ethical, equitable, and transparent recruiting processes, which are made available to all applicants. (New HOD Policy)

2. That AMA Policy D-200.985, "Strategies for Enhancing Diversity in the Physician Workforce," be amended by addition and deletion, to read as follows:

> Our AMA will recommend that medical school admissions committees <u>and residency/fellowship programs</u> use holistic assessments of ~~admission~~ applicants that take into account the diversity of preparation and the variety of talents that applicants bring to their education <u>with the goal of improving health care for all communities</u>. (Modify Current HOD Policy)

3. That our AMA advocate for residency and fellowship programs to avoid using objective criteria available in the Electronic Residency Application Service (ERAS) application process as the sole determinant for deciding which applicants to offer interviews. (Directive to Take Action)

4. That our AMA advocate to remove membership in medical honor societies as a mandated field of entry on the Electronic Residency Application Service (ERAS)—thereby limiting its use as an automated screening mechanism—and encourage applicants to share this information within other aspects of the ERAS application. (Directive to Take Action)

5. That our AMA advocate for and support innovation in the undergraduate medical education to graduate medical education transition, especially focusing on the efforts of the Accelerating Change in Medical Education initiative, to include pilot efforts to optimize the residency/fellowship application and matching process. (New HOD Policy)

6. That our AMA monitor use of novel online assessments for sampling personal characteristics for the purpose of medical school admissions or residency/fellowship selection and consider their impact on equity and diversity of the physician workforce. (New HOD Policy)

7. That AMA Policy D-295.963(5), "Continued Support for Diversity in Medical Education," be rescinded, as having been fulfilled through this report:

Our AMA will: … ~~work with appropriate stakeholders to study reforms to mitigate demographic and socioeconomic inequities in the residency and fellowship selection process, including but not limited to the selection and reporting of honor society membership and the use of standardized tools to rank applicants, with report back to the House of Delegates~~. (Rescind HOD Policy)

Your Reference Committee reviewed online and live testimony regarding this item. Testimony was largely supportive of the recommendations of this well-written and researched report and expressed support for efforts to reaffirm the AMA's commitment to equity. Testimony on Recommendation 4 called for nationwide standardization of the selection process into these honor societies in all medical schools, with a reexamination of the criteria for membership and creation of objectively fair metrics that deal with demographic and socioeconomic inequities in the selection process. Testimony offered the following amendments: opposition to use of online personality assessments, elimination of ERAS filters that could adversely impact international medical graduates, and study of the effect of ERAS filters on equitable admissions. Your Reference Committee believes these amendments go beyond the scope of this report and support future studies to support equitable processes for GME applications. Therefore, your Reference Committee recommends that CME Report 2 be adopted as amended.

(4) RESOLUTION 302 – EXPANDING EMPLOYEE LEAVE TO INCLUDE MISCARRIAGE AND STILLBIRTH

RESOLUTION 303 – MEDICAL STUDENT LEAVE POLICY

RESOLUTION 308 – PAID FAMILY/MEDICAL LEAVE IN MEDICINE

RECOMMENDATION A:

<u>Policy H-405.960, "Policies for Parental, Family, and Medical Necessity Leave," be amended by addition and deletion, to read as follows:</u>

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

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

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

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

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

4. Our AMA will study the impact on and feasibility of ~~encourages~~ medical schools, residency programs, specialty boards, and medical group practices ~~to incorporate~~ incorporating into their parental leave policies a ~~six~~12-week minimum leave allowance, with the understanding that no parent ~~should~~ be required to take a minimum leave.

5. Our AMA recommends that medical practices, departments and training programs strive to provide 12 weeks of paid parental, family and medical necessity

leave in a 12-month period for their attending and trainee physicians as needed.

~~5.~~ 6. Residency program directors should review federal and state law for guidance in developing policies for parental, family, and medical leave.

~~6.~~ 7. Medical students and physicians who are unable to work because of pregnancy, childbirth, abortion or stillbirth, and other related medical conditions should be entitled to such leave and other benefits on the same basis as other physicians who are temporarily unable to work for other medical reasons.

~~7.~~ 8. Residency programs should develop written policies on ~~parental leave, family leave, and medical~~ leave for physicians. Such written policies should include the following elements: (a) leave policy for birth or adoption; (b) duration of leave allowed before and after delivery; (c) duration of leave allowed after abortion or stillbirth; ~~(c)~~(d) category of leave credited (e.g., sick, vacation, parental, unpaid leave, short term disability); ~~(d)~~(e) whether leave is paid or unpaid; ~~(e)~~(f) whether provision is made for continuation of insurance benefits during leave and who pays for premiums; ~~(f)~~(g) whether sick leave and vacation time may be accrued from year to year or used in advance; ~~(g)~~(h) extended leave for resident physicians with extraordinary and long-term personal or family medical tragedies for periods of up to one year, without loss of previously accepted residency positions, for devastating conditions such as terminal illness, permanent disability, or complications of pregnancy that threaten maternal or fetal life; ~~(h)~~(i) how time can be made up in order for a resident physician to be considered board eligible; ~~(i)~~(j) what period of leave would result in a resident physician being required to complete an extra or delayed year of training; ~~(j)~~(k) whether time spent in making up a leave will be paid; and ~~(k)~~(l) whether schedule accommodations are allowed, such as reduced hours, no night call, modified rotation schedules, and permanent part-time scheduling.

~~8.~~ 9. Medical schools should develop written policies on parental leave, family leave, and medical leave for medical students. Such written policies should include the following elements: (a) leave policy for birth or

adoption; (b) duration of leave allowed before and after delivery; (c) extended leave for medical students with extraordinary and long-term personal or family medical tragedies, without loss of previously accepted medical school seats, for devastating conditions such as terminal illness, permanent disability, or complications of pregnancy that threaten maternal or fetal life; (d) how time can be made up in order for a medical students to be eligible for graduation with minimal or no delays; (e) what period of leave would result in a medical student being required to complete an extra or delayed year of training; and (f) whether schedule accommodations are allowed, such as modified rotation schedules, no night duties, and flexibility with academic testing schedules.

~~8.~~ 10. Our AMA endorses the concept of equal parental leave for birth and adoption as a benefit for resident physicians, medical students, and physicians in practice regardless of gender or gender identity.

~~9.~~ 11. Staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in the workloads of other physicians, particularly those in residency programs.

~~10.~~ 12. Physicians should be able to return to their practices or training programs after taking parental leave, family leave, or medical leave without the loss of status.

~~11.~~ 13. Residency program directors must assist residents in identifying their specific requirements (for example, the number of months to be made up) because of leave for eligibility for board certification and must notify residents on leave if they are in danger of falling below minimal requirements for board eligibility. Program directors must give these residents a complete list of requirements to be completed in order to retain board eligibility.

~~12.~~ 14. Our AMA encourages flexibility in residency ~~training~~ programs and medical schools incorporating parental leave and alternative schedules for pregnant trainees ~~house staff~~.

~~13.~~ 15. In order to accommodate leave protected by the federal Family and Medical Leave Act, our AMA encourages all specialties within the American Board of

Medical Specialties to allow graduating residents to extend training up to 12 weeks after the traditional residency completion date while still maintaining board eligibility in that year.

~~14.~~ 16. These policies as above should be freely available online and in writing to all current trainees and applicants to medical school, residency or fellowship. (Modify Current HOD Policy)

RECOMMENDATION B:

Policy H-420.979, "AMA Statement on Family and Medical Leave," be amended by addition, to read as follows:

H-420.979, AMA Statement on Family and Medical Leave

Our AMA supports policies that provide employees with reasonable job security and continued availability of health plan benefits in the event leave by an employee becomes necessary due to documented medical conditions. Such policies should provide for reasonable periods of paid or unpaid:

(1) medical leave for the employee, including pregnancy, abortion, and stillbirth;

(2) maternity leave for the employee-mother;

(3) leave if medically appropriate to care for a member of the employee's immediate family, i.e., a spouse or children; and

(4) leave for adoption or for foster care leading to adoption. Such periods of leave may differ with respect to each of the foregoing classifications, and may vary with reasonable categories of employers. Such policies should encourage voluntary programs by employers and may provide for appropriate legislation (with or without financial assistance from government). Any legislative proposals will be reviewed through the Association's normal legislative process for appropriateness, taking into consideration all elements therein, including classifications of employees and employers, reasons for the leave, periods of leave recognized (whether paid or unpaid), obligations on

return from leave, and other factors involved in order to achieve reasonable objectives recognizing the legitimate needs of employees and employers. (Modify Current HOD Policy)

RECOMMENDATION C:

Amended Policy H-405.960 and H-420.979 be adopted in lieu of Resolutions 302, 303, and 308.

HOD ACTION: Amended Policy H-405.960 and H-420.979 adopted in lieu of Resolutions 302, 303, and 308.

