Reference Committee C

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REPORT 1 OF THE COUNCIL ON MEDICAL EDUCATION
Guiding Principles and Appropriate Criteria for Assessing the Competency of Late Career Physicians (CME Report 1-N-21)
(Reference Committee C)

EXECUTIVE SUMMARY

Older physicians remain an essential part of the physician workforce as they continue to practice into their 70s and 80s. Although some studies of physicians have shown decreasing practice performance with increasing years in medical practice, the effect of age on any individual physician's competence can be highly variable. The call for increased accountability by the public has led regulators and policymakers to consider implementing some form of age-based competency screening to assure safe and effective practice. In addition, some hospitals and medical systems have initiated age-based screening, but there is no national standard. Older physicians are not required to pass a health assessment or an assessment of competency or quality performance in their area or scope of practice. Physicians must lead in developing standards for monitoring and assessing their own personal competency and that of their peers. Otherwise, other entities may take action, without evidence, to implement national guidelines and a mandatory retirement age.

The Council on Medical Education studied this issue and submitted reports on this topic in 2015 and 2018. The second report, "Competency of Senior Physicians" (I-18) was referred for further study due to concerns among the House of Delegates that the AMA was advocating for a screening process for senior/late career physicians. This report is in response to that referral. Due to the impact of COVID-19, this report was deferred for business until the N-21 Meeting of the HOD.

The 2015 report led to AMA Policy D-275.956, "Assuring Safe and Effective Care for Patients by Senior/Late Career Physicians," which charged the Council, in collaboration with the Senior Physicians Section, to identify organizations to work together to develop guidelines for screening and assessing the competency of the late career physician. The AMA Work Group on Assessment of Senior/Late Career Physicians included key stakeholders that represented physicians, medical specialty societies, accrediting and certifying organizations, hospitals and health systems, and patients' advocates as well as content experts who research physician competence and administer assessment programs.

The work group concurred that it was important to investigate the current screening practices and policies of the state medical and osteopathic boards, medical societies, large U.S. health systems, and remediation programs as well as to collect data and review the current literature to learn more about age and risk factors associated with the assessment of late career physicians in the United States and internationally. This report summarizes the activities of the work group and additional research findings on this topic.

This report does not mandate an assessment. The intent of this report is to outline a set of guiding principles that have been developed by the Council with extensive feedback from members of the work group as well as from other content experts who research physician competence and administer assessment programs. The guiding principles provide direction and serve as a reference for guidelines for screening and assessing late career physicians. The underlying assumption is that guidelines must be based on evidence and on the principles of medical ethics. Furthermore, guidelines should be relevant, supportive, fair, equitable, and transparent, and not result in undue cost or burden to physicians. The primary driver for the establishment of guidelines should be to fulfill the ethical obligation of the profession to the health of the public and patient safety.

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 1-N-21

Subject:	Guiding Principles and Appropriate Criteria for Assessing the Competency of Late Career Physicians
Presented by:	Niranjan Rao, MD, Chair
Referred to:	Reference Committee C

At the 2018 Interim Meeting of the American Medical Association (AMA) House of Delegates, the AMA Council on Medical Education presented Report 1-I-18, "Competency of Senior Physicians," which was in response to AMA Policy D-275.956, "Assuring Safe and Effective Care for Patients by Senior/Late Career Physicians," which directs the AMA to: "1) identify organizations that should participate in the development of guidelines and methods of screening and assessment to assure that senior/late career physicians remain able to provide safe and effective care for patients; and 2) convene organizations identified by the AMA to work together to develop preliminary guidelines for assessment of the senior/late career physician and develop a research agenda that could guide those interested in this field and serve as the basis for guidelines more grounded in research findings."

The HOD referred the report for further study. This report is in response to that referral. Due to the impact of COVID-19, this report was deferred for business until the N-21 Meeting of the House of Delegates.

It is important to note that this report does not mandate an assessment. The intent of this report is to outline a set of guiding principles to provide direction and serve as a reference for guidelines for screening and assessing late career physicians.

BACKGROUND: SCOPE OF THE ISSUE

The total number of physicians 65 years and older has increased greatly, from 50,993 in 1975 to 343,694 in 2019.[1] Physicians 65 and older currently represent 29.8 percent of all physicians in the United States.[1] Within this age group, two-fifths (43.6 percent) are actively engaged in patient care, while nearly half (49.3 percent) are listed as inactive in the AMA Physician Masterfile. The remainder are involved in teaching, administration, medical research or non-patient care.[1] Additionally, more than a quarter of physicians practicing in rural communities are age 60 years or older.[2-3] Many physicians are hesitant to retire and may continue to practice into their 70s and 80s due to professional satisfaction, increased life expectancy, and concerns regarding financial security.[4]

There is evidence that physical health and some cognitive abilities decline with aging.[5] For example, recent studies have associated hearing loss, which is one of the most prevalent disorders of aging, with dementia and decreasing cognition.[6-7] Research also shows that cognitive dysfunction is more prevalent among older adults, although aging does not necessarily result in cognitive impairment.[8] The effect of age on any physician's competence can be highly variable, and aging is just one of several factors that may impact performance.[4,9] Other factors may influence

clinical performance, e.g., practice setting, lack of board certification, high clinical volume, certain specialty practices, etc.[10, 11] Fatigue, stress, burnout, and health issues unrelated to aging are also risk factors that can affect clinical performance.[11] Performance also may be broadly determined by characteristics ranging from intelligence to personality.[5] However, some attributes relevant to the practice of medicine—such as wisdom, resilience, compassion, and tolerance of stress—may actually improve as a function of aging.[9, 12-15]

Although age alone may not be associated with reduced competence, the variation in cognitive abilities as physicians age suggests that the issue cannot be ignored. While physicians may retain expertise from years of experience, in some specialties (especially in procedurally oriented disciplines), the accuracy and precision of a practitioner's skills tend to deteriorate without continued practice and repeated training.[16] When a performance issue becomes apparent, the physician and health care system must ensure that the physician can demonstrate the necessary competence for practice skills or procedural expertise, retrain for the necessary skills, or retire that procedural expertise from their practice.[16-17]

There are a limited number of validated tools for measuring competence/performance, but these tools are primarily used when a physician is "referred for cause." In addition, physicians' practices vary throughout the United States and from specialty to specialty. A few hospitals have introduced mandatory age-based evaluations, but there is no national standard.[18-19] Furthermore, there is cultural resistance among physicians to externally imposed assessment approaches and concern about discriminatory policies and procedures.

Knowing when to give up practice remains an important decision for most doctors and a critically difficult decision for some.[20] Older physicians have decades of experience and contributions to medicine and to their patients. So, as they experience health changes that may or may not allow continued clinical practice, they deserve the same sensitivity and respect afforded their patients.[21] Shifting away from procedural work, allocating more time with individual patients, using memory aids, and seeking input from professional colleagues may help physicians successfully adjust to the cognitive changes that accompany aging yet continue providing valuable health care services for years to come.[9, 20]

PHYSICIANS' PROFESSIONAL RESPONSIBILITIES

Council on Ethical and Judicial Affairs (CEJA) Report 1-I-19, "Competence, Self-Assessment and Self-Awareness" notes that, "to fulfill their ethical responsibility of competence, physicians at all stages in their professional lives should cultivate and exercise skills of self-awareness and active self-observation; take advantage of tools for self-assessment that are appropriate to their practice settings and patient populations; and be attentive to environmental and other factors that may compromise their ability to bring their best skills to the care of individual patients." In its report, CEJA recommends that "individual physicians and physicians in training should strive to: recognize that different points of transition in professional life can make different demands on competence; and maintain their own health, in collaboration with a personal physician, in keeping with ethics guidance on physician health and wellness."

The AMA *Code of Medical Ethics* has always stated that physicians of all ages must maintain their health and wellness, and, if a health issue arises, they must seek appropriate help from a personal physician whose objectivity is not compromised to honestly assess their ability to continue practicing safely.[22] The prohibition of self-treatment is imperative. However, a recent review of studies associated with self-diagnosis, self-referral, and self-treatment among physicians showed that self-treatment is strongly embedded within the culture of physicians and medical students as an

accepted way to enhance/buffer work performance.[23] This may be due to a culture in medicine that physicians do not expect themselves or their colleagues to be sick.[23] In response, many hospitals are beginning to establish health and wellness committees to confidentially address concerns regarding practitioners' health.

It is also in physicians' best interest to proactively address issues related to aging in order to maintain professional self-regulation. Since its adoption at the founding meeting of the AMA in 1847, the AMA *Code of Medical Ethics* has articulated the values to which physicians commit themselves as members of the medical profession. Chapter 9, Opinions on Professional Self-Regulation, states, "Society permits medicine to set standards of ethical and professional conduct for physicians. In return, medicine is expected to hold physicians accountable for meeting those standards and to address lapses in professional conduct when they occur."[24] Self-regulation is an important aspect of medical professionalism, and helping colleagues recognize their declining skills is an important part of self-regulation.[25] Furthermore, contemporary methods of self-regulation (e.g., clinical performance measurement; continuing professional development requirements, including novel performance improvement continuing medical education programs; and continuing board certification programs) have been created by the profession to meet shared obligations for quality assurance and patient safety.

From a public protection perspective, the objective assessment option seems like an important intervention, given the strong impact of aging on performance, the extreme variability of cognitive function among older physicians, and the well-documented inability of physicians to self-assess—particularly among those physicians who are less competent.[26] In the literature, Eva advised caution regarding the above interventions, with significant resource and administrative implications; they should not be universally mandated but implemented through a case-by-case, assessment-driven process, given the extreme variability of cognitive findings among older physicians.[27] External, objective assessment also seems essential, given that non-analytic processes may be even less accessible to critical self-appraisal than the more conscious analytical processes.

The Joint Commission's Requirements

Health care entities that credential or employ physicians have an obligation to assess physicians' health in the hiring and privileging process. The Joint Commission standard MS.11.01.01 is specifically written to encourage medical staff to identify and manage matters of individual health for licensed independent practitioners which are separate from actions taken for disciplinary purposes. The standard focuses on the education of physicians to recognize issues in others and encourages self-referral to facilitate confidential diagnosis, treatment, and rehabilitation by assisting a practitioner to retain and regain optimal professional functioning consistent with the protection of patients. If it is determined, however, that a physician is unable to practice safely, The Joint Commission standard calls for the matter to be reported to the medical staff leadership for appropriate corrective action.[28]

WORK GROUP MEETINGS

To fulfill the directive of Policy D-275.956, the Council on Medical Education, in collaboration with the Senior Physicians Section, identified organizations to participate in a joint effort to develop guidelines for screening and assessing the late career physician. As summarized below, a work group meeting and two conference calls were convened to develop a research agenda that could guide those interested in this field and serve as the basis for guidelines supported by research.

March 16, 2016 Work Group Meeting

The work group meeting, held March 16, 2016, brought together key stakeholders that represented physicians, medical specialty societies, accrediting and certifying organizations, hospitals and other health care institutions, and patient advocates as well as content experts who research physician competence and administer assessment programs. Work group participants concurred that this first meeting raised important issues related to the rationale for developing guidelines to screen and assess the competence and practice performance of late career physicians, which is challenging for a number of reasons. Discussion centered around the evidence and factors related to competency and aging physicians, existing and needed policies, screening and assessment approaches, and legal requirements and challenges. Although current evidence and initial research pointed toward the need for developing guidelines, most work group participants felt that additional information/data should be gathered on aging physicians' competence and practice performance. In addition, the participants felt that a set of guiding principles should be developed to reflect the values and beliefs underlying any guidelines that may be developed for screening and assessing late career physicians.

July 19, 2016, Work Group Conference Call

The purpose of this conference call was to convene a smaller group of participants to develop guiding principles to support the guidelines to screen and assess late career physicians. During the call, the conversation focused upon the thresholds at which screening/assessment should be required. Although physicians of all ages can be assessed "for cause," the group discussed whether age alone is a sufficient rationale for monitoring beyond what is typical for all physicians. Other factors discussed included the influence of practice setting and medical specialty, as well as the metrics and standards for different settings that would have to be developed to determine at "what age" and "how do you test," etc. The need for surveillance, associated risk factors, and the ability to take appropriate corrective steps, if needed, were also discussed. It was noted that there is a need to be able to fairly and equitably identify physicians who may need help while assuring patient safety. It was also noted that very few hospitals have specific age guidelines, and evidence shows that the number of disciplinary actions increases between ages 65 and 70. The cost of and who will pay for screening/assessments were also discussed.

The group felt that more information and data were needed before the guiding principles could be finalized and agreed to reconvene after gathering more information and studying evidence-based data from the United States and other countries related to age and risk factors.

December 15, 2017, Work Group Conference Call

The purpose of this conference call was to reconvene the same smaller group of participants to review the literature and data that had been gathered and finalize guiding principles to support the guidelines to screen and assess late career physicians. Background information to help guide the guiding principles included:

1. Results from a survey of members of the Federation of State Medical Boards (FSMB), Council of Medical Specialty Societies (CMSS), and International Association of Medical Regulatory Authorities (IAMRA) regarding the screening and assessment of late career physicians.

2. A literature review of available data related to late career physician screening and assessment, focusing on international work in this area.

3. Data from large health systems regarding their screening and assessment policies and procedures.

Survey Results Related to Screening and Assessing Late Career Physicians

To support the development of guiding principles, data were gathered through surveys of professional associations (CMSS), state medical boards (FSMB), and international regulatory authorities (IAMRA). The goal was to learn if these organizations had processes in place to screen and assess late career physicians for clinical or cognitive competence and, if not, whether they had considered developing such processes.

The survey data showed that most respondents were not screening or assessing late career physicians, although a slightly larger number of respondents have thought about the issues around doing so.

Most respondents did not have clinical or cognitive screening/competence assessment policies in place. In addition, most did not know (42, or 46.7 percent) or were unsure (26, or 28.9 percent) whether other organizations had age-based screening in place. Regarding whether age-based screening should be included within physician wellness programs, only 28 (32.9 percent) said yes and nine (10.6 percent) no, while more than half, or 48 (56.5 percent) were unsure.

Respondents were asked if their organizations/boards offered educational resources regarding the effects of age on physician practice; eight (9.2 percent) said yes, 72 (82.8 percent) said no, and seven (8.0 percent) were unsure. The survey also asked organizations if they were interested in resources that promoted physician awareness of screening aging physicians in practice. Very few groups offered these types of resources, but 100 percent (11) of IAMRA respondents, 60.8 percent (31) of FSMB respondents, and 25 percent (3) of CMSS respondents were interested in offering them.

HIGHLIGHTS FROM THE LITERATURE REVIEW

As summarized below, the current literature on age and risk factors associated with the assessment of late career physicians (in the United States and internationally) is significant and offers some direction for appropriate solutions to this challenge.

Recently published peer-reviewed studies focus on institutional policies related to cognitive assessment of late career physicians. Dellinger et al. concluded that as physicians age, a required cognitive evaluation combined with a confidential, anonymous feedback evaluation by peers and coworkers, including a focus on wellness and competence, would be beneficial both to physicians and their patients.[29] The authors also recommended that large professional organizations identify a range of acceptable policies to address the aging physician, while leaving institutions the flexibility to customize the approach.[29] Hickson et al. suggested that evaluation tools be integrated into an evidence-based longitudinal assessment of cognitive and behavioral skills that allows for reliable determination of a physician's ability to practice.[30] However, the process of identification of physicians with declining cognitive and clinical skills must be done with an awareness of laws protecting colleagues from discrimination.[30] Institutions such as Cooper University Health Care in Camden, New Jersey, are developing late career practitioner policies that include cognitive assessment along with peer review and medical assessment to assure both the hospital and physicians that physician competency is present and that physicians can continue to practice with confidence.[31]

Studies related to the utility of professionalism, self-reporting, and peer review in heading off competency issues indicate that these methods are not always reliable. For example, DesRoches et al. found that more than one-third of physicians were not clear on their obligation to report a colleague who is impaired or incompetent, one-third were unprepared to deal with such colleagues, and many appeared to not take action. Among the 17% of physicians who reported being aware of an impaired or incompetent colleague, one-third said that they did not report that individual.[25, 32, 33] Since early "red flags" of cognitive impairment may include prescription errors, billing mistakes, irrational business decisions, skill deficits, patient complaints, office staff observations, unsatisfactory peer review, patient injuries, or lawsuits, Soonsawat et al. encouraged improved reporting of impaired physicians by patients, peers, and office staff.[4]

A study that utilized the national Patient Advocacy Report System (PARS®) database showed that patients may provide an important source of information for health care organizations interested in identifying professionals with evidence of cognitive impairment.[34] LoboPrabhu et al. suggested that either screening for cognitive impairment be implemented at a certain age or that rigorous evaluation after lapses in standard of care be the norm, regardless of age.[35]

Any screening process needs to achieve a balance between protecting patients from harm due to substandard practice while ensuring fairness to physicians and avoiding any unnecessary reductions in workforce.[5] A recent study of U.S. late career surgeons showed that a steady proportion of surgeons, even in the oldest age group (>65), are still learning new surgical innovations and participating in challenging cases.[36] Individual and institutional considerations require a dialogue among the interested parties to optimize the benefits while minimizing the risks for both.[37-38]

In 2018, the Society of Surgical Chairs (SCS) conducted an anonymous survey of its membership. The survey respondents defined an age for an aging surgeon as follows: 25 (53 percent) selected 65 years of age and 14 (30 percent) selected 70 years of age, while none believed that surgeons younger than 60 years would be considered an aging surgeon.[39] These results are consistent with a 2013 Report from the Coalition for Physician Enhancement Conference in which 72 percent of their respondents recommended screening beginning at ages 65 to 70 years.[9, 39] In 2019, the SCS released transition recommendations for the senior surgeon which include mandatory cognitive and psychomotor testing of surgeons by age 65, possibly as part of regular professional practice evaluations; discussions with surgeons about career transition starting early in their careers; careful consideration of the financial needs, work commitments, and various concerns of retiring surgeons; and creation of opportunities for senior surgeons in modified clinical or nonclinical roles (e.g., teaching, mentoring, or coaching and/or administrative).[72]

The international community continues to address this topic. In Canada, the aging medical workforce presents a challenge for medical regulatory authorities charged with protecting the public from unsafe practice. However, Adler and Constantinou argued that normal aging is associated with some cognitive decline as part of the aging process, but physicians, as highly educated individuals with advanced degrees, may be less at risk.[20]

A review of the aging psychiatric workforce in Australia showed how specific cognitive and other skills required for the practice of psychiatry vary from those applied by procedural specialists.[40] In 2017, the Medical Board of Australia proposed requiring physicians to undergo peer review and health checks at age 70 and every three years thereafter.[41] There is some uniformity in the way that Australian regulatory bodies deal with impairment that supports the dual goals of protecting the public and rehabilitating the physician.[42] However, there are no agreed-upon guidelines to help medical boards decide what level of cognitive impairment in a physician may put the public at risk.[20] In Australia, the primary approach to dealing with older physicians (age 55 and older) is

individualized and multi-level, beginning with assessment, and followed by rehabilitation where appropriate; secondary measures proposed for older impaired physicians include early notification and facilitation of career planning and timely retirement.[42]

It is the responsibility of licensing bodies in New Zealand, Canada, and the United Kingdom to use reasonable methods to determine whether performance remains acceptable.[43] For example, the College of Physicians and Surgeons of Ontario (Canada) assesses all practicing physicians not assessed in the last five years at age 70 and then every five years as long as they are in active practice, via chart review.[44, 45] However, high performance by all physicians throughout their careers cannot be fully ensured, and so it is not clear that an age threshold is the best method of assessment

A better understanding of physician aging and cognition can inform more effective approaches to continuous professional development and lifelong learning in medicine—a critical need in a global economy, where changing technology can quickly render knowledge and skills obsolete.[8] The development of continuing board certification programs provides an opportunity to study the knowledge base across the professional lifespan of physicians.[46, 47] For example, a recent study of initial certification and recertification examinees in the subspecialty of forensic psychiatry, using a common item test question bank, compared two examinee groups' performance and demonstrated that performance for those 60 and older was similar to that of those younger than 50. Diplomates recertifying for the second time outperformed those doing so for the first time.[48]

The Royal Australasian College of Surgeons developed strategies to support late career surgeons over 65 years of age (expected to be about 25 percent of surgeons by 2050). It also wrote a position statement that provides clear guidelines to aging surgeons, with a focus on continuing professional development.[49, 50] An assessment of the competence of practicing physicians in New Zealand, Canada, and the United Kingdom showed that maintenance of professional standards by continuing education did not identify the poorly performing physician; rather, assessment of clinical performance was needed.[43] Therefore, the most common approach to assessment may be responsive—following a complaint—or periodic, either for all physicians or for an identified high-risk group. However, a single, valid, reliable, and practical screening tool is not available.[43]

A review of the European literature to explore the effects of aging on surgeons' performance and to identify current practical methods for transitioning surgeons out of practice at the appropriate time and age was completed. The reviewers suggested that competence should be assessed at an individual level, focusing on functional ability over chronological age; this may inform retirement policies for surgeons, which differ worldwide.[36] Research conducted in Canada suggested that some interventions (external support, deliberate practice, and education and testing) might prove successful in remediating older physicians, who should be tested more thoroughly.[27]

Careful planning, innovative thinking, and the incorporation of new patterns of medical practice are all part of this complex transition into retirement in the United States.[37, 51] A literature review that looked at retirement ages for doctors in different countries found that most countries had no mandatory retirement age for doctors.[52] Anecdotal reports published in the *British Medical Journal* suggested that the decision to retire is getting harder for some physicians because requirements for reappraisal and other barriers are discouraging some from considering part-time work after retirement.[53, 54] In Canada, Ireland, and India, the retirement age (65) is limited to public sectors only, but older physicians can continue to practice in the private sector.[52] In Russia and China, the mandated retirement age is 60 for men and 55 for women.[52]

Studies show that doctors can mitigate the impact of cognitive decline by ceasing procedural work, allocating more time to each patient, using memory aids, seeking advice from trusted colleagues, and seeking second opinions.[20] Peisah et al. (Australia) proposed a range of secondary and primary prevention measures for dealing with the challenge of the older impaired doctor; these included educating the medical community, encouraging early notification, and facilitating career planning and timely retirement of older doctors.[42] Racine (Canada) suggested that physicians retire before health or competency issues arise.[55] Lee (Canada) suggested that older practicing physicians consider slowing down in aspects of practice that require rapid cognitive processing and listen carefully to the concerns of colleagues, patients, friends, and family.[56] The University of Toronto, Department of Surgery, has developed Guidelines for Late Career Transitions that require each full-time faculty surgeon to undergo an annual assessment of academic and surgical activity and productivity. As surgeons age, the University creates individual plans for a decrease in on-call surgical responsibilities and encourages late career surgeons to engage in greater levels of teaching, research, and administration.[57]

How Some U.S. Organizations Are Addressing the Screening and Assessment of Competency of Late Career Physicians

The public call for increased accountability led regulators and policymakers to consider implementing some form of age-based competency screening to assure safe and effective practice.[9] The work group concurred that it was important to investigate existing screening practices and policies of state medical and osteopathic boards, medical societies, large U.S. health systems, and remediation programs. Some of the more significant findings are summarized below.

All physicians must meet state licensure requirements to practice medicine in the United States. In addition, some hospitals and medical systems have initiated age-based screening,[18, 19] but there is no national standard. In many instances, older physicians are not required to pass a health assessment or an assessment of competency or quality performance in their area or scope of practice.

The American College of Surgeons (ACS) explored the challenges of assessing aging surgeons. Recognizing that the average age of the practicing surgeon is rising and approximately one-third of all practicing surgeons are 55 and older, the ACS was concerned that advanced age may influence competency and occupational performance. In January 2016, the ACS Board of Governors' Physician Competency and Health Workgroup published a statement that emphasized the importance of high-quality and safe surgical care.[56] The statement recognized that surgeons are not immune to age-related decline in physical and cognitive skills and stressed the importance of a healthy lifestyle. The ACS recommended that, starting at ages 65 to 70, surgeons undergo a voluntary and confidential baseline medical examination and visual testing for overall health assessment, with regular reevaluation thereafter. In addition, the ACS encouraged surgeons to voluntarily assess their neurocognitive function using confidential online tools and asserted a professional obligation to disclose any concerning findings, as well as inclusion of peer review reports, in the recredentialing process.[58]

The American College of Obstetricians and Gynecologists (ACOG) recommends that when evaluating an aging physician, focus should be placed on the quality of patient care.[59] ACOG's recommendations regarding the late career obstetrician-gynecologist also state that: 1) it is important to establish systems-based competency assessments to monitor and address physicians' health and the effect age has on performance and outcomes; 2) workplace adaptations should be adopted to help obstetrician-gynecologists transition and age well in their practice and throughout their careers; and 3) to avoid the potential for legal challenges, hospitals should address the

provisions of the Age Discrimination in Employment Act, making sure that assessments are equitably applied to all physicians, regardless of age.[59]

At Kaiser Permanente, within its federation of contracted Permanente Medical Groups, physicians are classified as "in partnership" or "incorporated" based on how the Permanente Medical Group in the applicable geographic region has been established as a legal entity. In a region where a partnership exists, such as Southern California, the normal retirement age as a partner is at the end of the calendar year when one turns 65.

