

REPORTS OF THE COUNCIL ON MEDICAL EDUCATION

The following reports were presented by Cynthia Jumper, MD, MPH, Chair:

1. LEAVE POLICIES FOR MEDICAL STUDENTS, RESIDENTS, FELLOWS, AND PHYSICIANS

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS
REMAINDER OF REPORT FILED
See policy H-405.947 and H-405.960

At the 2022 Interim Meeting of the American Medical Association (AMA) House of Delegates, testimony was received on three resolutions related to leave policies:

- 302-I-22, “Expanding employee leave to include miscarriage and stillbirth”
- 303-I-22, “Medical student leave policy”
- 308-I-22, “Paid family/medical leave in medicine”

As a result, two policies were adopted as amended in lieu of these resolutions, one of which requested study. Amended Policy [H-405.960 \(4\)](#), “Policies for Parental, Family and Medical Necessity Leave,” asks that the AMA:

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

Also, Resolution 309-I-22, “Bereavement Leave for Medical Students and Physicians,” was adopted as amended with a change in title (from “Bereavement” to “Compassionate”). It has become new policy [H-405.947 \(2\) and \(5\)](#) and asks that the AMA:

2. study components of compassionate leave policies for medical students and physicians, to include: (a) whether cases requiring extensive travel qualify for additional days of leave and, if so, how many days; (b) policy and duration of leave for an event impacting pregnancy or fertility including pregnancy loss, an unsuccessful round of intrauterine insemination or of an assisted reproductive technology procedure, a failed adoption arrangement, a failed surrogacy arrangement, or an event that impacts pregnancy or fertility; (c) whether leave is paid or unpaid; (d) whether obligations and time must be made up; and (e) whether make-up time will be paid.
5. study the concept of equal compassionate leave for pregnancy loss and other such events impacting fertility in a physician or their partner as a benefit for medical students and physicians regardless of gender or gender identity.

This report is written in direct response to these calls for study regarding parental and compassionate leave policies.

BACKGROUND

Considerations of competency in medical education

Before addressing the particulars of parental and compassionate leave, the tantamount issue of educational and professional competency must be acknowledged. Upon completion of medical school, medical students (“students”) must achieve established requirements and competencies to be awarded a MD/DO degree; hence, taking leave may prolong training and related costs. Likewise, resident and fellow (“trainee”) physicians must achieve competencies for independent practice in the specialty of their program. Different from medical school, residency is a service-learning experience where trainees provide patient care services. Thus, it is important to distinguish which educational activities and/or clinical services are essential to demonstrate competency and could be missed when a trainee is on leave. Nonetheless, all medical students and trainees should have access to leave; but there can be consequences for taking leave due to the demands of professionalism and duty to patients and the public. Physicians in practice are equally deserving of such leave but may also face consequences.

For the purposes of this report and its recommendations, the use of the word “trainees” includes those individuals in non-standard training (NST) programs.

Parental leave

History of FMLA and unpaid leave

The federal [Family and Medical Leave Act](#) (FMLA) was introduced in Congress every year from 1984 to 1993, when it finally was signed into law by President Bill Clinton. It entitles “eligible employees of covered employers to take unpaid, job-protected leave for specified family and medical reasons with continuation of group health insurance coverage under the same terms and conditions as if the employee had not taken leave. Eligible employees are entitled to:

- Twelve workweeks of leave in a 12-month period for:
 - the birth of a child and to care for the newborn child within one year of birth;
 - the placement with the employee of a child for adoption or foster care and to care for the newly placed child within one year of placement;
 - to care for the employee’s spouse, child, or parent who has a serious health condition;
 - a serious health condition that makes the employee unable to perform the essential functions of his or her job;
 - 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;” or
- Twenty-six work weeks of leave during a single 12-month period to care for a covered servicemember with a serious injury or illness if the eligible employee is the servicemember’s spouse, son, daughter, parent, or next of kin (military caregiver leave).¹

If an employee has worked for their employer at least 12 months, at least 1,250 hours over the past 12 months, and worked at a location where the company employs 50 or more employees within 75 miles, then they are eligible for FMLA leave.¹ The minimum 1,250 hours of service is set by the [Fair Labor Standards Act](#) (FLSA) principles for determining compensable hours or work. Also, special rules may apply if both parents are employed by the same company.

The FMLA is administered by the U.S. Department of Labor for most employees and by the Office of Personnel Management for most federal employees. Answers to frequently asked questions are provided on the FMLA [website](#). States are allowed to determine standards that go beyond the federal law. In response to the COVID-19 pandemic, many states have enacted or expanded family leave permanently. As of June 2022, seven states (WA, CA, NY, CT, RI, MA, NJ) had enacted and implemented state FMLA laws; four states (OR, CO, MD, DE) had enacted but not yet implemented such laws.² For members of the armed forces, FMLA leave may also be applied to the foreign deployment of the employee’s spouse, son, daughter, or parent and is called “qualifying exigency.”³

Medical students

Given that FMLA applies to employed persons, it does not apply to medical students. Thus, such policies are at the discretion of educational institutions. Kraus et al., studied the current state of parental leave policies for medical students by reviewing 199 MD-granting and DO-granting medical schools in the U.S. and its territories. They concluded that many schools do not have easily accessible parental leave policies; many such policies are not separate from formal leaves of absence and do not allow for the minimum 12 weeks allowed per FMLA. Further, schools do not ensure on-time completion of medical education by tailoring policies to the student academic year.⁴ Likewise, medical students outside of the U.S. are facing similar issues.⁵ Without explicit, equitable leave time, students are forced to make difficult decisions about family planning and/or delays in medical education.⁶

A recent article by the Association of American Medical Colleges discusses two studies which reviewed parental leave policies at U.S. MD and DO schools. The article references research that found only about 1/3 of medical schools had a parental leave policy. Further, it noted a difference in MD vs DO schools; while 25% of the MD-granting schools had a public policy, 60% of the 44 DO-granting schools did.⁴ The second study found that “only 14% had “substantive, stand-alone parental leave policies.” While most schools offered general leave of absence policies that were not specific to parenting, the researchers also found that policies crafted specifically for pregnant and parenting people were substantially different from general leave policies.”⁷

An example of a medical school's own parental leave policy is the University of North Carolina School of Medicine's [New Child Adjustment Policy](#), which offers up to six months parental leave while retaining health insurance and financial aid and avails remote classes options during the transition back to school.⁸ By comparison, the University of Chicago Pritzker School of Medicine uses the same policy as the undergraduate school, allowing a one-quarter/ten-week leave with benefits.⁸

Trainees

Given that many residency programs fall short of the 50 employees required to qualify for FMLA's 12-week minimum leave, many programs or institutions have been implementing their own policies. In July 2021, the American Board of Medical Specialties released a new [policy](#) to their member boards regarding parental, caregiver, and medical leave during training for achieving board eligibility. The policy states that such boards "must allow for a minimum of 6 weeks of time away from training for purposes of parental, caregiver, and medical leave at least once during training, without exhausting all other allowed time away from training and without extending training."⁹ One year later, the Accreditation Council for Graduate Medical Education (ACGME) issued a requirement that all ACGME-accredited programs offer six weeks of paid leave to all residents/fellows for medical, parental, and caregiver leave, effective on the trainees' first day in their program.¹⁰ To further address resident leave policies, in 2022, the ACGME published an article in their "ACGME Answers" series.¹¹

Many boards have their own leave policies for trainees to achieve board eligibility. For example, the [American Board of Surgery](#) (ABS), starting with the 2021-2022 academic year, states that "48 weeks of full-time clinical activity in each of the five years of residency, regardless of the amount of operative experience obtained" are required.¹² The remaining four weeks of the year are considered non-clinical time that may be used for any purpose, such as vacation, conferences, interviews, etc. All time away from clinical activity (i.e., non-clinical time), including vacation and time taken for interviews, visa issues, etc., must be accounted for on the application for certification."¹² Details are available on the ABS website. Many specialty societies have policies regarding parental leave; some even support paid leave.

Research published in the last few years indicates that several specialties have been analyzing their leave policies and are developing guidance for program directors to help make the transition back to work after parental leave smoother and less overwhelming. As an example of such research, a national survey of 422 program directors in internal medicine showed that while many programs do have program-level policies, others default to institutional policies which tend to be less flexible. It concluded that more than half of respondents favored a national standard to guide the development of program-level parental leave policies so long as programs with limited resources are provided flexibility.¹³

Physicians

Parental leave policies for physicians may vary depending on the employer, given physicians work in a variety of settings—private practice, group practice, academia, hospitals, health systems, insurers, associations, etc. As stated earlier, a physician qualifies for FMLA (or their state policy that may go beyond FMLA) if their employer has 50 or more employees. Otherwise, the physician is likely bound by non-federal employer policies that may or may not include paid or unpaid leave.

The American College of Obstetricians and Gynecologists (ACOG) supports paid parental leave as essential for the well-being of parent and child, endorsing a minimum of six weeks with full benefits and 100% of pay. ACOG also offers guidance for medical schools, training programs, ACGME, specialty boards, and medical practices regarding the incorporation of paid parental leave policies as part of the physician's standard benefit package.¹⁴

What about paid leave?

The established federal norm, per FMLA, is twelve weeks of unpaid leave despite ample evidence of the benefits (for both parent and child) of paid leave, including improved health and job satisfaction.¹⁵ In the U.S., employer-provided paid leave is more prevalent among high-paying, professional occupations and within large companies.¹⁶ Many other countries endorse paid leave. Among the 38 countries that are members of the Organization for Economic Co-operation and Development, the U.S. is the only one without a national paid maternity or family leave policy.¹⁷ Recent attempts to change U.S. law to paid leave have failed. In 2021, the Robert Wood Johnson

Foundation published a brief entitled “Improving Access to Paid Family Leave to Achieve Health Equity,” which not only provides principles for a paid family leave program for all but explains how paid leave policies can support economic growth and address racial and socioeconomic disparities in order to promote health equity.¹⁶

Bereavement/compassionate leave

Definition and terminology

According to the Fair Labor Standards Act (FLSA), the U.S. Department of Labor does not require payment for time not worked, even if it is to attend a funeral.¹⁸ Rather, this type of benefit is determined by an employer. An employer has the authority to decide if it will offer bereavement leave to its employees and set its own definition of such leave, as well as to determine the number of paid and/or unpaid days of absence from work and if documentation is required to explain the absence. For example, AMA Human Resources Policy 615.01 states that bereavement leave “allows employees to take time off without loss of pay for bereavement due to a death of an immediate family member, i.e., spouse, child, stepchild, grandchild, mother, father, stepmother, stepfather, grandmother, grandfather, mother-in-law, father-in-law, brother, sister, significant other, or domestic partner, or any other individual related by blood or whose close association with the employees is the equivalent of a family relationship.”¹⁹ Employers must abide by state laws. As of 2019, California was the only state to legally require paid bereavement leave for certain public-sector workers, such as state employees. Relatedly, Oregon requires bereavement leave for qualifying employees, but the employer can decide if paid or unpaid.²⁰ Globally, the U.S. falls behind such countries as Canada, France, and the United Kingdom that support more generous leave.²⁰

In the past, such leave may have been referred to as “funeral leave.” While “bereavement” has been a more commonly used term, an even more inclusive adjective is “compassionate” which acknowledges that there may be other reasons, besides death, in which a person is bereaved and in need of time off work. While new AMA human resources policy uses the term “compassionate,” it was noted in doing the research for this report that most schools and programs still use the term “bereavement”; thus, the latter term will be used in this report.

Compassionate leave in medical education and practice

There is little published research on this topic. A PubMed® search of the terms “funeral leave,” “bereavement leave,” and “compassionate leave” yielded zero results in regard to policies in medical schools, training programs, and physician practices.

Bereavement policies vary across medical schools. Given students are not employees of their school, they are not offered paid leave. However, they may be allowed time off. Some medical schools may establish their own policy, while many others follow the same bereavement policy as their university. For example, the University of Illinois Urbana-Champaign provides publicly available student bereavement [guidelines](#).²¹ Without standardized leave time and grief resources across medical schools, some students took matters into their own hands and started [BereaveMed](#), an “online resource that is designed to help medical students address their experiences with death and grief through connection and collaboration.” It also provides a directory of mental health and wellness resources that are available at many medical schools.²²

Graduate Medical Education (GME) programs, as employers, are more likely to have established bereavement policies, which may be established by the program itself or may follow the policy of the institution. As such, the number of days and requirements may vary. For example, the policy of the GME program at Emory School of Medicine notes that a program director may approve up to five days of paid bereavement leave per occurrence.²³

Physicians in medical group practices will likely have bereavement leave available, but the details will vary depending on the size and ownership of the practice.

DISCUSSION

Parental leave: Feasibility and possible impact of increasing minimum to 12 weeks

If a medical student is absent from school for 12 weeks, that equates to approximately three months of schooling (i.e., nearly a semester). While this absence poses challenges, medical schools may consider investigating

institutions with established best practices in parental policies, such as those that include a provision of an academic adjustment option guaranteeing approval to return from such leave.⁷ Establishment and implementation of such policies may also contribute to the furtherance of equity among medical students. In doing so, institutions should consider the merits of a broad versus prescriptive policy given the challenges that may be unique to students and institutions. The rise in interest and implementation of competency-based medical education (CBME) may one day foster paths for students to take such leave and still demonstrate competency in order to graduate. On the other hand, there may be unintended consequences that impact not only the student on leave, but also their peers, the faculty who are overseeing their competency, and the institution which carries the fiscal responsibilities. Consideration should be given to whether a student's financial aid covers prolonged schooling due to leave, if schools will incur additional expense for providing make-up education, and if there should be additional tuition costs for students who need significant make-up time.

Like students, a 12-week absence from training can have an impact on the resident/fellow competency given the missed educational and clinical experiences. It can also impact their peers who may need to assume added responsibilities for the absent resident/fellow, the program staff who must figure out how to supplement the missed training in order to ensure successful completion of a residency/fellowship as well as monitor any impact on other residents and patients, and the program/institution which has the fiscal responsibility. As pointed out earlier, paid leave versus unpaid leave is an additional consideration. For GME, consideration must be given to the sources of GME funding and if/how trainees are funded on leave versus those who are active in their training.

To teach an effective educational program, students, residents, and fellows play an important role. Large or sudden changes in the participation of learners can impact the quality of education. Such education requires both teachers and learners to take responsibility for the educational program. If possible, advanced notification of the need for leave, with privacy protections, may be important to maintain quality education.

Similar to residents/fellows, the feasibility and impact on the group practice of a physician taking 12-week parental leave time can be tenuous and difficult. While there are clear benefits to the physician-parent and child, the other practice members would need to provide coverage which impacts their time—both professional and personal—and possibly their wellness. In smaller practices, there may not be enough personnel to provide such coverage.

Compassionate leave: Feasibility and possible impact

The calls for study in Policy H-405.947 seeks information on the components of such policy and/or exceptions to said policy. These factors may include extensive travel calling for additional days of leave or events affecting pregnancy, fertility, surrogacy, and adoption. Further, it seeks to clarify whether notification should be required in advance of taking said leave, if such leave is paid or unpaid, if obligations and time must be made up, and if said make-up time will be paid.

Despite the variance and lack of standardization of such policies across medical schools, resident and fellowship programs, and physician practices, generalized notions of the feasibility and impact of such policies can be postulated but may not apply to every environment.

