# HOD business items of relevance to medical education and academic physicians

**October 25, 2022**

<table>
<thead>
<tr>
<th>Item</th>
<th>R</th>
<th>C</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Res 005</td>
<td>C</td>
<td>Strengthening Interview Guidelines for American Indian and Alaska Native Medical School, Residency, and Fellowship Applicants</td>
</tr>
<tr>
<td>2.</td>
<td>Res 202</td>
<td>B</td>
<td>Advocating for State GME Funding</td>
</tr>
<tr>
<td>3.</td>
<td>Res 208</td>
<td>B</td>
<td>Comparing Student Debt, Earnings, Work Hours, and Career Satisfaction Metrics in Physicians v. Other Health Professionals</td>
</tr>
<tr>
<td>4.</td>
<td>Res 209</td>
<td>C</td>
<td>Comprehensive Solutions for Medical School Graduates Who Are Unmatched or Did Not Complete Training</td>
</tr>
<tr>
<td>6.</td>
<td>CME 01</td>
<td>C</td>
<td>The Impact of Private Equity on Medical Training</td>
</tr>
<tr>
<td>7.</td>
<td>CME 02</td>
<td>C</td>
<td>Mitigating Demographic and Socioeconomic Inequities in the Residency and Fellowship Selection Process</td>
</tr>
<tr>
<td>8.</td>
<td>Res 301</td>
<td>B</td>
<td>Increasing Musculoskeletal Education in Primary Care Specialties and Medical School Education through Inclusion of Osteopathic Manual Therapy Education NOT FOR CONSIDERATION</td>
</tr>
<tr>
<td>9.</td>
<td>Res 302</td>
<td>C</td>
<td>Expanding Employee Leave to Include Miscarriage and Stillbirth</td>
</tr>
<tr>
<td>10.</td>
<td>Res 303</td>
<td>C</td>
<td>Medical Student Leave Policy</td>
</tr>
<tr>
<td>11.</td>
<td>Res 304</td>
<td>C</td>
<td>Protecting State Medical Licensing Boards from External Political Influence</td>
</tr>
<tr>
<td>12.</td>
<td>Res 305</td>
<td>C</td>
<td>Encouraging Medical Schools to Sponsor Pipeline Programs to Medicine for Underrepresented Groups</td>
</tr>
<tr>
<td>13.</td>
<td>Res 306</td>
<td>C</td>
<td>Increased Credit for Continuing Medical Education Preparation</td>
</tr>
<tr>
<td>15.</td>
<td>Res 308</td>
<td>C</td>
<td>Paid Family/Medical Leave in Medicine</td>
</tr>
<tr>
<td>16.</td>
<td>Res 309</td>
<td>C</td>
<td>Bereavement Leave for Medical Students and Physicians</td>
</tr>
<tr>
<td>17.</td>
<td>Res 310</td>
<td>C</td>
<td>Enforce AMA Principles on Continuing Board Certification</td>
</tr>
<tr>
<td>18.</td>
<td>Res 311</td>
<td>C</td>
<td>Supporting a Hybrid Residency and Fellowship Interview Process</td>
</tr>
<tr>
<td>19.</td>
<td>Res 312</td>
<td>C</td>
<td>Reporting of Residency Demographic Data</td>
</tr>
<tr>
<td>20.</td>
<td>Res 313</td>
<td>C</td>
<td>Request a two-year delay in ACCME Changes to State Medical Society Recognition Program</td>
</tr>
<tr>
<td>21.</td>
<td>Res 314</td>
<td>C</td>
<td>Balancing Supply and Demand for Physicians by 2030</td>
</tr>
<tr>
<td>22.</td>
<td>Res 315</td>
<td>C</td>
<td>Bedside Nursing and Health Care Staff Shortages</td>
</tr>
<tr>
<td>23.</td>
<td>Res 316</td>
<td>C</td>
<td>Recognizing Specialty Certifications for Physicians</td>
</tr>
<tr>
<td>24.</td>
<td>CMS 02</td>
<td>J</td>
<td>Corporate Practice of Medicine (Resolution 721-A-22)</td>
</tr>
</tbody>
</table>
Whereas, The Association of Native American Medical Students has communicated to the AMA-MSS Committee on American Indian Affairs, Association of American Medical Colleges, National Residency Matching Program, and Accreditation Council for Graduate Medical Education that they have received reports of residency interviewers asking American Indian and Alaska Native applicants inappropriate interview questions about blood quantum; and

Whereas, Mathematical blood quantum was implemented by the federal government, requiring the Bureau of Indian Affairs (BIA) to issue a Certificate Degree of Indian Blood (CDIB) that provided evidence of descent from pureblood (full-fraction) Tribal members; and

Whereas, The role of blood quantum in the identity of Indigenous Peoples is a topic of controversy, with foundations in colonization and disenfranchisement; and

Whereas, There is no practical or biological basis for blood quantum and its persistence in these communities is a relic of external governmental influences; and

Whereas, Many Tribes have foregone blood quantum as a determinant in favor of direct lineage, while the Tribes that continue to evaluate lineage by blood quantum have no absolute minimum; and

Whereas, Of the racial groups defined in the United States Census, American Indians and Alaskan Natives are the only group that have identity associated with fractions of blood (blood quantum), which may introduce significant potential for discrimination; and

Whereas, Multiple evidence-based studies detailed the complexities of Indigenous identity formation and the specific barriers that cause exclusion of Indigenous learners that lead to continued underrepresentation of Indigenous students in all stages of medical training; and

Whereas, It is recognized that current admissions and interview practices, whether intentionally or unintentionally, may be racially biased; studies suggest that creating a culturally safe environment in interviews can successfully reduce racial biases; and

Whereas, Compared to other residency interview methods, 64% of unstructured interviews were found to include inappropriate questions about applicant marital status, family planning, ethnicity, and religion, despite the presence of anti-discrimination laws, which greatly increases bias and applicant stereotyping; and
Whereas, The AAMC’s Best Practice Guidelines for Residency Program Interviews encourage the use of standardized interview content, clearly defined criteria, scoring guidelines, and interview training to decrease bias and applicant stereotyping; and

Whereas, Addressing structural, interpersonal, and individual bias in residency selection has been shown to increase the percentage of entering underrepresented minority interns;

Whereas, American Indian and Alaskan Native applicants subjected to questioning about their blood quantum may discourage applicants from advancing their education, further exacerbating the shortage of American Indian medical trainees; and

Whereas, Our AMA supports the inclusion of American Indians in established medical training programs in numbers adequate to meet their needs; and

Whereas, Our AMA opposes questions regarding applicant race during the medical school, residency, and fellowship application process, but questioning based on American Indian and Alaska Native “blood quantum” is not based on race; therefore be it

RESOLVED, That our American Medical Association work with the Accreditation Council for Graduate Medical Education, the National Residency Matching Program, the Association of American Medical Colleges, and other interested parties to eliminate questioning about or discrimination based on American Indian and Alaska Native blood quantum during the medical school, residency, and fellowship application process. (Directive to Take Action)

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

Received: 09/20/22

References:
1. Association of Native American Medical Students. Private email communication to AMA Medical Student Section Committee on American Indian Affairs. November 2021.

RELEVANT AMA POLICY

Residents and Fellows’ Bill of Rights H-310.912
1. Our AMA continues to advocate for improvements in the ACGME Institutional and Common Program Requirements that support AMA policies as follows: a) adequate financial support for and guaranteed leave to attend professional meetings; b) submission of training verification information to requesting agencies within 30 days of the request; c) adequate compensation with consideration to local cost-of-living factors and years of
training, and to include the orientation period; d) health insurance benefits to include dental and vision services; e) paid leave for all purposes (family, educational, vacation, sick) to be no less than six weeks per year; and f) stronger due process guidelines.

2. Our AMA encourages the ACGME to ensure access to educational programs and curricula as necessary to facilitate a deeper understanding by resident physicians of the US health care system and to increase their communication skills.

3. Our AMA regularly communicates to residency and fellowship programs and other GME stakeholders this Resident/Fellows Physicians’ Bill of Rights.

4. Our AMA: a) will promote residency and fellowship training programs to evaluate their own institution’s process for repayment and develop a leaner approach. This includes disbursement of funds by direct deposit as opposed to a paper check and an online system of applying for funds; b) encourages a system of expedited repayment for purchases of $200 or less (or an equivalent institutional threshold), for example through payment directly from their residency and fellowship programs (in contrast to following traditional workflow for reimbursement); and c) encourages training programs to develop a budget and strategy for planned expenses versus unplanned expenses, where planned expenses should be estimated using historical data, and should include trainee reimbursements for items such as educational materials, attendance at conferences, and entertaining applicants. Payment in advance or within one month of document submission is strongly recommended.

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

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

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

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

RESIDENT/FELLOW PHYSICIANS’ BILL OF RIGHTS

Residents and fellows have a right to:

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

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

B. Appropriate supervision by qualified physician faculty with progressive resident responsibility toward independent practice.

With regard to supervision, residents and fellows must be ultimately supervised by physicians who are adequately qualified and allow them to assume progressive responsibility appropriate to their level of education, competence, and experience. In instances where clinical education is provided by non-physicians, there must be an identified physician supervisor providing indirect supervision, along with mechanisms for reporting inappropriate, non-physician supervision to the training program, sponsoring institution or ACGME as appropriate.

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

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

D. A safe and supportive workplace with appropriate facilities.

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

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

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

(2) With regard to compensation, residents and fellows should receive: a. Compensation for time at orientation; and b. Salaries commensurate with their level of training and experience. Compensation should reflect cost of living differences based on local economic factors, such as housing, transportation, and energy costs (which affect the purchasing power of wages), and include appropriate adjustments for changes in the cost of living.

(3) With regard to benefits, residents and fellows must be fully informed of and should receive: a. Quality and affordable comprehensive medical, mental health, dental, and vision care for residents and their families, as well as retirement plan options, professional liability insurance and disability insurance to all residents for disabilities resulting from activities that are part of the educational program; b. An institutional written policy on and education in the signs of excessive fatigue, clinical depression, substance abuse and dependence, and other physician impairment issues; c. Confidential access to mental health and substance abuse services; d. A guaranteed, predetermined amount of paid vacation leave, sick leave, family and medical leave and educational/professional leave during each year in their training program, the total amount of which should not be less than six weeks; e. Leave in compliance with the Family and Medical Leave Act; and f. The conditions under which sleeping quarters, meals and laundry or their equivalent are to be provided.

F. Clinical and educational work hours that protect patient safety and facilitate resident well-being and education.

With regard to clinical and educational work hours, residents and fellows should experience: (1) A reasonable work schedule that is in compliance with clinical and educational work hour requirements set forth by the ACGME; and (2) At-home call that is not so frequent or demanding such that rest periods are significantly diminished or that clinical and educational work hour requirements are effectively circumvented. Refer to AMA Policy H-310.907, “Resident/Fellow Clinical and Educational Work Hours,” for more information.

G. Due process in cases of allegations of misconduct or poor performance.

With regard to the complaints and appeals process, residents and fellows should have the opportunity to defend themselves against any allegations presented against them by a patient, health professional, or training program in accordance with the due process guidelines established by the AMA.

H. Access to and protection by institutional and accreditation authorities when reporting violations.

With regard to reporting violations to the ACGME, residents and fellows should: (1) Be informed by their program at the beginning of their training and again at each semi-annual review of the resources and processes available within the residency program for addressing resident concerns or complaints, including the program director, Residency Training Committee, and the designated institutional official; (2) Be able to file a formal complaint with the ACGME to address program violations of residency training requirements without fear of retribution 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.
Indian Health Service H-350.977
The policy of the AMA is to support efforts in Congress to enable the Indian Health Service to meet its obligation to bring American Indian health up to the general population level. The AMA specifically recommends: (1) Indian Population: (a) In current education programs, and in the expansion of educational activities suggested below, special consideration be given to involving the American Indian and Alaska native population in training for the various health professions, in the expectation that such professionals, if provided with adequate professional resources, facilities, and income, will be more likely to serve the tribal areas permanently; (b) Exploration with American Indian leaders of the possibility of increased numbers of nonfederal American Indian health centers, under tribal sponsorship, to expand the American Indian role in its own health care; (c) Increased involvement of private practitioners and facilities in American Indian care, through such mechanisms as agreements with tribal leaders or Indian Health Service contracts, as well as normal private practice relationships; and (d) Improvement in transportation to make access to existing private care easier for the American Indian population.
(2) Federal Facilities: Based on the distribution of the eligible population, transportation facilities and roads, and the availability of alternative nonfederal resources, the AMA recommends that those Indian Health Service facilities currently necessary for American Indian care be identified and that an immediate construction and modernization program be initiated to bring these facilities up to current standards of practice and accreditation.
(3) Manpower: (a) Compensation for Indian Health Service physicians be increased to a level competitive with other Federal agencies and nongovernmental service; (b) Consideration should be given to increased compensation for service in remote areas; (c) In conjunction with improvement of Service facilities, efforts should be made to establish closer ties with teaching centers, thus increasing both the available manpower and the level of professional expertise available for consultation; (d) Allied health professional staffing of Service facilities should be maintained at a level appropriate to the special needs of the population served; (e) Continuing education opportunities should be provided for those health professionals serving these communities, and especially those in remote areas, and, increased peer contact, both to maintain the quality of care and to avert professional isolation; and (f) Consideration should be given to a federal statement of policy supporting continuation of the Public Health Service to reduce the great uncertainty now felt by many career officers of the corps.
(4) Medical Societies: In those states where Indian Health Service facilities are located, and in counties containing or adjacent to Service facilities, that the appropriate medical societies should explore the possibility of increased formal liaison with local Indian Health Service physicians. Increased support from organized medicine for improvement of health care provided under their direction, including professional consultation and involvement in society activities should be pursued.
(5) Our AMA also support the removal of any requirement for competitive bidding in the Indian Health Service that compromises proper care for the American Indian population.

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

Medical Student Involvement and Validation of the Standardized Video Interview Implementation D-310.949
Our AMA: (1) will work with the Association of American Medical Colleges and its partners to advocate for medical students and residents to be recognized as equal stakeholders in any changes to the residency application process, including any future working groups related to the residency application process; (2) will advocate for delaying expansion of the Standardized Video Interview until data demonstrates the Association of American Medical Colleges’ stated goal of predicting resident performance, and make timely recommendations
regarding the efficacy and implications of the Standardized Video Interview as a mandatory residency application requirement; and (3) will, in collaboration with the Association of American Medical Colleges, study the potential implications and repercussions of expanding the Standardized Video Interview to all residency applicants.

Res. 960, I-17

Educating Competent and Caring Health Professionals H-295.975

(1) Programs of health professions education should foster educational strategies that encourage students to be independent learners and problem-solvers. Faculty of programs of education for the health professions should ensure that the mission statements of the institutions in which they teach include as an objective the education of practitioners who are both competent and compassionate.

(2) Admission to a program of health professions education should be based on more than grade point average and performance on admissions tests. Interviews, applicant essays, and references should continue to be part of the application process in spite of difficulties inherent in evaluating them. Admissions committees should review applicants' extra-curricular activities and employment records for indications of suitability for health professions education. Admissions committees should be carefully prepared for their responsibilities, and efforts should be made to standardize interview procedures and to evaluate the information gathered during interviews. Research should continue to focus on improving admissions procedures. Particular attention should be paid to improving evaluations of subjective personal qualities.

(3) Faculty of programs of education for the health professions must continue to emphasize than they have in the past on educating practitioners who are skilled in communications, interviewing and listening techniques, and who are compassionate and technically competent. Faculty of health professions education should be attentive to the environment in which education is provided; students should learn in a setting where respect and concern are demonstrated. The faculty and administration of programs of health professions education must ensure that students are provided with appropriate role models; whether a faculty member serves as an appropriate role model should be considered when review for promotion or tenure occurs. Efforts should be made by the faculty to evaluate the attitudes of students toward patients. Where these attitudes are found lacking, students should be counseled. Provisions for dismissing students who clearly indicate personality characteristics inappropriate to practice should be enforced.

(4) In spite of the high degree of specialization in health care, faculty of programs of education for the health professions must prepare students to provide integrated patient care; programs of education should promote an interdisciplinary experience for their students.


Residency Interview Schedules H-310.998

1. Our AMA encourages residency and fellowship programs to incorporate in their interview dates increased flexibility, whenever possible, to accommodate applicants' schedules. Our AMA encourages the ACGME and other accrediting bodies to require programs to provide, by electronic or other means, representative contracts to applicants prior to the interview. Our AMA encourages residency and fellowship programs to inform applicants in a timely manner confirming receipt of application and ongoing changes in the status of consideration of the application.

2. Our AMA will: (a) oppose changes to residency and fellowship application requirements unless (i) those changes have been evaluated by working groups which have students and residents as representatives, (ii) there are data which demonstrates that the proposed application components contribute to an accurate representation of the candidate, (iii) there are data available to demonstrate that the new application requirements reduce, or at least do not increase, the impact of bias that affects medical students and residents from underrepresented minority backgrounds, and (iv) the costs to medical students and residents are mitigated; and (b) continue to work with specialty societies, the Association of American Medical Colleges, the National Resident Matching Program and other relevant stakeholders to improve the application process in an effort to accomplish these requirements.


Gender-Based Questioning in Residency Interviews H-310.976

The AMA (1) opposes gender-based questioning during residency interviews in both public and private institutions for the purpose of sexual discrimination; (2) supports inclusion in the AMA Fellowship and Residency Interactive Database Access (FREIDA) system information on residency Family and Medical Leave policies; and (3) supports monitoring the Accreditation Council for Graduate Medical Education as it proposes
changes to the "Common Requirements" and the "Institutional Requirements" of the "Essentials of Accredited Residencies," to ensure that there is no gender-based bias.  

**Housestaff Input During the ACGME Review Process H-310.952**  
The AMA asks its representatives to the Accreditation Council for Graduate Medical Education to support a requirement that site visitors to both residency training programs and institutions conduct interviews with residents, including peer-selected residents, as well as with administrators and faculty.  

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

**Continued Support for Diversity in Medical Education D-295.963**  
Our AMA will:  
1. publicly state and reaffirm its stance on diversity in medical education;  
2. request that the Liaison Committee on Medical Education regularly share statistics related to compliance with accreditation standards IS-16 and MS-8 with medical schools and with other stakeholder groups;  
3. work with appropriate stakeholders to commission and enact the recommendations of a forward-looking, cross-continuum, external study of 21st century medical education focused on reimagining the future of health equity and racial justice in medical education, improving the diversity of the health workforce, and ameliorating inequitable outcomes among minoritized and marginalized patient populations;  
4. advocate for funding to support the creation and sustainability of Historically Black College and University (HBCU), Hispanic-Serving Institution (HSI), and Tribal College and University (TCU) affiliated medical schools and residency programs, with the goal of achieving a physician workforce that is proportional to the racial, ethnic, and gender composition of the United States population;  
5. 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.  

**AMA Support of American Indian Health Career Opportunities H-350.981**  
AMA policy on American Indian health career opportunities is as follows:  
1. Our AMA, and other national, state, specialty, and county medical societies recommend special programs for the recruitment and training of American Indians in health careers at all levels and urge that these be expanded.
(2) Our AMA support the inclusion of American Indians in established medical training programs in numbers adequate to meet their needs. Such training programs for American Indians should be operated for a sufficient period of time to ensure a continuous supply of physicians and other health professionals.

(3) Our AMA utilize its resources to create a better awareness among physicians and other health providers of the special problems and needs of American Indians and that particular emphasis be placed on the need for additional health professionals to work among the American Indian population.

(4) Our AMA continue to support the concept of American Indian self-determination as imperative to the success of American Indian programs, and recognize that enduring acceptable solutions to American Indian health problems can only result from program and project beneficiaries having initial and continued contributions in planning and program operations.


**Competency-Based Portfolio Assessment of Medical Students D-295.318**

1. Our AMA will work with the Association of American Medical Colleges, the American Osteopathic Association and the Accreditation Council for Graduate Medical Education, and other organizations to examine new and emerging approaches to medical student evaluation, including competency-based portfolio assessment.

2. Our AMA will work with the NRMP, ACGME and the 11 schools in the AMA's Accelerating Change in Medical Education consortium to develop pilot projects to study the impact of competency-based frameworks on student graduation, the residency match process and off-cycle entry into residency programs.

Res. 314, A-10, Appended: Res. 311, A-14

**Eliminating Questions Regarding Marital Status, Dependents, Plans for Marriage or Children, Sexual Orientation, Gender Identity, Age, Race, National Origin and Religion During the Residency and Fellowship Application Process H-310.919**

Our AMA: 1. opposes questioning residency or fellowship applicants regarding marital status, dependents, plans for marriage or children, sexual orientation, gender identity, age, race, national origin, and religion; 2. will work with the Accreditation Council for Graduate Medical Education, the National Residency Matching Program, and other interested parties to eliminate questioning about or discrimination based on marital and dependent status, future plans for marriage or children, sexual orientation, age, race, national origin, and religion during the residency and fellowship application process; 3. will continue to support efforts to enhance racial and ethnic diversity in medicine. Information regarding race and ethnicity may be voluntarily provided by residency and fellowship applicants; 4. encourages the Association of American Medical Colleges (AAMC) and its Electronic Residency Application Service (ERAS) Advisory Committee to develop steps to minimize bias in the ERAS and the residency training selection process; and 5. will advocate that modifications in the ERAS Residency Application to minimize bias consider the effects these changes may have on efforts to increase diversity in residency programs.

Res. 307, A-09 Appended: Res. 955, I-17
AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 202
(I-22)

Introduced by: Young Physicians Section

Subject: Advocating for State GME Funding

Referred to: Reference Committee B

Whereas, “The number of Medicare-funded graduate medical education (GME) positions has been capped at 1996 levels, and there is little political will for increasing Medicare’s contribution to GME”;¹ and

Whereas, Our “AMA has long been an advocate for preservation and expansion of GME funding to mitigate projected physician shortages and ensure that positions are available for medical school graduates applying to residency programs;”²,³ and

Whereas, In some states, state legislatures have funded several graduate medical education positions; and

Whereas, For example, the Commonwealth of Virginia has been funding 25 new residency slots (the “majority of which must be in primary care,” and “encouraging applications from programs that offer the opportunity to train in underserved areas”) since 2018;⁴,⁵ and

Whereas, Information about these state-funded GME positions⁶-⁹ is not easy to find online; and

Whereas, There have been some news reports about how some state budgets are flush with cash these days;¹⁰ therefore be it

RESOLVED, That our American Medical Association publicize best practice examples of state-funded Graduate Medical Education positions and develop model state legislation where appropriate. (Directive to Take Action)

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

Received: 08/19/22

References:
5. “Graduate Medical Education” at the Virginia Medicaid Dept of Medical Assistance Services (DMAS), at <https://www.dmas.virginia.gov/for-providers/rates-and-rate-setting/graduate-medical-education/>
6. 303#31s (DMAS) Graduate Medical Education Residency Slots. SB30 - Member Request (virginia.gov), at <https://budget.lis.virginia.gov/amendment/2018/1/SB30/Introduced/MR/303/31s/>
7. 303#14h (DMAS) Allow Supplemental Funding for UVA Medical Center and VCU Health System. HB30 - Committee Approved (virginia.gov), at <https://budget.lis.virginia.gov/amendment/2018/1/HB30/Introduced/CA/303/14h/>
8. 303#14s (DMAS) Graduate Medical Education Residency Slots. SB30 - Committee Approved (virginia.gov), at <https://budget.lis.virginia.gov/amendment/2018/1/SB30/Introduced/CA/303/14s/>
RELEVANT AMA POLICY

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

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

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

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

4. Our AMA will strenuously advocate for increasing the number of GME positions to address the future physician workforce needs of the nation.

5. Our AMA will oppose efforts to move federal funding of GME positions to the annual appropriations process that is subject to instability and uncertainty.

6. Our AMA will oppose regulatory and legislative efforts that reduce funding for GME from the full scope of resident educational activities that are designated by residency programs for accreditation and the board certification of their graduates (e.g. didactic teaching, community service, off-site ambulatory rotations, etc.).

7. Our AMA will actively explore additional sources of GME funding and their potential impact on the quality of residency training and on patient care.

8. Our AMA will vigorously advocate for the continued and expanded contribution by all payers for health care (including the federal government, the states, and local and private sources) to fund both the direct and indirect costs of GME.

9. Our AMA will work, in collaboration with other stakeholders, to improve the awareness of the general public that GME is a public good that provides essential services as part of the training process and serves as a necessary component of physician preparation to provide patient care that is safe, effective and of high quality.

10. Our AMA staff and governance will continuously monitor federal, state and private proposals for health care reform for their potential impact on the preservation, stability and expansion of full funding for the direct and indirect costs of GME.

11. Our AMA: (a) recognizes that funding for and distribution of positions for GME are in crisis in the United States and that meaningful and comprehensive reform is urgently needed; (b) will immediately work with Congress to expand medical residencies in a balanced fashion based on expected specialty needs throughout our nation to produce a geographically distributed and appropriately sized physician workforce; and to make increasing support and funding for GME programs and residencies a top priority of the AMA in its national political agenda; and (c) will continue to work closely with the Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, American Osteopathic Association, and other key stakeholders to raise awareness among policymakers and the public about the importance of expanded GME funding to meet the nation's current and anticipated medical workforce needs.

12. Our AMA will collaborate with other organizations to explore evidence-based approaches to quality and accountability in residency education to support enhanced funding of GME.

13. Our AMA will continue to strongly advocate that Congress fund additional graduate medical education (GME) positions for the most critical workforce needs, especially considering the current and worsening maldistribution of physicians.

14. Our AMA will advocate that the Centers for Medicare and Medicaid Services allow for rural and other underserved rotations in Accreditation Council for Graduate Medical Education (ACGME)-accredited residency programs, in disciplines of particular local/regional need, to occur in the offices of physicians who meet the qualifications for adjunct faculty of the residency program's sponsoring institution.
15. Our AMA encourages the ACGME to reduce barriers to rural and other underserved community experiences for graduate medical education programs that choose to provide such training, by adjusting as needed its program requirements, such as continuity requirements or limitations on time spent away from the primary residency site.

16. Our AMA encourages the ACGME and the American Osteopathic Association (AOA) to continue to develop and disseminate innovative methods of training physicians efficiently that foster the skills and inclinations to practice in a health care system that rewards team-based care and social accountability.

17. Our AMA will work with interested state and national medical specialty societies and other appropriate stakeholders to share and support legislation to increase GME funding, enabling a state to accomplish one or more of the following: (a) train more physicians to meet state and regional workforce needs; (b) train physicians who will practice in physician shortage/underserved areas; or (c) train physicians in undersupplied specialties and subspecialties in the state/region.

18. Our AMA supports the ongoing efforts by states to identify and address changing physician workforce needs within the GME landscape and continue to broadly advocate for innovative pilot programs that will increase the number of positions and create enhanced accountability of GME programs for quality outcomes.

19. Our AMA will continue to work with stakeholders such as Association of American Medical Colleges (AAMC), ACGME, AOA, American Academy of Family Physicians, American College of Physicians, and other specialty organizations to analyze the changing landscape of future physician workforce needs as well as the number and variety of GME positions necessary to provide that workforce.

20. Our AMA will explore innovative funding models for incremental increases in funded residency positions related to quality of resident education and provision of patient care as evaluated by appropriate medical education organizations such as the Accreditation Council for Graduate Medical Education.

21. Our AMA will utilize its resources to share its content expertise with policymakers and the public to ensure greater awareness of the significant societal value of graduate medical education (GME) in terms of patient care, particularly for underserved and at-risk populations, as well as global health, research and education.

22. Our AMA will advocate for the appropriation of Congressional funding in support of the National Healthcare Workforce Commission, established under section 5101 of the Affordable Care Act, to provide data and healthcare workforce policy and advice to the nation and provide data that support the value of GME to the nation.

23. Our AMA supports recommendations to increase the accountability for and transparency of GME funding and continue to monitor data and peer-reviewed studies that contribute to further assess the value of GME.

24. Our AMA will explore various models of all-payer funding for GME, especially as the Institute of Medicine (now a program unit of the National Academy of Medicine) did not examine those options in its 2014 report on GME governance and financing.

25. Our AMA encourages organizations with successful existing models to publicize and share strategies, outcomes and costs.

26. Our AMA encourages insurance payers and foundations to enter into partnerships with state and local agencies as well as academic medical centers and community hospitals seeking to expand GME.

27. Our AMA will develop, along with other interested stakeholders, a national campaign to educate the public on the definition and importance of graduate medical education, student debt and the state of the medical profession today and in the future.

28. Our AMA will collaborate with other stakeholder organizations to evaluate and work to establish consensus regarding the appropriate economic value of resident and fellow services.

29. Our AMA will monitor ongoing pilots and demonstration projects, and explore the feasibility of broader implementation of proposals that show promise as alternative means for funding physician education and training while providing appropriate compensation for residents and fellows.

30. Our AMA will monitor the status of the House Energy and Commerce Committee's response to public comments solicited regarding the 2014 IOM report, Graduate Medical Education That Meets the Nation's Health Needs, as well as results of ongoing studies, including that requested of the GAO, in order to formulate new advocacy strategy for GME funding, and will report back to the House of Delegates regularly on important changes in the landscape of GME funding.

31. Our AMA will advocate to the Centers for Medicare & Medicaid Services to adopt the concept of “Cap-Flexibility” and allow new and current Graduate Medical Education teaching institutions to extend their cap-building window for up to an additional five years beyond the current window (for a total of up to ten
years), giving priority to new residency programs in underserved areas and/or economically depressed areas.

32. Our AMA will: (a) encourage all existing and planned allopathic and osteopathic medical schools to thoroughly research match statistics and other career placement metrics when developing career guidance plans; (b) strongly advocate for and work with legislators, private sector partnerships, and existing and planned osteopathic and allopathic medical schools to create and fund graduate medical education (GME) programs that can accommodate the equivalent number of additional medical school graduates consistent with the workforce needs of our nation; and (c) encourage the Liaison Committee on Medical Education (LCME), the Commission on Osteopathic College Accreditation (COCA), and other accrediting bodies, as part of accreditation of allopathic and osteopathic medical schools, to prospectively and retrospectively monitor medical school graduates' rates of placement into GME as well as GME completion.

33. Our AMA encourages the Secretary of the U.S. Department of Health and Human Services to coordinate with federal agencies that fund GME training to identify and collect information needed to effectively evaluate how hospitals, health systems, and health centers with residency programs are utilizing these financial resources to meet the nation's health care workforce needs. This includes information on payment amounts by the type of training programs supported, resident training costs and revenue generation, output or outcomes related to health workforce planning (i.e., percentage of primary care residents that went on to practice in rural or medically underserved areas), and measures related to resident competency and educational quality offered by GME training programs.


Proposed Revisions to AMA Policy on the Financing of Medical Education Programs H-305.929

1. It is AMA policy that:
A. Since quality medical education directly benefits the American people, there should be public support for medical schools and graduate medical education programs and for the teaching institutions in which medical education occurs. Such support is required to ensure that there is a continuing supply of well-educated, competent physicians to care for the American public.
B. Planning to modify health system organization or financing should include consideration of the effects on medical education, with the goal of preserving and enhancing the quality of medical education and the quality of and access to care in teaching institutions are preserved.
C. Adequate and stable funding should be available to support quality undergraduate and graduate medical education programs. Our AMA and the federation should advocate for medical education funding.
D. Diversified sources of funding should be available to support medical schools' multiple missions, including education, research, and clinical service. Reliance on any particular revenue source should not jeopardize the balance among a medical school's missions.
E. All payers for health care, including the federal government, the states, and private payers, benefit from graduate medical education and should directly contribute to its funding.
F. Full Medicare direct medical education funding should be available for the number of years required for initial board certification. For combined residency programs, funding should be available for the longest of the individual programs plus one additional year. There should be opportunities to extend the period of full funding for specialties or subspecialties where there is a documented need, including a physician shortage.
G. Medical schools should develop systems to explicitly document and reimburse faculty teaching activity, so as to facilitate faculty participation in medical student and resident physician education and training.
H. Funding for graduate medical education should support the training of resident physicians in both hospital and non-hospital (ambulatory) settings. Federal and state funding formulas must take into account the resources, including volunteer faculty time and practice expenses, needed for training residents in all specialties in non-hospital, ambulatory settings. Funding for GME should be allocated to the sites where teaching occurs.
I. New funding should be available to support increases in the number of medical school and residency training positions, preferably in or adjacent to physician shortage/underserved areas and in undersupplied specialties.