Res 302:

RESOLVED, That our American Medical Association amend Policy H-405.960, “Policies for Parental, Family, and Medical Necessity Leave,” by addition and deletion to read as follows:

Policies for Parental, Family and Medical Necessity Leave H-405.960
AMA adopts as policy the following guidelines for, and encourages the implementation of, Parental, Family and Medical Necessity Leave for Medical Students and Physicians:

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

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

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

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

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

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

7. Residency programs should develop written policies on parental leave, family leave, and medical leave for physicians. Such written policies should include the following elements: (a) leave policy for birth or adoption; (b) duration of leave allowed before and after delivery; (c) duration of leave allowed after miscarriage or stillbirth ; ~~(c)~~(d) category of leave credited (e.g., sick, vacation, parental, unpaid leave, short term disability); ~~(d)~~(e) whether leave is paid or unpaid; ~~(e)~~(f) whether provision is made for continuation of insurance benefits during leave and who pays for premiums; ~~(f)~~(g) whether sick leave and vacation time may be accrued from year to year or used in advance; ~~(g)~~(h) extended leave for resident physicians with extraordinary and long-term personal or family medical tragedies for periods of up to one year, without loss of previously accepted residency positions, for devastating conditions such as terminal illness, permanent disability, or complications of pregnancy that threaten maternal or fetal life; ~~(h)~~(i) how time can be made up in order for a resident physician to be considered board eligible; ~~(i)~~(j) what period of leave would result in a resident physician being required to complete an extra or delayed year of training; ~~(j)~~(k) whether time spent in making up a leave will be paid; and ~~(k)~~(l) whether schedule accommodations are allowed, such as reduced hours, no night call, modified rotation schedules, and permanent part-time scheduling.

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

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

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

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

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

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

14. These policies as above should be freely available online and in writing to all applicants to medical school, residency or fellowship. (Modify Current HOD Policy); and be it further
RESOLVED, That due to the prevalence of miscarriage and stillbirth and the need for physical and psychological healing afterwards, our AMA amend Policy H-420.979 “AMA Statement on Family and Medical Leave,” by addition to read as follows:
AMA Statement on Family and Medical Leave H-420.979
Our AMA supports policies that provide employees with reasonable job security and continued availability of health plan benefits in the event leave by an employee becomes necessary due to documented medical conditions. Such policies should provide for reasonable periods of paid or unpaid:
(1) medical leave for the employee, including pregnancy~~;~~, miscarriage, and stillbirth;
(2) maternity leave for the employee-mother;
(3) leave if medically appropriate to care for a member of the employee's immediate family, i.e., a spouse or children; and
(4) leave for adoption or for foster care leading to adoption. Such periods of leave may differ with respect to each of the foregoing classifications, and may vary with reasonable categories of employers. Such policies should encourage voluntary programs by employers and may provide for appropriate legislation (with or without financial assistance from government). Any legislative proposals will be reviewed through the Association's normal legislative process for appropriateness, taking into consideration all elements therein, including classifications of employees and employers, reasons for the leave, periods of leave recognized (whether paid or unpaid), obligations on return from leave, and other factors involved in order to achieve reasonable objectives recognizing the legitimate needs of employees and employers. (Modify Current HOD Policy)

Res 303:

RESOLVED, That our American Medical Association amend policy H-405.960 “Policies for Parental, Family and Medical Necessity Leave” by addition and deletion to read as follows:

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

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

1. Our AMA urges ~~medical schools,~~ residency training programs, medical specialty boards, the Accreditation Council for Graduate Medical Education, and medical group practices to incorporate and/or encourage development of leave policies, including

parental, family, and medical leave policies, as part of the physician's standard benefit agreement.

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

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

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

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

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

7. Residency programs should develop written policies on parental leave, family leave, and medical leave for physicians. Such written policies should include the following elements: (a) leave policy for birth or adoption; (b) duration of leave allowed before and after delivery; (c) category of leave credited (e.g., sick, vacation, parental, unpaid leave, short term disability); (d) whether leave is paid or unpaid; (e) whether provision is made for continuation of insurance benefits during leave and who pays for premiums; (f) whether sick leave and vacation time may be accrued from year to year or used in advance; (g) extended leave for resident physicians with extraordinary and long-term personal or family medical tragedies for periods of up to one year, without loss of previously accepted residency positions, for devastating conditions such as terminal illness, permanent disability, or complications of pregnancy that threaten maternal or fetal life; (h) how time can be made up in order for a resident physician to be considered board eligible; (i) what period of leave would result in a resident physician being required to complete an extra or delayed year of training; (j) whether time spent in making up a leave will be paid; and (k)

whether schedule accommodations are allowed, such as reduced hours, no night call, modified rotation schedules, and permanent part-time scheduling.

8. Medical schools should develop written policies on parental leave, family leave, and medical leave for medical students. Such written policies should include the following elements: (a) leave policy for birth or adoption; (b) duration of leave allowed before and after delivery; (c) extended leave for medical students with extraordinary and long-term personal or family medical tragedies, without loss of previously accepted medical school seats, for devastating conditions such as terminal illness, permanent disability, or complications of pregnancy that threaten maternal or fetal life; (d) how time can be made up in order for a medical students to be eligible for graduation without delays; (e) what period of leave would result in a medical student being required to complete an extra or delayed year of training; and (f) whether schedule accommodations are allowed, such as modified rotation schedules, no night duties, and flexibility with academic testing schedules.

~~8.~~ 9.Our AMA endorses the concept of equal parental leave for birth and adoption as a benefit for resident physicians, medical students, and physicians in practice regardless of gender or gender identity.

~~9.~~ 10. Staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in the workloads of other physicians, particularly those in residency programs.

~~10.~~ 11. Physicians should be able to return to their practices or training programs after taking parental leave, family leave, or medical leave without the loss of status.

~~11.~~ 12. Residency program directors must assist residents in identifying their specific requirements (for example, the number of months to be made up) because of leave for eligibility for board certification and must notify residents on leave if they are in danger of falling below minimal requirements for board eligibility. Program directors must give these residents a complete list of requirements to be completed in order to retain board eligibility.

~~12.~~ 13. Our AMA encourages flexibility in residency training programs and medical schools incorporating parental leave and alternative schedules for pregnant trainees ~~house staff~~.

~~13.~~ 14. In order to accommodate leave protected by the federal Family and Medical Leave Act, our AMA encourages all specialties within the American Board of Medical Specialties to allow graduating residents to extend training up to 12 weeks after the traditional residency completion date while still maintaining board eligibility in that year.

~~14.~~ 15. These policies as above should be freely available online and in writing to all current trainees and applicants to medical school, residency or fellowship. (Modify Current HOD Policy)

Res 308:

RESOLVED, That our American Medical Association policy H-405.960 “Policies for Parental Family and Medical Necessity Leave” be amended by addition and deletion to read as follows:

AMA adopts as policy the following guidelines for, and encourages the implementation of, Parental, Family and Medical Necessity Leave for Medical Students and Physicians:
1. Our AMA urges medical schools, residency training programs, medical specialty boards, the Accreditation Council for Graduate Medical Education, and medical group practices to incorporate and/or encourage development of leave policies, including parental, family, and medical leave policies, as part of the physician's standard benefit agreement.
2. Recommended components of parental leave policies for medical students and physicians include: (a) duration of leave allowed before and after delivery; (b) category of leave credited; (c) whether leave is paid or unpaid; (d) whether provision is made for continuation of insurance benefits during leave, and who pays the premium; (e) whether sick leave and vacation time may be accrued from year to year or used in advance; (f) how much time must be made up in order to be considered board eligible; (g) whether make-up time will be paid; (h) whether schedule accommodations are allowed; and (i) leave policy for adoption.
3. AMA policy is expanded to include physicians in practice, reading as follows: (a) residency program directors and group practice administrators should review federal law concerning maternity leave for guidance in developing policies to assure that pregnant physicians are allowed the same sick leave or disability benefits as those physicians who are ill or disabled; (b) staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in other physicians' workloads, particularly in residency programs; and (c) physicians should be able to return to their practices or training programs after taking parental leave without the loss of status.
4. Our AMA encourages medical schools, residency programs, specialty boards, and medical group practices to incorporate into their parental, family, and medical necessity leave policies a ~~six~~ twelve-week minimum leave allowance, with the understanding that no ~~parent~~ individual should be required to take a minimum leave.
5. Our AMA recommends that medical practices, departments and training programs strive to provide 12 weeks of paid parental, family and medical necessity leave in a 12-month period for their attending and trainee physicians as needed.
~~5~~6. Residency program directors should review federal and state law for guidance in developing policies for parental, family, and medical leave.
~~6~~7. Medical students and physicians who are unable to work because of pregnancy, childbirth, and other related medical conditions should be entitled to such leave and other benefits on the same basis as other physicians who are temporarily unable to work for other medical reasons.
~~7~~8. Residency programs should develop written policies on parental leave, family leave, and medical leave for physicians. Such written policies should include the following elements: (a) leave policy for birth or adoption; (b) duration of leave allowed before and after delivery; (c) category of leave credited (e.g., sick, vacation, parental, unpaid leave, short term disability); (d) whether leave is paid or unpaid; (e) whether provision is made for continuation of insurance benefits during leave and who pays for premiums; (f) whether