The University of California, San Diego, Physician Assessment and Clinical Education (PACE) Program is the largest assessment and remediation program for health care professionals in the country. Recently, PACE conducted a pilot screening project to assess physicians. Thirty volunteer physicians, aged 50 to 83, were recruited to participate in the screening regimen. Preliminary data analysis showed that some late career physicians performed less than optimally (seven of 30 participants). However, the pilot study did not have sufficient power to reach significance. Also, it did not include enough participants to provide a breakdown on specialties.[60]

How Some Hospitals are Addressing the Screening and Assessment of Competency of Late Career Physicians

Studies show that a more proactive and physician-friendly approach for evaluating physicians of all ages is to utilize multisource feedback or 360-degree survey screenings, either routinely as part of the recredentialling process or, alternatively, when significant risk factors occur, such as adverse events or patient complaints.[17, 61-67] For the 360-degree screening, physicians are invited to select raters such as colleagues and staff with whom they work, and the chief/leader of the department "validates" the list by ensuring the final rater pool is a comprehensive and representative sample. A 360-degree survey, validated against quality indicators such as malpractice claims and patient satisfaction, is sent to the selected raters so they can provide qualitative and quantitative feedback to the physician. Finally, comments and/or questions associated with cognitive impairment (e.g., seems forgetful about important information), irritability or compromised communication (e.g., overreacts to small mistakes), and competence (e.g., has sound clinical judgment) are scored and compared against national benchmarks for the physician's specialty. Physicians scoring in outlying ranges are referred for a second-line assessment, such as discussions with the clinical supervisor, peer review, practice evaluation, and/or cognitive screening. If that assessment is positive for significant findings, the physician may be referred for a third-line evaluation, including physical or mental health testing and/or a comprehensive neurocognitive assessment. The Medical Staff Peer Review Committee assesses the findings in terms of the potential to impair the physician's quality of care and makes a recommendation to the credentials committee. The assessed physician is encouraged to review the survey results with a trained coach.

Multiple studies show that a very small percentage (2 percent to 8 percent) of clinicians are associated with patterns of unprofessional behavior and performance. Of those physicians who receive awareness interventions, most respond (>75 percent), but some who do not change may be affected by some form of cognitive impairment.[30] The 360-degree survey process is currently used at hospitals such as Massachusetts General Hospital, Brigham and Women's Hospital, and University of Michigan to assess physicians on various core competencies.[67]

The Medical Executive Committee at Yale New Haven (Connecticut) Hospital elected to require a neurologic and ophthalmologic examination of all applicants for reappointment to the medical staff who are aged 70 years and older.[68, 69] From October 2017 through January 2019, 141 clinicians underwent a neuropsychological assessment. After completion of screening and/or full

neuropsychological testing, the hospital's Medical Staff Review Committee determined that 18 (12.7 percent) of the clinicians were found to have impaired cognition, raising concerns about their clinical abilities.[68] None of these 18 clinicians had previously been brought to the attention of medical staff leadership because of performance problems.[68] These 18 clinicians elected to discontinue their practice or moved into a closely proctored environment. All of these physicians agreed to make changes in their practice voluntarily.[68] In early 2020, a lawsuit was filed by the U.S. Equal Employment Opportunity Commission (EEOC) on behalf of the medical staff alleging that Yale New Haven Hospital violated federal law by adopting and implementing a discriminatory "Late Career Practitioner Policy".[70]

Another lawsuit was filed by the Equal Employment Opportunity Commission (EEOC) against Hennepin Healthcare System, Inc., a healthcare provider in Hennepin County, Minnesota, to resolve investigations conducted by the EEOC under the Age Discrimination in Employment Act of 1967, as amended (ADEA), and the Americans with Disabilities Act of 1990, as amended (ADA). The EEOC investigation determined Hennepin's "Late Career Practitioner Policy" discriminated against practitioners aged 70 and older which required them to participate in age-related screenings. In January 2021, the EEOC announced a settlement which will provide monetary relief to affected staff for out-of-pocket costs not covered by insurance. For the next three years, Hennepin must report to the EEOC on formal complaints related to age discrimination, unlawful medical inquiries, and/or any such retaliations, and notify its employees of the resolution.[71]

PROPOSED GUIDING PRINCIPLES

The Council on Medical Education proposes a set of guiding principles as a basis for developing guidelines for the screening and assessment of late career physicians. The underlying assumption is that guidelines must be based on evidence and on the principles of medical ethics. Furthermore, guidelines should be relevant, supportive, fair, equitable, and transparent, and not result in undue cost or burden to late career physicians. The primary driver for the establishment of guidelines should be to fulfill the ethical obligation of the profession to the health of the public and patient safety.

The Council developed the following eight guiding principles with extensive feedback from members of the AMA Work Group on Assessment of Senior/Late Career Physicians, as well as feedback from other content experts who research physician competence and administer screening and assessment programs.

1. *Evidence-based:* Guidelines for assessing and screening late career physicians should be based on evidence of the importance of cognitive changes associated with aging that are relevant to physician performance. Some physicians may suffer from declines in practice performance with advancing age. Research also suggests that the effects of age on an individual physician's competency can be highly variable, and since wide variations are seen in cognitive performance with aging, age alone should not be a precipitating factor.

2. *Ethical:* Guidelines should be based on the principles of medical ethics. Self-regulation is an important aspect of medical professionalism. Physicians should be involved in the development of guidelines/standards for monitoring and assessing both their own and their colleagues' competency.

3. *Relevant:* Guidelines, procedures, or methods of assessment should be relevant to physician practices to inform judgments and provide feedback regarding physicians' ability to perform the tasks specifically required in their practice environment.

4. *Accountable:* The ethical obligation of the profession to the health of the public and patient safety should be the primary driver for establishing guidelines and informing decision making about physician screening and assessment results.

5. *Fair and equitable:* The goal of screening and assessment is to optimize physician competency and performance through education and modifications to a physician's practice environment or scope. Unless public health or patient safety is directly threatened, physicians should retain the right to modify their practice environment to allow them to continue to provide safe and effective care.

6. *Transparent:* Guidelines, procedures, or methods of screening and assessment should be transparent to all parties, including the public. Physicians should be aware of the specific methods used, performance expectations and standards against which performance will be judged, and the possible outcomes of the screening or assessment.

7. *Supportive:* Education and/or remediation practices that result from screening and /or assessment procedures should be supportive of physician wellness, ongoing, and proactive.

8. *Cost conscious:* Procedures and screening mechanisms that are distinctly different from "for cause" assessments should not result in undue cost or burden to late career physicians providing patient care. Hospitals and health care systems should provide easily accessible screening assessments for their employed late career physicians. Similar procedures and screening mechanisms should be available to late career physicians who are not employed by hospitals and health care systems.

AMA POLICY

AMA policy urges members of the profession to discover and rehabilitate if possible or exclude if necessary, physicians whose practices are incompetent and to fulfill their responsibility to the public and to their profession by reporting to the appropriate authority those physicians who, by being impaired, are in need of help or whose practices are incompetent (H-275.998). AMA policy urges licensing boards, specialty boards, hospitals and their medical staffs, and other organizations that evaluate physician competence to inquire only into conditions that impair a physician's current ability to practice medicine (H-275.978[6]). AMA policy also reaffirms that it is the professional responsibility of every physician to participate in voluntary quality assurance, peer review, and CME activities (H-300.973 and H-275.996). These and other related policies are shown in the Appendix.

SUMMARY AND RECOMMENDATIONS

The Council on Medical Education concurs that physicians should be allowed to remain in practice as long as patient safety is not endangered and they are providing appropriate and effective care. However, data and anecdotal information support guidelines for the screening and assessment of late career physicians. The variations in cognitive skills as physicians age, as well as the changing demographics of the physician workforce, are key factors contributing to this need. Physicians must lead in developing standards for monitoring and assessing the competency of themselves and their peers; otherwise, other entities, may move for nationally implemented guidelines and a

mandatory retirement age that lack a solid evidence base. The guiding principles outlined in this report provide direction and serve as a reference for setting priorities and standards for further action.

It is important to note that this report does not mandate an assessment. Its intent, rather, is to outline a set of guiding principles to provide direction and serve as a reference for guidelines for screening and assessing late career physicians.

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

1. That our American Medical Association (AMA) support the following Guiding Principles on the Assessment of Late Career Physicians:

    a) Evidence-based: Guidelines for assessing and screening late career physicians should be based on evidence of the importance of cognitive changes associated with aging that are relevant to physician performance. Some physicians may suffer from declines in practice performance with advancing age. Research also suggests that the effect of age on an individual physician's competency can be highly variable; and since wide variations are seen in cognitive performance with aging, age alone should not be a precipitating factor.

    b) Ethical: Guidelines should be based on the principles of medical ethics. Self-regulation is an important aspect of medical professionalism. Physicians should be involved in the development of guidelines/standards for monitoring and assessing both their own and their colleagues' competency.

    c) Relevant: Guidelines, procedures, or methods of assessment should be relevant to physician practices to inform judgments and provide feedback regarding physicians' ability to perform the tasks specifically required in their practice environment.

    d) Accountable: The ethical obligation of the profession to the health of the public and patient safety should be the primary driver for establishing guidelines and informing decision making about physician screening and assessment results.

    e) Fair and equitable: The goal of screening and assessment is to optimize physician competency and performance through education, remediation, and modifications to a physician's practice environment or scope. Unless public health or patient safety is directly threatened, physicians should retain the right to modify their practice environment to allow them to continue to provide safe and effective care.

    f) Transparent: Guidelines, procedures, or methods of screening and assessment should be transparent to all parties, including the public. Physicians should be aware of the specific methods used, performance expectations, and standards against which performance will be judged and the possible outcomes of the screening or assessment.

    g) Supportive: Education and/or remediation practices that result from screening and /or assessment procedures should be supportive of physician wellness, ongoing, and proactive.

    h) Cost conscious: Procedures and screening mechanisms that are distinctly different from "for cause" assessments should not result in undue cost or burden to late career physicians providing patient care. Hospitals and health care systems should provide easily accessible

screening assessments for their employed late career physicians. Similar procedures and screening mechanisms should be available to late career physicians who are not employed by hospitals and health care systems. (Directive to Take Action)

2. That our AMA encourage the Council of Medical Specialty Societies and other interested organizations to develop educational materials on the effects of age on physician practice. (Directive to Take Action)

3. That Policy D-275.956, "Assuring Safe and Effective Care for Patients by Senior/Late Career Physicians," be rescinded, as having been fulfilled by this report. (Rescind HOD Policy)

Fiscal note: $1,000.

APPENDIX: AMA POLICIES

D-275.956, "Assuring Safe and Effective Care for Patients by Senior/Late Career Physicians"

Our American Medical Association: (1) will identify organizations that should participate in the development of guidelines and methods of screening and assessment to assure that senior/late career physicians remain able to provide safe and effective care for patients; and (2) will convene organizations identified by the AMA to work together to develop preliminary guidelines for assessment of the senior/late career physician and develop a research agenda that could guide those interested in this field and serve as the basis for guidelines more grounded in research findings. (CME Rep. 5, A-15)

H-275.936, "Mechanisms to Measure Physician Competency"

Our AMA: (1) continues to work with the American Board of Medical Specialties and other relevant organizations to explore alternative evidence-based methods of determining ongoing clinical competency; (2) reviews and proposes improvements for assuring continued physician competence, including but not limited to performance indicators, board certification and recertification, professional experience, continuing medical education, and teaching experience; and (3) opposes the development and/or use of "Medical Competency Examination" and establishment of oversight boards for current state medical boards as proposed in the fall 1998 Report on Professional Licensure of the Pew Health Professions Commission, as an additional measure of physician competency.
(Res. 320, I-98 Amended: Res. 817, A-99 Reaffirmed: CME Rep. 7, A-02 Reaffirmed: CME Rep. 7, A-07 Reaffirmed: CME Rep. 16, A-09 Reaffirmed in lieu of Res. 313, A-12 Modified: Res. 309, I-16)

H-275.996, "Physician Competence"

Our AMA: (1) urges the American Board of Medical Specialties and its constituent boards to reconsider their positions regarding recertification as a mandatory requirement rather than as a voluntarily sought and achieved validation of excellence; (2) urges the Federation of State Medical Boards and its constituent state boards to reconsider and reverse their position urging and accepting specialty board certification as evidence of continuing competence for the purpose of re-registration of licensure; and (3) favors continued efforts to improve voluntary continuing medical education programs, to maintain the peer review process within the profession, and to develop better techniques for establishing the necessary patient care data base. (CME Rep. J, A-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CME Rep. 7, A-02; Reaffirmed: CME Rep. 7, A-07; Reaffirmed: CME Rep. 16, A-09; Reaffirmed in lieu of Res. 302, A-10; Reaffirmed in lieu of Res. 320, A-14)

H-275.998, "Physician Competence"

Our AMA urges: (1) The members of the profession of medicine to discover and rehabilitate if possible, or to exclude if necessary, the physicians whose practices are incompetent. (2) All physicians to fulfill their responsibility to the public and to their profession by reporting to the appropriate authority those physicians who, by being impaired, need help, or whose practices are incompetent. (3) The appropriate committees or boards of the medical staffs of hospitals which have the responsibility to do so, to restrict or remove the privileges of physicians whose practices are known to be incompetent, or whose capabilities are impaired, and to restore such physicians to limited or full privileges as appropriate when corrective or rehabilitative measures have been

successful. (4) State governments to provide to their state medical licensing boards resources adequate to the proper discharge of their responsibilities and duties in the recognition and maintenance of competent practitioners of medicine. (5) State medical licensing boards to discipline physicians whose practices have been found to be incompetent. (6) State medical licensing boards to report all disciplinary actions promptly to the Federation of State Medical Boards and to the AMA Physician Masterfile. (Failure to do so simply allows the incompetent or impaired physician to migrate to another state, even after disciplinary action has been taken against him, and to continue to practice in a different jurisdiction but with the same hazards to the public.) (CME Rep. G, A-79; Reaffirmed: CLRPD Rep. B, I-89; Reaffirmed: Sunset Report, A-00; Reaffirmation I-03; Reaffirmed: CME Rep. 2, A-13)

H-275.978, "Medical Licensure"

The AMA: (1) urges directors of accredited residency training programs to certify the clinical competence of graduates of foreign medical schools after completion of the first year of residency training; however, program directors must not provide certification until they are satisfied that the resident is clinically competent;
(2) encourages licensing boards to require a certificate of competence for full and unrestricted licensure;
(3) urges licensing boards to review the details of application for initial licensure to assure that procedures are not unnecessarily cumbersome and that inappropriate information is not required. Accurate identification of documents and applicants is critical. It is recommended that boards continue to work cooperatively with the Federation of State Medical Boards to these ends;
(4) will continue to provide information to licensing boards and other health organizations in an effort to prevent the use of fraudulent credentials for entry to medical practice;
(5) urges those licensing boards that have not done so to develop regulations permitting the issuance of special purpose licenses. It is recommended that these regulations permit special purpose licensure with the minimum of educational requirements consistent with protecting the health, safety and welfare of the public;
(6) urges licensing boards, specialty boards, hospitals and their medical staffs, and other organizations that evaluate physician competence to inquire only into conditions which impair a physician's current ability to practice medicine. (BOT Rep. I-93-13; CME Rep. 10 - I-94);
(7) urges licensing boards to maintain strict confidentiality of reported information;
(8) urges that the evaluation of information collected by licensing boards be undertaken only by persons experienced in medical licensure and competent to make judgments about physician competence. It is recommended that decisions concerning medical competence and discipline be made with the participation of physician members of the board;
(9) recommends that if confidential information is improperly released by a licensing board about a physician, the board take appropriate and immediate steps to correct any adverse consequences to the physician;
(10) urges all physicians to participate in continuing medical education as a professional obligation;
(11) urges licensing boards not to require mandatory reporting of continuing medical education as part of the process of reregistering the license to practice medicine;
(12) opposes the use of written cognitive examinations of medical knowledge at the time of reregistration except when there is reason to believe that a physician's knowledge of medicine is deficient;
(13) supports working with the Federation of State Medical Boards to develop mechanisms to evaluate the competence of physicians who do not have hospital privileges and who are not subject to peer review;

(14) believes that licensing laws should relate only to requirements for admission to the practice of medicine and to assuring the continuing competence of physicians, and opposes efforts to achieve a variety of socioeconomic objectives through medical licensure regulation;
(15) urges licensing jurisdictions to pass laws and adopt regulations facilitating the movement of licensed physicians between licensing jurisdictions; licensing jurisdictions should limit physician movement only for reasons related to protecting the health, safety and welfare of the public;
(16) encourages the Federation of State Medical Boards and the individual medical licensing boards to continue to pursue the development of uniformity in the acceptance of examination scores on the Federation Licensing Examination and in other requirements for endorsement of medical licenses;
(17) urges licensing boards not to place time limits on the acceptability of National Board certification or on scores on the United State Medical Licensing Examination for endorsement of licenses;
(18) urges licensing boards to base endorsement on an assessment of physician competence and not on passing a written examination of cognitive ability, except in those instances when information collected by a licensing board indicates need for such an examination;
(19) urges licensing boards to accept an initial license provided by another board to a graduate of a US medical school as proof of completion of acceptable medical education;
(20) urges that documentation of graduation from a foreign medical school be maintained by boards providing an initial license, and that the documentation be provided on request to other licensing boards for review in connection with an application for licensure by endorsement;
(21) urges licensing boards to consider the completion of specialty training and evidence of competent and honorable practice of medicine in reviewing applications for licensure by endorsement; and
(22) encourages national specialty boards to reconsider their practice of decertifying physicians who are capable of competently practicing medicine with a limited license.
(CME Rep. A, A-87 Modified: Sunset Report, I-97 Reaffirmation A-04 Reaffirmed: CME Rep. 3, A-10 Reaffirmation I-10 Reaffirmed: CME Rep. 6, A-12 Appended: Res. 305, A-13 Reaffirmed: BOT Rep. 3, I-14)

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REPORT 2 OF THE COUNCIL ON MEDICAL EDUCATION (November 2021)
A Study to Evaluate Barriers to Medical Education for Trainees with Disabilities
(Reference Committee C)

EXECUTIVE SUMMARY

The Americans with Disabilities Act (ADA), which was enacted in 1990 and amended in 2008, protects people with disabilities from discrimination; works to provide fair access to goods, services, and education; and promotes equal opportunity. The ADA was amended to specify and expand on who is considered disabled and lowered the burden of proof to establish oneself as a person with a disability. An impairment or disability does not need to prevent or significantly restrict a major life activity to be considered as substantially limiting, and not every impairment will qualify as a disability. An individualized assessment is required to determine if the individual's impairment substantially limits a major life activity as compared to most people in the general population.

Among the employed U.S. adult population (ages 16 and older), 5.8 percent report some sort of disability (that is, difficulties with hearing, vision, cognition, mobility, selfcare, and independent living). Recent data indicate that 4.6 percent of enrolled medical students have requested an accommodation for a disability, a percentage that has grown recently. Attention deficit hyperactivity disorder was the most commonly reported disability, followed by psychological disability and learning disability. Considerably less is known of the prevalence of disabilities in residents and fellows in graduate medical education (GME). Results from a recent national survey suggest that approximately 3 percent of practicing physicians have a disability.

Medical schools maintain technical standards that inform a prospective or current medical student what a school's expectations are for cognitive, sensory, and mobility abilities. GME institutions are required to have policy regarding accommodations for disabilities consistent with all applicable laws and regulations. Students and residents with disabilities may encounter two types of barriers—structural and cultural. Structural barriers may include restrictive and outdated policies and procedures, the inability to locate or correctly interpret the technical standards for a given institution, poor understanding of clinical accommodations, a lack of disability and wellness support services, and a physical environment that limits accessibility. Cultural barriers include the attitudes, beliefs, and values of the medical community.

Learners with disabilities require access to information to make informed decisions about whether an educational environment has the appropriate resources and institutional culture to support necessary accommodations. Institutions should review and evaluate their technical standards to ensure that they embrace the functional capabilities of individual learners. Standards should emphasize what the learner can do rather than what they cannot do. Institutions, both undergraduate and graduate, should have readily available designated disability service providers who are expert in the ADA and aware of current resources and strategies to best process accommodation requests. Research on which accommodations are most effective in clinical learning environments will assist in determining future strategies for creating a safe and inclusive medical workforce.

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 2-N-21

Subject: A Study to Evaluate Barriers to Medical Education for Trainees with Disabilities

Presented by: Niranjan Rao, MD, Chair

Referred to: Reference Committee C

American Medical Association (AMA) Policy D-295.929, "A Study to Evaluate Barriers to Medical Education for Trainees with Disabilities," directs our AMA to "work with relevant stakeholders to study available data on: (1) medical trainees with disabilities and consider revision of technical standards for medical education programs; and (2) medical graduates with disabilities and challenges to employment after training."

This report, which is in response to this directive, includes: 1) a brief summary of the Americans with Disabilities Act and its later amendment, as well as a summary of Section 504 of the Rehabilitation Act of 1973; 2) a review of available data on the prevalence of disabilities among medical students, residents, and physicians; 3) examples of accommodations made for medical learners and physicians as well as types of barriers; and 4) a discussion of proposed recommendations.

BACKGROUND

The Americans with Disabilities Act (ADA), which was enacted in 1990 and amended in 2008, protects people with disabilities from discrimination; works to provide fair access to goods, services, and education; and promotes equal opportunity. The ADA was amended to specify and expand on who is considered disabled and lowered the burden of proof to establish oneself as a person with a disability. The law requires an interactive process between a job applicant (or employee or student) and the employer (or educational program) to share information about the nature of the disability and limitations that may affect the individual's ability to perform essential duties. The employer (or educational program), in turn, must engage in a flexible dialogue that addresses the employee's specific disability and investigate reasonable accommodations that allow equal access to the work (or educational) environment.[1] Section 504 of the Rehabilitation Act of 1973 works with the ADA, in that it prohibits discrimination against an otherwise qualified person with a disability in programs or activities that receive federal funding.[2,3]

In the amended ADA, a disability is defined as a "physical or mental impairment that substantially limits one or more life activities; a record (or past history) of such an impairment; or being regarded as having a disability."[4] This contrasts with an impairment, which is a loss of function that results from some cause, injury, or body part. An impairment does not need to significantly restrict a major life activity to be considered as substantially limiting and not every impairment will qualify as a disability. An individualized assessment is required to determine if an individual's impairment substantially limits a major life activity as compared to most people in the general population. With the exception of eyeglasses or contact lenses, a determination of whether an impairment substantially limits a major life activity is made without regard to improvement resulting from mitigating factors, such as medication or hearing aids. Non-ameliorative effects also

may be considered when determining if an impairment is substantially limiting, including negative side effects of medication or burdens associated with following a particular treatment regimen.[4,5]

Medical School Accreditation Standards Regarding Student Disabilities

The Liaison Committee on Medical Education (LCME) accredits medical education programs leading to the MD degree in the United States. Requirements concerning medical students with disabilities are addressed in Standard 10.5: A medical school develops and publishes technical standards for the admission, retention, and graduation of applicants or medical students in accordance with legal requirements. Element 10.5 provides further detail:

> Element 10.5: Technical standards for the admission, retention, and graduation of applicants or medical students: A statement by a medical school of the: 1) essential academic and non-academic abilities, attributes, and characteristics in the areas of intellectual-conceptual, integrative, and quantitative abilities; 2) observational skills; 3) physical abilities; 4) motor functioning; 5) emotional stability; 6) behavioral and social skills; and 7) ethics and professionalism that a medical school applicant or enrolled medical student must possess or be able to acquire, with or without reasonable accommodation, in order to be admitted to, be retained in, and graduate from that school's medical educational program.[6]

In addition, schools are to communicate Standard 10.5 in hard copy and/or online in a manner that is easily available to and accessible by the public.

In assessing compliance with Standard 10.5, the LCME survey team during the site visit (typically occurring every eight years) will ask the school to provide the following information:[7]

1. How does the medical school disseminate its technical standards for admission, retention, and graduation to potential and actual applicants, enrolled medical students, faculty, and others?

2. How are medical school applicants and/or medical students expected to document that they are familiar with and capable of meeting the technical standards, with or without accommodation (e.g., by formally indicating that they have received and reviewed the standards)?

In addition, Element 3.4, Anti-Discrimination Policy, requires that a medical school has policy in place to ensure that it does not discriminate on the basis of age, disability, gender identity, national origin, race, religion, sex, sexual orientation, or any basis protected by federal law. This language, revised by the LCME in October 2019, is in effect for schools in the academic year 2021-2022. Schools will be asked to describe how their anti-discrimination policy is made known to members of the medical education community.

The American Osteopathic Association's Commission on Osteopathic College Accreditation (COCA) accredits medical education programs leading to the DO degree in the United States. Element 9.1 addresses admissions policies for a college of osteopathic medicine (COM):

> A COM must establish and publish, to the public, admission requirements for potential applicants to the osteopathic medical education program and must use effective policies and procedures for osteopathic medical student selection for admission and enrollment, including technical standards for admissions. A COM must tie all admissions to the COM mission.

Submission 9.1: Admission Policy

1. Provide all admission requirements and policies and procedures for osteopathic medical student selection and enrollment.
2. Provide a copy of the technical standards required of matriculants.
3. Provide a public link to where the documents are published.