2. Our AMA endorses the following principles of social accountability and promotes their application to GME funding: (a) Adequate and diverse workforce development; (b) Primary care and specialty practice workforce distribution; (c) Geographic workforce distribution; and (d) Service to the local community and the public at large.

3. Our AMA encourages transparency of GME funding through models that are both feasible and fair for training sites, affiliated medical schools and trainees.

4. Our AMA believes that financial transparency is essential to the sustainable future of GME funding and therefore, regardless of the method or source of payment for GME or the number of funding streams, institutions should publically report the aggregate value of GME payments received as well as what these payments are used for, including: (a) Resident salary and benefits; (b) Administrative support for graduate medical education; (c) Salary reimbursement for teaching staff; (d) Direct educational costs for residents and fellows; and (e) Institutional overhead.

5. Our AMA supports specialty-specific enhancements to GME funding that neither directly nor indirectly reduce funding levels for any other specialty.

US Physician Shortage H-200.954

Our AMA:
(1) explicitly recognizes the existing shortage of physicians in many specialties and areas of the US;
(2) supports efforts to quantify the geographic maldistribution and physician shortage in many specialties;
(3) supports current programs to alleviate the shortages in many specialties and the maldistribution of physicians in the US;
(4) encourages medical schools and residency programs to consider developing admissions policies and practices and targeted educational efforts aimed at attracting physicians to practice in underserved areas and to provide care to underserved populations;
(5) encourages medical schools and residency programs to continue to provide courses, clerkships, and longitudinal experiences in rural and other underserved areas as a means to support educational program objectives and to influence choice of graduates' practice locations;
(6) encourages medical schools to include criteria and processes in admission of medical students that are predictive of graduates' eventual practice in underserved areas and with underserved populations;
(7) will continue to advocate for funding from public and private payers for educational programs that provide experiences for medical students in rural and other underserved areas;
(8) will continue to advocate for funding from all payers (public and private sector) to increase the number of graduate medical education positions in specialties leading to first certification;
(9) will work with other groups to explore additional innovative strategies for funding graduate medical education positions, including positions tied to geographic or specialty need;
(10) continues to work with the Association of American Medical Colleges (AAMC) and other relevant groups to monitor the outcomes of the National Resident Matching Program; and
(11) continues to work with the AAMC and other relevant groups to develop strategies to address the current and potential shortages in clinical training sites for medical students.

12 will: (a) promote greater awareness and implementation of the Project ECHO (Extension for Community Healthcare Outcomes) and Child Psychiatry Access Project models among academic health centers and community-based primary care physicians; (b) work with stakeholders to identify and mitigate barriers to broader implementation of these models in the United States; and (c) monitor whether health care payers offer additional payment or incentive payments for physicians who engage in clinical practice improvement activities as a result of their participation in programs such as Project ECHO and the Child Psychiatry Access Project; and if confirmed, promote awareness of these benefits among physicians.

13 will work to augment the impact of initiatives to address rural physician workforce shortages.

Whereas, Our healthcare system has had a steady increase in the amount of physician assistants (PAs) and nurse practitioners (NPs) assuming physician duties and responsibilities; and

Whereas, PAs and NPs have also advocated successfully for increased pay as evidenced in multiple state legislatures and even federal legislation; and

Whereas, Student debt of physicians is notoriously some of the highest in American education; and

Whereas, PAs and NPs have access to the same programs as physicians which include public service loan forgiveness, national health service corps, Indian health services loan repayment program, armed forces, income-driven repayment, etc.¹,²; and

Whereas, A recent report on resident salary and debt found that 57% of resident physicians were dissatisfied with their compensation, 81% felt that their compensation did not adequately reflect the number of hours they worked, and 77% felt that their compensation was not comparable to what physician’s assistants, nurses, and other medical staff were paid⁵; and

Whereas, Today, burnout among physicians in training such as medical students and trainees ranges from 50-70%; and

Whereas, Within nursing, burnout is discussed in terms of turnover rate at hospitals, as registered nurses (RN) turnover rate ranges between 20-30%⁴; and

Whereas, Among nurse practitioners, 25% of those in primary care environments have experienced burnout⁵; and

Whereas, Current research on burnout indirectly being used to measure work-life balance does not account for differences among individuals, especially those with varying socioeconomic, racial and/or sexual minoritized backgrounds; therefore be it

RESOLVED, That our American Medical Association’s advocacy efforts be informed by the fact that student debt burden is higher for physicians when compared to physician assistants and nurse practitioners (Directive to Take Action); and be it further
RESOLVED, That our AMA work with relevant stakeholders to study: (a) how total career earnings of physicians compare to those physician assistants and nurse practitioners in order to specifically discern if there is a financial disincentive to becoming a physician, considering the relatively high student debt burden and work hours of physicians; (b) if resident physicians provide a net financial benefit for hospitals and healthcare institutions; (c) best practices for increasing resident physician compensation so that their services may be more equitably reflected in their earnings; and (d) burnout metrics using a standardized system to compare differences among physicians, physician assistants and nurse practitioners (Directive to Take Action); and be it further

RESOLVED, That our AMA recognize that burnout-centered metrics do not fully characterize work-life balance, particularly for individuals with varying socioeconomic, racial and/or sexual minoritized backgrounds (New HOD Policy); and be it further

RESOLVED, That our AMA seek to publish its findings in a peer-reviewed medical journal. (Directive to Take Action)

Fiscal Note: Estimated cost of $306K to implement this resolution.

Received: 09/14/22

REFERENCES
1. https://students-residents.aamc.org/financial-aid-resources/postponing-loan-repayment-during-residency
2. https://www.aamc.org/news-insights/7-ways-reduce-medical-school-debt#:~:text=According%20to%20a%20recent%20AAMC%20report%2C%20the%20average%20medical%20school%20debt%20was%20%2420200%20in%202019
RELEVANT AMA POLICY

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

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

1. Collaborate with members of the Federation and the medical education community, and with other interested organizations, to address the cost of medical education and medical student debt through public- and private-sector advocacy.
2. Vigorously advocate for and support expansion of and adequate funding for federal scholarship and loan repayment programs—such as those from the National Health Service Corps, Indian Health Service, Armed Forces, and Department of Veterans Affairs, and for comparable programs from states and the private sector—to promote practice in underserved areas, the military, and academic medicine or clinical research.
3. Encourage the expansion of National Institutes of Health programs that provide loan repayment in exchange for a commitment to conduct targeted research.
4. Advocate for increased funding for the National Health Service Corps Loan Repayment Program to assure adequate funding of primary care within the National Health Service Corps, as well as to permit: (a) inclusion of all medical specialties in need, and (b) service in clinical settings that care for the underserved but are not necessarily located in health professions shortage areas.
5. Encourage the National Health Service Corps to have repayment policies that are consistent with other federal loan forgiveness programs, thereby decreasing the amount of loans in default and increasing the number of physicians practicing in underserved areas.
6. Work to reinstate the economic hardship deferment qualification criterion known as the “20/220 pathway,” and support alternate mechanisms that better address the financial needs of trainees with educational debt.
7. Advocate for federal legislation to support the creation of student loan savings accounts that allow for pre-tax dollars to be used to pay for student loans.
8. Work with other concerned organizations to advocate for legislation and regulation that would result in favorable terms and conditions for borrowing and for loan repayment, and would permit 100% tax deductibility of interest on student loans and elimination of taxes on aid from service-based programs.
9. Encourage the creation of private-sector financial aid programs with favorable interest rates or service obligations (such as community- or institution-based loan repayment programs or state medical society loan programs).
10. Support stable funding for medical education programs to limit excessive tuition increases, and collect and disseminate information on medical school programs that cap medical education debt, including the types of debt management education that are provided.
11. Work with state medical societies to advocate for the creation of either tuition caps or, if caps are not feasible, pre-defined tuition increases, so that medical students will be aware of their tuition and fee costs for the total period of their enrollment.
12. Encourage medical schools to (a) Study the costs and benefits associated with non-traditional instructional formats (such as online and distance learning, and combined baccalaureate/MD or DO programs) to determine if cost savings to medical schools and to medical students could be realized without jeopardizing the quality of medical education; (b) Engage in fundraising activities to increase the availability of scholarship support, with the support of the Federation, medical schools, and state and specialty medical societies, and develop or enhance financial aid opportunities for medical students, such as self-managed, low-interest loan programs; (c) Cooperate with postsecondary institutions to establish collaborative debt counseling for entering first-year medical students; (d) Allow for flexible scheduling for medical students who encounter financial difficulties that can be remedied only by employment, and consider creating opportunities for paid employment for medical students; (e) Counsel individual medical student borrowers on the status of their indebtedness and payment schedules prior to their graduation; (f) Inform students of all government loan opportunities and disclose the reasons that preferred lenders were chosen; (g) Ensure that all medical student fees are earmarked for specific and well-defined purposes, and avoid charging any overly broad and ill-defined fees, such as but not limited to professional fees; (h) Use their collective purchasing power to obtain discounts for their students on necessary medical equipment, textbooks, and other educational supplies; (i) Work to ensure stable funding, to eliminate the need for increases in tuition and fees to compensate for unanticipated decreases in other sources of revenue; mid-year and retroactive tuition increases should be opposed.
13. Support and encourage state medical societies to support further expansion of state loan repayment programs, particularly those that encompass physicians in non-primary care specialties.

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

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

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

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

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

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

20. Related to the Public Service Loan Forgiveness (PSLF) Program, our AMA supports increased medical student and physician benefits the program, and will: (a) Advocate that all resident/fellow physicians have access to PSLF during their training years; (b) Advocate against a monetary cap on PSLF and other federal loan forgiveness programs; (c) Work with the United States Department of Education to ensure that any cap on loan forgiveness under PSLF be at least equal to the principal amount borrowed; (d) Ask the United States Department of Education to include all terms of PSLF in the contractual obligations of the Master Promissory Note; (e) Encourage the Accreditation Council for Graduate Medical Education (ACGME) to require residency/fellowship programs to include within the terms, conditions, and benefits of program appointment information on the PSLF program qualifying status of the employer; (f) Advocate that the profit status of a physicians training institution not be a factor for PSLF eligibility; (g) Encourage medical school financial advisors to counsel wise borrowing by medical students, in the event that the PSLF program is eliminated or severely curtailed; (h) Encourage medical school financial advisors to increase medical student engagement in service-based loan repayment options, and other federal and military programs, as an attractive alternative to the PSLF in terms of financial prospects as well as providing the opportunity to provide care in medically underserved areas; (i) Strongly advocate that the terms of the PSLF that existed at the time of the agreement remain unchanged for any program participant in the event of any future restrictive changes.

21. Advocate for continued funding of programs including Income-Driven Repayment plans for the benefit of reducing medical student load burden.
22. Formulate a task force to look at undergraduate medical education training as it relates to career choice, and develop new polices and novel approaches to prevent debt from influencing specialty and subspecialty choice.

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


Competency Based Medical Education Across the Continuum of Education and Practice D-295.317

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

Citation: CME Rep. 3, A-14; Appended: CME Rep. 04, A-16

Resident/Fellow Clinical and Educational Work Hours H-310.907

Our AMA adopts the following Principles of Resident/Fellow Clinical and Educational Work Hours, Patient Safety, and Quality of Physician Training: 1. Our AMA supports the 2017 Accreditation Council for Graduate Medical Education (ACGME) standards for clinical and educational work hours (previously referred to as “duty hours”). 2. Our AMA will continue to monitor the enforcement and impact of clinical and educational work hour standards, in the context of the larger issues of patient safety and the optimal learning environment for residents. 3. Our AMA encourages publication and supports dissemination of studies in peer-reviewed publications and educational sessions about all aspects of clinical and educational work hours, to include such topics as extended work shifts, handoffs, in-house call and at-home call, level of supervision by attending physicians, workload and growing service demands, moonlighting, protected sleep periods, sleep deprivation and fatigue, patient safety, medical error, continuity of care, resident well-being and burnout, development of professionalism, resident learning outcomes, and preparation for independent practice. 4. Our AMA endorses the study of innovative models of clinical and educational work hour requirements and, pending the outcomes of ongoing and future research, should consider the evolution of specialty- and rotation-specific requirements that are evidence-based and will optimize patient safety and competency-based learning opportunities. 5. Our AMA encourages the ACGME to: a) Decrease the barriers to reporting of both clinical and educational work hour violations and resident intimidation. b) Ensure that readily accessible, timely and accurate information about clinical and educational work hours is not constrained by the cycle of ACGME survey visits. c) Use, where possible, recommendations from respective specialty societies and evidence-based approaches to any future revision or introduction of clinical and educational work hour rules. d) Broadly disseminate aggregate data from the annual ACGME survey on the educational environment of resident physicians, encompassing all aspects of clinical and educational work hours. 6. Our AMA recognizes the ACGME for its work in ensuring an appropriate balance between resident education and patient safety, and encourages the ACGME to continue to: a) Offer incentives to programs/institutions to ensure compliance with clinical and educational work hour standards. b) Ensure that site visits include meetings with peer-selected or randomly selected residents and that residents who are not interviewed during site visits have the opportunity to provide information directly to the site visitor. c) Collect data on at-home call from both program directors and resident/fellow physicians; release these aggregate data annually; and develop standards to ensure that appropriate education and supervision are maintained, whether the setting is in-house or at-home. d) Ensure that resident/fellow physicians receive education on sleep deprivation and fatigue. 7. Our AMA supports the following statements related to clinical and educational work hours: a) Total clinical and educational work hours must not exceed 80 hours per week, averaged
over a four-week period (Note: “Total clinical and educational work hours” includes providing direct patient care or supervised patient care that contributes to meeting educational goals; participating in formal educational activities; providing administrative and patient care services of limited or no educational value; and time needed to transfer the care of patients). b) Scheduled on-call assignments should not exceed 24 hours. Residents may remain on-duty for an additional 4 hours to complete the transfer of care, patient follow-up, and education; however, residents may not be assigned new patients, cross-coverage of other providers' patients, or continuity clinic during that time. c) Time spent in the hospital by residents on at-home call must count towards the 80-hour maximum weekly hour limit, and on-call frequency must not exceed every third night averaged over four weeks. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one-day-in-seven free of duty, when averaged over four weeks. d) At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident. e) Residents are permitted to return to the hospital while on at-home call to care for new or established patients. Each episode of this type of care, while it must be included in the 80-hour weekly maximum, will not initiate a new “off-duty period.” f) Given the different education and patient care needs of the various specialties and changes in resident responsibility as training progresses, clinical and educational work hour requirements should allow for flexibility for different disciplines and different training levels to ensure appropriate resident education and patient safety; for example, allowing exceptions for certain disciplines, as appropriate, or allowing a limited increase to the total number of clinical and educational work hours when need is demonstrated. g) Resident physicians should be ensured a sufficient duty-free interval prior to returning to duty. h) Clinical and educational work hour limits must not adversely impact resident physician participation in organized educational activities. Formal educational activities must be scheduled and available within total clinical and educational work hour limits for all resident physicians. i) Scheduled time providing patient care services of limited or no educational value should be minimized. j) Accurate, honest, and complete reporting of clinical and educational work hours is an essential element of medical professionalism and ethics. k) The medical profession maintains the right and responsibility for self-regulation (one of the key tenets of professionalism) through the ACGME and its purview over graduate medical education, and categorically rejects involvement by the Centers for Medicare & Medicaid Services, The Joint Commission, Occupational Safety and Health Administration, and any other federal or state government bodies in the monitoring and enforcement of clinical and educational work hour limits. l) Increased financial assistance for residents/fellows, such as subsidized child care, loan deferment, debt forgiveness, and tax credits, may help mitigate the need for moonlighting. At the same time, resident/fellow physicians in good standing with their programs should be afforded the opportunity for internal and external moonlighting that complies with ACGME policy. m) Program directors should establish guidelines for scheduled work outside of the residency program, such as moonlighting, and must approve and monitor that work such that it does not interfere with the ability of the resident to achieve the goals and objectives of the educational program. n) The costs of clinical and educational work hour limits should be borne by all health care payers. Individual resident compensation and benefits must not be compromised or decreased as a result of changes in the graduate medical education system. o) The general public should be made aware of the many contributions of resident/fellow physicians to high-quality patient care and the importance of trainees’ realizing their limits (under proper supervision) so that they will be able to competently and independently practice under real-world medical situations. 8. Our AMA is in full support of the collaborative partnership between allopathic and osteopathic professional and accrediting bodies in developing a unified system of residency/fellowship accreditation for all residents and fellows, with the overall goal of ensuring patient safety. 9. Our AMA will actively participate in ongoing efforts to monitor the impact of clinical and educational work hour limitations to ensure that patient safety and physician well-being are not jeopardized by excessive demands on post-residency physicians, including program directors and attending physicians.

Citation: CME Rep. 5, A-14; Modified: CME Rep. 06, I-18; Reaffirmation: A-22
Whereas, Fully trained physicians are in shortage now and forecasted to be in shortage in the
future; and

Whereas, This shortage does not extend to all specialties and several specialties such as
Emergency Medicine and Radiation Oncology are projected to be in oversupply; and

Whereas, No current body with direct regulatory oversight over residencies can act to allocate
and re-allocate funding and positions from fields projected to be in oversupply to fields in greater
shortage due to antitrust restrictions; and

Whereas, Almost all other countries allocate residency positions based to some extent on the
future workforce needs of the nation, instead of local factors; and

Whereas, The United States population could benefit greatly from available governmental
funding for first year categorical positions being allocated in ratio to the projected physician
workforce needs of the nation; and

Whereas, Many US allopathic and osteopathic medical school graduates cannot make the time
or location commitment to a residency program due to personal, financial, or other
commitments; therefore be it

RESOLVED, That our American Medical Association work with US Centers for Medicare and
Medicaid Services and other relevant stakeholders to create a commission to estimate future
physician workforce needs and suggest re-allocation of available residency funding and
available first-year positions accordingly (Directive to Take Action); and be it further

RESOLVED, That our AMA work with relevant stakeholders to study the possibility of alternative
pathways to ACGME certification of training, ABMS board certification, and medical practice for
unmatched medical school graduates. (Directive to Take Action)

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

Received: 09/14/22
REFERENCES:

RELEVANT AMA POLICY

Securing Funding for Graduate Medical Education H-310.917
Our American Medical Association: (1) continues to be vigilant while monitoring pending legislation that may change the financing of medical services (health system reform) and advocate for expanded and broad-based funding for graduate medical education (from federal, state, and commercial entities); (2) continues to advocate for graduate medical education funding that reflects the physician workforce needs of the nation; (3) encourages all funders of GME to adhere to the Accreditation Council for Graduate Medical Education's requirements on restrictive covenants and its principles guiding the relationship between GME, industry and other funding sources, as well as the AMA's Opinion 8.061, and other AMA policy that protects residents and fellows from exploitation, including physicians training in non-ACGME-accredited programs; and (4) encourages entities planning to expand or start GME programs to develop a clear statement of the benefits of their GME activities to facilitate potential funding from appropriate sources given the goals of their programs.


Proposed Revisions to AMA Policy on the Financing of Medical Education Programs D-305.973
Our AMA will work with:
(1) the federal government, including the Centers for Medicare and Medicaid Services, and the states, along with other interested parties, to bring about the following outcomes:
(a) ensure adequate Medicaid and Medicare funding for graduate medical education;
(b) ensure adequate Disproportionate Share Hospital funding;
(c) make the Medicare direct medical education per-resident cost figure more equitable across teaching hospitals while assuring adequate funding of all residency positions;
(d) revise the Medicare and Medicaid funding formulas for graduate medical education to recognize the resources utilized for training in non-hospital settings;
(e) stabilize funding for pediatric residency training in children's hospitals;
(f) explore the possibility of extending full direct medical education per-resident payment beyond the time of first board eligibility for specialties/subspecialties in shortage/defined need;
(g) identify funding sources to increase the number of graduate medical education positions, especially in or adjacent to physician shortage/underserved areas and in undersupplied specialties; and
(h) act on existing policy by seeking federal legislation requiring all health insurers to support graduate medical education through an all-payer trust fund created for this purpose; and
(2) other interested parties to ensure adequate funding to support medical school educational programs, including creating mechanisms to fund additional medical school positions.

Citation: (CME Rep. 7, A-05; Reaffirmation I-06; Reaffirmation I-07; Reaffirmed: Res. 921, I-12; Reaffirmation A-13; Reaffirmed: CME Rep. 5, A-13)

The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education D-305.967
1. Our AMA will actively collaborate with appropriate stakeholder organizations, (including Association of American Medical Colleges, American Hospital Association, state medical societies, medical specialty societies/associations) to advocate for the preservation, stability and expansion of full funding for the direct and indirect costs of graduate medical education (GME) positions from all existing sources (e.g. Medicare, Medicaid, Veterans Administration, CDC and others).
2. Our AMA will actively advocate for the stable provision of matching federal funds for state Medicaid programs that fund GME positions.
3. Our AMA will actively seek congressional action to remove the caps on Medicare funding of GME positions for resident physicians that were imposed by the Balanced Budget Amendment of 1997 (BBA-1997).
4. Our AMA will strenuously advocate for increasing the number of GME positions to address the future physician workforce needs of the nation.
5. Our AMA will oppose efforts to move federal funding of GME positions to the annual appropriations process that is subject to instability and uncertainty.
6. Our AMA will oppose regulatory and legislative efforts that reduce funding for GME from the full scope of resident educational activities that are designated by residency programs for accreditation and the board certification of their graduates (e.g. didactic teaching, community service, off-site ambulatory rotations, etc.).
7. Our AMA will actively explore additional sources of GME funding and their potential impact on the quality of residency training and on patient care.
8. Our AMA will vigorously advocate for the continued and expanded contribution by all payers for health care (including the federal government, the states, and local and private sources) to fund both the direct and indirect costs of GME.
9. Our AMA will work, in collaboration with other stakeholders, to improve the awareness of the general public that GME is a public good that provides essential services as part of the training process and serves as a necessary component of physician preparation to provide patient care that is safe, effective and of high quality.
10. Our AMA staff and governance will continuously monitor federal, state and private proposals for health care reform for their potential impact on the preservation, stability and expansion of full funding for the direct and indirect costs of GME.
11. Our AMA: (a) recognizes that funding for and distribution of positions for GME are in crisis in the United States and that meaningful and comprehensive reform is urgently needed; (b) will immediately work with Congress to expand medical residencies in a balanced fashion based on expected specialty needs throughout our nation to produce a geographically distributed and appropriately sized physician workforce; and to make increasing support and funding for GME programs and residencies a top priority of the AMA in its national political agenda; and (c) will continue to work closely with the Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, American Osteopathic Association, and other key stakeholders to raise awareness among policymakers and the public about the importance of expanded GME funding to meet the nation's current and anticipated medical workforce needs.
12. Our AMA will collaborate with other organizations to explore evidence-based approaches to quality and accountability in residency education to support enhanced funding of GME.
13. Our AMA will continue to strongly advocate that Congress fund additional graduate medical education (GME) positions for the most critical workforce needs, especially considering the current and worsening maldistribution of physicians.
14. Our AMA will advocate that the Centers for Medicare and Medicaid Services allow for rural and other underserved rotations in Accreditation Council for Graduate Medical Education (ACGME)-accredited residency programs, in disciplines of particular local/regional need, to occur in the offices of physicians who meet the qualifications for adjunct faculty of the residency program's sponsoring institution.
15. Our AMA encourages the ACGME to reduce barriers to rural and other underserved community experiences for graduate medical education programs that choose to provide such training, by adjusting as needed its program requirements, such as continuity requirements or limitations on time spent away from the primary residency site.
16. Our AMA encourages the ACGME and the American Osteopathic Association (AOA) to continue to develop and disseminate innovative methods of training physicians efficiently that foster the skills and inclinations to practice in a health care system that rewards team-based care and social accountability.
17. Our AMA will work with interested state and national medical specialty societies and other appropriate stakeholders to share and support legislation to increase GME funding, enabling a state to accomplish one or more of the following: (a) train more physicians to meet state and regional workforce needs; (b) train physicians who will practice in physician shortage/underserved areas; or (c) train physicians in undersupplied specialties and subspecialties in the state/region.
18. Our AMA supports the ongoing efforts by states to identify and address changing physician workforce needs within the GME landscape and continue to broadly advocate for innovative pilot programs that will increase the number of positions and create enhanced accountability of GME programs for quality outcomes.
19. Our AMA will continue to work with stakeholders such as Association of American Medical Colleges (AAMC), ACGME, AOA, American Academy of Family Physicians, American College of Physicians, and
other specialty organizations to analyze the changing landscape of future physician workforce needs as well as the number and variety of GME positions necessary to provide that workforce.

20. Our AMA will explore innovative funding models for incremental increases in funded residency positions related to quality of resident education and provision of patient care as evaluated by appropriate medical education organizations such as the Accreditation Council for Graduate Medical Education.

21. Our AMA will utilize its resources to share its content expertise with policymakers and the public to ensure greater awareness of the significant societal value of graduate medical education (GME) in terms of patient care, particularly for underserved and at-risk populations, as well as global health, research and education.

22. Our AMA will advocate for the appropriation of Congressional funding in support of the National Healthcare Workforce Commission, established under section 5101 of the Affordable Care Act, to provide data and healthcare workforce policy and advice to the nation and provide data that support the value of GME to the nation.

23. Our AMA supports recommendations to increase the accountability for and transparency of GME funding and continue to monitor data and peer-reviewed studies that contribute to further assess the value of GME.

24. Our AMA will explore various models of all-payer funding for GME, especially as the Institute of Medicine (now a program unit of the National Academy of Medicine) did not examine those options in its 2014 report on GME governance and financing.

25. Our AMA encourages organizations with successful existing models to publicize and share strategies, outcomes and costs.

26. Our AMA encourages insurance payers and foundations to enter into partnerships with state and local agencies as well as academic medical centers and community hospitals seeking to expand GME.

27. Our AMA will develop, along with other interested stakeholders, a national campaign to educate the public on the definition and importance of graduate medical education, student debt and the state of the medical profession today and in the future.

28. Our AMA will collaborate with other stakeholder organizations to evaluate and work to establish consensus regarding the appropriate economic value of resident and fellow services.

29. Our AMA will monitor ongoing pilots and demonstration projects, and explore the feasibility of broader implementation of proposals that show promise as alternative means for funding physician education and training while providing appropriate compensation for residents and fellows.

30. Our AMA will monitor the status of the House Energy and Commerce Committee's response to public comments solicited regarding the 2014 IOM report, Graduate Medical Education That Meets the Nation's Health Needs, as well as results of ongoing studies, including that requested of the GAO, in order to formulate new advocacy strategy for GME funding, and will report back to the House of Delegates regularly on important changes in the landscape of GME funding.

31. Our AMA will advocate to the Centers for Medicare & Medicaid Services to adopt the concept of “Cap-Flexibility” and allow new and current Graduate Medical Education teaching institutions to extend their cap-building window for up to an additional five years beyond the current window (for a total of up to ten years), giving priority to new residency programs in underserved areas and/or economically depressed areas.

32. Our AMA will: (a) encourage all existing and planned allopathic and osteopathic medical schools to thoroughly research match statistics and other career placement metrics when developing career guidance plans; (b) strongly advocate for and work with legislators, private sector partnerships, and existing and planned osteopathic and allopathic medical schools to create and fund graduate medical education (GME) programs that can accommodate the equivalent number of additional medical school graduates consistent with the workforce needs of our nation; and (c) encourage the Liaison Committee on Medical Education (LCME), the Commission on Osteopathic College Accreditation (COCA), and other accrediting bodies, as part of accreditation of allopathic and osteopathic medical schools, to prospectively and retrospectively monitor medical school graduates’ rates of placement into GME as well as GME completion.

33. Our AMA encourages the Secretary of the U.S. Department of Health and Human Services to coordinate with federal agencies that fund GME training to identify and collect information needed to effectively evaluate how hospitals, health systems, and health centers with residency programs are utilizing these financial resources to meet the nation’s health care workforce needs. This includes information on payment amounts by the type of training programs supported, resident training costs and revenue generation, output or outcomes related to health workforce planning (i.e., percentage of primary
care residents that went on to practice in rural or medically underserved areas), and measures related to resident competency and educational quality offered by GME training programs.


National Resident Matching Program Reform D-310.977

Our AMA:

(1) will work with the National Resident Matching Program (NRMP) to develop and distribute educational programs to better inform applicants about the NRMP matching process, including the existing NRMP waiver and violations review policies;

(2) will actively participate in the evaluation of, and provide timely comments about, all proposals to modify the NRMP Match;

(3) will request that the NRMP explore the possibility of including the Osteopathic Match in the NRMP Match;

(4) will continue to review the NRMP’s policies and procedures and make recommendations for improvements as the need arises, to include making the conditions of the Match agreement more transparent while assuring the confidentiality of the match;

(5) will work with the Accreditation Council for Graduate Medical Education (ACGME) and other appropriate agencies to assure that the terms of employment for resident physicians are fair and equitable and reflect the unique and extensive amount of education and experience acquired by physicians;

(6) does not support the current the “All-In” policy for the Main Residency Match to the extent that it eliminates flexibility within the match process;

(7) will work with the NRMP, and other residency match programs, in revising Match policy, including the secondary match or scramble process to create more standardized rules for all candidates including application timelines and requirements;

(8) will work with the NRMP and other external bodies to develop mechanisms that limit disparities within the residency application process and allow both flexibility and standard rules for applicants;

(9) encourages the National Resident Matching Program to study and publish the effects of implementation of the Supplemental Offer and Acceptance Program on the number of residency spots not filled through the Main Residency Match and include stratified analysis by specialty and other relevant areas;

(10) will work with the NRMP and ACGME to evaluate the challenges in moving from a time-based education framework toward a competency-based system, including: a) analysis of time-based implications of the ACGME milestones for residency programs; b) the impact on the NRMP and entry into residency programs if medical education programs offer variable time lengths based on acquisition of competencies; c) the impact on financial aid for medical students with variable time lengths of medical education programs; d) the implications for interprofessional education and rewarding teamwork; and e) the implications for residents and students who achieve milestones earlier or later than their peers;

(11) will work with the Association of American Medical Colleges (AAMC), American Osteopathic Association (AOA), American Association of Colleges of Osteopathic Medicine (AACOM), and National Resident Matching Program (NRMP) to evaluate the current available data or propose new studies that would help us learn how many students graduating from US medical schools each year do not enter into a US residency program; how many never enter into a US residency program; whether there is disproportionate impact on individuals of minority racial and ethnic groups; and what careers are pursued by those with an MD or DO degree who do not enter residency programs;

(12) will work with the AAMC, AOA, AACOM and appropriate licensing boards to study whether US medical school graduates and international medical graduates who do not enter residency programs may be able to serve unmet national health care needs;

(13) will work with the AAMC, AOA, AACOM and the NRMP to evaluate the feasibility of a national tracking system for US medical students who do not initially match into a categorical residency program;
(14) will discuss with the National Resident Matching Program, Association of American Medical Colleges, American Osteopathic Association, Liaison Committee on Medical Education, Accreditation Council for Graduate Medical Education, and other interested bodies potential pathways for reengagement in medicine following an unsuccessful match and report back on the results of those discussions;
(15) encourages the Association of American Medical Colleges to work with U.S. medical schools to identify best practices, including career counseling, used by medical schools to facilitate successful matches for medical school seniors, and reduce the number who do not match;
(16) supports the movement toward a unified and standardized residency application and match system for all non-military residencies;
(17) encourages the Educational Commission for Foreign Medical Graduates (ECFMG) and other interested stakeholders to study the personal and financial consequences of ECFMG-certified U.S. IMGs who do not match in the National Resident Matching Program and are therefore unable to get a residency or practice medicine;
(18) encourages the AAMC, AACOM, NRMP, and other key stakeholders to jointly create a no-fee, easily accessible clearinghouse of reliable and valid advice and tools for residency program applicants seeking cost-effective methods for applying to and successfully matching into residency; and
(19) will work with appropriate stakeholders to study options for improving transparency in the resident application process.