sick leave and vacation time may be accrued from year to year or used in advance; (g) extended leave for resident physicians with extraordinary and long-term personal or family medical tragedies for periods of up to one year, without loss of previously accepted residency positions, for devastating conditions such as terminal illness, permanent disability, or complications of pregnancy that threaten maternal or fetal life; (h) how time can be made up in order for a resident physician to be considered board eligible; (i) what period of leave would result in a resident physician being required to complete an extra or delayed year of training; (j) whether time spent in making up a leave will be paid; and (k) whether schedule accommodations are allowed, such as reduced hours, no night call, modified rotation schedules, and permanent part-time scheduling.
~~8~~9. Our AMA endorses the concept of equal parental leave for birth and adoption as a benefit for resident physicians, medical students, and physicians in practice regardless of gender or gender identity.
~~9~~10. Staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in the workloads of other physicians, particularly those in residency programs.
~~10~~11. Physicians should be able to return to their practices or training programs after taking parental leave, family leave, or medical leave without the loss of status.
~~11~~12. Residency program directors must assist residents in identifying their specific requirements (for example, the number of months to be made up) because of leave for eligibility for board certification and must notify residents on leave if they are in danger of falling below minimal requirements for board eligibility. Program directors must give these residents a complete list of requirements to be completed in order to retain board eligibility.
~~12~~13. Our AMA encourages flexibility in residency training programs, incorporating parental leave and alternative schedules for pregnant house staff.
~~13~~14. In order to accommodate leave protected by the federal Family and Medical Leave Act, our AMA encourages all specialties within the American Board of Medical Specialties to allow graduating residents to extend training up to 12 weeks after the traditional residency completion date while still maintaining board eligibility in that year.
~~14~~15. These policies as above should be freely available online and in writing to all applicants to medical school, residency or fellowship. (Modify Current HOD Policy)

Your Reference Committee reviewed live and online testimony regarding Resolutions 302, 303, and 308. These items were heard separately during the hearing, and are combined here because all three recommend changes to Policy H-405.960 (with 302 also proposing edits to H-420.979). The authors of Resolution 302 testified in strong support of the need to amend current policy to include miscarriage and stillbirth as part of employee leave to allow time for the affected families to heal and cope with these tragic and traumatic experiences. Testimony was received requesting that abortion, the medical terminology for miscarriage, be used in AMA policy. Your Reference Committee concurs with this testimony and has revised the policy throughout, as noted. While acknowledging the sensitivity of the issue, the term abortion is standard medical terminology and therefore your Reference Committee supports its use in AMA policy.

For Resolution 303, the authors called for a universal leave policy for all medical schools to protect and promote the health of both parent and child. This is particularly of importance as child-bearing years align with career development years, with inevitable conflicts and challenges arising thereof. Testimony was supportive of adoption and offered

an amendment to Section 8, subsection D to change the word “without” to “with minimal or no delay.” The Council on Medical Education, meanwhile, expressed its support for substitute language for clause 8, to allow for medical schools to create more generalized and flexible policy that can be tailored to students’ specific situations and in concordance with the institution’s curricular requirements.

For Resolution 308, testimony was predominately supportive, particularly for the proposed increase in paid parental, family and medical necessity leave from 6 to 12 weeks. The Council on Medical Education recommended that clause 4 of this resolution be studied, given the impacts of leave on competency and medical practice.

(5) RESOLUTION 305 – ENCOURAGING MEDICAL SCHOOLS TO SPONSOR PIPELINE PROGRAMS TO MEDICINE FOR UNDERREPRESENTED GROUPS

RECOMMENDATION A:

The first Resolve of Resolution 305 be amended by addition and deletion, to read as follows:

RESOLVED, That our American Medical Association urge medical schools to develop or expand the reach of existing ~~pipeline~~ pathway programs for underrepresented middle school, high school and college aged students to motivate them to pursue and prepare them for a career in medicine (New HOD Policy); and be it further

RECOMMENDATION B:

The third Resolve of Resolution 305 be amended by addition and deletion, to read as follows:

RESOLVED, That our AMA recommend that medical school ~~pipeline~~ pathway programs for underrepresented students be free-of-charge or provide financial support with need-based scholarships and grants (New HOD Policy); and be it further

RECOMMENDATION C:

Resolution 305 be adopted as amended.

HOD ACTION: Resolution 305 adopted as amended

Resolution 305 be amended by addition of a fifth Resolve, to read as follows:

<u>RESOLVED, That our AMA consider quality of K-12 education a social determinant of health and thus advocate for implementation of Policy H-350.979, (1) (a) encouraging state and local governments to make quality elementary and secondary education available to all.</u>

The title of Resolution 305 be <u>amended</u>, to read as follows:

ENCOURAGING MEDICAL SCHOOLS TO SPONSOR PATHWAY PROGRAMS TO MEDICINE FOR UNDERREPRESENTED GROUPS

RESOLVED, That our American Medical Association urge medical schools to develop or expand the reach of existing pipeline programs for underrepresented middle school, high school and college aged students to motivate them to pursue and prepare them for a career in medicine (New HOD Policy); and be it further

RESOLVED, That our AMA encourage collegiate programs to establish criteria by which completion of such programs will secure an interview for admission to the sponsoring medical school (New HOD Policy); and be it further

RESOLVED, That our AMA recommend that medical school pipeline programs for underrepresented students be free-of-charge or provide financial support with need-based scholarships and grants (New HOD Policy); and be it further

RESOLVED, That our AMA encourage all physicians to actively participate in programs and mentorship opportunities that help expose underrepresented students to potential careers in medicine. (New HOD Policy)

Your Reference Committee reviewed live and online testimony regarding this item. Testimony expressed support for both the downstream recommendations made by the authors as well as suggested amendments to incorporate upstream interventions such as encouraging governmental support for quality Kindergarten through 12th grade education as a social determinant of health and as a method to increase the number of qualified applicants to medical school. Your Reference Committee felt that this request was beyond the scope of this proposed policy. A friendly amendment was also offered to update the nomenclature for programs aimed at increasing access to medical education among those who have been historically excluded to “pathway” programs as referenced in an earlier Council on Medical Education Report to demonstrate there are many ways to enter the field of medicine and away from the perspective associated with “pipeline,” a metaphor that implies a rigid and reductionist perspective. This verbiage may also give rise to negative connotations for Native Americans (that is, the all-too-common despoilation of their ancestral lands by pipelines, distended with petroleum and other hazardous substances). Therefore, your Reference Committee recommends that Resolution 305 be adopted as amended.

(6) RESOLUTION 306 – INCREASED CREDIT FOR CONTINUING MEDICAL EDUCATION PREPARATION

RECOMMENDATION A:

Resolution 306 be amended by addition and deletion, to read as follows:

RESOLVED, That our American Medical Association, through its AMA-PRA credit system, ~~collaborate with the Accreditation Council on Continuing Medical Education (ACCME), to~~ allow physicians to claim an amount of Category 1 CME credits that ~~more~~ accurately reflects the learning associated with preparing and presenting CME programs. Physicians may claim ~~minimum of~~ up to four (4) Category 1 CME hours per each hour of presentation. (Directive to Take Action).

RECOMMENDATION B:

Resolution 306 be adopted as amended.

HOD ACTION: Resolution 306 adopted as amended

RESOLVED, That our American Medical Association collaborate with the Accreditation Council on Continuing Medical Education (ACCME), to allow physicians to claim an amount of Category 1 CME credits that more accurately reflects the hours they spend on preparing and presenting CME programs to a maximum of four (4) Category 1 CME hours. (Directive to Take Action)

Your Reference Committee reviewed live and online testimony regarding this item. Testimony was unanimously supportive of this resolution. Testimony from the Council on Medical Education provided important background information on the claiming of continuing medical education (CME) credit, including the reminder that the number of Category 2 CME credits that can be claimed is not limited, as long as the activity meets the stipulated requirements in the AMA Physician's Recognition Award (AMA PRA) booklet, and that this would be a mechanism for declaring actual hours spent. The Council proffered amendments to in effect double the number of Category 1 credits that could be claimed per hour of time preparing and presenting a CME program. As the owner of the AMA PRA credit system, our AMA is entitled to make this change without the need to collaborate with the Accreditation Council for Continuing Medical Education which was reflected in the Council's additional edit to remove that ask from the resolution. Therefore, your Reference Committee recommends that Resolution 306 be adopted as amended.

(7) RESOLUTION 309 – BEREAVEMENT LEAVE FOR MEDICAL STUDENTS AND PHYSICIANS

RECOMMENDATION A:

Resolution 309 be amended by addition and deletion, to read as follows:

RESOLVED, That our American Medical Association support ~~bereavement~~ compassionate leave for medical students and physicians:

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

2. Our AMA will study ~~Rrecommended~~ components of ~~bereavement~~ compassionate leave policies for medical students and physicians, to include:
a. whether cases requiring extensive travel qualify for additional days of leave and, if so, how many days;
b. policy and duration of leave for an event impacting pregnancy or fertility including pregnancy loss, an unsuccessful round of intrauterine insemination or of an assisted reproductive technology procedure, a failed adoption arrangement, a failed surrogacy arrangement, or an event that impacts pregnancy or fertility;
c. whether leave is paid or unpaid;
d. whether obligations and time must be made up; and
e. whether make-up time will be paid.

