

Reference Committee C

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REPORT 1 OF THE COUNCIL ON MEDICAL EDUCATION (I-22)
The Impact of Private Equity on Medical Training
(Reference Committee C)

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.

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 1-I-22

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.⁴ 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.⁵ In 2018, PE hospitals were on average located in lower-income, more-rural areas and had fewer patients discharged and employees per bed.⁶

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 2019⁷ with hospitals that are owned by PE firms being a subset of investor-owned hospitals that has increased in recent years.

<u>American Hospital Association (AHA) Annual Survey</u>	<u>FY 2019⁸</u>	<u>FY 2015⁹</u>
Total Number of All U.S. Hospitals⁸	6,090	5,564
Number of U.S. Community Hospitals (i.e., all nonfederal, short-term general, and other special hospitals)	5,141	4,862
• Number of Nongovernment Not-for-Profit Community Hospitals	2,946	2,845
• Number of Investor-Owned (For-Profit) Community Hospitals	1,233	1,034
• Number of State and Local Government Community Hospitals	962	983

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

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.¹⁰ 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.¹¹ 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.¹²

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.⁶ 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,¹³ and the residency positions were redistributed by CMS using their existing process which prioritizes local hospitals without charge.¹⁴

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.¹⁵ Since Pennsylvania required that all physicians have tail coverage from previous employers, this effort was particularly important.¹⁶

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.¹⁷ 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.¹⁸

Closure of Emergency Medicine department at Summa Health Care

Summa HealthTM 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 HealthTM 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.¹⁹

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.²⁰

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-specialties 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.³¹ 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

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

4
5 To illustrate, dermatology practices represent 15 percent of recent private equity acquisitions of
6 medical practices even though dermatologists account for only one percent of physicians in the
7 U.S.³² PE firms invest in dermatology management groups (DMGs) which operate multiple clinics
8 and have been known to acquire smaller, physician-owned practices. Research suggests that this
9 consolidation of dermatology practices may be associated with changes in practice management
10 and that PE firms have a financial stake in an increasing number of dermatology practices in the
11 U.S.³³ PE's interest in dermatology points to several factors including: treatment of skin cancer,
12 which is the most common cancer in the U.S.³⁴; a growing older population in need of skin care; a
13 specialty with a history of fragmentation; demand for dermatologists; and profitability of the
14 specialty as well as its specialized services such as Mohs and dermatopathology.³⁵ However, there
15 are considerations for dermatologists. As stated by AMA President Jack Resneck, Jr., MD,
16 "Practice acquisitions at inflated prices in a competitive quest to quickly consolidate fragmented
17 markets and sell practices at a profit to future investors may eventually lead to bankruptcies,
18 leaving dermatologists without practices and patients without services."³⁶ Further, the impact on
19 dermatology training programs is unclear. The American Academy of Dermatology and American
20 Board of Dermatology do not appear to have issued statements regarding private equity and its role
21 in the specialty or impact on GME.

22
23 Another example of PE growth is within ophthalmology, for reasons similar to dermatology. As of
24 2019, 30-35 PE firms were in this market.²⁷ PE's focus is on large and regionally important
25 practices as well as those with a strong ambulatory surgery center (ASC) component. It is believed
26 that such interest in ASCs will increase, as "stable ASC profits and comparatively low enterprise
27 complexity are most in keeping with a corporate environment—much more so than the massive
28 complexity and volatility of the underlying practices themselves."⁴⁶ The American Academy of
29 Ophthalmology (AAO) notes, "Purchases of private equity in the health care market have soared in
30 recent years with hospitals and larger practice acquiring smaller practices. The Academy urges
31 every physician who is considering a practice equity acquisition to perform careful due diligence
32 and seek good counsel." The [AAO](#) offers information to physicians who are considering such
33 opportunities.⁴⁷

34
35 In April 2022, the American College of Emergency Physicians (ACEP) issued a statement on
36 Private Equity and Corporate Investment in Emergency Medicine. In it, they expressed increased
37 concerns about the expanding presence of PE and corporate investment in health care, including
38 emergency medicine.⁴⁸

39
40 Prior to this, the American Academy of Emergency Medicine (AAEM) Resident and Student
41 Association issued an open letter addressing their concerns with regards to training in an
42 environment influenced by corporate entities. Specifically, they urge the profession to, "Purge our
43 specialty societies from the influence and funding from corporate entities" among other
44 recommendations.⁴⁹ Further, this letter calls for a moratorium on new EM residency training
45 programs until issues are addressed, namely concerns about program quality as well as the
46 oversupply of EM physicians.

47
48 Likewise, a 2021 position paper from the American College of Physicians (ACP) concluded,
49 "Ultimately, professionalism, medical ethics, and the patient-physician relationship must guide
50 how physicians navigate the business side of medicine. Nonprofits must act like nonprofits and
51 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.”⁵⁰

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.⁵¹

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.³⁰ 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.⁵²

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.”⁵³ 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

- 1 training sites and make these policies available to current and prospective GME
2 learners. (Directive to Take Action)
3
- 4 3. Encourage necessary changes in Public Service Loan Forgiveness Program (PSLF) to
5 allow medical students and physicians to enroll in the program even if they receive some or
6 all of their training at a for-profit or governmental institution. (Directive to Take Action)
7
- 8 4. Support publicly funded independent research on the impact that private equity has on
9 graduate medical education. (New HOD Policy)
10
- 11 5. Encourage physician associations, boards, and societies to draft policy or release their own
12 issue statements on private equity to heighten awareness among the physician community.
13 (Directive to Take Action)
14
- 15 6. Encourage physicians who are contemplating corporate investor partnerships to consider
16 the ongoing education and welfare for trainee physicians who train under physicians in that
17 practice, including the financial implications of existing funding that is used to support that
18 training. (Directive to Take Action)
19
- 20 7. Amend Policy [D-310.948](#) "Protection of Resident and Fellow Training in the Case of
21 Hospital or Training Program Closure" by addition to read as follows:
22
- 23 Our AMA: (6) will continue to work with ACGME, interested specialty societies,
24 and others to monitor issues, collect data, and share information related to training
25 programs run by corporate and nonprofit entities and their effect on medical
26 education. (Modify HOD Policy)
27
- 28 8. Reaffirm the following policies:
29
 - [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)
33
- 34 9. Rescind AMA Policy D-310.947 as having been accomplished by this report. (Rescind
35 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.

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REPORT 2 OF THE COUNCIL ON MEDICAL EDUCATION (I-22)
Mitigating Demographic and Socioeconomic Inequities in the Residency and Fellowship Selection
Process
(Reference Committee C)

EXECUTIVE SUMMARY

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

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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.”¹ 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.² 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.³

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.”⁴

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).⁵ 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.⁶

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.

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

Source: [AAMC ERAS Statistics website](#)

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 survey⁷ 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

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

Factors Reflecting Personal Characteristics

	Percent Citing as a Factor	Average Weight
Letters of recommendation in specialty	85.1	4.2
Personal statement (overall)	83.8	3.9
Diversity characteristics	80.9	4.1
Perceived commitment to specialty	79.5	4.3
Having overcome significant obstacles	75.5	4.1

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.)

1 It should be noted that while considering academic performance as a factor in choosing whom to
 2 interview, the weight provided to those factors is relatively low compared to some other factors,
 3 with the exception of “any USMLE failure.” Still, a significant number of programs acknowledge
 4 filtering applicants based upon academic performance on standardized exams.