Preliminary Year Program Placement H-310.910

1. Our AMA encourages the Accreditation Council for Graduate Medical Education, the American Osteopathic Association, and other involved organizations to strongly encourage residency programs that now require a preliminary year to match residents for their specialty and then arrange with another department or another medical center for the preliminary year of training unless the applicant chooses to pursue preliminary year training separately.
2. Our AMA encourages appropriate stakeholders to explore options to decrease the burden upon medical students who must apply to separate preliminary PGY-1 and categorical PGY-2 positions.
3. Our AMA will work with the Accreditation Council for Graduate Medical Education to encourage programs with PGY-2 positions in the National Resident Matching Program (NRMP) with insufficient availability of local PGY-1 positions to create local PGY-1 positions that will enable coordinated applications and interviews for medical students.
4. Our AMA encourages the NRMP, the San Francisco Match, the American Urological Association, the Electronic Residency Application Service, and other stakeholders to reduce barriers for medical students, residents, and physicians applying to match into training programs, including barriers to “couples matching,” and to ensure that all applicants have access to robust, informative statistics to assist in decision-making.
5. Our AMA encourages the NRMP, San Francisco Match, American Urological Association, Electronic Residency Application Service, and other stakeholders to collect and publish data on a) the impact of separate matches on the personal and professional lives of medical students and b) the impact on medical students who are unable to successfully “couples match” with their significant others due to staggered entry into residency, utilization of unlinked match services, or other causes.

Citation: Res. 306, A-12; Appended: CME Rep. 03, A-19
Whereas, Minoritized populations, including people of color, immigrants, and people with chronic diseases were disproportionately affected by the pandemic; and

Whereas, International medical graduates, board-certified and trained in the U.S. institutions, are often the frontline physicians in the federally designated health professional shortage areas (HPSA) for their waiver requirements; and

Whereas, Physicians in the HPSA serve the lower income and immigrant population, and the older and sicker population covered by Medicare and Medicaid; and

Whereas, In response to the COVID-19 pandemic, most states took measures to alleviate practice restrictions for in-training, out-of-state, and retired physicians to allow the additional workforce to join hands in managing critical staff shortages during public health emergencies; and

Whereas, IMG physicians serving in the HPSA are restricted to one healthcare organization, further limited to one geographical location by definition of the work location listed in their Labor Condition Application (ETA Form 9035) as a prerequisite to their work Visa, H1B; and

Whereas, Except for a few specific instances like that in New York and New Jersey states, IMG physicians were excluded from the special provisions for in and out-of-state expedited physicians licensing, preventing them from helping out the workforce shortage during the public health emergency, and providing urgent access to medical care for underserved patient populations; therefore be it

RESOLVED, That our American Medical Association advise the state medical boards and other stakeholders to allow physicians in the health professional shortage areas to have temporary access to all unique and expedited licensing options, both inside and outside of the state of their practice during public health emergencies, to facilitate workforce utilization at the time of critical shortage (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate at the state and national level and advise the Department of Labor and the Department of Homeland Security to allow temporary provisions for such licensing inclusions for the physicians on a Visa during public health emergencies. (Directive to Take Action)

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

Received: 09/27/22
References
Reference Committee C

CME Report(s)

01  The Impact of Private Equity on Medical Training
02  Mitigating Demographic and Socioeconomic Inequities in the Residency and Fellowship Selection Process

Resolution(s)

302  Expanding Employee Leave to Include Miscarriage and Stillbirth
303  Medical Student Leave Policy
304  Protecting State Medical Licensing Boards from External Political Influence
305  Encouraging Medical Schools to Sponsor Pipeline Programs to Medicine for Underrepresented Groups
306  Increased Credit for Continuing Medical Education Preparation
307  Fair Compensation of Residents and Fellows
308  Paid Family/Medical Leave in Medicine
309  Bereavement Leave for Medical Students and Physicians
EXECUTIVE SUMMARY

Private equity (PE) refers broadly to any activity where investors buy an ownership, or equity, stake in companies or other financial assets that are not traded on public stock or bond exchanges. In recent years, the AMA Council on Medical Education and Council on Medical Service have studied related issues as demonstrated in their reports, “Graduate Medical Education and the Corporate Practice of Medicine” (CME 2-N-20), “Protection of Resident and Fellow Training in the Case of Hospital or Training Program Closure” (CME 3-N-20), “Corporate Investors” (CMS 11-A-19), and “Sources of Funding for Graduate Medical Education” (CME 1-I-15). Per a new directive from the House of Delegates, the AMA has been asked to study the level of financial involvement and influence private equity firms have in graduate medical education training programs and report back to the House of Delegates with possible publication of their findings.

PE’s role in health care has increased in recent years, as has its influence on graduate medical education (GME). This report reviews the extent of PE in health care and provides examples of PE and for-profit ownership of GME. It also summarizes the impact of PE on the GME learning environment and trainees and offers perspectives from key stakeholders, including the AMA and its related policies.

Understanding of the impact and mitigating any potential negative consequences of PE and for-profit entities in GME will take a concerted effort on the part of the medical and academic communities. There are numerous layers of complexity in what is a rapidly evolving health care practice model, and increasing data collection to recognize trends and ultimately outcomes is warranted. As PE involvement evolves, sponsoring institutions must be open to many kinds of partnerships that can support excellent residency and fellowship programs. This includes diligent monitoring of these programs to minimize disruptions to training and ensure that continuity of excellent education is maintained. The commitment to the educational mission is not only a commitment to residents, fellows, and faculty, but also to the communities and patients they serve.

This report proposes amendments to current AMA policy as well as new recommendations which support institutions or medical education training programs in upholding current policies and developing new policies; protect trainees and empower designated institutional officials (DIOs); encourage transparency as well as changes to the Public Student Loan Forgiveness Program (PSLF); and promote more research and public statements on PE in order to heighten awareness among the physician community.
Subject: The Impact of Private Equity on Medical Training

Presented by: John Williams, MD, Chair

Referred to: Reference Committee C

INTRODUCTION

American Medical Association (AMA) Policy D-310.947, adopted at the June 2021 Special Meeting, asks that our AMA:

Work with relevant stakeholders including specialty societies and the Accreditation Council for Graduate Medical Education to study the level of financial involvement and influence private equity firms have in graduate medical education training programs and report back to the House of Delegates with possible publication of their findings.

This report is in response to the directive. Testimony on this item raised concern for recent incidents where private equity has impacted graduate medical education (GME) funded training positions, such as the Hahnemann closure in the fall of 2019. Additional testimony recognized the importance of recent Council reports on similar topics.

BACKGROUND

What is private equity?

The American Investment Council (AIC), an advocacy and resource organization established to develop and provide information about the private investment industry, describes private equity (PE) such that “private equity invests capital in companies that are perceived to have growth potential and then works with these companies to expand or turnaround the business. This capital is contributed by large institutional investors and is organized into a fund. After three to seven years of ownership and working with the company, the fund manager will seek to ‘exit’ the company by taking the business public or selling it for a higher valuation than it was purchased. This exit distributes profits from the sale (‘returns’) to the investors in the fund and the fund manager.”1

The Medicare Payment Advisory Commission (MedPAC) adds to this definition: “Private equity refers broadly to any activity where investors buy an ownership, or equity, stake in companies or other financial assets that are not traded on public stock or bond exchanges.”2

According to the National Association of Securities Dealers Automated Quotations (NASDAQ), a private equity firm is one that uses its own capital or capital raised from investors to take companies private with the aim of running them better and later taking them public or selling them at a profit.”3
Simply put, PE firms invest in health systems and in health care to make a profit. Investors pool money to accumulate large sums of cash that are used to invest through the purchase of a business (e.g., physician practice or health system) with the goal of streamlining operations and cutting costs to make a short-term profit after selling the business. Sometimes, the return on the investment can be 20-30% of the original investment.

Strategies used by PE firms to ultimately turn a profit include the merging of multiple health care practices, reducing staff, closing down portions of a hospital or health care practice’s operations, focusing on growing a specific aspect of a health care practice’s offerings, and renegotiating reimbursement rates with insurers. As PE is not publicly traded, there is little transparency to the public regarding the business dealings of the PE firm, and with a focus on short-term profit, there is often little regard to the downstream effects of these strategies on employees, patients, or in the present case, the residents/fellows training at the institution.

In 2020, it was found that hospitals acquired by PE were associated with larger increases in net income, charges, charge to cost ratios, and case mix index as well as with improvement in some quality measures when compared to control. In 2018, PE hospitals were on average located in lower-income, more-rural areas and had fewer patients discharged and employees per bed.

In recent years, the AMA Council on Medical Education and Council on Medical Service have studied related issues as demonstrated in their reports, “Graduate Medical Education and the Corporate Practice of Medicine” (CME 2-N-20), “Protection of Resident and Fellow Training in the Case of Hospital or Training Program Closure” (CME 3-N-20), “Corporate Investors” (CMS 11-A-19) and related issue brief, and “Sources of Funding for Graduate Medical Education” (CME 1-I-15). Further, the AMA developed a guide designed to answer some of the frequently asked questions posed by trainees faced with closure of their hospital or residency program.

**Extent of Private Equity in Health Care**

Investments by PE firms in U.S. health care increased from $23.1B in 2015 to $78.9B in 2019 with hospitals that are owned by PE firms being a subset of investor-owned hospitals that has increased in recent years.

<table>
<thead>
<tr>
<th>American Hospital Association (AHA) Annual Survey</th>
<th>FY 2019</th>
<th>FY 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total Number of All U.S. Hospitals</strong></td>
<td>6,090</td>
<td>5,564</td>
</tr>
<tr>
<td>Number of U.S. Community Hospitals (i.e., all nonfederal, short-term general, and other special hospitals)</td>
<td>5,141</td>
<td>4,862</td>
</tr>
<tr>
<td>- Number of Nongovernment Not-for-Profit Community Hospitals</td>
<td>2,946</td>
<td>2,845</td>
</tr>
<tr>
<td>- Number of Investor-Owned (For-Profit) Community Hospitals</td>
<td>1,233</td>
<td>1,034</td>
</tr>
<tr>
<td>- Number of State and Local Government Community Hospitals</td>
<td>962</td>
<td>983</td>
</tr>
</tbody>
</table>
### Number of Federal Government Hospitals

<table>
<thead>
<tr>
<th></th>
<th>208</th>
<th>212</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Federal Government Hospitals</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of Nonfederal Psychiatric Hospitals</td>
<td>625</td>
<td>401</td>
</tr>
<tr>
<td>Other Hospitals (i.e., nonfederal long term care hospitals and hospital units within an institution such as a prison hospital or school infirmary)</td>
<td>116</td>
<td>89</td>
</tr>
</tbody>
</table>

While there is no clear picture of how many for-profit hospitals, or those owned by PE, have one or more GME programs, the most recent results of the National GME Census of active GME programs provide a glimpse. Results indicated that 7,695 programs’ trainees are paid by a nonprofit entity; 1,620 programs’ trainees are paid by a for-profit; while 3,550 programs did not answer.

When analyzing this data, it is important to note that the salary-paying entity may not always be the same as the sponsoring institution or hospital.

As the number of investor-owned (for-profit) hospitals grows in GME, the greater the dependency of GME programs on their stability and success. Conversely, the closure of such institutions directly impacts GME programs including the residents, fellows, and physician faculty who rely on them for training and employment. One such recent example was the sudden closure of Hahnemann.

### EXAMPLES OF PRIVATE EQUITY AND FOR-PROFIT OWNERSHIP OF GME

**Closure of Hahnemann University Hospital**

In fall 2019, Hahnemann University Hospital (HUH), a 500-bed teaching hospital and community safety net in downtown Philadelphia, closed. The closure was the culmination of 20+ years of financial troubles and changing ownerships. Tenet Healthcare Corporation, a for-profit health care company, acquired the hospital in 1998. American Academic Health System, LLC (AAHS), an affiliate of the private equity firm Paladin Healthcare Capital, LLC, purchased HUH in 2018 in partnership with a Chicago-based health care real estate private equity firm, Harrison Street Real Estate Capital, LLC. At the time, suspicions loomed that the purchase of the hospital was really a means to acquire and develop the valuable Center City Philadelphia real estate property rather than to provide patient care in service to the community. While there is a state law that a hospital cannot be closed with less than 90 days’ notice, AAHS filed for bankruptcy and shut down HUH’s service to the community in about half that time. This left 572 trainee physicians without an Accreditation Council for Graduate Medical Education (ACGME)-accredited program in which to continue their medical education. This included 140 newly matched trainees and 59 individuals on J-1 visas who were required to find a position with another GME program within 30 days of the hospital closing or face deportation from the U.S.

To improve their financial gain, AAHS attempted to sell its government-funded residency slots as “assets” during bankruptcy proceedings, which was allowed by the presiding judge at the time. Bids included a coalition of local hospitals ($55 million) intending to keep the residency positions in the Philadelphia region, as well as a health care firm in California ($60 million) that wanted to increase the number of funded physicians in its hospitals. However, the Centers for Medicare & Medicaid Services (CMS) objected to the judge’s ruling, arguing that the allocation of Medicare-funded slots is their sole purview and that the auction would set a dangerous precedent. As a result, the auction did not go forward, and the residency positions were redistributed by CMS using their existing process which prioritizes local hospitals without charge.
Not only were these professionals left to endure the stress of finding new training positions elsewhere throughout the country, but they were also faced with the loss of the long-tail medical liability insurance coverage needed to continue practice. The AMA and other organizations took action in support of the affected trainees. Specifically, the AMA joined the Pennsylvania Medical Society (PAMED) and the Philadelphia County Medical Society (PCMS), as well as the Educational Commission for Foreign Medical Graduates (ECFMG), Association of American Medical Colleges (AAMC), and ACGME to pursue a solution for the physicians affected by the closure. This advocacy included encouraging the purchasing of tail coverage by the institutions that accepted HUH trainees among a host of other measures.

Ultimately, a federal bankruptcy judge approved a settlement with AAHS in early 2020 to pay for the long-tail medical liability insurance coverage for the residents, fellows, and alumni of the hospital’s training programs. Since Pennsylvania required that all physicians have tail coverage from previous employers, this effort was particularly important. Together, the AMA and AMA Foundation committed $70,000 to assist the trainees affected. Many other organizations contributed to the Hahnemann University Displaced Resident Fund including the American Osteopathic Association, American Board of Medical Specialties, Council of Medical Specialty Societies, National Board of Medical Examiners, PAMED, PCMS, and AAMC. In addition, the ECFMG, now a member of Intealth, created a fund for trainees who had J-1 visas. The ACGME also took several steps to support these trainees such as the enactment of their Extraordinary Circumstances Policy to expediently arrange for the transfer of trainees, drafting a compilation of available positions, and making two separate filings with the bankruptcy court.

**Closure of Emergency Medicine department at Summa Health Care**

Summa Health™ is an integrated nonprofit health care delivery system in the Akron, OH area that sponsors 19 GME programs, of which 15 are ACGME-accredited residency and fellowship programs. While Summa’s employed physician group provided most of the educational and clinical services for these programs, the emergency medicine (EM) services (i.e., staffing of five emergency departments; faculty for EM residency program) were provided by a contracted third-party vendor owned by the private equity company U.S. Acute Care Solutions (USACS). A contract dispute between Summa Health™ and USACS in late 2016 ended in nonrenewal of the longstanding contract. The EM service physicians were forced to leave the institution and program. The program acquired new leadership and faculty but ultimately lost accreditation causing disruption of services for patients as well as for the trainees within the EM residency program. The experience for the trainees who went through the change in groups and subsequent closure of the program was difficult for all and devastating for some. It was particularly difficult for the PGY3s given they had long-standing relationships and mentoring from their former attendings, faculty, and program leadership, not to mention a familiarity and comfort from working in a stable learning environment. The AMA, AMA Foundation, and others offered financial support to the affected trainees in need of relocating.

This experience led to a revision of Summa’s GME Disaster or Interruption in Patient Care Policy as well as a comprehensive restructuring of the institutional contracting process. This overhaul included clarifying the definition of a disaster to include a “catastrophic loss of faculty”; reinforcing the authority and responsibilities of the GME Committee (GMEC) members to call an emergency GMEC meeting to discuss a potential impending disaster; making transparent the disaster action steps and procedure; creating a linkage of the GME Disaster Policy to the new contracting process; cataloging all clinical and education service agreements and contracts that
involved third-party groups; and quarterly review by the Designated Institutional Official (DIO) of
the status of each agreement at a GMEC meeting to provide the committee oversight of this aspect
of the learning environment. USACS continues to invest in education and has shared best practices
from other institutions where they provide care and operate residencies. In September 2019,
Summa’s EM Program was given initial accreditation status by the ACGME effective
immediately.21 Emergency medicine training at Summa is once again thriving.

Example of extensive PE ownership of GME

HCA Healthcare is the nation’s leading provider of GME and has 5000+ trainees working across
61 hospitals in 16 states. They were responsible for 20% of the 667 new EM residency slots created
in the U.S. from 2016-2019.22 In 2006, HCA was acquired by Bain Capital, Kohlberg Kravis
Roberts & Co. (KKR), and Merrill Lynch and facilitated massive multi-hospital consolidation with
seemingly marginal benefit for patients as well as increased cost-to-charge ratios/profits.23,24,25 In
2011, HCA became a public company again. In the meantime, the PE investors had turned a $956
million contribution into $3.14 billion in proceeds.25 HCA bought back 3.8 million shares from
Bain for about $294 million and spent $750 million to buy back 9.4 million of its common shares
from KKR in 2016.26 The potential impacts of HCA’s enormous market share within GME is
concerning and highlights the need for publicly funded, independent research on the impact of
private equity in GME and health care delivery alike.

PRIVATE EQUITY AND THE GME LEARNING ENVIRONMENT

As mentioned previously, PE is fundamentally driven by the desire to generate a positive margin
for investors through a variety of strategies. Ultimately, these strategies are to grow, repackage, and
sell.27 While it does not appear that PE invests in hospitals, health systems, or practices with the
intent of eliminating or dramatically altering GME, such programs as well as their trainees can be
impacted. Examples include but are not limited to:

- **Erosion of educational mission:** One key outcome of GME training is the intentional
  exploration of self-directed learning and pursuit of scholarly activity. The focus of PE is on
  creating a wide profit margin through operational decisions and efficiencies, and these are
  likely to directly or indirectly impact a trainee’s ability to learn. Education and learning
  require time and mentoring, especially in GME, and thus it is inherently inefficient. PE
  firms driven toward profit are likely to eliminate or minimize key aspects of trainee
  professional development.

- **Disruption to trainee supervision:** A sudden transition of leadership can result in new
  faculty not familiar with ACGME common program requirements and/or institutional
  requirements which mandate resident supervision of trainees.

- **Residents are not employees:** Trainees are commonly in a unique situation in which they
  are able to provide significant value to a health system by caring for patients and making
  independent decisions that generate clinical revenue. For institutions driven by profit,
  however, there may be undue pressure for trainees to contribute to the positive margin
  either through their medical practice or being utilized as a relatively low-cost employee
  (e.g., shift scheduling).

- **Replacing residents with non-physicians:** There is concern that some for-profit institutions
  are driving to replace resident physicians with non-physicians in order to not be beholden
  to regulatory rules, reduce recruiting budgets, and pay lower cumulative salaries over the
  long term.
• Academic instability: The situation at Hahnemann has been described as a “…concerning trend that underscores the dissonance in mission of private equity and academic medicine.”28 This dissonance creates an unstable, if not adverse, working and learning environment that unquestionably impacts trainees and their professional growth.

IMPACT ON PHYSICIANS IN TRAINING

As referenced in the above examples, trainees and faculty are significantly impacted by disruptions to GME imposed by PE. The interruption to a trainee’s education and experience can impact their ability to finish as scheduled, which has natural implications for their future careers and leaves them at financial risk. The potential loss of long-tail medical liability insurance coverage needed to continue practice as well as confusion regarding the amount of funding that would travel with a transferring trainee from a suddenly closed program is problematic.

Additionally, the stress of uncertainty, having to find a new GME program, needing to upend their lives to move to the next location, and the cost of moving and rehoming place a heavy weight on the shoulders of residents, faculty, and their families. This problem is further compounded by the likely change of mentorship and planned educational trajectory for learners as they re-enter at another institution.

International medical graduates (IMGs) with J-1 visas must adhere to rules set forth by their J-1 visa status. In the event of a sudden hospital/GME program closure, the implication for these trainees is that they face deportation to their home country if they do not find a new position at another GME program within 30 days of such closure. This short timeline presents significant challenges to professional continuity for reasons in which the IMG has no control.

Further, the trainees may not have received clarity from all the boards on how the closure could impact the number of rotations or number of procedures (especially those nearing the end of training) they need to complete. The ABIM did state that “all accredited training continues to meet ABIM’s policies for initial certification eligibility. Additionally, should a trainee have a ‘gap’ in training due to relocation, we are committed to working with you and the receiving institutions/program directors to ensure that the maximum flexibility possible under ABIM’s Leave and Deficits in Required Training Time policies can be applied.”29

As a result of the Hahnemann closure, CMS changed its rules related to the transfer of indirect medical education (IME) and direct graduate medical education (DGME) funding to accepting institutions. Current Medicare policy allows a temporary cap adjustment for hospitals that accept displaced residents from a hospital or program that is closing so that these hospitals can receive Medicare funding for the displaced residents for the duration of their training. The definition of a displaced resident was such that the resident be physically present at the hospital training on the day prior to or the day of hospital or program closure; however, the revised definition now states that a resident will be considered displaced from the day the hospital or training program publicly announces the closure.30 This rule, however, does not impact GME trainees whose salaries are not paid for through Medicare funds (e.g., trainees in programs that are not accredited by the ACGME, such as sub-subspecialties that receive approval/certification from specialty societies). Without guarantees for ongoing trainees, the educational continuity of these learners is dramatically impacted.

The impact on the income of trainees is another important consideration. One study found that while there was significant growth of newly ACGME accredited for-profit affiliated EM residency programs from 2016–2021, the for-profit affiliated programs paid lower salaries to first-year
trainees than the nonprofit affiliated programs (even after controlling for other factors that could influence salary). It concluded that better oversight of the salary determination process is needed to protect trainees from underpayment and ensure equity. While this study was specific to EM programs, there could be broader implications to other specialties where PE investment is a factor.

Finally, the emotional and psychological toll on trainees working in an unfamiliar, possibly unwelcoming, learning environment likely has significant implications on professional identity formation. Most trainees do not understand and have not received formal education regarding the corporate practice of medicine and thus may not understand or appreciate the economic forces that directly or indirectly impact their education.

Public Service Loan Forgiveness Program

The involvement of private equity can also impact a physician’s eligibility for the Public Service Loan Forgiveness Program (PSLF). The PSLF Program forgives the remaining balance on an individual’s direct loans after making 120 qualifying monthly payments under a qualifying repayment plan while working full-time for a qualifying employer. From the 2019 data presented in the AHA table above, 4,116 hospitals are PSLF-eligible, or roughly about 68 percent of hospitals in the U.S. Although most residency and fellowship programs are in nonprofit institutions, the for-profit or nonprofit status of programs is not generally readily discernible to a medical student or resident investigating training options. Additionally, residents and fellows who are training in a nonprofit university-based residency or fellowship program will be excluded from the PSLF Program if they are officially employees of an affiliated for-profit hospital or health system. During the match process, medical students may not be aware of or have access to information about the for-profit status of the entity that will pay their salary as GME often takes place within complicated institutional arrangements of “sponsoring” and “participating” institutions. Even if residents and fellows rotate to several nonprofit clinical sites and funds are contributed to that salary by nonprofit or government institutions, the institution writing the salary check may not be a nonprofit and thus not be a qualifying employer for the PSLF Program. This system can create multiple hurdles for physicians hoping to enter the PSLF Program and means that students will need to be cautious about choosing institutions as part of the residency matching process and physicians must do the same when picking their future place of employment.

In July 2022, the Department of Education (DOE) announced proposed rule changes including amendments to regulations governing PSLF in the Direct Loan program to improve the application process and to clarify and expand definitions for full-time employment, qualifying employers, and qualifying monthly payments. The AMA responded to the open comment period encouraging the DOE to adopt the clarifying language developed by the California Medical Association and Texas Medical Association following the definition of “employee” or “employed” so that CA and TX physicians working full-time in private nonprofit hospitals and other organizations that meet the definition of “public service organization” and satisfy all the other PSLF requirements may lawfully participate in the program. The AMA letter also encouraged extension of the current PSLF waiver deadline and expansion of the program so that more associations and a larger range of nonprofits be considered “qualified employers.” Further, the letter urged reconsideration of the proposed definition of “public education service” as being too narrow and unclear, as well as reconsideration of the proposal which would allow a total and permanent disability discharge application to be certified by a nurse practitioner, physician’s assistant, or a licensed certified psychologist, in addition to an MD or DO.

PERSPECTIVES FROM STAKEHOLDERS
Medical specialties that have notably attracted the majority of PE investment include dermatology, orthopaedics, radiology, cardiology, gastroenterology, urgent care/emergency medicine, anesthesiology, and ophthalmology.

To illustrate, dermatology practices represent 15 percent of recent private equity acquisitions of medical practices even though dermatologists account for only one percent of physicians in the U.S. PE firms invest in dermatology management groups (DMGs) which operate multiple clinics and have been known to acquire smaller, physician-owned practices. Research suggests that this consolidation of dermatology practices may be associated with changes in practice management and that PE firms have a financial stake in an increasing number of dermatology practices in the U.S. PE’s interest in dermatology points to several factors including: treatment of skin cancer, which is the most common cancer in the U.S; a growing older population in need of skin care; a specialty with a history of fragmentation; demand for dermatologists; and profitability of the specialty as well as its specialized services such as Mohs and dermatopathology. However, there are considerations for dermatologists. As stated by AMA President Jack Resneck, Jr., MD, “Practice acquisitions at inflated prices in a competitive quest to quickly consolidate fragmented markets and sell practices at a profit to future investors may eventually lead to bankruptcies, leaving dermatologists without practices and patients without services.” Further, the impact on dermatology training programs is unclear. The American Academy of Dermatology and American Board of Dermatology do not appear to have issued statements regarding private equity and its role in the specialty or impact on GME.

Another example of PE growth is within ophthalmology, for reasons similar to dermatology. As of 2019, 30-35 PE firms were in this market. PE’s focus is on large and regionally important practices as well as those with a strong ambulatory surgery center (ASC) component. It is believed that such interest in ASCs will increase, as “stable ASC profits and comparatively low enterprise complexity are most in keeping with a corporate environment—much more so than the massive complexity and volatility of the underlying practices themselves.” The American Academy of Ophthalmology (AAO) notes, “Purchases of private equity in the health care market have soared in recent years with hospitals and larger practice acquiring smaller practices. The Academy urges every physician who is considering a practice equity acquisition to perform careful due diligence and seek good counsel.” The AAO offers information to physicians who are considering such opportunities.

In April 2022, the American College of Emergency Physicians (ACEP) issued a statement on Private Equity and Corporate Investment in Emergency Medicine. In it, they expressed increased concerns about the expanding presence of PE and corporate investment in health care, including emergency medicine.

Prior to this, the American Academy of Emergency Medicine (AAEM) Resident and Student Association issued an open letter addressing their concerns with regards to training in an environment influenced by corporate entities. Specifically, they urge the profession to, “Purge our specialty societies from the influence and funding from corporate entities” among other recommendations. Further, this letter calls for a moratorium on new EM residency training programs until issues are addressed, namely concerns about program quality as well as the oversupply of EM physicians.

Likewise, a 2021 position paper from the American College of Physicians (ACP) concluded, “Ultimately, professionalism, medical ethics, and the patient-physician relationship must guide how physicians navigate the business side of medicine. Nonprofits must act like nonprofits and have a community-oriented mission, private equity firms and investor-owned organizations must
attend to the needs of patients and not just shareholders, and physicians should not have a financial
stake in an organization with which they have a referral relationship.”

The ACGME is actively monitoring this situation as indicated in the 2021 National Reporting of
Findings from their Clinical Learning Environment Review (CLER) Site Visits. This report noted,
“Over the past few years, U.S. health care has experienced a number of accelerated changes. There
has been a dramatic increase in mergers and acquisitions of hospitals and related health care
entities, resulting in increasingly large and complex health care organizations. There has also been
rapid entry of private equity in ownership of physician group practices, particularly among certain
specialty-based clinical practices.” By examining clinical learning environments (CLE) during this
rapid evolution of the U.S. health care system, the ACGME can illuminate the challenges and
opportunities related to how CLEs engage their trainees in planning for and implementing system
changes. ACGME programs continue to assist the GME community in testing and sharing new
approaches to improving complex challenges in the CLE. Also, the ACGME will revise its
institutional requirements in 2022 as part of a 10-year major revision cycle. Thus, the CLER
Evaluation Committee is studying the results of their current report and past reports to highlight
opportunities for improvement to be considered by the Institutional Review Committee.

Despite the significant level of concern that has been expressed, not all stakeholders have
implemented policies designed to combat the impact of PE on GME. The associations and societies
that represent residents and physicians should have a vested interest in the impact that PE may have
on trainees who belong in the GME programs of said specialties. However, few have released
policy statements or positions on the subject; for those who have not, such action may be
considered. Further, the water gets muddied when physicians associated with PE firms are
outspoken in their societies or if the leadership of such societies has financial relationships with
PE-backed management firms.

Clearly there is concern about PE and its impact on the practice of medicine, but little is known or
commented about the impact of PE on GME, whether that be for an individual residency program
or for an institution.

CHANGES TO DATE

As a result of the Hahnemann closure, CMS implemented a rule change related to the transfer of
GME funding from one institution to another in the case of sudden closure of an institution or a
program. As described earlier, this change updated the definition of a “displaced resident” and
applies to residents currently training in the closing program as well as residents who are not
physically present because they have not started training or do not intend to return to training at the
closing institution. Allowing the closing hospital to temporarily transfer the slots as soon as the
closing is made public allows trainees flexibility in finding new programs and allows for more
certainty in the continuity of training. This change was encouraged by AMA and AAMC.

The Summa example provides other changes that have occurred at an institutional or systemic level
that have helped to optimize training at that institution while also taking provisional steps to
prevent dramatic closures from recurring in the future.

While positive developments, there remains concern that the positive changes implemented to date
are only temporary and may not lead to lasting change or prevent dramatic closures from
happening again as a result of PE investment.

Proposed federal legislation
In October 2021, the Stop Wall Street Looting Act (S. 3022) was introduced to subject certain private funds to joint and several liability with respect to the liabilities of firms acquired and controlled by those funds. The sponsor described it as “a comprehensive bill to fundamentally reform the private equity industry and level the playing field by forcing private investment firms to take responsibility for the outcomes of companies they take over, empowering workers, and protecting investors.” A similar bill by the same name, H.R. 5648, also was introduced. Such legislation could pave the way for greater scrutiny and accountability of PE, and ultimately, more protection for trainees and residency programs.

RELEVANT AMA POLICY

The AMA has extensive policy addressing the financial involvement of for-profit institutions in GME and the influence of private equity firms on the practice of medicine. The most specific policies related to this topic are as follows:

- **D-310.948**, “Protection of Resident and Fellow Training in the Case of Hospital or Training Program Closure,” addresses concerns related to the protection of residents and fellows in the case of training program closures and specifically encourages the AMA to work with other stakeholders to ensure that GME trainees can continue safely on their training pathway despite needing to change institutions mid-training.

- **H-310.904**, “Graduate Medical Education and the Corporate Practice of Medicine,” acknowledges that the learning environment for trainees must be free of conflict between fiduciary responsibilities of an institution and the educational mission.

- **H-310.943**, “Closing of Residency Programs,” provides recommendations for some medical education regulatory bodies to actively monitor GME programs for non-educational closing and accommodate those trainees who are impacted when GME programs close for this reason. In addition, it calls for federal regulation to increase transparency and accountability of the training institution in the event of hospital or training program closure.

- **H-310.929**, “Principles for Graduate Medical Education,” identifies a list of principles for GME including the institutional responsibility as it relates to supporting trainees and their program as well as promoting an environment that is conducive to learning.

- **H-160.891**, “Corporate Investors,” provides a list of detailed guidelines for physicians who are contemplating investor partnerships.

- **H-215.981**, “Corporate Practice of Medicine,” opposes federal legislation that preempts state laws prohibiting the corporate practice of medicine, offers guidance to state societies, and encourages continued monitoring of the corporate practice of medicine.