For example, extensive travel for bereavement leave is a very real possibility in the case of a death, where an individual may need to journey a long way to attend to such matters. Travel alone takes up some of those leave days, let alone the intended actions and time to grieve. Negative events related to fertility, pregnancy, and childbirth (e.g., co-morbidities, pregnancy loss, an unsuccessful round of an assisted reproductive technology procedure) as well as failed adoption or surrogacy arrangements also result in emotional grief and may require time and rest. These circumstances may apply to an individual as well as their partner, regardless of gender and gender identity. As discussed earlier, determining if education/work time must be made up is largely at the level of the individual circumstance. For residents, fellows, and physicians, determining whether such leave is paid or unpaid and if that make-up time (should it be required) will be paid is a financial decision for the employer; there may be opportunity to provide standardization to such decisions so that all parties are informed in advance. Another consideration is that by establishing policies, the opportunities for flexibility may be diminished or removed. Such considerations do seem feasible but require time and attention from leadership to be successfully implemented. There are pros and cons when it comes to impact that need to be considered for each environment, balancing competency, well-being, and equity for all individuals.

RELEVANT AMA POLICY AND ENGAGEMENT

The AMA has ample policy in support of leave for students, residents, fellows, and physicians, including a new policy on compassionate leave (I-22). While this list provides links to each item, the full policies are enumerated in the Appendix:

- [Policies for Parental, Family and Medical Necessity Leave H-405.960](#)
- [AMA Statement on Family and Medical Leave H-420.979](#)
- [Compassionate Leave for Medical Students and Physicians H-405.947](#)
- [Parental Leave H-405.954](#)
- [Paid Sick Leave H-440.823](#)
- [Parental Leave and Planning Resources for Medical Students D-295.308](#)
- [Support for Residents and Fellows During Family and Medical Leave Time H-310.908](#)
- [Support for the Study of the Timing and Causes for Leave of Absence and Withdrawal from United States Allopathic and Osteopathic Medical Undergraduate and Graduate Education Programs H-295.856](#)
- [FMLA Equivalence H-270.951](#)
- [To Amend The Family Leave Act D-420.999](#)
- [Gender-Based Questioning in Residency Interviews H-310.976](#)
- [Residents and Fellows' Bill of Rights H-310.912](#)
- [Principles for Graduate Medical Education H-310.929](#)
- [CMS to Pay for Residents? Vacation and Sick Leave D-305.968](#)
- [Eliminating Religious and Cultural Discrimination from Residency and Fellowship Programs and Medical Schools H-310.923](#)
- [Cultural Leave for American Indian Trainees H-350.957](#)

In particular, “Policies for Parental, Family and Medical Necessity Leave” (H-405.960) recommends that medical practices, departments, and training programs strive to provide 12 weeks of paid parental, family, and medical necessity leave in a 12-month period for their attending and trainee physicians as needed. “Parental Leave” (H-405.954) 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 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. Also, the “Residents and Fellows’ Bill of Rights” (H-310.912) supports paid leave for all purposes (family, educational, vacation, sick) to be no less than six weeks per year.

On a related note, the Council’s [report](#) on “Support for Institutional Policies for Personal Days for Undergraduate Medical Students was adopted at the 2022 Annual Meeting. As a result, new policy states that the AMA “support a requirement that each medical school have policy defining 1) the number of days a medical student may be excused from each curricular component; 2) the processes for using excused absences, providing alternative, timely means of achieving curricular goals when absent from a curricular component; and 3) effective mechanisms to communicate these policies at appropriate times throughout the curriculum; and that schools be encouraged to create a mechanism by which at least some portion of such days can be used without requiring explanation.” This policy further demonstrates AMA’s encouragement of institutional policies and its commitment to address the well-being of students.

SUMMARY AND RECOMMENDATIONS

The AMA recognizes the importance of leave policies for medical students, residents, fellows, and physicians. Such policies may positively impact one’s physical, mental, and emotional health, thereby reducing stress and burnout, improving satisfaction, and ultimately uplifting patient care. The lack of standardization of parental and bereavement leave policies may contribute to inequities. Given that each institution, program, or practice develops its own related policies, informed by state laws as well as human resources and legal counsel, it is difficult to create universal standards.

Medical schools, graduate medical education programs, and physician practices should be encouraged to offer parental and bereavement leaves that, at minimum, are consistent with federal and state laws and institutional policies. Medical schools should acknowledge that delay of childrearing for the sake of education has significant personal implications. Programs or practices with fewer than 50 employees should address how they can best

accommodate their employees. All authorities discussed in this report must evaluate the benefits and challenges of implementing such policies and do what is best for the learner/physician's well-being.

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

1. That the fifth and fifteenth clauses of AMA Policy [H-405.960](#), "Policies for Parental, Family and Medical Necessity Leave," be amended by addition and deletion, to read as follows:

5. Our AMA recommends that medical practices, departments, and training programs strive to provide 12 weeks of paid parental, family, and medical necessity leave in a 12-month period for their attending and trainee physicians as needed, with the understanding that no parent be required to take a minimum leave.

15. In order to accommodate leave protected by the federal Family and Medical Leave Act, our AMA encourages all specialties within the American Board of Medical Specialties (ABMS) 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 in the event of leave beyond six weeks. Our AMA encourages specialty boards to develop flexible policies for board certification for those physicians who take leave beyond the minimum of six weeks of family or medical leave (per ABMS policy) and whose residency programs are able to certify that residents meet appropriate competencies for program completion.

2. That AMA Policy [H-405.960](#), "Policies for Parental, Family and Medical Necessity Leave," be amended by addition to read as follows:

19. Medical schools are encouraged to develop clear, equitable parental leave policies and determine how a 12-week parental, family, or medical leave may be incorporated with alternative, timely means of completing missed curriculum while still meeting competency requirements necessary to complete a medical degree.

3. That the first and fifth clauses of AMA Policy [H-405.947](#), "Compassionate Leave for Medical Students and Physicians," be amended by addition and deletion with a change in title to read as follows:

Compassionate Leave for Physicians, Medical Students, Medical Trainees, and Physician Residents and Fellows and Physicians

1. Our AMA urges:

(a) ~~medical schools, and the residency and fellowship training programs, medical specialty boards, the Accreditation Council for Graduate Medical Education, and medical group practices Liaison Committee on Medical Education and Commission on Osteopathic College Accreditation~~ to incorporate and/or encourage development of compassionate leave policies as part of the physician's standard benefit agreement. Such compassionate leave policies should consider inclusion of extensive travel and events impacting family planning, pregnancy, or fertility (including pregnancy loss, an unsuccessful round of intrauterine insemination or of an assisted reproductive technology procedure, a failed adoption arrangement, or a failed surrogacy arrangement). These policies should determine how compassionate leave may be incorporated with alternative, timely means of achieving curricular goals when absent from curricular components and to meet competency requirements necessary to complete a medical degree;

(b) ~~residency and fellowship training programs, their sponsoring institutions, and Accreditation Council for Graduate Medical Education~~ to incorporate and/or encourage development of compassionate leave policies as part of the physician's standard benefit agreement. Such compassionate leave policies should consider appropriateness of coverage during extensive travel and events impacting family planning, pregnancy, or fertility (including pregnancy loss, an unsuccessful round of intrauterine insemination or of an assisted reproductive technology procedure, a failed adoption arrangement, or a failed surrogacy arrangement). These policies should also include whether the leave is paid or unpaid, outline what obligations and absences must be made up, and determine how compassionate leave may be incorporated with alternative, timely means of achieving curricular goals when absent from curricular components and to meet competency requirements necessary to achieve independent practice and board eligibility for their

specialty:

(c) medical group practices to incorporate and/or encourage development of compassionate leave policies as part of the physician's standard benefit agreement. Such compassionate leave policies should consider appropriateness of coverage during extensive travel and events impacting family planning, pregnancy, or fertility (including pregnancy loss, an unsuccessful round of intrauterine insemination or of an assisted reproductive technology procedure, a failed adoption arrangement, or a failed surrogacy arrangement). These policies should also include whether the leave is paid or unpaid and what obligations and absences must be made up.

5. Our AMA will study supports the concept of equal compassionate leave for death or loss (e.g., pregnancy loss and other such events impacting fertility in a physician or their partner) as a benefit for physicians, medical students and physicians, medical trainees, and physician residents and fellows, regardless of gender or gender identity.

4. That the fourth clause of AMA Policy [H-405.960](#), “Policies for Parental, Family and Medical Necessity Leave,” be rescinded, as having been fulfilled by this report.

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

5. That the second clause of AMA Policy [H-405.947](#), “Compassionate Leave for Medical Students and Physicians,” be rescinded, as having been fulfilled by this report.

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

APPENDIX: RELEVANT AMA POLICIES

[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 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 physicians include: (a) duration of leave allowed before and after delivery; (b) category of leave credited; (c) whether leave is paid or unpaid; (d) whether provision is made for continuation of insurance benefits during leave, and who pays the premium; (e) whether sick leave and vacation time may be accrued from year to year or used in advance; (f) how much time must be made up in order to be considered board eligible; (g) whether make-up time will be paid; (h) whether schedule accommodations are allowed; and (i) leave policy for adoption.
3. AMA policy is expanded to include physicians in practice, reading as follows: (a) residency program directors and group practice administrators should review federal law concerning maternity leave for guidance in developing policies to assure that pregnant physicians are allowed the same sick leave or disability benefits as those physicians who are ill or disabled; (b) staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in other physicians' workloads, particularly in residency programs; and (c) physicians should be able to return to their practices or training programs after taking parental leave without the loss of status.
4. Our AMA will study the impact on and feasibility of medical schools, residency programs, specialty boards, and medical group practices incorporating into their parental leave policies a 12-week minimum leave allowance, with

the understanding that no parent be required to take a minimum leave.

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

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

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

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

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

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

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

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

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

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

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

16. Our AMA will work with appropriate stakeholders to encourage that residency programs annually publish and share with FREIDA and other appropriate stakeholders, self-identified and other demographic data, including but not limited to the composition of their program over the last 5 years by age; historically marginalized, minoritized, or excluded status; sexual orientation and gender identity.

17. Our AMA will encourage the Accreditation Council for Graduate Medical Education and other relevant stakeholders to annually collect data on childbirth and parenthood from all accredited US residency programs and publish this data with disaggregation by gender identity and specialty.

18. These policies as above should be freely available online through FREIDA and in writing to all current trainees and applicants to medical school, residency or fellowship.

H-420.979, AMA Statement on Family and Medical Leave

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

- (1) medical leave for the employee, including pregnancy, abortion, and stillbirth;
- (2) maternity leave for the employee-mother;
- (3) leave if medically appropriate to care for a member of the employee's immediate family, i.e., a spouse or children; and
- (4) leave for adoption or for foster care leading to adoption. Such periods of leave may differ with respect to each of the foregoing classifications, and may vary with reasonable categories of employers. Such policies should encourage voluntary programs by employers and may provide for appropriate legislation (with or without financial assistance from government). Any legislative proposals will be reviewed through the Association's normal legislative process for appropriateness, taking into consideration all elements therein, including classifications of employees and employers, reasons for the leave, periods of leave recognized (whether paid or unpaid), obligations on return from leave, and other factors involved in order to achieve reasonable objectives recognizing the legitimate needs of employees and employers.

H-405.954, Parental Leave

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 childcare and unpaid childcare 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.

H-440. 823, Paid Sick Leave

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.

D-295.308, Parental Leave and Planning Resources for Medical Students

1. Our AMA will work with key stakeholders to advocate that parties involved in medical training (including but not limited to residency programs, administration, fellowships, away rotations, physician evaluators, and research opportunities) do not discriminate against students who take family/parental leave.
2. Our AMA encourages medical schools to create comprehensive informative resources that promote a culture that is supportive of their students who are parents, including information and policies on parental leave and relevant make up work, options to preserve fertility, breastfeeding, accommodations during pregnancy, and resources for childcare that span the institution and the surrounding area.

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

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.

H-295.856, Support for the Study of the Timing and Causes for Leave of Absence and Withdrawal from United States Allopathic and Osteopathic Medical Undergraduate and Graduate Education Programs

Our AMA: (1) supports the study of factors surrounding leaves of absence and withdrawal from allopathic and osteopathic medical undergraduate and graduate education programs, including the timing of and reasons for these actions, as well as the sociodemographic information of the students involved; and (2) encourages the Association of American Medical Colleges and the American Association of Colleges of Osteopathic Medicine to support the study of factors surrounding leaves of absence and withdrawal from allopathic and osteopathic medical undergraduate and graduate education programs, including the timing of and reasons for these actions, as well as the sociodemographic information of the students involved.

H-405.947, Compassionate Leave for Medical Students and Physicians

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

H-270.951, FMLA Equivalence

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.

D-420.999, To Amend The Family Leave Act

Our AMA will work to simplify the Family Medical Leave Act form, reducing the physician work required for completion.

H-310.976, Gender-Based Questioning in Residency Interviews

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

H-310.912, Residents and Fellows' Bill of Rights

1. Our AMA continues to advocate for improvements in the ACGME Institutional and Common Program Requirements that support AMA policies as follows:
 - a) adequate financial support for and guaranteed leave to attend professional meetings;
 - b) submission of training verification information to requesting agencies within 30 days of the request;
 - c) adequate compensation with consideration to local cost-of-living factors and years of training, and to include the orientation period;
 - d) health insurance benefits to include dental and vision services;
 - e) paid leave for all

purposes (family, educational, vacation, sick) to be no less than six weeks per year; and f) stronger due process guidelines.

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

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

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

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

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

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

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

RESIDENT/FELLOW PHYSICIANS' BILL OF RIGHTS

Residents and fellows have a right to:

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

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

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

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

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

With regard to evaluation and assessment processes, residents and fellows should expect: (1) Timely and substantive evaluations during each rotation in which their competence is objectively assessed by faculty who have directly supervised their work; (2) To evaluate the faculty and the program confidentially and in writing at least once annually and expect that the training program will address deficiencies revealed by these evaluations in a timely fashion; (3) Access to their training file and to be made aware of the contents of their file on an annual basis; and (4)

Training programs to complete primary verification/credentialing forms and recredentialing forms, apply all required signatures to the forms, and then have the forms permanently secured in their educational files at the completion of training or a period of training and, when requested by any organization involved in credentialing process, ensure the submission of those documents to the requesting organization within thirty days of the request.

D. A safe and supportive workplace with appropriate facilities.

With regard to the workplace, residents and fellows should have access to: (1) A safe workplace that enables them to fulfill their clinical duties and educational obligations; (2) Secure, clean, and comfortable on-call rooms and parking 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.

H-310.929, Principles for Graduate Medical Education

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

(1) PURPOSE OF GRADUATE MEDICAL EDUCATION AND ITS RELATIONSHIP TO PATIENT CARE.

There must be objectives for residency education in each specialty that promote the development of the knowledge, skills, attitudes, and behavior necessary to become a competent practitioner in a recognized medical specialty.

Exemplary patient care is a vital component for any residency/fellowship program. Graduate medical education enhances the quality of patient care in the institution sponsoring an accredited program. Graduate medical education must never compromise the quality of patient care. Institutions sponsoring residency programs and the director of each program must assure the highest quality of care for patients and the attainment of the program's educational objectives for the residents.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

D-305.968, CMS to Pay for Residents? Vacation and Sick Leave

Our AMA will lobby the Centers for Medicare and Medicaid Services to continue to reimburse the direct and indirect costs of graduate medical education for the time resident physicians are on vacation or sick leave.

H-310.923, Eliminating Religious and Cultural Discrimination from Residency and Fellowship Programs and Medical Schools

Our AMA encourages residency programs, fellowship programs, and medical schools to: (1) allow trainees to take leave and attend religious and cultural holidays and observances, provided that patient care and the rights of other trainees are not compromised; and (2) explicitly inform applicants and entrants about their policies and procedures related to accommodation for religious and cultural holidays and observances.