In addition, Element 1.5 addresses non-discrimination:

> A COM must demonstrate non-discrimination in the selection of administrative personnel, faculty and staff, and students based on race, ethnicity, color, sex, sexual orientation, gender, gender identity, national origin, age or disabilities, and religion.[8]

Furthermore, the Educational Council on Osteopathic Principles (ECOP) has recommended non-academic criteria for admission and continued program participation for osteopathic medical students enrolled in DO programs. A "Technical Standards Document," made available through ECOP and distributed by the American Association of Colleges of Osteopathic Medicine (AACOM) defines the reasonable expectations of osteopathic medical students and physicians in performing common and important functions of the osteopathic physician.[9]

Residency/Fellowship Program Accreditation Standards Regarding Trainee Disabilities

The Accreditation Council for Graduate Medical Education (ACGME) accredits residency and fellowship programs and sets requirements for programs as well as the institutions in which training occurs.

The ACGME's Common Program Requirements (CPRs) outline resources that must be provided to residents and fellows.[10] The program, with its sponsoring institution, must ensure a healthy and safe learning and working environment that, among other things, provides "accommodations for residents with disabilities consistent with the Sponsoring Institution's policy." [I.D.2.e]. In addition, the program director and the leadership team must "ensure the program's compliance with the Sponsoring Institution's policies and procedures on employment and non-discrimination" [II.A.4.a).(13)]. Finally, the learning environment must be a "professional, equitable, respectful, and civil environment that is free from discrimination, sexual and other forms of harassment, mistreatment, abuse, or coercion of students, residents, faculty, and staff" [VI.B.6.].

The ACGME's Institutional Requirements delineate the responsibility of the sponsoring institution regarding graduate medical education (GME). Among other services provided to trainees, such as behavioral health counseling, the institution "must have a policy, not necessarily GME-specific, regarding accommodations for disabilities consistent with all applicable laws and regulations." [IV.H.4.][11]

In all situations for UME and GME, accommodations for an individual with a disability are expected, provided that the accommodation does not fundamentally alter the program, service, or activity associated with the job function or if it would impose undue financial or administrative burden upon the program or institution.

PREVALENCE OF DISABILITIES AMONG MEDICAL STUDENTS, RESIDENTS/FELLOWS, AND PHYSICIANS

Among the employed U.S. adult population (ages 16 and older), 5.8 percent report some sort of disability (that is, difficulties with hearing, vision, cognition, mobility, self-care, and independent living). The most commonly reported disability for employed adults is mobility (2.0 percent), followed by hearing (1.8 percent), cognitive (1.7 percent), vision (1.3 percent), independent living (1.0 percent), and self-care (0.4 percent).[12]

Two major surveys have been conducted to assess the prevalence and categories of disabilities among students of MD-granting medical schools. Medical school staff responsible for assisting students with implementing accommodations for their disabilities were surveyed in 2016.[13] Complete data were provided by 89 of 133 schools surveyed. Disabilities were reported for 2.7 percent of total enrollment, ranging from 0 percent to 12 percent. Attention deficit hyperactivity disorder (ADHD) was the most prevalent disability (33.7 percent), followed by learning disabilities (21.5 percent); psychological disabilities, such as depression or anxiety (20.0 percent); chronic health issues (13.1 percent); other functional impairment (3.9 percent); visual impairment (3.0 percent); mobility disability (2.5 percent); and deafness (2.2 percent).

A follow-up survey in 2019 allows a comparison across time for the same schools.[14] Overall, the 87 schools that responded in 2019 with complete data reported that 2,600 students had a disability, representing 4.6 percent of enrollment, a 69 percent increase compared to 2016. Data for the 64 schools that responded to both surveys is presented in the table.

Number of MD students (percent) with a disability, 2016 and 2019		
	2016	*2019*
ADHD	369 (32.3)	617 (30.4)
Learning disability	245 (21.4)	371 (18.3)
Psychological disability	233 (20.4)	655 (32.3)
Chronic health disabilities	152 (13.3)	365 (18.0)
Mobility disability	38 (3.3)	74 (3.6)
Visual disabilities	34 (3.0)	46 (2.3)
Deaf or hard of hearing	20 (1.8)	25 (1.2)
Other functional impairment	51 (4.5)	49 (2.4)
Overall disabilities	1,142 (2.7)	2,028 (4.6)

The increase overall, and the changes in the reported type of disability, may represent more students with disabilities being admitted to medical school, more existing students reporting a disability, more complete reporting by the schools, more psychological disability presenting during medical school (the largest difference between years), or a combination of these factors.[14]

A third survey has documented the prevalence and categories of disabilities among students of DO-granting medical schools.[15] Using the same techniques as the surveys of MD-granting schools, 32 eligible DO medical schools were surveyed, and 24 responded. Similar to MD schools, ADHD, psychological disabilities, and chronic health disabilities were most frequently reported. Compared to the total 2019 MD data (not shown), DO-granting schools reported significantly higher rates of ADHD (33.5 percent) among those students with a disability than MD-granting programs (29.1 percent), and lower rates of psychological disability (23.7 percent vs 32.3 percent). Other disabilities were reported at similar rates.

Less is known about the prevalence of disabilities in residents and fellows in GME. A recent survey of academic family medicine departments (n=191) concerning prevalence of residents with disabilities as well as residency program processes for accommodation, found relatively few department chairs reporting having residents in the preceding five years who had a disability. Fifty percent of the 66 respondents reported no resident with a disability, 16.7 percent reported one resident, and 33.3 percent reported two to five residents.[16] There are more than 700 family medicine GME programs in the United States, so these findings may not be representative of family medicine residency programs overall.

The GME environment, in which the learner is also an employee, may discourage trainees from disclosing disabilities, either during the interview for a residency position or after joining the program.[17] Furthermore, the difference in administrative structure in GME, compared to medical school, may challenge residents/fellows seeking accommodation, and thus deter them from reporting a disability.[18] Nonetheless, it can be assumed that disabilities reported in medical school will continue to be experienced by trainees in GME.

Information on the prevalence of disabilities among practicing physicians is also relatively scarce. One survey distributed in 2014 to 148 family medicine department chairs found that 31 (of the 88 respondents) reported faculty with a physical or sensory disability.[19] The most common disabilities reported for the 50 faculty members were mobility, hearing, and mental health problems. Only seven of the department chairs knew of these disabilities at hiring. A similar survey conducted in 2019 found fewer family medicine department chairs reporting faculty members with disabilities (21 chairs reporting out of 68 respondents).[16] Both surveys had low response rates, and it is likely that disability among faculty physicians is under-reported. A national survey of physicians in 2019 included questions regarding disabilities. Of 6,000 physicians (a representative sample), 178 (3.1 percent of the weighted sample) self-identified as having a disability. The most commonly reported disability was a chronic health condition (30.1 percent), followed by psychological (14.2 percent), other disabilities (e.g., essential tremors) (13.4 percent), hearing (12.1 percent), ADHD (10.4 percent), visual (7.8 percent), and learning (2.6 percent). Multiple disabilities were reported by 15.7 percent.[20] The proportion of physicians reporting a disability is considerably lower than that reported by the employed adult population overall[12] and may reflect under-reporting and/or that the profession of medicine is perceived as inhospitable and discouraging to those with disabilities.

EXAMPLES OF ACCOMMODATION

Similar to data on the prevalence of disabilities, information on the types of accommodations provided is more common for medical students than for physicians. The most frequent accommodations reported in 2016 by medical schools for students with disabilities include the following:

- Testing, such as providing extra time and/or low distraction environments (97.8 percent)
- Facilitated learning, such as note takers and/or recorded lectures (69.7 percent)
- Assistive technologies, such as text-to-speech (42.7 percent)
- Clinical, such as leaves of absence and/or relief from overnight call (34.8 percent)
- Housing, such as single rooms and reserved parking (23.6 percent)
- Hearing-related, such as employing a transcriptionist or sign language interpreter (18.0 percent)
- Ergonomic (15.7 percent)[13]

In the follow-up survey in 2019, questions about accommodations were divided into didactic and clinical environments and results were similar. Testing accommodations were most often reported in the didactic years (100 percent of schools), but 75 percent of schools reported this

accommodation for the clinical years as well. Facilitated learning was reported only for didactic years by 77.4 percent of schools, as were ergonomic accommodations (35.7 percent). Accommodations in the clinical environment were reported by 68.7 percent of schools.[14] In the similar study of DO-granting schools, all DO students disclosing disability received a form of didactic or clinical accommodations, compared to 93.3 percent of MD students. Accommodations to the clinical environment, such as a decelerated clinical year or release from overnight call, were more frequently provided in MD-granting programs when compared to DO-granting programs (68.7 percent vs 21.7 percent).[15]

New and existing technologies allow trainees to meet standards and work within a clinical setting. For example, amplified and visual stethoscopes, standing wheelchairs, dictation software, and Communication Access Real-Time Translation have allowed students and physicians with disabilities, such as hearing/visual impairment or spinal cord injuries, to earn their medical degrees and enter practice. Intermediaries can also be used in the clinical setting, in which students or physicians direct trained professionals to perform actions that the disabled individuals cannot conduct themselves.[21] An example of an adaptive environment for a deaf medical student in a one-month visiting rotation in emergency medicine has been described in which a designated health care interpreter, captioning added to instructional videos in online learning platforms, an adaptive headset, and specialized medical sign language developed for the rotation (for terms not in American Sign Language) were successfully integrated into the rotation.[1]

In a study of family medicine faculty, the most commonly reported accommodations provided for faculty with disabilities were adjusting the work schedule and providing additional time to complete tasks. Also common was the use of assistive technology and durable equipment.[19]

In a review of medical school technical standards, found online or available upon request, roughly 40 percent of schools provided information on types of accommodations allowed for hearing, vision, and mobility disabilities. Of those, 97 percent allowed auxiliary aids for all three types of disabilities. A slightly smaller number of schools (approximately 85 percent) provided information on whether intermediaries (such as interpreters) were allowed as accommodations; few schools allowed them (approximately 15 percent).[3]

BARRIERS FACED BY TRAINEES

A recent report by the Association of American Medical Colleges (AAMC), "Accessibility, Inclusion, and Action in Medical Education: Lived Experiences of Learners and Physicians with Disabilities,"[18] represents the culmination of in-depth interviews with students, residents, and physicians with disabilities. Several of the report's many recommendations are highlighted below.

The report describes two types of barriers confronting students and residents with disabilities—structural and cultural. Structural barriers include restrictive and outdated policies and procedures, poor understanding of clinical accommodations, a lack of disability and wellness support services, and a physical environment that limits accessibility. These barriers can have immediate and practical implications for trainees.[21] Cultural barriers include the attitudes, beliefs, and values of the medical community.

Medical School Technical Standards and Facilitating Access

The technical standards (TS) that a medical school publishes are used to inform a prospective or current medical student about a school's expectations are for cognitive, sensory, and mobility abilities. The AAMC has released guidelines for TS and a handbook on students with disabilities,

but it is up to schools to develop their own standards.[22] There is great variability between schools, with some using inclusive, detailed language and identifying possible accommodations, such as interpreters and transcriptionists. Other schools state, for example, that students need to hear "adequately" for communication and that an intermediary is not appropriate, or that "significant" disabilities must be disclosed. Leaving the definition of "adequately" and "significant" up to a prospective student may deter those with disabilities from applying.[22]

Clear, easily obtainable TS are important for prospective students with disabilities in ascertaining which schools may be welcoming and supportive. In 2016 Zazove et al. published the results of a study to determine the availability of TS in medical schools and evaluated the language used in TS relative to the ADA.[3] Their research covered the years 2012-2014 and included all MD- and DO-granting schools. They found that 84 percent of all schools had TS available on their websites. Ten percent of MD schools and six percent of DO schools did not have TS on their websites or make their TS available even after two inquiries. One-third of schools used language that expressed a willingness to provide accommodations for disabilities, 49 percent used equivocal language, five percent used unsupportive language, and 14 percent did not provide information on accommodations. One-third of schools required full function of hearing, 26 percent required full function of vision, and 24 percent required full mobility functionality. Roughly 10 percent did not provide information on function level required. Overall, schools with language in the TS that expressed a willingness to accommodate students with disabilities were also more likely to allow reasonable accommodations, assume responsibility for providing those accommodations (rather than the student), accept auxiliary aides, and accept intermediaries. Additional study is required to determine any changes in the number of schools making available their TS and their willingness to provide accommodations.

A criticism leveled at many TS is that there may be a focus on deficits rather than on the ability to perform the work.[23] An "organic" standard requires students to demonstrate physical, cognitive, behavioral, and sensory abilities without assistance. For example, students are expected to have hearing ability at a particular decibel level without assistance. A "functional" standard focuses on the student's abilities, with or without assistive technology or accommodation, and may state that students must be able to obtain the necessary information by hearing or other means. McKee et al.[23] discuss how organic TS are based on three assumptions that are not derived from empirical evidence: 1) accommodations pose patient safety risks; 2) accommodations are costly; and 3) graduates, even those with disabilities, should be able to pass licensure exams without accommodation.

Concerning patient safety, no legal case has been found to demonstrate harm to a patient based on an accommodation provided to a physician with a disability. Physicians and students with disabilities typically are aware of their limitations and develop strategies to adapt to the environment. The costs of accommodation vary greatly. The ADA does not allow cost to justify discrimination toward students or physicians with disabilities. Medical schools, residency/fellowship programs, and employers are ultimately responsible for paying for reasonable accommodations. Assistive technologies rapidly change, and appropriate, cost-effective accommodations can be found on industry and government websites. The ADA requires licensure examinations to provide appropriate accommodations such as sign language interpreters and extended test time. The incorporation of accommodation into the testing environment thus mimics the learning and practicing environment of the student or physician, and the examination assesses performance more accurately than if the disabled test taker were denied accommodation.[23]

The Association of Academic Physiatrists has addressed the issue of updating medical school TS.[24] Stating that a functional approach to TS promotes inclusivity by emphasizing abilities rather than

limitations, its report describes standards that allow students to use accommodations and permit incorporation of technological and medical advances as they become available. Functional TS describe what skills the student must master—e.g., effective communication with patients and the care team—but not the manner in which the student must achieve them (e.g., must use vision, etc.). Changes in medical practice and medical education coincide with an increased use of assistive technology, for all health professionals regardless of limitations. Team-based care, new information management skills, and an emphasis on problem-solving skills rather than memorization of facts combined with competency-based education can allow for performance assessment of students with disabilities using reasonable accommodations. Students can demonstrate mastery of skills through alternative methods.

Entry to GME

Students in or graduates from MD-granting medical schools who are applying to U.S. residency programs generally must pass or at least have taken USMLE® Step 1 and Step 2 to be offered an interview invitation from a residency program. The National Board of Medical Examiners® (NBME), which co-owns the USMLE with the Federation of State Medical Boards, provides a process through which a prospective exam taker can request disability accommodations for the examinations. Extensive documentation of the disability as well as evidence of previous educational examination and educational accommodations is required. The NBME requests at least 60 days to process a request. Applicants who have applied for and received accommodations for Step 1 must apply again for accommodations for Step 2.[25] Medical schools provide timelines for students who may seek accommodation from the NBME and advise a minimum of 6 months to include document preparation, submission, and review by the NBME plus additional time in case of an appeal.[26,27] Students, however, have anecdotally reported lengthier response times from the NBME, resulting in delays in taking the exam(s), which have in turn impacted application to and acceptance into residency programs.

Similarly, students in or graduates from DO-granting institutions who are applying to U.S. residency programs generally must pass or at least have taken COMLEX-USA Examination Level 1 and Level 2 to be offered an interview invitation from a residency program. The National Board of Osteopathic Medical Examiners® (NBOME) provides a process through which a prospective exam taker can request disability accommodations for the examinations. Documentation of the disability and a completed application is required. The NBOME states that the process may require 90 days from receipt of a completed application to process a request, though additional time may be necessary prior to rendering a decision.[28]

Once in GME, similar to the undergraduate environment, structural barriers for disabled learners include an absence of 1) clearly defined policies and processes; 2) a knowledgeable and responsible point person for facilitating accessibility requests; and 3) an understanding of legal requirements under the ADA.[18]

The ACGME requires that sponsoring institutions have policy regarding accommodations for disabilities and that GME programs both provide accommodations for residents with disabilities consistent with the employing sponsoring institution as well as comply with that institution's policy on employment and nondiscrimination. Unlike medical school TS, there is no requirement as to where or how an applicant to a training program can find that information. A recent review was conducted of institutional policies of the 50 largest training institutions to assess compliance with the ACGME's Common Program Requirements and Institutional Requirements (I.D.2.e, and IV.H.4., respectively) concerning disability.[29] The review also analyzed GME policy in terms of alignment with recommendations included in the AAMC's report (mentioned above) on disability.

The majority of institutions maintained a GME policy online (76 percent) or provided one upon request (18 percent). Of the 47 institutions with GME policy available, 32 (68 percent) contained a statement on disability in compliance with ACGME requirements, 23 with the statement found online. Of those institutions with a disability policy, 12 (38 percent) included language that encouraged disability disclosure, 17 (53 percent) provided a statement regarding the confidential nature of documentation regarding accommodation, and 19 (59 percent) described a procedure for disclosing disabilities and requesting accommodation. The AAMC report on accessibility and inclusion in medical education recommends institutions have on staff a designated point person(s) for disability concerns, through which accommodation requests should pass. Of the institutions with policy reviewed, only 5 reported such a process. Over half of the 32 institutions required residents to disclose a disability to program directors (some to program directors and a member of human resources), not in line with AAMC recommendations. In addition, findings from the survey of chairs of family medicine departments found that while 56.3 percent of chairs reported they had a written policy for disability disclosure, 36.6 percent did not know if they had one, and seven percent reported no written policy available. As found in the above study of institutions, over half of family medicine department chairs confirmed that the program director was the contact for disability disclosure, which can be a conflict of interest and against recommendations.[16]

Clearly stated and easily found accommodation policies can help applicants determine if a program and its institution are willing to work with the resident to maximize the learning environment. Ambiguous or absent policies may lead an applicant to assume that the program will not make accommodations, which will discourage applying to the program, or, if accepted, may prevent the resident from seeking assistance with a disability.[30] Students are encouraged to discuss accommodations with a program immediately after matching into the program to ensure ample time for implementing schedule changes or accommodations; however, students may be reluctant to do so if they perceive that a disability will be seen as a liability.[18, 30]

It is possible that some disabilities may be less apparent in virtual versus live interviews (e.g., physical disabilities). A review of the literature on best practices for virtual interviews for residency did not include a discussion on the impact of virtual interviews may have on disability disclosure.[31]

A designated, qualified person responsible for processing requests for accommodation and managing disability services is essential to ensure that residents are confident that the process is administered professionally and confidentially. A disabilities service provider may be within the human resources department or a part of an institution-wide disabilities committee. The provider or committee will be aware of the legal obligations of the ADA, unlike program directors or program staff, who may not be.[30] A program may offer accommodations to residents with apparent disabilities; residents with non- or less-apparent disabilities, but who are uncomfortable disclosing disabilities to program directors, may not receive an offer. Without clearly stated policy and an expert to manage the interactive process of determining reasonable accommodations, residents may fruitlessly disclose their disabilities to staff who are without knowledge or authority to assist and may experience delays in obtaining accommodations.[30]

BALANCE WITH PATIENT SAFETY

Melnick cautions that the laudable goal of increasing inclusion must be balanced against the medical profession's responsibility to place the interests of patients "above the interests of aspiring students."[32] Furthermore, the profession has done little to develop consensus on what accommodations would fundamentally alter the formation and assessment of a physician. Medical schools employ TS to provide guidance, but GME lacks similar standards. A goal of current

medical education is to prepare a physician who can demonstrate proficiency in the undifferentiated practice of medicine. State licensing authorities lack consensus on what comprises essential physical and cognitive capabilities for physicians. Melnick proposes discussion and research on what those essential abilities are, so that individual learners with disabilities can be supported in a way that does not alter the profession's ability to teach and assess those essential abilities. Meeks et al.[21] also propose an ecological study to measure the performance path of learners with disabilities, identify what assistance and accommodations are best suited to various disabilities, track the employment experiences of physicians with disabilities, and examine the effect of those physicians on patient care. Little is known about the process by which physicians with disabilities find employment, although it is assumed that they are guided by past experience with the ADA process and responses of various educational and institutional administrations.

CURRENT AMA POLICY

AMA policies related to this topic are listed in the Appendix.

SUMMARY AND RECOMMENDATIONS

The medical education community should accelerate the pace of inclusion of physicians with disabilities for several reasons. The ADA stipulation that institutions cannot discriminate against a qualified individual on the basis of disability and requires institutions to make reasonable accommodations to allow the individual equal opportunity to participate in the institution's programs (or employment). Second, in 2016 the U.S. population was estimated to have a disability rate of 12.8 percent (some estimates are higher), increasing by 7.6 percent since 2010.[11] The rate at which medical students present with disabilities is also growing—specifically, 4.6 percent of students enrolled in 2019 compared to 2.7 percent in 2016. Although the number of physicians with disabilities in the health care workforce is small, estimated at 3.1 percent, it is believed that these physicians can better understand and empathize with patients with disabilities. A more diverse population of medical students and physicians, including those with disabilities, can introduce new approaches to care, both for patients with and without disabilities.[23] Improved education about disability coupled with the opportunity to learn directly from peers with disabilities in the medical education setting can challenge existing beliefs about disabilities and increase awareness of the potential of both patients and physicians with disabilities.[22]

To increase access to medical education for learners with disabilities, it is important that applicants, either to medical schools or residency programs, have ready access to the information necessary to make an informed decision about whether that educational environment has the appropriate resources and institutional culture to support necessary accommodations. Institutions should review and evaluate their technical standards to remove restrictive "organic" standards and replace them with "functional" standards that emphasize what learners can do rather than what they cannot do. Institutions, undergraduate and graduate, should have readily available designated disability service providers who are knowledgeable about the ADA and aware of current resources and strategies to best process accommodation requests. Providers of high-stakes examinations need to remain responsive and flexible in reviewing and approving accommodations, especially if the number of exam takers with disabilities increases. Research on which accommodations are most effective in the patient care and learning environment will assist in determining future strategies for creating a safe and inclusive medical workforce. Future study may be warranted to examine challenges to employment after training for individuals with disabilities, as there are limited data available on physicians with disabilities in the workforce.

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

1. That our American Medical Association (AMA) urge that all medical schools and graduate medical education (GME) institutions and programs create, review, and revise technical standards, concentrating on replacing "organic" standards with "functional" standards that emphasize abilities rather than limitations, and that those institutions also disseminate these standards and information on how to request accommodations for disabilities in a prominent and easily found location on their websites. (Directive to Take Action)

2. That our AMA urge all medical schools and GME institutions to a) make available to students and trainees a designated, qualified person or committee knowledgeable of the Americans with Disabilities Act and available support services and b) encourage students and trainees to avail themselves of support services. (Directive to Take Action)

3. That our AMA encourage the National Board of Medical Examiners and National Board of Osteopathic Medical Examiners to evaluate and enhance their processes for reviewing requests for accommodations from applicants with disabilities in order to reduce delays in completion of the USMLE and COMLEX, including an assessment of the experience of those applicants and the development of a transparent communication process that keeps applicants informed about the expected timeline to address their requests. (Directive to Take Action)

4. That our AMA encourage research and broad dissemination of results in the area of disabilities accommodation in the medical environment that includes: the efficacy of established accommodations; innovative accommodation models that either reduce barriers or provide educational approaches to facilitate the avoidance of barriers; impact of disabled learners and physicians on the delivery of health care to patients with disabilities; and research on the safety of established and potential accommodations for use in clinical programs and practice. (Directive to Take Action)

5. That our AMA rescind Policy D-295.929, "A Study to Evaluate Barriers to Medical Education for Trainees with Disabilities," as having been fulfilled by this report. (Rescind HOD Policy)

Fiscal note: $2,500.

APPENDIX: RELEVANT AMA POLICY

D-90.991, "Advocacy for Physicians with Disabilities"

1. Our AMA will study and report back on eliminating stigmatization and enhancing inclusion of physicians with disabilities including but not limited to: (a) enhancing representation of physicians with disabilities within the AMA, and (b) examining support groups, education, legal resources and any other means to increase the inclusion of physicians with disabilities in the AMA.
2. Our AMA will identify medical, professional and social rehabilitation, education, vocational training and rehabilitation, aid, counseling, placement services and other services which will enable physicians with disabilities to develop their capabilities and skills to the maximum and will hasten the processes of their social and professional integration or reintegration.
3. Our AMA supports physicians and physicians-in-training education programs about legal rights related to accommodation and freedom from discrimination for physicians, patients, and employees with disabilities.