These policies addressing PE are listed in full detail in Appendix A.

SUMMARY AND RECOMMENDATIONS

Understanding of the impact and mitigating any potential negative consequences of PE and for-profit entities in GME will take a concerted effort on the part of the medical and academic communities. There are numerous layers of complexity in what is a rapidly evolving health care practice model and increasing data collection to recognize trends and ultimately outcomes is
warranted. AMA Policy D-310.948 instructs the AMA to work with the ACGME to monitor issues related to training programs run by corporate entities and the effect on medical education. Research into this work should continue in concert with affected specialty societies and others.

Specialty associations and societies that represent trainees and physicians have a vested interest in the impact of PE on GME training, yet few have studied the issue and released policy or statements on the subject. The AMA Council on Medical Education encourages this work from the physician and medical education communities.

The AMA must continue to advocate that full GME funding follows trainees of a suddenly closed institution to the new location and that funding stays with the institution for the duration of the displaced resident’s term. For institutions and systems, tail coverage for malpractice insurance should be mandated and institutional transparency increased to trainees on the closure process as well as disclosure of the intent to sell or close. Benefits (such as COBRA) should be continued in instances where new residency programs are not found in a timely manner. Finally, upon a shutdown, all trainees should be protected from being held captive at a hospital that is not actively admitting patients but hasn’t officially “closed.” The AMA must also continue to work with the ACGME, ABMS, and ABOMS to accommodate trainees who have been displaced because of program or institutional closure.

Conclusion

It is likely that the involvement of PE in health care systems, physician practices, and thus, GME programs, is not going away. As this space evolves, sponsoring institutions must be open to many kinds of partnerships that can support excellent residency and fellowship programs. This includes diligent monitoring of these programs to minimize disruptions to training and ensure that continuity of excellent education is maintained. The commitment to the educational mission is not only a commitment to residents, fellows, and faculty, but also to the communities and patients they serve.

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

Fiscal note: $1,000
APPENDIX A: RELEVANT AMA POLICY

Corporate Investors H-160.891
1. Our AMA encourages physicians who are contemplating corporate investor partnerships to consider the following guidelines:
   a. Physicians should consider how the practice’s current mission, vision, and long-term goals align with those of the corporate investor.
   b. Due diligence should be conducted that includes, at minimum, review of the corporate investor’s business model, strategic plan, leadership and governance, and culture.
   c. External legal, accounting and/or business counsels should be obtained to advise during the exploration and negotiation of corporate investor transactions.
   d. Retaining negotiators to advocate for best interests of the practice and its employees should be considered.
   e. Physicians should consider whether and how corporate investor partnerships may require physicians to cede varying degrees of control over practice decision-making and day-to-day management.
   f. Physicians should consider the potential impact of corporate investor partnerships on physician and practice employee satisfaction and future physician recruitment.
   g. Physicians should have a clear understanding of compensation agreements, mechanisms for conflict resolution, processes for exiting corporate investor partnerships, and application of restrictive covenants.
   h. Physicians should consider corporate investor processes for medical staff representation on the board of directors and medical staff leadership selection.
   i. Physicians should retain responsibility for clinical governance, patient welfare and outcomes, physician clinical autonomy, and physician due process under corporate investor partnerships.
2. Our AMA supports improved transparency regarding corporate investment in physician practices and subsequent changes in health care prices.
3. Our AMA encourages national medical specialty societies to research and develop tools and resources on the impact of corporate investor partnerships on patients and the physicians in practicing in that specialty.
4. Our AMA supports consideration of options for gathering information on the impact of private equity and corporate investors on the practice of medicine.

Graduate Medical Education and the Corporate Practice of Medicine H-310.904
Our AMA: (1) recognizes and supports that the environment for education of residents and fellows must be free of the conflict of interest created between a training site’s fiduciary responsibility to shareholders and the educational mission of residency or fellowship training programs; (2) encourages the Accreditation Council for Graduate Medical Education (ACGME) to update its “Principles to Guide the Relationship between Graduate Medical Education, Industry, and Other Funding Sources for Programs and Sponsoring Institutions Accredited by the ACGME” to include corporate-owned lay entity funding sources; and (3) will continue to monitor issues, including waiver of due process requirements, created by corporate control of graduate medical education sites.

Corporate Practice of Medicine H-215.981
1. Our AMA vigorously opposes any effort to pass federal legislation preempting state laws prohibiting the corporate practice of medicine.
2. At the request of state medical associations, our AMA will provide guidance, consultation, and model legislation regarding the corporate practice of medicine, to ensure the autonomy of hospital medical staffs, employed physicians in non-hospital settings, and physicians contracting with corporately owned management service organizations.
3. Our AMA will continue to monitor the evolving corporate practice of medicine with respect to its effect on the patient-physician relationship, financial conflicts of interest, patient-centered care, and other relevant issues.

**Protection of Resident and Fellow Training in the Case of Hospital or Training Program Closure D-310.948**

Our AMA:
1. will ask the Centers for Medicare & Medicaid Services (CMS) to stipulate in its regulations that residency slots are not assets that belong to the teaching institution;
2. will encourage the Association of American Medical Colleges (AAMC), American Association of Colleges of Osteopathic Medicine (AACOM), and National Resident Matching Program (NRMP) to develop a process similar to the Supplemental Offer and Acceptance Program (SOAP) that could be used in the event of a sudden teaching institution or program closure;
3. will encourage the Accreditation Council for Graduate Medical Education (ACGME) to specify in its Institutional Requirements that sponsoring institutions are to provide residents and residency applicants information regarding the financial health of the institution, such as its credit rating, or if it has recently been part of an acquisition or merger;
4. will work with AAMC, AACOM, ACGME, and relevant state and specialty societies to coordinate and collaborate on the communication with sponsoring institutions, residency programs, and resident physicians in the event of a sudden institution or program closure to minimize confusion, reduce misinformation, and increase clarity;
5. will encourage ACGME to revise its Institutional Requirements, under section IV.E., Professional Liability Insurance, to state that sponsoring institutions must create and maintain a fund that will ensure professional liability coverage for residents in the event of an institution or program closure; and
6. will continue to work with ACGME to monitor issues related to training programs run by corporate entities and the effect on medical education.

**Closing of Residency Programs H-310.943**

1. Our AMA: (a) encourages the Accreditation Council for Graduate Medical Education (ACGME) to address the problem of non-educational closing or downsizing of residency training programs; (b) reminds all institutions involved in educating residents of their contractual responsibilities to the resident; (c) encourages the ACGME and the various Residency Review Committees to reexamine requirements for “years of continuous training” to determine the need for implementing waivers to accommodate residents affected by non-educational closure or downsizing; (d) will work with the American Board of Medical Specialties Member Boards to encourage all its member boards to develop a mechanism to accommodate the discontinuities in training that arise from residency closures, regardless of cause, including waiving continuity care requirements and granting residents credit for partial years of training; (e) urges residency programs and teaching hospitals be monitored by the applicable Residency Review Committees to ensure that decreases in resident numbers do not place undue stress on remaining residents by affecting work hours or working conditions, as specified in Residency Review Committee requirements; (f) opposes the closure of residency/fellowship programs or reductions in the number of current positions in programs as a result of changes in GME funding; and (g) will work with the Centers for Medicare and Medicaid Services (CMS), ACGME, and other appropriate organizations to advocate for the development and implementation of effective policies to permit graduate medical education funding to follow the resident physician from a closing to the receiving residency program (including waivers of CMS caps), in the event of temporary or permanent residency program closure.
2. Our AMA will work with the Centers for Medicare and Medicaid Services (CMS) to establish regulations that protect residents and fellows impacted by program or hospital closure, which may include recommendations for:
A. Notice by the training hospital, intending to file for bankruptcy within 30 days, to all residents and fellows primarily associated with the training hospital, as well as those contractually matched at that training institution who may not yet have matriculated, of its intention to close, along with provision of reasonable and appropriate procedures to assist current and matched residents and fellows to find and obtain alternative training positions that minimize undue financial and professional consequences, including but not limited to maintenance of specialty choice, length of training, initial expected time of graduation, location and reallocation of funding, and coverage of tail medical malpractice insurance that would have been offered had the program or hospital not closed;

B. Revision of the current CMS guidelines that may prohibit transfer of funding prior to formal financial closure of a teaching institution;

C. Improved provisions regarding transfer of GME funding for displaced residents and fellows for the duration of their training in the event of program closure at a training institution; and

D. Protections against the discrimination of displaced residents and fellows consistent with H-295.969.

3. Our AMA will work with the Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, National Resident Matching Program, Educational Commission for Foreign Medical Graduates, Centers for Medicare and Medicaid Services, and other relevant stakeholders to identify a process by which displaced residents and fellows may be directly represented in proceedings surrounding the closure of a training hospital or program.

4. Our AMA will work with the Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, National Resident Matching Program, Educational Commission for Foreign Medical Graduates, Centers for Medicare and Medicaid Services, and other relevant stakeholders to:
   A. Develop a stepwise algorithm for designated institutional officials and program directors to assist residents and fellows with finding and obtaining alternative training positions;
   B. Create a centralized, regulated process for displaced residents and fellows to obtain new training positions; and
   C. Develop pathways that ensure that closing and accepting institutions provide liability insurance coverage to residents, at no cost to residents.

Principles for Graduate Medical Education H-310.929

Our AMA urges the Accreditation Council for Graduate Medical Education (ACGME) to incorporate these principles in its Institutional Requirements, if they are not already present.

1) PURPOSE OF GRADUATE MEDICAL EDUCATION AND ITS RELATIONSHIP TO PATIENT CARE. There must be objectives for residency education in each specialty that promote the development of the knowledge, skills, attitudes, and behavior necessary to become a competent practitioner in a recognized medical specialty.

Exemplary patient care is a vital component for any residency/fellowship program. Graduate medical education enhances the quality of patient care in the institution sponsoring an accredited program. Graduate medical education must never compromise the quality of patient care.

Institutions sponsoring residency programs and the director of each program must assure the highest quality of care for patients and the attainment of the program’s educational objectives for the residents.

2) RELATION OF ACCREDITATION TO THE PURPOSE OF RESIDENCY TRAINING. Accreditation requirements should relate to the stated purpose of a residency program and to the knowledge, skills, attitudes, and behaviors that a resident physician should have on completing residency education.

3) EDUCATION IN THE BROAD FIELD OF MEDICINE. GME should provide a resident physician with broad clinical experiences that address the general competencies and
professionalism expected of all physicians, adding depth as well as breadth to the competencies introduced in medical school.

(4) SCHOLARLY ACTIVITIES FOR RESIDENTS. Graduate medical education should always occur in a milieu that includes scholarship. Resident physicians should learn to appreciate the importance of scholarly activities and should be knowledgeable about scientific method. However, the accreditation requirements, the structure, and the content of graduate medical education should be directed toward preparing physicians to practice in a medical specialty. Individual educational opportunities beyond the residency program should be provided for resident physicians who have an interest in, and show an aptitude for, academic and research pursuits. The continued development of evidence-based medicine in the graduate medical education curriculum reinforces the integrity of the scientific method in the everyday practice of clinical medicine.

(5) FACULTY SCHOLARSHIP. All residency faculty members must engage in scholarly activities and/or scientific inquiry. Suitable examples of this work must not be limited to basic biomedical research. Faculty can comply with this principle through participation in scholarly meetings, journal club, lectures, and similar academic pursuits.

(6) INSTITUTIONAL RESPONSIBILITY FOR PROGRAMS. Specialty-specific GME must operate under a system of institutional governance responsible for the development and implementation of policies regarding the following: the initial authorization of programs, the appointment of program directors, compliance with the accreditation requirements of the ACGME, the advancement of resident physicians, the disciplining of resident physicians when this is appropriate, the maintenance of permanent records, and the credentialing of resident physicians who successfully complete the program. If an institution closes or has to reduce the size of a residency program, the institution must inform the residents as soon as possible. Institutions must make every effort to allow residents already in the program to complete their education in the affected program. When this is not possible, institutions must assist residents to enroll in another program in which they can continue their education. Programs must also make arrangements, when necessary, for the disposition of program files so that future confirmation of the completion of residency education is possible. Institutions should allow residents to form house staff organizations, or similar organizations, to address patient care and resident work environment concerns. Institutional committees should include resident members.

(7) COMPENSATION OF RESIDENT PHYSICIANS. All residents should be compensated. Residents should receive fringe benefits, including, but not limited to, health, disability, and professional liability insurance and parental leave and should have access to other benefits offered by the institution. Residents must be informed of employment policies and fringe benefits, and their access to them. Restrictive covenants must not be required of residents or applicants for residency education.

(8) LENGTH OF TRAINING. The usual duration of an accredited residency in a specialty should be defined in the “Program Requirements.” The required minimum duration should be the same for all programs in a specialty and should be sufficient to meet the stated objectives of residency education for the specialty and to cover the course content specified in the Program Requirements. The time required for an individual resident physician’s education might be modified depending on the aptitude of the resident physician and the availability of required clinical experiences.

(9) PROVISION OF FORMAL EDUCATIONAL EXPERIENCES. Graduate medical education must include a formal educational component in addition to supervised clinical experience. This component should assist resident physicians in acquiring the knowledge and skill base required for practice in the specialty. The assignment of clinical responsibility to resident physicians must permit time for study of the basic sciences and clinical pathophysiology related to the specialty.

(10) INNOVATION OF GRADUATE MEDICAL EDUCATION. The requirements for accreditation of residency training should encourage educational innovation and continual improvement. New topic areas such as continuous quality improvement (CQI), outcome
management, informatics and information systems, and population-based medicine should be included as appropriate to the specialty.

(11) THE ENVIRONMENT OF GRADUATE MEDICAL EDUCATION. Sponsoring organizations and other GME programs must create an environment that is conducive to learning. There must be an appropriate balance between education and service. Resident physicians must be treated as colleagues.

(12) SUPERVISION OF RESIDENT PHYSICIANS. Program directors must supervise and evaluate the clinical performance of resident physicians. The policies of the sponsoring institution, as enforced by the program director, and specified in the ACGME Institutional Requirements and related accreditation documents, must ensure that the clinical activities of each resident physician are supervised to a degree that reflects the ability of the resident physician and the level of responsibility for the care of patients that may be safely delegated to the resident. The sponsoring institution’s GME Committee must monitor programs’ supervision of residents and ensure that supervision is consistent with: (A) Provision of safe and effective patient care; (B) Educational needs of residents; (C) Progressive responsibility appropriate to residents’ level of education, competence, and experience; and (D) Other applicable Common and specialty/subspecialty specific Program Requirements. The program director, in cooperation with the institution, is responsible for maintaining work schedules for each resident based on the intensity and variability of assignments in conformity with ACGME Review Committee recommendations, and in compliance with the ACGME clinical and educational work hour standards. Integral to resident supervision is the necessity for frequent evaluation of residents by faculty, with discussion between faculty and resident. It is a cardinal principle that responsibility for the treatment of each patient and the education of resident and fellow physicians lies with the physician/faculty to whom the patient is assigned and who supervises all care rendered to the patient by residents and fellows. Each patient’s attending physician must decide, within guidelines established by the program director, the extent to which responsibility may be delegated to the resident, and the appropriate degree of supervision of the resident’s participation in the care of the patient. The attending physician, or designate, must be available to the resident for consultation at all times.

(13) EVALUATION OF RESIDENTS AND SPECIALTY BOARD CERTIFICATION. Residency program directors and faculty are responsible for evaluating and documenting the continuing development and competency of residents, as well as the readiness of residents to enter independent clinical practice upon completion of training. Program directors should also document any deficiency or concern that could interfere with the practice of medicine and which requires remediation, treatment, or removal from training. Inherent within the concept of specialty board certification is the necessity for the residency program to attest and affirm to the competence of the residents completing their training program and being recommended to the specialty board as candidates for examination. This attestation of competency should be accepted by specialty boards as fulfilling the educational and training requirements allowing candidates to sit for the certifying examination of each member board of the ABMS.

(14) GRADUATE MEDICAL EDUCATION IN THE AMBULATORY SETTING. Graduate medical education programs must provide educational experiences to residents in the broadest possible range of educational sites, so that residents are trained in the same types of sites in which they may practice after completing GME. It should include experiences in a variety of ambulatory settings, in addition to the traditional inpatient experience. The amount and types of ambulatory training is a function of the given specialty.

(15) VERIFICATION OF RESIDENT PHYSICIAN EXPERIENCE. The program director must document a resident physician’s specific experiences and demonstrated knowledge, skills, attitudes, and behavior, and a record must be maintained within the institution.
REFERENCES


7 Tanne J H. US Congress investigates effects of $80bn private equity industry on government healthcare programme. BMJ. 2020;370:m3490. doi:10.1136/bmj.m3490.


10 American Medical Association (AMA), Graduate Medical Education Database. AMA. Accessed May 21, 2022.


American Medical Association (AMA) Policy D-295.963 (5) calls on our AMA to:

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.

This report, which is in response to this directive, reviews the current status of the residency selection process, which has led to increasing pressures for both applicant and program; responses to those pressures; and the potential downstream consequences of the residency selection process on perpetuating demographic and socioeconomic inequities. (Note: This report uses the term “residency selection process” to comprise both residency and fellowship program selection.)

To provide context, the report starts by providing data regarding recent trends in application processing, including specific factors used by program directors when determining which applicants to interview for residency. Specific discussion about the use of “filters” of objective metrics is included. Next the report reviews three medical honor societies—Alpha Omega Alpha, Gold Humanism Honor Society, and Sigma Sigma Phi—and their efforts to address the perpetuation of inequities within their honoree selection processes.

Lastly, the report reviews various attempts, including several pilot programs, designed to optimize the residency selection process, including a review of various standardized tools and other innovations designed to help minimize the burden on program directors while ensuring ample opportunity for applicants and programs to find a good “fit” with each other. It concludes with recommendations calling for AMA action to promote equity in the residency application and selection process.
REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 2-I-22

Subject: Mitigating Demographic and Socioeconomic Inequities in the Residency and Fellowship Selection Process

Presented by: John P. Williams, MD, Chair

Referred to: Reference Committee C

American Medical Association (AMA) Policy D-295.963 (5) calls on our AMA to:

- 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.

This report is in response to that directive and encompasses a review of the current residency selection process, which has led to increasing pressures for both applicant and program; responses to those pressures, including the use of innovative processes and tools; and the potential downstream consequences of the residency selection process on perpetuating demographic and socioeconomic inequities. Examination of these issues is important as disparities in the medical student population are transmitted into residency and fellowship, as matriculants of U.S. medical schools comprise the largest pool of applicants to those programs.

BACKGROUND

Current Medical Student and Resident/Fellow Demographics

Racial, ethnic, socioeconomic, and geographic diversity is lacking in the physician workforce. A 2019 study of allopathic medical school programs revealed that, “Hispanic individuals are underrepresented among medical school applicants and matriculants by nearly 70% relative to the age-adjusted US population; black male applicants and matriculants, nearly 60%; black female applicants, nearly 30%; and black female matriculants, nearly 40%. Similarly, [American Indian and Alaska Native] AIAN individuals are underrepresented by more than 60% among applicants and matriculants.”

Likewise, data from the Association of American Medical Colleges (AAMC) for academic years 2018-2019 through 2021-22 show little appreciable change in disparities in socioeconomic status among applicants and matriculants to medical school as determined by parental occupation and highest level of education completed. Examination of family income of medical students also indicates a lack of diversity, with approximately three-quarters of medical school matriculants from the top two household-income quintiles—a distribution that has not changed in three decades.

Furthermore, Shipman et al. reported a 15-year decline in the number of medical students from rural areas, to fewer than five percent of all incoming medical students in 2017. In addition, fewer than 0.5 percent of new medical students in 2017 with rural backgrounds were from underrepresented racial/ethnic minoritized groups in medicine (URM). The authors conclude,
“Both URM and non-URM students with rural backgrounds are substantially and increasingly underrepresented in medical school. If the number of rural students entering medical school were to become proportional to the share of rural residents in the US population, the number would have to quadruple.”

Current trends, however, have shown positive outcomes stemming from efforts to diversify the physician workforce in recent years. For allopathic medical schools, the number of Black or African American students increased by 21.0 percent from 2020 to 2021, which is likely due to a 9.5 percent increase in matriculants (first-year students), with Black or African American men making the most significant gains. Likewise, matriculants who identify as Hispanic, Latino, or of Spanish origin increased by 7.1 percent (although American Indian or Alaska Native matriculants declined by 8.5 percent during this time period). While these gains are important, disparities remain.

Existing disparities in the applicant pool may also be exacerbated as URM applicants match disproportionately into certain specialties (e.g., primary care fields) versus more competitive and remunerative specialties (e.g., surgical subspecialties). Overall, these disparities influence the composition of the physician workforce, which may have repercussions for patient care. For example, studies have demonstrated that health outcomes are improved when there is racial concordance between physician and patient.

Residency Selection Process

After completion of medical school, nearly all medical students enter a residency program to continue their training. The competition for these programs can be intense, especially for some specialties with a limited number of residency positions. While competition between students is nothing new, the pressure felt by a student to match into a residency program in their specialty of choice has increased over recent years. A proxy measure for this perceived pressure is an increase in the number of applications per applicant.

<table>
<thead>
<tr>
<th></th>
<th>2017</th>
<th>2021</th>
<th>% change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Applicants using Electronic Residency Application Service (ERAS)</td>
<td>45,395</td>
<td>50,830</td>
<td>+12.0%</td>
</tr>
<tr>
<td>Average number of applications per applicant</td>
<td>90</td>
<td>101</td>
<td>+12.3%</td>
</tr>
<tr>
<td>Average number of applications received by program (all applicants)</td>
<td>1,206</td>
<td>1,058</td>
<td>-13.3%</td>
</tr>
<tr>
<td>Average number of applications received by program (USMGs only)</td>
<td>387</td>
<td>469</td>
<td>+21.2%</td>
</tr>
</tbody>
</table>

Source: [AAMC ERAS Statistics website](https://www.aamc.org/data/eras/statistics/)

The reasons for this increase in the number of applications per applicant are numerous and likely include the perception of an increasing number of students applying to a relatively static number of residency positions, the ever-increasing medical education debt in relation to potential future earning potential, and lifestyle priorities of younger generations. The increasing number of applications likely has been exacerbated since the onset of the COVID-19 pandemic, when residency interviews transitioned to a fully virtual format, thereby allowing students to apply to, accept, and conduct interviews at a larger number of programs.
This trend causes significant pressure on program directors, as the administrative burden to review such a large volume of applications per residency position can understandably lead to the use of objective metrics such as GPA, standardized test scores, or honor society membership to narrow a large pool of applications to a more manageable size for detailed review. Program directors can use these and other objective metrics that are reported on the ERAS application as searchable “filters” to help determine which candidates to consider.

The National Resident Matching Program (NRMP) program director survey provides insight into how program directors review applications and choose to offer interview positions. The 2021 survey showed the percentage of program directors (all specialties) who cite a specific factor when considering whether to offer an interview to an applicant and, for those who cite these factors, their average importance on a scale of 1 (not important at all) to 5 (very important). These factors can be broken out into those that reflect academic performance and those that reflect personal characteristics. The following tables highlight the top five factors identified for each category; see Appendix C for graphics illustrating the full data. (Note: The survey response rate was 24.3 percent.)

### Factors Reflecting Education and Academic Performance

<table>
<thead>
<tr>
<th>Factor</th>
<th>Percent Citing as a Factor</th>
<th>Average Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>United States Medical Licensing Examination® (USMLE®) Step 1 Score</td>
<td>86.2</td>
<td>3.7</td>
</tr>
<tr>
<td>Medical Student Performance Evaluation (MSPE/Dean’s Letter)</td>
<td>85.9</td>
<td>4.0</td>
</tr>
<tr>
<td>USMLE Step 2 CK Score</td>
<td>78.8</td>
<td>3.8</td>
</tr>
<tr>
<td>Grades in required clerkships</td>
<td>74.6</td>
<td>3.9</td>
</tr>
<tr>
<td>Any failed attempt at USMLE</td>
<td>74.1</td>
<td>4.4</td>
</tr>
</tbody>
</table>

### Factors Reflecting Personal Characteristics

<table>
<thead>
<tr>
<th>Factor</th>
<th>Percent Citing as a Factor</th>
<th>Average Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>Letters of recommendation in specialty</td>
<td>85.1</td>
<td>4.2</td>
</tr>
<tr>
<td>Personal statement (overall)</td>
<td>83.8</td>
<td>3.9</td>
</tr>
<tr>
<td>Diversity characteristics</td>
<td>80.9</td>
<td>4.1</td>
</tr>
<tr>
<td>Perceived commitment to specialty</td>
<td>79.5</td>
<td>4.3</td>
</tr>
<tr>
<td>Having overcome significant obstacles</td>
<td>75.5</td>
<td>4.1</td>
</tr>
</tbody>
</table>

While providing insight into what program directors consider important, this survey only tangentially looks at the process of filtering the objective metrics that are available through the ERAS application. Other data available in the same survey show that of those programs that use USMLE Step 1 scores in determining which applicants to interview, 60 percent use a set target score while 41 percent require only a passing score. These numbers are 68 percent and 25 percent, respectively, for those programs that screen using USMLE Step 2 CK. Comparable data for graduates of osteopathic medical school programs who take the Comprehensive Osteopathic Medical Licensing Examination of the United States (COMLEX-USA) Level 1 are 51 percent and 31 percent, respectively, with COMLEX-USA Level 2-CE scores 57 percent and 23 percent, respectively. (Note: These data on USMLE and COMLEX were gathered before conversion of USMLE Step 1 and COMLEX Level 1 reporting to pass/fail, which may have impact on program interpretation of Step 1/Level 1 and Step 2/Level 2 scores.)
It should be noted that while considering academic performance as a factor in choosing whom to interview, the weight provided to those factors is relatively low compared to some other factors, with the exception of “any USMLE failure.” Still, a significant number of programs acknowledge filtering applicants based upon academic performance on standardized exams.

One positive sign is that a significant number of program directors use an applicant’s diversity characteristics as an influence on their decision regarding whether to interview that applicant. This practice is in alignment with the intent of the Common Program Requirements of the Accreditation Council for Graduate Medical Education, which state that residency programs and their sponsoring institutions “must engage in practices that focus on mission-driven, ongoing, systematic recruitment and retention of a diverse and inclusive workforce of residents, fellows, faculty members, senior administrative staff members and other relevant members of the academic community.”

Overall, in the 2021 Residency Match, the average number of residency positions for all programs was nine, for which the average number of applications received by a program was 1,013. Of these applications, 506 (49.9 percent) were rejected based upon a standardized screening process and 423 (41.8 percent) received an in-depth holistic review.

Although these data do not provide information on what the standardized screening process entailed, one survey of internal medicine program directors (who can receive up to 3,000 applicants per program) found that USMLE Step 2 CK score, USMLE Step 1 score, and attendance at a specific medical school were the top three filters used for initial application review.

While evidence is limited, there is concern that the use of test scores for this type of initial screening review may introduce and exacerbate racial and socioeconomic biases into the selection process. Numerous studies have demonstrated the link between standardized tests—common in K-12 as well as higher education, along with the medical education continuum—and perpetuation of racial and socioeconomic bias. It is not the examinations themselves, however, that are the issue (for example, the Medical College Admission Test, or MCAT, for which the psychometric literature shows no evidence of bias) but rather the larger and more insidious patterns of systemic racism, which limit economic success and educational opportunity for minoritized populations.

Finally, and most importantly, research shows that the ability to pass a test is not especially relevant to one’s ability to provide quality medical care. Emotional intelligence, empathy, and communication are more valuable to the successful practice of medicine than sheer raw intelligence. Indeed, as Lucey and Saguil note, “the MCAT exam is designed to measure applicants’ academic preparation for medical school . . . not . . . to measure or predict their performance related to other, essential competencies, such as interpersonal skills and communication, professionalism, and ethical behavior, or to take the place of other attributes that nonexam aspects of the admissions process evaluate.”

MEDICAL HONOR SOCIETIES AND THEIR ROLE IN RESIDENCY SELECTION

Background

Similar to concerns about overreliance on standardized testing for advancement in higher education and medical education, the use of medical honor society membership to screen applicants has become a subject of increasing scrutiny in recent years. The next section considers three medical honor societies, their role in the residency selection process, and their respective work to increase attention to diversity and equity.
Alpha Omega Alpha

Formed in 1902, Alpha Omega Alpha (AΩA) has as its mission recognizing high educational achievement, honoring gifted teaching, encouraging the development of leaders in academia and the community, supporting the ideals of humanism, and promoting service to others. With over 200,000 members, AΩA has chapters in the majority of Liaison Committee on Medical Education (LCME)-accredited medical schools in the US, including all historically Black colleges and universities (HBCUs).

According to the AΩA website, “Membership in AΩA may be attained as a medical student, resident, fellow, faculty member, alumni, clinician, or distinguished leader in medicine. Each school may elect up to 20% of the graduating class of students, up to 25 residents/fellows, up to 10 faculty, and three to five alumni, who, based on merit, demonstrate the characteristics of excellent physicians in alignment with AΩA’s mission and values.” Each chapter makes decisions on proposed members in alignment with that institution’s mission statement. As to diversity of membership, individual chapters may collect those data, but at the national level, the AΩA collects only member name, school, year of induction, and contact information (along with specialty if provided by the member).

Gold Humanism Honor Society

The Gold Foundation was founded in 1988 to preserve and elevate the tradition of humanism in health care. To focus and enhance the foundation’s efforts, the Gold Humanism Honor Society (GHHS) was founded in 2002; this international program now comprises 180 chapters and has close to 45,000 members. As stated in a February 7, 2022, memorandum from the Gold Foundation to the AMA (see Appendix A), the GHHS “identifies medical student exemplars of humanism using a validated, peer-nomination system.” No information is available regarding the diversity of its membership.

Sigma Sigma Phi

Founded in 1921, Sigma Sigma Phi (SSP) is an honorary service organization for osteopathic medical students who are selected by peers. Selection into SSP includes a blinded process that considers a minimum grade requirement and good standing by the medical school and then predominately the contributions made by the candidate to serve the community and humanity. Membership is open to all who apply and meet the minimum standards and is limited to no more than 25 percent of the total population of the student body. Students must have completed at least one semester of classroom work and show a high degree of scholarship and service to the college and/or profession. The SSP website lists 47 chapters as of February 2022. No information is available regarding the diversity of its membership.

Role of honor societies in the residency selection process

Medical honor societies are intended to recognize excellence in academic achievement and other markers of future success as physicians, including scholarship, aptitude for research, humanism, and professionalism. As with other variables previously mentioned, induction into these organizations may be used by program directors and other program personnel to evaluate applicants during the residency selection process; evidence suggests, however, that this factor is not as important as others.
In the 2021 NRMP data set, student membership in AΩA was 13th on the list of important factors of an applicant, cited by 50.6 percent of program directors. Comparable data showed GHHS membership at 14th (50.5 percent) and SSP membership at 22nd (21 percent).

**Concern about perpetuating disparities**

Despite the perceived value of recognizing excellence, medical honor societies have come under criticism in recent years as potentially exclusionary if not antithetical to efforts to increase equity, diversity, and belonging (EDB) in medical education and practice. One of the first institutions to address this concern was the Icahn School of Medicine at Mount Sinai, which in 2018 put a moratorium on student nominations to AΩA because it determined the selection process discriminates against students of color. Additionally, in May 2020, the University of California – San Francisco School of Medicine announced that it was suspending its AΩA affiliation, beginning with the class of 2021, stating, in part, that the selection process and membership limitations may subvert efforts toward increased equity, through a misplaced emphasis on grades, assessments, and performance and demonstrated bias against non-white students.

Evidence to support these concerns exists. One study, published in *JAMA*, found that, “the odds of AΩA membership for white students were nearly 6 times greater than those for black students and nearly 2 times greater than for Asian students” which “may undermine the pipeline of minorities entering the academic health care workforce.” Other research shows that these trends extend beyond race/ethnicity to socioeconomic status, as students from backgrounds with lower income than their peers were less likely to be AΩA members. This phenomenon has been described as an “amplification cascade,” in which “small differences in assessed performance lead to larger differences in grades and selection for awards,” such that medical students from populations underrepresented in medicine (UIM) “received approximately half as many honors grades as not-UIM students and were three times less likely to be selected for honor society membership.”