H-350.957, Cultural Leave for American Indian Trainees

Our AMA recognizes the importance of cultural identity in fostering trainee success and encourages residency programs, fellowship programs, and medical schools to accommodate cultural observances for trainees from American Indian, Alaska Native, and Native Hawaiian communities.

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2. UPDATING ON CONTINUING BOARD CERTIFICATION

Informational report; no reference committee hearing.

HOUSE ACTION: FILED

At the 2022 Annual Meeting, the House of Delegates (HOD) called upon the American Medical Association (AMA) to “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” (Policy [D-275.954](#)). This policy resulted from [CME Report 2-A-22](#), “An Update on Continuing Board Certification,” which provided a detailed account of updates as well as a list of improvements to assessment of knowledge, judgment, and skills (Part III) and improvement in medical practice (Part IV) found in the appendix.

Further, the AMA reaffirmed Policy [H-275.924](#), “Continuing Board Certification,” at the 2022 Interim Meeting and amended Policy D-275.954 to include a new clause that the AMA “continue to publicly report its work on enforcing AMA Principles on Continuing Board Certification.”

Given the interest of the HOD demonstrated at A-22 and I-22, the Council offers this informational report to provide allopathic and osteopathic updates on CBC since the last report was adopted at A-22.

BACKGROUND

CBC is an ongoing process that simultaneously supports diplomates in keeping their knowledge and skills current while validating their increasing expertise in a specialty. First established in 1933, the American Board of Medical Specialties (ABMS) is comprised of 24 certifying boards, representing nearly one million active board-certified physicians. The ABMS oversees continuing certification, and its mission is “to serve the public and the medical profession by improving the quality of health care through setting professional standards for lifelong certification in partnership with Member Boards.”¹ The ABMS has been very engaged in the continued evolution of CBC. Such efforts are summarized in this report.

Standards for Continuing Certification

In 2018, the ABMS formed an independent body comprised of 27 individuals representing diverse stakeholders called the [Vision for the Future Commission](#) (“Commission”). They were tasked with reviewing continuing certification within the current context of the medical profession. The Commission released draft recommendations, on which the AMA Council on Medical Education provided comments.² The Commission released their final report in 2019, which contained research, testimony, and public feedback from stakeholders throughout the member boards and health care communities. The report offered 14 recommendations intended to modernize CBC and included a commitment by the ABMS to develop new, integrated Standards for continuing certification programs.³ Delayed due to the COVID-19 pandemic, the final [Standards](#) were released in late 2021.⁴ The Commission and new Standards are described in detail in [CME 2-A-22](#).⁵

ALLOPATHIC CONTINUING CERTIFICATION UPDATES

As of June 30, 2022, the ABMS database of board certification reflects 975,000 ABMS board-certified diplomates across 40 specialties and 89 subspecialties. Among them, 690,518 diplomates participate in continuing certification.⁶ Board-certified diplomates are required to participate in continuing certification; however, some individuals do not as the requirement may not have been in place when they were first certified. Voluntary participation is strongly encouraged.

ABMS Strategic Plan

In 2022, the ABMS began drafting a five-year [Strategic Plan](#) (2023-2028) to define major needs, expectations, and opportunities and define guiding themes and topics (“imperatives”) as well as to anticipate key changes and new demands in the external environment.⁷ Approximately 100 individuals from ABMS, the Member Boards, and partner organizations participated in the development of this plan and formed 10 workgroups using a community-based process of exploration, discussion, and decision-making while also being mindful of internal and external conditions. The title of each workgroup represents an identified “imperative.” The titles/ imperatives are Advocacy; Communications; Culture; Diversity, Equity, and Inclusion (DEI); Governance; Innovation; Metrics; Products and Services; Professionalism; and Program Evaluation. Each workgroup developed an aim and strategic goals for their respective imperative. These imperatives are represented within five strategic themes. Specific initiatives and tactics are being established and deployed to meet the goals of these five strategic themes: increase value for stakeholders, promote professionalism, commit to DEI, promote and protect the ABMS brand, and enhance ABMS culture and decision-making. More information is available in the [Executive Summary](#) of the strategic plan.⁸

Given the advent of the workgroups and plan, the previous task forces of the Vision Commission were disbanded. Those task forces, as described in CME 2-A-22, were: Achieving the Vision, Improving Health & Health Care, Information and Data Sharing, Professionalism, Remediation, and Standards.

ABMS Committees

The Committee on Continuing Certification (“3C”) oversees the review process of Member Boards’ continuing certification programs and any progress regarding the implementation of the new Standards by collecting data, developing metrics, and monitoring progress toward meeting the new Standards. Also, 3C reviews and makes recommendations for program and policy improvements, performance standards, security considerations, and psychometric characteristics of longitudinal assessment programs. ABMS staff provide additional support to the Member Boards. This committee continues to work with Member Boards to review assessment data and make recommendations for modifications in their longitudinal assessment programs. Specifically, a Psychometrician Advisory Group is working to define best practices for Member Boards so that 3C may consider them in designing and assessing continuing certification assessments.

The ABMS Stakeholder Council, established in 2018 to ensure that the decisions of the ABMS Board of Directors are grounded in an understanding of the perspectives, concerns, and interests of the multiple constituents impacted by ABMS’ work, is an advisory body representing the viewpoints of practicing physicians, patients, and the public. Since the publication of the Council on Medical Education’s last *Update on Continuing Board Certification*, the Stakeholder Council has provided guidance to the ABMS Board of Directors regarding a comprehensive communications strategy, including engagement with hospitals, patients, and diplomates; offered input into ABMS’ recently completed five year strategic planning process; described insights related to a more transparent display of diplomate certification status; shared thinking regarding how to better communicate recent changes to ABMS Member Board certification programming; reviewed a draft ABMS policy related to diplomate professionalism; discussed the role of Member Boards in supporting diplomate mental health; and made recommendations in support of efforts related to diversity, equity, and inclusion.

The Accountability and Resolution Committee (ARC) is a dispute resolution body that has jurisdiction over allegations against directors or members of the ABMS regarding violations of or a failure to comply with actions or standards adopted by the Board of Directors; the amended and restated bylaws of the ABMS; and any other policies, procedures, regulations, rules, or standards adopted by the Board of Directors. Upon receipt of a referral for noncompliance that has not been resolved through other mechanisms, ARC is authorized to attempt to resolve the complaint through an established dispute resolution process, after which it may issue findings of fact and

recommendations to the Board of Directors for its consideration and adoption. The ARC also maintains oversight of the ABMS Organizational Standards, which establish core standards for the Member Boards regarding issues related to organizational mission; governance and leadership; financial and organizational management; stakeholder engagement; examinations; and data management.

After the release of the new Standards, the ABMS formed the Improving Health and Health Care Learning Collaborative (IHHC-LC) to assist Member Boards with meeting Standards 18 and 19. They host quarterly meetings to foster meaningful engagement opportunities for diplomates across all specialties.

Updates and Innovations in Assessment

All 24 ABMS Member Boards have implemented formative assessments for continuing certification since the release of ABMS' Vision [recommendations](#), which called for Member Boards to create formative processes that offer opportunities for learning and improvement and an alternative to the secure, point-in-time examinations of knowledge. Longitudinal assessment is now implemented by 17 of the Member Boards, offering assessments that are shorter, content specific, current, and based on needs and interests; recurring assessments over time to reinforce concepts and promote retention; ongoing performance feedback to note areas of additional learning; and follow-up assessments to gauge proficiency. Physicians can choose when, where, and how they answer questions given accessibility of longitudinal assessments on personal devices. Of the 17, seven Member Boards execute their longitudinal assessments via [CertLink®](#), a technology platform developed by ABMS; more than four million questions have been answered to date. Further updates from Member Boards include:

- Four boards now provide point-in-time knowledge assessments, offered at less frequent intervals (e.g., semi-annual, every three years). They are the American Board of Allergy and Immunology (ABAI), American Board of Emergency Medicine, American Board of Neurological Surgery, and American Board of Surgery.
- Three boards have implemented “customized to practice” assessments whereby physicians can select from among topic areas based on practice setting and/or patient mix. They can be question-based and use multiple-choice questions or article-based and involve reviewing articles and responding to related questions. They are the American Board of Obstetrics & Gynecology (ABOG), American Board of Psychiatry and Neurology (ABPN), and American Board of Thoracic Surgery (ABTS).
- Eight boards no longer offer the traditional exam. They are the American Board of Colon and Rectal Surgery, American Board of Dermatology, American Board of Emergency Medicine, American Board of Medical Genetics and Genomics, American Board of Neurological Surgery, American Board of Ophthalmology, American Board of Pathology, American Board of Plastic Surgery, and ABTS.
- Three boards only use the traditional exam for re-entry. They are the American Board of Anesthesiology, American Board of Urology, and ABAI.
- Twelve boards have elected to keep an exam option, at the discretion of the physician. They are the American Board of Family Medicine, American Board of Internal Medicine, American Board of Nuclear Medicine, American Board of Orthopaedic Surgery, American Board of Otolaryngology – Head and Neck Surgery (2023 is the last year), American Board of Pediatrics, American Board of Physical Medicine and Rehabilitation, American Board of Preventive Medicine, American Board of Radiology, ABU, ABOG, and ABPN (ABMS, written communications, June-August, 2023).

In addition, there are examples of new board-specific innovations. According to the ABMS, the American Board of Pediatrics (ABP) reports that nearly 30,000 board-certified pediatricians and pediatric subspecialists now participate in an ABP continuing certification activity called “Question of the Week.” It provides participants with relevant, high-quality questions and supporting material. Each question features a case scenario, pre-test, abstract, commentary, and final question. Participants can answer as many questions as they wish and can share their thoughts with each other by leaving comments. Feedback to ABP has been positive.

In 2024, the American Board of Internal Medicine (ABIM), in collaboration with the Society of Hospital Medicine, will launch assessment options designed for those who practice primarily in an inpatient setting, including an Internal Medicine Longitudinal Knowledge Assessment (LKA[®]) and a traditional, 10-year exam. These options will be available to any eligible diplomate certified in internal medicine.

Following the successful pilot and launch of longitudinal assessment for continuing certification in Physical Medicine and Rehabilitation, the American Board of Physical Medicine and Rehabilitation (ABPMR) will offer

longitudinal assessment for Brain Injury Medicine (LA-BIM). Starting in 2024, this assessment for continuing certification in BIM is shorter and will be offered quarterly with a five-year cycle. The BIM examination will be offered for diplomates with cycle end dates in 2024. All BIM diplomates are encouraged to participate in LA-BIM to continue their certification.

ABMS Portfolio Program

The [ABMS Portfolio Program](#)TM enables a national network of organizations (“sponsors”) to assist physicians and physician assistants in submitting their quality improvement (QI) efforts for continuing certification credit. Program sponsors administer activity submissions and attestation approvals and send confirmation of activity completion to ABMS. These sponsors have facilitated more than 27,000 individuals in receiving certification credit for thousands of QI activities. The ABMS supports a myriad of [sponsors](#) including the AMA. To aid sponsors in their work, ABMS offered a webinar in May 2023 entitled “Offer a More Meaningful and Relevant QI Experience with the ABMS Portfolio Program” that featured two program sponsors who are creating thriving programs in their organization.

Exploring Competency-Based Medical Education

The ABMS is collaborating with the Accreditation Council for Graduate Medical Education (ACGME) to investigate competency-based medical education (CBME) as it relates to CBC. The ACGME accredits programs that assess individuals during residency, and the ABMS Member Boards assess individuals for specialty certification as they make the transition from training into practice. Given some of the boards are incorporating, piloting, or exploring assessment approaches as part of a CBME model, this collaborative will foster communication and information sharing.

OSTEOPATHIC CONTINUING CERTIFICATION UPDATES

The American Osteopathic Association (AOA) is the professional home for more than 178,000 osteopathic physicians (DOs) and medical students. AOA offers board certification in 27 primary specialties and 48 subspecialties (including certificate of added qualification). Nine of the 48 subspecialties are conjoint certifications managed by multiple AOA specialty boards. As of December 31, 2022, a total of 39,111 physicians held 46,101 active certifications issued by the AOA’s specialty certifying boards. AOA Certifying Board Services Department, in collaboration with each of the 16 osteopathic medical specialty certifying boards, develops and implements certification programs and assessments. With the guidance of the AOA Bureau of Osteopathic Specialists, specialty certifying boards commit to enhancing board certification services that better serve candidates and diplomates pursuing and maintaining AOA board certification and life-long learning. AOA specialty certifying boards provide a modernized, expedited approach to the delivery of relevant and meaningful competency assessment for board-certified diplomates. As part of Osteopathic Continuous Certification (OCC), longitudinal assessment programs have been developed and implemented for each of the 27 primary specialty board certifications. The longitudinal assessments replaced the high stakes recertification exams previously required. AOA specialty certifying boards are beginning the process of developing longitudinal assessment programs for 14 of the subspecialty board certifications, five of which are anticipated to launch in 2024. AOA continues to offer its candidates and diplomates online remote proctored delivery of its certification and OCC exams. (AOA, written communications, June-August, 2023).

LITERATURE REVIEW

The body of evidence regarding the value and importance of CBC continues to grow. A review of the literature published between January 1, 2022 – July 4, 2023, illuminated a number of relevant articles addressing continuing certification and maintenance of certification. An annotated bibliography of such articles can be found in Appendix A of this report.

AMA ENGAGEMENT IN CBC

Council on Medical Education

The AMA and its [Council on Medical Education](#) (CME) have been actively engaged in the evolution of CBC, formerly called maintenance of certification (MOC) in past reports and resolutions, for many years. At this time, the Council has made available on its [webpage](#) 18 reports addressing certification and licensure since 2012. These reports are informed by the work of the ABMS. The board certification program of the ABMS provides continuous development and professional assessment.

The CME maintains a close relation with the ABMS and its member boards. The 2023-2024 chair of the Council also serves as a member of the ABMS Stakeholders Council. Dr. Richard Hawkins, president and CEO of the ABMS, was invited by the Council to attend its fall 2022 meeting to provide an update on the new [Standards](#) for continuing certification. He also presented to the AMA on April 5, 2023, co-hosted by the Academic Physician Section and Young Physician Sections, to further discuss the new Standards as well as share related concerns from physicians and the ABMS response to those concerns. Dr Hawkins also discussed structural changes to ABMS governance and the organization's collaboration with associate members. He clarified current misinformation. Further, the Council invited Dr. Hawkins to attend their assembly during the 2023 Annual Meeting. Dr. Hawkins shared that they've received largely favorable feedback on the new Standards. Boards are working on their implementation plans given that the Standards take effect January 1, 2024; the Council asked that ABMS consider challenges faced by physicians in independent private practice. Also, Dr. Hawkins reported on their collaboration with ACGME on CBME and attentiveness to equity in assessment. He shared concerns regarding alternative certifying bodies, specifically the National Board of Physicians and Surgeons, citing how they fall short of the norms set by the ABMS as publicly addressed in their July 2022 [statement](#).⁹ Lastly, Dr. Hawkins shared that ABMS is looking into ways continuing certification can promote well-being and decrease burnout.

In addition, the Council will proffer a report at the 2023 Interim Meeting that provides an overview of several entities that provide board certification including the ABMS, AOA Bureau of Osteopathic Specialists (BOS), National Board of Physicians and Surgeons (NBPAS), American Board of Physician Specialties (ABPS), and American Board of Cosmetic Surgery (ABCS) and how their standards for board certification differ. It is important to note that while there are different ways to achieve continuing board certification, it is debatable whether they produce the same outcomes for patients.