3. Our AMA encourages medical schools, residency and fellowship programs, specialty boards, specialty societies and medical group practices to incorporate into their ~~bereavement~~ compassionate leave policies a three-day minimum leave, with the understanding that no medical student or physician ~~or medical student~~ should be required to take a minimum leave.

4. Medical students and physicians who are unable to work beyond the defined ~~bereavement~~ compassionate leave period because of physical or psychological stress, medical complications of pregnancy loss, or another related reason should refer to their institution's

sick leave policy, family and medical leave policy, and other benefits on the same basis as other physicians who are temporarily unable to work for other reasons.

5. Our AMA ~~supports~~ will study the concept of equal ~~bereavement~~ compassionate leave for pregnancy loss and other such events impacting fertility in a physician or their partner as a benefit for medical students and physicians regardless of gender or gender identity.

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

7. These guidelines as above should be freely available online and in writing to all applicants to medical school, residency, or fellowship. (Directive to Take Action)

RECOMMENDATION B:

Resolution 309 be adopted as amended.

HOD ACTION: Resolution 309 adopted as amended

RESOLVED, That our American Medical Association support bereavement leave for medical students and physicians:
1. Our AMA urges medical schools, residency and fellowship training programs, medical specialty boards, the Accreditation Council for Graduate Medical Education, and medical group practices to incorporate and/or encourage development of bereavement leave policies as part of the physician's standard benefit agreement.
2. Recommended components of bereavement leave policies for medical students and physicians include:
a. whether cases requiring extensive travel qualify for additional days of leave and, if so, how many days;
b. policy and duration of leave for an event impacting pregnancy or fertility including pregnancy loss, an unsuccessful round of intrauterine insemination or of an assisted reproductive technology procedure, a failed adoption arrangement, a failed surrogacy arrangement, or an event that impacts pregnancy or fertility;
c. whether leave is paid or unpaid;
d. whether obligations and time must be made up; and
e. whether make-up time will be paid.
3. Our AMA encourages medical schools, residency and fellowship programs, specialty boards, specialty societies and medical group practices to incorporate into their bereavement leave policies a three-day minimum leave, with the understanding that no physician or medical student should be required to take a minimum leave.

4. Medical students and physicians who are unable to work beyond the defined bereavement leave period because of physical or psychological stress, medical complications of pregnancy loss, or another related reason should refer to their institution's sick leave policy, family and medical leave policy, and other benefits on the same basis as other physicians who are temporarily unable to work for other reasons.
5. Our AMA supports the concept of equal bereavement leave for pregnancy loss and other such events impacting fertility in a physician or their partner as a benefit for medical students and physicians regardless of gender or gender identity.
6. Staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in the workloads of other physicians, particularly those in residency programs.
7. These guidelines as above should be freely available online and in writing to all applicants to medical school, residency, or fellowship. (Directive to Take Action)

Your Reference Committee reviewed live and online testimony regarding this item. While the majority of testimony was supportive, there was sentiment in support of referral, as bereavement is not considered a component of family medical leave. Additionally, testimony expressed concern that "bereavement" could intimate "personhood," with an amendment offered to replace "bereavement" with "compassionate" throughout the resolution, including the title. Your Reference Committee appreciates that the issues associated with this resolution are complex and believes that clauses 2 and 5 of the resolution require a comprehensive review to formulate a comprehensive policy—hence, the recommendation for our AMA to study these issues further. Therefore, your Reference Committee recommends that Resolution 309 be adopted as amended.

(8) RESOLUTION 310 – ENFORCE AMA PRINCIPLES ON CONTINUING BOARD CERTIFICATION

RECOMMENDATION A:

Policy H-275.924 be reaffirmed in lieu of the first Resolve of Resolution 310.

RECOMMENDATION B:

The second Resolve of Resolution 310 be amended by addition and deletion, to read as follows:

RESOLVED, That our AMA continue to publicly report ~~their~~ its work on enforcing AMA Principles on Continuing Board Certification ~~at the Annual and Interim meetings of the AMA House of Delegates~~. (Directive to Take Action)

RECOMMENDATION C:

Resolution 310 be adopted as amended.

HOD ACTION: Resolution 310 adopted as amended

RESOLVED, That our American Medical Association continue to actively work to enforce current AMA Principles on Continuing Board Certification (Directive to Take Action); and be it further

RESOLVED, That our AMA publicly report their work on enforcing AMA Principles on Continuing Board Certification at the Annual and Interim meetings of the AMA House of Delegates. (Directive to Take Action)

Your Reference Committee reviewed live and online testimony regarding this item. Testimony from the Council on Medical Education recommended that AMA policy be reaffirmed in lieu of the first resolve, and that the second resolve be amended to reinforce the value of the AMA's core principles on continuing board certification (CBC) and remove references to timing of a report back. Further testimony was supportive of the Council's recommendations. Your Reference Committee appreciates that the Council will continue to monitor this important subject, as some testimony noted continued concerns about CBC, particularly among specific specialties. Your Reference Committee concurs with the Council's recommendations to the first and second resolves and clarifies that the AMA's core principles on CBC, namely, H-275.924, be reaffirmed in lieu of the first resolve. Therefore, your Reference Committee recommends that Resolution 310 be adopted as amended.

Policy recommended for reaffirmation:

H-275.924, "Continuing Board Certification"

AMA Principles on Continuing Board Certification

1. Changes in specialty-board certification requirements for CBC programs should be longitudinally stable in structure, although flexible in content.

2. Implementation of changes in CBC must be reasonable and take into consideration the time needed to develop the proper CBC structures as well as to educate physician diplomates about the requirements for participation.

3. Any changes to the CBC process for a given medical specialty board should occur no more frequently than the intervals used by that specialty board for CBC.

4. Any changes in the CBC process should not result in significantly increased cost or burden to physician participants (such as systems that mandate continuous documentation or require annual milestones).

5. CBC requirements should not reduce the capacity of the overall physician workforce. It is important to retain a structure of CBC programs that permits physicians to complete modules with temporal flexibility, compatible with their practice responsibilities.

6. Patient satisfaction programs such as The Consumer Assessment of Healthcare Providers and Systems (CAHPS) patient survey are neither appropriate nor effective survey tools to assess physician competence in many specialties.

7. Careful consideration should be given to the importance of retaining flexibility in pathways for CBC for physicians with careers that combine clinical patient care with significant leadership, administrative, research and teaching responsibilities.

8. Legal ramifications must be examined, and conflicts resolved, prior to data collection and/or displaying any information collected in the process of CBC. Specifically, careful consideration must be given to the types and format of physician-specific data to be publicly released in conjunction with CBC participation.

9. Our AMA affirms the current language regarding continuing medical education (CME): “Each Member Board will document that diplomates are meeting the CME and Self-Assessment requirements for CBC Part II. The content of CME and self-assessment programs receiving credit for CBC will be relevant to advances within the diplomate’s scope of practice, and free of commercial bias and direct support from pharmaceutical and device industries. Each diplomate will be required to complete CME credits (AMA PRA Category 1 Credit”, American Academy of Family Physicians Prescribed, American College of Obstetricians and Gynecologists, and/or American Osteopathic Association Category 1A).”

10. In relation to CBC Part II, our AMA continues to support and promote the AMA Physician’s Recognition Award (PRA) Credit system as one of the three major credit systems that comprise the foundation for continuing medical education in the U.S., including the Performance Improvement CME (PICME) format; and continues to develop relationships and agreements that may lead to standards accepted by all U.S. licensing boards, specialty boards, hospital credentialing bodies and other entities requiring evidence of physician CME.

11. CBC is but one component to promote patient safety and quality. Health care is a team effort, and changes to CBC should not create an unrealistic expectation that lapses in patient safety are primarily failures of individual physicians.

12. CBC should be based on evidence and designed to identify performance gaps and unmet needs, providing direction and guidance for improvement in physician performance and delivery of care.

13. The CBC process should be evaluated periodically to measure physician satisfaction, knowledge uptake and intent to maintain or change practice.

14. CBC should be used as a tool for continuous improvement.

15. The CBC program should not be a mandated requirement for licensure, credentialing, recredentialing, privileging, reimbursement, network participation, employment, or insurance panel participation.

16. Actively practicing physicians should be well-represented on specialty boards developing CBC.

17. Our AMA will include early career physicians when nominating individuals to the Boards of Directors for ABMS member boards.

18. CBC activities and measurement should be relevant to clinical practice.

19. The CBC process should be reflective of and consistent with the cost of development and administration of the CBC components, ensure a fair fee structure, and not present a barrier to patient care.

20. Any assessment should be used to guide physicians' self-directed study.

21. Specific content-based feedback after any assessment tests should be provided to physicians in a timely manner.

22. There should be multiple options for how an assessment could be structured to accommodate different learning styles.

23. Physicians with lifetime board certification should not be required to seek recertification.

24. No qualifiers or restrictions should be placed on diplomates with lifetime board certification recognized by the ABMS related to their participation in CBC.