**Addressing disparities in medical honor society selection**

AΩA

The upper limit for the percentage of medical student electees from a given chapter rose from 16 percent to 20 percent in October 2020, when the organization changed its constitution. This change was intended to help reduce the focus on grades as one of the highest determinants of achievement and instead highlight character attributes such as “trustworthiness, character, caring, knowledge, scholarship, proficiency in the doctor-patient relationship, leadership, compassion, empathy, altruism, and servant leadership,” as described on the AΩA website. The move reflects changes at many medical schools to eliminate or reduce grading and use a more holistic approach to selection and advancement.

In 2020, AΩA declared a renewed focus on EDB to mitigate both conscious and unconscious bias in medical education, including assessments of medical students, resident physicians, and faculty in the nominations, selection, and election processes for the AΩA. These principles are reflected in a statement on the AΩA website, which notes that the organization “advocates for diversity in all of its forms – identity, cultural, geographic, experiential, race, ethnicity, gender, age, economic and social status, physical abilities, aptitude, and religious beliefs, political beliefs, and other ideologies.” In addition, an AΩA award recognizes medical schools that “demonstrate exemplary leadership, innovation, and engagement in fostering an inclusive culture that transforms the ideals of inclusion, diversity, and equity into successful programs.” This work has also included efforts to increase the diversity of the AΩA board. Potential future reforms include the annual reporting of
member demographic data; standardized, transparent criteria for selecting members that mitigate
the potential for bias; and increased diversity within organizational leadership. Individual chapters
also have a role to play, through such actions as implementing holistic review of potential members
and annually reviewing newly elected cohorts to ensure that they match the institution’s overall
demographics. 18

GHHS

In the memo noted above, the Gold Foundation states, “In the past 23 months, the foundation and
the GHHS have pivoted to respond vigorously to the challenges of COVID-19 and have redoubled
our efforts to address [diversity, equity, and inclusion] in response to the racial reckoning following
George Floyd’s murder to support healthcare in which human interests, values, and dignity
predominate.” One of the organization’s actions in this regard is the 2020-2021 GHHS national
initiative, “Humanism and Healing: Structural Racism and its Impact on Medicine,” which was
followed by a virtual conference of the same name hosted by GHHS. In addition, the Gold
Foundation is engaged in a continuous improvement project to determine best practices in diversity
and inclusivity through work with the AAMC and individual GHHS chapters. To further the
collective understanding of this issue, the Foundation and GHHS are also conducting research on
the socio-demographic makeup of GHHS members to determine where differences exist to mitigate
future issues. The results of this analysis are forthcoming.

SSP

Related to diversity of applicants or honorees, SSP staff indicate that such data are not tracked at
the national level, but that meetings with chapter presidents and review of the lists of graduating
seniors indicate an appropriate level of diversity. Staff added, “At this point we see no problems
with the selection process. This has not been an issue or a problem with our organization, but if this
is brought up and becomes a concern, we are ready to do whatever needs to be done to address this
situation.”

That said, it is important to provide context and note that DO schools report even lower levels of
diversity than allopathic schools. Data from the AAMC and the American Association of Colleges
of Osteopathic Medicine Application Services (AACOMAS) show a medical school matriculation
rate of 16.9 percent for URM individuals entering allopathic programs19 versus 12.1 percent for
osteopathic programs.20 In short, the “appropriate” level of diversity may be proportionate to the
overall level of diversity in a given field, but that does not mitigate the core issue of inequity.

ATTEMPTS TO OPTIMIZE THE RESIDENCY SELECTION PROCESS

Standardized Tools

In 2018, the AAMC piloted a standardized video interview (SVI) for emergency medicine
programs, with the intent of providing a useful supplementary tool for selecting applicants to
interview. Its intent was to measure knowledge of professional behaviors along with interpersonal
skills and communication. The SVI, however, was discontinued after three cycles due to lack of
interest among both applicants and program directors. A letter from key stakeholders in emergency
medicine to the AAMC delineated three reasons for the program’s dissolution: “lack of evidence to
support the SVI as an assessment tool, uncertainty around the cost of the program, and student
perceptions.”21
In addition to helping program directors decide which applicants to interview, it was hoped that use of the SVI would reduce bias in the selection process, as the interviews were scored by trained reviewers not associated with the programs, and the performance of those reviewers was subject to quality control. During the pilot phase, however, this standardized approach was subverted, in that the videos were shared with programs in addition to the scores.

Other standardized approaches to ranking applicants include CASPer (Computer-based Assessment for Sampling Personal characteristics (https://takealtus.com/casper/), an online, open-response situational judgment test. CASPer is used by some medical schools in the application process and has seen limited but increasing use in the residency selection process as well. For the 2022-23 application cycle, ophthalmology is piloting the use of the Altus Suite for Graduate Medical Education, comprising supplemental applications that include CASPer and two other tests:

- Snapshot, a one-way video interview designed to assess communication skills, self-reflection, and motivation for the profession, and
- Duet, designed to assess alignment of values between an applicant and a program.

One article notes the use of CASPer in some general surgery residency programs led to a greater number of interview offers to applicants from minoritized populations. With growing interest in ensuring professionalism, communication skills, and emotional intelligence among the physician workforce, the use of this and similar tools may grow. Currently, these are either used too infrequently or by so few programs that evidence is lacking to support or refute their use, especially in the context of equity.

Another tool, described in a 2017 study, “validates a process for selecting and weighting components of the ERAS application and interview day to create a customizable, institution-specific tool for ranking candidates to postgraduate medical education programs.” The authors do not discuss whether this tool might have any impact on equity or diversity of applicants.

Holistic Review

Holistic review of applicants to medical school has been defined as “a flexible, individualized way of assessing an applicant’s capabilities by which balanced consideration is given to experiences, attributes, and academic metrics… and, when considered in combination, how the individual might contribute value as a medical student and future physician.” The authors of a 2021 NEJM Perspective note that holistic review “has been shown to enhance diversity without affecting the average grade-point average or exam scores for the entering class.” Extending this process, holistic review has been encouraged to mitigate biases in the residency selection process and shift focus to factors associated with success in residency.

While holistic review is viewed favorably by most, its practical use continues to face significant barriers. Widespread adoption is hampered by the growing number of residency applications, which exacerbates the administrative burden of reviewing a large volume of applications per open residency slot and can lead to the use of objective metrics to filter applications. One experiment seeks to use augmented intelligence and “big data” as tools for holistic screening of applicants to improve the process at the medical school admissions level. Research at New York University Grossman School of Medicine used clustering and other statistical techniques to develop profiles or “signatures” that charted the academic success and trajectory of four different types of applicants—“riskers,” “improvers,” “solids,” and “statics.” Using this approach “can more sensitively uncover success potential since it takes into account the inherent heterogeneity within the student population.”
Supplemental ERAS Application and Preference Signaling

A recent effort by the AAMC, the Supplemental ERAS Application, seeks to empower applicants to share more information about themselves using a fair process and driving holistic review in the context of a high volume of applications. A list of FAQs on the AAMC website (see https://students-residents.aamc.org/applying-residencies-eras/supplemental-eras-application-faq) indicates that the application is “intended to help programs better identify applicants who are genuinely interested in their program, and whose interests and experience align well with the program’s setting, mission, and goals.” The supplemental application comprises three sections: past experiences about the applicant’s most meaningful work, volunteer or research experiences; geographic information (by region and by urban/rural setting); and preference signals for specific programs. It shows promise as a vehicle to communicate information more relevant to residency selection in these early pilots, but its impact on equity is still unknown. Use of the supplemental application is growing, from the three fields of dermatology, general surgery, and internal medicine in 2021 to 16 specialties planning to use it for the 2023 ERAS season, representing more than 2,900 programs.

Interview capping

In response to the COVID-19 pandemic, ophthalmology, which participates in the San Francisco Match and thus has a different match timeline compared to most other specialties, has placed caps on the number of programs to which a student can apply.29 This cap is currently at 15 programs for the 2022-23 application cycle.

AMA ChangeMedEd Initiative

The AMA funds a number of collaborative projects to address the transition from medical school to residency. During its ChangeMedEd® 2021 conference, for example, the AMA funded three submissions out of an initial pool of 135 applicants from institutions or collaborations related to improving EDB in medical education. One program looks to view medical student evaluation and assessment through an equity lens to make needed changes that support increased diversity. The other two aim to help future physicians representing first-generation college attendees and students from socioeconomically disadvantaged backgrounds make the transition from community college to medical school in an expeditious and cost-effective way and to provide mentorship and physician role models to young people considering a career in medicine.30

RELEVANT AMA POLICY

The AMA has a number of policies related to increased diversity in medical education and (ultimately) practice, as shown in Appendix B. In particular, edits to D-200.985, “Strategies for Enhancing Diversity in the Physician Workforce,” are noted in this report’s recommendations, to extend policy in favor of holistic review from solely medical school admissions to encompass residency/fellowship program application as well.

CONCLUSION

A 2020 article describes the opportunity for reform in the program application, interview, and matching process occasioned by the pandemic and the potential for positive impact related to EDB: “This transformation to virtual interviews may allow us to reconsider how our present systems perpetuate sociocultural biases.” The article also notes, “In the current social climate, it is
incumbent on program leaders to consider their own processes to minimize bias—both at a personal level for their interviewers, but also at a systemic level within the systems we use.31

A related article from the same authors, in a three-part series on recruiting, interviewing, and ranking residency program applicants, calls on program leadership to “deliberately incorporate procedures that ensure equity.”32 When considering equity, virtual interviews have both pros and cons. On the plus side, students with less means, who were not as able as their more affluent peers to travel to multiple interviews, had greater access via virtual interviews. On the other hand, candidates and programs may not attain a true sense of each other, making ranking difficult and likely defaulting to familiarity and certainty, as opposed to choosing the best “fit.” This may perpetuate existing bias. A secondary concern is the potential for a digital divide, with some candidates lacking the technology and/or expertise with visual rhetoric to ensure a professionally enhancing video image; this may also exacerbate existing inequities.

In their 2020 article, Lucey et al. classify equity in medical assessment and advancement as a “wicked problem”—in other words, one that is multilayered, complex, complicated, and rife with inherent conflict and dynamic tensions.33 Addressing this problem will require continued innovation and sustained attention.

SUMMARY AND RECOMMENDATIONS

The current pressures related to the residency selection process contributed to the use of readily accessible comparative metrics (e.g., membership in one or more medical honor societies) when determining which applicants to interview. Overreliance on these “objective” measures can unintentionally perpetuate inequities and inhibit diversity in medical education. The current pressures related to the residency selection process contributed to the use of readily accessible comparative metrics (e.g., membership in one or more medical honor societies) when determining which applicants to interview. However, measures once viewed as objective can unintentionally perpetuate inequities and inhibit diversity in medical education. Numerous projects are underway to optimize the residency selection process, including several sponsored by our AMA. Moving forward, the profession must develop a resident selection process that is mutually beneficial for applicants as well as program directors and institutions, while ensuring a commitment to a diverse, equitable, and inclusive workforce.

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

1. That our AMA 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 and residency/fellowship programs 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 with the goal of improving health care for all communities. (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)

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)

Fiscal note: $1,000.
This briefing by The Arnold P. Gold Foundation (Gold Foundation) is in response to the request from the American Medical Association (AMA) for information on honor societies in American medical schools as they relate to equity and diversity in medical education and practice.

The Gold Foundation was founded in 1988 to preserve and elevate the tradition of humanism in healthcare (see https://www.gold-foundation.org/). As a means to focus and enhance the foundation’s efforts, we created the Gold Humanism Honor Society (GHHS) in 2002 (https://www.gold-foundation.org/programs/ghhs/), and it now is an international program with 180 chapters and close to 45,000 members.

As an expression of the Gold Foundation itself, and as described below, the GHHS identifies medical student exemplars of humanism using a validated, peer-nomination system (McCormack et al., 2007). In the past 23 months, the foundation and the GHHS have pivoted to respond vigorously to the challenges of COVID-19 and have redoubled our efforts to address DEI in response to the racial reckoning following George Floyd’s murder to support healthcare in which human interests, values, and dignity predominate.

We appreciate that AMA is also working on ensuring diversity and equity in medical education and practice, and we are pleased to share these updates on our work with the AMA House of Delegates. Should you have any questions regarding this response, please let us know.
Response to AMA regarding the GHHS in American Medical Education and Practice

The Gold Foundation established the Gold Humanism Honor Society (GHHS) twenty years ago as a signature program to recognize exemplary medical students, residents, and faculty who practice patient-centered care by modeling the qualities of integrity, excellence, compassion, respect, and empathy.

What began in 2002 at only a few medical schools now includes 180 chapters, with more than 3,000 students inducted each year and a total membership that numbers close to 45,000. The GHHS is an active society promoting humanism within medical schools and hospitals. Chapters participate in annual programs such as Thank a Resident Day and Solidarity Week for Compassionate Patient Care, and also undertake individual chapter-initiated projects on their campuses and within their communities. GHHS members are expected to be leaders of humanism on their campus and throughout their careers.

The GHHS leadership structure includes a national Advisory Council of 23 members comprising both the career stages and the broad functions represented in healthcare and academic medicine. The Advisory Council provides guidance and support to the society with committees and working groups, and the GHHS Advisory Council Chair and the Chair-Elect sit on the Gold Foundation Board of Trustees. Medical schools wishing to start a GHHS chapter apply and are thoroughly vetted. As noted, student selection into a GHHS chapter is based on peer nomination using a validated tool (McCormack et al., 2007). The initial group of peer-nominated students is then typically evaluated by a selection committee that considers academic eligibility, program director evaluations, an additional essay, interview, or other indication of the nominee’s demonstrated humanism. While GHHS allows for some flexibility, all selection processes are vetted and approved when a medical school applies for a chapter and then reviewed periodically thereafter.

The Gold Foundation has long understood that equity, diversity, and inclusion are part of the very fabric of humanism. This was further spurred by the pandemics of COVID-19 and racism, which have highlighted inequalities and disparities, and compelled a closer look at flaws within our healthcare system. Within this broad context, the Gold Foundation reviewed all its programming through the lens of diversity, equity, inclusion, and anti-racism and has placed explicit emphasis on these issues within our work and strategic plan. (Click to read Gold Foundation statement on diversity, equity, inclusion and anti-racism)

The GHHS has specifically addressed this topic throughout the past two years in a number of ways, including:

1. Engaging a researcher to assess the demographics of GHHS
2. Establishing a National Initiative in 2020-21 for chapters on the impact of structural racism in medicine, which concluded with a large international conference in May 2021 to share what had been learned, as well as steps that schools and systems could take to begin addressing racism in medicine
3. Engaging in a continuous improvement project to determine best practices in diversity and inclusivity through work with the AAMC and individual GHHS chapters.
Research on GHHS Demographics

While racial/ethnic disparities in Alpha Omega Alpha (AΩA) membership have been documented (Boatright et al., 2017) and formally responded to by the AΩA (Byyny et al., 2020), less is known about how the demographic composition of GHHS reflects the diversity of medical schools nationally. One study of GHHS published in Academic Medicine in 2019 demonstrated no difference in the likelihood of Black or African-American medical students being inducted into GHHS compared to white medical students (Wijesekera, et al., 2019).

Recognizing the importance of more deeply understanding the demographic composition of our members, the Gold Foundation decided in 2020 to reach out to an academic researcher to examine this issue. With the assistance of a Gold Foundation Board of Trustees advisory committee, Dr. D owin Boatright, MD, MBA, MHS, Assistant Professor of Emergency Medicine and Officer for Diversity and Inclusion at Yale School of Medicine, was identified and agreed to include GHHS in his work.

Dr. Boatright and his research team are examining the association between GHHS membership and several aspects of student identity including race/ethnicity, sex, sexual orientation, and socioeconomic status (SES) in a national cohort of medical students. Although the results are preliminary and currently unpublished, per Dr. Boatright, so far, they are finding no disparities by sex, sexual orientation, or SES. Additionally, they are finding no difference in the likelihood of membership between Black, Hispanic, and Native American students and white students, but they are seeing some differences between white and Asian students favoring white students. The cause of this disparity is unknown and warrants further examination (D. Boatright, personal communication, January 19, 2022). Dr. Boatright expects to finalize his analysis and publish later this year, and the Gold Foundation has committed to supporting open access publication of this research.

The Gold Foundation is committed to continuing to transparently assess, understand, and address inequities. To that end, Dr. Boatright notes:

“Disparities in honor society membership are important to acknowledge and address. Nevertheless, it is unclear if removing honor societies from the ERAS application will solve the underlying problem contributing to these disparities nor ameliorate the downstream implication of these disparities on the physician workforce as medical students could always self-report honor society membership on the ERAS application.

Instead, it is likely more important for honor societies, like GHHS, to continuously examine honor society membership for systematic disparities and investigate evidence-based interventions to ensure equity in membership. Moreover, honor societies should be transparent in their findings and make data concerning disparities public. Additionally, as GHHS is committed to doing, the national honor societies should work with local chapters to promote equity and inclusion in membership selection.” (D. Boatright, personal communication, January 19, 2022)
GHHS Programmatic Focus on Diversity, Equity, Inclusion and Anti-Racism

GHHS chapters have undertaken many projects dedicated to serving populations most in need. Recent projects include: Engagement in Justice in Middle Tennessee and the Nation (Vanderbilt), Chicago Street Medicine (University of Chicago, Illinois), The Invisible Minority: Healthcare Disparities in Appalachia (West Virginia University), How We Heal: Applying Structural Competency to Care for Immigrant Communities (UC Riverside), and many others.

The events of 2020 compelled GHHS leadership to create a focused National Initiative for 2020-2021 titled “Humanism and Healing: Structural Racism and its Impact on Medicine.” Chapters were encouraged to use their leadership roles to start or extend conversations about racism and its impact on healthcare in their local communities and beyond, to create space for grieving, processing, and bearing witness around this topic, or to take action in one of many powerful ways that humanism can begin to heal. Chapter projects included such activities as:

- Creation of an anti-racism library collection (Cooper Medical School)
- Video Vignettes of Bias and Racism workshop (Central Michigan University)
- Panel discussion titled “A Calculated Risk: Engaging with Black Patients in Discussion About the Covid-19 Vaccine” (Emory University)
- Panel discussion titled “Fad-vocacy Armchair Empathy: Maintaining Social Justice Momentum” (joint project with Howard University and University of Michigan)
- Panel discussion titled “The Dismissal of Black Suffering” (University of California Irvine)
- Panel discussion titled “Medical Students Partner and Learn from Women Who are Incarcerated” (GHHS member Michelle Harper, MD, and the Ohio State University)

The National Initiative concluded with a large virtual conference on May 6-8, 2021. The conference, hosted by GHHS, included presentations from GHHS members (including panel discussions, workshops, and poster sessions) as well as many other Gold Foundation partners. Keynote presentations included:

- “The Ultimate ‘Anti-Racism Statement’ that Medicine Can Make is to Diversify Our Ranks” (Quinn Capers, MD, Associate Dean for Faculty Diversity and Vice Chair for Diversity and Inclusion, Department of Internal Medicine, UT Southwestern)
- “Partnership with HBCUs: Challenging Systemic Racism in Health Education, A Nursing Story” (Dr. Gina S. Brown, Dean, College of Nursing and Allied Health Sciences at Howard University; Dr. Eileen Sullivan-Marx, Dean of the New York University Rory Meyers College of Nursing; Dr. George Thibault (Ignitor), Immediate Past President of the Josiah Macy Junior Foundation)
- “COVID-19 and the Racial Reckoning” (Dr. Richard I. Levin, President and CEO of the Gold Foundation; Dr. Wayne Riley, President of SUNY Downstate Health Sciences University)

Many insightful and thought-provoking sessions encouraging participants to work toward increased health equity and racial equality were part of the conference, including a panel discussion on advocacy and grassroots change, a film screening of Black Men in White Coats, a panel on vaccine deliberation, and many more. The 2021-23 GHHS International Initiative expands on this work, titled “Healing the Heart of Healthcare: Reimagining How We Listen, Connect and Collaborate.” GHHS members are leaders in humanism and will, with Gold Foundation support, continue to work toward greater diversity, equity, and inclusion within healthcare for years to come.
Continuous Improvement Project to Determine Best Practices in Diversity and Inclusivity

The Gold Foundation is continually working with GHHS chapters to provide guidance and determine best practices for ensuring that membership is inclusive and diverse. Currently, the GHHS leadership is nearing the conclusion of a biennial check-in with chapters. The 2021 check-in added questions to gather information regarding how each chapter is working to ensure and improve diversity and inclusion within its selection process, including members of the selection committee. The Gold Foundation is concurrently working with the AAMC to consider URM medical student representation within chapters as it compares with each chapter’s medical school at large. These efforts will be used to create best practice strategies for GHHS chapters to ensure inclusivity and diversity.

Summary

The Gold Foundation established the Gold Humanism Honor Society (GHHS) twenty years ago as a signature program to recognize exemplary medical students, residents, and faculty who practice patient-centered care by modeling the qualities of integrity, excellence, compassion, respect, and empathy. What began in 2002 at only a few medical schools now includes 180 chapters, with more than 3,000 students inducted each year, and a membership that numbers close to 45,000. The Gold Foundation is committed to ensuring that the society is diverse and inclusive.

- Research on GHHS demographic makeup is underway by a Yale research team led by Dr. Dovin Boatright. Publication is expected shortly.
- The 2020-2021 GHHS National Initiative, “Humanism and Healing: Structural Racism and its Impact on Medicine,” was followed by a virtual conference of the same name hosted by GHHS.
- The Gold Foundation is engaged in a continuous improvement project to determine best practices in diversity and inclusivity through work with the AAMC and individual GHHS chapters.
APPENDIX B: RELEVANT AMA POLICY


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

2. Our AMA will work to obtain full restoration and protection of federal Title VII funding, and similar state funding programs, for the Centers of Excellence Program, Health Careers Opportunity Program, Area Health Education Centers, and other programs that support physician training, recruitment, and retention in geographically underserved areas.

3. Our AMA will take a leadership role in efforts to enhance diversity in the physician workforce, including engaging in broad-based efforts that involve partners within and beyond the medical profession and medical education community.

4. Our AMA will encourage the Liaison Committee on Medical Education to assure that medical schools demonstrate compliance with its requirements for a diverse student body and faculty.

5. Our AMA will develop an internal education program for its members on the issues and possibilities involved in creating a diverse physician population.

6. Our AMA will provide on-line educational materials for its membership that address diversity issues in patient care including, but not limited to, culture, religion, race and ethnicity.

7. Our AMA will create and support programs that introduce elementary through high school students, especially those from groups that are underrepresented in medicine (URM), to healthcare careers.

8. Our AMA will create and support pipeline programs and encourage support services for URM college students that will support them as they move through college, medical school and residency programs.

9. Our AMA will recommend that medical school admissions committees use holistic assessments of admission applicants that take into account the diversity of preparation and the variety of talents that applicants bring to their education.

10. Our AMA will advocate for the tracking and reporting to interested stakeholders of demographic information pertaining to URM status collected from Electronic Residency Application Service (ERAS) applications through the National Resident Matching Program (NRMP).

11. Our AMA will continue the research, advocacy, collaborative partnerships and other work that was initiated by the Commission to End Health Care Disparities.

12. Our AMA opposes legislation that would undermine institutions' ability to properly employ affirmative action to promote a diverse student population.

13. Our AMA will work with the AAMC and other stakeholders to create a question for the AAMC electronic medical school application to identify previous pipeline program (also known as pathway program) participation and create a plan to analyze the data in order to determine the effectiveness of pipeline programs.

D-295.963, “Continued Support for Diversity in Medical Education”

1. Our American Medical Association will publicly state and reaffirm its stance on diversity in medical education.
2. Our AMA will request that the Liaison Committee on Medical Education regularly share statistics related to compliance with accreditation standards IS-16 and MS-8 with medical schools and with other stakeholder groups.

(H-295.888, “Progress in Medical Education: the Medical School Admission Process”)

1. Our AMA encourages: (A) research on ways to reliably evaluate the personal qualities (such as empathy, integrity, commitment to service) of applicants to medical school and support broad dissemination of the results. Medical schools should be encouraged to give significant weight to these qualities in the admissions process; (B) premedical coursework in the humanities, behavioral sciences, and social sciences, as a way to ensure a broadly-educated applicant pool; and (C) dissemination of models that allow medical schools to meet their goals related to diversity in the context of existing legal requirements, for example through outreach to elementary schools, high schools, and colleges.
2. Our AMA: (A) will continue to work with the Association of American Medical Colleges (AAMC) and other relevant organizations to encourage improved assessment of personal qualities
in the recruitment process for medical school applicants including types of information to be solicited in applications to medical school; (B) will work with the AAMC and other relevant organizations to explore the range of measures used to assess personal qualities among applicants, including those used by related fields; (C) encourages the development of innovative methodologies to assess personal qualities among medical school applicants; (D) will work with medical schools and other relevant stakeholder groups to review the ways in which medical schools communicate the importance of personal qualities among applicants, including how and when specified personal qualities will be assessed in the admissions process; (E) encourages continued research on the personal qualities most pertinent to success as a medical student and as a physician to assist admissions committees to adequately assess applicants; and (F) encourages continued research on the factors that impact negatively on humanistic and empathetic traits of medical students during medical school.


H-65.952, “Racism as a Public Health Threat”

1. Our AMA acknowledges that, although the primary drivers of racial health inequity are systemic and structural racism, racism and unconscious bias within medical research and health care delivery have caused and continue to cause harm to marginalized communities and society as a whole.
2. Our AMA recognizes racism, in its systemic, cultural, interpersonal, and other forms, as a serious threat to public health, to the advancement of health equity, and a barrier to appropriate medical care.
3. Our AMA will identify a set of current, best practices for healthcare institutions, physician practices, and academic medical centers to recognize, address, and mitigate the effects of racism on patients, providers, international medical graduates, and populations.
4. Our AMA encourages the development, implementation, and evaluation of undergraduate, graduate, and continuing medical education programs and curricula that engender greater understanding of: (a) the causes, influences, and effects of systemic, cultural, institutional, and interpersonal racism; and (b) how to prevent and ameliorate the health effects of racism.
5. Our AMA: (a) supports the development of policy to combat racism and its effects; and (b) encourages governmental agencies and nongovernmental organizations to increase funding for research into the epidemiology of risks and damages related to racism and how to prevent or repair them.
6. Our AMA will work to prevent and combat the influences of racism and bias in innovative health technologies.

(Res. 5, I-20)
APPENDIX C – NRMP PROGRAM DIRECTOR SURVEY RESULTS

Source:
Results of the 2021 NRMP Program Director Survey.
National Resident Matching Program, August 2021.
Figure PD_13

**Personal Characteristics and Other Knowledge of Applicants Considered in Deciding Whom to Interview (%)**

<table>
<thead>
<tr>
<th>Feature</th>
<th>Percent of Respondents Endorsing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Letters of recommendation in specialty</td>
<td>85.1</td>
</tr>
<tr>
<td>Personal statement (overall)</td>
<td>83.8</td>
</tr>
<tr>
<td>Diversity characteristics</td>
<td>80.9</td>
</tr>
<tr>
<td>Perceived commitment to specialty</td>
<td>79.6</td>
</tr>
<tr>
<td>Having overcome significant obstacles</td>
<td>75.5</td>
</tr>
<tr>
<td>Professionalism and ethics</td>
<td>73.9</td>
</tr>
<tr>
<td>Perceived interest in program</td>
<td>72.3</td>
</tr>
<tr>
<td>Leadership qualities</td>
<td>70.1</td>
</tr>
<tr>
<td>Volunteer/extracurricular experience</td>
<td>64.8</td>
</tr>
<tr>
<td>Personal prior knowledge of applicant</td>
<td>63.6</td>
</tr>
<tr>
<td>Other life experience</td>
<td>62.8</td>
</tr>
<tr>
<td>Audition elective/rotation in PD's dept</td>
<td>44.8</td>
</tr>
<tr>
<td>Involvement and interest in research</td>
<td>41.1</td>
</tr>
<tr>
<td>Ability to work legally w/o visa</td>
<td>35.5</td>
</tr>
<tr>
<td>Visa status</td>
<td>33.4</td>
</tr>
<tr>
<td>Fluency in language of pt population</td>
<td>31.0</td>
</tr>
<tr>
<td>NRMP flag for match violation</td>
<td>27.8</td>
</tr>
<tr>
<td>Interest in academic career</td>
<td>24.2</td>
</tr>
<tr>
<td>Away rotation in specialty elsewhere</td>
<td>18.9</td>
</tr>
</tbody>
</table>

Figure PD_14

**Mean Importance of Personal Characteristics and Other Knowledge of Applicants Considered in Deciding Whom to Interview**

<table>
<thead>
<tr>
<th>Feature</th>
<th>Mean Importance Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Letters of recommendation in specialty</td>
<td>4.2</td>
</tr>
<tr>
<td>Personal statement (overall)</td>
<td>3.9</td>
</tr>
<tr>
<td>Diversity characteristics</td>
<td>4.1</td>
</tr>
<tr>
<td>Perceived commitment to specialty</td>
<td>4.3</td>
</tr>
<tr>
<td>Having overcome significant obstacles</td>
<td>4.1</td>
</tr>
<tr>
<td>Professionalism and ethics</td>
<td>4.5</td>
</tr>
<tr>
<td>Perceived interest in program</td>
<td>4.2</td>
</tr>
<tr>
<td>Leadership qualities</td>
<td>4.2</td>
</tr>
<tr>
<td>Volunteer/extracurricular experience</td>
<td>3.9</td>
</tr>
<tr>
<td>Personal prior knowledge of applicant</td>
<td>4.1</td>
</tr>
<tr>
<td>Other life experience</td>
<td>3.9</td>
</tr>
<tr>
<td>Audition elective/rotation in PD's dept</td>
<td>4.1</td>
</tr>
<tr>
<td>Involvement and interest in research</td>
<td>3.6</td>
</tr>
<tr>
<td>Ability to work legally w/o visa</td>
<td>4.2</td>
</tr>
<tr>
<td>Visa status</td>
<td>3.9</td>
</tr>
<tr>
<td>Fluency in language of pt population</td>
<td>3.6</td>
</tr>
<tr>
<td>NRMP flag for match violation</td>
<td>4.7</td>
</tr>
<tr>
<td>Interest in academic career</td>
<td>3.8</td>
</tr>
<tr>
<td>Away rotation in specialty elsewhere</td>
<td>3.8</td>
</tr>
</tbody>
</table>

*Rated on a scale of 1 (not at all important) to 5 (very important)*
REFERENCES


AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 301
(I-22)

Introduced by: Resident and Fellow Section

Subject: Increasing Musculoskeletal Education in Primary Care Specialties and Medical School Education Through Inclusion of Osteopathic Manual Therapy Education

Referred to: Reference Committee C

Whereas, According to the American Osteopathic Association, osteopathic manipulative medicine/treatment (OMM/OMT) is special training for the musculoskeletal system that doctors of osteopathy receive to provide care that involves using the hands to diagnose, treat, and prevent illness or injury; and

Whereas, The evidence basis for OMT is quite broad and spans many disease processes and organ systems and supports its use as an adjunct treatment in a variety of conditions; and

Whereas, In order to train residents in osteopathic practice and principles (OPP) and osteopathic manipulative treatment (OMT), faculty must be available and qualified; and

Whereas, Osteopathic Recognition (OR) is a “designation conferred by the ACGME’s Osteopathic Principles Committee upon ACGME-accredited programs that demonstrate, through a formal application process, the commitment to teaching and assessing Osteopathic Principles and Practice (OPP) at the graduate medical education level”; and

Whereas, Programs must meet criteria laid out by that committee and apply for recognition¹; and

Whereas, Residents in a recognized program must be assessed for OPP knowledge and “skill proficiency in OMT as applicable to [their] specialty”²; and

Whereas, As of the 2021-2022 academic year there are approximately 250 PGY-1 GME programs with osteopathic recognition out of the 4,780 available programs (roughly 5%)¹¹; therefore be it

RESOLVED, That our American Medical Association continue to support equal treatment of osteopathic students, trainees and physicians in the residency application cycle and workplace through continued education on the training of osteopathic physicians (New HOD Policy); and be it further

RESOLVED, That our AMA encourage education on the benefits of evidence-based OsteopathicManual Therapy for musculoskeletal conditions in medical education of allopathic students and in primary care residencies. (New HOD Policy)

Fiscal Note: Not yet determined

Received: 09/14/22
REFERENCES

RELEVANT AMA POLICY

Definition of a Physician H-405.969
1. The AMA affirms that a physician is an individual who has received a "Doctor of Medicine" or a "Doctor of Osteopathic Medicine" degree or an equivalent degree following successful completion of a prescribed course of study from a school of medicine or osteopathic medicine. 2. AMA policy requires anyone in a hospital environment who has direct contact with a patient who presents himself or herself to the patient as a "doctor," and who is not a "physician" according to the AMA definition above, must specifically and simultaneously declare themselves a "non-physician" and define the nature of their doctorate degree. 3. Our AMA actively supports the Scope of Practice Partnership in the Truth in Advertising campaign.