Relevant AMA policies

AMA policy related to CBC and lifelong learning can be accessed in the [AMA PolicyFinder](#) database. Policies most relevant to CBC are provided in Appendix B and are listed here:

- [H-275.924](#), "Continuing Board Certification"
- [D-275.954](#), "Continuing Board Certification"
- [H-275.926](#), "Medical Specialty Board Certification Standards"
- [D-275.957](#), "An Update on Maintenance of Licensure"

CONCLUSION

The AMA will continue to monitor the evolution of CBC and provide updates, as directed by this House of Delegates. The Council is grateful to ABMS and AOA for their contributions to the creation of this report. Following this report, the Council will provide further updates in the form of issue briefs as pertinent information arises. In the event of significant changes to CBC impacting practicing physicians, the Council will consider initiating a report to the House of Delegates. Reports and issue briefs are posted to the Council's report [webpage](#) and promoted through various AMA medical education communications. Reports can also be found via the AMA [Council Report Finder](#) search tool.

APPENDIX A: ANNOTATED BIBLIOGRAPHY

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3. ENSURING EQUITY IN INTERVIEW PROCESSES FOR ENTRY TO UNDERGRADUATE AND GRADUATE MEDICAL EDUCATION

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS REMAINDER OF REPORT FILED

See Policies H-295.844

American Medical Association (AMA) Policy D-295.303, “Support Hybrid Interview Techniques for Entry to Graduate Medical Education,” states that our AMA will:

“1. work with relevant stakeholders to study the advantages and disadvantages of an online medical school interview option for future medical school applicants, including but not limited to financial implications and potential solutions, long term success, and well-being of students and residents.

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

Defining “hybrid”

During the COVID-19 pandemic, medical schools and residency programs shifted from in-person to virtual interviews due to the public health emergency. With both virtual and in-person modalities now available, medical educators are debating the most equitable and appropriate means of conducting interviews in the application processes. To inform AMA policy on this topic, it is critical to clearly define the different methods of conducting interviews of applicants.

Specifically, the term “hybrid” should be defined with clarity, as it is referenced in the title and body of the policy serving as impetus for this report. This term has been used to describe the use of virtual (also called online) and in-person interviews. In this report, we refer to interview techniques as either virtual or in-person, rather than using the term “hybrid.”

For clarity, this report will define “hybrid” interviews as the use of a mix of virtual and in-person interviews of applicants for the same class, as determined either by the school or program and/or individual applicant, resulting in some applicants having virtual interviews and others having in-person interviews. This definition of “hybrid” is consistent with definitions used by the Association of American Medical Colleges (AAMC) and Coalition for Physician Accountability (CPA).

Some schools or programs use both virtual and in-person interviews, through which all applicants are interviewed using one modality, with a subset of applicants then interviewed again via another modality (i.e., a virtual interview followed by an in-person interview) before the medical school offers an admission or the residency program submits a match list. This method of interviewing will be referred to as a “two-step interview” in this report.

In the application process, applicants may wish to visit a school or program outside of the formal interview after the medical school offers an admission or the residency program submits a match list to obtain the additional information they need to select the medical school or residency that best fits their needs. We will refer to this process as the “second look in-person visit.”

BACKGROUND

As a result of the COVID-19 pandemic, many businesses and individuals shifted from face-to-face communications and meetings to virtual technologies. The move was motivated by public health considerations, but even now, with the pandemic much less a health concern than it had been, virtual forms of communication continue and are now

considerably more entrenched in both the business world and everyday life for many people. This large-scale, societal communications shift has occurred in medical education as well. The application, interview, and entry process into undergraduate medical education (UME, or medical school) and graduate medical education (GME, or residency/fellowship programs) has seen increased usage of video conferencing since spring 2020, when the pandemic began.

Indeed, current guidance from the AAMC recommends that both medical schools¹ and residency/fellowship programs² use virtual applicant interviews but does acknowledge that schools and programs may choose a specific format (i.e., either virtual or in-person interviews) based on their specific mission, goals, and context. The AAMC cites the following considerations when recommending virtual interview formats for both UME and GME:

1. The financial costs associated with interviewing for medical school and residency or fellowship programs are high.
2. Most applicants prefer virtual interviews.
3. Time spent away from school, work, or other commitments due to travel associated with in-person interviews is an undue burden for applicants to bear.
4. Separating assessment and recruitment efforts is an important step to mitigate risk of bias in interview ratings.
5. Medical schools, teaching hospitals and health systems, and the AAMC have made commitments to reduce their carbon footprints.

Similarly, the CPA, which comprises national organizations (including the AMA) responsible for the oversight, education, and assessment of medical students and physicians throughout their medical careers, has called for virtual interviews for applicants to residency/fellowship positions. A 2021 report of 34 recommendations for improving the UME to GME transition³ from the CPA's Undergraduate Medical Education-Graduate Medical Education Review Committee (UGRC) noted, "To ensure equity and fairness, there should be ongoing study of the impact of virtual interviewing as a permanent means of interviewing for residency." In addition, the CPA stated, "Hybrid interviewing (virtual combined with onsite interviewing) should be prohibited." (Note: These recommendations were not updated beyond the 2021-2022 interview season.) This recommendation to avoid offering both types of interviews at the same time mirrors guidance from the AAMC in its document referenced above, "Interviews in UME: Where Do We Go From Here?"

Potential benefits and disadvantages of virtual versus in-person interviews

Use of virtual interviewing in the selection of medical students and resident/fellow physicians may be an efficient option for institutions and could lead to decreased costs for both applicants and institutions/programs. AMA policy is supportive of efforts to mitigate barriers associated with entry to and progress in medical education.

This format offers increased efficiency and lower (or nonexistent) travel costs for applicants, alongside significant cost savings for schools/programs (e.g., catering and food costs), and potential savings in reduced time commitment and the costs of hosting applicants. That said, schools and programs face significant scheduling and administrative overhead, even in a virtual environment, so time savings for schools and programs may be minor. The virtual interview format also offers admissions personnel and program directors the opportunity to gauge applicants' "virtual etiquette" (or lack thereof)—an important skill for future physicians to develop as telehealth becomes more widespread.

On the negative side, virtual-only interviews eliminate "face time" for both applicants and programs to fully evaluate each other through standard social interactions (e.g., with support and administrative staff). The ways in which an applicant interacts with other individuals in a live setting can be revealing as to emotional intelligence and "bedside manner." This may be indirectly captured by scheduling breaks in the virtual interview process and other strategies to provide opportunities for evaluation of informal interactions.

Another potential pitfall to virtual interviews is the security of the interview. Can the institution/program assure that the applicant is alone and not receiving help from another individual or an off-camera electronic device? Does the applicant have notes available? What if the applicant is recording the interview in some way? Interruptions in the internet connection, electrical failures, or technological glitches in software can also derail virtual interviews. Finally, the personal safety of applicants may be an issue (as the institution does not know where they are located).

This can be important should an applicant have a medical or psychological emergency during the interview.

Another potential downside of virtual interviews relates to the possibility of “interview hoarding” by a candidate who may be able to schedule multiple interviews within a shortened time frame and inadvertently limit the opportunities for other applicants to obtain interviews.

Finally, more research is needed on the impact of virtual interviews on the diversity of the medical workforce, which hinges largely on the diversity of medical school entrants. As noted in Council on Medical Education Report 2-I-22, “Mitigating Demographic and Socioeconomic Inequities in the Residency and Fellowship Selection Process:”

“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.”⁴

Pros and cons of a “hybrid” interview format

The AAMC document referenced in this report includes a table describing virtual only, in-person only, or hybrid interview formats with proposed steps for successfully using each modality. A key concern with the hybrid interview format is that applicants interviewed through one modality may be unfairly advantaged over applicants interviewed by the other modality, affecting equity and fairness in the application process. For example, an applicant who can interview in-person may have opportunities to directly interact with their interviewers and other faculty, is less likely to encounter technical issues that may affect the quality of the interview, and may be perceived by the program faculty as more interested in the program than an applicant who interviews virtually.

In certain circumstances, however, allowing hybrid interviews may not have as significant of an impact on equity and fairness. For example, students who are doing away rotations at institutions where they are applying for residency are likely already interacting in-person with residency faculty and would be available for an in-person interview during their rotation. Requiring an additional virtual interview in this instance may be superfluous and impose additional cost and time burdens on both applicant and program. This reasoning would extend as well to students applying to a medical school or residency at the same university or teaching hospital in which they performed a clerkship in that specialty, as they are already familiar to the faculty. More challenging are those instances where students, to help solidify their own decision-making, choose to visit the school or program in-person to evaluate the institution and the local environs (e.g., cost of living, affordability, career and educational opportunities for partners or children, etc.) where they may be spending many years in training. Should these applicants be given an opportunity for an in-person interview?

In short, the “hybrid” interview format likely presents significant difficulties for schools and programs regarding fairness, equity, and avoidance of bias. In its discussion of this format in “Interviews in GME: Where Do We Go From Here?” the AAMC suggests the following “steps for success” for this modality:

1. Implement policies, procedures, and interviewer training to ensure standardization across formats and to mitigate risk of bias.
2. Ensure admissions/selection committees are blinded to interview format.
3. Inform applicants about steps taken to make the hybrid approach equitable.
4. Offer virtual recruiting activities to all applicants.

Inherently, these recommendations lack specificity and may be difficult to implement. For example, no guidance is provided for the first recommendation as to what policies and procedures would mitigate the risk of bias in hybrid interviews. The second recommendation would mean that any residency faculty involved in developing the program’s match list, including the program director, could not interact with applicants during the interview process to ensure they were blinded as to interview format. They do, however, provide a starting point for further consideration and exploration.

Helping applicants make informed decisions: The “second look in-person visit”

While it is important that the interview/application process is equitable in determining medical school admissions or residency program match lists, it is also important that applicants obtain the information they need to select the medical school or residency that best fits their needs.

Medical schools and residencies conduct interviews to inform their selection of applicants; however, applicants need opportunities to select a school or residency as well, given that they will be spending years not only in training but also residing in that locality. In addition to the formal school/program interview process, reviewing the school/program website, talking to colleagues and classmates, and interviewing graduates are other means by which an applicant can make an informed and educated decision. Applicants who interview virtually may also wish to undertake a campus visit or “second look in-person visit” at a program or institution to gain a more complete picture of their potential landing place prior to accepting an admission or submitting their match rank list.

To help promote and sustain efforts at equity, it is critical for programs and institutions to ensure that any format allowing for a second look in-person visit protects applicants from the perception that a second look is required or confers an advantage for their application. To mitigate these risks, residency programs in fields such as neurological surgery have adopted specialty-wide guidance supporting the idea of campus visits to allow students to visit programs, with the caveat that such programs have their rank lists submitted prior to students’ visits so that students do not feel such a visit will impact their standing with any program. Earlier this year, the National Resident Matching Program (NRMP) sought feedback regarding the potential for programs to “voluntarily lock” their rank lists early to achieve this purpose⁵ and found that submitting and locking this list early in the process may unintentionally limit the number of applicants to a program or cause programs to not thoroughly evaluate applicants to meet an earlier deadline. To explore this further, an innovations summit to evaluate potential changes to the match process in this new climate of virtual interviews will be convened by NRMP stakeholders.⁶

DISCUSSION

The policy that served as impetus for this report calls for an online interview “option” for medical school applicants in clause one and incorporating videoconferencing for residency program applicants as an “adjunct” to GME interviews in clause two. In the current environment, it may be more appropriate to refer to the in-person interview format as an option or adjunct to virtual interviewing. As stated, the need for fairness and equity in the UME and GME interview and application process remains critical, with the overarching goal being to facilitate meaningful interactions and informed decisions between applicants and programs/institutions. Doing so requires mitigating bias in the process. Unfortunately, both in-person and virtual interviews have the potential for real or perceived bias as described above. Using both methods simultaneously likely exacerbates the potential for bias from both approaches.

As Edge, et al. state, “In its current state, the resident selection process is ambiguous and has grown more so with the recent introduction of virtual components.”⁷ Undoubtedly, more information and understanding regarding this changing landscape is required, especially as it relates to unique factors including specialty, size, and location of program, duration of training, and proximity to other programs within a defined region.

A good opportunity for this work is the AMA’s continued participation in the CPA, which brings together leading medical education, accreditation, and certification bodies responsible for the oversight, education, and assessment of medical students and physicians throughout their medical careers. While the CPA published interview guidelines from its UGRC, these have not been updated past the 2021-2022 application cycle. Current research on the virtual interview format has expanded; such research should continue and should be used to inform future actions and recommendations. Another opportunity is to engage with the NRMP and its innovations summit, as mentioned in this report.

The preeminent concern is to create an equitable, fair experience for all applicants, whether they interview in-person or virtually. This need extends to institutions and programs as well.

SUMMARY AND RECOMMENDATIONS

Even as the COVID-19 pandemic recedes into the background, it is likely that virtual interactions are here to stay in social, business, and professional environments. Interviews for entry to medical school and residency/fellowship programs will continue to reflect this trend. Virtual interviews may lack the immediacy and social cues/clues

provided through in-person interactions but offer a host of benefits to both applicants and institutions/programs, some of which may help to mitigate bias and enhance equity. At the same time, however, virtual interviews may also introduce their own unique set of biases and problems related to the selection process, which can affect applicants and institutions/programs alike. To help address these concerns, and ensure a level playing field for all applicants, your Council agrees with the AAMC that all applicants for UME and GME should be evaluated using the same approach, whether in-person or virtual.

Attention to concerns about equity, diversity, and belonging in this new environment is warranted; the AMA should ensure continued attention to and action on such concerns. This would include working with relevant stakeholders (through the CPA, for example) to understand the real and potential biases of these interview formats; encouraging continued research to inform best practices in medical education application processes; disseminating these best practices; and helping facilitate consensus among medical schools, GME programs, and the various specialties with the goal of achieving equity and fairness while also allowing for meaningful interaction and informed decision-making by all parties.

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 interested parties to study the impact of different interview formats on applicants, programs, and institutions.
2. That our AMA continue to monitor the impact of different interview formats for medical school and graduate medical education programs and their effect upon equity, access, monetary cost, and time burden along with the potential downstream effects upon on applicants, programs, and institutions.
3. That our AMA recommend that individual medical schools use the same interview format for all applicants to the same class at their institution to promote equity and fairness while allowing for accommodations for individuals with disabilities.
4. That our AMA recommend that individual graduate medical education programs use the same interview format for all applicants to the same program to promote equity and fairness while allowing for accommodations for individuals with disabilities.
5. That AMA Policy D-295.303, "Support Hybrid Interview Techniques for Entry to Graduate Medical Education," be rescinded, as having been addressed through this report.

APPENDIX: RELEVANT AMA POLICIES

[D-310.949](#), "Medical Student Involvement and Validation of the Standardized Video Interview Implementation"

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

[H-310.966](#), "Residency Interview Costs"

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. (Res. 265, A-90; Reaffirmed: Sunset Report, I-00; Modified: CME Rep. 2, A-10; Appended: Res. 308, A-15)

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- 2 Interviews in GME: Where Do We Go From Here? Association of American Medical Colleges. Available at: <https://www.aamc.org/about-us/mission-areas/medical-education/interviews-gme-where-do-we-go-here>. Accessed June 21, 2023.
- 3 Recommendations for Comprehensive Improvement of the UME-GME Transition. Coalition for Physician Accountability's Undergraduate Medical Education-Graduate Medical Education Review Committee (UGRC). Available at: <https://physicianaccountability.org/wp-content/uploads/2021/08/UGRC-Coalition-Report-FINAL.pdf>. Accessed June 21, 2023.
- 4 Mitigating Demographic and Socioeconomic Inequities in the Residency and Fellowship Selection Process. AMA Council on Medical Education. Available at: https://councilreports.ama-assn.org/councilreports/downloadreport?uri=/councilreports/CME_2_I_22_final_annotated.pdf. Accessed June 22, 2023.
- 5 NRMP® Call for Public Comment – Consideration of Voluntary Locking Functionality for Program Rank Order Lists. National Resident Matching Program. Available at: <https://www.nrmp.org/about/news/2023/03/nrmp-call-for-public-comment-consideration-of-voluntary-locking-functionality-for-program-rank-order-lists/>. Accessed August 15, 2023.
- 6 NRMP to engage constituents in a Match Innovations Summit in response to public comments on the proposed Voluntary Rank Order List (ROL) Lock functionality. National Resident Matching Program. Available at: <https://www.nrmp.org/about/news/2023/06/nrmp-to-engage-constituents-in-a-match-innovations-summit-in-response-to-public-comments-on-the-proposed-voluntary-rank-order-list-rol-lock-functionality/>. Accessed July 24, 2023.
- 7 Edge L, Casillas C, O'Toole JK. Strategies to Counteract Impact of Harmful Bias in Selection of Medical Residents. *Acad Med*. April 26, 2023. Available at: https://journals.lww.com/academicmedicine/fulltext/2023/08001/strategies_to_counteract_impact_of_harmful_bias_in.10.aspx. Accessed August 15, 2023.