H-65.965, "Support of Human Rights and Freedom"

Our AMA:
(1) continues to support the dignity of the individual, human rights and the sanctity of human life, (2) reaffirms its long-standing policy that there is no basis for the denial to any human being of equal rights, privileges, and responsibilities commensurate with his or her individual capabilities and ethical character because of an individual's sex, sexual orientation, gender, gender identity, or transgender status, race, religion, disability, ethnic origin, national origin, or age; 3) opposes any discrimination based on an individual's sex, sexual orientation, gender identity, race, religion, disability, ethnic origin, national origin or age and any other such reprehensible policies; (4) recognizes that hate crimes pose a significant threat to the public health and social welfare of the citizens of the United States, urges expedient passage of appropriate hate crimes prevention legislation in accordance with our AMA's policy through letters to members of Congress; and registers support for hate crimes prevention legislation, via letter, to the President of the United States.
Work Plan for Maintaining Privacy of Physician Medical Information D-180.991
The AMA shall recommend that medical staffs, managed care organizations and other credentialing and licensing bodies adopt credentialing processes that are compliant with the Americans with Disabilities Act and communicate this recommendation to all appropriate entities.

H-90.987, "Equal Access for Physically Challenged Physicians"

Our AMA supports equal access to all hospital facilities for physically challenged physicians as part of the Americans with Disabilities Act.

H-200.951, "Strategies for Enhancing Diversity in the Physician Workforce"

Our AMA (1) supports increased diversity across all specialties in the physician workforce in the categories of race, ethnicity, gender, sexual orientation/gender identity, socioeconomic origin and persons with disabilities; (2) commends the Institute of Medicine for its report, "In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce," and supports the concept that a racially and ethnically diverse educational experience results in better educational outcomes; and (3) encourages medical schools, health care institutions, managed care and other appropriate groups to develop policies articulating the value and importance of diversity as a goal that benefits all participants, and strategies to accomplish that goal.

9.5.4, "Civil Rights & Medical Professionals"

Opportunities in medical society activities or membership, medical education and training, employment and remuneration, academic medicine and all other aspects of professional endeavors must not be denied to any physician or medical trainee because of race, color, religion, creed, ethnic affiliation, national origin, gender or gender identity, sexual orientation, age, family status, or disability or for any other reason unrelated to character, competence, ethics, professional status, or professional activities.

AMA Principles of Medical Ethics: IV: Balance with patient safety

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REPORT 3 OF THE COUNCIL ON MEDICAL EDUCATION (N-21)
Rural Health Physician Workforce Disparities
(Reference Committee C)

EXECUTIVE SUMMARY

The supply of practicing physicians in rural settings in the United States has been insufficient to meet the demand for health care services of the rural population. Physician shortages in rural settings have been an enduring and widespread concern, with only 12 percent of primary care physicians working in rural areas (and only eight percent in other specialties). The impact of these numbers is real. Rural communities most likely to suffer from a shortage of physicians can be characterized by low population density, extreme poverty, and high proportions of racial and ethnic minoritized, as well as a lack of physical and cultural amenities.

According to the 2010 Census, nearly 60 million people live in rural communities, and 20 percent of people in the U.S. are rural residents. The size of this population has been stable for several decades. Additionally, more than 15 percent of these rural residents are members of racial/ethnic minoritized groups, and this percentage is growing. In 2002, seven national family medicine organizations adopted a new model of practice that established a reasonable physician-to-population ratio at 1:1,200. In 2014, the primary care physician-to-population ratio was 1:1,300 in the United States as a whole, versus a 1:1,910 ratio in rural areas.

A recent decline in the percentage of students who report an interest in practicing in small towns and rural communities is cause for concern as these communities struggle to sustain their access to health care. A multitude of factors may contribute to this decline, including inadequate exposure to rural medicine as a career pathway, lack of pathway programs targeting rural students, and limited resources to support preparation for medical school and residency for rural students.

The federal government has established several programs to recruit and retain a diverse workforce and encourage physicians to practice in shortage specialties and underserved communities such as rural settings. These programs include the National Health Service Corps (NHSC), Title VII of the Public Health Service Act, the Conrad 30 Waiver, and Area Health Education Centers (AHECs).

Additionally, there have been other efforts to recruit and retain physicians in rural areas such as 3RNet, the Community Apgar Project, Rural Training Tracks, the Columbia-Bassett Program, and the California Oregon Medical Partnership to Address Disparities in Rural Education and Health (COMPADRE) Project. The utilization of telehealth has also provided opportunities for physicians to consult with specialists and increase access to physicians, specialists, and other health care professionals for patients in rural areas.

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 3-N-21

Subject: Rural Health Physician Workforce Disparities

Presented by: Niranjan Rao, MD, Chair

Referred to: Reference Committee C

INTRODUCTION

American Medical Association (AMA) Policy H-465.988 (2,3,4), "Educational Strategies for Meeting Rural Health Physician Shortage," directs our AMA to:

> 2. work with state and specialty societies, medical schools, teaching hospitals, the Accreditation Council for Graduate Medical Education (ACGME), the Centers for Medicare and Medicaid Services (CMS) and other interested stakeholders to identify, encourage and incentivize qualified rural physicians to serve as preceptors and volunteer faculty for rural rotations in residency.
>
> 3. (a) work with interested stakeholders to identify strategies to increase residency training opportunities in rural areas with a report back to the House of Delegates; and (b) work with interested stakeholders to formulate an actionable plan of advocacy with the goal of increasing residency training in rural areas.
>
> 4. undertake a study of issues regarding rural physician workforce shortages, including federal payment policy issues, and other causes and potential remedies (such as telehealth) to alleviate rural physician workforce shortages.

This report, which is in response to this directive, builds on information from a previous Council on Medical Education report to the House of Delegates on this topic [Report 7-A-14, "Physician Workforce Shortage: Approaches to GME Financing"] and addresses the policy above by providing information on:

1. The current state of the rural physician workforce;
2. The impact of closing rural hospitals and critical access hospitals on the rural physician shortage;
3. Current efforts to address the rural physician workforce shortage; and
4. Current AMA policy.

CURRENT STATE OF THE RURAL PHYSICIAN WORKFORCE

There is broad recognition that the United States is facing a physician workforce shortage. In 2020, the Association of American Medical Colleges (AAMC) reported that the nation "could see an estimated shortage of between 54,100 and 139,000 physicians, including shortfalls in both primary and specialty care, by 2033" as demand for physicians continues to grow faster than supply.[1] The major factor driving demand for physicians continues to be a growing, aging population. According

to the U.S. Census Bureau, the nation's population is estimated to grow by more than 10 percent by 2032, with those over age 65 increasing by 48 percent. Additionally, the aging population will affect physician supply, since one-third of all currently active doctors will be older than 65 in the next decade. The retirement of these physicians could have a significant impact on supply.[2]

The supply of practicing physicians in rural settings in the United States has been insufficient to meet the demand for health care services of the rural population. Physician shortages in rural settings have been an enduring and widespread concern, with only 12 percent of primary care physicians, and eight percent in other specialties, working in rural areas.[2] According to the 2010 Census, nearly 60 million people live in rural communities, and 20 percent of people in the U.S. are rural residents. The size of this population measured as a percent has been stable for several decades.[3] Additionally, more than 15 percent of these rural residents are members of racial/ethnic minoritized groups, and this percentage is growing.[4]

In response to growing frustrations regarding continued inequities and inefficiencies in the U.S. health care system, the leadership of seven national family medicine organizations initiated the Future of Family Medicine (FFM) project in 2002. Through this project, a new model of practice was adopted, proposing that a reasonable physician-to-population ration be 1:1,200.[5] In 2014, the primary care physician-to-population ratio was 1:1,300 persons in the United States as a whole, versus a 1:1,910 ratio in rural areas.[6] In 2019, the Federation of State Medical Boards reported there were 985,026 physicians with Doctor of Medicine (MD) and Doctor of Osteopathic Medicine (DO) degrees licensed to practice medicine in the United States and the District of Columbia and available to serve a U.S. national population of 327,167,434.[7] Of these physicians, only 11 percent (108,353) practiced in rural counties serving 14 percent (46.1 million) of the U.S. population.[8,9]

The impact of these numbers is real. Rural communities most likely to suffer from a shortage of physicians can be characterized as communities that have low population density, extreme poverty, and high proportions of racial and ethnic minorities, as well as a lack of physical and cultural amenities.[10] These circumstances contribute to the difficulty in recruiting physicians to practice in these areas. Additionally, most of medical education is based in metropolitan areas limiting future physicians' exposure to medical practice in rural settings contributing to challenges in recruiting future physicians to train and practice in rural communities.

Studies have found that students who grew up in rural areas, as well as individuals who are racial and ethnic minorities and/or non-U.S.-citizen international medical graduates, are most likely to practice in medically underserved areas such as rural communities.[11,12] Pathman found that physicians who felt better prepared both medically and socially for practice in a rural environment stayed longer than those who felt unprepared or who were initially unaware of the special characteristics of rural practice.[13] Additional factors associated with increased likelihood that a physician will choose a rural practice include training at a medical school with a mission to train rural physicians, training at an osteopathic medical school, or training that includes rural components such as rural rotations.[14]

While medical students from rural backgrounds are more likely to practice in rural settings compared to students from non-rural areas, there was a recent 28 percent decline in rural medical school matriculants. This decline occurred between 2002 and 2017 when the overall number of medical school matriculants increased by 30 percent. In 2016 and 2017, students from rural backgrounds made up only 4.3% of the incoming medical student body.[8] That said, a recent decline in the percentage of rural medical students who report an interest in practicing in small towns and rural communities is cause for concern as these communities struggle to sustain their access to health care. A multitude of factors may contribute to this decline, including inadequate exposure to

rural medicine as a career pathway for both students in rural and nonrural environments, lack of pathway programs targeting rural students, and limited resources to support preparation for medical school and residency for rural students. The increasing number of rural hospital closures may also negatively impact medical student interest in pursuing a career in rural health.

According to the U.S. Government Accountability Office (GAO), 101 rural hospitals closed in the United States between 2013 and 2020. When rural hospitals closed, people living in areas who received health care from them had to travel farther to get the same health care services—about 20 miles farther for common services like inpatient care. People had to travel even farther—about 40 miles—for less common services like substance use disorder treatment. Before rural hospitals closed, counties where these hospitals were located had fewer doctors than counties without any closures. The number of doctors further decreased when hospitals closed.[15] Germack et al. found that rural hospital closures were associated with immediate and persistent decreases in the supply of physicians across multiple specialties.[16] For example, the percent of all rural counties in the U.S. without hospital obstetric services increased from 46 percent in 2004 to 55 percent in 2014.[17] In the period of 2004-2014, the closure of 14 rural hospitals with obstetrics units and the closure of 165 obstetric units within otherwise open hospitals, left the counties where they were located with no available obstetric services.[18]

Hospitals located in rural areas have been closing their doors more frequently and at higher rates than urban facilities in recent years—and a pattern of increasing financial distress suggests that more are likely to falter.[19] A February 2019 study found that 21 percent of U.S. rural hospitals remain at high risk of closing unless their financial situations improve. One factor driving the overall negative financial performance of rural hospitals is the losses they incur on reimbursement for Medicare patients. Excluding critical access hospitals, rural hospitals have an approximately negative 8.2 percent operating margin on Medicare patients, creating a dependence on commercial patients and employers to make up the difference.[20] Concurrently, a 2019 study of final-year medical residents found that "geographic location was their number one priority when considering a practice opportunity and 91 percent prefer to be an employee of a hospital, medical group or other facility than to be in private practice.[21] If the trend of rural hospital closures continues, physicians may be increasingly hesitant to accept positions at rural hospitals due to concerns about the financial viability of these institutions.

LEGISLATIVE PRINCIPLES TO REDUCE RURAL HEALTH DISPARITIES RELATED TO PHYSICIAN SHORTAGES

There are several current initiatives in Congress that seek to reduce the physician shortage. This includes efforts to increase Medicare support for GME, including increasing the number of Medicare-supported medical resident training positions as well as the number of physicians trained in pain management, addiction medicine, or addiction psychiatry. Another effort seeks to address the cap on full-time equivalent residents for purposes of payment for graduate medical education costs under the Medicare program for certain hospitals that have established a shortage specialty program. There are efforts underway to expand access to telehealth by waiving restrictions on Medicare payment for telehealth services. There are also efforts to examine strategies for increasing health professional workforce diversity.[1]

Current Graduate Medical Education Financing Structure

When considering health care workforce, it is important to "follow the money." The federal government is the largest contributor to physician training, through its funding of graduate medical education (GME), which exceeds $15 billion per year.[22] Funding for GME stems from both public

and private sources as well as federal mandatory and discretionary appropriations. The payroll tax funds Medicare Part A, while insurance premiums and federal mandatory appropriations fund Medicare Part B. Insurance premiums also fund private payers. The federal mandatory appropriations fund provides money to states through the federal Medicaid match and the Health Resources and Services Administration (HRSA). Meanwhile, the federal discretionary appropriations fund GME at the Department of Defense (DoD) and Veterans Health Administration (VHA). While most states support GME through their Medicaid program, some also provide GME support through state-based programs such as loan repayment incentives to address health workforce shortages.[23] Figure 1 below outlines the flow of GME funding.

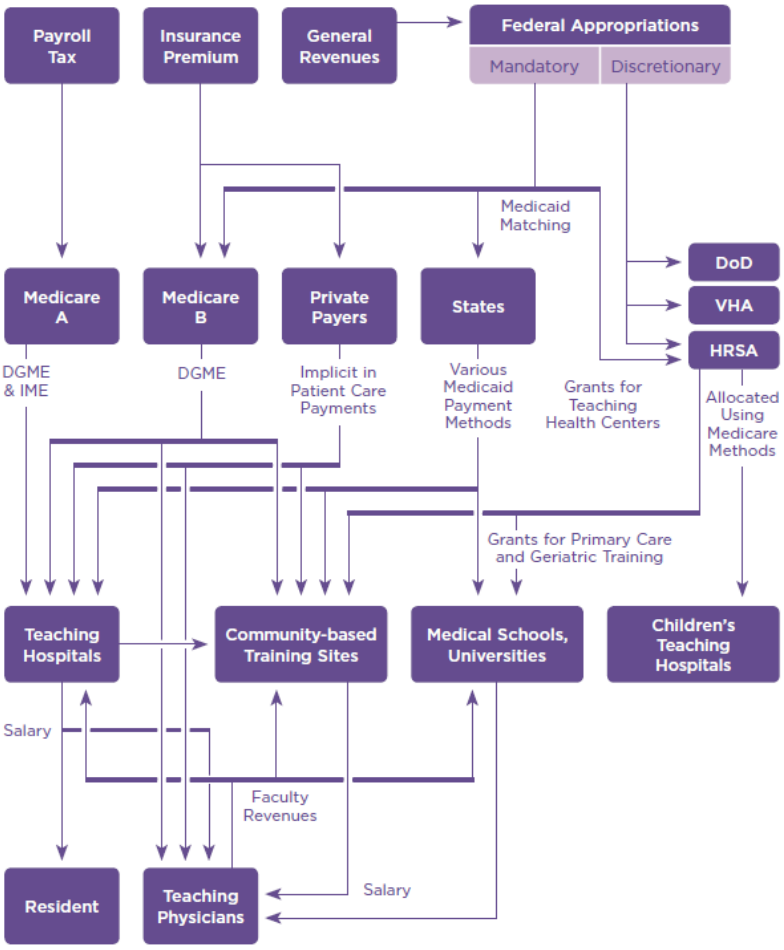

Figure 1: Flow of GME funding.

Note: DGME = direct graduate medical education; DoD = Department of Defense; HRSA = Health Resources and Services Administration; IME = indirect medical education.

Adapted from Wynn, 2012 (Committee of Interns and Residents Policy and Education Initiative White Paper, "Implementing the 2009 Institute of Medicine recommendations on resident physician work hours, supervision, and safety")

The most recent available estimates of GME funding by source indicate that Medicare is the single largest contributor to GME. A 2013 study by Henderson found that of the top three public contributors to GME, Medicare contributed $9.7 billion (~64 percent); Medicaid $3.9 billion (~26 percent); and the VHA $1.4 billion (~10 percent). Private funding for GME is difficult to quantify.

Private insurers support GME by paying higher rates to teaching institutions and health systems. Hospitals, universities, physicians' organizations, and faculty practice plans also support residencies and fellowships. In addition, private philanthropy as well as gifts and grants from industry provide GME support.[24]

When Medicare began funding GME in 1965, payments to teaching hospitals were based solely on hospitals' costs. With the arrival of the Medicare prospective payment system (PPS) for acute care hospitals in 1983, Medicare established two GME funding streams for teaching hospitals: Direct Graduate Medical Education (DGME) funding to cover the direct expenses related to residency training and Indirect Medical Education (IME) funding to help offset the additional costs of providing patient care thought to be associated with sponsoring residency programs.[25] Medicare GME was never intended to cover teaching costs for non-Medicare patients, and distribution of Medicare DGME and IME funds is governed by strict statutory formulas. Both the DGME and the IME formulas include variables that tie payment to a teaching institution's volume of Medicare patients. The DGME payment for an individual institution is calculated by multiplying three factors: weighted resident count, per-resident count, and Medicare day ratio. The weighted resident count is the rolling average of hospital's weighted number of full-time equivalent (FTE) residents in accredited programs in the most recent three-year reporting period. The per-resident amount is calculated by dividing the individual hospital's base year DGME costs by the weighted residents count, which is adjusted for geographic differences and inflation. The Medicare day ratio is the hospital's Medicare inpatient days to total inpatient days to approximate Medicare's share of training costs.[26] These formulas are not designed to account for differences in costs resulting from training residents of different specialties. The Department of Veterans Affairs, Medicaid, and the Children's Health Insurance Program are other federal sources of GME funding of varying levels. In addition, the Army, Navy, and Air Force support their own in-house residencies and fellowships to provide for the future physician workforce needs of those services. Figure 2 below highlights the breakdown of both mandatory and discretionary GME funding including the total funding, the number of trainees and cost per trainee.

Federal Funding for Graduate Medical Education (CRS, 2018)

Program Name *Control over trainees*	**Total Funding**	**Number of Trainees**	**Cost Per Trainee**
MANDATORY FUNDING			
Medicare GME Payments *The number of Medicare-supported residents and per-resident payment amount is capped for each hospital, but hospitals determine staffing needs and types of residents with the exception of certain primary care residents.*	FY2015 (est.): $10.3 - $12.5 billion	FY2015 (est.): 85,712 - 87,980 FTE (DGME) slots 85,578 - 88,416 FTE (IME) slots	FY2015 (est. average): $112,000 - 129,000 per FTE
Medicaid GME Payment *States are permitted to make these payments using their own criteria to determine which providers are eligible for payments.*	N/A.	N/A The Medicaid program does not require states to report these data.	N/A. The Medicaid program does not require states to report these data.
Teaching Health Centers GME Payment Program *Funding to applicant teaching health centers that meet the program's eligibility requirements.*	FY2018: $126.5 million (est.)	AY2016-AY2017: 742 FTE slots 771 total residents trained	N/A.
DISCRETIONARY FUNDING			
Veterans Affairs GME Payments *VA facilities determine their staffing needs and the number and type of residents supported.*	FY2017: $1.78 billion	AY2016-AY2017: 11,000 FTE slots and > 43,565 residents spent part of their training at a VA facility	FY2015 (est.): $137,792/resident

Children's Hospital GME Payment Program *Grant funding awarded to applicant children's hospitals that meet the program's eligibility requirements.*	FY2019: $325bmillion	FY2016-FY2017 58 hospitals received payments to support 7,164 FTE slots	N/A
Department of Defense GME Payments *Divisions of the armed forces determine their staffing needs and the number and type of residents supported.*	FY2012: $16.5 million	FY2017: 3,983 FTE residents	N/A

Source: CRS analysis of agency data, including review of various agency budget justification and The Robert Graham Center program data sourced from CMS Medicare hospital cost report data, and GAO report, *Physician Workforce: HHS Needs Better Information to Comprehensively Evaluate Graduate Medical Education Funding* (GAO-18-240, 2018).

Notes: AY = Academic year; Academic year 2016-2017 began on July 1, 2016, and concluded on June 30, 2017. DGME = direct graduate medical education. est. = estimate. FTE = full time equivalent. FY = fiscal year. IME = Indirect Medical Education. N/A = not available. VA = the Department of Veterans Affairs.

A key factor that may impact the physician workforce is the cap placed on Medicare GME funding more than two decades ago. The Balanced Budget Act (BBA) of 1997 (P.L.105-33) limited the number of medical residents at an institution that could be counted for purposes of calculating DGME and IME payments to the number of trainees as of 1996. This limitation effectively prohibits existing teaching hospitals from receiving Medicare support for any medical residency positions added after 1996. As medical school enrollment continues to grow in attempts to address the physician shortage, which has increased 30 percent since 2002, the Medicare GME cap has made it difficult for the number of medical residency slots to keep pace, resulting in a bottleneck in physician training.[1] Between 2005 and 2015, the number of residents grew by 22 percent. Additionally, it should be noted that the Balanced Budget Act of 1999 (P.L. 106-113) increased the resident cap for rural hospitals to 130 percent of its 1996 level, thereby mitigating somewhat the full impact of the Medicare GME cap.

LEGISLATION TO ADDRESS THE PHYSICIAN SHORTAGE

The recent Consolidated Appropriation Act of 2021 included several efforts to address the physician shortage.

Promoting Rural Hospital GME Funding Opportunity

This section makes changes to the Medicare graduate medical education (GME) Rural Training Tracks (RTT) program to provide greater flexibility for hospitals not located in a rural area that established or establish a medical residency training program (or rural tracks) in a rural area. The program also provides flexibility for hospitals that establish an accredited program where greater than 50 percent of the program occurs in a rural area to partner with rural hospitals and address the physician workforce needs of rural areas.

Medicare GME treatment of hospitals establishing new medical residency training programs after hosting medical resident rotators for short durations

This section allows hospitals to host a limited number of residents for short-term rotations without being negatively impacted by a set permanent full time equivalent (FTE) resident cap or a Per Resident Amount (PRA). A hospital must report full-time equivalent residents on its cost report for a cost reporting period if the hospital trains at least 1.0 full-time-equivalent resident in an approved medical residency training program or programs in such period.

Health Workforce

Health Resources and Services Administration (HRSA) will make $50,000,000 available for grants to public institutions of higher education to expand or support graduate education for physicians provided by such institutions. Priority will be given to public institutions located in states with a projected primary care physician shortage in 2025 and are limited to public institutions in states in the top quintile of states with a projected primary care physician shortage in 2025.

Distribution of additional residency positions

This section supports Medicare physician workforce development by providing for the distribution of 1,000 additional Medicare-funded graduate medical education (GME) residency positions. Not less than 10 percent of the aggregate number of these new positions will be given to each of the following categories: rural hospitals, hospitals that are already above their Medicare cap for residency positions, hospitals in states with new medical schools or new locations and branch campuses, and hospitals that serve Health Professional Shortage Areas. However, a hospital may not receive more than 25 additional full-time equivalent residency positions.[27]

Council on Medical Education Report 7-A-14, "Physician Workforce Shortage: Approaches to GME Financing," outlined the impact of Congressional actions and the Affordable Care Act on expansion of GME, as well as a summary of state-level funding models for GME. Since that time, a number of legislative efforts have been proposed and/or passed to support expansion of GME, including the following two examples.

Rural Residency Planning and Development Grants

In 2019, HRSA awarded approximately $20 million to recipients across 21 states for a three-year period to develop new rural residency programs while achieving program accreditation through the Accreditation Council for Graduate Medical Education. The program is intended to expand the physician workforce in rural areas by developing new, sustainable residencies in family medicine, internal medicine, and psychiatry. Award recipients included rural hospitals; community health centers; health centers operated by the Indian Health Service, Native American tribes or tribal organizations; and schools of medicine. The awards are intended to help recipients address challenges in securing sustainable financing and faculty support.[17]

PROGRAMS TO ADDRESS RURAL PHYSICIAN WORKFORCE SHORTAGES

Federal Efforts to Recruit and Retain Rural Health Physicians

The federal government has established several programs to recruit and retain a diverse workforce and encourage physicians to practice in shortage specialties and underserved communities such as rural settings. These programs include the National Health Service Corps (NHSC), Title VII of the Public Health Service Act, the Conrad 30 Waiver, and Area Health Education Centers (AHECs).

<u>National Health Service Corps (NHSC)</u>

Funded by HRSA, the NHSC awards scholarships and loan repayment to primary care physicians in eligible disciplines. The Consolidated Appropriation Act of 2021 provided an extension for community health centers, the National Health Service Corps, and teaching health centers that operate GME programs. This includes $4 billion in funding from 2019-2023 for community health centers and the National Health Service Corps and provides $310 million in additional funding

from 2021-2023 for the National Health Service Corps. It also provides additional funding, until 2023, for teaching health centers that operate graduate medical education programs. In FY 2019, the NHSC received $319 million in award funding to recruit, retain, and support clinicians serving in high-need areas. These funds were used to pay tuition, eligible fees, other reasonable educational costs, and a living stipend in exchange for a service commitment to work at an NHSC-approved site in a high-need urban, rural, or frontier community for at least two years. Frontier areas are the most remote and sparsely populated places along the rural-urban continuum and are often thought of in terms of population density and distance in minutes and miles to population centers and other resources, such as hospitals. In 2019, the NHSC placed more than 1,750 primary care clinicians in NHSC-approved sites in rural and frontier areas.[28] The NHSC recently implemented the Rural Community Loan Repayment Program (LRP) for physicians working to combat the opioid epidemic in the nation's rural communities. The recent expansion of the NHSC is cause for optimism as more than 75 percent of clinicians in the NHSC report that they plan to stay in the practice where they fulfilled their commitment for loan repayment.[29]

Title VII of the Public Health Service Act

Title VII funding supports rural physician training grants by recruiting students who are most likely to practice medicine in underserved rural communities. Eligible entities are nationally accredited or Secretary of Health and Human Services-approved schools of allopathic or osteopathic medicine or any combination or consortium of such schools. Priority is given to entities that demonstrate (1) an established record of rural community institutional partnerships; (2) having successfully trained students who practice medicine in underserved rural communities; and (3) having a high percentage of graduates from an existing program who practice medicine in underserved rural communities.[30]

Conrad 30 Waiver program

The Conrad 30 Waiver program allows physicians who have completed the J-1 exchange visitor program to apply for a waiver from the two-year residence requirement upon completing their training. J-1 visa physicians can stay in the United States after their training if they get a waiver and practice for three years in an underserved area. These physicians provide the majority of primary care services in underserved rural communities.[31] Legislation is needed to reauthorize and improve the Conrad 30 waiver program to protect patient access to care in medically underserved areas such as rural communities.