25. Members of our House of Delegates are encouraged to increase their awareness of and participation in the proposed changes to physician self-regulation through their specialty organizations and other professional membership groups.

26. The initial certification status of time-limited diplomates shall be listed and publicly available on all American Board of Medical Specialties (ABMS) and ABMS Member Boards websites and physician certification databases. The names and initial certification status of time-limited diplomates shall not be removed from ABMS and ABMS Member Boards websites or physician certification databases even if the diplomate chooses not to participate in CBC.

27. Our AMA will continue to work with the national medical specialty societies to advocate for the physicians of America to receive value in the services they purchase for Continuing Board Certification from their specialty boards. Value in CBC should include cost effectiveness with full financial transparency, respect for physicians' time and their patient care commitments, alignment of CBC requirements with other regulator and payer requirements, and adherence to an evidence basis for both CBC content and processes.

(9) RESOLUTION 312 – REPORTING OF RESIDENCY DEMOGRAPHIC DATA

RECOMMENDATION A:

The first Resolve of Resolution 312 be amended by addition and deletion, to read as follows:

RESOLVED, That our American Medical Association work with appropriate stakeholders to encourage that residency programs annually publish and share with FREIDA and other appropriate stakeholders, (a) self-identified and other demographic data, including but not limited to the composition of their program over the last 5 years by age;~~,~~ ~~gender identity,~~ ~~URM~~ historically marginalized, minoritized, or excluded status;~~,~~ sexual orientation and gender identity; ~~and LGBTQIA+ status; (b) parental and family leave policies; and (c) the number and/or proportion of residents who have utilized parental or family leave in the past 5 years~~ (Directive to Take Action); and be it further

RECOMMENDATION B:

The second Resolve of Resolution 312 be amended by deletion, to read as follows:

RESOLVED, That our AMA encourage the Accreditation Council for Graduate Medical Education and other relevant stakeholders to annually collect data on ~~pregnancy,~~ childbirth~~,~~ and parenthood from all accredited US residency programs and publish this data with disaggregation by gender identity and specialty. (New HOD Policy)

RECOMMENDATION C:

Policy H-405.960 be amended by addition, to read as follows:

AMA adopts as policy the following guidelines for, and encourages the implementation of, Parental, Family and Medical Necessity Leave for Medical Students and Physicians:
1. Our AMA urges medical schools, residency training programs, medical specialty boards, the Accreditation Council for Graduate Medical Education, and medical group practices to incorporate and/or encourage

development of leave policies, including parental, family, and medical leave policies, as part of the physician's standard benefit agreement.
2. Recommended components of parental leave policies for medical students and physicians include: (a) duration of leave allowed before and after delivery; (b) category of leave credited; (c) whether leave is paid or unpaid; (d) whether provision is made for continuation of insurance benefits during leave, and who pays the premium; (e) whether sick leave and vacation time may be accrued from year to year or used in advance; (f) how much time must be made up in order to be considered board eligible; (g) whether make-up time will be paid; (h) whether schedule accommodations are allowed; and (i) leave policy for adoption.
3. AMA policy is expanded to include physicians in practice, reading as follows: (a) residency program directors and group practice administrators should review federal law concerning maternity leave for guidance in developing policies to assure that pregnant physicians are allowed the same sick leave or disability benefits as those physicians who are ill or disabled; (b) staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in other physicians' workloads, particularly in residency programs; and (c) physicians should be able to return to their practices or training programs after taking parental leave without the loss of status.
4. Our AMA encourages medical schools, residency programs, specialty boards, and medical group practices to incorporate into their parental leave policies a six-week minimum leave allowance, with the understanding that no parent should be required to take a minimum leave.
5. Residency program directors should review federal and state law for guidance in developing policies for parental, family, and medical leave.
6. Medical students and physicians who are unable to work because of pregnancy, childbirth, and other related medical conditions should be entitled to such leave and other benefits on the same basis as other physicians who are temporarily unable to work for other medical reasons.
7. Residency programs should develop written policies on parental leave, family leave, and medical leave for physicians. Such written policies should include the

following elements: (a) leave policy for birth or adoption; (b) duration of leave allowed before and after delivery; (c) category of leave credited (e.g., sick, vacation, parental, unpaid leave, short term disability); (d) whether leave is paid or unpaid; (e) whether provision is made for continuation of insurance benefits during leave and who pays for premiums; (f) whether sick leave and vacation time may be accrued from year to year or used in advance; (g) extended leave for resident physicians with extraordinary and long-term personal or family medical tragedies for periods of up to one year, without loss of previously accepted residency positions, for devastating conditions such as terminal illness, permanent disability, or complications of pregnancy that threaten maternal or fetal life; (h) how time can be made up in order for a resident physician to be considered board eligible; (i) what period of leave would result in a resident physician being required to complete an extra or delayed year of training; (j) whether time spent in making up a leave will be paid; and (k) whether schedule accommodations are allowed, such as reduced hours, no night call, modified rotation schedules, and permanent part-time scheduling.

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

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

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

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

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

13. In order to accommodate leave protected by the federal Family and Medical Leave Act, our AMA encourages all specialties within the American Board of Medical Specialties to allow graduating residents to extend training up to 12 weeks after the traditional residency completion date while still maintaining board eligibility in that year.
14. These policies as above should be freely available online <u>through FREIDA</u> and in writing to all applicants to medical school, residency or fellowship.

RECOMMENDATION D:

Resolution 312 be <u>adopted as amended</u>.

HOD ACTION: Resolution 312 <u>adopted as amended</u>

RESOLVED, That our American Medical Association work with appropriate stakeholders to encourage that residency programs annually publish and share with FREIDA and other appropriate stakeholders, (a) demographic data, including but not limited to the composition of their program over the last 5 years by age, gender identity, URM status, and LGBTQIA+ status; (b) parental and family leave policies; and (c) the number and/or proportion of residents who have utilized parental or family leave in the past 5 years (Directive to Take Action); and be it further

RESOLVED, That our AMA encourage the Accreditation Council for Graduate Medical Education and other relevant stakeholders to annually collect data on pregnancy, childbirth, and parenthood from all accredited US residency programs and publish this data with disaggregation by gender identity and specialty. (New HOD Policy)

Your Reference Committee heard supportive testimony for the intent of this item, which is intended to encourage transparency. The author noted the value in having such data available during the decision-making process, while also acknowledging the importance of protecting privacy. Regarding clause (a) of the first resolve, your Reference Committee discussed the sensitivity of some of the data listed in the first resolve and therefore recommended that “self-identified” be added. Further, your Reference Committee recommended reordering the data points such that “gender identity” and “sexual orientation” are adjacent, and recommended changing “URM” to “historically marginalized, minoritized, or excluded,” in keeping with the AMA and AAMC’s resource, “<u>Advancing Health Equity: A Guide to Language, Narrative and Concepts</u>.” In lieu of clause (b), your Reference Committee recommends that AMA Policy H-405.960 be amended to include “FREIDA.” Your Reference Committee also recommends striking clause (c) due to legal and privacy concerns.

Regarding the second resolve, your Reference Committee recommends that “pregnancy” be stricken, given the privacy concerns and inappropriate nature of requesting this information. With these revisions, your Reference Committee recommends that Resolution 312 be adopted as amended.

(10) RESOLUTION 313 – REQUEST A TWO-YEAR DELAY IN ACCME CHANGES TO STATE MEDICAL SOCIETY RECOGNITION PROGRAM

RECOMMENDATION A:

Resolution 313 be amended by addition and deletion, to read as follows:

RESOLVED, That our American Medical Association collaborate with Accreditation Council for Continuing Medical Education (ACCME) ~~with a goal~~ to ~~secure a two-year~~ delay ~~in the~~ implementation of any changes to the state medical society accreditor program until such time that a mutual agreement can be reached. During that time, AMA, ACCME and state medical societies will work collaboratively to study the impact and unintended consequences of the proposed action and ~~to~~ create a plan that is in the best interests of all parties, including the continuing medical education providers currently accredited by state medical societies. (Directive to Take Action)

RECOMMENDATION B:

Resolution 313 be adopted as amended.

HOD ACTION: Resolution 313 adopted as amended

RESOLVED, That our American Medical Association collaborate with Accreditation Council for Continuing Medical Education (ACCME) with a goal to secure a two-year delay in the implementation of any changes to the state medical society accreditor program. During that time, AMA, ACCME and state medical societies will work collaboratively to study the impact and unintended consequences of the proposed action and to create a plan that is in the best interests of all parties, including the continuing medical education providers currently accredited by state medical societies. (Directive to Take Action)

Your Reference Committee reviewed live and online testimony regarding this item. Online testimony from the Accreditation Council for Continuing Medical Education (ACCME) noted that this topic will be addressed as a key agenda item at its annual meeting with the state medical societies next month; therefore, they asked that the AMA not act on this resolution at this time. Further testimony supportive of the resolution expressed several concerns, such as the impact on education in rural areas and in less populous states; the arbitrary nature of the ACCME’s proposed changes to the state medical society programs and lack of data linking the number of programs in a given state to the quality of these programs; and an implementation date that does not allow sufficient time for affected states to assess and address the impact of the proposed changes. Testimony expressed urgency to address this matter. Your Reference Committee concurs with the concerns

raised and recommends striking “two-year” and adding language requiring mutual agreement among all parties. Therefore, your Reference Committee recommends that Resolution 313 be adopted as amended.