5
 6 One positive sign is that a significant number of program directors use an applicant’s diversity
 7 characteristics as an influence on their decision regarding whether to interview that applicant. This
 8 practice is in alignment with the intent of the Common Program Requirements of the Accreditation
 9 Council for Graduate Medical Education, which state that residency programs and their sponsoring
 10 institutions “must engage in practices that focus on mission-driven, ongoing, systematic
 11 recruitment and retention of a diverse and inclusive workforce of residents, fellows, faculty
 12 members, senior administrative staff members and other relevant members of the academic
 13 community.”⁸

14
 15 Overall, in the 2021 Residency Match, the average number of residency positions for all programs
 16 was nine, for which the average number of applications received by a program was 1,013. Of these
 17 applications, 506 (49.9 percent) were rejected based upon a standardized screening process and 423
 18 (41.8 percent) received an in-depth holistic review.⁷

19
 20 Although these data do not provide information on what the standardized screening process
 21 entailed, one survey of internal medicine program directors (who can receive up to 3,000 applicants
 22 per program) found that USMLE Step 2 CK score, USMLE Step 1 score, and attendance at a
 23 specific medical school were the top three filters used for initial application review.⁹

24
 25 While evidence is limited, there is concern that the use of test scores for this type of initial
 26 screening review may introduce and exacerbate racial and socioeconomic biases into the selection
 27 process. Numerous studies have demonstrated the link between standardized tests—common in K-
 28 12 as well as higher education, along with the medical education continuum—and perpetuation of
 29 racial and socioeconomic bias. It is not the examinations themselves, however, that are the issue
 30 (for example, the Medical College Admission Test, or MCAT, for which the psychometric
 31 literature shows no evidence of bias) but rather the larger and more insidious patterns of systemic
 32 racism, which limit economic success and educational opportunity for minoritized populations.
 33 Finally, and most importantly, research shows that the ability to pass a test is not especially
 34 relevant to one’s ability to provide quality medical care. Emotional intelligence, empathy, and
 35 communication are more valuable to the successful practice of medicine than sheer raw
 36 intelligence. Indeed, as Lucey and Saguil note, “the MCAT exam is designed to measure
 37 applicants’ academic preparation for medical school . . . not . . . to measure or predict their
 38 performance related to other, essential competencies, such as interpersonal skills and
 39 communication, professionalism, and ethical behavior, or to take the place of other attributes that
 40 nonexam aspects of the admissions process evaluate.”¹⁰

41 42 MEDICAL HONOR SOCIETIES AND THEIR ROLE IN RESIDENCY SELECTION

43 44 *Background*

45
 46 Similar to concerns about overreliance on standardized testing for advancement in higher education
 47 and medical education, the use of medical honor society membership to screen applicants has
 48 become a subject of increasing scrutiny in recent years. The next section considers three medical
 49 honor societies, their role in the residency selection process, and their respective work to increase
 50 attention to diversity and equity.

Alpha Omega Alpha

Formed in 1902, Alpha Omega Alpha (ΑΩΑ) 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, ΑΩΑ 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 ΑΩΑ website, “Membership in ΑΩΑ 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 ΑΩΑ’s mission and values.”¹¹ 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 ΑΩΑ 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.”¹² 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.¹³

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.”¹⁴ 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.¹⁵ 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.”¹⁶

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.¹⁷ 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, ophthalmology²² is piloting the use of the Altus Suite for Graduate Medical Education,²³ 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.²⁴ 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.”²⁵ 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.”²⁶ 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.”²⁷ 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—“risers,” “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.”²⁸

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)

- 1 3. That our AMA advocate for residency and fellowship programs to avoid using objective
2 criteria available in the Electronic Residency Application Service (ERAS) application
3 process as the sole determinant for deciding which applicants to offer interviews.
4 (Directive to Take Action)
5
- 6 4. That our AMA advocate to remove membership in medical honor societies as a mandated
7 field of entry on the Electronic Residency Application Service (ERAS)—thereby limiting
8 its use as an automated screening mechanism—and encourage applicants to share this
9 information within other aspects of the ERAS application. (Directive to Take Action)
10
- 11 5. That our AMA advocate for and support innovation in the undergraduate medical
12 education to graduate medical education transition, especially focusing on the efforts of the
13 Accelerating Change in Medical Education initiative, to include pilot efforts to optimize
14 the residency/fellowship application and matching process. (New HOD Policy)
15
- 16 6. That our AMA monitor use of novel online assessments for sampling personal
17 characteristics for the purpose of medical school admissions or residency/fellowship
18 selection and consider their impact on equity and diversity of the physician workforce.
19 (New HOD Policy)
20
- 21 7. That AMA Policy D-295.963(5), “Continued Support for Diversity in Medical Education,”
22 be rescinded, as having been fulfilled through this report:
23
24 Our AMA will: ... ~~work with appropriate stakeholders to study reforms to mitigate~~
25 ~~demographic and socioeconomic inequities in the residency and fellowship selection~~
26 ~~process, including but not limited to the selection and reporting of honor society~~
27 ~~membership and the use of standardized tools to rank applicants, with report back to the~~
28 ~~House of Delegates.~~ (Rescind HOD Policy)

Fiscal note: \$1,000.

APPENDIX A: MEMORANDUM FROM THE ARNOLD P. GOLD FOUNDATION TO THE AMA, FEBRUARY 7, 2022

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 (ΑΩΑ) membership have been documented ([Boatright et al., 2017](#)) and formally responded to by the ΑΩΑ ([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. Dowin 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. Dowin 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

D-200.985, "Strategies for Enhancing Diversity in the Physician Workforce"

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

D-295.963, "Continued Support for Diversity in Medical Education"

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; and (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.

(Res. 325, A-03; Appended: CME Rep. 6, A-11; Modified: CME Rep. 3, A-13; Appended: CME Rep. 5, A-21)

H-350.960, "Underrepresented Student Access to US Medical Schools"

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; and (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.

(Res. 908, I-08; Reaffirmed in lieu of Res. 311, A-15)

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.

(Res. 325, A-03; Appended: CME Rep. 6, A-11; Modified: CME Rep. 3, A-13)

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.

(CME Rep. 8, I-99; Reaffirmed: CME Rep. 2, A-09; Appended: CME Rep. 3, A-11)

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.

<https://www.nrmp.org/wp-content/uploads/2021/11/2021-PD-Survey-Report-for-WWW.pdf>.

Figure PD_I1

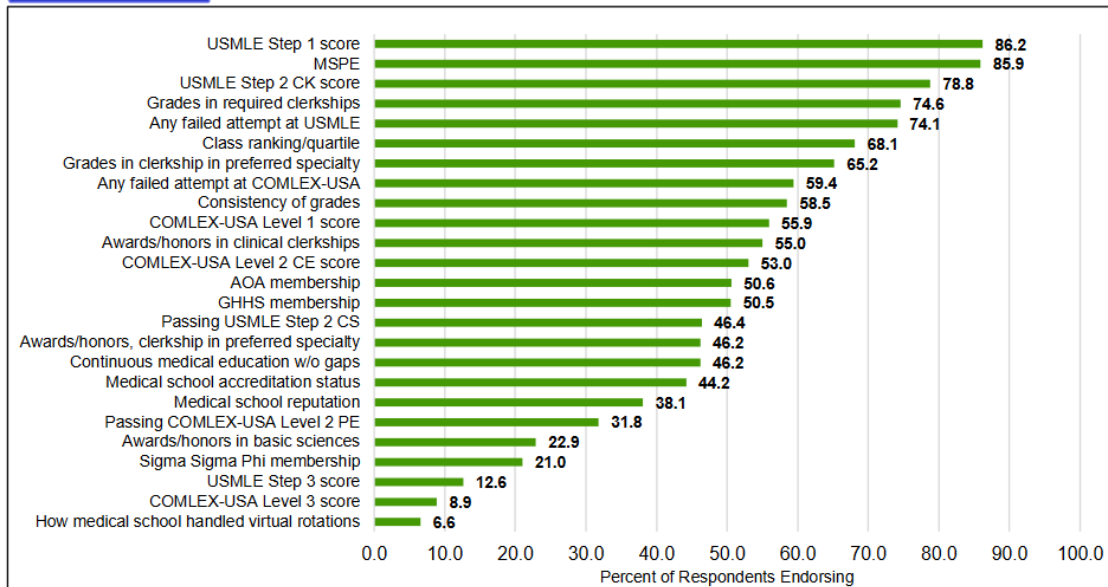
Education and Academic Performance Characteristics Considered in Deciding Whom to Interview (%)