4. RECOGNIZING SPECIALITY CERTIFICATIONS FOR PHYSICIANS

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: RECOMMENDATIONS ADOPTED REMAINDER OF REPORT FILED

See Policies H-275.926

Resolution 316-I-22, Recognizing Specialty Certifications for Physicians was authored by the Congress of Neurological Surgeons and American Association of Neurological Surgeons and submitted to the 2022 Interim Meeting of the House of Delegates (HOD). The second resolve reads as follows:

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

The second resolve was referred by the HOD for a report back; this report is in response to the referral.

Background

The need for standardized certification

The history of board certification can be traced back to the late 19th century when the need for standardized medical education and training became apparent. In the early years of medical practice, there were no standardized requirements or guidelines for physicians to demonstrate their specialty qualifications. The first board was the American Board of Ophthalmology, which was incorporated on May 3, 1917, to allow ophthalmologists to distinguish themselves from other physicians as eye specialists. Other specialties also formed their own boards leading the AMA to establish the American Board of Medical Specialties (ABMS) in 1933 to bring order to the proliferation of specialty boards and address conflicts arising between specialty boards. Additionally, other entities were established to provide board certification including, but not limited to, the American Osteopathic Association Bureau of Osteopathic Specialists, the National Board of Physicians and Surgeons, the American Board of Physician Specialties, the American Board of Cosmetic Surgery, and the American Board of Facial Plastic and Reconstructive Surgery.

Medical education and training varied widely, and there was a lack of standardized curricula and evaluation methods. Society relies on and grants physicians the ability to establish and enforce standards for medical practice; that is, grants the profession collectively the privilege and obligation of self-regulation. This privilege depends on trust, and this privilege can and has been lost when the public no longer trusts professional oversight.¹ Thus, certification programs were established to help the public select a physician to meet their needs, as an indicator that a physician has been determined by their peers to be competent in a chosen specialty, and as a testament to the mastery that the physician has shown in their respective field of medicine. Board certification serves as an independent evaluation of a physician's or specialist's knowledge and skills to practice safely and effectively in a specialty.

As part of its efforts, the Council on Medical Education (Council) recognized the importance of assessing physicians' competency after completing their formal education and the need for standardized certification in medical specialties. Several factors were influential in the development of standardized certification in medical specialties, including variation in medical education, calls for professional regulation to ensure competency and accountability of physicians, rapid advancement of medical knowledge, desire for expertise and specialization, and standardization and quality assurance.

The establishment of the American Board of Medical Specialties

These developments led to the AMA establishing the ABMS in 1933 to ensure that physicians met certain standards of knowledge and skill in their respective fields. The founding members of ABMS were the American Board of Dermatology, the American Board of Obstetrics and Gynecology, the American Board of Ophthalmology, and the American Board of Otolaryngology – Head and Neck Surgery.² Member boards are established by their respective specialties and are physician-led, non-profit, independent evaluation organizations whose accountability is both to the profession and to the public. Members of the governing bodies include representatives from among the national specialty organizations in related fields. Now an independent organization, ABMS is governed by a Board of Directors, which includes representation from each of the ABMS Member Boards and members of the public. These individuals are working and retired physicians and professionals from across the country who have a broad range of experience in patient care, health policy, business, and community service. The Board of Directors is organized so that a significant portion of its activities are conducted by its committees, each of which operates under a written charter. All committees report to the Board of Directors, and all significant findings of a committee are presented to the Board of Directors for review, discussion, and approval. Additionally, the Board of Directors oversees the activities of the ABMS management team. The governance of ABMS is an essential component of the U.S. medical profession's system of collective self-regulation.

Member boards certify physicians in their primary specialty and subspecialty areas and encourage the professional development of those board-certified physicians throughout their career. This is accomplished through a comprehensive process involving educational requirements, professional peer evaluation, examination, and professional development. Member boards can also revoke certifications when an individual breaches them. There are currently 24 certifying boards or Member Boards of ABMS. In 2022, ABMS published descriptions of all the medical specialties where certification is offered by an ABMS Member Board in the ABMS Guide to Medical

Specialties. The ABMS certification process provides an independent evaluation of a physician's or specialist's knowledge and skills to practice safely and effectively in a specialty and serves as a trusted credential patients can rely upon when selecting a physician for their needs.

ABMS/ACGME Core Competencies

To evaluate a physician's knowledge and skills, the ABMS and Accreditation Council for Graduate Medical Education (ACGME) co-developed six core competencies integral to the delivery of high-quality patient care. These competencies are the basis of the milestones physicians and specialists must meet during training and are also the basis for continuing certification assessment. The table below outlines the six core competencies.

Table 1. ABMS/ACGME Core Competencies

PRACTICE-BASED LEARNING & IMPROVEMENT	Show ability to investigate and evaluate patient care practices, appraise and assimilate scientific evidence, and improve practice.
PATIENT CARE & PROCEDURAL SKILLS	Provide care that is compassionate, appropriate, and effective for the treatment of health problems and to promote health.
SYSTEMS-BASED PRACTICE	Demonstrate awareness of and responsibility to systems of health care. Be able to call on system resources to provide optimal care.
MEDICAL KNOWLEDGE	Demonstrate knowledge about established and evolving biomedical, clinical, and cognate sciences and their application in patient care.
INTERPERSONAL & COMMUNICATION SKILLS	Demonstrate skills that result in effective information exchange and teaming with patients, their families, and professional associates.
PROFESSIONALISM	Demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to diverse patient populations.

Each ABMS Member Board's continuing certification program is developed by practicing physicians and specialists according to the standards set through ABMS. Activities and requirements must be met in the following four main components: professionalism, lifelong learning, assessment, and improvement.

Governance of ABMS Member Boards

The governance process used by the Member Boards of the ABMS involves a combination of self-regulation and collaboration within the framework established by the ABMS. While each individual specialty board operates independently, they adhere to certain common principles and guidelines set forth by the ABMS. The ABMS establishes general standards and requirements that Member Boards must meet to ensure consistency and quality across specialties. These standards include criteria for education, training, examinations, and ongoing professional development. The Member Boards are responsible for designing and implementing the certification process for their respective specialties. This process typically involves a combination of educational qualifications, completion of an accredited training program, passing written and/or oral examinations, and meeting specific practice experience criteria. The ABMS promotes the concept of lifelong learning and ongoing professional development through continuing board certification (CBC) programs. Member Boards develop and administer their own CBC programs, which often include requirements such as participation in continuing medical education (CME) activities, self-assessment modules, practice improvement activities, and periodic assessments. While each specialty board operates independently, collaboration and standardization are fostered among the Member Boards. The ABMS provides a forum for sharing best practices, collaborating on research and development, and ensuring consistency in certification standards and processes across specialties. The governance process emphasizes continuous improvement and adaptation to changes in medical knowledge, technology, and health care delivery. Member Boards regularly review and update their certification and CBC processes to align with evolving standards and practices.

ABMS and Board Eligibility

The ABMS defines board eligibility as the period of time between when a physician completes an ACGME-accredited residency program and when initial certification in a specialty or subspecialty is achieved. The ABMS Board Eligibility Policy for Specialty Certification and the ABMS Eligibility Policy for Subspecialty Certification enable Member Boards to set parameters for how candidates can use the term “board eligible” to signal their preparations for certification while at the same time closing off the potential for abuse through using the term indefinitely. The ability to become board certified by an ABMS Member Board is directly related to when the candidate completed an ACGME-accredited residency or fellowship program. A candidate’s eligibility for board certification (board eligible period) expires on a date determined by the ABMS Member Board. For initial certification in a specialty and subspecialty, that date must be no more than seven years following the successful completion of accredited training. In addition, individual Member Board requirements must be met, including time in practice required (if any) for admissibility to the qualifying or certifying examination.³

AOA-BOS, Certification Process, and Board Eligibility

The Bureau of Osteopathic Specialists (BOS) is the supervisory body for the approved specialty certifying boards of the American Osteopathic Association (AOA) and is dedicated to establishing and maintaining high standards for certification of osteopathic and non-osteopathic physicians. The BOS ensures that all physicians it certifies demonstrate expertise and competence in their respective areas of specialization. The BOS serves as the certifying body for 29 primary medical specialties and 77 medical subspecialties. The BOS monitors the processes for all certifications, including primary certification, continuous certification, and certificates of added qualification; provides a mechanism to evaluate the validity and reliability of all certification examinations conducted by AOA specialty certifying boards; assesses examination scores and pass rates; and ensures notification of appropriate examination information to the ACGME. The BOS also provides pass rates as well as individual physician examination results (pass/fail) to physicians’ training programs.

The BOS defines board eligibility status as “the time frame between a physician’s completion of a residency or fellowship training program in a specialty or subspecialty and when the physician achieves initial certification in that specialty or subspecialty or when the physician’s board eligibility status expires. The BOS certification examination process includes steps for initial entry, re-entry, and final entry. The re-entry process provides a pathway to certification for candidates who did not achieve board certification through the initial process and the final entry process is for candidates who did not achieve board certification through the re-entry process. To qualify for initial primary certification from the AOA through a specialty certifying board, the applicant must first meet one of five eligibility requirements and then meet additional requirements related to licensure, code of ethics, training, examinations, and clinical practice. Board eligibility status commences upon the physician’s completion of a residency or fellowship training program in a specialty or subspecialty. Board eligibility status terminates when the physician achieves initial certification in that specialty or subspecialty or on December 31st of the following sixth (6th) year.” Board certification issued by the AOA provides assurance to the public that a physician has demonstrated high levels of clinical competence and is an indication of excellence. Certification is issued upon successful completion of an AOA or ACGME accredited training program and by passing the associated examination(s) administered by an AOA specialty certifying board.

Other board certification entities

In addition to ABMS and AOA-BOS, there are several other entities that provide initial and continuing board certification. These entities have varying standards for obtaining initial board certification and maintaining continuing certification over time. These entities include:

- American Association of Neuromuscular & Electrodiagnostic Medicine (AANEM)
- American Board of Cosmetic Surgery (ABCS)
- American Board of Facial Plastic and Reconstructive Surgery (ABFPRS)
- American Board of Oral & Maxillofacial Surgery (ABOMS)
- American Board of Physician Specialties (ABPS)
- National Board of Physicians and Surgeons (NBPAS)
- United Council for Neurologic Subspecialties (UCNS)

American Association of Neuromuscular & Electrodiagnostic Medicine

In 1987, the AANEM established the American Board of Electrodiagnostic Medicine (ABEM), now an independent credentialing organization in electrodiagnostic medicine. The maintenance of certification program for physicians was added in 1994 to assure that the ABEM followed the requirements of the ABMS. Initial certification for ABEM involves a process where candidates are evaluated in the core competencies. Candidates for the ABEM Initial Examination must meet the following requirements:⁴

- Board certified through American Board of Psychiatry and Neurology, American Board of Physical Medicine and Rehabilitation, American Osteopathic Board of Neurology and Psychiatry, or American Osteopathic Board of Physical Medicine and Rehabilitation (or a Canadian equivalent)
- Six or more months of electrodiagnostic (EDX) training during a residency and/or fellowship program
- Completed 200 EDX studies during training
- One or more years of independent experience
- Completed 200 EDX studies during independent experience
- Complete and pass the annual online CoreComp questions to maintain continuous certification

To maintain one's Continuous Certification with ABEM, one must:

- Attest to possess an active, unrestricted license to practice medicine
- Attest to possess an active primary board certification in either neurology or physical medicine and rehabilitation
- Complete 150 CME credits within one's 10-year cycle
- Pay an annual administrative fee to gain access to the online CoreComp questions.
- Complete and pass the annual online CoreComp questions

American Board of Cosmetic Surgery

The ABCS requires all interested surgeons complete an ACGME or AOA residency program in a related specialty:

- General surgery
- Plastic surgery
- Neurological surgery
- Obstetrics and gynecology
- Orthopedic surgery
- Otolaryngology
- Thoracic surgery
- Urology
- American Board of Oral and Maxillofacial Surgery (ABOMS) with MD degree

Candidate surgeons must also complete an American Academy of Cosmetic Surgery certified fellowship in cosmetic surgery and pass both written and oral examinations. With all specialties except plastic surgery, the candidate surgeon must also be board certified in one or more of the aforementioned specialties by a board recognized by the ABMS, the AOA, the ABOMS, or the Royal College of Physicians and Surgeons of Canada (RCPSC)

To maintain continuous certification, applicants for ABCS must also pass the ABCS Annual Certifying Examination, which consists of both an oral and written component that is prepared and psychometrically evaluated by the National Board of Osteopathic Medical Examiners (NBOME)⁵.