(11) RESOLUTION 316 – RECOGNIZING SPECIALTY CERTIFICATIONS FOR PHYSICIANS

RECOMMENDATION A:

The first Resolve of Resolution 316 be amended by addition and deletion, to read as follows:

RESOLVED, That our American Medical Association amend Policy H-275.926, “Medical Specialty Board Certification Standards,” by addition to read as follows:

(1) Opposes any action, regardless of intent, that appears likely to confuse the public about the unique credentials of American Board of Medical Specialties (ABMS) or American Osteopathic Association Bureau of Osteopathic Specialists (AOA-BOS) board certified physicians in any medical specialty, or take advantage of the prestige of any medical specialty for purposes contrary to the public good and safety.
(2) Opposes any action, regardless of intent, by organizations providing board certification for non-physicians that appears likely to confuse the public about the unique credentials of medical specialty board certification or take advantage of the prestige of medical specialty board certification for purposes contrary to the public good and safety.
(3) Continues to work with other medical organizations to educate the profession and the public about the ABMS and AOA-BOS board certification process. It is AMA policy that when the equivalency of board certification must be determined, the certification program must first meet ~~industry~~ accepted standards for certification that include both 1) a process for defining specialty-specific standards for knowledge and skills and 2) offer an independent, external assessment of knowledge and skills for both initial certification and recertification in the medical specialty. In addition, accepted standards, such as those adopted by state medical boards or the Essentials for Approval of Examining Boards in Medical Specialties, will be utilized for that determination.
(4) Opposes discrimination against physicians based solely on lack of ABMS or equivalent AOA-BOS

board certification, or where board certification is one of the criteria considered for purposes of measuring quality of care, determining eligibility to contract with managed care entities, eligibility to receive hospital staff or other clinical privileges, ascertaining competence to practice medicine, or for other purposes. Our AMA also opposes discrimination that may occur against physicians involved in the board certification process, including those who are in a clinical practice period for the specified minimum period of time that must be completed prior to taking the board certifying examination.
(5) Advocates for nomenclature to better distinguish those physicians who are in the board certification pathway from those who are not.
(6) Encourages member boards of the ABMS to adopt measures aimed at mitigating the financial burden on residents related to specialty board fees and fee procedures, including shorter preregistration periods, lower fees and easier payment terms. (Modify Current HOD Policy); and be it further

RECOMMENDATION B:

The second Resolve of Resolution 316 be <u>amended by addition and deletion</u>, to read as follows:

RESOLVED, that our AMA advocate for federal and state legislatures, federal and state regulators, physician credentialing organizations, hospitals, <u>and</u> other health care stakeholders ~~and the public~~ to define physician board certification as establishing specialty-specific standards for knowledge and skills, using an independent assessment process to determine the acquisition of knowledge and skills for initial certification and recertification. (Directive to Take Action)

RECOMMENDATION C:

Resolution 316 be <u>adopted as amended</u>.

HOD ACTION: Resolution 316 <u>adopted as amended</u>

The first Resolve of Resolution 316 be <u>amended by addition and deletion</u>, to read as follows:

RESOLVED, That our American Medical Association amend Policy H-275.926, "Medical Specialty Board Certification Standards," by addition, to read as follows:

(1) Opposes any action, regardless of intent, that appears likely to confuse the public about the unique credentials of American Board of Medical Specialties (ABMS) or American Osteopathic Association Bureau of Osteopathic Specialists (AOA-BOS) board certified physicians in any medical specialty, or take advantage of the prestige of any medical specialty for purposes contrary to the public good and safety.

(2) Opposes any action, regardless of intent, by organizations providing board certification for non-physicians that appears likely to confuse the public about the unique credentials of medical specialty board certification or take advantage of the prestige of medical specialty board certification for purposes contrary to the public good and safety.

(3) Continues to work with other medical organizations to educate the profession and the public about the ABMS and AOA-BOS board certification process. It is AMA policy that when the equivalency of board certification must be determined, the certification program must first meet ~~industry~~ accepted standards for certification that include both 1) a process for defining specialty-specific standards for knowledge and skills and 2) offer an independent, external assessment of knowledge and skills for both initial certification and recertification or continuous certification in the medical specialty. In addition, accepted standards, such as those adopted by state medical boards or the Essentials for Approval of Examining Boards in Medical Specialties, will be utilized for that determination.

(4) Opposes discrimination against physicians based solely on lack of ABMS or equivalent AOA-BOS board certification, or where board certification is one of the criteria considered for purposes of measuring quality of care, determining eligibility to contract with managed care entities, eligibility to receive hospital staff or other clinical privileges, ascertaining competence to practice medicine, or for other purposes. Our AMA also opposes discrimination that may occur against physicians involved in the board certification process, including those who are in a clinical practice period for the specified minimum period of time that must be

completed prior to taking the board certifying examination.

(5) Advocates for nomenclature to better distinguish those physicians who are in the board certification pathway from those who are not.

(6) Encourages member boards of the ABMS to adopt measures aimed at mitigating the financial burden on residents related to specialty board fees and fee procedures, including shorter preregistration periods, lower fees and easier payment terms. (Modify Current HOD Policy); and be it further

The second Resolve of Resolution 316 be referred.

RESOLVED, That our American Medical Association amend Policy H-275.926, “Medical Specialty Board Certification Standards,” by addition to read as follows:

1) Opposes any action, regardless of intent, that appears likely to confuse the public about the unique credentials of American Board of Medical Specialties (ABMS) or American Osteopathic Association Bureau of Osteopathic Specialists (AOA-BOS) board certified physicians in any medical specialty, or take advantage of the prestige of any medical specialty for purposes contrary to the public good and safety.

2) Opposes any action, regardless of intent, by organizations providing board certification for non-physicians that appears likely to confuse the public about the unique credentials of medical specialty board certification or take advantage of the prestige of medical specialty board certification for purposes contrary to the public good and safety.

3) Continues to work with other medical organizations to educate the profession and the public about the ABMS and AOA-BOS board certification process. It is AMA policy that when the equivalency of board certification must be determined, the certification program must first meet industry standards for certification that include both 1) a process for defining specialty-specific standards for knowledge and skills and 2) offer an independent, external assessment of knowledge and skills for both initial certification and recertification in the medical specialty. In addition, accepted standards, such as those adopted by state medical boards or the Essentials for Approval of Examining Boards in Medical Specialties, will be utilized for that determination.

4) Opposes discrimination against physicians based solely on lack of ABMS or equivalent AOA-BOS board certification, or where board certification is one of the criteria considered for purposes of measuring quality of care, determining eligibility to contract with managed care entities, eligibility to receive hospital staff or other clinical privileges, ascertaining competence to practice medicine, or for other purposes. Our AMA also opposes discrimination that may occur against physicians involved in the board certification process, including those who are in a clinical practice period for the specified minimum period of time that must be completed prior to taking the board certifying examination.

5) Advocates for nomenclature to better distinguish those physicians who are in the board certification pathway from those who are not.

6) Encourages member boards of the ABMS to adopt measures aimed at mitigating the financial burden on residents related to specialty board fees and fee procedures, including shorter preregistration periods, lower fees and easier payment terms. (Modify Current HOD Policy); and be it further

RESOLVED, that our AMA advocate for federal and state legislatures, federal and state regulators, physician credentialing organizations, hospitals, other health care stakeholders and the public to define physician board certification as establishing specialty-specific standards for knowledge and skills, using an independent assessment process to determine the acquisition of knowledge and skills for initial certification and recertification. (Directive to Take Action)

Your Reference Committee reviewed live and online testimony regarding this item. Live testimony expressed support for this resolution and acknowledged the complexities of this issue. Further testimony recommended clarifying that this resolution addresses “initial and continuing certification.” In clause (3) of the first resolve, your Reference Committee recommended that the term “industry” be stricken, given its lack of definition, and replaced by “accepted.” For the second resolve, testimony from the Council on Medical Education recommended removal of “and the public”; the author concurred with this amendment. Therefore, your Reference Committee recommends that Resolution 316 be adopted as amended.

(12) RESOLUTION 317 - SUPPORT FOR GME TRAINING IN REPRODUCTIVE SERVICES

RECOMMENDATION A:

Resolution 317 be amended by addition and deletion, to read as follows:

RESOLVED, That AMA policy H-295.923, “Medical Training and Termination of Pregnancy,” be amended by addition and deletion, to read as follows:

Medical Training and Termination of Pregnancy

1. Our AMA supports the education of medical students, residents and young physicians about the need for physicians who provide termination of pregnancy services, the medical and public health importance of access to safe termination of pregnancy, and the medical, ethical, legal and psychological principles associated with termination of pregnancy.