Figure PD_I2

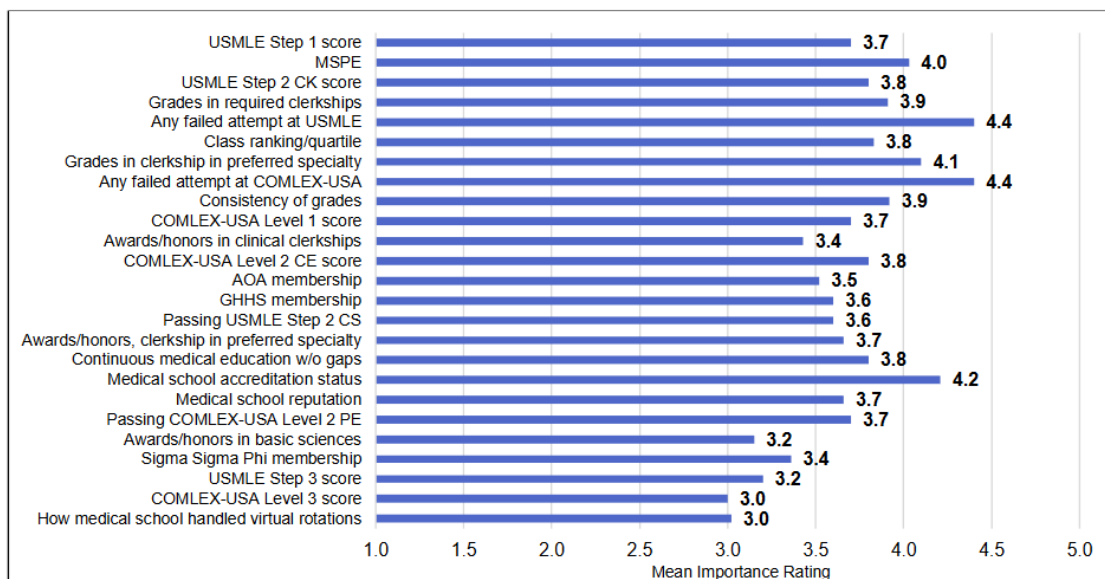
Mean Importance of Education and Academic Performance Characteristics Considered in Deciding Whom to Interview¹¹ Rated on a scale of 1 (not at all important) to 5 (very important)

Figure PD_I3

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

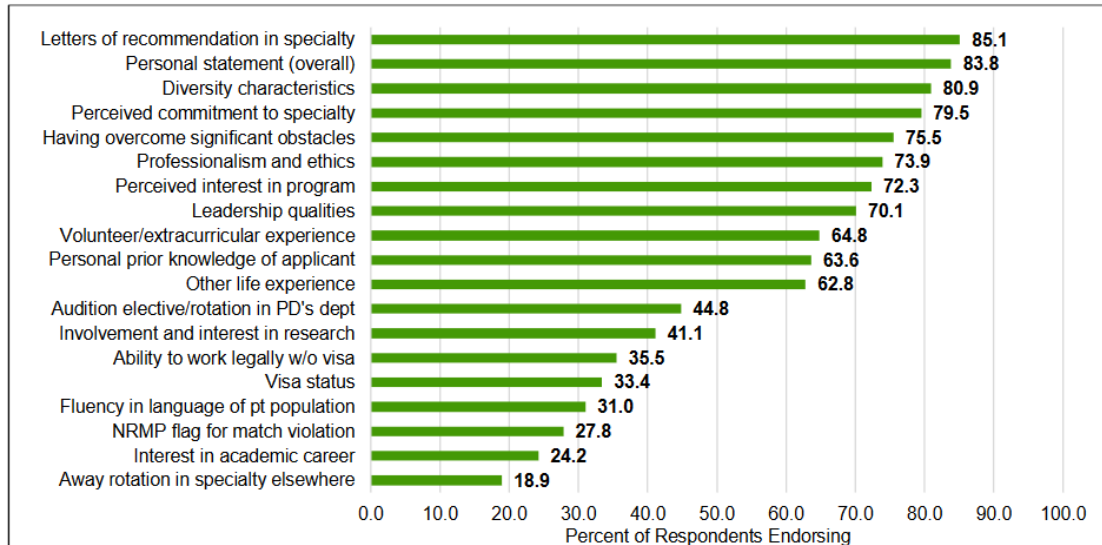
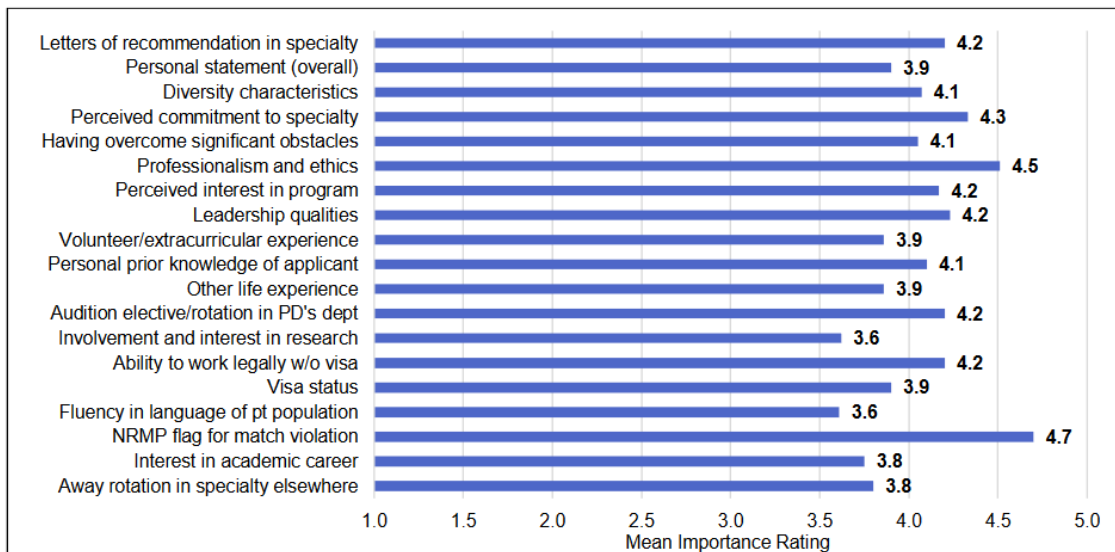


Figure PD_I4

Mean Importance of Personal Characteristics and Other Knowledge of Applicants Considered in Deciding Whom to Interview¹



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

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 302
(I-22)

Introduced by: Medical Student Section

Subject: Expanding Employee Leave to Include Miscarriage and Stillbirth

Referred to: Reference Committee C

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

5
6 Whereas, An estimated 26% of all pregnancies and 10% of clinically recognized pregnancies
7 end in miscarriage¹; and

8
9 Whereas, An estimated 24,000 stillbirths occur each year in the United States²; and

10
11 Whereas, It takes at least two weeks to physically recover from a miscarriage and the World
12 Health Organization (WHO) recommends waiting 6 months after a miscarriage to try again to
13 get pregnant^{3,4}; and

14
15 Whereas, The risk of severe maternal morbidity is more than four times higher for stillbirths
16 compared with live birth deliveries^{5,6}; and

17
18 Whereas, In multiple studies, PTSD prevalence ranged from 33.3% to 60% after pregnancy
19 loss, and the prevalence of anxiety was 20%, the prevalence of depression ranged from 5% to
20 54% respectively, and 77% of parents experienced emotional and psychological distress
21 following a stillbirth^{7,8,9,10}; and

22
23 Whereas, Black women and women of lower socioeconomic status are twice as likely to
24 experience late miscarriage and stillbirth, have limited access to bereavement support, and are
25 less likely to have access to paid leave time after miscarriage or stillbirth¹¹; and

26
27 Whereas, Paid sick leave has been shown to lead to an increase in employment, reduction in
28 workforce turnover, and increases in household incomes¹²; and

29
30 Whereas, The District of Columbia recently expanded bereavement leave to include leave for
31 loss of a pregnancy, several states, including Illinois, Maryland, Oregon, and Washington, have
32 bereavement of family leave policies but do not specify if pregnancy loss meets criteria for such
33 leave, and multiple countries, including New Zealand and South Korea, mandate paid leave for
34 miscarriages and similar legislation, such as the Support through Loss Act, has been introduced
35 in the United States^{13, 14, 15, 16, 17, 18}; and

36
37 Whereas, Our AMA supports medical and family leave (H-420.979 and H-405.960) but we do
38 not have policy that explicitly notes that this should include leave for pregnancy loss; therefore
39 be it

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

3
4 **Policies for Parental, Family and Medical Necessity Leave H-405.960**

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

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

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

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

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

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

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

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

or delayed year of training; ~~(j)~~(k) whether time spent in making up a leave will be paid; and ~~(k)~~(l) whether schedule accommodations are allowed, such as reduced hours, no night call, modified rotation schedules, and permanent part-time scheduling.