Area Health Education Centers (AHECs)

Developed by Congress in 1971, Area Health Education Centers (AHECs) were established to recruit, train, and retain a health professions workforce committed to treating underserved populations. In 1972, Congress initially awarded funds to establish AHEC programs in 11 states. The AHEC program helps bring the resources of academic medicine to address local community health needs. AHECs have a continual focus on improving the health care system by working with academic institutions, health care settings (including community health centers), behavioral health practices, and community-based organizations. Through these long-standing partnerships, AHECs employ traditional and innovative approaches to develop and train a diverse health care workforce prepared to deliver culturally appropriate, high-quality, team-based care, with an emphasis on primary care for rural and underserved communities. Presently, 235 centers across 56 AHEC programs are in operation in almost every state and the District of Columbia.[32] The national AHEC network consists of more than 300 AHEC program offices and centers, serving over 85 percent of the counties in the United States.[33]

Health Professional Shortage Area Physician Bonus Program

To offer an incentive to physicians who work in Medicare Health Professional Shortage Areas (HPSAs), CMS established the Health Professional Shortage Area Physician Bonus Program. The program provides a 10 percent bonus for Medicare-covered services to beneficiaries in a geographic HPSA. Paid quarterly, the bonus is based on the amount paid for professional services.

Additional Efforts to Recruit and Retain Physicians in Rural Areas

Grassroots organizations such as 3RNet have also established resources to support health care recruitment and retention efforts for rural communities. Founded in 1995, 3RNet's mission is to improve rural and underserved communities' access to quality health care through the recruitment and retention of physicians and other health care professionals, development of community-based recruitment and retention activities, and national advocacy on rural and underserved health care workforce issues. To achieve this mission, 3RNet developed a website (https://www.3rnet.org/), which serves as a clearinghouse for its members. Each member maintains state and regional pages within the 3RNet website, providing information about communities, available opportunities for physician employment, and loan repayment programs. Members and health care facilities can post opportunities directly to the website and members can access a candidate database. Notable members include both the Department of Veterans Affairs and the Indian Health Service. 3RNet has also collaborated with the NHSC on recruitment and retention trainings.[34]

The University of North Dakota School of Medicine and Health Sciences Center for Rural Health utilizes the Community Apgar Project (CAP) to assist rural hospitals in North Dakota in identifying strengths and challenges related to recruiting family medicine physicians through a research-validated questionnaire. The CAP was developed by the family medicine residency of Idaho and Boise State University. The University of North Dakota School of Medicine and Health Sciences Department of Family and Community Medicine, the North Dakota Center for Rural Health, and the North Dakota AHEC are currently utilizing the CAP process and methodology to examine what makes a community health care facility a good training environment for health professions education through a new tool called Health Professions Education in Rural Communities (HPERC). HPERC will provide data that can help determine site readiness for developing an educational campus for health professions students.[35]

Rural Training Tracks (RTT) were first established by Providence Northwest Washington Medical Group in 1986 in response to the lack of rural physicians produced by family medicine residency programs. The original "1-2" model provides for one year in an urban sponsoring institution, followed by two years in a more rural location. The initial programs experienced significant hardship due to a lack of funding and a general decline in student interest in family medicine. In response, a federally funded consortium of individuals and programs established the RTT Technical Assistance program (RTT TA) in 2010 to sustain the 1-2 RTT as a national strategy in training physicians for rural practice. While the project ended in August 2016, the RTT TA program was responsible for the creation of the RTT Collaborative, which currently works to sustain health professions education in rural places through mutual encouragement, peer learning, practice improvement, and the delivery of technical expertise, all in support of a quality rural workforce. In addition to providing technical assistance, the RTT Collaborative convenes an annual meeting, which is hosted by a participating program, to provide a collaborative forum for problem solving and innovation for the education of medical professionals in rural areas. A 2013 study found that at least half of RTT graduates reside in rural areas after graduation, two to three times the proportion of family medicine graduates overall, thereby demonstrating that RTTs are beneficial to increasing the supply of rural physicians.[36] A 2016 report found that among RTT

graduates tracked after graduation (2008-2015), more than 35 percent of graduates were practicing in rural areas during most of that time, about twice the proportion of family medicine residency graduates overall. Rural practice choices were also persistent over time. Furthermore, the study found that 56 percent of RTT graduates provided health care in primary care Health Professional Shortage Areas (HPSAs) one year post-graduation, and by seven years post-graduation, 50 percent were still in primary care HPSAs. These findings suggest that graduates of RTT programs provide care to rural and underserved populations at higher proportions than family medicine residency graduates overall, and these practice choices persist over time.[37] Opportunities to cultivate the RTT Collaborative could be explored, as this collaborative provides a pathway to identify, encourage, and incentivize qualified rural physicians to serve as preceptors and volunteer faculty for rural rotations during residency. However, it should also be noted that several ACGME Review Committees are now placing restrictions on distant sites that may impact the ability of urban centers to offer rural rotations.

In 2008, the University of Washington School of Medicine: Washington, Wyoming, Alaska, Montana, and Idaho (WWAMI) Program developed the Targeted Rural Underserved Track (TRUST) initiative to ensure access to health care in rural and underserved areas. TRUST utilizes an innovative four-year rural and underserved medical school curriculum that matches incoming students with a mentor and a community in a rural environment that they will continue to connect with during their four years of medical school. The goal of the TRUST program is to select students with rural and underserved backgrounds who are most likely to return to these areas. The students are also encouraged to choose specialties that serve those areas, generally a primary care specialty such as family medicine, internal medicine, or pediatrics.

Texas Tech University Health Sciences Center School of Medicine developed a rural residency track that provides residents with experience working one on one with a family physician practicing full-spectrum care including: general and preventive medicine, operative procedures, surgical obstetrics, and Texas-Mexico “border medicine” which focuses on improving health and quality of life along the U.S.-Mexico border. The program aims to increase the number of family medicine residents and mental health fellows providing care in both Midland and Odessa as well as rural communities across West Texas and eastern New Mexico.

In 2010, Columbia University College of Physicians and Surgeons and Bassett Medical Center joined forces to launch a new model of medical training to address the severe shortage of rural physicians and train a new generation of doctors capable of leading health systems that promote both quality of practice and cost-effective delivery of care.[38] Students begin their training for 18 months in Manhattan and then head to Cooperstown for two and a half years to obtain clinical training. Students experience both an urban health care setting and a rural health care environment, while being exposed to features not typically part of the medical school curriculum, such as finance, risk management, patient safety, quality improvement, and medical informatics. In addition, every Columbia-Bassett student receives grant funding at a minimum of $30,000 per year for all four years.

In 2019, Oregon Health & Science University (OHSU) and the University of California, Davis (UC Davis) were awarded $1.8 million by the AMA Reimagining Residency grant program to create educational interventions designed to expand access to quality health care between Sacramento and Portland through a network of teaching hospitals and clinics (in mostly rural areas). OHSU and UC Davis partnered to establish a GME collaborative known as the California Oregon Medical Partnership to Address Disparities in Rural Education and Health (COMPADRE). COMPADRE places hundreds of medical students and resident physicians to train with faculty and community physicians at 10 health care systems, 16 hospitals, and a network of Federally Qualified Health

Center partners throughout Northern California and Oregon. The main goals of COMPADRE are to address health care workforce shortages in rural, tribal, urban, and other communities that lack resources; increase access to physicians; and improve the health of patients from ethnic and racial minoritized groups who are disproportionately affected by certain health conditions.[39]

Additionally, the AMA also awarded $1.8 million over five years to the University of North Carolina School of Medicine to support the significant expansion of the Fully Integrated Readiness for Service (FIRST) Program to new geographic areas of North Carolina and additional high needs specialties including family medicine, general surgery, pediatrics, and psychiatry. The FIRST Program was founded in 2015 at the University of North Carolina School of Medicine to link family medicine workforce pathways from medical school to residency and to service in rural/underserved North Carolina. Participating students have the opportunity to complete their medical degree in three years, followed by the opportunity for placement with the Family Medicine Residency program of North Carolina. FIRST scholar graduates commit to three years of service in an underserved area of North Carolina, during which time they receive ongoing support from UNC Family Medicine in partnership with the NC Office of Rural Health and Community Care, AHEC, Piedmont Health Services, and the North Carolina Academy of Family Physicians.

UTILIZATION OF TELEHEALTH TO ADDRESS RURAL PHYSICIAN WORKFORCE SHORTAGES

Telehealth broadly encompasses technology and health care fields that deliver education, health care, and medical services over a distance. Telehealth modalities for physician/patient interaction may be synchronous (live video), asynchronous (store and forward), remote patient monitoring, or mobile health. In addition, telehealth in rural areas provides the ability for physicians to consult with specialists. Telehealth allows for increased access to physicians, specialists, and other health care professionals for patients in rural areas. In July 2016, the AMA conducted a comprehensive study of physicians' motivations and requirements for the adoption of digital clinical tools. The AMA repeated the study in 2019 to determine the degree to which adoption has occurred in the past three years and to identify attitudinal shifts among physicians toward their use and adoption. The 2019 study found an increase in the number of physicians who see a definite advantage in digital tools; significant growth in the adoption of digital tools among all physicians regardless of gender, specialty, or age; increased adoption of remote care tools such as tele-visits and remote monitoring; and fairly high awareness of emerging technologies such as artificial or augmented intelligence.

Despite telehealth's promise as a means by which to alleviate the shortage of rural physicians, prior to the flexibilities provided during the COVID-19 Public Health Emergency (PHE), telehealth faced several barriers that hindered its widespread adoption in rural areas. Medicare's site of service payment differences impact payments for telehealth services. For example, the originating sites, which are based on the patient's location, were paid facility fees and the distant/receiving sites were paid according to the Medicare physician payment schedule. Additionally, infrastructure presents a challenge, in that many rural areas do not have access to adequate broadband service to allow for the use of telehealth. During the PHE, Medicare has allowed patients to receive telehealth services in their homes instead of having to go to a health care facility and has been paying for telehealth services at in-person office rates. The PHE policies are expected to continue at least through the end of 2021, and the AMA is supporting legislation that would make these flexibilities permanent.

As licensure requirements vary by state, the need for physicians to be licensed in multiple states can also present a burden and a barrier to telehealth implementation. To address this, in the past

few years licensure compacts have been implemented in medicine across state lines to allow for provision of telehealth services to patients in these jurisdictions.[40] The Interstate Medical Licensure Compact (IMLC), which the AMA supports, expedites the process for licensure in multiple states. At the time of this report, 29 states, the District of Columbia, and Guam are members of the IMLC, and six other states have introduced legislation to adopt the IMLC this year. One of the promises of the IMLC is to reduce the burden of obtaining multiple state licenses to practice telehealth, while maintaining the important state-based licensure structure.

Credentialing and privileging are also challenging in telehealth delivery in rural locations due to the costs associated with credentialing. While the Centers for Medicare & Medicaid Services (CMS) approved proxy credentialing in 2011, not all state policies align with proxy credentialing, so this will remain a challenge in some areas.[41]

Despite these challenges, innovative models of health care delivery are being developed through telehealth. For example, telehealth provider Avera eCARE partners with health care systems, rural hospitals, outpatient clinics, and long-term care facilities to reach medically underserved populations in South Dakota, North Dakota, Minnesota, Iowa, Nebraska, Montana, Wyoming, and Kansas through telehealth. Avera eCARE has also expanded to include telehealth services for intensive care, emergency departments, pharmacy, long-term care, and correctional facilities. Avera eCARE programs seek to improve efficiencies while decreasing physician burnout and turnover and keeping patients closer to home, all while improving quality of care.

Using telehealth in intensive care units (ICUs) began in 1982 when the first clinical trial was conducted by Grundy et al. In Alaska, Providence Alaska Medical Center established in 2009 the eICU system, a patient monitoring system that uses telehealth to help care for critically ill patients in multiple hospitals from a single location. It is staffed with experienced intensivists and critical care nurses who monitor patients' vital signs, medications, test results, and other data, continuously analyzing their conditions. This allows critical care specialists to alert clinical staff at the bedside to potential problems before they occur and to guide interventions. The eICU allows staff in Anchorage, Alaska to help treat patients at three other hospitals in remote locations, while also adding an extra layer of care for patients in the Anchorage ICU. It costs Providence $2 million a year to operate the system; the rural hospitals pay about $40,000 a year to connect each bed to the system. Research shows that these monies are well spent. A 2011 study in *JAMA* found that eICUs prevent deaths by helping doctors follow best clinical practices and showed that eICUs cut two days off the average length of an ICU stay.[42]

Project ECHO® (Extension for Community Healthcare Outcomes) was created in 2003 to increase chronic disease management capacity in rural New Mexico for patients with hepatitis C. To treat as many such patients as possible, Project ECHO provided a free educational model and mentored community physicians across New Mexico in how to treat patients with this condition. A 2011 study in the *New England Journal of Medicine* found that hepatitis C care provided by Project ECHO-trained community physicians was as good as care provided by specialists at a university.[43] The Project ECHO model utilizes telementoring, a guided practice model through which the participating clinician retains responsibility for managing the patient. Its principles include appropriate use of technology to leverage scarce resources, sharing best practices to reduce disparity, case-based learning to master complexity, and use of a web-based database to monitor outcomes and the program has been expanded to address other clinical needs beyond hepatitis C care.

Utilization of Technology to Enhance Educational Needs for Rural Training Programs

The PHE necessitated a sudden transition to remote learning in medical schools, and distance E-learning emerged as a new method of teaching to maintain the continuity of medical education. Distance E-Learning is defined as using computer technology to deliver training, including technology-supported learning—either online, offline, or both.[44] Distance E-learning may be beneficial in enhancing educational opportunities for trainees in rural training programs and support alignment with the ACGME Common Program Requirements for scholarship by increasing access to scholarly activities on quality improvement, population health, and teaching, in addition to more classic forms of biomedical research as the focus for scholarship.

Alternative Workforce Initiatives to Address the Physician Shortage in Rural Areas

One approach to meeting demand for primary care is a redefinition, and often expansion, of the scope of practice and licensure for non-physician practitioners, such as nurse practitioners and physician assistants. Many states have taken steps to increase the procedures, treatments, actions, processes, and authority that are permitted by law, regulation, and licensure for non-physician primary care providers. According to the AMA Advocacy Resource Center, 16 states require physician supervision or collaboration of nurse practitioners (NPs) to diagnose, treat, and prescribe; 10 states require physician supervision or collaboration of NPs to prescribe; 10 states require physician supervision or collaboration for a certain number of hours or years; and 15 states plus the District of Columbia allow NPs to practice independently.

DISCUSSION

Rural communities experience significant health disparities due to a number of institutional and structural factors, such as limited access to health care specialists and subspecialists and limited job opportunities for rural residents. According to the Centers for Disease Control and Prevention (CDC), rates for the five leading causes of death in the United States—heart disease, cancer, unintentional injury (including vehicle accidents and opioid overdoses), chronic lower respiratory disease, and stroke—are higher in rural communities.[45] This inequality is intensified as rural residents are less likely to have employer-provided health insurance coverage and, if they are poor, are often not covered by Medicaid. Unfortunately, the supply of rural physicians has not met the demand for health care services among these communities. To meet this need, investments are needed to increase the number of students from rural areas and other students committed to rural and family medicine who are enrolled in medical school and to increase resident exposure to rural practice opportunities.

The current structure of medical education is predominately based in metropolitan areas and disproportionately exposes future physicians to medical practice in urban and suburban settings.[3] While recruitment efforts have focused on strengthening the career pathways for those populations traditionally underrepresented in medicine (URM), these efforts tend to target racial and ethnic groups rather than explicitly targeting students from rural areas. Opportunities to increase rural students' exposure to careers in medicine should be explored to help expand rural physician pathways. Additionally, medical schools should consider rural background as an important component of a diverse student body. Medical schools should consider widespread adoption of holistic admissions practices that value a broad set of life and leadership experiences among applicants.

Beyond educational interventions, efforts should be made to decrease rural hospital closures, as physicians are not likely to practice in an area that is remote from a hospital. There is a symbiotic

relationship between physicians and hospitals; research has found that rural hospital closures are associated with long-term decreases in the supply of rural physicians. Rural hospitals in states that had expanded Medicaid as of April 2018 were less likely to close compared to rural hospitals in states that had not expanded Medicaid. At the time this report was drafted, the North Carolina Rural Health Research Program had identified 163 rural hospital closures, 35 percent of which have occurred since 2016. In its 2018 report, the GAO found that from 2013 through 2017 rural hospitals located in the U.S. South represented 77 percent of rural hospital closures; Medicare Dependent Hospitals accounted for 25 percent; and for-profit rural hospitals 36 percent.

Addressing this issue is essential to ensuring an adequate supply of physicians for rural areas. The Association of State and Territorial Health Officials (ASTHO) reports that states are using a variety of measures to prevent rural hospital closures, including tax incentives, technical assistance, and increased Medicaid reimbursement rates. States are also working to improve rural health care access by creating new licensure options, reducing regulatory barriers for clinics that serve rural populations, and exploring legislation that would recruit and train a rural health workforce.[46]

RELEVANT AMA POLICY

Our AMA has numerous existing policies and directives that are relevant to the topic of rural health; these are shown in the appendix.

SUMMARY AND RECOMMENDATIONS

Addressing the gap of rural health services in the U.S. requires a multifaceted approach. In its role as convener of key organizations and stakeholders, our AMA continues to work to help identify ways to encourage and incentivize qualified physicians to practice in our nation's underserved areas. In addition, our AMA continues to advocate for state and national legislative action and other efforts that (1) expand the health careers pathways for Americans in rural areas and others interested in serving these populations; (2) fund residency training in rural areas; (3) promote telehealth and training in telehealth as a promising paradigm to bridge the gaps in care in rural areas; and (4) address the rising tide of rural hospital closures that threatens to further weaken the health care infrastructure in the rural U.S.

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

1. That our AMA amend Policy H-465.988, "Educational Strategies for Meeting Rural Health Physician Shortage," by addition and deletion to read as follows: ~~Our AMA will undertake a study of issues regarding rural physician workforce shortages, including federal payment policy issues, and other causes and potential remedies (such as telehealth) to alleviate rural physician workforce shortages.~~ (4) Our AMA will encourage ACGME review committees to consider adding exposure to rural medicine as appropriate, to encourage the development of rural program tracks in training programs and increase physician awareness of the conditions that pose challenges and lack of resources in rural areas. (5) Our AMA will encourage adding educational webinars, workshops and other didactics via remote learning formats to enhance the educational needs of smaller training programs. (Modify Current HOD Policy)

2. That our AMA monitor the status and outcomes of the 2020 Census to assess the impact of physician supply and patient demand in rural communities. (Directive to Take Action)

3. That our AMA amend Policy H-200.954, "US Physician Shortage," by addition to read as follows: "(13) will monitor the impact of initiatives to address rural physician workforce shortages." (Modify Current HOD Policy)

4. That our AMA reaffirm Policy H-465.988, "Educational Strategies for Meeting Rural Health Physician Shortage," which states, in part "(1.a) Our AMA encourage medical schools and residency programs to develop educationally sound rural clinical preceptorships and rotations consistent with educational and training requirements, and to provide early and continuing exposure to those programs for medical students and residents. (1.b) Our AMA encourage medical schools to develop educationally sound primary care residencies in smaller communities with the goal of educating and recruiting more rural physicians." (Reaffirm HOD Policy).

Fiscal note: $500.

APPENDIX: RELEVANT AMA POLICY

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

1. Our AMA will actively collaborate with appropriate stakeholder organizations, (including Association of American Medical Colleges, American Hospital Association, state medical societies, medical specialty societies/associations) to advocate for the preservation, stability and expansion of full funding for the direct and indirect costs of graduate medical education (GME) positions from all existing sources (e.g. Medicare, Medicaid, Veterans Administration, CDC and others).
2. Our AMA will actively advocate for the stable provision of matching federal funds for state Medicaid programs that fund GME positions.
3. Our AMA will actively seek congressional action to remove the caps on Medicare funding of GME positions for resident physicians that were imposed by the Balanced Budget Amendment of 1997 (BBA-1997).
4. Our AMA will strenuously advocate for increasing the number of GME positions to address the future physician workforce needs of the nation.
5. Our AMA will oppose efforts to move federal funding of GME positions to the annual appropriations process that is subject to instability and uncertainty.
6. Our AMA will oppose regulatory and legislative efforts that reduce funding for GME from the full scope of resident educational activities that are designated by residency programs for accreditation and the board certification of their graduates (e.g. didactic teaching, community service, off-site ambulatory rotations, etc.).
7. Our AMA will actively explore additional sources of GME funding and their potential impact on the quality of residency training and on patient care.
8. Our AMA will vigorously advocate for the continued and expanded contribution by all payers for health care (including the federal government, the states, and local and private sources) to fund both the direct and indirect costs of GME.
9. Our AMA will work, in collaboration with other stakeholders, to improve the awareness of the general public that GME is a public good that provides essential services as part of the training process and serves as a necessary component of physician preparation to provide patient care that is safe, effective and of high quality.
10. Our AMA staff and governance will continuously monitor federal, state and private proposals for health care reform for their potential impact on the preservation, stability and expansion of full funding for the direct and indirect costs of GME.
11. Our AMA: (a) recognizes that funding for and distribution of positions for GME are in crisis in the United States and that meaningful and comprehensive reform is urgently needed; (b) will immediately work with Congress to expand medical residencies in a balanced fashion based on expected specialty needs throughout our nation to produce a geographically distributed and appropriately sized physician workforce; and to make increasing support and funding for GME programs and residencies a top priority of the AMA in its national political agenda; and (c) will continue to work closely with the Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, American Osteopathic Association, and other key stakeholders to raise awareness among policymakers and the public about the importance of expanded GME funding to meet the nation's current and anticipated medical workforce needs.
12. Our AMA will collaborate with other organizations to explore evidence-based approaches to quality and accountability in residency education to support enhanced funding of GME.
13. Our AMA will continue to strongly advocate that Congress fund additional graduate medical education (GME) positions for the most critical workforce needs, especially considering the current and worsening maldistribution of physicians.

14. Our AMA will advocate that the Centers for Medicare and Medicaid Services allow for rural and other underserved rotations in Accreditation Council for Graduate Medical Education (ACGME)-accredited residency programs, in disciplines of particular local/regional need, to occur in the offices of physicians who meet the qualifications for adjunct faculty of the residency program's sponsoring institution.
15. Our AMA encourages the ACGME to reduce barriers to rural and other underserved community experiences for graduate medical education programs that choose to provide such training, by adjusting as needed its program requirements, such as continuity requirements or limitations on time spent away from the primary residency site.
16. Our AMA encourages the ACGME and the American Osteopathic Association (AOA) to continue to develop and disseminate innovative methods of training physicians efficiently that foster the skills and inclinations to practice in a health care system that rewards team-based care and social accountability.
17. Our AMA will work with interested state and national medical specialty societies and other appropriate stakeholders to share and support legislation to increase GME funding, enabling a state to accomplish one or more of the following: (a) train more physicians to meet state and regional workforce needs; (b) train physicians who will practice in physician shortage/underserved areas; or (c) train physicians in undersupplied specialties and subspecialties in the state/region.
18. Our AMA supports the ongoing efforts by states to identify and address changing physician workforce needs within the GME landscape and continue to broadly advocate for innovative pilot programs that will increase the number of positions and create enhanced accountability of GME programs for quality outcomes.
19. Our AMA will continue to work with stakeholders such as Association of American Medical Colleges (AAMC), ACGME, AOA, American Academy of Family Physicians, American College of Physicians, and other specialty organizations to analyze the changing landscape of future physician workforce needs as well as the number and variety of GME positions necessary to provide that workforce.
20. Our AMA will explore innovative funding models for incremental increases in funded residency positions related to quality of resident education and provision of patient care as evaluated by appropriate medical education organizations such as the Accreditation Council for Graduate Medical Education.
21. Our AMA will utilize its resources to share its content expertise with policymakers and the public to ensure greater awareness of the significant societal value of graduate medical education (GME) in terms of patient care, particularly for underserved and at-risk populations, as well as global health, research and education.
22. Our AMA will advocate for the appropriation of Congressional funding in support of the National Health care Workforce Commission, established under section 5101 of the Affordable Care Act, to provide data and health care workforce policy and advice to the nation and provide data that support the value of GME to the nation.
23. Our AMA supports recommendations to increase the accountability for and transparency of GME funding and continue to monitor data and peer-reviewed studies that contribute to further assess the value of GME.
24. Our AMA will explore various models of all-payer funding for GME, especially as the Institute of Medicine (now a program unit of the National Academy of Medicine) did not examine those options in its 2014 report on GME governance and financing.
25. Our AMA encourages organizations with successful existing models to publicize and share strategies, outcomes and costs.
26. Our AMA encourages insurance payers and foundations to enter into partnerships with state and local agencies as well as academic medical centers and community hospitals seeking to expand GME.