American Board of Facial Plastic and Reconstructive Surgery

The ABFPRS was established in 1986 to improve the quality of medical and surgical treatment available to the public through the establishment of a mechanism for the education, qualification, training, review, and certification of surgeons specializing in facial plastic and reconstructive surgery. Candidates for the ABFPRS initial certification must:⁶

- Have completed a residency program approved by the ACGME or the RCPSC in one of the two medical specialties containing identifiable training in facial plastic and reconstructive surgery: otolaryngology/head-

- and-neck surgery or plastic surgery
- Have earned prior certification by the American Board of Otolaryngology, the American Board of Plastic Surgery or the RCPSC in otolaryngology/head-and-neck surgery or plastic surgery
- Have been in practice a minimum of two years
- Have 100 operative reports accepted by a peer-review committee
- Successfully pass an 8-hour written and oral examination
- Operate in an accredited facility
- Hold the appropriate licensure and adhere to the ABFPRS Code of Ethics
- Complete the FACEforward® online longitudinal assessments annually to maintain certification

American Board of Oral & Maxillofacial Surgery

Board Certification by the ABOMS requires successful completion of the Qualifying and Oral Certifying Applications and Examinations. Once certified by ABOMS, candidates must participate in the Certification Maintenance process. For initial certification, a candidate must successfully complete both the qualifying examination and the oral certifying examination. The ABOMS also allows internationally trained applicants an opportunity to take the qualifying exam by meeting different requirements that hold the same caliber as the application for individuals taking the examination for the first time. Candidates have three consecutive years following successful completion of the qualifying examination to take and pass the oral certifying examination. Candidates who successfully complete these examinations become diplomates that have time-limited certifications. To maintain one's status as an ABOMS diplomate, one must complete the components of certification maintenance in four areas: professional standing, lifelong learning, cognitive expertise, and performance in practice. Certification Maintenance is a continuous process of learning, self-assessment, and testing that proceeds over a 10-year period.⁷

American Board of Physician Specialties

ABPS is the official multi-specialty board certifying body of the American Association of Physician Specialists, Inc. ABPS assists the certifying bodies by guiding the planning, development, and psychometric evaluation of assessment procedures designed to measure professional competency. Eligibility requirements and examinations of the boards of certification are developed based on a substantial review and analysis of the current state of clinical knowledge in the field of a particular specialty, as reflected in medical literature and the patient-care setting. Candidates can apply for either certification or recertification and ABPS verifies credentials for both certification and recertification applicants using various sources including, but not limited to, the Federation of State Medical Boards Credentials Verification service and the American Medical Association Physicians Profiling services. ABPS offers two exam processes: one for specialties such as anesthesiology, emergency medicine, and orthopedic surgery that require two steps (written/computer-based and oral exams) and one for specialties such as dermatology, family medicine, and internal medicine that are a single-level (written/computer-based exam).⁸

National Board of Physicians and Surgeons

The NBPAS was established in 2015 and is a non-profit, physician-led organization that provides an alternative pathway for continuous certification from ABMS or AOA in all the broadly recognized areas of specialty medical practice. The NBPAS does not provide initial board certification; it is a pathway for continuous certification after completing the initial board certification from an ABMS or AOA member board. NBPAS performs primary source verification of physician education and training as required by the National Committee for Quality Assurance, Utilization Review Accreditation Commission, The Joint Commission, and Det Norske Veritas, Inc. accreditation standards. The NBPAS requires all physicians to meet the following criteria to be eligible for certification:

- Previous certification through an ABMS/AOA Member Board
- An active, valid, unrestricted license to practice medicine in at least one U.S. state or territory
- Submission of continuing medical education credits
- Active privileges to practice that specialty in at least one U.S. hospital or outpatient facility licensed by a nationally recognized credentialing organization with deeming authority from Centers for Medicare & Medicaid Services
- Medical staff appointment/membership

While the NBPAS indicates it reserves the right to deny certification to any individual believed by the board to lack sufficient qualifications, it also expresses on its website that certification by NBPAS is a measure of training, experience, and life-long learning and does not guarantee competence or any specific medical outcomes.⁹

Existing AMA policy conflicts with support for NBPAS because the board does not offer initial certification. Specifically, AMA Policy H-275.926, “Medical Specialty Board Certification Standards” states Our AMA (1) Opposes any action, regardless of intent, that appears likely to confuse the public about the unique credentials of American Board of Medical Specialties (ABMS) or American Osteopathic Association Bureau of Osteopathic Specialists (AOA-BOS) board certified physicians in any medical specialty, or take advantage of the prestige of any medical specialty for purposes contrary to the public good and safety. (3) Continues to work with other medical organizations to educate the profession and the public about the ABMS and AOA-BOS board certification process. It is AMA policy that when the equivalency of board certification must be determined, the certification program must first meet accepted standards for certification that include both a) a process for defining specialty-specific standards for knowledge and skills and b) offer an independent, external assessment of knowledge and skills for both initial certification and recertification or continuous certification in the medical specialty. In addition, accepted standards, such as those adopted by state medical boards or the Essentials for Approval of Examining Boards in Medical Specialties, will be utilized for that determination. (4) Opposes discrimination against physicians based solely on lack of ABMS or equivalent AOA-BOS board certification, or where board certification is one of the criteria considered for purposes of measuring quality of care, determining eligibility to contract with managed care entities, eligibility to receive hospital staff or other clinical privileges, ascertaining competence to practice medicine, or for other purposes. Our AMA also opposes discrimination that may occur against physicians involved in the board certification process, including those who are in a clinical practice period for the specified minimum period of time that must be completed prior to taking the board certifying examination.

United Council for Neurologic Subspecialties

UCNS certification has been the recognized certification for emerging neurologic subspecialties since 2003. Requirements for eligibility for UCNS initial certification include¹⁰:

- Applicants must be certified by an ABMS certifying board or possess equivalent certification by the RCPSC or the AOA.
- Applicants must hold a current, active, valid, unrestricted, and unqualified license to practice medicine in at least one jurisdiction in the United States, its territories, or Canada, and in each jurisdiction in which they practice.
- Applicants must complete one of four eligibility pathways. The pathways are:
 1. UCNS-accredited fellowship
 2. Practice track
 3. Academic appointment at a UCNS-accredited fellowship
 4. Internationally trained faculty at UCNS-accredited training programs
- Applicants must provide documentation of a 36-month* period of time in which the applicant has spent a minimum of 25% of their time in the practice of their specialty.
- Applicants for continuous certification must complete and pass annual online assessments.

Below is a table that provides a comparative overview of these entities based on current AMA policy.

Table 1. Comparison of Credentialing Organizations

Medical Specialty Board Certification Standards H-275.926 (3)	Credentialing Organizations								
	ABMS	AOA-BOS	AANEM	ABCS ⁱ	ABFPRS ⁱⁱ	ABOMS	ABPS ⁱⁱⁱ	NBPAS ^{iv}	UCNS
Certification programs must include a process for defining specialty-specific standards for knowledge and skills	X	X	X	X	X	X	X	X	X
Certification programs must offer an independent, external assessment of knowledge and skills for initial certification in the medical specialty	X	X	X	X	X	X	X		X
Certification programs must offer an independent, external assessment of knowledge and skills for recertification or continuous certification in the medical specialty	X	X	X	X	X	X	X		X

ⁱWith all specialties except plastic surgery, must also be board certified in one or more of these specialties, by a board recognized by the ABMS, AOA, ABOMS, or the RCPSC.

ⁱⁱMust have earned prior certification by the American Board of Otolaryngology, the American Board of Plastic Surgery, or the RCPSC in otolaryngology/head-and-neck surgery or plastic surgery.

ⁱⁱⁱMust be currently board certified through the ABMS or AOA to be eligible for recertification.

^{iv} Must hold a previous certification through an ABMS or AOA member board in the same specialty.

AMA's Truth in Advertising Campaign

The AMA believes that patients deserve to have increased clarity and transparency in health care. There is no place for confusing or misleading health care advertising that has the potential to put patient safety at risk. Recognizing that there is confusion among the public as to the education, training, and skills of different health care professionals, which can lead to patients seeking and obtaining inappropriate and potentially unsafe medical care, the AMA created the "Truth in Advertising" campaign to help ensure patients know the education, training, and qualifications of their health care professionals. The campaign does not increase or limit anyone's scope of practice. Instead, the campaign increases the transparency of health care professionals' qualifications for patients, so that patients can clearly see and make informed decisions about who provides their care.

The campaign includes a model bill created by the AMA that states can use to advocate for health care professional transparency. The model bill features two main components: (1) prohibition of deceptive or misleading advertisements and requiring all health care practitioners to indicate their license in any advertisements and (2) requirement that all health care practitioners wear a name badge during all patient encounters that includes, among other information, the health care practitioner's license. Presently the "Truth in Advertising" campaign does not acknowledge that there are non-ACGME and non-AOA fellowships that should not be excluded (e.g., ABPS). The model bill also includes an optional drafting note on board certification. This item is optional because it is not AMA policy. The optional drafting note language outlines parameters physicians must meet to be able to claim they are "board certified" in any advertisements and states as follows:

Drafting Note Re: Board Certification—To provide further guidance on an additional type of requirement related to MD or DO board certification, this drafting note provides the following sample.

A medical doctor or doctor of osteopathic medicine may not hold oneself out to the public in any manner as being certified by a public or private board including but not limited to a multidisciplinary board or "board certified," unless all of the following criteria are satisfied:

(a) The advertisement states the full name of the certifying board.

(b) The board either:

1. Is a member board of the American Board of Medical Specialties (ABMS) or the American Osteopathic Association (AOA); or

2. Is a non-ABMS or non-AOA board that requires as prerequisites for issuing certification:

(i) successful completion of a postgraduate training program approved by the Accreditation Council for Graduate Medical Education (ACGME) or the AOA that provides complete training in the specialty or subspecialty certified by the non-ABMS or non-AOA board;

(ii) certification by an ABMS or AOA board covering that training field that provides complete ACGME or AOA-accredited training in the specialty or subspecialty certified by the non-ABMS or non-AOA board; and

(iii) successful passage of examination in the specialty or subspecialty certified by the non-ABMS or non-AOA board.

Discussion

Continuing demonstration of physician competency sets the qualifications of physicians above other health professionals. Ongoing assessment and demonstration of competency help identify gaps in knowledge or skills as medicine advances, allowing physicians to address those gaps and provide safe, up-to-date, and effective care to patients. Demonstrating ongoing competency helps build and maintain public trust in the medical profession. Patients and the broader community have confidence in physicians who actively engage in professional development and demonstrate their commitment to providing high-quality care. Physicians have a professional responsibility to continuously improve and maintain their competence. By engaging in ongoing assessment and self-reflection, physicians demonstrate accountability for their own practice and commitment to meeting the highest standards of patient care. The field of medicine is constantly evolving, with new research, technologies, and treatment options emerging regularly. Continuing education and assessment help physicians stay up to date with the latest evidence-based practices and guidelines, ensuring that patients receive the most current and effective treatments. While there are different ways to achieve continuing board certification, it is debatable whether they produce the same outcomes for patients.

The ABMS has established principles for determining physician competency. These principles guide the certification and continuation of certification processes for medical specialties. The key principles are evidence-based standards, ongoing assessment, lifelong learning, specialty-specific criteria, transparency and fairness, quality improvement, and collaboration. Other entities also require ongoing assessment of knowledge and skills and should not be discriminated against for purposes of measuring quality of care, determining eligibility to contract with managed care entities, eligibility to receive hospital staff or other clinical privileges, ascertaining competence to practice medicine, or for other purposes.

The resolution directly impacts the optional drafting note on board certification in the [AMA's Truth in Advertising Campaign](#). Broadly speaking, the campaign addresses transparency in the level of training, education, and licensing of health care professionals to ensure patients know who is providing their care [and whether they are sufficiently qualified to perform a given procedure or treat a particular disease or condition]. The optional drafting note on board

certification specifically addresses whether a physician can advertise as board certified and has been revised multiple times since it was originally added in 2011. More than 25 states have enacted the advertising language and/or name badge language of our Truth in Advertising bill, while three states have enacted language related to board certification and two states have enacted language like the board certification optional drafting note in AMA's model bill. There is not consensus regarding the definition of "board certification" and therefore the future of the optional drafting note in the Truth in Advertising campaign will need to be determined by the House of Delegates.

Summary and Recommendation

The Council on Medical Education therefore recommends that the following resolve be adopted in lieu of Resolution 304-A-22 and the remainder of this report be filed.

That our American Medical Association (AMA):

1. Encourage continued advocacy to federal and state legislatures, federal and state regulators, physician credentialing organizations, hospitals, and other interested parties to define physician board certification as the medical profession establishing specialty-specific standards for knowledge and skills, using an independent assessment process to determine the acquisition of knowledge and skills for initial certification and recertification. (Directive to Take Action)
2. Reaffirm the following policy:
 - [H-275.926](#), "Medical Specialty Board Certification Standards"

APPENDIX: RELEVANT AMA POLICIES

Medical Specialty Board Certification Standards H-275.926

I. Our AMA:

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

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.
40. Our AMA will continue to publicly report its work on enforcing AMA Principles on Continuing Board Certification.

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.

Mechanisms to Measure Physician Competency H-275.936

Addressing Public Health Disinformation Disseminated by Health Professionals D-440.914

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5. ORGANIZING TO REPRESENT THE INTERESTS OF RESIDENT AND FELLOW PHYSICIANS

Reference committee hearing: see report of Reference Committee C.

**HOUSE ACTION: RECOMMENDATIONS ADOPTED
REMAINDER OF REPORT FILED**
See Policy H-310.900 and H-310.912

Resolution 304-A-22, “Accountable Organizations to Resident and Fellow Trainees,” was authored by the American Medical Association (AMA) Resident and Fellow Section and submitted to the 2022 Annual Meeting of the House of Delegates (HOD). The resolution reads as follows:

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

The resolution was subsequently referred by the HOD for a report back the House; this report is in response to the referral. The title of this report has been revised slightly to avoid potential confusion of the term “accountable organization” with “accountable care organization” or ACO.

Background

AMA Residents and Fellows’ Bill of Rights

In 2011, the AMA adopted policy [H-310.912, “Residents and Fellows’ Bill of Rights”](#) with the intent to protect the rights and well-being of medical residents and fellows in the United States. This set of guidelines and principles aims to ensure the professional development, well-being, and rights of medical residents and fellows are safeguarded, allowing them to provide quality care and grow in their medical careers. The key provisions of the bill can be summarized as follows:

1. An education that fosters professional development, takes priority over service, and leads to independent practice.
2. Appropriate supervision by qualified physician faculty with progressive resident responsibility toward independent practice.
3. Regular and timely feedback and evaluation based on valid assessments of resident performance.
4. A safe and supportive workplace with appropriate facilities.
5. Adequate compensation and benefits that provide for resident well-being and health.
6. Clinical and educational work hours that protect patient safety and facilitate resident well-being and education.
7. Due process in cases of allegations of misconduct or poor performance.
8. Access to and protection by institutional and accreditation authorities when reporting violations.

The need to establish this bill of rights stems from a history of reforms to improve the training experience for residents and fellows. Prior to 1989, there had been no national standardized duty hour regulations for residents in the United States. Residency programs typically had arbitrary work hour policies, and it was common for residents to work extremely long hours, including shifts that lasted over 24 consecutive hours or more. On-duty hours of first-year residents exceeded a mean of 80 hours per week (e.g., neurosurgery residents reported averaging 110 hours per week).¹ The lack of uniform regulations produced significant variations in work hour practices across different institutions and specialties. Excessive work hours also raised growing concern about the working conditions and treatment of medical residents due to high-profile cases of medical errors or adverse outcomes for patients. Several research studies conducted in the late 1980s and early 2000s shed light on the adverse effects of long work hours and sleep deprivation on resident physicians.^{2,3,4,5} These studies highlighted the increased risk of medical errors,

decreased quality of patient care, and the negative impact on resident well-being, and they provided empirical evidence that supported the need for reform in residency training.

One high-profile case that was instrumental to policy changes for residents was Libby Zion. Ms. Zion died while under the care of fatigued and overworked residents at New York Hospital (now New York Presbyterian Hospital).⁶ Following a civil trial for this case, David Axelrod, the New York State commissioner of public health, appointed a commission led by Bertrand M. Bell, MD, to investigate her death and evaluate the circumstances that led to it. The New York State Ad Hoc Advisory Committee on Emergency Services report, which became known as the Bell Commission Report, examined the broader issues of patient safety, quality of care, and supervision within the medical context and brought attention to the need for appropriate supervision and patient safety measures within medical settings. Following the recommendations of the Bell Commission, New York State enacted the Libby Zion law in 1989, which implemented regulations on resident work hours, supervision, and the qualifications of supervising physicians. The law mandated a limit of 80 hours of work per week for residents, with additional restrictions on the duration of continuous work shifts.

The Libby Zion Law led to increased awareness and discussions about the need for national standards and guidelines regarding resident work hours, which eventually influenced the development of duty hour regulations at the national level by the Accreditation Council for Graduate Medical Education (ACGME).