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

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

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

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

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

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

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

RESOLVED, That due to the prevalence of miscarriage and stillbirth and the need for physical and psychological healing afterwards, our AMA amend Policy H-420.979 "AMA Statement on Family and Medical Leave," by addition to read as follows:

AMA Statement on Family and Medical Leave H-420.979

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

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

(2) maternity leave for the employee-mother;

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

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

(Modify Current HOD Policy)

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

Received: 09/20/22

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RELEVANT AMA POLICY

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

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

1. Our AMA urges medical schools, residency training programs, medical specialty boards, the Accreditation Council for Graduate Medical Education, and medical group practices to incorporate and/or encourage development of leave policies, including parental, family, and medical leave policies, as part of the physician's standard benefit agreement.
2. Recommended components of parental leave policies for medical students and physicians include: (a) duration of leave allowed before and after delivery; (b) category of leave credited; (c) whether leave is paid or unpaid; (d) whether provision is made for continuation of insurance benefits during leave, and who pays the premium; (e) whether sick leave and vacation time may be accrued from year to year or used in advance; (f) how much time must be made up in order to be considered board eligible; (g) whether make-up time will be paid; (h) whether schedule accommodations are allowed; and (i) leave policy for adoption.
3. AMA policy is expanded to include physicians in practice, reading as follows: (a) residency program directors and group practice administrators should review federal law concerning maternity

leave for guidance in developing policies to assure that pregnant physicians are allowed the same sick leave or disability benefits as those physicians who are ill or disabled; (b) staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in other physicians' workloads, particularly in residency programs; and (c) physicians should be able to return to their practices or training programs after taking parental leave without the loss of status.

4. Our AMA encourages 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.

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.

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.

Res. 215, I-16, Appended: BOT Rep. 11, A-19, Appended: Res. 403, A-22

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.

CMS Rep. 03, A-16, Reaffirmed: BOT Rep. 11, A-19

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

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 303
(I-22)

Introduced by: Medical Student Section

Subject: Medical Student Leave Policy

Referred to: Reference Committee C

1 Whereas, The age of matriculation to medical school has been gradually increasing over the
2 past several years resulting in an increase in trainees whose peak reproductive years now
3 overlap partially or entirely with their medical school education^{1,2}; and
4

5 Whereas, As of 2021, over seven percent of graduating medical students had at least one non-
6 spouse dependent, the majority of whom are likely children³; and
7

8 Whereas, A 2017 single-institution study conducted at the University of South Dakota Sanford
9 School of Medicine revealed that parenthood may affect an even larger proportion of the student
10 body at some institutions, as they reported that 25 of 185 (13%) of surveyed students had
11 become parents or were currently pregnant at the time of the study⁴; and
12

13 Whereas, Further, more than half of matriculants to medical school now are female, meaning
14 that these trainees bear the responsibility of coping with the physical, mental, and emotional
15 changes of pregnancy, labor, and delivery, as well as infant- and child-care, in addition to the
16 high-stakes, demanding, and often exhausting rigors of medical school¹; and
17

18 Whereas, Despite a growing number of medical students pursuing parenthood concomitantly
19 with medical training, medical schools lag behind other levels of medical training—namely
20 graduate medical education (GME), aka residency—in providing their trainee-parents supportive,
21 accessible, and clear parental leave policies; and
22

23 Whereas, For many medical students, even locating the parental leave policy for their school
24 can be time-consuming and ultimately fruitless, as many medical schools fail to publish or do
25 not have—a parental leave policy for their students and a 2019 study sifted through the websites
26 and student-handbooks of 199 allopathic and osteopathic medical schools in the US⁵; and
27

28 Whereas, The researchers found that only 65 of 199 (33%) of schools had parental leave
29 policies available on their website or in their handbook and the policies located were far from
30 standardized; and
31

32 Whereas, Only 38 of the 65 (58%) available policies specifically included maternity AND
33 paternity leave; 23 (35%) policies allowed for maternity leave only; of the 65 available policies,
34 only 21 (32%) included an option to maintain the student's original graduation date following the
35 leave; and only 3 (5%) school policies included parental leave for adoption⁵; and
36

37 Whereas, The stress of having to locate parental leave policies, request and/or advocate for
38 time off at a school which does not have a published parental leave policy, and, at most
39 institutions, face the financial and psychological barriers of delay of graduation, and can be
40 prohibitive to students wanting to begin families during their training; and

1 Whereas, The American Board of Medical Specialties (ABMS), recently recognized the need for
2 parental leave policies and standardized requirements among all GME institutions nationwide,
3 citing issues of trainee mental and physical wellness and work-life balance as well as “helping to
4 narrow the gender gap in [women’s] career advancement” as chief reasons for implementing
5 such policies⁶; and
6

7 Whereas, Like medical students, GME matriculants are becoming parents, and having
8 institutional support for the critical adjustment and bonding period of having a newborn is
9 important to both mothers and fathers; and
10

11 Whereas, As of July 2021, the ABMS required that all Accreditation Council for Graduate
12 Medical Education (ACGME)-accredited residency programs “allow for a minimum of six weeks
13 away once during training for purposes of parental, caregiver, and medical leave, without
14 exhausting time allowed for vacation or sick leave and without requiring an extension in training”
15 ⁶; and
16

17 Whereas, This new requirement indicates a recognition among the medical community that a
18 visible and non-negotiable parental leave policy is important for the health and well-being of
19 medical trainees and should be in place at all institutions with graduate medical learners; and
20

21 Whereas, In fact, the American College of Obstetricians and Gynecologists (ACOG), the leading
22 experts in pregnancy and transition to parenthood, agree with the ABMS policy, and endorse a
23 6-week minimum parental leave, which they note has several benefits, including improving
24 maternal health and decreasing infant mortality, as well as increasing worker morale,
25 productivity, and likelihood to return to work⁷; and
26

27 Whereas, Evidence supports the statements made by ABMS and ACOG that parental leave
28 contributes to the overall health and wellness of new parents and studies have demonstrated
29 that returning to work too early after childbearing is associated with negative mental health
30 outcomes for mothers, including an increase in the rate of postpartum depression⁸; and
31

32 Whereas, Further, a 2018 study found that each additional week of maternity leave (for leaves
33 totaling <12 weeks) proportionally decreased the risk of experiencing postpartum depression⁹;
34 and
35

36 Whereas, In another 2018 study, specifically focused on medical residents, early return to work
37 translated to a decreased length of breastfeeding (impacting maternal-infant bonding and infant
38 health), decreased perceived support, and overall decreased satisfaction with parenthood^{10,11};
39 and
40

41 Whereas, Although the challenges presented by taking parental leave in medical school are
42 different than those presented in residency and fellowship, the costs to families—parents and
43 their children— of being denied parental leave of adequate length and/or being denied the peace
44 of mind of having an easily accessible, comprehensive parental leave policy available from their
45 institution, are the same; and
46

47 Whereas, Thus, it is of paramount importance that our AMA have policies to support them in
48 advocating on behalf of current and future medical student parents, that they receive the
49 equitable, appropriate, and visible parental leave policies and benefits already guaranteed to
50 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

1 loss of previously accepted residency positions, for devastating conditions such as
 2 terminal illness, permanent disability, or complications of pregnancy that threaten
 3 maternal or fetal life; (h) how time can be made up in order for a resident physician to
 4 be considered board eligible; (i) what period of leave would result in a resident
 5 physician being required to complete an extra or delayed year of training; (j) whether
 6 time spent in making up a leave will be paid; and (k) whether schedule
 7 accommodations are allowed, such as reduced hours, no night call, modified rotation
 8 schedules, and permanent part-time scheduling.

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

21 ~~8- 9.~~ Our AMA endorses the concept of equal parental leave for birth and adoption as
 22 a benefit for resident physicians, medical students, and physicians in practice
 23 regardless of gender or gender identity.

24 ~~9- 10.~~ Staffing levels and scheduling are encouraged to be flexible enough to allow for
 25 coverage without creating intolerable increases in the workloads of other physicians,
 26 particularly those in residency programs.

27 ~~10- 11.~~ Physicians should be able to return to their practices or training programs after
 28 taking parental leave, family leave, or medical leave without the loss of status.

29 ~~11- 12.~~ Residency program directors must assist residents in identifying their specific
 30 requirements (for example, the number of months to be made up) because of leave
 31 for eligibility for board certification and must notify residents on leave if they are in
 32 danger of falling below minimal requirements for board eligibility. Program directors
 33 must give these residents a complete list of requirements to be completed in order to
 34 retain board eligibility.

35 ~~12- 13.~~ Our AMA encourages flexibility in residency training programs and medical
 36 schools incorporating parental leave and alternative schedules for pregnant trainees
 37 ~~house staff.~~

38 ~~13- 14.~~ In order to accommodate leave protected by the federal Family and Medical
 39 Leave Act, our AMA encourages all specialties within the American Board of Medical
 40 Specialties to allow graduating residents to extend training up to 12 weeks after the
 41 traditional residency completion date while still maintaining board eligibility in that
 42 year.