27. Our AMA will develop, along with other interested stakeholders, a national campaign to educate the public on the definition and importance of graduate medical education, student debt and the state of the medical profession today and in the future.
28. Our AMA will collaborate with other stakeholder organizations to evaluate and work to establish consensus regarding the appropriate economic value of resident and fellow services.
29. Our AMA will monitor ongoing pilots and demonstration projects, and explore the feasibility of broader implementation of proposals that show promise as alternative means for funding physician education and training while providing appropriate compensation for residents and fellows.
30. Our AMA will monitor the status of the House Energy and Commerce Committee's response to public comments solicited regarding the 2014 IOM report, Graduate Medical Education That Meets the Nation's Health Needs, as well as results of ongoing studies, including that requested of the GAO, in order to formulate new advocacy strategy for GME funding, and will report back to the House of Delegates regularly on important changes in the landscape of GME funding.
31. Our AMA will advocate to the Centers for Medicare & Medicaid Services to adopt the concept of Cap-Flexibility and allow new and current Graduate Medical Education teaching institutions to extend their cap-building window for up to an additional five years beyond the current window (for a total of up to ten years), giving priority to new residency programs in underserved areas and/or economically depressed areas.
32. Our AMA will: (a) encourage all existing and planned allopathic and osteopathic medical schools to thoroughly research match statistics and other career placement metrics when developing career guidance plans; (b) strongly advocate for and work with legislators, private sector partnerships, and existing and planned osteopathic and allopathic medical schools to create and fund graduate medical education (GME) programs that can accommodate the equivalent number of additional medical school graduates consistent with the workforce needs of our nation; and (c) encourage the Liaison Committee on Medical Education (LCME), the Commission on Osteopathic College Accreditation (COCA), and other accrediting bodies, as part of accreditation of allopathic and osteopathic medical schools, to prospectively and retrospectively monitor medical school graduates rates of placement into GME as well as GME completion.
33. Our AMA encourages the Secretary of the U.S. Department of Health and Human Services to coordinate with federal agencies that fund GME training to identify and collect information needed to effectively evaluate how hospitals, health systems, and health centers with residency programs are utilizing these financial resources to meet the nation’s health care workforce needs. This includes information on payment amounts by the type of training programs supported, resident training costs and revenue generation, output or outcomes related to health workforce planning (i.e., percentage of primary care residents that went on to practice in rural or medically underserved areas), and measures related to resident competency and educational quality offered by GME training programs.

D-400.985, “Geographic Practice Cost Index”

Our AMA will: (1) use the AMA Physician Practice Information Survey to determine actual differences in rural vs. urban practice expenses; (2) seek Congressional authorization of a detailed study of the way rents are reflected in the Geographic Practice Cost Index (GPCI); (3) advocate that payments under physician quality improvement initiatives not be subject to existing geographic variation adjustments (i.e., GPCIs); and (4) provide annual updates on the Centers for Medicare and Medicaid Services efforts to improve the accuracy of Medicare Economic Index weights and geographic adjustments and their impact on the physician payment schedule, and AMA advocacy efforts on these issues.

D-400.989, "Equal Pay for Equal Work"

Our AMA: (1) shall make its first legislative priority to fix the Medicare payment update problem because this is the most immediate means of increasing Medicare payments to physicians in rural states and will have the greatest impact; (2) shall seek enactment of legislation directing the General Accounting Office to develop and recommend to Congress policy options for reducing any unjustified geographic disparities in Medicare physician payment rates and improving physician recruitment and retention in underserved rural areas; and (3) shall advocate strongly to the current administration and Congress that additional funds must be put into the Medicare physician payment system and that continued budget neutrality is not an option.

H-200.949, Principles of and Actions to Address Primary Care Workforce

1. Our patients require a sufficient, well-trained supply of primary care physicians--family physicians, general internists, general pediatricians, and obstetricians/gynecologists--to meet the nation's current and projected demand for health care services.
2. To help accomplish this critical goal, our American Medical Association (AMA) will work with a variety of key stakeholders, to include federal and state legislators and regulatory bodies; national and state specialty societies and medical associations, including those representing primary care fields; and accreditation, certification, licensing, and regulatory bodies from across the continuum of medical education (undergraduate, graduate, and continuing medical education).
3. Through its work with these stakeholders, our AMA will encourage development and dissemination of innovative models to recruit medical students interested in primary care, train primary care physicians, and enhance both the perception and the reality of primary care practice, to encompass the following components: a) Changes to medical school admissions and recruitment of medical students to primary care specialties, including counseling of medical students as they develop their career plans; b) Curriculum changes throughout the medical education continuum; c) Expanded financial aid and debt relief options; d) Financial and logistical support for primary care practice, including adequate reimbursement, and enhancements to the practice environment to ensure professional satisfaction and practice sustainability; and e) Support for research and advocacy related to primary care.
4. Admissions and recruitment: The medical school admissions process should reflect the specific institution's mission. Those schools with missions that include primary care should consider those predictor variables among applicants that are associated with choice of these specialties.
5. Medical schools, through continued and expanded recruitment and outreach activities into secondary schools, colleges, and universities, should develop and increase the pool of applicants likely to practice primary care by seeking out those students whose profiles indicate a likelihood of practicing in primary care and underserved areas, while establishing strict guidelines to preclude discrimination.
6. Career counseling and exposure to primary care: Medical schools should provide to students career counseling related to the choice of a primary care specialty, and ensure that primary care physicians are well-represented as teachers, mentors, and role models to future physicians.
7. Financial assistance programs should be created to provide students with primary care experiences in ambulatory settings, especially in underserved areas. These could include funded preceptorships or summer work/study opportunities.
8. Curriculum: Voluntary efforts to develop and expand both undergraduate and graduate medical education programs to educate primary care physicians in increasing numbers should be continued. The establishment of appropriate administrative units for all primary care specialties should be encouraged.

9. Medical schools with an explicit commitment to primary care should structure the curriculum to support this objective. At the same time, all medical schools should be encouraged to continue to change their curriculum to put more emphasis on primary care.
10. All four years of the curriculum in every medical school should provide primary care experiences for all students, to feature increasing levels of student responsibility and use of ambulatory and community-based settings.
11. Federal funding, without coercive terms, should be available to institutions needing financial support to expand resources for both undergraduate and graduate medical education programs designed to increase the number of primary care physicians. Our AMA will advocate for public (federal and state) and private payers to a) develop enhanced funding and related incentives from all sources to provide education for medical students and resident/fellow physicians, respectively, in progressive, community-based models of integrated care focused on quality and outcomes (such as the patient-centered medical home and the chronic care model) to enhance primary care as a career choice; b) fund and foster innovative pilot programs that change the current approaches to primary care in undergraduate and graduate medical education, especially in urban and rural underserved areas; and c) evaluate these efforts for their effectiveness in increasing the number of students choosing primary care careers and helping facilitate the elimination of geographic, racial, and other health care disparities.
12. Medical schools and teaching hospitals in underserved areas should promote medical student and resident/fellow physician rotations through local family health clinics for the underserved, with financial assistance to the clinics to compensate their teaching efforts.
13. The curriculum in primary care residency programs and training sites should be consistent with the objective of training generalist physicians. Our AMA will encourage the Accreditation Council for Graduate Medical Education to (a) support primary care residency programs, including community hospital-based programs, and (b) develop an accreditation environment and novel pathways that promote innovations in graduate medical education, using progressive, community-based models of integrated care focused on quality and outcomes (such as the patient-centered medical home and the chronic care model).
14. The visibility of primary care faculty members should be enhanced within the medical school, and positive attitudes toward primary care among all faculty members should be encouraged.
15. Support for practicing primary care physicians: Administrative support mechanisms should be developed to assist primary care physicians in the logistics of their practices, along with enhanced efforts to reduce administrative activities unrelated to patient care, to help ensure professional satisfaction and practice sustainability.
16. There should be increased financial incentives for physicians practicing primary care, especially those in rural and urban underserved areas, to include scholarship or loan repayment programs, relief of professional liability burdens, and Medicaid case management programs, among others. Our AMA will advocate to state and federal legislative and regulatory bodies, among others, for development of public and/or private incentive programs, and expansion and increased funding for existing programs, to further encourage practice in underserved areas and decrease the debt load of primary care physicians. The imposition of specific outcome targets should be resisted, especially in the absence of additional support to the schools.
17. Our AMA will continue to advocate, in collaboration with relevant specialty societies, for the recommendations from the AMA/Specialty Society RVS Update Committee (RUC) related to reimbursement for E&M services and coverage of services related to care coordination, including patient education, counseling, team meetings and other functions; and work to ensure that private payers fully recognize the value of E&M services, incorporating the RUC-recommended increases adopted for the most current Medicare RBRVS.
18. Our AMA will advocate for public (federal and state) and private payers to develop physician reimbursement systems to promote primary care and specialty practices in progressive, community-based models of integrated care focused on quality and outcomes such as the patient-

centered medical home and the chronic care model consistent with current AMA Policies H-160.918 and H-160.919.
19. There should be educational support systems for primary care physicians, especially those practicing in underserved areas.
20. Our AMA will urge urban hospitals, medical centers, state medical associations, and specialty societies to consider the expanded use of mobile health care capabilities.
21. Our AMA will encourage the Centers for Medicare & Medicaid Services to explore the use of telemedicine to improve access to and support for urban primary care practices in underserved settings.
22. Accredited continuing medical education providers should promote and establish continuing medical education courses in performing, prescribing, interpreting and reinforcing primary care services.
23. Practicing physicians in other specialties--particularly those practicing in underserved urban or rural areas--should be provided the opportunity to gain specific primary care competencies through short-term preceptorships or postgraduate fellowships offered by departments of family medicine, internal medicine, pediatrics, etc., at medical schools or teaching hospitals. In addition, part-time training should be encouraged, to allow physicians in these programs to practice concurrently, and further research into these concepts should be encouraged.
24. Our AMA supports continued funding of Public Health Service Act, Title VII, Section 747, and encourages advocacy in this regard by AMA members and the public.
25. Research: Analysis of state and federal financial assistance programs should be undertaken, to determine if these programs are having the desired workforce effects, particularly for students from disadvantaged groups and those that are underrepresented in medicine, and to gauge the impact of these programs on elimination of geographic, racial, and other health care disparities. Additional research should identify the factors that deter students and physicians from choosing and remaining in primary care disciplines. Further, our AMA should continue to monitor trends in the choice of a primary care specialty and the availability of primary care graduate medical education positions. The results of these and related research endeavors should support and further refine AMA policy to enhance primary care as a career choice.

H-200.954, "US Physician Shortage"

Our AMA:
(1) explicitly recognizes the existing shortage of physicians in many specialties and areas of the US;
(2) supports efforts to quantify the geographic maldistribution and physician shortage in many specialties;
(3) supports current programs to alleviate the shortages in many specialties and the maldistribution of physicians in the US;
(4) encourages medical schools and residency programs to consider developing admissions policies and practices and targeted educational efforts aimed at attracting physicians to practice in underserved areas and to provide care to underserved populations;
(5) encourages medical schools and residency programs to continue to provide courses, clerkships, and longitudinal experiences in rural and other underserved areas as a means to support educational program objectives and to influence choice of graduates' practice locations;
(6) encourages medical schools to include criteria and processes in admission of medical students that are predictive of graduates' eventual practice in underserved areas and with underserved populations;
(7) will continue to advocate for funding from public and private payers for educational programs that provide experiences for medical students in rural and other underserved areas;

(8) will continue to advocate for funding from all payers (public and private sector) to increase the number of graduate medical education positions in specialties leading to first certification;
(9) will work with other groups to explore additional innovative strategies for funding graduate medical education positions, including positions tied to geographic or specialty need;
(10) continues to work with the Association of American Medical Colleges (AAMC) and other relevant groups to monitor the outcomes of the National Resident Matching Program; and
(11) continues to work with the AAMC and other relevant groups to develop strategies to address the current and potential shortages in clinical training sites for medical students.
(12) will: (a) promote greater awareness and implementation of the Project ECHO (Extension for Community Health care Outcomes) and Child Psychiatry Access Project models among academic health centers and community-based primary care physicians; (b) work with stakeholders to identify and mitigate barriers to broader implementation of these models in the United States; and (c) monitor whether health care payers offer additional payment or incentive payments for physicians who engage in clinical practice improvement activities as a result of their participation in programs such as Project ECHO and the Child Psychiatry Access Project; and if confirmed, promote awareness of these benefits among physicians.

H-200.972, "Primary Care Physicians in Underserved Areas"

1. Our AMA should pursue the following plan to improve the recruitment and retention of physicians in underserved areas:
(a) Encourage the creation and pilot-testing of school-based, faith-based, and community-based urban/rural family health clinics, with an emphasis on health education, prevention, primary care, and prenatal care.
(b) Encourage the affiliation of these family health clinics with local medical schools and teaching hospitals.
(c) Advocate for the implementation of AMA policy that supports extension of the rural health clinic concept to urban areas with appropriate federal agencies.
(d) Encourage the AMA Senior Physicians Section to consider the involvement of retired physicians in underserved settings, with appropriate mechanisms to ensure their competence.
(e) Urge hospitals and medical societies to develop opportunities for physicians to work part-time to staff health clinics that help meet the needs of underserved patient populations.
(f) Encourage the AMA and state medical associations to incorporate into state and federal health system reform legislative relief or immunity from professional liability for senior, part-time, or other physicians who help meet the needs of underserved patient populations.
(g) Urge hospitals and medical centers to seek out the use of available military health care resources and personnel, which can be used to help meet the needs of underserved patient populations.
2. Our AMA supports efforts to: (a) expand opportunities to retain international medical graduates after the expiration of allocated periods under current law; and (b) increase the recruitment and retention of physicians practicing in federally designated health professional shortage areas.

H. 240.971, "Elimination of Payment Differentials Between Urban and Rural Medical Care"

Our AMA (1) supports elimination of Medicare reimbursement differentials between urban and rural medical care; and (2) supports efforts to inform the Congress of the impact of such programs on the rural population.

H-400.988, "Medicare Reimbursement, Geographical Differences"

The AMA reaffirms its policy that geographic variations under a Medicare payment schedule should reflect only valid and demonstrable differences in physician practice costs, especially liability premiums, with other non-geographic practice cost index (GPCI) -based adjustments as needed to remedy demonstrable access problems in specific geographic areas.
(Sub. Res. 82, A-89 Reaffirmed: BOT Rep. DD, I-92 Reaffirmed: CMS Rep. 10, A-03 Reaffirmation A-06 Reaffirmation I-07 Reaffirmation A-08 Reaffirmation A-09 Reaffirmed: BOT Action in response to referred for decision Res. 212, A-09 Modified: CMS Rep. 4, A-11 Reaffirmed: CMS Rep. 1, I-11 Reaffirmed in lieu of Res. 122, A-12 Reaffirmed in lieu of Res. 113, A-13)

H-465.979, "Economic Viability of Rural Sole Community Hospitals"

Our AMA: (1) recognizes that economically viable small rural hospitals are critical to preserving patient access to high-quality care and provider sustainability in rural communities; and (2) supports the efforts of organizations advocating directly on behalf of small rural hospitals provided that the efforts are consistent with AMA policy.

H-465.980, "Rural Community Health Networks"

AMA policy is that development of rural community health networks be organized using the following principles: (1) Local delivery systems should be organized around the physical, mental and social needs of the community; (2) Clinical decision-making and financial management should reside within the community health network whenever feasible with physicians retaining responsibility for a network's medical, quality and utilization management; (3) Savings generated by community health networks should be reinvested in the local health care delivery system, rather than redirected elsewhere, since rural health systems and economies are fundamentally intertwined; (4) Patients should retain access to the spectrum of local health services, thereby preserving patient-physician relationships and continuity of care; and (5) Participation in rural community health networks should be voluntary, but open to all qualified rural physicians and other health care providers wishing to participate.

H-465.981, "Enhancing Rural Physician Practices"

The AMA: (1) supports legislation to extend the 10% Medicare payment bonus to physicians practicing in rural counties and other areas where the poverty rate exceeds a certain threshold, regardless of the areas' Health Professional Shortage Area (HPSA) status; (2) encourages federal and state governments to make available low interest loans and other financial assistance to assist physicians with shortage area practices in defraying their costs of compliance with requirements of the Occupational Safety and Health Administration, Americans with Disabilities Act and other national or state regulatory requirements; (3) will explore the feasibility of supporting the legislative and/or regulatory changes necessary to establish a waiver process through which shortage area practices can seek exemption from specific elements of regulatory requirements when improved access, without significant detriment to quality, will result; and (4) supports legislation that would allow shortage area physician practices to qualify as Rural Health Clinics without the need to employ one or more physician extenders.

H-465.982, "Rural Health"

The AMA: (1) encourages state medical associations to study the relevance of managed competition proposals to meeting health care needs of their rural populations; (2) encourages state associations to work with their respective state governments to implement rural health demonstration projects; and (3) will provide all adequate resources to assist state associations in dealing with managed competition in rural areas.

H-465.989, "Rural Health"

It is the policy of the AMA that: (1) the AMA closely monitor the impact of balance billing restrictions mandated by the Budget Reconciliation legislation on reimbursement levels and access to care in rural areas, and take action as needed to moderate that impact; (2) the AMA closely monitor implementation of the legislation establishing essential access community hospitals and rural primary care hospitals, to ensure that this program is implemented in a manner conducive to high quality of patient care and consistent with Association policy concerning the functions and supervision of physician assistants and nurse practitioners; (3) state medical associations be encouraged to monitor similarly and to influence any legislation or regulations governing the development and operation of such limited service rural hospital facilities in their own jurisdictions; and (4) the AMA establish liaison with the American Hospital Association, Congress and the Centers for Medicare & Medicaid Services regarding any further development of essential access community hospitals and rural primary care hospitals grants.

H-465.990, "Closing of Small Rural Hospitals"

Our AMA encourages legislation to reduce the financial constraints on small rural hospitals in order to improve access to health care.

H-465.994, "Improving Rural Health"

1. Our AMA (a) supports continued and intensified efforts to develop and implement proposals for improving rural health care, (b) urges physicians practicing in rural areas to be actively involved in these efforts, and (c) advocates widely publicizing AMA's policies and proposals for improving rural health care to the profession, other concerned groups, and the public.

2. Our AMA will work with other entities and organizations interested in public health to:
- Identify and disseminate concrete examples of administrative leadership and funding structures that support and optimize local, community-based rural public health.
- Develop an actionable advocacy plan to positively impact local, community-based rural public health including but not limited to the development of rural public health networks, training of current and future rural physicians in core public health techniques and novel funding mechanisms to support public health initiatives that are led and managed by local public health authorities.
- Study efforts to optimize rural public health.

H.465.997, "Access to and Quality of Rural Health Care"

(1) Our AMA believes that solutions to access problems in rural areas should be developed through the efforts of voluntary local health planning groups, coordinated at the regional or state level by a similar voluntary health planning entity. Regional or statewide coordination of local efforts will not only help to remedy a particular community's problems, but will

also help to avoid and, if necessary, resolve existing duplication of health care resources. (2) In addition to local solutions, our AMA believes that on a national level, the implementation of Association policy for providing the uninsured and underinsured with adequate protection against health care expense would be an effective way to help maintain and improve access to care for residents of economically depressed rural areas who lack adequate health insurance coverage. Efforts to place National Health Service Corps physicians in underserved areas of the country should also be continued.

D-255.985, "Conrad 30 - J-1 Visa Waivers"

1. Our AMA will: (A) lobby for the reauthorization of the Conrad 30 J-1 Visa Waiver Program; (B) advocate that the J-1 Visa waiver slots be increased from 30 to 50 per state; (C) advocate for expansion of the J-1 Visa Waiver Program to allow IMGs to serve on the faculty of medical schools and residency programs in geographic areas or specialties with workforce shortages; (D) publish on its website J-1 visa waiver (Conrad 30) statistics and information provided by state Conrad 30 administrators along with a frequently asked questions (FAQs) document about the Conrad 30 program; (E) advocate for solutions to expand the J-1 Visa Waiver Program to increase the overall number of waiver positions in the US in order to increase the number of IMGs who are willing to work in underserved areas to alleviate the physician workforce shortage; (F) work with the Educational Commission for Foreign Medical Graduates and other stakeholders to facilitate better communication and information sharing among Conrad 30 administrators, IMGs, US Citizenship and Immigration Services and the State Department; and (G) continue to communicate with the Conrad 30 administrators and IMGS members to share information and best practices in order to fully utilize and expand the Conrad 30 program.
2. Our AMA will continue to monitor legislation and provide support for improvements to the J-1 Visa Waiver program.
3. Our AMA will continue to promote its educational or other relevant resources to IMGs participating or considering participating in J-1 Visa waiver programs.
4. As a benefit of membership, our AMA will provide advice and information on Federation and other resources (but not legal opinions or representation), as appropriate to IMGs in matters pertaining to work-related abuses.
5. Our AMA encourages IMGs to consult with their state medical society and consider requesting that their state society ask for assistance by the AMA Litigation Center, if it meets the Litigation Center's established case selection criteria.

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REPORT 4 OF THE COUNCIL ON MEDICAL EDUCATION (November 2021)
Medical Student Debt and Career Choice
(Reference Committee C)

EXECUTIVE SUMMARY

American Medical Association (AMA) Policy H-305.925 (22), "Principles of and Actions to Address Medical Education Costs and Student Debt," asks our AMA to:

> Formulate a task force to look at undergraduate medical education training as it relates to career choice, and develop new polices and novel approaches to prevent debt from influencing specialty and subspecialty choice.

To implement the policy, the Council on Medical Education developed a task force comprising representatives of AMA member sections as well as the National Association of Advisors for the Health Professions. The task force held two calls, in April and July, to review the literature on this topic, discuss the issues and potential solutions, and develop recommendations for consideration by the Council on Medical Education.

The task force reflected on a multitude of issues related to medical student career choice and the influence of debt; these include trends in medical student debt, gaps in financial literacy among medical students, the potential role of debt on diversity of the medical profession, and the impact of loan forgiveness programs and free medical school tuition.

Although high levels of medical school debt are a personal concern from a financial perspective for many medical students, trainees, and physicians, the ultimate impact of debt on career choice is variable and is not strongly associated with specialty selection. The Council on Medical Education will continue to monitor the literature and data regarding the influence of medical education debt on the physician workforce, especially with regard to the potentially intersecting impacts of race/ethnicity, socioeconomic status, and other key sociodemographic factors.

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 4-N-21

Subject: Medical Student Debt and Career Choice

Presented by: Niranjan Rao, MD, Chair

Referred to: Reference Committee C

American Medical Association (AMA) Policy H-305.925 (22), "Principles of and Actions to Address Medical Education Costs and Student Debt," asks our AMA to:

> Formulate a task force to look at undergraduate medical education training as it relates to career choice, and develop new polices and novel approaches to prevent debt from influencing specialty and subspecialty choice.

During the 2019 Annual Meeting of the AMA House of Delegates (HOD), testimony before Reference Committee C was in support of this addition to policy. Indeed, education debt continues to be a significant burden on medical students, residents, and physicians. The AMA has numerous policies on this topic and advocates to legislators for mechanisms to alleviate or eliminate education debt. Similarly, the AMA continues to call for improved workforce planning, to ensure access to health care services nationwide, particularly in underserved rural and urban areas and in specific fields of need (e.g., primary care).

DEVELOPMENT OF THE TASK FORCE

To implement the policy, the Council on Medical Education assigned the chair of its 2019-2020 undergraduate medical education committee (Robert Goldberg, DO) as lead for the task force, which comprised representatives of the following AMA sections, along with the National Association of Advisors for the Health Professions (NAAHP):

• Medical Student Section	Faith Crittenden
• Resident and Fellow Section	Gunjan Malhotra, MD
• Young Physicians Section	Hilary Fairbrother, MD, MPH
• Academic Physicians Section	Hal B. Jenson, MD, MBA
• Women Physicians Section	Anita Ravi, MD, MPH, MSHP
• Minority Affairs Section	Frank Clark, MD
• Senior Physicians Section	Louis Weinstein, MD
• NAAHP	Francie Cuffney, PhD

The task force held two teleconferences, in April and July; appointed representatives contributed the expertise and unique perspectives of their specific demographic groups to the background and recommendations of this report.