2. Our AMA ~~supports~~ will advocate for the availability of abortion education and ~~hands-on~~ clinical exposure to medication and procedural abortion ~~procedures for termination of pregnancy, including medication~~

~~abortions,~~ for medical students and resident/fellow physicians and opposes efforts to interfere with or restrict the availability of this education and training.

3. In the event that medication and procedural abortion are limited or illegal in a home institution, our AMA will support~~s~~ pathways for medical students and resident/fellow physicians to receive this training at another location~~, including cost subsidization, to ensure trainees traveling to another program have hands-on training in medication and procedural abortion, and will advocate for legal protections for both trainees who cross state lines to receive education on reproductive health services, including medication and procedural abortion, as well as the institutions facilitating these opportunities~~.

4. Our AMA will advocate for funding for institutions that provide clinical training on reproductive health services, including medication and procedural abortion, to medical students and resident/fellow physicians from other programs, so that they can expand their capacity to accept out-of-state medical students and resident/fellow physicians seeking this training.

~~3~~5. Our AMA encourages the Accreditation Council for Graduate Medical Education to consistently enforce compliance with the standardization of abortion training opportunities as per the requirements set forth by the relevant Residency Review Committees ~~Review Committee for Obstetrics and Gynecology~~ ~~and the American College of Obstetricians and Gynecologists' recommendations~~; and be it further

RESOLVED, That our AMA reaffirm policies H-100.948 "Supporting Access to Mifepristone (Mifeprex)" and H-425.969 "Support for Access to Preventive and Reproductive Health Services"; and be it further

RECOMMENDATION B:

AMA Policy D-5.999 be amended by addition and deletion, to read as follows:

RESOLVED, That AMA Policy D-5.999, "Preserving Access to Reproductive Health Services," be amended by addition, to read as follows:

Our AMA: (1) recognizes that healthcare, including reproductive health services like contraception and abortion, is a human right; (2) opposes limitations on access to evidence-based reproductive health services, including fertility treatments, contraception, and abortion; (3) will work with interested state medical societies and medical specialty societies to vigorously advocate for broad, equitable access to reproductive health services, including fertility treatments, contraception, and abortion; (4) supports shared decision-making between patients and their physicians regarding reproductive healthcare; (5) opposes any effort to undermine the basic medical principle that clinical assessments, such as viability of the pregnancy and safety of the pregnant person, are determinations to be made only by healthcare professionals with their patients; (6) opposes the imposition of criminal and civil penalties or other retaliatory efforts against patients, patient advocates, physicians, other healthcare workers, and health systems for receiving, assisting in, referring patients to, or providing reproductive health services; (7) will advocate for legal protections for patients who cross state lines to receive reproductive health services, including contraception and abortion, or who receive medications for contraception and abortion from across state lines, and legal protections for those that provide, support, or refer patients to these services; (8) will advocate for legal protections for medical students and physicians who cross state lines to receive education in or deliver reproductive health services, including contraception and abortion, and (~~8~~9) will review the AMA policy compendium and recommend policies which should be amended or rescinded to reflect these core values, with report back at the 2022 Interim Meeting.

RECOMMENDATION C:

Resolution 317 be adopted as amended.

HOD ACTION: Resolution 317 adopted as amended

RESOLVED, That AMA policy H-295.923, “Medical Training and Termination of Pregnancy,” be amended by addition and deletion to read as follows:

Medical Training and Termination of Pregnancy

1. Our AMA supports the education of medical students, residents and young physicians about the need for physicians who provide termination of pregnancy

services, the medical and public health importance of access to safe termination of pregnancy, and the medical, ethical, legal and psychological principles associated with termination of pregnancy.

2. Our AMA ~~supports~~ will advocate for the availability of abortion education and hands-on exposure to medication and procedural abortion ~~procedures for termination of pregnancy, including medication abortions,~~ for medical students and resident/fellow physicians and opposes efforts to interfere with or restrict the availability of this education and training.

3. In the event that medication and procedural abortion are limited or illegal in a home institution, our AMA supports pathways, including cost subsidization, to ensure trainees traveling to another program have hands-on training in medication and procedural abortion, and will advocate for legal protections for both trainees who cross state lines to receive education on reproductive health services, including medication and procedural abortion, as well as the institutions facilitating these opportunities.

~~3~~4. Our AMA encourages the Accreditation Council for Graduate Medical Education to consistently enforce compliance with the standardization of abortion training opportunities as per the requirements set forth by the relevant Residency Review Committees ~~Review Committee for Obstetrics and Gynecology~~ and the American College of Obstetricians and Gynecologists' recommendations.; and be it further

RESOLVED, That our AMA reaffirm policies H-100.948 "Supporting Access to Mifepristone (Mifeprex)" and H-425.969 "Support for Access to Preventive and Reproductive Health Services."

Your Reference Committee heard live testimony on this item that indicated strong support for the intent of this resolution and the need to support such medical training. Testimony noted great concern regarding lack of training in certain states, given new restrictions and the impact on competency, as the implications could go beyond availability of abortion services. Your Reference Committee reviewed the amendments offered and gave careful consideration to terminology. The Council on Medical Education offered amendments to the second clause of AMA policy H-295.923 including removal of "hands-on"; your Reference Committee agreed with the Council's amendments and recommended replacing "hands-on" with "clinical." For the third and fourth clauses, the Council offered amended language; your Reference Committee concurred and further recommended adding "fellows" after "residents" in the latter part of the sentence, changing "support" to "advocate" to strengthen the ask. In addition, the revised resolution calls for funding to support institutions that provide this training and therefore minimize the costs to the resident and sponsoring institution. Further, your Reference Committee recommended that AMA Policy D-5.999, "Preserving Access to Reproductive Health Services," be amended by the addition of a new clause to advocate for legal protections for medical students and physicians who cross state lines to receive education in or provide reproductive health services, including contraception and abortion. Therefore your Reference Committee recommends that Resolution 317 be adopted as amended.

RECOMMENDED FOR REAFFIRMATION IN LIEU OF

(13) RESOLUTION 307 – FAIR COMPENSATION OF RESIDENTS AND FELLOWS

RECOMMENDATION:

Policy H-310.912 and H-305.930 be reaffirmed in lieu of Resolution 307.

HOD ACTION: Policy H-310.912 and H-305.930 reaffirmed in lieu of Resolution 307

RESOLVED, That our American Medical Association advocate for increasing the Resident and Fellow salary substantially (by at least 50% of current levels or better), along with all benefits including retirement benefits with institutional match as available to institutional administration, and peg yearly salary increase thereafter to COLA (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate for enhanced and uniform payment per resident and fellow for all educational and training institutions across the country (Directive to Take Action); and be it further

RESOLVED, That our AMA amend the Residents and Fellows Bill of Rights: H-310.912 (last modified 2022) accordingly. (Modify Current HOD Policy)

Your Reference Committee reviewed live and online testimony regarding this item. The author stated that teaching hospitals receive labor at well below market value. Despite significant sentiment for the spirit of the resolution, testimony reflected numerous concerns with its details. For example, the resolution's proposed increase in salaries of 50 percent could have the adverse consequence of lowering the total number of resident/fellow physician slots, with obvious negative implications for the physician workforce. Programs in smaller community hospitals could experience significant negative repercussions, due to insufficient resources and impact on meeting service needs. Other testimony noted concerns with the phrase "uniform payment" in the second resolve, in that the cost of living varies significantly based on geographic location. In response to concerns, the author proposed an amendment to the item, which, serendipitously, is nearly the same as existing Policy H-305.930. Accordingly, your Reference Committee urges reaffirmation of this policy, as well as H-310.912, in lieu of Resolution 307.

Policy recommended for reaffirmation:

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 will partner with ACGME and other relevant stakeholders to encourage training programs to reduce financial burdens on residents and fellows by providing employee benefits including, but not limited to, on-call meal allowances, transportation support, relocation stipends, and childcare services.

6. Our AMA will work with the Accreditation Council for Graduate Medical Education (ACGME) and other relevant stakeholders to amend the ACGME Common Program Requirements to allow flexibility in the specialty-specific ACGME program requirements enabling specialties to require salary reimbursement or "protected time" for resident and fellow education by "core faculty," program directors, and assistant/associate program directors.

7. Our AMA encourages teaching institutions to offer retirement plan options, retirement plan matching, financial advising and personal finance education.