43 ~~14- 15.~~ These policies as above should be freely available online and in writing to all
 44 current trainees and applicants to medical school, residency or fellowship. (Modify
 45 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.

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RELEVANT AMA POLICY

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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.
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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.

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.

Res. 215, I-16, Appended: BOT Rep. 11, A-19, Appended: Res. 403, A-22

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

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 304
(I-22)

Introduced by: New York

Subject: Protecting State Medical Licensing Boards from External Political Influence

Referred to: Reference Committee C

1 Whereas, The US and world populations are in the midst of a COVID pandemic; and

2
3 Whereas, Hospitals, physicians and other healthcare workers are strained to contain the
4 outbreak and treat individuals who have contracted COVID; and

5
6 Whereas, There has been progress in prevention through means of social isolation, mask
7 wearing and vaccine prophylaxis; and

8
9 Whereas, Medical boards and other regulators across the country are scrambling to penalize
10 doctors who spread misinformation about vaccines, and promote unproven cures for COVID–
11 19; and

12
13 Whereas, In Idaho, local GOP officials appointed a pathologist who promoted unproven virus
14 treatments to a local public health board, despite complaints from his peers to state regulators;
15 and

16
17 Whereas, As of this date, Politico reports that medical boards have sanctioned eight physicians
18 since January 2021 for spreading coronavirus–related misinformation, according to the
19 Federation of State Medical Boards, which has recommended that health officials consider
20 action against medical professionals who dispense false medical claims in public forums; and

21
22 Whereas, In some cases the responses from some medical boards and state officials have
23 been stymied by political backlash, including in Tennessee and North Dakota; and

24
25 Whereas, Some state boards also lack the legal tools to discipline doctors for sharing unreliable
26 information via social media, and “With the click of a mouse button, two million people can get
27 information that's incorrect,” and legal structures developed for the 20th century are, in many
28 states, not suited to discipline doctors who broadcast misinformation on social media because
29 the physicians are not directly treating patients, Federation of State Medical Boards CEO
30 Humayun Chaudhry said; and

31
32 Whereas, Misinformation distorts the public debate over vaccines, and has helped create a
33 market for unproven drugs and treatment against COVID–19, sometimes with harmful side
34 effects; and

35
36 Whereas, Poison centers have recorded [increased numbers of calls related to ivermectin](#) and
37 [oleandrin](#), with some patients requiring hospitalizations; and

1 Whereas, A recent study in *The New England Journal of Medicine* projected nearly \$2.5 million
2 in wasteful insurance spending on ivermectin in a single week; and
3

4 Whereas, When the Medical Board of California started to crack down last year on doctors
5 spreading misinformation about the coronavirus vaccines, the head of the Board began getting
6 threats; and
7

8 Whereas, The federation said that two-thirds of their members had seen an increased number
9 of complaints related to disinformation in a December 2021 survey; therefore be it
10

11 RESOLVED, That our American Medical Association work with the Federation of State Medical
12 Boards and other interested parties to minimize external interference with the independent
13 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](#)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 305
(I-22)

Introduced by: Illinois

Subject: Encouraging Medical Schools to Sponsor Pipeline Programs to Medicine for Underrepresented Groups

Referred to: Reference Committee C

1 Whereas, Structural inequities and system-level biases amongst members of admission
2 committees contribute to non-inclusive environments and result in unequal opportunities for
3 potential underrepresented minority (URM) applicants to enter the field of medicine; and
4

5 Whereas, The racial injustices, social tragedies, and health care inequities particularly
6 highlighted throughout the COVID-19 pandemic reinforce the demand for the implementation of
7 strategies to support diversity, equity, and inclusion; and
8

9 Whereas, Middle and high school pipeline programs providing comprehensive educational
10 support and enrichment have improved test scores and raised school graduation and college
11 matriculation rates; and
12

13 Whereas, A study examining undergraduate students found that lower grade achievement of
14 URM students in pre-health courses may not be fully attributable to the precollege educational
15 pipeline, and can potentially be improved by academic and social supports during college; and
16

17 Whereas, Nascent pipeline programs that have connected medical students and high school
18 students in context specific and culturally relevant manner have the potential to help
19 underrepresented students with identity formation and perceived achievement goals; and
20

21 Whereas, Outreach and pipeline programs targeting students underrepresented in medicine are
22 beneficial to the participants and the community by 1) exposing underserved and
23 underrepresented youth to medicine, 2) improving their candidacy by providing opportunities for
24 research, shadowing, and volunteering, and 3) increasing diversity in healthcare; and
25

26 Whereas, Engaging with such programs provides value to the medical schools by 1) fulfilling
27 accreditation requirements, 2) granting medical students the opportunity to interact with the
28 surrounding community, and 3) serving as a source of qualified applicants who are
29 underrepresented in medicine; therefore be it
30

31 RESOLVED, That our American Medical Association urge medical schools to develop or
32 expand the reach of existing pipeline programs for underrepresented middle school, high school
33 and college aged students to motivate them to pursue and prepare them for a career in
34 medicine (New HOD Policy); and be it further
35

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

1 RESOLVED, That our AMA recommend that medical school pipeline programs for
2 underrepresented students be free-of-charge or provide financial support with need-based
3 scholarships and grants (New HOD Policy); and be it further
4

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

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

Received: 09/27/22

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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.

Citation: CME Rep. 1, I-06; Reaffirmation I-10; Reaffirmation A-13; Modified: CCB/CLRPD Rep. 2, A-14; Reaffirmation: A-16; Appended: Res. 313, A-17; Appended: Res. 314, A-17; Modified: CME Rep. 01, A-18; Appended: Res. 207, I-18; Reaffirmation: A-19; Appended: Res. 304, A-19; Appended: Res. 319, A-19; Modified: CME Rep. 5, A-21

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

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

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

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

(4) Increasing the supply of minority health professionals.

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

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

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

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

Citation: CLRPD Rep. 3, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmed: CME Rep. 01, A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 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*".

Citation: (CME Rep. 3, A-94; Reaffirmed: CME Rep. 2, A-05; Modified: CME Rep. 1, A-15)

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;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 307
(I-22)

Introduced by: Arkansas

Subject: Fair Compensation of Residents and Fellows

Referred to: Reference Committee C

1 Whereas, Residents and Fellows form the backbone and the future of our healthcare system (1,
2 2); and
3

4 Whereas, Residents and Fellows are usually under heavy financial debt of student loans
5 accumulated over eight years of intense college and medical school education (3, 4); and
6

7 Whereas, Residents and Fellows, having to be employed for 3-7 years, who are dependent on
8 their salary for those years for daily living and payment of student debt (5); and
9

10 Whereas, The Centers for Medicare & Medicaid Services (CMS) provides direct and indirect
11 compensation for Residents and Fellows to cover their cost to the institution, and usually in
12 excess (6, 7, 8, 9); and
13

14 Whereas, CMS payments per resident/fellow vary widely exacerbating financial strain for some
15 training institutions (8, 9); and
16

17 Whereas, Residents and Fellows provide patient care services that are mission critical and an
18 important source of revenue for their institutions (10, 11, 12, 13); and
19

20 Whereas, Current Resident and Fellow compensation, approaching minimum wage, is
21 inadequate and unfair from all reasonable perspectives (14, 15, 16, 17); and
22

23 Whereas, The Arkansas Delegation believes that our AMA must advocate on behalf of its most
24 vulnerable and most important constituency; therefore be it
25

26 RESOLVED, That our American Medical Association advocate for increasing the Resident and
27 Fellow salary substantially (by at least 50% of current levels or better), along with all benefits
28 including retirement benefits with institutional match as available to institutional administration,
29 and peg yearly salary increase thereafter to COLA (Directive to Take Action); and be it further
30

31 RESOLVED, That our AMA advocate for enhanced and uniform payment per resident and
32 fellow for all educational and training institutions across the country (Directive to Take Action);
33 and be it further
34

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

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

Received: 09/27/22

References:

1. <https://www.ama-assn.org/medical-residents/residency-life/vital-role-residents-play-health-care-during-pandemic>;
2. van der Leeuw et al. BMC Medicine 2012, 10:65 <http://www.biomedcentral.com/1741-7015/10/65>
3. <https://educationdata.org/average-medical-school-debt>
4. <https://www.nerdwallet.com/article/loans/student-loans/average-medical-school-debt>
5. <https://mededits.com/residency-admissions/timeline-length/>
6. <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/DGME>
7. <https://www.fiercehealthcare.com/practices/study-suggests-medicare-overpaying-1-28b-annually-to-support-residency-programs#:~:text=The%20study%20found%20GME%20payment,the%20%24150%2C000%20per%20resident%20rate.>
8. CRS Report R44376, Federal Support for Graduate Medical Education: An Overview. Feb 19, 2019
9. Physician Workforce: Caps on Medicare-Funded Graduate Medical Education at Teaching Hospitals. GAO-21-391. Published: May 21, 2021. Publicly Released: Jun 21, 2021.
10. <https://doi.org/10.1371/journal.pone.0258633>
11. <https://thejns.org/downloadpdf/journals/j-neurosurg/135/1/article-p164.pdf>
12. <https://thesheriffsofsodium.com/2022/02/04/how-much-are-resident-physicians-worth/>
13. <https://link.springer.com/article/10.1007/s10198-021-01368-z>
14. <https://www.beckershospitalreview.com/leadership/how-medical-resident-salaries-compare-to-other-entry-level-pay.html>
15. <https://www.beckershospitalreview.com/compensation-issues/physician-assistant-salary-by-state-alaska-is-no-1-at-150-430.html>
16. <https://www.beckershospitalreview.com/compensation-issues/nurse-practitioner-salary-by-state-california-is-no-1-at-145-970.html>
17. <https://www.beckershospitalreview.com/compensation-issues/rn-average-hourly-wage-salary-for-all-50-states-calif-tops-list-at-120k.html>

RELEVANT AMA POLICY

Residents and Fellows' Bill of Rights H-310.912

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

RESIDENT/FELLOW PHYSICIANS' BILL OF RIGHTS

Residents and fellows have a right to:

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

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

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

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

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

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

D. A safe and supportive workplace with appropriate facilities.

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

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

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

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

(3) With regard to benefits, residents and fellows must be fully informed of and should receive: a. Quality and affordable comprehensive medical, mental health, dental, and vision care for residents and their families, as well as retirement plan options, professional liability insurance and disability insurance to all residents for disabilities resulting from activities that are part of the educational program; b. An institutional written policy on and education in the signs of excessive fatigue, clinical depression, substance abuse and dependence, and other physician impairment issues; c. Confidential access to mental health and substance abuse services; d. A guaranteed, predetermined amount of paid vacation leave, sick leave, family and medical leave and educational/professional leave during each year in their

training program, the total amount of which should not be less than six weeks; e. Leave in compliance with the Family and Medical Leave Act; and f. The conditions under which sleeping quarters, meals and laundry or their equivalent are to be provided.

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

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

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

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

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

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

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

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

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

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

Citation: CME Rep. 8, A-11; Appended: Res. 303, A-14; Reaffirmed: Res. 915, I-15; Appended: CME Rep. 04, A-16; Modified: CME Rep. 06, I-18; Appended: Res. 324, A-19; Modified: Res. 304, A-21; Modified: Res. 305, A-21; Modified: BOT Rep. 18, I-21; Reaffirmation: A-22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 308
(I-22)

Introduced by: American College of Radiology, American Academy of Pediatrics, Maryland, Radiological Society of North America, Society of Interventional Radiology, American Society for Radiation Oncology, American Institute of Ultrasound in Medicine, American Roentgen Ray Society, American College of Radiation Oncology, Association of University Radiologists, American College of Nuclear Medicine, American Society of Neuroradiology, Society of Nuclear Medicine and Molecular Imaging, Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont

Subject: Paid Family/Medical Leave in Medicine

Referred to: Reference Committee C

1 Whereas, The mission of the American Medical Association is “to promote the art and science
2 of medicine and the betterment of public health...by representing physicians with a unified voice
3 in courts and legislative bodies across the nation, removing obstacles that interfere with patient
4 care...and driving the future of medicine to tackle the biggest challenges in health care.” [1]; and
5

6 Whereas, The federal Family Medical Leave Act (FMLA) of 1993 requires private employers
7 with 50 or more employees within 75 miles of the eligible employee’s worksite and all public
8 agencies to provide eligible employees* up to 12 work weeks of unpaid leave in a 12-month
9 period for the birth and care of a newborn, adopted child, or foster child, as well as for care of
10 oneself or an immediate family member with a serious health condition [2]**; and
11

12 Whereas, “The American Academy of Pediatrics has publicly endorsed 12 weeks of paid family
13 leave based upon the scientific evidence of benefits to the child.” [3]; and
14

15 Whereas, Since April 2022, the American College of Radiology (ACR) “recommends that
16 diagnostic radiology, interventional radiology, radiation oncology, medical physics, and nuclear
17 medicine practices, departments and training programs strive to provide 12 weeks of paid
18 family/medical leave in a 12-month period for its attending physicians, medical physicists, and
19 members in training as needed.” [4]; and
20

21 Whereas, The business case for paid family/medical leave is compelling, with “significant
22 rewards that outweigh the costs: improved employee retention; better talent attraction;
23 reinforced values; improved engagement, morale, and productivity; and enhanced brand
24 equity.” [5]. For instance, research has shown that the average time to fill a vacant position is 42
25 days, and the average cost of a hire is at least 21% of annual salary [6]; and
26

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

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

3
4 AMA adopts as policy the following guidelines for, and encourages the
5 implementation of, Parental, Family and Medical Necessity Leave for Medical
6 Students and Physicians:

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

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

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

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

33 5. Our AMA recommends that medical practices, departments and training programs
34 strive to provide 12 weeks of paid parental, family and medical necessity leave in a
35 12-month period for their attending and trainee physicians as needed.

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

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

42 ~~78.~~ Residency programs should develop written policies on parental leave, family
43 leave, and medical leave for physicians. Such written policies should include the
44 following elements: (a) leave policy for birth or adoption; (b) duration of leave allowed
45 before and after delivery; (c) category of leave credited (e.g., sick, vacation, parental,
46 unpaid leave, short term disability); (d) whether leave is paid or unpaid; (e) whether
47 provision is made for continuation of insurance benefits during leave and who pays for
48 premiums; (f) whether sick leave and vacation time may be accrued from year to year
49 or used in advance; (g) extended leave for resident physicians with extraordinary and
50 long-term personal or family medical tragedies for periods of up to one year, without
51 loss of previously accepted residency positions, for devastating conditions such as
52 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.

~~910.~~ 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.

~~412.~~ 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:

- (1) American Medical Association. About. Accessed June 14, 2022. <https://www.ama-assn.org/about>
- (2) US Department of Labor. Wage and Hour Division (WHD). Family and Medical Leave Act. Accessed February 25, 2019. <https://www.dol.gov/whd/fmla/>
- (3) Riano NS, Linos E, Accurso EC, Sung D, Linos E, Simard JF, Mangurian C. Paid Family and Childbearing Leave Policies at Top US Medical Schools. JAMA. 2018 Feb 13;319(6):611-614. doi: 10.1001/jama.2017.19519. PMID: 29450516; PMCID: PMC5838606.
- (4) Resolution#13: Paid family/medical leave in radiology, interventional radiology and radiation oncology. Accessed May 6, 2022. [https://www.aawr.org/Portals/10/Focus/Spring%202022/AAWR.ResolutionPaidFamilyMedicalLeaveFor2022.FINAL_%20\(1\).pdf?ver=dptncUDp-LiVfKBSp7XrZw%3d%3d](https://www.aawr.org/Portals/10/Focus/Spring%202022/AAWR.ResolutionPaidFamilyMedicalLeaveFor2022.FINAL_%20(1).pdf?ver=dptncUDp-LiVfKBSp7XrZw%3d%3d)
- (5) Huang G. The business case for paid leave at your company. *Forbes*. Available at: <https://www.forbes.com/sites/georgenehuang/2017/02/28/the-business-case-for-paid-family-leave-at-your-company/#2c14371e4eae>. Published February 28, 2017. Accessed August 13, 2018.
- (6) Arleo EK. Paid family/medical leave: That's great - What's next? Clin Imaging. 2020 May;61:A1-A3. doi: 10.1016/j.clinimag.2020.02.004. Epub 2020 Feb 20. PMID: 32115344.
- (7) State Paid Family and Medical Leave Insurance Laws, as of January 2021: California, New Jersey, Rhode Island, New York, District of Columbia, Washington, Massachusetts, Connecticut, Oregon. <https://www.nationalpartnership.org/our-work/resources/economic-justice/paid-leave/state-paid-family-leave-laws.pdf>. Accessed July 14, 2021.