ACGME Duty Hour Standards

Prior to 2003, the ACGME did not have national standardized duty hour regulations for residents in the United States. Residency programs had flexibility in setting their own work hour policies, resulting in significant variations in duty hour practices across institutions and specialties. The absence of specific ACGME duty hour standards meant that work hour practices were determined by individual residency programs and could vary widely. Some programs implemented more restrictive policies voluntarily, while others adhered to more traditional models with longer work hours and limited time off. In response to mounting concerns about resident well-being, patient safety, and the need for standardized guidelines, the ACGME developed formal duty hour regulations, which were implemented in 2003.⁷ These regulations marked a significant shift in the approach to resident work hours and aimed to balance resident well-being, patient safety, educational opportunities, and work hours and mitigate fatigue while maintaining high-quality training experiences. Key reforms that were introduced in 2003 include:

1. **Work Hours Limits:** Residents were not to work more than 80 hours per week, averaged over a four-week period.
2. **Mandatory Time Off:** Residents were required to have at least one day off per week, averaged over four weeks, or at least one day off every seven days.
3. **Maximum Shift Length:** Residents would have a maximum shift length of 24 consecutive hours, with an additional six hours permitted for specific patient care activities and transitions. Following each shift, residents were required to have a minimum of 10 hours off duty for rest.
4. **Supervision and Handovers:** Residents were required to be supervised appropriately and strategies needed to be in place to ensure smooth handovers of patient care during shift changes. These changes aimed to enhance patient safety and ensure effective communication and continuity of care during transitions between resident physicians.
5. **Moonlighting Restrictions:** Moonlighting, referring to engaging in additional paid work outside of the residency program, was regulated to prevent excessive work hours and potential fatigue.
6. **Educational Requirements:** To emphasize the importance of education and learning opportunities, residents should have dedicated time for educational activities, including conferences, didactic sessions, and self-directed learning.
7. **Oversight and Compliance:** This reform established mechanisms to monitor and enforce compliance with the new duty hour standards. This included conducting regular site visits, surveys, and evaluations of residency programs to ensure adherence to the regulations.

In 2011, ACGME implemented additional reforms in duty hour standards to further address concerns about resident well-being, patient safety, and the need for enhanced educational experiences.⁸ These reforms aimed to build upon the previous regulations, further enhancing resident well-being, patient safety, and educational experiences. Key reforms that were introduced in 2011 include:

1. **Limiting Shift Length for First-Year Residents:** Established stricter limits on shift duration for first-year residents (interns). Interns' shifts were capped at a maximum of 16 consecutive hours, recognizing the increased vulnerability of inexperienced residents to fatigue-related errors.
2. **Enhanced Supervision:** Emphasized the importance of appropriate supervision and oversight of resident physicians. Faculty and senior physicians were required to provide direct supervision and be physically present during critical patient care activities and procedures.
3. **Handover Principles:** Introduced principles for safe and effective handovers of patient care during shift changes. These principles aimed to ensure seamless transitions between resident physicians, minimizing the potential for errors and miscommunication.
4. **Individualized Learning Plans:** Emphasized the development of individualized learning plans for residents. These plans were intended to align with each resident's educational goals and ensure adequate opportunities for professional development and learning.
5. **Enhanced Monitoring and Compliance:** Implemented more robust mechanisms for monitoring and enforcing compliance with the duty hour standards. This included increased oversight, regular program evaluations, and the use of data-driven metrics to assess and address issues related to resident work hours.
6. **Resident Input and Feedback:** Emphasized the importance of resident input and feedback in shaping duty hour policies and ensuring resident well-being. Encouraged open communication channels for residents to voice concerns and provide input on work hour practices and the learning environment.

ACGME continues to conduct ongoing evaluations of the duty hour standards to optimize both resident training and patient care outcomes.

Additionally, the National Academy of Medicine (formerly known as the Institute of Medicine), published "Resident Duty Hours: Enhancing Sleep, Supervision, and Safety" in 2009. This report specifically examined the impact of resident duty hours on patient safety, resident well-being, and education. It highlighted concerns about the potential negative effects of long work hours and sleep deprivation on patient outcomes and resident performance. The report recommended several changes, including reducing the maximum number of continuous work hours, providing protected sleep periods, enhancing supervision, and promoting a culture of professionalism and shared responsibility.

Negative impacts of private equity in medical education: Hahnemann and Summa Health

The impact of private equity ownership of teaching hospitals and medical groups has raised concerns of new weaknesses and gaps in protecting residents and fellows' education and rights. As detailed in Council on Medical Education Report 1-I-22, "[The Impact of Private Equity on Medical Training](#)," the closure of Philadelphia's Hahnemann University Hospital (HUH) in fall 2019 highlighted the growing and damaging influence of private equity on medical education and training. It may be analogous to compare the excesses of managed care organizations in the 1990s, which provided impetus for the AMA to develop the Physicians for Responsible Negotiation, to the corporate overreaching exhibited by the owners of HUH, which has similarly served to catalyze opposition to the interference of private equity in medical education.

HUH's closing left 572 resident and fellow physicians without an ACGME-accredited program in which to continue their medical education.⁹ They were also affected by the loss of long-tail medical liability insurance needed to continue practice. While the AMA and other local and national organizations in medical education came together to aid the affected physicians, residents and fellow trainees remain vulnerable to the negative effects of hospital closures that threaten the quality and completion of their graduate medical education (GME), financial well-being, and legal status within the United States.

A similar event occurred in 2016 at Summa Health™, an integrated nonprofit health care delivery system in the Akron, Ohio area that sponsors 15 ACGME-accredited residency and fellowship programs. A contract dispute between Summa Health™ and Summa Emergency Associates (SEA), an independent physician group that is separate from the health system led to the replacement of about 60 faculty physicians and 30 residents in Summa's emergency medicine program. The 60 physicians were replaced by a group of emergency physicians paid by Canton-based US Acute Care Solutions.¹⁰ This event led to the loss of accreditation for the institution's emergency medicine residency in 2017, causing displacement to the education of the affected residents and disruption to patient care services. The program acquired new leadership and faculty but remained nonaccredited until 2019.¹¹ As with HUH, the AMA and other organizations offered financial support to the affected trainees seeking relocation.

Organizations with purview over resident/fellow training and work conditions

As the needs of residents and fellows continue to evolve with the changing medical education ecosystem, understanding what entities are best suited to protect the rights and well-being of resident and fellow trainees, as detailed in the Residents and Fellows' Bill of Rights, becomes necessary. These organizations include governmental agencies, accreditors, resident/fellow forums, resident medical staff organizations, associations, and unions.

Governmental agencies

State and federal governments have broad authority to regulate workplace safety and standards through law and regulation. Federal authority to regulate residencies is linked to the federal government's major role as a funder of GME and health care.

In the United States, the abolition of slavery and the rise of the industrial economy after the Civil War led to the legal principle where workers bargained with owners for wages in exchange for their labor, leading to the formation of labor unions. With industrialization, workplace hazards expanded, and the study of workplace hazards became included in the scope of public health referred to as occupational safety and health.

With the New Deal, the National Labor Relations Act of 1935 established the right of employees to form and join unions, obligated employers to bargain collectively, and created the National Labor Relations Board (NLRB) to enforce employee rights. In addition, the first federal legislation to control workplace conditions was enacted. State and the federal departments of labor began to establish and enforce workplace health and safety standards, and unions bargained with employers for improved working conditions. In 1970, the Occupational Safety and Health Act established the National Institute of Occupational Safety and Health (NIOSH) in the National Institutes of Health to research workplace safety and the Occupational Safety and Health Administration (OSHA) to regulate working conditions.

OSHA health care standards focus on workplace exposures to infection, drugs, chemicals, and radiation; musculoskeletal injuries from patient handling; and workplace violence. OSHA standards are not specific to residents. OSHA does not regulate work hours, and there are no laws generally limiting work hours for adult employees. OSHA twice rejected petitions to regulate resident duty hours in 2002 and 2011. Agencies regulating specific industries (e.g., Federal Aviation Administration) may limit duty hours for workers in that specific industry. There are no federal agencies regulating resident work hours; however, the Centers for Medicare and Medicaid Services (CMS) grants deeming authority to ACGME to set standards for residency education as a requirement for receiving Medicare GME funding.

CMS primarily oversees the Medicare and Medicaid programs including Medicare GME funding. CMS does not usually set standards on working conditions, although in November 2022, CMS issued a memo on workplace violence and safety requirements in hospitals. Hospitals' failure to meet CMS regulatory expectations may lead to citations. The full CMS memo is featured as Appendix B of this report.

States also have labor agencies that regulate workplace health and safety, but state laws specific to residency duty hours and working conditions, such as New York's Libby Zion law, are the exception rather than the rule. States also regulate hospitals and other clinical facilities, licenses physicians including residents, and may set standards for health and safety requirements for employees and patients.

Workplace laws and regulations are enforceable, but enforcement is divided between different agencies and levels of government (federal, state, local). It should also be noted that workplace regulations are rarely specific to residency and usually do not consider educational issues. Additionally, the process of changing laws and regulations is a long, complex legal process involving a broad array of interested parties whose political influence may shape outcomes with unintended consequences. Professional self-governance in establishing and enforcing professional standards has long been advocated by the AMA and the Federation of Medicine.

Accreditors

An accreditor is a non-governmental or private professional organization that develops professional standards and criteria and conducts peer evaluations and expert visits to assess if the criteria are met. An accreditor is entitled to

accord formal status to operate an educational institution, program, or facility following successful examination of the application and evaluation of such entities. Accreditors are often deemed authority by governmental agencies because of their expertise and capacity to encourage compliance with standards.

The primary accreditors setting standards affecting residents are the ACGME and the Joint Commission, previously known as the Joint Commission on Accreditation of Healthcare Organizations. The ACGME accredits residency programs and their sponsoring institutions and the Joint Commission accredits health care organizations, including those sponsoring residency education.

The ACGME sets accreditation standards and requirements for all allopathic (MD) and osteopathic (DO) residency programs across various specialties and their sponsoring institutions. As of July 1, 2020, the ACGME became the accrediting body for all residency programs, including those previously accredited by the American Osteopathic Association.¹² The ACGME Board of Directors is comprised of members nominated by the AMA, American Board of Medical Specialties (ABMS), American Hospital Association, Association of American Medical Colleges, Council of Medical Specialty Societies, American Osteopathic Association, and American Association of Colleges of Osteopathic Medicine; public and at-large members; the chair of the Council of Review Committee Chairs, and two resident members. The ACGME also oversees each specialty's review committee, which all include a resident/fellow member, that accredits individual residency programs and proposes specialty-specific accreditation requirements. The ACGME also oversees the Institutional Review Committee, which accredits sponsoring institutions. ACGME accreditation requirements address the resident learning and working environment including work hours, leave, well-being, facilities, and services to support resident rest, safety, and well-being. The ACGME also requires at least two peer-selected residents to serve on each ACGME-accredited Sponsoring Institution's Graduate Medical Education Committee, which is required to oversee the learning and work environment at all residency programs sponsored by the institution.

ACGME's Council of Review Committee Residents (CRCR) also serves as a forum for resident physicians serving on the ACGME's board and review committees to provide input, feedback, and perspective on matters related to GME and accreditation. The CRCR consists of residents from various specialties across the United States appointed by their respective residency programs or specialty organizations to provide a resident physician perspective on accreditation policy.

In recognition of professional self-governance, government agencies usually defer to ACGME to set standards for resident education.

The ACGME promulgates educational standards for residency programs and sponsoring institutions that are enforceable through corrective actions such as probation or loss of accreditation. However, accreditors have few intermediate sanctions short of loss of accreditation, which would also negatively impact the affected residents at that institution/program. Accreditation standards must be related to education and the learning environment, which may limit accreditation standards from addressing workplace and patient care issues that cannot be tied to resident education. Furthermore, accreditation standards apply broadly and may not address specific problems at individual institutions or programs.

The Joint Commission accredits and certifies health care organizations and programs in the United States. The Joint Commission board includes representatives from the AMA, American College of Physicians, American College of Surgeons, American Dental Association, American Hospital Association, and public/at-large members. While the Joint Commission does not have specific accreditation standards or requirements pertaining directly to resident learning environment or work conditions, the Joint Commission indirectly impacts resident physician training and work conditions through its broader standards related to patient safety and quality of care. By emphasizing patient safety, organizations accredited by the Joint Commission are encouraged to create environments that prioritize patient well-being, which can impact working conditions for resident physicians.

Resident/fellow forum or resident medical staff organization

A resident/fellow forum or resident medical staff organization provides an opportunity for residents to give feedback directly to their sponsoring institution leaders including the designated institutional official (DIO). Additionally, the resident medical staff model gives residents a formal role in the medical staff, where they can influence institutional policy through the medical staff.

The ACGME requires sponsoring institutions with multiple ACGME-accredited programs to have a Graduate Medical Education Committee (GMEC) that includes a minimum of two peer-selected residents/fellows from among its ACGME-accredited programs. When a program only has one resident/fellow, the sponsoring institution must include that individual on its program's GMEC among its voting members. The ACGME requirements also mandate that sponsoring institutions with more than one program must ensure availability of an organization, council, town hall, or other platform (resident/fellow forum) that allows all residents/fellows across the sponsoring institution's ACGME-accredited programs to communicate and exchange information relevant to their ACGME-accredited programs and their learning and working environment. This requirement also mandates that any resident/fellow from that sponsoring institution can directly raise a concern to the forum; conduct their forum without the DIO, faculty members, or other administrators present; and have the option to present concerns that arise from discussions at the forum to the DIO and GMEC.¹³ However, these requirements do not mandate that a sponsoring institution establish or support an ongoing resident organization at the institution. The resident/fellow forum can facilitate organizing and collective action by residents at the institution and discussion of institution or program specific issues, but without ongoing institutional support and with frequent resident turnover, the resident/fellow forum's ability to address long-term resident concerns can be limited.

A resident medical staff organization formally incorporates residents into the organized medical staff with their own governance structure. The organized medical staff has responsibility for credentialing, privileging, peer review, and oversight of clinical quality and patient safety, and the organized medical staff is a self-regulating organization of professionals governed by bylaws that are a binding, mutually enforceable agreement between the organized medical staff and the hospital governing body. The resident medical staff organization can advocate for workplace health and safety through the medical staff and engage in peer review of residents. In addition, since most residency physician faculty are also members of the medical staff, the organized medical staff can enable formal discussions between residents and faculty about the learning and work environments at the institution. A limitation of the resident medical staff is that the organized medical staff is associated with a specific health care organization. Residents may have clinical rotations in other health care facilities independent of the sponsoring institution where the organized medical staff, and thus the resident medical staff, does not have authority.

Associations

Professional associations, such as the AMA and other medical societies, organize members of the profession to establish practice, educational, and ethical standards, advance professional knowledge and skills, and advocate for the profession and the people the profession serves. Government bodies usually give considerable deference to professional association standards, providing professional associations authority beyond that gained through advocacy by the association. Professional associations facilitate organizing and collective action by members and enable unified effort in dealings with government bodies, businesses, organizations, and other professions and trades. Professional associations can also enable mobilization of the resources of the profession including collective expertise and professional networks.

Since its founding, the AMA, through the Council on Medical Education, made advancing medical educational standards a high priority, having established accreditation and credentialing bodies including the ACGME and the ABMS. Federation members including state and specialty medical associations collaborate with the AMA on accreditation, certification, and licensure issues. The American Osteopathic Association has a similar role for osteopathic physician education. The Association of American Medical Colleges (AAMC) is the professional association of medical schools and teaching hospitals and takes a leadership role in allopathic medical education accreditation, and the American Association of Colleges of Osteopathic Medicine (AACOM) takes a similar role in osteopathic medicine education.

As association members, residents and fellows can leverage the influence of their professional associations to advocate for the rights and well-being of resident and fellow trainees. The Residents and Fellows' Bill of Rights is a leading example of AMA policy to protect resident and fellow rights and well-being. The AMA provides many opportunities for residents and fellows to influence and formulate AMA policy. The Resident and Fellow Section is composed of peer-selected resident and fellow leaders from state and specialty medical societies who develop section policy that is then proposed for adoption as AMA policy. Residents and fellows also have designated voting seats on AMA governing bodies including the House of Delegates, AMA Councils, and the Board of Trustees. Through the AMA, residents and fellows have influenced ACGME accreditation standards on the learning and working environment, including work hour standards, and have mobilized the medical profession to assist residents

harmful by the closure of Hahnemann University Hospital.