8. Our AMA adopts the following "Residents and Fellows' Bill of Rights" as applicable to all resident and fellow physicians in ACGME-accredited training programs:

RESIDENT/FELLOW PHYSICIANS' BILL OF RIGHTS

Residents and fellows have a right to:
A. An education that fosters professional development, takes priority over service, and leads to independent practice.
With regard to education, residents and fellows should expect: (1) A graduate medical education experience that facilitates their professional and ethical development, to include regularly scheduled didactics for which they are released from clinical duties. Service obligations should not interfere with educational opportunities and clinical education should be given priority over service obligations; (2) Faculty who devote sufficient time to the educational program to fulfill their teaching and supervisory responsibilities; (3) Adequate clerical and clinical support services that minimize the extraneous, time-consuming work that draws attention from patient care issues and offers no educational value; (4) 24-hour per day access to information resources to educate themselves further about appropriate patient care; and (5) Resources that will allow them to pursue scholarly activities to include financial support and education leave to attend professional meetings.
B. Appropriate supervision by qualified physician faculty with progressive resident responsibility toward independent practice.
With regard to supervision, residents and fellows must be ultimately supervised by physicians who are adequately qualified and allow them to assume progressive responsibility appropriate to their level of education, competence, and experience. In instances where clinical education is provided by non-physicians, there must be an identified physician supervisor providing indirect supervision, along with mechanisms for reporting inappropriate, non-physician supervision to the training program, sponsoring institution or ACGME as appropriate.
C. Regular and timely feedback and evaluation based on valid assessments of resident performance.
With regard to evaluation and assessment processes, residents and fellows should expect: (1) Timely and substantive evaluations during each rotation in which their competence is objectively assessed by faculty who have directly supervised their work; (2) To evaluate the faculty and the program confidentially and in writing at least once annually and expect that the training program will address deficiencies revealed by these evaluations in a timely fashion; (3) Access to their training file and to be made aware of the contents of their file on an annual basis; and (4) Training programs to complete primary verification/credentialing forms and recredentialing forms, apply all required signatures to the forms, and then have the forms permanently secured in their educational files at the completion of training or a period of training and, when requested by any organization involved in credentialing process, ensure the submission of those documents to the requesting organization within thirty days of the request.
D. A safe and supportive workplace with appropriate facilities.
With regard to the workplace, residents and fellows should have access to: (1) A safe workplace that enables them to fulfill their clinical duties and educational obligations; (2) Secure, clean, and comfortable on-call rooms and parking

1 facilities which are secure and well-lit; (3) Opportunities to participate on
2 committees whose actions may affect their education, patient care, workplace,
3 or contract.
4 E. Adequate compensation and benefits that provide for resident well-being and
5 health.
6 (1) With regard to contracts, residents and fellows should receive: a. Information
7 about the interviewing residency or fellowship program including a copy of the
8 currently used contract clearly outlining the conditions for (re)appointment,
9 details of remuneration, specific responsibilities including call obligations, and a
10 detailed protocol for handling any grievance; and b. At least four months advance
11 notice of contract non-renewal and the reason for non-renewal.
12 (2) With regard to compensation, residents and fellows should receive: a.
13 Compensation for time at orientation; and b. Salaries commensurate with their
14 level of training and experience. Compensation should reflect cost of living
15 differences based on local economic factors, such as housing, transportation,
16 and energy costs (which affect the purchasing power of wages), and include
17 appropriate adjustments for changes in the cost of living.
18 (3) With regard to benefits, residents and fellows must be fully informed of and
19 should receive: a. Quality and affordable comprehensive medical, mental health,
20 dental, and vision care for residents and their families, as well as retirement plan
21 options, professional liability insurance and disability insurance to all residents
22 for disabilities resulting from activities that are part of the educational program;
23 b. An institutional written policy on and education in the signs of excessive
24 fatigue, clinical depression, substance abuse and dependence, and other
25 physician impairment issues; c. Confidential access to mental health and
26 substance abuse services; d. A guaranteed, predetermined amount of paid
27 vacation leave, sick leave, family and medical leave and
28 educational/professional leave during each year in their training program, the
29 total amount of which should not be less than six weeks; e. Leave in compliance
30 with the Family and Medical Leave Act; and f. The conditions under which
31 sleeping quarters, meals and laundry or their equivalent are to be provided.
32 F. Clinical and educational work hours that protect patient safety and facilitate
33 resident well-being and education.
34 With regard to clinical and educational work hours, residents and fellows should
35 experience: (1) A reasonable work schedule that is in compliance with clinical
36 and educational work hour requirements set forth by the ACGME; and (2) At-
37 home call that is not so frequent or demanding such that rest periods are
38 significantly diminished or that clinical and educational work hour requirements
39 are effectively circumvented. Refer to AMA Policy H-310.907, “Resident/Fellow
40 Clinical and Educational Work Hours,” for more information.
41 G. Due process in cases of allegations of misconduct or poor performance.
42 With regard to the complaints and appeals process, residents and fellows should
43 have the opportunity to defend themselves against any allegations presented
44 against them by a patient, health professional, or training program in accordance
45 with the due process guidelines established by the AMA.
46 H. Access to and protection by institutional and accreditation authorities when
47 reporting violations.

With regard to reporting violations to the ACGME, residents and fellows should: (1) Be informed by their program at the beginning of their training and again at each semi-annual review of the resources and processes available within the residency program for addressing resident concerns or complaints, including the program director, Residency Training Committee, and the designated institutional official; (2) Be able to file a formal complaint with the ACGME to address program violations of residency training requirements without fear of recrimination and with the guarantee of due process; and (3) Have the opportunity to address their concerns about the training program through confidential channels, including the ACGME concern process and/or the annual ACGME Resident Survey.

9. Our AMA will work with the ACGME and other relevant stakeholders to advocate for ways to defray additional costs related to residency and fellowship training, including essential amenities and/or high cost specialty-specific equipment required to perform clinical duties.

10. Our AMA believes that healthcare trainee salary, benefits, and overall compensation should, at minimum, reflect length of pre-training education, hours worked, and level of independence and complexity of care allowed by an individual's training program (for example when comparing physicians in training and midlevel providers at equal postgraduate training levels).

11.The Residents and Fellows' Bill of Rights will be prominently published online on the AMA website and disseminated to residency and fellowship programs.

12. Our AMA will distribute and promote the Residents and Fellows' Bill of Rights online and individually to residency and fellowship training programs and encourage changes to institutional processes that embody these principles.

H-305.930, "Residents' Salaries"

Our AMA supports appropriate increases in resident salaries.

RECOMMENDED FOR ADOPTION IN LIEU OF

(14) RESOLUTION 311 – SUPPORTING A HYBRID RESIDENCY AND FELLOWSHIP INTERVIEW PROCESS

RECOMMENDATION:

Alternate Resolution 311 be adopted in lieu of Resolution 311, to read as follows:

SUPPORT HYBRID INTERVIEW TECHNIQUES FOR ENTRY TO GRADUATE MEDICAL EDUCATION

RESOLVED, That our AMA work with relevant stakeholders to study the advantages and disadvantages of an online medical school interview option for future medical school applicants, including but not limited to financial implications and potential solutions, long term success, and well-being of students and residents (New HOD Policy); and be it further

RESOLVED, That our AMA encourage appropriate stakeholders, such as the Association of American Medical Colleges, American Association of Colleges of Osteopathic Medicine, Intealth, and Accreditation Council for Graduate Medical Education, to study the feasibility and utility of videoconferencing for graduate medical education (GME) interviews and examine interviewee and program perspectives on incorporating videoconferencing as an adjunct to GME interviews, in order to guide the development of equitable protocols for expansion of hybrid GME interviews (Directive to Take Action).

HOD ACTION: Alternate Resolution 311 adopted in lieu of Resolution 311

RESOLVED, That our American Medical Association support incorporating virtual interviews as a component to the residency and fellowship interview process as a means to increase interviewing efficiency (New HOD Policy); and be it further

RESOLVED, That our AMA work with appropriate stakeholders, such as the Association of American Medical Colleges and the Accreditation Council for Graduate Medical Education, to study interviewee and program perspectives on incorporating videoconferencing as an adjunct to residency and fellowship interviews, in order to guide the development of protocols for expansion of hybrid residency and fellowship interviews. (Directive to Take Action)

1 Your Reference Committee reviewed live and online testimony regarding this item.
2 Testimony was supportive of the second resolve seeking study. Testimony also favored
3 study of the first resolve, noting that data derived from the study of interviewee and
4 program perspectives, per the second resolve, could help to inform how to best address
5 the first resolve. The Council on Medical Education supported study of both resolves
6 and recommended amendments, offering substitute language for the first resolve to
7 study the advantages and disadvantages of an online medical school interview option
8 for future medical school applicants, and amending the second resolve with clarifying
9 language. The author of the resolution supported the Council's recommendations. In the
10 second resolve, testimony recommended adding the American Association of Colleges
11 of Osteopathic Medicine and Intealth (the parent organization of the Educational
12 Commission for Foreign Medical Graduates) to the relevant stakeholders. Your
13 Reference Committee recommended retitling the resolution for clarity, as the current
14 wording could be misconstrued as a joint process for entry to residency and fellowship.
15 Therefore, your Reference Committee recommends that Resolution 311 be adopted as
16 amended.

1 This concludes the report of Reference Committee C. I would like to thank committee
2 members T. Jann Caison-Sorey, Marygrace Elson, Renato Guerrieri, Heidi Hullinger,
3 Pauline Huynh, and Alex Malter; our AMA team Amber Ryan, Tanya Lopez, Fred Lenhoff,
4 Sanjay Desai, and Richard Pan; and all those who testified before the committee.

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