*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

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 309
(I-22)

Introduced by: Resident and Fellow Section

Subject: Bereavement Leave for Medical Students and Physicians

Referred to: Reference Committee C

1 Whereas, The aging of the U.S. population stands to increase the number of senior citizens
2 dying every year, and the bereavement felt by their loved ones in all sectors, including medical
3 students and physicians; and¹

4
5 Whereas, Medical students and physicians also suffer emotional trauma related to reproductive
6 complications such as pregnancy loss, as 10% of known pregnancies end in miscarriage or
7 stillbirth,² and many students and physicians suffer failure of assisted reproductive technology
8 and adoption; and

9
10 Whereas, States of mental and emotional distress have been associated with unsafe patient
11 care, as demonstrated in a 2016 systematic review that found poor wellbeing and moderate to
12 high levels of burnout in healthcare staff were associated, in the majority of studies reviewed,
13 with poor patient safety outcomes such as medical errors; and³

14
15 Whereas, The Fair Labor Standards Act and the Family and Medical Leave Act do not require a
16 U.S. employer to provide an employee with paid leave to attend a funeral, grieve a family
17 member, or grieve a pregnancy loss; and⁴

18
19 Whereas, Only 60% of private-sector workers were granted paid bereavement leave in 2012,
20 per a report from the Bureau of Labor Statistics; and⁵

21
22 Whereas, Other countries have instituted bereavement leave policies, such as Canada and
23 France which guarantee three to five days of bereavement leave to employees suffering the
24 loss of a close family member,⁶ and India and New Zealand which have pregnancy loss laws
25 entitling Indian women to 6 weeks of paid leave and New Zealand women and their partners to
26 3 days of paid leave; and⁷

27
28 Whereas, AMA policy H-405.960, "Policies for Parental, Family and Medical Necessity Leave,"
29 sets precedent for the AMA providing detailed recommendations for medical schools, residency
30 programs, medical specialty boards, the ACGME, and medical group practices to provide leave
31 benefits to their medical students and physicians; therefore be it

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

- 3 1. Our AMA urges medical schools, residency and fellowship training
4 programs, medical specialty boards, the Accreditation Council for
5 Graduate Medical Education, and medical group practices to incorporate and/or
6 encourage development of bereavement leave policies as part of the physician's
7 standard benefit agreement.
- 8 2. Recommended components of bereavement leave policies for medical students and
9 physicians include:
 - 10 a. whether cases requiring extensive travel qualify for additional days of leave
11 and, if so, how many days;
 - 12 b. policy and duration of leave for an event impacting pregnancy or fertility
13 including pregnancy loss, an unsuccessful round of intrauterine insemination or of
14 an assisted reproductive technology procedure, a failed adoption arrangement, a
15 failed surrogacy arrangement, or an event that impacts pregnancy or fertility;
 - 16 c. whether leave is paid or unpaid;
 - 17 d. whether obligations and time must be made up; and
 - 18 e. whether make-up time will be paid.
- 19 3. Our AMA encourages medical schools, residency and fellowship programs,
20 specialty boards, specialty societies and medical group practices to incorporate into
21 their bereavement leave policies a three-day minimum leave, with the understanding
22 that no physician or medical student should be required to take a minimum leave.
- 23 4. Medical students and physicians who are unable to work beyond the defined
24 bereavement leave period because of physical or psychological stress, medical
25 complications of pregnancy loss, or another related reason should refer to their
26 institution's sick leave policy, family and medical leave policy, and other benefits on the
27 same basis as other physicians who are temporarily unable to work for other reasons.
- 28 5. Our AMA supports the concept of equal bereavement leave for pregnancy loss and
29 other such events impacting fertility in a physician or their partner as a benefit for
30 medical students and physicians regardless of gender or gender identity.
- 31 6. Staffing levels and scheduling are encouraged to be flexible enough to allow for
32 coverage without creating intolerable increases in the workloads of other physicians,
33 particularly those in residency programs.
- 34 7. These guidelines as above should be freely available online and in writing to all
35 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

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2. Wilcox AJ, Weinberg CR, O'Connor JF, et al. Incidence of early loss of pregnancy. *N Engl J Med*. 1988 Jul 28;319(4):189-94.
3. Hall LH, Johnson J, Watt I, et al. Healthcare Staff Wellbeing, Burnout, and Patient Safety: A Systematic Review. *PLoS One*. 2016;11(7):e0159015. doi:10.1371/journal.pone.0159015. Published July 8, 2016. Retrieved September 10, 2021
4. Funeral leave. United States Department of Labor. <https://www.dol.gov/general/topic/benefits-leave/funeral-leave>. Accessed September 10, 2021.
5. Van Giezen RW. Paid leave in private industry over the past 20 years. Beyond the Numbers. <https://www.bls.gov/opub/btn/volume-2/paid-leave-in-private-industry-over-the-past-20-years.htm>. Published August 1, 2013. Accessed September 18, 2021.
6. Tveten J. When it comes to bereavement leave, the U.S. is unspeakably cruel. Salon. https://www.salon.com/2019/09/30/when-it-comes-to-bereavement-leave-the-u-s-is-unspeakably-cruel_partner/. Published August 12, 2020. Accessed September 17, 2021.
7. Wamsley L. New Zealand approves paid leave after a miscarriage. NPR. <https://www.npr.org/2021/03/25/981309826/new-zealand-approves-paid-leave-after-a-miscarriage>. Published March 25, 2021. Accessed September 17, 2021.

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: CCB/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

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

5
6 Whereas, These longstanding principles clearly demand a continuing board certification process
7 that is low cost, evidence-based, untied to insurance and hospital credentialing, and free of
8 harm to the physician workforce; and

9
10 Whereas, The proprietary American Board of Medical Specialties (ABMS) and American
11 Osteopathic Association (AOA) continuing board certification product continues to be high cost,
12 high stress, without evidence over other forms of continuing medical education, required for
13 insurance and hospital credentialing, and harmful to the physician workforce; and

14
15 Whereas, ABMS and AOA boards are still not fully aligned with the AMA's policy on continuing
16 board certification; and

17
18 Whereas, A failure to protect physicians from recertification harm has significant effects upon
19 cost of care, physician burnout, and access to qualified physicians; and

20
21 Whereas, Organized medicine has been called upon to advocate successfully for these
22 principles in order to defend physicians and our right to care for patients; therefore be it

23
24 RESOLVED, That our American Medical Association continue to actively work to enforce
25 current AMA Principles on Continuing Board Certification (Directive to Take Action); and be it
26 further

27
28 RESOLVED, That our AMA publicly report their work on enforcing AMA Principles on
29 Continuing Board Certification at the Annual and Interim meetings of the AMA House of
30 Delegates. (Directive to Take Action)

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

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.

Citation: CME Rep. 2, I-15; Appended: Res. 911, I-15; Appended: Res. 309, A-16; Appended: CME Rep. 02, A-16; Appended: Res. 307, I-16; Appended: Res. 310, I-16; Modified: CME Rep. 02, A-17; Reaffirmed: Res. 316, A-17; Reaffirmed in lieu of: Res. 322, A-17; Appended: CME Rep. 02, A-18; Appended: Res. 320, A-18; Appended: Res. 957, I-18; Reaffirmation: A-19; Modified: CME Rep. 02, A-19; Appended: CME Rep. 1, I-20; Appended: Res. 310, A-21; Modified: CME Rep. 2, A-22;

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.