TRENDS IN MEDICAL STUDENT DEBT

As with tuition and expenses across higher education, data on medical student debt reflect a continuing upward trend. The Association of American Medical Colleges (AAMC) reports that median medical school debt in 2019 was $200,000, which increased from $195,000 in 2018.[1] Data for osteopathic medical school programs reflect a similar upward trend, according to the American Association of Colleges of Osteopathic Medicine (AACOM), with an overall median expected debt for matriculants in 2019 at $192,000—up nine percent over the previous two years.[2] AACOM data also show that median expected debt for entering students at private osteopathic schools is $200,000, versus $160,000 for those in public osteopathic schools.

These data show a significant and growing debt burden on medical students in aggregate but may disguise the actual debt load that many individual students face, due to a sizeable and growing cross-section of students who report no medical student debt. The proportion of those reporting no debt has been increasing and appears concentrated in students from wealthy backgrounds. The reported percentage of 2015 medical school graduates who graduated with no medical school debt was 21.5 percent; this figure grew to 28.7 percent for 2019 graduates.[1] Although this trend may at first glance seem positive, report Grischkan et al., it may have negative consequences both for the diversity of the physician workforce and physician distribution across medical specialties, in that "primary care-oriented fields seem to have less of an increase in graduates without debt."[3] In fact, as Grischkan et al. note, six specialties are experiencing the largest absolute increase in no debt; radiology, dermatology, neurology, obstetrics and gynecology, ophthalmology, and pathology—many of which are competitive choices for careers among medical school graduates seeking to match into a residency program. In short, it appears that higher overall debt is concentrated among a smaller number of individuals. This underscores the potential misinterpretations that may arise from viewing these data in aggregate, which may cloud the overall picture, as a significant subset of students have outside funding sources to offset debt, including personal or family wealth, scholarships, debt relief through military service, and loan forgiveness due to future service in an underserved urban and rural area.

One of the largest contributors to medical school debt is rising tuition. According to the AAMC, the cost of allopathic medical education has been increasing steadily for both public and private institutions, as shown in Table 1, with a 20 percent to 23 percent increase in less than a decade.[4] Similar data from the AACOM (see Table 2) show a 30 percent to 34 percent increase over 11 years.[5]

Table 1. Average tuition, U.S. allopathic medical school programs (public and private)

	2012-2013		2019-2020	
	In-state	Out of state	In-state	Out of state
Public	$23,954	$45,047	$32,520	$56,001
Private	$42,407	$43,943	$55,337	$56,946

Table 2. Mean tuition, U.S. osteopathic medical school programs (public and private aggregated)

2008-2009		2019-2020	
In-state	Out of state	In-state	Out of state
$33,420	$38,683	$50,563	$55,853

It is important to note that while tuition has been steadily increasing, it has not discouraged applications to medical school; this number as well as overall enrollments have continued to increase over the last decade for both allopathic[6] and osteopathic[7] medical school programs. These increases in tuition could influence specialty choice among graduates of public versus private medical schools in different ways. Phillips et al. reported that high educational debt deters graduates of public medical schools from choosing primary care but does not appear to influence private school graduates in the same way. They note that "[r]educing debt of selected medical students may be effective in promoting a larger primary care physician workforce."[8]

GAPS IN FINANCIAL LITERACY AMONG MEDICAL STUDENTS

While the increase in medical school costs is a significant factor in rising medical student debt, it is also important to consider the relative lack of financial education among medical students as a concern.

A study of first- and fourth-year medical students by Jayakumar et al. found low levels of financial literacy and lack of preparedness for managing personal finances, including strategies for effective saving and investing and practice management.[9] Equally concerning, the study's authors describe the lack of improvement in financial literacy between entering and graduating medical students, regardless of whether their medical school offered such education. They conclude that reform efforts in undergraduate medical education by institutions and policymakers should encompass improvements to existing curricula to fill this gap in medical students' knowledge, and ensure that financial counseling is tailored to meet students' needs and occurs before key personal finance decisions are made.

The Liaison Committee on Medical Education, which accredits medical school programs in the U.S. leading to the MD (allopathic) degree, includes as part of its accreditation standards a requirement that programs provide the following services to students:

> *12.1 Financial Aid/Debt Management Counseling/Student Educational Debt*
>
> *A medical school provides its medical students with effective financial aid and debt management counseling and has mechanisms in place to minimize the impact of direct educational expenses (i.e., tuition, fees, books, supplies) on medical student indebtedness.*

Similarly, the Commission on Osteopathic College Accreditation, the accrediting body for osteopathic medical school programs, has the following requirements related to debt counseling and student debt outcomes:

> *Element 9.7: Financial Aid and Debt Management Counseling*
>
> *A COM [college of medicine] must provide its students with counseling to assist them with financial aid applications and debt management.*
>
> > *Submission 9.7: Financial Aid and Debt Management Counseling*
> >
> > *1. Provide a description of all financial aid and debt counseling sessions provided to its students, including:*
> > *a. When the financial aid and debt counseling sessions are/were provided to the students;*
> > *b. The OMS year during which students are required to receive these sessions;*

c. A roster of students that received financial aid and debt counseling.

Element 11.3: Student Debt Outcomes

A COM and/or its parent institution must collect and publish data on the debt load and student loan default rates of its students in such a way that applicants can be aware of the information.

Submission 11.3: Student Debt Outcomes

1. Provide the current average debt for the last four years of students.
2. Provide a public link to where the information is published.
3. For each of the four academic years preceding the submission of this information, provide the student loan default rate for all federal financial aid obtained under the Higher Education Act of 1965 (HEA), as amended, including financial aid provided under Title IV of the HEA.

DEBT AND DIVERSITY

In considering the connections between career choice and medical student debt, it is imperative to examine the differences in financial circumstances and barriers that exist for subsets of medical graduates.

Data regarding debt that account for racial/ethnic diversity of medical students and physicians demonstrate that Black/African American and Hispanic/Latina/o/x medical students graduate with higher levels of medical school debt compared to the overall population. According to AACOM, 91 percent of Black/African American and 88 percent of Hispanic/Latina/o/x entering students expect to graduate with medical education debt—versus 77 percent of Asian entering students and 86 percent of white students.[10] These trends have been supported by other studies that report higher debt burden in Black medical students compared to other races/ethnicities. A study by Dugger et al. found that 77.3 percent of Black medical students anticipated debt in excess of $150,000 upon graduation, versus White (65.1 percent), Hispanic (57.2 percent), and Asian students (50.2 percent).[11] These findings are supported by Jolly[12] and Phillips et al.[13] (Dugger et al. do note that Hispanic students are a "notable exception to this general relationship," and call for research of the "relatively high matriculation and low debt of Hispanics in comparison to other minority groups.")

The literature concerning medical school debt among students from groups historically marginalized in medicine is limited, it is important to consider additional disparities that exist in medical school. While the current evidence reflects higher amounts of debt for Black/African American and Hispanic/Latina/o/x groups, students from minoritized groups also experience a higher incidence of discrimination and burnout and may have more limited access to resources compared to non-minoritized medical students. Medical student debt levels are negatively associated with mental well-being and academic outcomes, according to a review by Pisaniello et al.[14] Perceived risk of not completing an educational program creates additional burden regarding one's ability to ultimately repay educational debt. It is important to lower these hurdles for minoritized students; improved strategies and programs for decreasing and mitigating medical school debt and its impacts is only one aspect of addressing systemic disparities within medical education.

FACTORS THAT INFLUENCE MEDICAL CAREER CHOICE

It is inarguable that high levels of medical school debt are a personal concern from a financial perspective for many medical students, trainees, and physicians. Increasing evidence suggests that the impact of debt on career choice is variable and is not strongly associated with specialty selection, including the choice of primary care fields.[15,16,17,18]

In contrast, the strongest and most predictive influences of specialty choice, according to the AAMC survey of 2019 medical school graduates,[1] are the following:

Influence	Percent
Fit with personality, interests, and skills	87.2
Content of specialty	83.4
Role model influence	50.9

These data have been consistent, in that they represent the three most frequently cited influences on specialty choice by each of the past five classes of medical school graduates, from 2015 to 2019.

A recent systematic literature review and meta-analysis of 75 studies encompassing more than 880,000 individuals by Yang et al.[19] outlined the factors influencing medical students' choice of subspecialty training; as shown, student debt was cited as a factor by the fewest respondents:

Factor	Percent
Academic interests	75.3
Competencies	55.2
Controllable lifestyles or flexible work schedules	53
Patient service orientation	50
Medical teachers or mentors	46.9
Career opportunities	44
Workload or working hours	37.9
Income	34.7
Length of training	32.3
Prestige	31.2
Advice from others	28.2
Student debt	15.3

Income is certainly among the drivers of career choice; this variable is even more critical when considering lifetime earning potential. Leigh et al. reported that estimates of additional lifetime earnings for the broad categories of surgery, internal medicine, and pediatric subspecialties and other specialties over that for primary care were $1,587,722, $1,099,655, and $761,402 respectively. For 41 specific specialties, the top additional earnings compared with family medicine as reference were neurological surgery ($2,880,601), medical oncology ($2,772,665), and radiation oncology ($2,659,657). The authors conclude, "After accounting for varying residency years and discounting future earnings, primary care specialties earned roughly $1 [million to] $3 million less than other specialties."[20]

Aside from the numbers, career satisfaction continues to be complex and multifaceted. Physician career satisfaction has been linked to better health care, patient satisfaction, and improved patient outcomes. Career satisfaction and dissatisfaction vary across specialty as well as by age, income, and region. A 2002 study by Leigh et al. found a "relatively high proportion of dissatisfied physicians among those practicing certain 'procedural' specialties" (including ophthalmology,

otolaryngology, and orthopaedic surgery), which the authors deemed "puzzling" due to the high income and prestige associated with these fields. In contrast, physicians practicing some "cognitive" specialties (e.g., infectious diseases, geriatrics, and pediatrics) were unlikely to be dissatisfied. The authors conclude that the advent of recent changes wrought by managed care is responsible for the levels of dissatisfaction among these procedural fields.[21]

Several current and future events may also become relevant with regard to the impact of medical student debt upon career choice. With the transition of the United States Medical Licensing Examination® (USMLE®) Step 1 exam to pass/fail reporting, previously perceived barriers to consideration of certain specialties may become less relevant to applicants. Increasing emphasis on holistic review of applicants may also affect medical student specialty choice. In addition, given the impact of the COVID-19 pandemic, there may be significant changes in the application process resulting from necessary innovation to adapt to travel limitations. Although it would be impossible to predict the impact of the changing landscape of medical education and medical student assessment, these factors may become relevant over time and warrant continued monitoring and potential future study.

LOAN FORGIVENESS PROGRAMS AND FREE TUITION

In one study of the role of debt and loan forgiveness/repayment programs in osteopathic medical graduates' plans to enter primary care, the use of loan forgiveness programs has been associated with choosing primary care specialties. Scheckel et al. found that "Graduates with high debt burden were more likely to enter primary care fields and use loan forgiveness/repayment programs."[22] In addition, Richards et al. found a strong association between participation in loan forgiveness programs and medical service in underserved areas.[23] These programs therefore serve a dual purpose—to mitigate the impact of medical school debt on career choice and help increase the medical workforce in underserved areas.

Some, however, have questioned the value of loan forgiveness programs. In their study, Phillips et al. state that it is surprising that individuals with high debt were "significantly less likely to pursue a career with a government-owned or subsidized practice, including an FQHC [federally qualified health center], rural health clinic, the Indian Health Service, the Public Health Service, a state or local government-operated clinic, or the Department of Veterans Affairs."[8] They conclude, "Existing National Health Service Corps [NHSC] loan repayment opportunities may not offer adequate incentives to primary care physicians with high debt," and call for policy changes, including increased investment in the NHSC, reform of the Public Service Loan Forgiveness program, and federal support for academic primary care.

Similarly, Asch, Grischkan, and Nicholson comment that loan repayment programs can create "perverse incentives" and may conflict with each other, leading to a financial disincentive to enter primary care careers. They also state that loan repayment does nothing to address the underlying costs of medical education and only provides a benefit to those who pursue participation in such programs.[24]

Additionally, free tuition and full scholarships alone were also not associated with students choosing primary care, conclude Nguyen and Bounds; they posit that concerns with work environment and lifestyle may dissuade those who were initially interested in primary care from staying with that decision, aside from any tuition and scholarship assistance.[25] This finding is important, in that the number of medical schools offering free tuition is growing, with seven total as of April 2019 (although some such offerings are limited to the first few graduating classes at newly accredited medical schools).[26] An article in *AAMC News* on the increase in free medical

schools notes that such efforts are unlikely to augment the primary care workforce, although they could attract a more diverse pool of applicants and allow for graduates to pursue their passion, regardless of profit. The article highlights data from the AAMC that debt has "little influence" on choice of specialty.[27] In addition, the authors opine that efforts to enhance compensation and reimbursements for primary care medical specialties, change negative perceptions of low prestige (all too common among a subset of medical education role models and mentors), and improve the primary care practice environment for these physicians could be more fruitful as a means to increase the primary care workforce. Future research by the Council on Medical Education and other stakeholders should monitor the impact of free tuition and scholarships on specialty choice and debt, as well as workforce composition and physician satisfaction.

CONCERNS WITH THE PUBLIC SERVICE LOAN FORGIVENESS (PSLF) PROGRAM

At the June 2021 of the AMA HOD, attendees discussed the Public Service Loan Forgiveness (PSLF) program. Discussion centered around concerns about the denial rate of PSLF applications, lack of transparency of and communication about program requirements, and oversight and accountability of PSLF loan servicers. Council on Medical Education offered to incorporate discussion of the issue into this report.

A 2017 report by the Council on Medical Education, "Expansion of Public Service Loan Forgiveness," provided background on the PSLF program, a taxpayer-funded program through which debt relief is afforded individuals to work in public service careers, such as teachers and social workers, as well as medical professionals. PSLF forgives the remaining balance on Direct Loans after the individual makes 120 qualifying monthly payments under a qualifying repayment plan while working full-time for a qualifying employer. According to Federal Student Aid, an office of the U.S. Department of Education (https://studentaid.gov/manage-loans/forgiveness-cancellation/public-service), PSLF requirements specify that recipients must:

- be employed by a U.S. federal, state, local, or tribal government or not-for-profit organization;
- work full-time for that agency or organization;
- have Direct Loans (or consolidate other federal student loans into a Direct Loan);
- repay loans under an income-driven repayment plan; and
- make 120 qualifying payments.

Despite the promise of the program, it has been beset by challenges and administrative difficulties, leading to "astronomical" denial rates, as the authors of Resolution 314-J-21 deemed it. A 2019 *New York Times*' article (https://www.nytimes.com/2019/11/28/us/politics/student-loan-forgiveness.html) ascribed blame for the program's failures to "loan servicers who at best failed to inform borrowers of what was needed to qualify, to the single company in charge of the program that has been repeatedly cited for shoddy service, mismanagement and poor record keeping, to lawmakers who wrote in a baffling list of requirements, and to the Education Department, which has failed to step in and correct the problem."

A 2019 report from the Government Accountability Office (https://www.gao.gov/products/gao-19-595) calls for increased availability of information on the program and decreasing/combining the number of application steps to make PSLF less confusing for borrowers.

A contrarian viewpoint, expressed by the founder of Student Loan Planner at https://www.studentloanplanner.com/pslf-snowball-effect/, takes a more sanguine approach to the PSLF and its prospects for debt relief. He writes, "The PSLF success rate for applications will be

exponentially increasing over the next few years thanks to the 'PSLF Snowball Effect.'" For medicine in particular, he adds that, due to the timing of the development of the program, and the 10-year window for the 120-payment requirement, physicians will not be receiving PSLF "en masse" until 2024.

AMA'S FEDERAL ADVOCACY EFFORTS REGARDING STUDENT LOAN DEBT

The AMA's Advocacy Group has been active in advocating before Congress for legislation that ensures continued funding of key programs, such as loan forgiveness, that help ensure availability of physicians in specific fields of medicine and/or underserved geographic areas to satisfy the nation's health care workforce needs.

Consolidated Appropriations Act, 2021 (H.R. 133)

This legislation (see https://rules.house.gov/sites/democrats.rules.house.gov/files/BILLS-116HR133SA-RCP-116-68.pdf) encompasses extension for community health centers, the National Health Service Corps, and teaching health centers that operate graduate medical education (GME) programs. It includes $4 billion in funding from 2019-2023 for community health centers and the National Health Service Corps and provides $310 million in additional funding from 2021-2023 for the National Health Service Corps. It also provides additional funding, until 2023, for teaching health centers that operate GME programs. (Sec. 301)

Specific relevant sections of the legislation include the following:

Promoting Rural Hospital GME Funding Opportunity

This section makes changes to Medicare graduate medical education (GME) Rural Training Tracks (RTT) program to provide greater flexibility for hospitals not located in a rural area that established or establish a medical residency program (or rural tracks) in a rural area or establish an accredited program where greater than 50 percent of the program occurs in a rural area to partner with rural hospitals and address the physician workforce needs of rural areas. (Sec. 127)

Medicare GME treatment of hospitals establishing new medical residency training programs after hosting medical resident rotators for short durations

This section allows hospitals to host a limited number of residents for short-term rotations without being negatively impacted by a set permanent full time equivalent (FTE) resident cap or a Per Resident Amount (PRA). A hospital must report full-time equivalent residents on its cost report for a cost reporting period if the hospital trains at least 1.0 full-time-equivalent residents in an approved medical residency training program or programs in such period. (Sec. 131)

Student Financial Assistance

A total of $24.5 billion shall be provided for carrying out Title IV of HEA and the maximum Pell Grant that a student can be eligible for during 2021-2022 will be $5,432. (Title III)

Student Aid Administration

A total of $1.9 billion will remain available through September 30, 2022 to carry out HEA and the Public Health Service Act, allowing students to pick from multiple servicers for their student loans and providing more support and transparency for borrowers. (Title III)

Strategy to prioritize and expand educational and professional exchange programs with Mexico

The section calls for assessment of the feasibility of fostering partnerships between universities in the United States and medical school and nursing programs in Mexico to ensure that Mexican programs have accreditation standards that are in line with the Accreditation and Standards in Foreign Medical Education and Accreditation Commission For Education in Nursing, so that Mexican medical and nursing students can pass medical and nursing licensing examinations, respectively, in the United States. (Sec. 1904)

General Provisions

A total of $50 million for public service loan forgiveness under the normal terms. (Sec. 311)

Health Workforce

A total of $50 million will be available for grants to public institutions of higher education to expand or support graduate education for physicians provided by such institutions. Priority will be given to public institutions located in states with a projected primary care shortage in 2025. Grants are limited to public institutions in states in the top quintile of states with a projected primary care shortage in 2025. (Title II)

Distribution of additional residency positions

This section supports Medicare physician workforce development by providing for the distribution of 1,000 additional Medicare-funded GME residency positions. Not less than 10 percent of the aggregate number of these new positions will be given to each of the following categories: rural hospitals, hospitals that are already above their Medicare cap for residency positions, hospitals in states with new medical schools or new locations and branch campuses, and hospitals that serve Health Professional Shortage Areas. However, a hospital may not receive more than 25 additional full-time equivalent residency positions. (Sec. 126). On June, 28, 2021, the AMA provided comments about how the new 1,000 GME slots should be distributed. The AMA also signed on to a letter discussing this same issue.

Higher Education Emergency Relief Fund

Funding will be provided to defray expenses associated with COVID-19, to carry out student support activities authorized by the HEA that address needs related to COVID-19, and to provide financial aid grants to students which may be used for any component of the student's cost of attendance or for emergency costs that arise due to COVID-19, including tuition, food, housing, health care, or childcare. Additional funding will be provided for Historically Black Colleges and Universities, Tribal Colleges and Universities, Hispanic Serving Institutions, and certain other institutions. (Sec. 314)

FAFSA Simplification

This provision makes it easier to apply for federal aid and makes that aid predictable. This provision provides a formula for determining the amount of need that a student has including tuition, room and board, dependents, book stipends, transportation, and personal expenses. It also considers parents' and spouses' potential financial contributions or lack thereof. (Title VII)

Emergency Financial Aid Grants

Students receiving qualified emergency financial aid grants after March 26, 2020, will not have those grants included in their gross income for purposes of the Internal Revenue Code. (Sec. 277)

Other Loan Forgiveness Legislation

The AMA offered technical assistance toward creation of the Health Heroes 2020 Act (H.R. 6650/ S. 3634), which proposes to bolster the National Health Service Corps (NHSC) by providing an additional $25 billion for both loan repayment and scholarship programs in fiscal year 2020 to increase the number of medical professionals in underserved communities. In addition, the proposal increases the mandatory NHSC funding level from $310 million to $690 million for fiscal years 2021-2026 to increase scholarship and loan forgiveness awards and meet the nation's growing health needs.

The AMA has voiced its support for the Strengthening America's Health Care Readiness Act, which increases supplemental funding for the NHSC by $10 billion. This increased funding will be used for additional loan repayment and scholarship programs. Moreover, the bill contains a 40 percent set-aside for historically underrepresented minorities in health care and provides mentoring and early recruitment for minorities. Additionally, the bill provides $50 million for a National Disaster Medical System (NDMS) pilot program, which would bolster health emergency surge capacity.

The AMA has also supported the Student Loan Forgiveness for Frontline Health Workers Act in the 116th and the 117th Congresses and urged the U.S. House of Representatives and the U.S. Senate to quickly pass this legislation. If adopted, this act would provide total student loan forgiveness for physicians, residents, and medical students who aid in responding to the COVID-19 crisis.

The AMA also drafted a letter to Congressional leaders in 2020 regarding the "phase four" coronavirus relief package intended to confront the economic impact of the COVID-19 pandemic. For resident physicians and early graduated medical students whose debt averages over $200,000 per individual, the AMA urged Congress to provide at least $20,000 of federal student loan forgiveness or $20,000 of tuition relief. The AMA believes these benefits should also be made available to third- and fourth-year medical students who are willing, and deemed competent, to begin providing early direct patient care for patients with COVID-19, or who are making other significant contributions to the pandemic response through research, public health, and telemedicine efforts.

Other AMA advocacy in 2021 toward alleviating the medical education debt burden includes the following:

- On March 24, the AMA signed on to a letter offering support for the "Resident Physician Shortage Reduction Act." This bipartisan legislation would gradually raise the number of Medicare-supported GME positions by 2,000 per year for seven years, for a total of 14,000 new slots. A share of these positions would be given to hospitals with diverse needs including hospitals in rural areas, hospitals serving patients from health professional shortage areas (HPSAs), hospitals in states with new medical schools or branch campuses, and hospitals already training over their caps. On April 8, the AMA sent a letter supporting S. 924, the "Rural America Health Corps Act." This legislation would establish a demonstration program to provide payments on qualified loans for individuals eligible for,

but not currently participating in, the National Health Service Corps (NHSC) Loan Repayment Program who agree to a five-year period of obligated full-time service in a rural health professional shortage area.

- On May 13, the AMA sent letters supporting H.R. 2917 and S. 1443, the "Retirement Parity for Student Loans Act," which would permit 401(k), 403(b), SIMPLE, and governmental 457(b) retirement plans to make voluntary matching contributions to workers as if their student loan payments were salary reduction contributions.

- On May 18, the AMA signed on to a letter asking that federal support for physician training be included in upcoming legislative efforts to improve the nation's infrastructure, and reaffirmed our support for the "Resident Physician Shortage Reduction Act of 2021," which asks for 14,000 additional Medicare-supported GME positions.

- On May 24, the AMA sent a letter supporting H.R. 3441, the "Substance Use Disorder Workforce Act," which would provide 1,000 additional Medicare-supported graduate medical education (GME) positions in hospitals that have, or are in the process of establishing, accredited residency programs in addiction medicine, addiction psychiatry, or pain medicine.

- On May 25, the AMA sent a letter voicing support for S. 1438, the "Opioid Workforce Act of 2021," which would provide 1,000 additional Medicare-supported graduate medical education (GME) positions in hospitals that have, or are in the process of establishing, accredited residency programs in addiction medicine, addiction psychiatry, or pain medicine. This is the companion bill for the "Substance Use Disorder Workforce Act."

- On June 10, the AMA sent a letter in support of the "Doctors of Community Act" or "DOC Act." This legislation would permanently authorize the Teaching Health Center Graduate Medical Education (THCGME) program. As such, if passed, this legislation would help ensure that patients in underserved areas continue to have access to needed health care services.

- On June 23, the AMA sent a letter voicing support for the "Physician Shortage GME Cap Flex Act of 2021." This legislation would help to address the national physician workforce shortage by providing teaching hospitals an additional five years to set their Medicare GME cap if they establish residency training programs in primary care or specialties that are facing shortages. (House; Senate)

- On July 1, the AMA sent a letter supporting H.R. 4122, the "Resident Education Deferred Interest (REDI) Act," which would allow borrowers to qualify for interest-free deferment on their student loans while serving in a medical or dental internship or residency program.

Higher Education Act (HEA) Reauthorization

The HEA was last comprehensively reauthorized in 2008 by the Higher Education Opportunity Act of 2008, which authorized most HEA programs through FY2014; it was extended through FY2015, under the General Education Provisions Act (GEPA). Many HEA programs that had been due to expire at the end of FY2015 were provided additional funding under a variety of appropriations bills and continuing resolutions, because Congress has not been able to agree on comprehensive reauthorization legislation. Earlier in 2020, Congressional lawmakers were close to reaching an agreement to update the HEA, but the emergence of the pandemic put this effort on hold. Today,

with the potential growing for a long-term economic downturn related to the COVID-19 pandemic, and as more people seek to further their education as a result, the need to reauthorize the HEA is more pressing than ever, and the AMA will continue advocacy in this regard.