Definition and Use of the Term Physician H-405.951
Our AMA: 1. Affirms that the term physician be limited to those people who have a Doctor of Medicine, Doctor of Osteopathic Medicine, or a recognized equivalent physician degree and who would be eligible for an Accreditation Council for Graduate Medical Education (ACGME) residency. 2. Will, in conjunction with the Federation, aggressively advocate for the definition of physician to be limited as defined above: a. In any federal or state law or regulation including the Social Security Act or any other law or regulation that defines physician; b. To any federal and state legislature or agency including the Department of Health and Human Services, Federal Aviation Administration, the Department of Transportation, or any other federal or state agency that defines physician; and c. To any accrediting body or deeming authority including the Joint Commission, Health Facilities Accreditation Program, or any other potential body or authority that defines physician. 3. Urges all physicians to insist on being identified as a physician, to sign only those professional or medical documents identifying them as physicians, and to not let the term physician be used by any other organization or person involved in health care. 4. Ensure that all references to physicians by government, payers, and other health care entities involving contracts, advertising, agreements, published descriptions, and other communications at all times distinguish between physician, as defined above, and non-physicians and to discontinue the use of the term provider. 5. Policy requires any individual who has direct patient contact and presents to the patient as a doctor, and who is not a physician, as defined above, must specifically and simultaneously declare themselves a non-physician and define the nature of their doctorate degree. 6. Will review and revise its own publications as necessary to conform with the House of Delegates’ policies on physician identification and physician reference and will refrain from any definition of physicians as providers that is not otherwise covered by existing Journal of the American Medical Association (JAMA) Editorial Governance Plan, which protects the editorial independence of JAMA. 7. Actively supports the Scope of Practice Partnership in the Truth in Advertising campaign.

We use the word "women" in the whereas clauses of this resolution when referring to people who have experienced pregnancy to stay consistent with the language of the sources and studies we have cited. However, this is not meant to be exclusionary, and we recognize that all people with a uterus, regardless of gender identity, can experience pregnancy loss.

Whereas, An estimated 26% of all pregnancies and 10% of clinically recognized pregnancies end in miscarriage; and

Whereas, An estimated 24,000 stillbirths occur each year in the United States; and

Whereas, It takes at least two weeks to physically recover from a miscarriage and the World Health Organization (WHO) recommends waiting 6 months after a miscarriage to try again to get pregnant; and

Whereas, The risk of severe maternal morbidity is more than four times higher for stillbirths compared with live birth deliveries; and

Whereas, In multiple studies, PTSD prevalence ranged from 33.3% to 60% after pregnancy loss, and the prevalence of anxiety was 20%, the prevalence of depression ranged from 5% to 54% respectively, and 77% of parents experienced emotional and psychological distress following a stillbirth; and

Whereas, Black women and women of lower socioeconomic status are twice as likely to experience late miscarriage and stillbirth, have limited access to bereavement support, and are less likely to have access to paid leave time after miscarriage or stillbirth; and

Whereas, Paid sick leave has been shown to lead to an increase in employment, reduction in workforce turnover, and increases in household incomes; and

Whereas, The District of Columbia recently expanded bereavement leave to include leave for loss of a pregnancy, several states, including Illinois, Maryland, Oregon, and Washington, have bereavement of family leave policies but do not specify if pregnancy loss meets criteria for such leave, and multiple countries, including New Zealand and South Korea, mandate paid leave for miscarriages and similar legislation, such as the Support through Loss Act, has been introduced in the United States; and

Whereas, Our AMA supports medical and family leave (H-420.979 and H-405.960) but we do not have policy that explicitly notes that this should include leave for pregnancy loss; therefore be it
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; (d) category of leave credited (e.g., sick, vacation, parental, unpaid leave, short term disability); (e) whether leave is paid or unpaid; (f) whether provision is made for continuation of insurance benefits during leave and who pays for premiums; (g) whether sick leave and vacation time may be accrued from year to year or used in advance; (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; (i) how time can be made up in order for a resident physician to be considered board eligible; (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

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)
Fiscal Note: Minimal - less than $1,000

Received: 09/20/22

References:

RELEVANT AMA POLICY

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

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

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

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

Resolution: 302 (I-22)
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 and in writing to all applicants to medical school, residency or fellowship.

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; (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.


Parental Leave H-405.954

1. Our AMA encourages the study of the health implications among patients if the United States were to modify one or more of the following aspects of the Family and Medical Leave Act (FMLA): a reduction in the number of employees from 50 employees; an increase in the number of covered weeks from 12 weeks; and creating a new benefit of paid parental leave.
2. Our AMA will study the effects of FMLA expansion on physicians in varied practice environments.
3. Our AMA: (a) encourages employers to offer and/or expand paid parental leave policies; (b) encourages state medical associations to work with their state legislatures to establish and promote paid parental leave policies; (c) advocates for improved social and economic support for paid family leave to care for newborns, infants and young children; and (d) advocates for federal tax incentives to support early child care and unpaid child care by extended family members.
4. Our AMA: (a) encourages key stakeholders to implement policies and programs that help protect against parental discrimination and promote work-life integration for physician parents, which should encompass prenatal parental care, equal parental leave for birthing and non-birthing parents, and flexibility for childcare; and (b) urges key stakeholders to include physicians and frontline workers in legislation that provides protections and considerations for paid parental leave for issues of health and childcare.


Paid Sick Leave H-440.823

Our AMA: (1) recognizes the public health benefits of paid sick leave and other discretionary paid time off; (2) supports employer policies that allow employees to accrue paid time off and to use such time to care for themselves or a family member; and (3) supports employer policies that provide employees with unpaid sick days to use to care for themselves or a family member where providing paid leave is overly burdensome.


FMLA Equivalence H-270.951

Our AMA will advocate that Family and Medical Leave Act policies include any individual related by blood or affinity whose close association with the employee is the equivalent of a family relationship.

Res. 002, A-18
Whereas, The age of matriculation to medical school has been gradually increasing over the
past several years resulting in an increase in trainees whose peak reproductive years now
overlap partially or entirely with their medical school education\(^1,2\); and

Whereas, As of 2021, over seven percent of graduating medical students had at least one non-
spouse dependent, the majority of whom are likely children\(^3\); and

Whereas, A 2017 single-institution study conducted at the University of South Dakota Sanford
School of Medicine revealed that parenthood may affect an even larger proportion of the student
body at some institutions, as they reported that 25 of 185 (13\%) of surveyed students had
become parents or were currently pregnant at the time of the study\(^4\); and

Whereas, Further, more than half of matriculants to medical school now are female, meaning
that these trainees bear the responsibility of coping with the physical, mental, and emotional
changes of pregnancy, labor, and delivery, as well as infant- and child-care, in addition to the
high-stakes, demanding, and often exhausting rigors of medical school\(^5\); and

Whereas, Despite a growing number of medical students pursuing parenthood concomitantly
with medical training, medical schools lag behind other levels of medical training—namely
graduate medical education (GME), aka residency—in providing their trainee-parents supportive,
accessible, and clear parental leave policies; and

Whereas, For many medical students, even locating the parental leave policy for their school
can be time-consuming and ultimately fruitless, as many medical schools fail to publish or do
not have—a parental leave policy for their students and a 2019 study sifted through the websites
and student-handbooks of 199 allopathic and osteopathic medical schools in the US\(^5\); and

Whereas, The researchers found that only 65 of 199 (33\%) of schools had parental leave
policies available on their website or in their handbook and the policies located were far from
standardized; and

Whereas, Only 38 of the 65 (58\%) available policies specifically included maternity AND
paternity leave; 23 (35\%) policies allowed for maternity leave only; of the 65 available policies,
only 21 (32\%) included an option to maintain the student’s original graduation date following the
leave; and only 3 (5\%) school policies included parental leave for adoption\(^5\); and

Whereas, The stress of having to locate parental leave policies, request and/or advocate for
time off at a school which does not have a published parental leave policy, and, at most
institutions, face the financial and psychological barriers of delay of graduation, and can be
prohibitive to students wanting to begin families during their training; and
Whereas, The American Board of Medical Specialties (ABMS), recently recognized the need for parental leave policies and standardized requirements among all GME institutions nationwide, citing issues of trainee mental and physical wellness and work-life balance as well as “helping to narrow the gender gap in [women’s] career advancement” as chief reasons for implementing such policies; and

Whereas, Like medical students, GME matriculants are becoming parents, and having institutional support for the critical adjustment and bonding period of having a newborn is important to both mothers and fathers; and

Whereas, As of July 2021, the ABMS required that all Accreditation Council for Graduate Medical Education (ACGME)-accredited residency programs “allow for a minimum of six weeks away once during training for purposes of parental, caregiver, and medical leave, without exhausting time allowed for vacation or sick leave and without requiring an extension in training”; and

Whereas, This new requirement indicates a recognition among the medical community that a visible and non-negotiable parental leave policy is important for the health and well-being of medical trainees and should be in place at all institutions with graduate medical learners; and

Whereas, In fact, the American College of Obstetricians and Gynecologists (ACOG), the leading experts in pregnancy and transition to parenthood, agree with the ABMS policy, and endorse a 6-week minimum parental leave, which they note has several benefits, including improving maternal health and decreasing infant mortality, as well as increasing worker morale, productivity, and likelihood to return to work; and

Whereas, Evidence supports the statements made by ABMS and ACOG that parental leave contributes to the overall health and wellness of new parents and studies have demonstrated that returning to work too early after childbearing is associated with negative mental health outcomes for mothers, including an increase in the rate of postpartum depression; and

Whereas, Further, a 2018 study found that each additional week of maternity leave (for leaves totaling <12 weeks) proportionally decreased the risk of experiencing postpartum depression; and

Whereas, In another 2018 study, specifically focused on medical residents, early return to work translated to a decreased length of breastfeeding (impacting maternal-infant bonding and infant health), decreased perceived support, and overall decreased satisfaction with parenthood; and

Whereas, Although the challenges presented by taking parental leave in medical school are different than those presented in residency and fellowship, the costs to families—parents and their children—of being denied parental leave of adequate length and/or being denied the peace of mind of having an easily accessible, comprehensive parental leave policy available from their institution, are the same; and

Whereas, Thus, it is of paramount importance that our AMA have policies to support them in advocating on behalf of current and future medical student parents, that they receive the equitable, appropriate, and visible parental leave policies and benefits already guaranteed to their trainee counterparts in GME; and
Whereas, While current AMA policy (H-405.960) demonstrates a clear intent to include medical students in these leave protections, a large proportion of the policies which address this population are not applicable and thus do not offer any true protections to them; therefore be it

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.

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.

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.

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.

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.
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.

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

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.

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)

Fiscal Note: Minimal - less than $1,000

Received: 09/20/22

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

1. Webb, Allison M.B. MD, MAT; Hasty, Brittany N. MD, MHPE; Andolshek, Kathryn M. MD, MPH; Mechaber, Hilit F. MD; Harris, Toi Blakley MD; Chatterjee, Archana MD, PhD; Lautenberger, Diana M. MA; Gottlieb, Amy S. MD. A Timely Problem: Parental Leave During Medical Training, Academic Medicine: November 2019 - Volume 94 - Issue 11 - p 1631-1634 doi: 10.1097/ACM.0000000000002733


5. Kraus, Molly B. MD; Talbott, Jennifer M.V.; Melikian, Ryan; Merrill, Sarah A.; Stonnington, Cynthia M. MD; Hayes, Sharonne N. MD; Files, Julia A. MD; Kouloumeris, Pelagia E. MD. Current Parental Leave Policies for Medical Students at U.S. Medical Schools: A Comparative Study, Academic Medicine: September 2021 - Volume 96 - Issue 9 - p 1315-1318 doi: 10.1097/ACM.000000000004074


RELEVANT AMA POLICY

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 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 and in writing to all applicants to medical school, residency or fellowship.

Citation: CCB/CLRPD Rep. 4, A-13; Modified: Res. 305, A-14; Modified: Res. 904, I-14; Modified: Res. 307, A-22

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;
(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.


Parental Leave H-405.954
1. Our AMA encourages the study of the health implications among patients if the United States were to modify one or more of the following aspects of the Family and Medical Leave Act (FMLA): a reduction in
the number of employees from 50 employees; an increase in the number of covered weeks from 12 weeks; and creating a new benefit of paid parental leave.

2. Our AMA will study the effects of FMLA expansion on physicians in varied practice environments.

3. Our AMA: (a) encourages employers to offer and/or expand paid parental leave policies; (b) encourages state medical associations to work with their state legislatures to establish and promote paid parental leave policies; (c) advocates for improved social and economic support for paid family leave to care for newborns, infants and young children; and (d) advocates for federal tax incentives to support early child care and unpaid child care by extended family members.

4. Our AMA: (a) encourages key stakeholders to implement policies and programs that help protect against parental discrimination and promote work-life integration for physician parents, which should encompass prenatal parental care, equal parental leave for birthing and non-birthing parents, and flexibility for childcare; and (b) urges key stakeholders to include physicians and frontline workers in legislation that provides protections and considerations for paid parental leave for issues of health and childcare.


Support for Residents and Fellows During Family and Medical Leave Time H-310.908

Our AMA encourages specialty boards, the Accreditation Council for Graduate Medical Education and residency review committees to study alternative mechanisms and pathways based on competency evaluation to ensure that individuals who have taken family and medical leave graduate as close to their original completion date as possible.

Res. 307, A-13
Whereas, The US and world populations are in the midst of a COVID pandemic; and

Whereas, Hospitals, physicians and other healthcare workers are strained to contain the outbreak and treat individuals who have contracted COVID; and

Whereas, There has been progress in prevention through means of social isolation, mask wearing and vaccine prophylaxis; and

Whereas, Medical boards and other regulators across the country are scrambling to penalize doctors who spread misinformation about vaccines, and promote unproven cures for COVID–19; and

Whereas, In Idaho, local GOP officials appointed a pathologist who promoted unproven virus treatments to a local public health board, despite complaints from his peers to state regulators; and

Whereas, As of this date, Politico reports that medical boards have sanctioned eight physicians since January 2021 for spreading coronavirus–related misinformation, according to the Federation of State Medical Boards, which has recommended that health officials consider action against medical professionals who dispense false medical claims in public forums; and

Whereas, In some cases the responses from some medical boards and state officials have been stymied by political backlash, including in Tennessee and North Dakota; and

Whereas, Some state boards also lack the legal tools to discipline doctors for sharing unreliable information via social media, and “With the click of a mouse button, two million people can get information that's incorrect,” and legal structures developed for the 20th century are, in many states, not suited to discipline doctors who broadcast misinformation on social media because the physicians are not directly treating patients, Federation of State Medical Boards CEO Humayun Chaudhry said; and

Whereas, Misinformation distorts the public debate over vaccines, and has helped create a market for unproven drugs and treatment against COVID–19, sometimes with harmful side effects; and

Whereas, Poison centers have recorded increased numbers of calls related to ivermectin and oleandrin, with some patients requiring hospitalizations; and
Whereas, A recent study in *The New England Journal of Medicine* projected nearly $2.5 million in wasteful insurance spending on ivermectin in a single week; and

Whereas, When the Medical Board of California started to crack down last year on doctors spreading misinformation about the coronavirus vaccines, the head of the Board began getting threats; and

Whereas, The federation said that two-thirds of their members had seen an increased number of complaints related to disinformation in a December 2021 survey; therefore be it

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)

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

Received: 09/20/22

REFERENCES:

*Medical boards get pushback as they try to punish doctors for Covid misinformation* - POLITICO
Whereas, Structural inequities and system-level biases amongst members of admission committees contribute to non-inclusive environments and result in unequal opportunities for potential underrepresented minority (URM) applicants to enter the field of medicine; and

Whereas, The racial injustices, social tragedies, and health care inequities particularly highlighted throughout the COVID-19 pandemic reinforce the demand for the implementation of strategies to support diversity, equity, and inclusion; and

Whereas, Middle and high school pipeline programs providing comprehensive educational support and enrichment have improved test scores and raised school graduation and college matriculation rates; and

Whereas, A study examining undergraduate students found that lower grade achievement of URM students in pre-health courses may not be fully attributable to the precollege educational pipeline, and can potentially be improved by academic and social supports during college; and

Whereas, Nascent pipeline programs that have connected medical students and high school students in context specific and culturally relevant manner have the potential to help underrepresented students with identity formation and perceived achievement goals; and

Whereas, Outreach and pipeline programs targeting students underrepresented in medicine are beneficial to the participants and the community by 1) exposing underserved and underrepresented youth to medicine, 2) improving their candidacy by providing opportunities for research, shadowing, and volunteering, and 3) increasing diversity in healthcare; and

Whereas, Engaging with such programs provides value to the medical schools by 1) fulfilling accreditation requirements, 2) granting medical students the opportunity to interact with the surrounding community, and 3) serving as a source of qualified applicants who are underrepresented in medicine; therefore be it

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)

Fiscal Note: Minimal - less than $1,000

Received: 09/27/22

REFERENCES:


RELEVANT AMA POLICY

Underrepresented Student Access to US Medical Schools H-350.960

Our AMA: (1) recommends that medical schools should consider in their planning: elements of diversity including but not limited to gender, racial, cultural and economic, reflective of the diversity of their patient population; (2) supports the development of new and the enhancement of existing programs that will identify and prepare underrepresented students from the high-school level onward and to enroll, retain and graduate increased numbers of underrepresented students; (3) recognizes some people have been historically underrepresented, excluded from, and marginalized in medical education and medicine because of their race, ethnicity, disability status, sexual orientation, gender identity, socioeconomic origin, and rurality, due to racism and other systems of exclusion and discrimination; (4) is committed to promoting truth and reconciliation in medical education as it relates to improving equity; and (5) recognizes the harm caused by the Flexner Report to historically Black medical schools, the diversity of the physician workforce, and the outcomes of minoritized and marginalized patient populations.

Citation: Res. 908, I-08; Reaffirmed in lieu of Res. 311, A-15; Appended: CME Rep. 5, A-21

Strategies for Enhancing Diversity in the Physician Workforce D-200.985

1. Our AMA, independently and in collaboration with other groups such as the Association of American Medical Colleges (AAMC), will actively work and advocate for funding at the federal and state levels and in the private sector to support the following: (a) Pipeline programs to prepare and motivate members of underrepresented groups to enter medical school; (b) Diversity or minority affairs offices at medical schools; (c) Financial aid programs for students from groups that are underrepresented in medicine; and (d) Financial support programs to recruit and develop faculty members from underrepresented groups.
2. Our AMA will work to obtain full restoration and protection of federal Title VII funding, and similar state funding programs, for the Centers of Excellence Program, Health Careers Opportunity Program, Area Health Education Centers, and other programs that support physician training, recruitment, and retention in geographically-underserved areas.
3. Our AMA will take a leadership role in efforts to enhance diversity in the physician workforce, including engaging in broad-based efforts that involve partners within and beyond the medical profession and medical education community.
4. Our AMA will encourage the Liaison Committee on Medical Education to assure that medical schools demonstrate compliance with its requirements for a diverse student body and faculty.

5. Our AMA will develop an internal education program for its members on the issues and possibilities involved in creating a diverse physician population.

6. Our AMA will provide on-line educational materials for its membership that address diversity issues in patient care including, but not limited to, culture, religion, race and ethnicity.

7. Our AMA will create and support programs that introduce elementary through high school students, especially those from groups that are underrepresented in medicine (URM), to healthcare careers.

8. Our AMA will create and support pipeline programs and encourage support services for URM college students that will support them as they move through college, medical school and residency programs.

9. Our AMA will recommend that medical school admissions committees use holistic assessments of admission applicants that take into account the diversity of preparation and the variety of talents that applicants bring to their education.

10. Our AMA will advocate for the tracking and reporting to interested stakeholders of demographic information pertaining to URM status collected from Electronic Residency Application Service (ERAS) applications through the National Resident Matching Program (NRMP).

11. Our AMA will continue the research, advocacy, collaborative partnerships and other work that was initiated by the Commission to End Health Care Disparities.

12. Our AMA opposes legislation that would undermine institutions' ability to properly employ affirmative action to promote a diverse student population.

13. Our AMA will work with the AAMC and other stakeholders to create a question for the AAMC electronic medical school application to identify previous pipeline program (also known as pathway program) participation and create a plan to analyze the data in order to determine the effectiveness of pipeline programs.


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

Our AMA supports increasing the representation of minorities in the physician population by: (1) Supporting efforts to increase the applicant pool of qualified minority students by: (a) Encouraging state and local governments to make quality elementary and secondary education opportunities available to all; (b) Urging medical schools to strengthen or initiate programs that offer special premedical and precollegiate experiences to underrepresented minority students; (c) urging medical schools and other health training institutions to develop new and innovative measures to recruit underrepresented minority students, and (d) Supporting legislation that provides targeted financial aid to financially disadvantaged students at both the collegiate and medical school levels.

(2) Encouraging all medical schools to reaffirm the goal of increasing representation of underrepresented minorities in their student bodies and faculties.

(3) Urging medical school admission committees to consider minority representation as one factor in reaching their decisions.

(4) Increasing the supply of minority health professionals.

(5) Continuing its efforts to increase the proportion of minorities in medical schools and medical school faculty.

(6) Facilitating communication between medical school admission committees and premedical counselors concerning the relative importance of requirements, including grade point average and Medical College Aptitude Test scores.

(7) Continuing to urge for state legislation that will provide funds for medical education both directly to medical schools and indirectly through financial support to students.

(8) Continuing to provide strong support for federal legislation that provides financial assistance for able students whose financial need is such that otherwise they would be unable to attend medical school.

Citation: CLRDPD Rep. 3, I-98; Reaffirmed: CLRDPD Rep. 1, A-08; Reaffirmed: CME Rep. 01, A-18
AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 306
(I-22)

Introduced by: New York

Subject: Increased Credit for Continuing Medical Education Preparation

Referred to: Reference Committee C

Whereas, Our American Medical Association offers a maximum of only two hours of Category 2 credit for the preparation and presentation of a one–hour continuing medical education (CME) program for physicians; and

Whereas, A physician may need many more hours — often as many as 50 — to create a one–hour CME program of acceptable quality and utility for his or her peers; and

Whereas, The small number (just two hours) of Category 2 credits dissuades many physicians from taking on the task of preparing and presenting CME programs; therefore be it

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)

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

Received: 09/27/22

RELEVANT AMA POLICY

Support for Development of Continuing Education Programs for Primary Care Physicians in Non-Academic Settings H-295.926

The AMA: (1) supports development, where appropriate, of programs of education for medical students and faculty in non-academic settings, making use of telecommunications as needed; (2) encourages that medical schools provide faculty development programs that are designated for AMA PRA Category 1 Credit®; and (3) encourages that teaching continue to be accepted for AMA PRA Category 2 Credit® when not designated for AMA PRA Category 1 Credit®.


Unification of Education Credits H-300.976

It is the policy of the AMA to develop, in cooperation with national specialty organizations and state medical associations, uniform nationwide standards for continuing medical education credits recognized by all medical associations and specialty societies.

Citation: Res. 102, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CME Rep. 2, A-10; Reaffirmed: CME Rep. 01, A-20;
Whereas, Residents and Fellows form the backbone and the future of our healthcare system (1, 2); and

Whereas, Residents and Fellows are usually under heavy financial debt of student loans accumulated over eight years of intense college and medical school education (3, 4); and

Whereas, Residents and Fellows, having to be employed for 3-7 years, who are dependent on their salary for those years for daily living and payment of student debt (5); and

Whereas, The Centers for Medicare & Medicaid Services (CMS) provides direct and indirect compensation for Residents and Fellows to cover their cost to the institution, and usually in excess (6, 7, 8, 9); and

Whereas, CMS payments per resident/fellow vary widely exacerbating financial strain for some training institutions (8, 9); and

Whereas, Residents and Fellows provide patient care services that are mission critical and an important source of revenue for their institutions (10, 11, 12, 13); and

Whereas, Current Resident and Fellow compensation, approaching minimum wage, is inadequate and unfair from all reasonable perspectives (14, 15, 16, 17); and

Whereas, The Arkansas Delegation believes that our AMA must advocate on behalf of its most vulnerable and most important constituency; therefore be it

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)

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

Received: 09/27/22
References:
3. https://educationdata.org/average-medical-school-debt
6. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/DGME
8. CRS Report R44376, Federal Support for Graduate Medical Education: An Overview. Feb 19, 2019
10. https://doi.org/10.1371/journal.pone.0258633

RELEVANT AMA POLICY

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

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

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

B. Appropriate supervision by qualified physician faculty with progressive resident responsibility toward independent practice.

With regard to supervision, residents and fellows must be ultimately supervised by physicians who are adequately qualified and allow them to assume progressive responsibility appropriate to their level of education, competence, and experience. In instances where clinical education is provided by non-physicians, there must be an identified physician supervisor providing indirect supervision, along with mechanisms for reporting inappropriate, non-physician supervision to the training program, sponsoring institution or ACGME as appropriate.

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

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

D. A safe and supportive workplace with appropriate facilities.

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

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

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

(2) With regard to compensation, residents and fellows should receive: a. Compensation for time at orientation; and b. Salaries commensurate with their level of training and experience. Compensation should reflect cost of living differences based on local economic factors, such as housing, transportation, and energy costs (which affect the purchasing power of wages), and include appropriate adjustments for changes in the cost of living.

(3) With regard to benefits, residents and fellows must be fully informed of and should receive: a. Quality and affordable comprehensive medical, mental health, dental, and vision care for residents and their families, as well as retirement plan options, professional liability insurance and disability insurance to all residents for disabilities resulting from activities that are part of the educational program; b. An institutional written policy on and education in the signs of excessive fatigue, clinical depression, substance abuse and dependence, and other physician impairment issues; c. Confidential access to mental health and substance abuse services; d. A guaranteed, predetermined amount of paid vacation leave, sick leave, family and medical leave and educational/professional leave during each year in their
training program, the total amount of which should not be less than six weeks; e. Leave in compliance with the Family and Medical Leave Act; and f. The conditions under which sleeping quarters, meals and laundry or their equivalent are to be provided.

F. Clinical and educational work hours that protect patient safety and facilitate resident well-being and education.

With regard to clinical and educational work hours, residents and fellows should experience: (1) A reasonable work schedule that is in compliance with clinical and educational work hour requirements set forth by the ACGME; and (2) At-home call that is not so frequent or demanding such that rest periods are significantly diminished or that clinical and educational work hour requirements are effectively circumvented. Refer to AMA Policy H-310.907, “Resident/Fellow Clinical and Educational Work Hours,” for more information.

G. Due process in cases of allegations of misconduct or poor performance.

With regard to the complaints and appeals process, residents and fellows should have the opportunity to defend themselves against any allegations presented against them by a patient, health professional, or training program in accordance with the due process guidelines established by the AMA.

H. Access to and protection by institutional and accreditation authorities when reporting violations.

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

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

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

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

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

Whereas, The mission of the American Medical Association is “to promote the art and science of medicine and the betterment of public health...by representing physicians with a unified voice in courts and legislative bodies across the nation, removing obstacles that interfere with patient care...and driving the future of medicine to tackle the biggest challenges in health care.” [1]; and

Whereas, The federal Family Medical Leave Act (FMLA) of 1993 requires private employers with 50 or more employees within 75 miles of the eligible employee’s worksite and all public agencies to provide eligible employees* up to 12 work weeks of unpaid leave in a 12-month period for the birth and care of a newborn, adopted child, or foster child, as well as for care of oneself or an immediate family member with a serious health condition [2]**; and

Whereas, “The American Academy of Pediatrics has publicly endorsed 12 weeks of paid family leave based upon the scientific evidence of benefits to the child.” [3]; and

Whereas, Since April 2022, the American College of Radiology (ACR) “recommends that diagnostic radiology, interventional radiology, radiation oncology, medical physics, and nuclear medicine practices, departments and training programs strive to provide 12 weeks of paid family/medical leave in a 12-month period for its attending physicians, medical physicists, and members in training as needed.” [4]; and

Whereas, The business case for paid family/medical leave is compelling, with “significant rewards that outweigh the costs: improved employee retention; better talent attraction; reinforced values; improved engagement, morale, and productivity; and enhanced brand equity.” [5]. For instance, research has shown that the average time to fill a vacant position is 42 days, and the average cost of a hire is at least 21% of annual salary [6]; and

Whereas, While the most frequent argument against paid family/parental leave is “we can’t afford it,” there are ways to mitigate the cost of paid leave. Some states offer a paid leave program that can be used to offset the cost to a practice [7]. Short-term disability insurance for all practice members can also protect a practice from unexpected medical issues. Lastly, practices can consider creating an account that is funded annually for circumstances requiring family/medical leave [6]; therefore be it
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.

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

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.

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.

89. 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.

90. 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.

4011. 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.

4412. 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.

4213. Our AMA encourages flexibility in residency training programs, incorporating parental leave and alternative schedules for pregnant house staff.

4314. 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.

4415. 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)

Fiscal Note: Minimal - less than $1,000

Received: 09/30/22

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

REFERENCES:

"Defined, per FMLA, as "Employees are eligible for leave if they have worked for their employer at least 12 months, at least 1,250 hours over the past 12 months, and work at a location where the company employs 50 or more employees within 75 miles."" [3]

**Additional reasons under the FMLA include:
- any qualifying exigency arising out of the fact that the employee’s spouse, son, daughter, or parent is a covered military member on "covered active duty"; and
- to care for a covered service member with a serious injury or illness if the eligible employee is the service member’s spouse, son, daughter, parent, or next of kin (leave entitlement is up to 26 weeks in a 12-month period). [2]

***Defined, as "the problem of employees who are not fully functioning in the workplace because of an illness, injury or other condition. Even though the employee may be physically at work, he may not be able to fully perform his duties and is more likely to make mistakes on the job." [12]

**RELEVANT AMA POLICY**

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

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

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

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

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

4. Our AMA encourages 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 and in writing to all applicants to medical school, residency or fellowship.

Citation: CCB/CLRPD Rep. 4, A-13; Modified: Res. 305, A-14; Modified: Res. 904, I-14; Modified: Res. 307, A-22

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; (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.

Citation: BOT Rep. A, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmation A-12; Reaffirmed: CMS Rep. 03, A-16;

Parental Leave H-405.954

1. Our AMA encourages the study of the health implications among patients if the United States were to modify one or more of the following aspects of the Family and Medical Leave Act (FMLA): a reduction in the number of employees from 50 employees; an increase in the number of covered weeks from 12 weeks; and creating a new benefit of paid parental leave.

2. Our AMA will study the effects of FMLA expansion on physicians in varied practice environments.

3. Our AMA: (a) encourages employers to offer and/or expand paid parental leave policies; (b) encourages state medical associations to work with their state legislatures to establish and promote paid parental leave policies; (c) advocates for improved social and economic support for paid family leave to care for newborns, infants and young children; and (d) advocates for federal tax incentives to support early child care and unpaid child care by extended family members.

4. Our AMA: (a) encourages key stakeholders to implement policies and programs that help protect against parental discrimination and promote work-life integration for physician parents, which should encompass prenatal parental care, equal parental leave for birthing and non-birthing parents, and flexibility for childcare; and (b) urges key stakeholders to include physicians and frontline workers in legislation that provides protections and considerations for paid parental leave for issues of health and childcare.