Citation: CME Rep. 16, A-09; Reaffirmed: CME Rep. 11, A-12; Reaffirmed: CME Rep. 10, A-12; Reaffirmed in lieu of Res. 313, A-12; Reaffirmed: CME Rep. 4, A-13; Reaffirmed in lieu of Res. 919, I-13; Appended: Sub. Res. 920, I-14; Reaffirmed: CME Rep. 2, A-15; Appended: Res. 314, A-15; Modified: CME Rep. 2, I-15; Reaffirmation A-16; Reaffirmed: Res. 309, A-16; Modified: Res. 307, I-16; Reaffirmed: BOT Rep. 05, I-16; Appended: Res. 319, A-17; Reaffirmed in lieu of: Res. 322, A-17; Modified: Res. 953, I-17; Reaffirmation: A-19; Modified: CME Rep. 02, A-19;

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

1 Whereas, The Association of American Medical Colleges released data suggesting residency
2 interviews cost medical students between \$1,000 to \$11,580, with a median cost of \$4,000 and
3 an average cost of \$200-499 per interview¹; and
4

5 Whereas, Studies suggest 71% of medical students borrow money for residency interviews and
6 four out of ten students decline interviews for financial reasons²; and
7

8 Whereas, Interviews costs residency programs a significant amount of money, with one plastic
9 surgery program reporting a cost of \$2763 per applicant interviewed, which includes applicant
10 receptions, food and beverage costs, and losses of clinical productivity³; and
11

12 Whereas, It is estimated virtual interviews would allow residency programs to reduce the
13 amount of time needed to conduct interviews by approximately 7 days, reducing faculty's time
14 away from clinical and teaching responsibilities⁴; and
15

16 Whereas, The standard model of in-person residency interviews takes time away from medical
17 student educational and clinical work, given that applicants devote an average of 20 days
18 towards residency interviews^{5,6}; and
19

20 Whereas, In a 2014 study of GI fellowship applicants with four in-person interviews and a single
21 video interview, 87% of applicants thought that video interviews should continue and 81%
22 reported that the video interview met or exceeded their expectations, which suggests web-
23 based video interviews has the potential to either be an effective screening tool or an
24 acceptable alternative to in-person interviews⁷; and
25

26 Whereas, In a survey of the 46 applicants and 36 program directors after the 2020
27 cardiothoracic fellowship match, the majority of the applicants and program directors thought
28 virtual interviews should be continued in the future; however, most do not think that virtual
29 interviews should completely replace in-person interviews⁸; and
30

31 Whereas, In the same 2020 cardiothoracic fellowship study, most applicants and program
32 directors did not believe virtual interviews negatively impacted applicants' chances of matching
33 into programs at the top of their rank list⁸; and
34

35 Whereas, An observational study of an anesthesiology residency program with options for in-
36 person or virtual interviews demonstrated a higher proportion of non-local applicants and the
37 preference for virtual format was driven by travel concerns and interview date conflicts⁷; 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 interviews^{10,11}; 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: Modest – between \$1,000 - \$5,000

Received: 10/12/22

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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

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, Alabama

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

Referred to: Reference Committee C

1 Whereas, The American Medical Association awards the *AMA PRA Category 1 Credit*™ for
2 continuing medical education credit; and
3

4 Whereas, The Accreditation Council for Continuing Medical Education (ACCME) is the
5 organization the AMA has given authority to accredit providers of *AMA PRA Category 1*
6 *Credit*™; and
7

8 Whereas, ACCME recognizes state medical societies to accredit local hospitals and
9 organizations to provide CME credit in their state; and
10

11 Whereas, In August 2022, the ACCME announced it would no longer allow state medical
12 societies with fewer than 20 accredited providers to be recognized accreditors. This change
13 directly affects 19 state medical societies and indirectly affects the rest. Those directly affected
14 include AL, AZ, HI, IA, IL, KY, ME, MN, MS, MO, NE, NH, NM, NC, OK, UT, VA, WV, and WI;
15 and
16

17 Whereas, The state medical societies with fewer than 20 CME providers have until March of
18 2023 to notify ACCME whether they will: (a) Expand their accreditation program through
19 recruitment of new providers to serve at least 20 eligible organizations; (b) Combine their
20 program with one or more state medical societies (within regions defined by the ACCME) so
21 that the merged/combined program has 20 or more accredited providers, or (c) Withdraw from
22 recognition; and
23

24 Whereas, The ACCME requires state medical societies to implement the changes by
25 January 1, 2024; and
26

27 Whereas, Most impacted state medical societies were not included in formal discussions about
28 this proposal and did not find out about this decision until receiving letters on August 1, 2022
29 from ACCME announcing their CME programs would no longer be included in the state medical
30 society accreditor program; and
31

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

1 Whereas, This proposed change will negatively affect hospitals and CME providers in rural and
2 other underserved areas; therefore be it
3

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

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

Received: 10/13/22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 314
(I-22)

Introduced by: Michigan

Subject: Balancing Supply and Demand for Physicians by 2030

Referred to: Reference Committee C

1 Whereas, Current demographics predict growth of an aging population of people over age 65 by
2 55 percent;; and
3

4 Whereas, Projected shortfalls in primary care physicians ranges between 7,300 and 43,000 by
5 2030; and
6

7 Whereas, If current underserved populations utilize health care at the same rate as other patient
8 populations, even higher demand is projected for primary care physicians; and
9

10 Whereas, Current proportion of internal medicine residents completing training and going into
11 primary care practice has fallen below 10 percent; and
12

13 Whereas, Lifestyle, medical student debt, complex patient care demands, silos of care,
14 electronic health record overload, and burnout all work against primary care physician
15 recruitment; therefore be it
16

17 RESOLVED, That our American Medical Association take action on all fronts to advocate for
18 and implement remedies that will rebalance the supply and demand equation for primary care
19 physicians by 2030 (Directive to Take Action); and be it further
20

21 RESOLVED, That our AMA reaffirm AMA Policies H-200.954, H-200.955, H-200.972,
22 H-465.988, and D-305.958. (Reaffirm HOD Policy)

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

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; Modified: CME Rep. 7, A-14; Reaffirmed: CME Rep. 03, A-16; Appended: Res. 323, A-19; Appended: 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.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 315
(I-22)

Introduced by: Michigan

Subject: Bedside Nursing and Health Care Staff Shortages

Referred to: Reference Committee C

1 Whereas, There is a national shortage of bedside nurses; and

2
3 Whereas, It has been reported that nurses working for travel nurse agencies receive higher
4 compensation than nurses employed directly by hospitals; and

5
6 Whereas, There is competition amongst hospitals, travel nurse agencies, and other
7 organizations for nurses; and

8
9 Whereas, Experienced nurses are leaving bedside nursing jobs and choosing nonclinical
10 careers; and

11
12 Whereas, Nursing students often wait to finish their education due to a lack of clinical sites or
13 nursing educator availability; and

14
15 Whereas, Hospitals have reduced numbers of ancillary staff; and

16
17 Whereas, There is a shortage of emergency medical services providers; and

18
19 Whereas, Working in a hospital is physically demanding, requires working long shifts, and may
20 require mandatory overtime; and

21
22 Whereas, Working in a hospital and other health care jobs pay lower wages than less
23 demanding occupations; and

24
25 Whereas, Many nurses, physicians, ancillary staff, and physician assistants are suffering from
26 moral injury and burnout related to the COVID-19 pandemic; and

27
28 Whereas, Hospitals had nursing and staff shortages before the COVID-19 pandemic and
29 hospitals have been receiving federal financial assistance during the pandemic; and

30
31 Whereas, There is a need for systematic long-term strategies to address bedside nursing and
32 other health care worker shortages including, but not limited to, improved staffing models and
33 employee wellness programming to improve career longevity; therefore be it

1 RESOLVED, That our AMA amend AMA policy D-360.998, "The Growing Nursing Shortage in
2 the United States" by addition to read as follows:

3
4 Our AMA: (1) recognizes the important role nurses and other allied health
5 professionals play in providing quality care to patients, and participate in activities with
6 state medical associations, county medical societies, and other local health care
7 agencies to enhance the recruitment and retention of qualified individuals to the
8 nursing profession and the allied health fields;

9 (2) encourages physicians to be aware of and work to improve workplace conditions
10 that impair the professional relationship between physicians and nurses in the
11 collaborative care of patients;

12 (3) encourages hospitals and other health care facilities to collect and analyze data on
13 the relationship between staffing levels, nursing interventions, and patient outcomes,
14 and to use this data in the quality assurance process;

15 (4) will work with nursing, hospital, and other appropriate organizations to enhance
16 the recruitment and retention of qualified individuals to the nursing and other allied
17 health professions;

18 (5) will work with nursing, hospital, and other appropriate organizations to seek to
19 remove administrative burdens, e.g., excessive paperwork, to improve efficiencies in
20 nursing and promote better patient care-;

21 (6) will approach appropriate stakeholders such as the American Hospital Association
22 to collaborate on the identification of and advocacy for short- and long-term strategies
23 and solutions to address nursing and other health care staff shortages in order to
24 promote a stable work force and career longevity. (Modify Current HOD Policy)

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

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 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; Reaffirmation A-13; Appended: Res. 324, A-17; Appended: CME Rep. 01, A-19;