In the AOA, the Bureau of Emerging Leaders is the representative body and advocate for all osteopathic medical students, osteopathic physicians in postdoctoral training, and early-career osteopathic physicians.

The AAMC established the Organization of Resident Representatives (ORR) to provide resident input into AAMC policy and to provide leadership opportunities for residents interested in academic medicine. ORR resident members are appointed by Council of Faculty and Academic Societies members representing either department chairs or program directors.

AACOM established the Assembly of Osteopathic Graduate Medical Education Residents and Fellows Council to develop future leaders in the osteopathic profession by creating a community and forum for residents and fellows to connect, collaborate, and learn.

Associations can facilitate organizing and collective action, providing residents with opportunities to network with residents from other institutions/regions/states. Residents may influence association policy that the association can utilize to support resident advocacy and lobby on their behalf. Associations can leverage their influence to help shape professional standards and norms. Associations also appoint members of accreditation organizations that develop standards and requirements. However, association policies are not directly enforceable; enforcement only occurs if adopted by governmental and regulatory bodies. Furthermore, association policies are usually not specific to problems at particular institutions or programs. Resident and fellow influence may also be limited by organization governance rules (e.g., resident leaders are not peer-selected, residents have no or limited participation in policymaking and/or leadership, and/or resources for resident activities are limited).

Unions

Through the National Labor Relations Act, a certified union has the sole legal authority to collectively bargain for employment terms and conditions for the class of employees the union represents. The employer is obligated to engage in collective bargaining with the union.

A union can serve as a collective voice for resident physicians representing their interests and concerns to their employer. Unions are recognized in law with the authority to negotiate binding labor contracts with employers, such as hospitals or healthcare systems. These enforceable contracts outline the terms and conditions of employment, including work hours, schedules, compensation, benefits, and grievance procedures. Through collective bargaining, unions can negotiate for improvements in work conditions, duty hours, supervision, workload, and other aspects that affect resident physicians' work and safety environment and well-being, but education standards are not part of collective bargaining. Unions often establish grievance procedures to address complaints and disputes regarding work conditions, training, or other employment-related matters. They provide support and guidance to resident physicians when filing grievances and assist in resolving conflicts. Unions can act as an intermediary between resident physicians and employers to ensure that concerns are addressed, and rights are protected. Unions can also advocate for changes in laws or regulations to enhance work hours, supervision, and other aspects of resident training. They can also offer educational support by providing educational resources, training programs, workshops, conferences, or seminars on topics such as contract negotiations, labor rights, and professional development. Unions that represent resident physicians include the Committee on Interns and Residents (CIR) of the Service Employees International Union (SEIU), the Union of American Physicians and Dentists and the Alliance of Resident Physicians.

Unions provide three basic functions: collective bargaining, political advocacy, and mutual aid (health insurance and pensions for membership). For physicians, the right to collectively bargain (i.e., negotiating contract terms with an employer on behalf of its employees) is a key driver of physician union development and participation. A study published in the *Journal of the American Medical Association* in 2022 focused specifically on resident/fellow unions as a tool to address burnout during training and serve as a needed counterweight to deleterious corporate influence in health care.¹⁴ However, unions are not a panacea to the growing trend of corporate influence in medical education and practice. For example, during the mass layoff of all residents at Hahnemann, a collective bargaining agreement would not have prevented the residents from losing their positions. The Worker Adjustment and Retraining Notification (WARN) Act requires advance notice in cases of mass layoffs, but it would not have ensured the residents would have continued their GME during that time. They would still have had to find new positions mid-

year. Further, certain states and regions of the country are less hospitable to the development of unions than others. In addition, even with a certified union at their workplace, some residents may opt out of joining the union and paying dues, because of a 2018 Supreme Court ruling banning mandatory union fees for public-sector workers;¹⁵ however, all residents would still fall under the collective bargaining agreement including the wages, benefits, and working and safety conditions the resident union obtained in negotiation. Reaching a collective bargaining agreement can be challenging, and employers may stall for years when employees choose to work without a contract instead of going on strike. While a union can provide some level of protection to its members' employment, a union cannot guarantee that residents' future employability would not be jeopardized by their activism. State labor laws and the composition of the NLRB may also affect the ability of a union to provide its members protection from retribution by employers.

A Comparison of Organizations for Residents

The table below provides a high-level perspective of which organizations can assist in protecting the rights and well-being of resident and fellow trainees as detailed in the Residents and Fellows' Bill of Rights.

Table 1. Organizations that can assist resident and fellow physicians with protecting their rights.

Bill of Rights	Governmental Agencies	Resident /Fellow Forum or Resident Medical Staff Organization	Accreditors	Associations	Unions
1. Education	✓	✓	✓	✓	
2. Supervision	✓	✓	✓	✓	✓
3. Assessment & Evaluation		✓	✓	✓	✓
4. Workplace Safety	✓	✓	✓	✓	✓
5. Compensation & Benefits	✓	✓		✓	✓
6. Patient Safety & Resident Well-being	✓	✓	✓	✓	✓
7. Due Process	✓	✓		✓	✓
8. Access & Protection	✓		✓	✓	

Communicating available residency positions to displaced residents

Residents may be displaced because of closure of their program or sponsoring institution or because of circumstances that make continued employment in their residency program untenable. To meet the NRMP Match agreement, Section 6.1.2 (Duty to Act in an Ethical and Professional Manner) and 10.0.b (Binding Commitment) state a resident must enter and remain at their matched training program for 45 calendar days after the start date of the relevant appointment contract. For residents and program directors, there is not a single, unified mechanism for displaced residents to find appropriate residency position vacancies to facilitate a transfer.

While the Match is designed to place residents starting with first-year positions, it does have subcategories such as Physician-R—meaning, reserved for doctors with previous residency experience—and Advanced, which places

residents into PGY-2 positions. These positions may present an avenue to transfer through the Match. Program directors may share information about their residents seeking transfers and vacancies at their program through their program director association or informal networks. The AAMC developed FindAResident that compiles listings of potential residency openings, which is accessible for a subscription fee. ResidentSwap is a website providing anonymous listings of positions currently filled by residents who would like to swap their current location or specialty with another resident.

The AMA has been a leader in providing data and information to residents and fellows to support their careers as physicians. The AMA Residency and Fellowship Database, FREIDA™ offers guidance on finding residency programs by helping members compare and rank programs.

Discussion

There is no single organization or government entity suited to being permanently responsible for resident and fellow interests that can hold organizations accountable for fulfilling the Residents and Fellows' Bill of Rights as described in AMA policy. In addition, any organization or governmental entity with the authority to implement such standards will not be free of political influence, given the stakes involved in GME and physician workforce. Residents and fellows must be empowered to be the leading advocates for the Resident and Fellows' Bill of Rights to make this policy a reality.

Residents and fellows have many opportunities as described in this report to advocate for implementing the Residents and Fellows' Bill of Rights at their programs and institutions. What is fundamental to their success is representation and empowerment of residents and fellows to advocate within their institution and more broadly to influence national medical education and workplace policies. The AMA and Federation of Medicine can advocate for resident empowerment, both within our profession and at the residents and fellows' sponsoring institutions to facilitate implementation of the Resident and Fellows' Bill of Rights. In addition, self-advocacy requires protection from retaliation and threats to the careers and livelihood of residents participating in good faith advocacy. As the AMA seeks to empower our physician members to advocate for patients and their practices, the AMA can similarly support resident and fellow physicians doing the same at their hospitals and clinics during training.

Unfortunately, there are sometimes circumstances in a residency program in which the employment situation for a resident or fellow is not sustainable and efforts for change are ineffective or too prolonged. A formal process needs to be developed for resident or fellow physicians to be able to transfer to another GME program without penalty to their education and career. Beyond the Match, transfer seekers are often on their own to secure a position. At the organizational level, the AMA could explore expanding the capacity for FREIDA™ to support program, resident, and fellow postings of available residency and fellowship positions.

Summary and Recommendations

The Council on Medical Education therefore recommends that the following recommendations be adopted in lieu of Resolution 304-A-22 and the remainder of this report be filed:

1. That Our AMA will encourage the formation of peer-led resident/fellow organizations that can advocate for trainees' interests, as outlined by the AMA's Residents and Fellows' Bill of Rights, at sponsoring institutions.
2. That Our AMA will encourage the development of a formal process for resident/fellow physicians to transfer to another graduate medical education program, without penalty, when an employment situation is not sustainable for a trainee and/or program.
3. That Our AMA will investigate promoting the current capacity of FREIDA™ to post open positions and adding the ability for FREIDA™ to facilitate the process of residents and fellows who wish to transfer programs.
4. That AMA Policy H-310.912, "Residents and Fellows' Bill of Rights," be amended by addition, to read as follows:

“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, including resident/fellow empowerment and peer-selected representation in institutional leadership.”

“13. Our AMA encourages development of accreditation standards and institutional policies designed to facilitate and protect residents/fellows who seek to exercise their rights.”

APPENDIX A: RELEVANT AMA POLICIES

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 health care 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.

Resident Physicians, Unions and Organized Labor H-383.998

Our AMA strongly advocates for the separation of academic issues from terms of employment in determining negotiable items for labor organizations representing resident physicians and that those organizations should adhere to the AMA's Principles of Medical Ethics, which prohibits such organizations or any of its members from engaging in any strike by the withholding of essential medical services from patients.

1.2.10 Political Action by Physicians

Like all Americans, physicians enjoy the right to advocate for change in law and policy, in the public arena, and within their institutions. Indeed, physicians have an ethical responsibility to seek change when they believe the requirements of law or policy are contrary to the best interests of patients. However, they have a responsibility to do so in ways that are not disruptive to patient care.

Physicians who participate in advocacy activities should:

- (a) Ensure that the health of patients is not jeopardized and that patient care is not compromised.
- (b) Avoid using disruptive means to press for reform. Strikes and other collection actions may reduce access to care, eliminate or delay needed care, and interfere with continuity of care and should not be used as a bargaining tactic. In rare circumstances, briefly limiting personal availability may be appropriate as a means of calling attention to the need for changes in patient care. Physicians should be aware that some actions may put them or their organizations at risk of violating antitrust laws or laws pertaining to medical licensure or malpractice.
- (c) Avoid forming workplace alliances, such as unions, with workers who do not share physicians' primary and overriding commitment to patients.
- (d) Refrain from using undue influence or pressure colleagues to participate in advocacy activities and should not punish colleagues, overtly or covertly, for deciding not to participate.

[AMA Principles of Medical Ethics: I,III,VI](#)

The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law.

APPENDIX B: CMS Memo on Workplace Violence in Hospitals

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-16
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Center for Clinical Standards and Quality

Ref: QSO-23-04-Hospitals

DATE: November 28, 2022

TO: State Survey Agency Directors

FROM: Directors, Quality, Safety & Oversight Group (QSOG) and Survey & Operations Group (SOG)

SUBJECT: Workplace Violence-Hospitals

Memorandum Summary

- Workers in hospitals, nursing homes, and other healthcare settings face risks of workplace violence. Many factors contribute to this risk, including working directly with people who have a history of aggressive behavior, behavioral issues, or may be under the influence of drugs.
- An April 2020 Bureau of Labor Statistics Fact Sheet found that healthcare workers accounted for 73 percent of all nonfatal workplace injuries and illnesses due to violence in 2018. This number has been steadily growing since tracking of these specific events began in 2011.
- Exposure to workplace violence hazards come at a high cost; however, with appropriate controls in place, it can be addressed.
- CMS will continue to enforce the regulatory expectations that patient and staff have an environment that prioritizes their safety to ensure effective delivery of healthcare.

Background

CMS believes that healthcare workers have a right to provide care in a safe setting. CMS health and safety requirements do not preclude healthcare workers from taking appropriate action to protect themselves from workplace violence. However, it is incumbent on the leadership at these healthcare facilities to ensure they provide adequate training, sufficient staffing levels, and ongoing assessment of patients and residents for aggressive behavior and indicators to adapt their care interventions and environment appropriately.

Medicare certified hospitals have a regulatory obligation to care for patients in a safe setting under the Medicare Hospital Conditions of Participation (CoPs) at §482.13(c)(2). The intention of this requirement is to specify that each patient receives care in an environment that a reasonable person would consider to be safe. For example, hospital staff should follow current

standards of practice for patient environmental safety, infection control, and security. The hospital must protect vulnerable patients, including newborns and children. Additionally, this standard is intended to provide protection for the patient's emotional health and safety as well as his/her physical safety. Respect, dignity and comfort would also be components of an emotionally safe environment.

In order to provide care in a safe setting, hospitals should identify patients at risk for intentional harm to self or others, identify environmental safety risks for such patients, and provide education and training for staff and volunteers. Patients at risk of suicide (or other forms of self-harm) or who exhibit violent behaviors toward others receive healthcare services in both inpatient and outpatient locations of hospitals. Although all risks cannot be eliminated, hospitals are expected to demonstrate how they identify patients at risk of self-harm or harm to others and steps they are taking to minimize those risks in accordance with nationally recognized standards and guidelines. The potential risks include, but are not limited to, those from ligatures, sharps, harmful substances, access to medications, breakable windows, accessible light fixtures, plastic bags (for suffocation), oxygen tubing, bell cords, etc.

All hospitals are expected to implement a patient risk assessment strategy, but it is up to the hospital to implement the appropriate strategies. For example, a patient risk assessment strategy in a post-partum unit would most likely not be the same risk assessment strategy utilized in the emergency department.

Additionally, under the Medicare Hospital Emergency Preparedness CoP at §482.15(a), a hospital's emergency preparedness plan must be based on, and include, a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach. It must also include strategies for addressing emergency events identified by the risk assessment as well as address the patient population, including, but not limited to, persons at-risk.

Hospitals should also provide the appropriate level of education and training to the identification of patients at risk of harm to self or others, the identification patient safety risk factors, and mitigation strategies. Staff would include direct volunteers, contractors, per diem staff and any other individuals providing client arrangement. The Emergency Preparedness CoP at §482.15(d)(1) contains requirements for hospitals to train staff and to have policies and procedures aimed at protecting workforce and their patients.

Hospitals have the flexibility to tailor the training to the particular services and patient populations they serve. CMS expects hospitals to provide education and training to new staff initially upon orientation and whenever policies and procedures change. CMS recommends ongoing training at least every two years after initial training.

CMS has cited hospitals in the past for failures to meet these obligations. Examples include a nurse in a unit without adequate staffing who was sexually assaulted by a behaviorally aggressive patient who was stopped only through intervention by other patients; a patient who was held by hospital staff and law enforcement performed a takedown that resulted in a hospital employee holding the patient down on the floor with his knee against the patient's back,

patient stopped breathing and died; and a patient who was acting out and shot in his hospital room by off-duty police officers following the failure of hospital staff to perform appropriate assessment and de-escalation of the patient. These cases highlight systemic failures in facilities that place both patients and staff at risk.

CMS will continue to enforce the regulatory expectations that patient and staff have an environment that prioritizes their safety to ensure effective delivery of healthcare.

Contact: Questions about this memorandum should be addressed to QSOG_Hospital@cms.hhs.gov.

Effective Date: Immediately. This policy should be communicated to all survey and certification staff and managers immediately.

/s/

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David R. Wright
Director, Quality, Safety & Oversight Group

cc: Survey and Operations Group Management
Office of Program Operations and Local Engagement (OPOLE)
Centers for Clinical Standards and Quality (CCSQ)

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