Citation: Res. 215, I-16; Appended: BOT Rep. 11, A-19; Appended: Res. 403, A-22
Whereas, The aging of the U.S. population stands to increase the number of senior citizens
dying every year, and the bereavement felt by their loved ones in all sectors, including medical
students and physicians; and

Whereas, Medical students and physicians also suffer emotional trauma related to reproductive
complications such as pregnancy loss, as 10% of known pregnancies end in miscarriage or
stillbirth, and many students and physicians suffer failure of assisted reproductive technology
and adoption; and

Whereas, States of mental and emotional distress have been associated with unsafe patient
care, as demonstrated in a 2016 systematic review that found poor wellbeing and moderate to
high levels of burnout in healthcare staff were associated, in the majority of studies reviewed,
with poor patient safety outcomes such as medical errors; and

Whereas, The Fair Labor Standards Act and the Family and Medical Leave Act do not require a
U.S. employer to provide an employee with paid leave to attend a funeral, grieve a family
member, or grieve a pregnancy loss; and

Whereas, Only 60% of private-sector workers were granted paid bereavement leave in 2012,
per a report from the Bureau of Labor Statistics; and

Whereas, Other countries have instituted bereavement leave policies, such as Canada and
France which guarantee three to five days of bereavement leave to employees suffering the
loss of a close family member, and India and New Zealand which have pregnancy loss laws
entitling Indian women to 6 weeks of paid leave and New Zealand women and their partners to
3 days of paid leave; and

Whereas, AMA policy H-405.960, “Policies for Parental, Family and Medical Necessity Leave,”
sets precedent for the AMA providing detailed recommendations for medical schools, residency
programs, medical specialty boards, the ACGME, and medical group practices to provide leave
benefits to their medical students and physicians; therefore be it
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)

Fiscal Note: Minimal - less than $1,000

Received: 09/30/22

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

References:
RELEVANT AMA POLICY

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 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 and in writing to all applicants to medical school, residency or fellowship.

Citation: COB/CLRPD Rep. 4, A-13; Modified: Res. 305, A-14; Modified: Res. 904, I-14; Modified: Res. 307, A-22
AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 310 (I-22)

Introduced by: Michigan

Subject: Enforce AMA Principles on Continuing Board Certification

Referred to: Reference Committee C

Whereas, The AMA Principles on Continuing Board Certification have been developed through the democratic process of various states' Houses of Delegates and the AMA House of Delegates, reflecting the collective will of state and national medical societies and their physician members; and

Whereas, These longstanding principles clearly demand a continuing board certification process that is low cost, evidence-based, untied to insurance and hospital credentialing, and free of harm to the physician workforce; and

Whereas, The proprietary American Board of Medical Specialties (ABMS) and American Osteopathic Association (AOA) continuing board certification product continues to be high cost, high stress, without evidence over other forms of continuing medical education, required for insurance and hospital credentialing, and harmful to the physician workforce; and

Whereas, ABMS and AOA boards are still not fully aligned with the AMA's policy on continuing board certification; and

Whereas, A failure to protect physicians from recertification harm has significant effects upon cost of care, physician burnout, and access to qualified physicians; and

Whereas, Organized medicine has been called upon to advocate successfully for these principles in order to defend physicians and our right to care for patients; therefore be it

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)

Fiscal Note: Not yet determined

Received: 10/13/22
RELEVANT AMA POLICY

Continuing Board Certification D-275.954
Our AMA will:
1. Continue to monitor the evolution of Continuing Board Certification (CBC), continue its active engagement in discussions regarding their implementation, encourage specialty boards to investigate and/or establish alternative approaches for CBC, and prepare a report regarding the CBC process at the request of the House of Delegates or when deemed necessary by the Council on Medical Education.
2. Continue to review, through its Council on Medical Education, published literature and emerging data as part of the Council’s ongoing efforts to critically review CBC issues.
3. Continue to monitor the progress by the American Board of Medical Specialties (ABMS) and its member boards on implementation of CBC, and encourage the ABMS to report its research findings on the issues surrounding certification and CBC on a periodic basis.
4. Encourage the ABMS and its member boards to continue to explore other ways to measure the ability of physicians to access and apply knowledge to care for patients, and to continue to examine the evidence supporting the value of specialty board certification and CBC.
5. Work with the ABMS to streamline and improve the Cognitive Expertise (Part III) component of CBC, including the exploration of alternative formats, in ways that effectively evaluate acquisition of new knowledge while reducing or eliminating the burden of a high-stakes examination.
6. Work with interested parties to ensure that CBC uses more than one pathway to assess accurately the competence of practicing physicians, to monitor for exam relevance and to ensure that CBC does not lead to unintended economic hardship such as hospital de-credentialing of practicing physicians.
7. Recommend that the ABMS not introduce additional assessment modalities that have not been validated to show improvement in physician performance and/or patient safety.
8. Work with the ABMS to eliminate practice performance assessment modules, as currently written, from CBC requirements.
9. Encourage the ABMS to ensure that all ABMS member boards provide full transparency related to the costs of preparing, administering, scoring and reporting CBC and certifying examinations.
10. Encourage the ABMS to ensure that CBC and certifying examinations do not result in substantial financial gain to ABMS member boards, and advocate that the ABMS develop fiduciary standards for its member boards that are consistent with this principle.
11. Work with the ABMS to lessen the burden of CBC on physicians with multiple board certifications, particularly to ensure that CBC is specifically relevant to the physician’s current practice.
12. Work with key stakeholders to (a) support ongoing ABMS member board efforts to allow multiple and diverse physician educational and quality improvement activities to qualify for CBC; (b) support ABMS member board activities in facilitating the use of CBC quality improvement activities to count for other accountability requirements or programs, such as pay for quality/performance or PQRS reimbursement; (c) encourage ABMS member boards to enhance the consistency of quality improvement programs across all boards; and (d) work with specialty societies and ABMS member boards to develop tools and services that help physicians meet CBC requirements.
13. Work with the ABMS and its member boards to collect data on why physicians choose to maintain or discontinue their board certification.
14. Work with the ABMS to study whether CBC is an important factor in a physician’s decision to retire and to determine its impact on the US physician workforce.
15. Encourage the ABMS to use data from CBC to track whether physicians are maintaining certification and share this data with the AMA.
16. Encourage AMA members to be proactive in shaping CBC by seeking leadership positions on the ABMS member boards, American Osteopathic Association (AOA) specialty certifying boards, and CBC Committees.
17. Continue to monitor the actions of professional societies regarding recommendations for modification of CBC.
18. Encourage medical specialty societies’ leadership to work with the ABMS, and its member
boards, to identify those specialty organizations that have developed an appropriate and relevant CBC process for its members.

19. Continue to work with the ABMS to ensure that physicians are clearly informed of the CBC requirements for their specific board and the timelines for accomplishing those requirements.

20. Encourage the ABMS and its member boards to develop a system to actively alert physicians of the due dates of the multi-stage requirements of continuous professional development and performance in practice, thereby assisting them with maintaining their board certification.

21. Recommend to the ABMS that all physician members of those boards governing the CBC process be required to participate in CBC.

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

23. Encourage the PCPI Foundation, the ABMS, and the Council of Medical Specialty Societies to work together toward utilizing Consortium performance measures in Part IV of CBC.

24. Continue to assist physicians in practice performance improvement.

25. Encourage all specialty societies to grant certified CME credit for activities that they offer to fulfill requirements of their respective specialty board’s CBC and associated processes.

26. Support the American College of Physicians as well as other professional societies in their efforts to work with the American Board of Internal Medicine (ABIM) to improve the CBC program.

27. Oppose those maintenance of certification programs administered by the specialty boards of the ABMS, or of any other similar physician certifying organization, which do not appropriately adhere to the principles codified as AMA Policy on Continuing Board Certification.

28. Ask the ABMS to encourage its member boards to review their maintenance of certification policies regarding the requirements for maintaining underlying primary or initial specialty board certification in addition to subspecialty board certification, if they have not yet done so, to allow physicians the option to focus on continuing board certification activities relevant to their practice.

29. Call for the immediate end of any mandatory, secured recertifying examination by the ABMS or other certifying organizations as part of the recertification process for all those specialties that still require a secure, high-stakes recertification examination.

30. Support a recertification process based on high quality, appropriate Continuing Medical Education (CME) material directed by the AMA recognized specialty societies covering the physician’s practice area, in cooperation with other willing stakeholders, that would be completed on a regular basis as determined by the individual medical specialty, to ensure lifelong learning.

31. Continue to work with the ABMS to encourage the development by and the sharing between specialty boards of alternative ways to assess medical knowledge other than by a secure high-stakes exam.

32. Continue to support the requirement of CME and ongoing, quality assessments of physicians, where such CME is proven to be cost-effective and shown by evidence to improve quality of care for patients.

33. Through legislative, regulatory, or collaborative efforts, will work with interested state medical societies and other interested parties by creating model state legislation and model medical staff bylaws while advocating that Continuing Board Certification not be a requirement for: (a) medical staff membership, privileging, credentialing, or recredentialing; (b) insurance panel participation; or (c) state medical licensure.

34. Increase its efforts to work with the insurance industry to ensure that continuing board certification does not become a requirement for insurance panel participation.

35. Advocate that physicians who participate in programs related to quality improvement and/or patient safety receive credit for CBC Part IV.

36. Continue to work with the medical societies and the American Board of Medical Specialties (ABMS) member boards that have not yet moved to a process to improve the Part III secure, high-stakes examination to encourage them to do so.

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

39. Our AMA will work with the ABMS and its member boards to reduce financial burdens for physicians holding multiple certificates who are actively participating in continuing certification through an ABMS member board, by developing opportunities for reciprocity for certification requirements as well as consideration of reduced or waived fee structures.


Continuing Board Certification 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.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 311
(I-22)

Introduced by: Medical Student Section

Subject: Supporting a Hybrid Residency and Fellowship Interview Process

Referred to: Reference Committee C

Whereas, The Association of American Medical Colleges released data suggesting residency interviews cost medical students between $1,000 to $11,580, with a median cost of $4,000 and an average cost of $200-499 per interview; and

Whereas, Studies suggest 71% of medical students borrow money for residency interviews and four out of ten students decline interviews for financial reasons; and

Whereas, Interviews costs residency programs a significant amount of money, with one plastic surgery program reporting a cost of $2763 per applicant interviewed, which includes applicant receptions, food and beverage costs, and losses of clinical productivity; and

Whereas, It is estimated virtual interviews would allow residency programs to reduce the amount of time needed to conduct interviews by approximately 7 days, reducing faculty's time away from clinical and teaching responsibilities; and

Whereas, The standard model of in-person residency interviews takes time away from medical student educational and clinical work, given that applicants devote an average of 20 days towards residency interviews; and

Whereas, In a 2014 study of GI fellowship applicants with four in-person interviews and a single video interview, 87% of applicants thought that video interviews should continue and 81% reported that the video interview met or exceeded their expectations, which suggests web-based video interviews has the potential to either be an effective screening tool or an acceptable alternative to in-person interviews; and

Whereas, In a survey of the 46 applicants and 36 program directors after the 2020 cardiothoracic fellowship match, the majority of the applicants and program directors thought virtual interviews should be continued in the future; however, most do not think that virtual interviews should completely replace in-person interviews; and

Whereas, In the same 2020 cardiothoracic fellowship study, most applicants and program directors did not believe virtual interviews negatively impacted applicants’ chances of matching into programs at the top of their rank list; and

Whereas, An observational study of an anesthesiology residency program with options for in-person or virtual interviews demonstrated a higher proportion of non-local applicants and the preference for virtual format was driven by travel concerns and interview date conflicts; and
Whereas, A 2020 survey of 1711 medical students and 113 residents in Texas medical programs indicated majority of respondents believed virtual interviews were less stressful than in-person interviews, and residency programs should offer both options for interviewing⁹; and

Whereas, In May 2020, the American Association of Medical Colleges released resources and protocols for residency interviewees and program directors to use in preparing for virtual interviews¹⁰,¹¹; and

Whereas, Several studies from August 2020-June 2021 showed that although residency interviewees expressed concerns about the limitations of virtual interviews such as ability to assess the program, ability to fully demonstrate their personality, and increased emphasis on exam scores and class rank, residency programs may be able to improve the virtual interview experience, by developing comprehensive marketing materials, hosting a resident panel for interviewees, and creating an informal virtual gathering for interviewees and residents¹²-¹⁴; and

Whereas, The 2020-2021 MATCH success rate for applicants was 94.9 percent and 99.6 percent at the conclusion of the Supplemental Offer and Acceptance Program (SOAP), which were comparable to that of years before the COVID-19 pandemic¹⁵; and

Whereas, The National Resident Matching Program reported that 60% of surveyed program directors from the 2021 MATCH intended to use virtual platforms for future recruitment seasons, including two-thirds of these respondents intending to use these platforms for the interview¹⁶; and

Whereas, Incorporating video conferencing into residency interviews as an adjunct to in-person interviews is proposed as a means to increase efficiency and lower costs, given its perceived feasibility from the 2021 MATCH¹⁷; and

Whereas, Most existing American Medical Association policy supports studying methods to reduce residency interviewing cost (H-310.966, D-310.949), but does not take a stance to support the incorporation of technologies, such as videoconferencing, as a method to increase interview efficiency; therefore be it

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)

Fiscal Note: Not yet determined

Received: 10/12/22

REFERENCES:
RELEVANT AMA POLICY

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

Medical Student Involvement and Validation of the Standardized Video Interview Implementation D-310.949
Our AMA: (1) will work with the Association of American Medical Colleges and its partners to advocate for medical students and residents to be recognized as equal stakeholders in any changes to the residency application process, including any future working groups related to the residency application process; (2) will advocate for delaying expansion of the Standardized Video Interview until data demonstrates the Association of American Medical Colleges stated goal of predicting resident performance, and make timely recommendations regarding the efficacy and implications of the Standardized Video Interview as a mandatory residency application requirement; and (3) will, in collaboration with the Association of American Medical Colleges, study the potential implications and repercussions of expanding the Standardized Video Interview to all residency applicants.
Citation: Res. 960, I-17
Resolution: 312
(I-22)

Introduced by: Medical Student Section

Subject: Reporting of Residency Demographic Data

Referred to: Reference Committee C

Whereas, While organizations, including the American Medical Association, Association of American Medical Colleges (AAMC), National Resident Matching Program (NRMP), and Accreditation Council for Graduate Medical Education (ACGME), have gathered data on current residents and residency applicants, this information typically captures very little demographic information and no family planning or parental leave data; and

Whereas, The AMA’s Fellowship and Residency Electronic Interactive Database (FREIDA) offers information on academic background of residents (United States MD, United States DO, International Medical Graduate) and the Male to Female ratio, but largely focuses on the academic and professional experiences of residents; and

Whereas, FREIDA’s data is derived from the ACGME’s annual survey of all residents, which captures little additional demographic and familial data; and

Whereas, AAMC gathers this information, as well as a residency applicant’s self-identification, via its Electronic Residency Application Service (ERAS); and

Whereas, ERAS makes it possible for the AAMC to sort this data by specialty, which is of particular importance because of the limited number of professional medical societies that have developed surveys to capture this information; and

Whereas, The National Resident Matching Program (NRMP) stated their intention to capture demographic data following the 2022 Main Residency Match, but has primarily gathered information on residents’ attitudes towards the graduate medical education experience to date; and

Whereas, Studies on diversity and inclusion in graduate medical education have largely relied upon the little demographic data published by these national surveys; and

Whereas, To date, endeavors to gather information on trends in pregnancy, childbirth, and parenthood among residents have been restricted to academic studies, which typically maintain a limited regional focus; and

Whereas, A recent study of the residency programs affiliated with US News & World Report’s top 50 medical schools made some information on national family leave policies available; and

Whereas, Forty-two percent of the study’s residency programs offered unpaid leave in accordance with the Family Medical Leave Act (FMLA), which ensures employees of a company or institution for at least 1 year, with 1250 hours of service, qualify for up to 12 weeks of unpaid job protection for family and medical reasons; and
Whereas, Forty-two percent of the studied residency programs offered paid parental leave in some capacity, and twenty-two percent of the study’s programs referred residents to state-funded paid family leave programs; and

Whereas, No mention was made of adherence to the additional parental leave guidelines imposed by professional specialty societies; and

Whereas, It is of note that these family leave policies were not necessarily published on each program’s website, and the authors of this study conducted a web search to find publicly available information, then contacted schools directly for this data; and

Whereas, Even after these efforts, there was one school that did not publish family leave information on their website and did not respond to inquiries, indicating this information may not be readily accessible to prospective residency applicants and current residents; and

Whereas, In addition to gathering and publishing information on the items identified in FREIDA, ACGME surveys, and internal residency program surveys should consider collecting information on ability, religion, and immigration status to identify additional resources necessary to support current residents; and

Whereas, To date, there is a scarcity of information on the demographic and parenthood of residents, and existing surveys from FREIDA, ACGME, and internal residency programs could be used to gather this information, as well as data on factors such as incoming and current residents’ ability, religion, and immigration status; and

Whereas, Gathering this robust array of data on the background of residents has the potential to elucidate the path to equity, diversity, and inclusion in medicine; therefore be it

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)

Fiscal Note: Not yet determined

Received: 10/13/22

REFERENCES:
RELEVANT AMA POLICY

Strategies for Enhancing Diversity in the Physician Workforce D-200.985

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

2. Our AMA will work to obtain full restoration and protection of federal Title VII funding, and similar state funding programs, for the Centers of Excellence Program, Health Careers Opportunity Program, Area Health Education Centers, and other programs that support physician training, recruitment, and retention in geographically-underserved areas.

3. Our AMA will take a leadership role in efforts to enhance diversity in the physician workforce, including engaging in broad-based efforts that involve partners within and beyond the medical profession and medical education community.

4. Our AMA will encourage the Liaison Committee on Medical Education to assure that medical schools demonstrate compliance with its requirements for a diverse student body and faculty.

5. Our AMA will develop an internal education program for its members on the issues and possibilities involved in creating a diverse physician population.

6. Our AMA will provide on-line educational materials for its membership that address diversity issues in patient care including, but not limited to, culture, religion, race and ethnicity.

7. Our AMA will create and support programs that introduce elementary through high school students, especially those from groups that are underrepresented in medicine (URM), to healthcare careers.

8. Our AMA will create and support pipeline programs and encourage support services for URM college students that will support them as they move through college, medical school and residency programs.

9. Our AMA will recommend that medical school admissions committees use holistic assessments of admission applicants that take into account the diversity of preparation and the variety of talents that applicants bring to their education.

10. Our AMA will advocate for the tracking and reporting to interested stakeholders of demographic information pertaining to URM status collected from Electronic Residency Application Service (ERAS) applications through the National Resident Matching Program (NRMP).

11. Our AMA will continue the research, advocacy, collaborative partnerships and other work that was initiated by the Commission to End Health Care Disparities.

12. Our AMA opposes legislation that would undermine institutions’ ability to properly employ affirmative action to promote a diverse student population.

13. Our AMA will work with the AAMC and other stakeholders to create a question for the AAMC electronic medical school application to identify previous pipeline program (also known as pathway program) participation and create a plan to analyze the data in order to determine the effectiveness of pipeline programs.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 313
(I-22)

Introduced by: Oklahoma, Arizona, District of Columbia, Hawaii, Iowa, Kansas, Kentucky, Maine, Minnesota, Mississippi, Missouri, Montana, Nebraska, New Hampshire, New Mexico, North Carolina, North Dakota, Utah, Virginia

Subject: Request a two-year delay in ACCME Changes to State Medical Society Recognition Program

Referred to: Reference Committee C

Whereas, The American Medical Association awards the AMA PRA Category 1 Credit™ for continuing medical education credit; and

Whereas, The Accreditation Council for Continuing Medical Education (ACCME) is the organization the AMA has given authority to accredit providers of AMA PRA Category 1 Credit™; and

Whereas, ACCME recognizes state medical societies to accredit local hospitals and organizations to provide CME credit in their state; and

Whereas, In August 2022, the ACCME announced it would no longer allow state medical societies with fewer than 20 accredited providers to be recognized accreditors. This change directly affects 19 state medical societies and indirectly affects the rest. Those directly affected include AL, AZ, HI, IA, IL, KY, ME, MN, MS, MO, NE, NH, NM, NC, OK, UT, VA, WV, and WI; and

Whereas, The state medical societies with fewer than 20 CME providers have until March of 2023 to notify ACCME whether they will: (a) Expand their accreditation program through recruitment of new providers to serve at least 20 eligible organizations; (b) Combine their program with one or more state medical societies (within regions defined by the ACCME) so that the merged/combined program has 20 or more accredited providers, or (c) Withdraw from recognition; and

Whereas, The ACCME requires state medical societies to implement the changes by January 1, 2024; and

Whereas, Most impacted state medical societies were not included in formal discussions about this proposal and did not find out about this decision until receiving letters on August 1, 2022 from ACCME announcing their CME programs would no longer be included in the state medical society accradiator program; and

Whereas, Several state medical societies dispute the ACCME rationale for the change that reliability and accuracy of accreditation decisions are linked to the number of providers a state medical society accredits; and

Whereas, This proposed change will negatively affect hospitals and CME providers in rural and other underserved areas; therefore be it
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)

Fiscal Note: Not yet determined

Received: 10/13/22
Whereas, Current demographics predict growth of an aging population of people over age 65 by 55 percent; and

Whereas, Projected shortfalls in primary care physicians ranges between 7,300 and 43,000 by 2030; and

Whereas, If current underserved populations utilize health care at the same rate as other patient populations, even higher demand is projected for primary care physicians; and

Whereas, Current proportion of internal medicine residents completing training and going into primary care practice has fallen below 10 percent; and

Whereas, Lifestyle, medical student debt, complex patient care demands, silos of care, electronic health record overload, and burnout all work against primary care physician recruitment; therefore be it

RESOLVED, That our American Medical Association take action on all fronts to advocate for and implement remedies that will rebalance the supply and demand equation for primary care physicians by 2030 (Directive to Take Action); and be it further


Fiscal Note: Not yet determined

Received: 10/13/22

RELEVANT AMA POLICY

US Physician Shortage H-200.954

Our AMA:
(1) explicitly recognizes the existing shortage of physicians in many specialties and areas of the US;
(2) supports efforts to quantify the geographic maldistribution and physician shortage in many specialties;
(3) supports current programs to alleviate the shortages in many specialties and the maldistribution of physicians in the US;
(4) encourages medical schools and residency programs to consider developing admissions policies and practices and targeted educational efforts aimed at attracting physicians to practice in underserved areas and to provide care to underserved populations;
(5) encourages medical schools and residency programs to continue to provide courses, clerkships, and longitudinal experiences in rural and other underserved areas as a means to support educational program objectives and to influence choice of graduates' practice locations;
(6) encourages medical schools to include criteria and processes in admission of medical students that
are predictive of graduates' eventual practice in underserved areas and with underserved populations;
(7) will continue to advocate for funding from public and private payers for educational programs that
provide experiences for medical students in rural and other underserved areas;
(8) will continue to advocate for funding from all payers (public and private sector) to increase the number
of graduate medical education positions in specialties leading to first certification;
(9) will work with other groups to explore additional innovative strategies for funding graduate medical
education positions, including positions tied to geographic or specialty need;
(10) continues to work with the Association of American Medical Colleges (AAMC) and other relevant
groups to monitor the outcomes of the National Resident Matching Program; and
(11) continues to work with the AAMC and other relevant groups to develop strategies to address the
current and potential shortages in clinical training sites for medical students.
(12) will: (a) promote greater awareness and implementation of the Project ECHO (Extension for
Community Healthcare Outcomes) and Child Psychiatry Access Project models among academic health
centers and community-based primary care physicians; (b) work with stakeholders to identify and mitigate
barriers to broader implementation of these models in the United States; and (c) monitor whether health
care payers offer additional payment or incentive payments for physicians who engage in clinical practice
improvement activities as a result of their participation in programs such as Project ECHO and the Child
Psychiatry Access Project; and if confirmed, promote awareness of these benefits among physicians.
(13) will work to augment the impact of initiatives to address rural physician workforce shortages.
Citation: Res. 807, I-03; Reaffirmation I-06; Reaffirmed: CME Rep. 7, A-08; Appended: CME Rep. 4, A-
10; Appended: CME Rep. 16, A-10; Reaffirmation: I-12; Reaffirmation A-13; Appended: Res. 922, I-13;
CME Rep. 3, I-21;

Revisions to AMA Policy on the Physician Workforce H-200.955
It is AMA policy that:
(1) any workforce planning efforts, done by the AMA or others, should utilize data on all aspects of the
health care system, including projected demographics of both providers and patients, the number and
roles of other health professionals in providing care, and practice environment changes. Planning should
have as a goal appropriate physician numbers, specialty mix, and geographic distribution.
(2) Our AMA encourages and collaborates in the collection of the data needed for workforce planning and
in the conduct of national and regional research on physician supply and distribution. The AMA will
independently and in collaboration with state and specialty societies, national medical organizations, and
other public and private sector groups, compile and disseminate the results of the research.
(3) The medical profession must be integrally involved in any workforce planning efforts sponsored by
federal or state governments, or by the private sector.
(4) In order to enhance access to care, our AMA collaborates with the public and private sectors to
ensure an adequate supply of physicians in all specialties and to develop strategies to mitigate the
current geographic maldistribution of physicians.
(5) There is a need to enhance underrepresented minority representation in medical schools and in the
physician workforce, as a means to ultimately improve access to care for minority and underserved
groups.
(6) There should be no decrease in the number of funded graduate medical education (GME) positions.
Any increase in the number of funded GME positions, overall or in a given specialty, and in the number
of US medical students should be based on a demonstrated regional or national need.
(7) Our AMA will collect and disseminate information on market demands and workforce needs, so as to
assist medical students and resident physicians in selecting a specialty and choosing a career.
(8) Our AMA will encourage the Health Resources & Service Administration to collaborate with specialty
societies to determine specific changes that would improve the agency's physician workforce projections
process, to potentially include more detailed projection inputs, with the goal of producing more accurate
and detailed projections including specialty and subspecialty workforces.
(9) Our AMA will consider physician retraining during all its deliberations on physician workforce planning.
Citation: CME Rep. 2, I-03; Reaffirmation I-06; Reaffirmation I-07; Reaffirmed: CME Rep. 15, A-10;
Reaffirmation: I-12;

Primary Care Physicians in Underserved Areas H-200.972
1. Our AMA should pursue the following plan to improve the recruitment and retention of physicians in
underserved areas:
(a) Encourage the creation and pilot-testing of school-based, faith-based, and community-based urban/rural family health clinics, with an emphasis on health education, prevention, primary care, and prenatal care.

(b) Encourage the affiliation of these family health clinics with local medical schools and teaching hospitals.

(c) Advocate for the implementation of AMA policy that supports extension of the rural health clinic concept to urban areas with appropriate federal agencies.

(d) Encourage the AMA Senior Physicians Section to consider the involvement of retired physicians in underserved settings, with appropriate mechanisms to ensure their competence.

(e) Urge hospitals and medical societies to develop opportunities for physicians to work part-time to staff health clinics that help meet the needs of underserved patient populations.

(f) Encourage the AMA and state medical associations to incorporate into state and federal health system reform legislative relief or immunity from professional liability for senior, part-time, or other physicians who help meet the needs of underserved patient populations.

(g) Urge hospitals and medical centers to seek out the use of available military health care resources and personnel, which can be used to help meet the needs of underserved patient populations.

2. Our AMA supports efforts to: (a) expand opportunities to retain international medical graduates after the expiration of allocated periods under current law; and (b) increase the recruitment and retention of physicians practicing in federally designated health professional shortage areas.

Citation: CMS Rep. I-93-2; Reaffirmation A-01; Reaffirmation I-03; Modified: CME Rep. 13, A-06; Reaffirmed: CMS Rep. 01, A-16; Modified: CME Rep. 04, I-18; Appended: Res. 206, I-19;

Educational Strategies for Meeting Rural Health Physician Shortage H-465.988

1. In light of the data available from the current literature as well as ongoing studies being conducted by staff, the AMA recommends that:

A. Our AMA encourage medical schools and residency programs to develop educationally sound rural clinical preceptorships and rotations consistent with educational and training requirements, and to provide early and continuing exposure to those programs for medical students and residents.

B. Our AMA encourage medical schools to develop educationally sound primary care residencies in smaller communities with the goal of educating and recruiting more rural physicians.

C. Our AMA encourage state and county medical societies to support state legislative efforts toward developing scholarship and loan programs for future rural physicians.

D. Our AMA encourage state and county medical societies and local medical schools to develop outreach and recruitment programs in rural counties to attract promising high school and college students to medicine and the other health professions.

E. Our AMA urge continued federal and state legislative support for funding of Area Health Education Centers (AHECs) for rural and other underserved areas.

F. Our AMA continue to support full appropriation for the National Health Service Corps Scholarship Program, with the proviso that medical schools serving states with large rural underserved populations have a priority and significant voice in the selection of recipients for those scholarships.

G. Our AMA support full funding of the new federal National Health Service Corps loan repayment program.

H. Our AMA encourage continued legislative support of the research studies being conducted by the Rural Health Research Centers funded by the National Office of Rural Health in the Department of Health and Human Services.

I. Our AMA continue its research investigation into the impact of educational programs on the supply of rural physicians.

J. Our AMA continue to conduct research and monitor other progress in development of educational strategies for alleviating rural physician shortages.

K. Our AMA reaffirm its support for legislation making interest payments on student debt tax deductible.

L. Our AMA encourage state and county medical societies to develop programs to enhance work opportunities and social support systems for spouses of rural practitioners.

2. Our AMA will work with state and specialty societies, medical schools, teaching hospitals, the Accreditation Council for Graduate Medical Education (ACGME), the Centers for Medicare and Medicaid Services (CMS) and other interested stakeholders to identify, encourage and incentivize qualified rural physicians to serve as preceptors and volunteer faculty for rural rotations in residency.

3. Our AMA will: (a) work with interested stakeholders to identify strategies to increase residency training opportunities in rural areas with a report back to the House of Delegates; and (b) work with interested
stakeholders to formulate an actionable plan of advocacy with the goal of increasing residency training in rural areas.
4. Our AMA will encourage ACGME review committees to consider adding exposure to rural medicine as appropriate, to encourage the development of rural program tracks in training programs and increase physician awareness of the conditions that pose challenges and lack of resources in rural areas.
5. Our AMA will encourage adding educational webinars, workshops and other didactics via remote learning formats to enhance the educational needs of smaller training programs.

Citation: CME Rep. C, I-90; Reaffirmation A-00; Reaffirmation A-01; Reaffirmation I-01; Reaffirmed: CME Rep. 1, I-08; Reaffirmed: CEJA Rep. 06, A-18; Appended: Res. 956, I-18; Appended: Res. 318, A-19; Modified: CME Rep. 3, I-21;

Increasing Graduate Medical Education Positions as a Component to any Federal Health Care Reform Policy D-305.958
1. Our AMA will ensure that actions to bolster the physician workforce must be part of any comprehensive federal health care reform.
2. Our AMA will work with the Centers for Medicare and Medicaid Services to explore ways to increase graduate medical education slots to accommodate the need for more physicians in the US.
3. Our AMA will work actively and in collaboration with the Association of American Medical Colleges and other interested stakeholders to rescind funding caps for GME imposed by the Balanced Budget Act of 1997.
4. Our AMA will actively advocate for expanded funding for entry and continued training positions in specialties and geographic regions with documented medical workforce shortages.
5. Our AMA will lobby Congress to find ways to increase graduate medical education funding to accommodate the projected need for more physicians.
6. Our AMA will work with key organizations, such as the US Health Resources and Services Administration, the Robert Graham Center, and the Cecil G. Sheps Center for Health Services Research, to: (A) support development of reports on the economic multiplier effect of each residency slot by geographic region and specialty; and (B) investigate the impact of GME funding on each state and its impact on that state’s health care workforce and health outcomes.

Citation: (Sub. Res. 314, A-09; Appended: Res. 316, A-12; Reaffirmed: Res. 921, I-12; Reaffirmation A-13; Reaffirmed: CME Rep. 5, A-13)

Sources:
1. Complexities of Physician supply and Demand 2017 Association of American Medical Colleges; IHS Markit report 2019 update
2. Trends in Career Paths of Internal Medicine Residents. Internal Medicine In-Training Exam Survey of interest to disclose.
Resolved, that the American Medical Association House of Delegates:

Whereas, There is a national shortage of bedside nurses; and
Whereas, It has been reported that nurses working for travel nurse agencies receive higher compensation than nurses employed directly by hospitals; and
Whereas, There is competition amongst hospitals, travel nurse agencies, and other organizations for nurses; and
Whereas, Experienced nurses are leaving bedside nursing jobs and choosing nonclinical careers; and
Whereas, Nursing students often wait to finish their education due to a lack of clinical sites or nursing educator availability; and
Whereas, Hospitals have reduced numbers of ancillary staff; and
Whereas, There is a shortage of emergency medical services providers; and
Whereas, Working in a hospital is physically demanding, requires working long shifts, and may require mandatory overtime; and
Whereas, Working in a hospital and other health care jobs pay lower wages than less demanding occupations; and
Whereas, Many nurses, physicians, ancillary staff, and physician assistants are suffering from moral injury and burnout related to the COVID-19 pandemic; and
Whereas, Hospitals had nursing and staff shortages before the COVID-19 pandemic and hospitals have been receiving federal financial assistance during the pandemic; and
Whereas, There is a need for systematic long-term strategies to address bedside nursing and other health care worker shortages including, but not limited to, improved staffing models and employee wellness programming to improve career longevity; therefore be it
RESOLVED, That our AMA amend AMA policy D-360.998, “The Growing Nursing Shortage in the United States” by addition to read as follows:

Our AMA: (1) recognizes the important role nurses and other allied health professionals play in providing quality care to patients, and participate in activities with state medical associations, county medical societies, and other local health care agencies to enhance the recruitment and retention of qualified individuals to the nursing profession and the allied health fields;
(2) encourages physicians to be aware of and work to improve workplace conditions that impair the professional relationship between physicians and nurses in the collaborative care of patients;
(3) encourages hospitals and other health care facilities to collect and analyze data on the relationship between staffing levels, nursing interventions, and patient outcomes, and to use this data in the quality assurance process;
(4) will work with nursing, hospital, and other appropriate organizations to enhance the recruitment and retention of qualified individuals to the nursing and other allied health professions;
(5) will work with nursing, hospital, and other appropriate organizations to seek to remove administrative burdens, e.g., excessive paperwork, to improve efficiencies in nursing and promote better patient care;
(6) will approach appropriate stakeholders such as the American Hospital Association to collaborate on the identification of and advocacy for short- and long-term strategies and solutions to address nursing and other health care staff shortages in order to promote a stable work force and career longevity. (Modify Current HOD Policy)

Fiscal Note: Not yet determined

Received: 10/13/22

RELEVANT AMA POLICY

The Growing Nursing Shortage in the United States D-360.998
Our AMA: (1) recognizes the important role nurses and other allied health professionals play in providing quality care to patients, and participate in activities with state medical associations, county medical societies, and other local health care agencies to enhance the recruitment and retention of qualified individuals to the nursing profession and the allied health fields;
(2) encourages physicians to be aware of and work to improve workplace conditions that impair the professional relationship between physicians and nurses in the collaborative care of patients;
(3) encourages hospitals and other health care facilities to collect and analyze data on the relationship between staffing levels, nursing interventions, and patient outcomes, and to use this data in the quality assurance process;
(4) will work with nursing, hospital, and other appropriate organizations to enhance the recruitment and retention of qualified individuals to the nursing and other allied health professions;
(5) will work with nursing, hospital, and other appropriate organizations to seek to remove administrative burdens, e.g., excessive paperwork, to improve efficiencies in nursing and promote better patient care. Citation: (CMS Rep. 7, A-01; Modified: Res. 708, A-03; Reaffirmed: CME Rep. 2, A-13)
Revisions to AMA Policy on the Physician Workforce H-200.955

It is AMA policy that:

(1) any workforce planning efforts, done by the AMA or others, should utilize data on all aspects of the health care system, including projected demographics of both providers and patients, the number and roles of other health professionals in providing care, and practice environment changes. Planning should have as a goal appropriate physician numbers, specialty mix, and geographic distribution.

(2) Our AMA encourages and collaborates in the collection of the data needed for workforce planning and in the conduct of national and regional research on physician supply and distribution. The AMA will independently and in collaboration with state and specialty societies, national medical organizations, and other public and private sector groups, compile and disseminate the results of the research.

(3) The medical profession must be integrally involved in any workforce planning efforts sponsored by federal or state governments, or by the private sector.

(4) In order to enhance access to care, our AMA collaborates with the public and private sectors to ensure an adequate supply of physicians in all specialties and to develop strategies to mitigate the current geographic maldistribution of physicians.

(5) There is a need to enhance underrepresented minority representation in medical schools and in the physician workforce, as a means to ultimately improve access to care for minority and underserved groups.

(6) There should be no decrease in the number of funded graduate medical education (GME) positions. Any increase in the number of funded GME positions, overall or in a given specialty, and in the number of US medical students should be based on a demonstrated regional or national need.

(7) Our AMA will collect and disseminate information on market demands and workforce needs, so as to assist medical students and resident physicians in selecting a specialty and choosing a career.

(8) Our AMA will encourage the Health Resources & Service Administration to collaborate with specialty societies to determine specific changes that would improve the agencies physician workforce projections process, to potentially include more detailed projection inputs, with the goal of producing more accurate and detailed projections including specialty and subspecialty workforces.

(9) Our AMA will consider physician retraining during all its deliberations on physician workforce planning.

Citation: CME Rep. 2, I-03; Reaffirmation I-06; Reaffirmation I-07; Reaffirmed: CME Rep. 15, A-10; Reaffirmation: I-12; Reaffirmation A-13; Appended: Res. 324, A-17; Appended: CME Rep. 01, A-19;
Whereas, Specialty certification is a critical component of our system of physician self-regulation and is essential to serve the public and the medical profession by improving the quality of health care through setting professional standards for lifelong certification; and

Whereas, The Institute for Credentialing Excellence defines a professional certification program as one that provides an independent assessment of the knowledge, skills, and/or competencies required for competent performance of a professional role or specific work-related tasks and responsibilities; and

Whereas, The Institute for Credentialing Excellence further states that certification is also intended to measure continued competence through recertification or renewal requirements; and

Whereas, Only the entity that initially certifies an individual should recertify the individual’s certificate thereafter; and

Whereas, According to policy H-275.926, “Medical Specialty Board Certification Standards,” our AMA opposes any action, regardless of intent, that appears likely to confuse the public about the unique credentials of the 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; and

Whereas, There are many legitimate certifying boards beyond the ABMS and AOA-BOS (e.g., American Board of Oral and Maxillofacial Surgery, American Board of Obesity Medicine, and American Board of Physician Specialties) that curate knowledge and set standards for required knowledge in a medical specialty and grant physicians certification who successfully meet their independent assessments of knowledge and skills; and

Whereas, According to policy H-275.926, “Medical Specialty Board Certification Standards,” our AMA advocates for nomenclature to better distinguish those physicians who are in the board certification pathway from those who are not; and

Whereas, Efforts by organizations that do not meet the basic standards for initial and continuing certification to gain recognition by state legislatures and national organizations are ongoing and will be confusing to the public and other health care stakeholders; therefore be it

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

Our AMA:

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

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

(3) Continues to work with other medical organizations to educate the profession and the public about the ABMS and AOA-BOS board certification process. It is AMA policy that when the equivalency of board certification must be determined, 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 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.

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)

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

Received: 10/19/22

REFERENCES:
1. Institute for Credentialing Excellence. Definition of Certification, at https://www.credentialingexcellence.org/About, accessed 19 October 2022
RELEVANT AMA POLICY

Medical Specialty Board Certification Standards H-275.926

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

Continuing Board Certification D-275.954

Our AMA will:
1. Continue to monitor the evolution of Continuing Board Certification (CBC), continue its active engagement in discussions regarding their implementation, encourage specialty boards to investigate and/or establish alternative approaches for CBC, and prepare a report regarding the CBC process at the request of the House of Delegates or when deemed necessary by the Council on Medical Education.
2. Continue to review, through its Council on Medical Education, published literature and emerging data as part of the Council’s ongoing efforts to critically review CBC issues.
3. Continue to monitor the progress by the American Board of Medical Specialties (ABMS) and its member boards on implementation of CBC, and encourage the ABMS to report its research findings on the issues surrounding certification and CBC on a periodic basis.
4. Encourage the ABMS and its member boards to continue to explore other ways to measure the ability of physicians to access and apply knowledge to care for patients, and to continue to examine the evidence supporting the value of specialty board certification and CBC.
5. Work with the ABMS to streamline and improve the Cognitive Expertise (Part III) component of CBC, including the exploration of alternative formats, in ways that effectively evaluate acquisition of new knowledge while reducing or eliminating the burden of a high-stakes examination.
6. Work with interested parties to ensure that CBC uses more than one pathway to assess accurately the competence of practicing physicians, to monitor for exam relevance and to ensure that CBC does not lead to unintended economic hardship such as hospital de-credentialing of practicing physicians.
7. Recommend that the ABMS not introduce additional assessment modalities that have not been validated to show improvement in physician performance and/or patient safety.
8. Work with the ABMS to eliminate practice performance assessment modules, as currently written, from CBC requirements.
9. Encourage the ABMS to ensure that all ABMS member boards provide full transparency related to the costs of preparing, administering, scoring and reporting CBC and certifying examinations.
10. Encourage the ABMS to ensure that CBC and certifying examinations do not result in substantial financial gain to ABMS member boards, and advocate that the ABMS develop fiduciary standards for its
member boards that are consistent with this principle.

11. Work with the ABMS to lessen the burden of CBC on physicians with multiple board certifications, particularly to ensure that CBC is specifically relevant to the physician’s current practice.

12. Work with key stakeholders to (a) support ongoing ABMS member board efforts to allow multiple and diverse physician educational and quality improvement activities to qualify for CBC; (b) support ABMS member board activities in facilitating the use of CBC quality improvement activities to count for other accountability requirements or programs, such as pay for quality/performance or PQRS reimbursement; (c) encourage ABMS member boards to enhance the consistency of quality improvement programs across all boards; and (d) work with specialty societies and ABMS member boards to develop tools and services that help physicians meet CBC requirements.

13. Work with the ABMS and its member boards to collect data on why physicians choose to maintain or discontinue their board certification.

14. Work with the ABMS to study whether CBC is an important factor in a physician’s decision to retire and to determine its impact on the US physician workforce.

15. Encourage the ABMS to use data from CBC to track whether physicians are maintaining certification and share this data with the AMA.

16. Encourage AMA members to be proactive in shaping CBC by seeking leadership positions on the ABMS member boards, American Osteopathic Association (AOA) specialty certifying boards, and CBC Committees.

17. Continue to monitor the actions of professional societies regarding recommendations for modification of CBC.

18. Encourage medical specialty societies’ leadership to work with the ABMS, and its member boards, to identify those specialty organizations that have developed an appropriate and relevant CBC process for its members.

19. Continue to work with the ABMS to ensure that physicians are clearly informed of the CBC requirements for their specific board and the timelines for accomplishing those requirements.

20. Encourage the ABMS and its member boards to develop a system to actively alert physicians of the due dates of the multi-stage requirements of continuous professional development and performance in practice, thereby assisting them with maintaining their board certification.

21. Recommend to the ABMS that all physician members of those boards governing the CBC process be required to participate in CBC.

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

23. Encourage the PCPI Foundation, the ABMS, and the Council of Medical Specialty Societies to work together toward utilizing Consortium performance measures in Part IV of CBC.

24. Continue to assist physicians in practice performance improvement.

25. Encourage all specialty societies to grant certified CME credit for activities that they offer to fulfill requirements of their respective specialty board’s CBC and associated processes.

26. Support the American College of Physicians as well as other professional societies in their efforts to work with the American Board of Internal Medicine (ABIM) to improve the CBC program.

27. Oppose those maintenance of certification programs administered by the specialty boards of the ABMS, or of any other similar physician certifying organization, which do not appropriately adhere to the principles codified as AMA Policy on Continuing Board Certification.

28. Ask the ABMS to encourage its member boards to review their maintenance of certification policies regarding the requirements for maintaining underlying primary or initial specialty board certification in addition to subspecialty board certification, if they have not yet done so, to allow physicians the option to focus on continuing board certification activities relevant to their practice.

29. Call for the immediate end of any mandatory, secured recertifying examination by the ABMS or other certifying organizations as part of the recertification process for all those specialties that still require a secure, high-stakes recertification examination.

30. Support a recertification process based on high quality, appropriate Continuing Medical Education (CME) material directed by the AMA recognized specialty societies covering the physician’s practice area, in cooperation with other willing stakeholders, that would be completed on a regular basis as determined by the individual medical specialty, to ensure lifelong learning.

31. Continue to work with the ABMS to encourage the development by and the sharing between specialty boards of alternative ways to assess medical knowledge other than by a secure high stakes exam.

32. Continue to support the requirement of CME and ongoing, quality assessments of physicians, where such CME is proven to be cost-effective and shown by evidence to improve quality of care for patients.
33. Through legislative, regulatory, or collaborative efforts, will work with interested state medical societies and other interested parties by creating model state legislation and model medical staff bylaws while advocating that Continuing Board Certification not be a requirement for: (a) medical staff membership, privileging, credentialing, or recredentialing; (b) insurance panel participation; or (c) state medical licensure.

34. Increase its efforts to work with the insurance industry to ensure that continuing board certification does not become a requirement for insurance panel participation.

35. Advocate that physicians who participate in programs related to quality improvement and/or patient safety receive credit for CBC Part IV.

36. Continue to work with the medical societies and the American Board of Medical Specialties (ABMS) member boards that have not yet moved to a process to improve the Part III secure, high-stakes examination to encourage them to do so.

37. Our AMA, through its Council on Medical Education, will continue to work with the American Board of Medical Specialties (ABMS), ABMS Committee on Continuing Certification (3C), and ABMS Stakeholder Council to pursue opportunities to implement the recommendations of the Continuing Board Certification: Vision for the Future Commission and AMA policies related to continuing board certification.

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

39. Our AMA will work with the ABMS and its member boards to reduce financial burdens for physicians holding multiple certificates who are actively participating in continuing certification through an ABMS member board, by developing opportunities for reciprocity for certification requirements as well as consideration of reduced or waived fee structures.

At the 2022 Annual Meeting, the House of Delegates referred Resolution 721, “Amend Policy H-215.981, ‘Corporate Practice of Medicine,’” which was sponsored by the Resident and Fellow Section. Resolution 721-A-22 asked the American Medical Association (AMA) to “amend AMA Policy H-215.981, ‘Corporate Practice of Medicine,’ by addition of a fourth clause that reads: ‘4. Our AMA acknowledges that the corporate practice of medicine has led to the erosion of the physician-patient relationship, erosion of physician-driven care and created a conflict of interest between profit and training the next generation of physicians.’”

The referral of Resolution 721-A-22 included specific concern that the study should include the impact of the corporate practice of medicine on all practice types. The Board of Trustees assigned this item to the Council on Medical Service for a report back to the House of Delegates. The Council notes that a related report is being presented by the Council on Medical Education at this meeting (CME Report 1-I-22 “The Impact of Private Equity on Medical Training”). The Council recognizes that private equity and corporate investors are becoming increasingly involved in graduate medical education, residencies, fellowships, and training of non-physician practitioners. We have chosen to focus this report on the general aspects of the corporate practice of medicine.

BACKGROUND

The Council recently prepared CMS Report 11 at the 2019 Annual Meeting which addressed a similar topic. The corporate practice of medicine is broadly defined as non-physician investment in medical practices. Two examples of corporate medicine include private equity investment funds and physician management groups. Private equity funds are pooled investments used to buy controlling shares of companies or other entities. After taking control, private equity funds typically streamline the business (which often includes cutting costs and reducing the ability for prior physician owners to make governance decisions) with the goal of selling the business for a profit in three to seven years. The types of investment range from venture capital (VC) firms that primarily invest in early-stage companies in exchange for minority ownership to more traditional private equity firms that borrow money to take a controlling stake in mature yet undervalued or underperforming companies through leveraged buyout deals. Alternatively, a practice management company is a privately held or publicly traded for-profit company that manages the back-end administrative functions of medical practices, such as insurance contracting and billing. Many practice management companies, often referred to as staffing companies, also contract with hospitals and ambulatory surgical centers to provide professional staffing and management services. Investments in practice management companies by private equity funds have led to an increase in their utilization.
While the extent of corporate investment in physician practices is not precisely known, a growing number of physicians are employed by corporations including hospitals, health systems, and insurers. Concerns regarding these partnerships have primarily centered on the potential for subsequent increases in prices, service volume, and internal referrals, as well as the use of unsupervised non-physician practitioners. An array of factors has led to these changes, including changes in payment and delivery models, physician payment challenges, high costs of new technology and equipment, and increased administrative and regulatory burdens.

In addition to employment by hospitals, health systems, and insurers, private equity firms and publicly traded for-profit corporations may invest in physician practices. Increasingly, private equity firms have acquired majority and/or controlling interests in entities that manage physician practices. However, there is little peer-reviewed evidence regarding the impact of these arrangements on physicians, patients or health care prices, and physician opinions vary. Hospitals, health systems, academic medical centers, large multispecialty groups, and corporate buyers frequently compete with private equity investors for the same physician practice targets. Corporate buyers may also partner with private equity investors or form consortia of buyers to acquire highly sought-after practices. Increased competition for physician groups in some specialties has led price valuations of these practices to rise. Because many private equity transactions are not disclosed (non-disclosure agreements are commonly used), the degree of investment in physician practices, while believed to be relatively small overall, cannot be precisely determined. Incomplete data on corporate transactions involving physician practices is a significant impediment to determining the impact of corporate investors on physicians, patients, and the health care marketplace.

State-by-State Differences

Generally, corporate practice of medicine doctrines prohibit corporations from practicing or interfering with the practice of medicine. The doctrines arise from state medical practice acts and are based on a number of public policy concerns, such as: (1) allowing corporations to practice medicine will result in the commercialization of the practice of medicine; (2) a corporation’s obligation to its shareholders may not align with a physician’s obligation to their patients; and (3) corporate interests may interfere with the physician’s independent medical judgment.

It is important to note that while most states have a prohibition on the corporate practice of medicine, every state provides an exception for professional corporations and many states provide an exception for employment of physicians by certain entities. For example, some states explicitly permit hospitals to employ physicians, some states allow nonprofit hospitals to employ physicians, and other states recognize an unwritten exception to the corporate practice of medicine for hospitals employing physicians. Many states that allow hospitals to employ physicians specifically prohibit the hospital from interfering with the independent medical judgment of the physician, thereby protecting the autonomy of the physician’s clinical decision-making. For example, in California and Indiana, clinics and hospitals may employ physicians as long as the entity does not direct or control independent medical acts, decisions or judgments of the licensed physician. On the other hand, in Colorado and Arkansas, all shareholders and officers of a medical corporation must be licensed physicians, consistent with each state’s licensing laws. In Texas, state laws allow critical access hospitals, sole community hospitals, and hospitals in counties with fewer than 50,000 people to employ physicians, with the requirement that physicians must “retain independent medical judgment in providing care to patients at the hospital or other health care facilities owned or operated by the hospital and may not be disciplined for reasonably advocating for patient care.”

Recently, there have been complaints filed in state courts arguing that some of these firms have oversstepped and are in violation of state corporate practice of medicine doctrines. One example is a lawsuit filed in California by the American Academy of Emergency Medicine Physician
Group (AAEM-PG) against Envision Healthcare Corporation. In its filing, AAEM-PG alleges that Envision is in violation of the state’s corporate practice of medicine doctrine, as Envision either forms new medical groups with non-physician officers or “installs Envision executives or officers in pre-existing medical groups.” Specifically, the lawsuit alleges that Envision: “decides how many and which physicians to hire, their compensation and work schedule...controls and influences advertising for physician vacancies, vetting physicians, establishing the terms of employment, the physician’s rate of pay, scheduling the hours physicians will work, staffing levels, the number of patient encounters and working conditions...when to terminate physicians and denies them rights to appeal via traditional medical staffing mechanisms...negotiates the groups’ contracts with third-party payers and health insurers and decides whether the group will agree to the terms...physicians are not made aware of the terms of their contracts with third-party payers.” The lawsuit was originally filed in December 2021. In May 2022, a judge for the United States District Court for the Northern District of California denied Envision Healthcare’s motion to dismiss the case; therefore, the case remains ongoing. The American College of Emergency Physicians and the California Medical Association have both filed amicus briefs in support of AAEM-PG. Further details and copies of court documents can be found on https://www.aaem.org/envision-lawsuit.

As previously stated, there is limited data on the extent of physician practice acquisition by private equity firms; however, private equity acquisition of physician practices increased from 59 deals in 2013 to 136 deals in 2016. In April 2022, JAMA Health Forum published data on the geographic variations in private equity penetration of physician practices (defined as the share of physicians in private equity-acquired practices) across six specialties: dermatology, gastroenterology, ophthalmology, obstetrics/gynecology, orthopaedics, and urology. Private equity penetration was highest in the Northeast (6.8 percent) and lowest in the Midwest (3.8 percent). Twelve states and the District of Columbia (DC) have an above average share of physicians in private equity practices, while eleven states have no identified acquisitions. States with the highest private equity penetration are Washington, DC (18.2 percent), Arizona (17.5 percent), New Jersey (13.6 percent), Maryland (13.1 percent), Connecticut (12.6 percent), and Florida (10.8 percent). By specialty, private equity penetration was highest in dermatology, followed by gastroenterology, ophthalmology, obstetrics/gynecology, and orthopaedics.

Risks and Benefits

As with any practice type, there are risks and benefits associated with entering into corporate partnerships. Risks include loss of control over the physician practice and future revenues, loss of autonomy in decision-making, an emphasis on profit or meeting financial goals, potential conflicts of interest, and potential uncertainties for non-owner early and mid-career physicians. Additionally, after a buyout there could be added layers of bureaucracy that could add burdens to physicians. Examples could be new checks and balances or updated workflows. Benefits include financially lucrative deals for physicians looking to exit ownership of their practices, access to capital for practice expenses or expansions (which may relieve physicians’ financial pressures), potentially fewer administrative and regulatory burdens on prior practice owners, and centralized resources for certain functions such as IT, marketing, and human resources.

There can also be risks to patients when physicians enter into these agreements. Recent evidence has shown a 10 percent increase in short-term mortality in private equity-owned nursing homes compared to non-private equity owned nursing homes. This is possibly due to decreases in nursing staff and declines in compliance with federal and state standards of care. Another study evaluating private equity acquisitions of US hospitals demonstrated increased charges, increased net income, and increased patient risk scores, along with fewer Medicaid patients admitted, after private equity acquisition relative to control groups. A third study showed that private...
equity-owned dermatology practices were associated with 3 percent-5 percent higher prices for routine medical visits at 1.5 years after acquisition as compared with non-private equity-owned practices. Other studies have shown increased rates of surprise billing, overutilization of high-margin or low-value services, and pressure to up-code charges after private equity acquisition.13

**Impact on Patient-Physician Relationship**

Research is ongoing about the effects of corporate medicine investment on patient outcomes and cost-savings. A study of 176 hospitals acquired by private equity firms during 2005-2014 was conducted to compare financial performance to matched control hospitals.14 Private equity acquisition of short-term acute care hospitals was associated with decreased costs per discharge and increased margins. The study highlights early findings on the impact private equity investment has on the health care system. Preliminary data show that financial performance improved after acquisition; however, patient utilization of services increased, and staffing decreased. Importantly, the study found that the decline in total costs per discharge was not adjusted for total full time hospital personnel, which suggests that hospitals cut costs in other dimensions, not only labor, after private equity acquisition. The authors of the study note that although improved financial performance occurred broadly, the findings are not evidence that gains in efficacy translate to improved patient outcomes or clinical experiences in either the short or long term.15

Under private equity investment, maintaining physician autonomy and a physician-led care team is crucial. Physicians should retain complete control of clinical decision making, as well as decisions regarding who is a member of their care team. Care provided by non-physician practitioners has been shown to be more costly than care provided by a physician-led team. An example of this is at the Hattiesburg Clinic in Mississippi. An examination of cost data for the South Mississippi system’s accountable care organization (ACO) revealed that care provided by non-physician practitioners working on their own patient panels was more expensive than care delivered by physicians. The 2017-2019 Centers for Medicare & Medicaid Services (CMS) cost data on Medicare patients without end-stage renal disease and who were not in a nursing home showed that per-member, per-month spending was $43 higher for patients whose primary health professional was a nonphysician instead of a physician. This finding could translate to $10.3 million more in spending annually if all patients were followed by non-physician practitioners. Citing the results of the clinic’s study, researchers found that “the results are consistent and clear: By allowing advanced practice providers to function with independent panels under physician supervision, we failed to meet our goals in the primary care setting of providing patients with an equivalent value-based experience.” These findings underscore the importance of physician-led care teams, regardless of business model or private equity investment, both to control costs and improve patient outcomes.16

**AMA POLICY**

Long-standing AMA policy states that physicians are free to choose their mode of practice and enter into contractual agreements as they see fit.

Policy H-215.981 opposes federal legislation preempting state laws prohibiting the corporate practice of medicine; states that the AMA will continue monitoring the corporate practice of medicine and its effect on the patient-physician relationship, financial conflicts of interest, and patient-centered care; and directs the AMA to provide guidance, consultation, and model legislation regarding the corporate practice of medicine, at the request of state medical associations, to ensure the autonomy of hospital medical staffs, employed physicians in non-hospital settings, and physicians contracting with corporately-owned management service organizations.
Policy H-285.951 states that physicians should have the right to enter into whatever contractual arrangements they deem desirable and necessary but should be aware of potential conflicts of interest due to the use of financial incentives in the management of care.

Policy H-215.968 supports and encourages competition between and among health facilities as a means of promoting the delivery of high-quality, cost-effective care.

Policy H-225.947 encourages physicians who seek employment as their mode of practice to strive for employment arrangements consistent with a series of principles, including: (a) physician clinical autonomy is preserved; (b) physicians are included and actively involved in integrated leadership opportunities; (c) physicians are encouraged and guaranteed the ability to organize under a formal self-governance and management structure; (d) physicians are encouraged and expected to work with others to deliver effective, efficient, and appropriate care; (e) a mechanism is provided for the open and transparent sharing of clinical and business information by all parties to improve care; and (f) a clinical information system infrastructure exists that allows capture and reporting of key clinical quality and efficiency performance data for all participants accountability across the system to those measures.

Policy H-160.960 states that when a private medical practice is purchased by corporate entities, patients shall be informed of the ownership arrangement by the corporate entities and/or physicians. Policy H-160.891 lists guidelines for physicians to consider when they are contemplating corporate investor partnerships. These guidelines include: (a) how the practice’s current mission, vision, and long-term goals align with those of the corporate investor; (b) due diligence should be conducted that includes, at minimum, review of the corporate investor’s business model, strategic plan, leadership and governance, and culture; (c) external legal, accounting and/or business counsels should be obtained to advise during the exploration and negotiation of corporate investor transactions; (d) retaining negotiators to advocate for best interests of the practice and its employees should be considered; (e) whether and how corporate investor partnerships may require physicians to cede varying degrees of control over practice decision-making and day-to-day management; (f) the potential impact of corporate investor partnerships on physician and practice employee satisfaction and future physician recruitment; (g) a clear understanding of compensation agreements, mechanisms for conflict resolution, processes for exiting corporate investor partnerships, and application of restrictive covenants; (h) corporate investor processes for medical staff representation on the board of directors and medical staff leadership selection; and (i) retain responsibility for clinical governance, patient welfare and outcomes, physician clinical autonomy, and physician due process under corporate investor partnerships. Additionally, Policy H-160.891 states that the AMA supports improved transparency regarding corporate investment in physician practices and subsequent changes in health care prices; encourages national medical specialty societies to research and develop tools and resources on the impact of corporate investor partnerships on patients and the physicians practicing in that specialty; and supports consideration of options for gathering information on the impact of private equity and corporate investors on the practice of medicine.

DISCUSSION

The Council recognizes that private equity investment and the corporate practice of medicine are continuing to change the health care landscape. This report describes various investment opportunities and their impact on medical practice. Anecdotally, there have been challenges associated with the corporate practice of medicine and evidence that some investment firms have overstepped and could be in violation of state corporate practice of medicine doctrines. It is clear
that in order to control spending and provide optimal care for patients, care teams should be physician-led.

The AMA has long-standing policy that supports a physician’s right to choose their mode of practice and type of employment, and we acknowledge that investor partnerships can be lucrative and successful. The AMA has published several resources and ethical opinions to guide physicians as they make the choice that is best for them.

The Council recommends new policy to address the concerns outlined in this report, including the potential to erode the patient-physician relationship and create conflicts of interest in medical education. In addition, the Council recognizes that the nature of corporate investor relationships could potentially change in the future and recommends amending Policy H-160.891 regarding corporate investors to strengthen the physician’s role in clinical decision-making, medical education, and determining the composition of the care team.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 721-A-22, and the remainder of the report be filed:

1. That our American Medical Association (AMA) acknowledge that the corporate practice of medicine has the potential to erode the patient-physician relationship. (New HOD Policy)

2. That our AMA acknowledge that the corporate practice of medicine may create a conflict of interest between profit and best practices in residency and fellowship training. (New HOD Policy)

3. That our AMA amend Policy H-160.891 by addition of two new clauses, as follows:
   j. Each individual physician should have the ultimate decision for medical judgment in patient care and medical care processes, including the use of mandated patient care algorithms or supervision of non-physician practitioners.
   k. Physicians should retain primary and final responsibility for structured medical education inclusive of undergraduate and graduate medical education including the structure of the program, program curriculum, selection of faculty and trainees, as well as educational and disciplinary issues related to these programs. (Modify Current HOD Policy)

Fiscal Note: Less than $500.
REFERENCES

5 Ibid.
6 Ibid.
7 Ibid.
10 Singh, Y. “Geographic Variation in Private Equity Penetration Across Select Office-Based Physician Specialties in the US.” JAMA Health Forum. April 2022. Available at: https://jamanetwork.com/journals/jama-health-forum/fullarticle/2791722
11 Ikram, Supra note 1.
12 Ikram, Supra note 1.
13 Ikram, Supra note 1.
15 Ibid.
Whereas, The majority of deaths from firearms (85%) in younger children ages 0-12 years occur in the home; and

Whereas, Older children (13-18 years) are equally likely to be killed at home (39%) or on the sidewalk/street; and

Whereas, Providing barriers to access to firearms in the home is a crucial mechanism to decrease the risks of unintentional firearm shooting as well as suicide and homicide; and

Whereas, Safer storage of guns in homes includes storing the firearm unloaded, storing the firearm locked, storing the ammunition separately from the firearm, and storing the ammunition locked; and

Whereas, Studies have demonstrated that parents underestimate their child’s response to encountering an unsecured gun; and

Whereas, Studies have also demonstrated that patients and families will accept safe storage devices for guns when provided by their physician; and

Whereas, In the context of suicide prevention, “lethal means counseling” means 1) assessing whether a person at risk for suicide has access to a firearm or other lethal means, and 2) working with them and their family and support system to limit their access to said lethal means until they are no longer at elevated risk; and

Whereas, Permanent or even temporary removal of a firearm from a home with a person at risk of lethal intent can prevent the injury or death from occurring; and

Whereas, In many instances firearms can be temporarily transferred to other people, stored at gun clubs or shooting ranges, or stored with the local police in many localities;

RESOLVED, That our American Medical Association and all interested medical societies educate physicians about firearm epidemiology, anticipatory guidance, and lethal means screening for and exploring potential restrictions to access to high-lethality means of suicide such as firearms. Health care clinicians, including trainees, should be provided training on the importance of anticipatory guidance and lethal means counseling to decrease firearm injuries and deaths and be provided training introducing evidence-based techniques, skills and strategies for having these discussions with patients and families (Directive to Take Action); and be it further
RESOLVED, That our AMA and all interested medical societies educate physicians about lethal means counseling in health care settings and intervention options to remove lethal means, either permanently or temporarily from the home (Directive to Take Action); and be it further

RESOLVED, That our AMA and all interested medical societies advocate for policies that support the provision of funding for physicians to provide affordable rapid-access safe storage devices to patients with firearms in the home (Directive to Take Action); and be it further

RESOLVED, That our AMA and all interested medical societies educate the public about: (1) best practices for firearm storage safety; (2) misconceptions families have regarding child response to encountering a gun in the home; and (3) he need to ask other families with whom the child interacts regarding the presence and storage of guns in other homes the child may enter. (Directive to Take Action)

Fiscal Note: Not yet determined

Received: 10/13/22