RELEVANT AMA POLICY

Our AMA calls for addressing and reducing the burden of medical education debt among students, residents/fellows, and physicians through the following policies:

- H-305.925, "Principles and Actions to Address Medical Education Costs and Student Debt"
- H-310.907, "Resident/Fellow Clinical and Educational Work Hours."

Similarly, the AMA backs strategies to combat rising costs for medical education:

- D-305-983, "Strategies to Combat Mid-year and Retroactive Tuition Increases"
- H-305.988, "Cost and Financing of Medical Education and Availability of First-Year Residency Positions"

The AMA supports loan forgiveness incentives and reduction in student loan interest rates for residents/fellows, physicians working in Veterans Affairs facilities, and those pursuing careers in research:

- D-305.984, "Reduction in Student Loan Interest Rates"
- D-510.990, "Fixing the VA Physician Shortage with Physicians"
- H-460.995, "Support for Careers in Research"

The AMA endorses expansion of financial incentives, aid, relief options to recruit and train primary care physicians, especially those in rural and urban underserved areas:

- H-200.949, "Principles of and Actions to Address Primary Care Workforce"
- H-465-988, "Educational Strategies for Meeting Rural Health Physician Shortage"

The AMA recommends increasing diversity in the physician workforce to address underserved areas via loan forgiveness programs and diversity pipeline programs, and improve transparency regarding tuition requirements:

- D-200.982, "Diversity in the Physician Workforce and Access to Care"
- D-200.985, "Strategies for Enhancing Diversity in the Physician Workforce"

SUMMARY AND RECOMMENDATIONS

After considering potential trends/solutions related to the connection between medical student debt and career choice and analyzing the peer-reviewed literature to ascertain whether existing data support these hypotheses, this report finds little solid evidence for a strong link between debt and career choice. This finding, however, may be limited by the lack of available data on the potentially intersecting impacts of race/ethnicity, socioeconomic status, and other key sociodemographic factors. In addressing the workforce need for primary care and other fields, a more deliberate approach to planning by federal agencies and stakeholder organizations may be helpful. The composition of the physician workforce is ultimately the result of economic and personal decisions by individual students, residents, and physicians to pursue professional satisfaction in whichever medical field, practice setting, and location that is right for them. Balancing the impact of these individual choices with society's workforce and population health needs may require new and/or improved programs (including financial incentives) that serve as inducements for those decisions that best serve the common good and ensure access to needed health care services for all Americans, now and in the future.

In addition, the AMA should closely monitor the PSLF program, particularly over the next few years, to ensure that it is a viable option for debt relief for physicians. If the denial rates for physician applicants continue to remain unacceptably high, further federal advocacy to encourage reforms to the program is recommended, as reflected in the proposed emendations to AMA policy below.

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

1. That our American Medical Association (AMA) encourage key stakeholders to collect and disseminate data on the impacts of medical education debt on career choice, especially with regard to the potentially intersecting impacts of race/ethnicity, socioeconomic status, and other key sociodemographic factors. (New HOD Policy)

2. That our AMA monitor new policies and novel approaches to influence career choice based on the key factors that affect the decision to enter a given specialty and subspecialty. (New HOD Policy)

3. That our AMA amend Policy H-305.925 (20), "Principles of and Actions to Address Medical Education Costs and Student Debt," by addition and deletion, to read as follows:

   "Related to the Public Service Loan Forgiveness (PSLF) Program, our AMA supports increased medical student and physician ~~benefits~~ participation in the program, and will: (a) Advocate that all resident/fellow physicians have access to PSLF during their training years; (b) Advocate against a monetary cap on PSLF and other federal loan forgiveness programs; (c) Work with the United States Department of Education to ensure that any cap on loan forgiveness under PSLF be at least equal to the principal amount borrowed; (d) Ask the United States Department of Education to include all terms of PSLF in the contractual obligations of the Master Promissory Note; (e) Encourage the Accreditation Council for Graduate Medical Education (ACGME) to require residency/fellowship programs to include within the terms, conditions, and benefits of program appointment information on the employer's PSLF program qualifying status ~~of the employer~~; (f) Advocate that the profit status of a physician's training institution not be a factor for PSLF eligibility; (g) Encourage medical school financial advisors to counsel wise borrowing by medical students, in the event that the PSLF program is eliminated or severely curtailed; (h) Encourage medical school financial advisors to increase medical student engagement in service-based loan repayment options, and other federal and military programs, as an attractive alternative to the PSLF in terms of financial prospects as well as providing the opportunity to provide care in medically underserved areas; (i) Strongly advocate that the terms of the PSLF that existed at the time of the agreement remain unchanged for any program participant in the event of any future restrictive changes; (j) Monitor the denial rates for physician applicants to the PSLF; and (k) Undertake expanded federal advocacy, in the event denial rates for physician applicants are unacceptably high, to encourage release of information on the basis for the high denial rates, increased transparency and streamlining of program requirements, consistent and accurate communication between loan servicers and borrowers, and clear expectations regarding oversight and accountability of the loan servicers responsible for the program." (Modify Current HOD Policy)

4. That our AMA rescind Policy H-305.925 (22), "Principles of and Actions to Address Medical Education Costs and Student Debt," as having been fulfilled through this report:

"~~Formulate a task force to look at undergraduate medical education training as it relates to career choice, and develop new polices and novel approaches to prevent debt from influencing specialty and subspecialty choice~~." (Rescind HOD Policy)

Fiscal note: $1,000.

Acknowledgment: The AMA appreciates the assistance with this report of David Mata, MS, MD Candidate, Class of 2023, Stritch School of Medicine at Loyola University Chicago.

APPENDIX: RELEVANT AMA POLICY

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

The costs of medical education should never be a barrier to the pursuit of a career in medicine nor to the decision to practice in a given specialty. To help address this issue, our American Medical Association (AMA) will:
1. Collaborate with members of the Federation and the medical education community, and with other interested organizations, to address the cost of medical education and medical student debt through public- and private-sector advocacy.
2. Vigorously advocate for and support expansion of and adequate funding for federal scholarship and loan repayment programs--such as those from the National Health Service Corps, Indian Health Service, Armed Forces, and Department of Veterans Affairs, and for comparable programs from states and the private sector--to promote practice in underserved areas, the military, and academic medicine or clinical research.
3. Encourage the expansion of National Institutes of Health programs that provide loan repayment in exchange for a commitment to conduct targeted research.
4. Advocate for increased funding for the National Health Service Corps Loan Repayment Program to assure adequate funding of primary care within the National Health Service Corps, as well as to permit: (a) inclusion of all medical specialties in need, and (b) service in clinical settings that care for the underserved but are not necessarily located in health professions shortage areas.
5. Encourage the National Health Service Corps to have repayment policies that are consistent with other federal loan forgiveness programs, thereby decreasing the amount of loans in default and increasing the number of physicians practicing in underserved areas.
6. Work to reinstate the economic hardship deferment qualification criterion known as the "20/220 pathway," and support alternate mechanisms that better address the financial needs of trainees with educational debt.
7. Advocate for federal legislation to support the creation of student loan savings accounts that allow for pre-tax dollars to be used to pay for student loans.
8. Work with other concerned organizations to advocate for legislation and regulation that would result in favorable terms and conditions for borrowing and for loan repayment, and would permit 100% tax deductibility of interest on student loans and elimination of taxes on aid from service-based programs.
9. Encourage the creation of private-sector financial aid programs with favorable interest rates or service obligations (such as community- or institution-based loan repayment programs or state medical society loan programs).
10. Support stable funding for medical education programs to limit excessive tuition increases, and collect and disseminate information on medical school programs that cap medical education debt, including the types of debt management education that are provided.
11. Work with state medical societies to advocate for the creation of either tuition caps or, if caps are not feasible, pre-defined tuition increases, so that medical students will be aware of their tuition and fee costs for the total period of their enrollment.
12. Encourage medical schools to (a) Study the costs and benefits associated with non-traditional instructional formats (such as online and distance learning, and combined baccalaureate/MD or DO programs) to determine if cost savings to medical schools and to medical students could be realized without jeopardizing the quality of medical education; (b) Engage in fundraising activities to increase the availability of scholarship support, with the support of the Federation, medical schools, and state and specialty medical societies, and develop or enhance financial aid opportunities for medical students, such as self-managed, low-interest loan programs; (c) Cooperate with postsecondary institutions to establish collaborative debt counseling for entering first-year medical students; (d) Allow for flexible scheduling for medical students who encounter financial difficulties

that can be remedied only by employment, and consider creating opportunities for paid employment for medical students; (e) Counsel individual medical student borrowers on the status of their indebtedness and payment schedules prior to their graduation; (f) Inform students of all government loan opportunities and disclose the reasons that preferred lenders were chosen; (g) Ensure that all medical student fees are earmarked for specific and well-defined purposes, and avoid charging any overly broad and ill-defined fees, such as but not limited to professional fees; (h) Use their collective purchasing power to obtain discounts for their students on necessary medical equipment, textbooks, and other educational supplies; (i) Work to ensure stable funding, to eliminate the need for increases in tuition and fees to compensate for unanticipated decreases in other sources of revenue; mid-year and retroactive tuition increases should be opposed.
13. Support and encourage state medical societies to support further expansion of state loan repayment programs, particularly those that encompass physicians in non-primary care specialties.
14. Take an active advocacy role during reauthorization of the Higher Education Act and similar legislation, to achieve the following goals: (a) Eliminating the single holder rule; (b) Making the availability of loan deferment more flexible, including broadening the definition of economic hardship and expanding the period for loan deferment to include the entire length of residency and fellowship training; (c) Retaining the option of loan forbearance for residents ineligible for loan deferment; (d) Including, explicitly, dependent care expenses in the definition of the "cost of attendance"; (e) Including room and board expenses in the definition of tax-exempt scholarship income; (f) Continuing the federal Direct Loan Consolidation program, including the ability to "lock in" a fixed interest rate, and giving consideration to grace periods in renewals of federal loan programs; (g) Adding the ability to refinance Federal Consolidation Loans; (h) Eliminating the cap on the student loan interest deduction; (i) Increasing the income limits for taking the interest deduction; (j) Making permanent the education tax incentives that our AMA successfully lobbied for as part of Economic Growth and Tax Relief Reconciliation Act of 2001; (k) Ensuring that loan repayment programs do not place greater burdens upon married couples than for similarly situated couples who are cohabitating; (l) Increasing efforts to collect overdue debts from the present medical student loan programs in a manner that would not interfere with the provision of future loan funds to medical students.
15. Continue to work with state and county medical societies to advocate for adequate levels of medical school funding and to oppose legislative or regulatory provisions that would result in significant or unplanned tuition increases.
16. Continue to study medical education financing, so as to identify long-term strategies to mitigate the debt burden of medical students, and monitor the short-and long-term impact of the economic environment on the availability of institutional and external sources of financial aid for medical students, as well as on choice of specialty and practice location.
17. Collect and disseminate information on successful strategies used by medical schools to cap or reduce tuition.
18. Continue to monitor the availability of and encourage medical schools and residency/fellowship programs to (a) provide financial aid opportunities and financial planning/debt management counseling to medical students and resident/fellow physicians; (b) work with key stakeholders to develop and disseminate standardized information on these topics for use by medical students, resident/fellow physicians, and young physicians; and (c) share innovative approaches with the medical education community.
19. Seek federal legislation or rule changes that would stop Medicare and Medicaid decertification of physicians due to unpaid student loan debt. The AMA believes that it is improper for physicians not to repay their educational loans, but assistance should be available to those physicians who are experiencing hardship in meeting their obligations.
20. Related to the Public Service Loan Forgiveness (PSLF) Program, our AMA supports increased medical student and physician benefits the program, and will: (a) Advocate that all resident/fellow physicians have access to PSLF during their training years; (b) Advocate against a monetary cap on

PSLF and other federal loan forgiveness programs; (c) Work with the United States Department of Education to ensure that any cap on loan forgiveness under PSLF be at least equal to the principal amount borrowed; (d) Ask the United States Department of Education to include all terms of PSLF in the contractual obligations of the Master Promissory Note; (e) Encourage the Accreditation Council for Graduate Medical Education (ACGME) to require residency/fellowship programs to include within the terms, conditions, and benefits of program appointment information on the PSLF program qualifying status of the employer; (f) Advocate that the profit status of a physicians training institution not be a factor for PSLF eligibility; (g) Encourage medical school financial advisors to counsel wise borrowing by medical students, in the event that the PSLF program is eliminated or severely curtailed; (h) Encourage medical school financial advisors to increase medical student engagement in service-based loan repayment options, and other federal and military programs, as an attractive alternative to the PSLF in terms of financial prospects as well as providing the opportunity to provide care in medically underserved areas; (i) Strongly advocate that the terms of the PSLF that existed at the time of the agreement remain unchanged for any program participant in the event of any future restrictive changes.
21. Advocate for continued funding of programs including Income-Driven Repayment plans for the benefit of reducing medical student load burden.
22. Formulate a task force to look at undergraduate medical education training as it relates to career choice, and develop new polices and novel approaches to prevent debt from influencing specialty and subspecialty choice.

H-310.907, "Resident/Fellow Clinical and Educational Work Hours"

Our AMA adopts the following Principles of Resident/Fellow Clinical and Educational Work Hours, Patient Safety, and Quality of Physician Training:
1. Our AMA supports the 2017 Accreditation Council for Graduate Medical Education (ACGME) standards for clinical and educational work hours (previously referred to as "duty hours").
2. Our AMA will continue to monitor the enforcement and impact of clinical and educational work hour standards, in the context of the larger issues of patient safety and the optimal learning environment for residents.
3. Our AMA encourages publication and supports dissemination of studies in peer-reviewed publications and educational sessions about all aspects of clinical and educational work hours, to include such topics as extended work shifts, handoffs, in-house call and at-home call, level of supervision by attending physicians, workload and growing service demands, moonlighting, protected sleep periods, sleep deprivation and fatigue, patient safety, medical error, continuity of care, resident well-being and burnout, development of professionalism, resident learning outcomes, and preparation for independent practice.
4. Our AMA endorses the study of innovative models of clinical and educational work hour requirements and, pending the outcomes of ongoing and future research, should consider the evolution of specialty- and rotation-specific requirements that are evidence-based and will optimize patient safety and competency-based learning opportunities.
5. Our AMA encourages the ACGME to:
a) Decrease the barriers to reporting of both clinical and educational work hour violations and resident intimidation.
b) Ensure that readily accessible, timely and accurate information about clinical and educational work hours is not constrained by the cycle of ACGME survey visits.
c) Use, where possible, recommendations from respective specialty societies and evidence-based approaches to any future revision or introduction of clinical and educational work hour rules.
d) Broadly disseminate aggregate data from the annual ACGME survey on the educational environment of resident physicians, encompassing all aspects of clinical and educational work hours.

6. Our AMA recognizes the ACGME for its work in ensuring an appropriate balance between resident education and patient safety, and encourages the ACGME to continue to:
a) Offer incentives to programs/institutions to ensure compliance with clinical and educational work hour standards.
b) Ensure that site visits include meetings with peer-selected or randomly selected residents and that residents who are not interviewed during site visits have the opportunity to provide information directly to the site visitor.
c) Collect data on at-home call from both program directors and resident/fellow physicians; release these aggregate data annually; and develop standards to ensure that appropriate education and supervision are maintained, whether the setting is in-house or at-home.
d) Ensure that resident/fellow physicians receive education on sleep deprivation and fatigue.
7. Our AMA supports the following statements related to clinical and educational work hours:
a) Total clinical and educational work hours must not exceed 80 hours per week, averaged over a four-week period (Note: "Total clinical and educational work hours" includes providing direct patient care or supervised patient care that contributes to meeting educational goals; participating in formal educational activities; providing administrative and patient care services of limited or no educational value; and time needed to transfer the care of patients).
b) Scheduled on-call assignments should not exceed 24 hours. Residents may remain on-duty for an additional 4 hours to complete the transfer of care, patient follow-up, and education; however, residents may not be assigned new patients, cross-coverage of other providers' patients, or continuity clinic during that time.
c) Time spent in the hospital by residents on at-home call must count towards the 80-hour maximum weekly hour limit, and on-call frequency must not exceed every third night averaged over four weeks. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one-day-in-seven free of duty, when averaged over four weeks.
d) At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident.
e) Residents are permitted to return to the hospital while on at-home call to care for new or established patients. Each episode of this type of care, while it must be included in the 80-hour weekly maximum, will not initiate a new "off-duty period."
f) Given the different education and patient care needs of the various specialties and changes in resident responsibility as training progresses, clinical and educational work hour requirements should allow for flexibility for different disciplines and different training levels to ensure appropriate resident education and patient safety; for example, allowing exceptions for certain disciplines, as appropriate, or allowing a limited increase to the total number of clinical and educational work hours when need is demonstrated.
g) Resident physicians should be ensured a sufficient duty-free interval prior to returning to duty.
h) Clinical and educational work hour limits must not adversely impact resident physician participation in organized educational activities. Formal educational activities must be scheduled and available within total clinical and educational work hour limits for all resident physicians.
i) Scheduled time providing patient care services of limited or no educational value should be minimized.
j) Accurate, honest, and complete reporting of clinical and educational work hours is an essential element of medical professionalism and ethics.
k) The medical profession maintains the right and responsibility for self-regulation (one of the key tenets of professionalism) through the ACGME and its purview over graduate medical education, and categorically rejects involvement by the Centers for Medicare & Medicaid Services, The Joint Commission, Occupational Safety and Health Administration, and any other federal or state government bodies in the monitoring and enforcement of clinical and educational work hour regulations, and opposes any regulatory or legislative proposals to limit the work hours of practicing physicians.

l) Increased financial assistance for residents/fellows, such as subsidized child care, loan deferment, debt forgiveness, and tax credits, may help mitigate the need for moonlighting. At the same time, resident/fellow physicians in good standing with their programs should be afforded the opportunity for internal and external moonlighting that complies with ACGME policy.
m) Program directors should establish guidelines for scheduled work outside of the residency program, such as moonlighting, and must approve and monitor that work such that it does not interfere with the ability of the resident to achieve the goals and objectives of the educational program.
n) The costs of clinical and educational work hour limits should be borne by all health care payers. Individual resident compensation and benefits must not be compromised or decreased as a result of changes in the graduate medical education system.
o) The general public should be made aware of the many contributions of resident/fellow physicians to high-quality patient care and the importance of trainees' realizing their limits (under proper supervision) so that they will be able to competently and independently practice under real-world medical situations.
8. Our AMA is in full support of the collaborative partnership between allopathic and osteopathic professional and accrediting bodies in developing a unified system of residency/fellowship accreditation for all residents and fellows, with the overall goal of ensuring patient safety.
9. Our AMA will actively participate in ongoing efforts to monitor the impact of clinical and educational work hour limitations to ensure that patient safety and physician well-being are not jeopardized by excessive demands on post-residency physicians, including program directors and attending physicians.

H-465.988, "Educational Strategies for Meeting Rural Health Physician Shortage"

1. In light of the data available from the current literature as well as ongoing studies being conducted by staff, the AMA recommends that:
A. Our AMA encourage medical schools and residency programs to develop educationally sound rural clinical preceptorships and rotations consistent with educational and training requirements, and to provide early and continuing exposure to those programs for medical students and residents.
B. Our AMA encourage medical schools to develop educationally sound primary care residencies in smaller communities with the goal of educating and recruiting more rural physicians.
C. Our AMA encourage state and county medical societies to support state legislative efforts toward developing scholarship and loan programs for future rural physicians.
D. Our AMA encourage state and county medical societies and local medical schools to develop outreach and recruitment programs in rural counties to attract promising high school and college students to medicine and the other health professions.
E. Our AMA urge continued federal and state legislative support for funding of Area Health Education Centers (AHECs) for rural and other underserved areas.
F. Our AMA continue to support full appropriation for the National Health Service Corps Scholarship Program, with the proviso that medical schools serving states with large rural underserved populations have a priority and significant voice in the selection of recipients for those scholarships.
G. Our AMA support full funding of the new federal National Health Service Corps loan repayment program.
H. Our AMA encourage continued legislative support of the research studies being conducted by the Rural Health Research Centers funded by the National Office of Rural Health in the Department of Health and Human Services.
I. Our AMA continue its research investigation into the impact of educational programs on the supply of rural physicians.

J. Our AMA continue to conduct research and monitor other progress in development of educational strategies for alleviating rural physician shortages.
K. Our AMA reaffirm its support for legislation making interest payments on student debt tax deductible.
L. Our AMA encourage state and county medical societies to develop programs to enhance work opportunities and social support systems for spouses of rural practitioners.
2. Our AMA will work with state and specialty societies, medical schools, teaching hospitals, the Accreditation Council for Graduate Medical Education (ACGME), the Centers for Medicare and Medicaid Services (CMS) and other interested stakeholders to identify, encourage and incentivize qualified rural physicians to serve as preceptors and volunteer faculty for rural rotations in residency.
3. Our AMA will: (a) work with interested stakeholders to identify strategies to increase residency training opportunities in rural areas with a report back to the House of Delegates; and (b) work with interested stakeholders to formulate an actionable plan of advocacy with the goal of increasing residency training in rural areas.
4. Our AMA will undertake a study of issues regarding rural physician workforce shortages, including federal payment policy issues, and other causes and potential remedies (such as telehealth) to alleviate rural physician workforce shortages.

D-305.984, "Reduction in Student Loan Interest Rates"

1. Our AMA will actively lobby for legislation aimed at establishing an affordable student loan structure with a variable interest rate capped at no more than 5.0%.
2. Our AMA will work in collaboration with other health profession organizations to advocate for a reduction of the fixed interest rate of the Stafford student loan program and the Graduate PLUS loan program.
3. Our AMA will consider the total cost of loans including loan origination fees and benefits of federal loans such as tax deductibility or loan forgiveness when advocating for a reduction in student loan interest rates.
4. Our AMA will advocate for policies which lead to equal or less expensive loans (in terms of loan benefits, origination fees, and interest rates) for Grad-PLUS loans as this would change the status quo of high-borrowers paying higher interest rates and fees in addition to having a higher overall loan burden.
5. Our AMA will work with appropriate organizations, such as the Accreditation Council for Graduate Medical Education and the Association of American Medical Colleges, to collect data and report on student indebtedness that includes total loan costs at completion of graduate medical education training.

D-510.990, "Fixing the VA Physician Shortage with Physicians"

1. Our AMA will work with the VA to enhance its loan forgiveness efforts to further incentivize physician recruiting and retention and improve patient access in the Veterans Administration facilities.
2. Our AMA will call for an immediate change in the Public Service Loan Forgiveness Program to allow physicians to receive immediate loan forgiveness when they practice in a Veterans Administration facility.
3. Our AMA will work with the Veterans Administration to minimize the administrative burdens that discourage or prevent non-VA physicians without compensation (WOCs) from volunteering their time to care for veterans.
4. Our AMA will: (a) continue to support the mission of the Department of Veterans Affairs Office of Academic Affiliations for expansion of graduate medical education (GME) residency positions;

and (b) collaborate with appropriate stakeholder organizations to advocate for preservation of Veterans Health Administration funding for GME and support its efforts to expand GME residency positions in the federal budget and appropriations process.
5. Our AMA supports postgraduate medical education service obligations through programs where the expectation for service, such as military service, is reasonable and explicitly delineated in the contract with the trainee.
6. Our AMA opposes the blanket imposition of service obligations through any program where physician trainees rotate through the facility as one of many sites for their training.

H-460.995, "Support for Careers in Research"

Our AMA: (1) recognizes the serious decline in the number of physicians seeking to prepare for a career in research, which is fundamental to the advancement of the practice of medicine, and urges that: (a) medical students be made aware of the challenging and important career option of biomedical research, and (b) schools of medicine be made aware of the impending shortage and provide increased opportunities for students to participate in research; and (2) supports policies and legislation designed to increase the number of physician-investigators. Such support should include encouragement for training of physicians in careers in biomedical research and for supportive legislation to make physician-investigators eligible for forgiveness in certain government scholarship and loan programs for qualified candidates in numbers consistent with national needs.

H-200.949, "Principles of and Actions to Address Primary Care Workforce"

1. Our patients require a sufficient, well-trained supply of primary care physicians--family physicians, general internists, general pediatricians, and obstetricians/gynecologists--to meet the nation's current and projected demand for health care services.
2. To help accomplish this critical goal, our American Medical Association (AMA) will work with a variety of key stakeholders, to include federal and state legislators and regulatory bodies; national and state specialty societies and medical associations, including those representing primary care fields; and accreditation, certification, licensing, and regulatory bodies from across the continuum of medical education (undergraduate, graduate, and continuing medical education).
3. Through its work with these stakeholders, our AMA will encourage development and dissemination of innovative models to recruit medical students interested in primary care, train primary care physicians, and enhance both the perception and the reality of primary care practice, to encompass the following components: a) Changes to medical school admissions and recruitment of medical students to primary care specialties, including counseling of medical students as they develop their career plans; b) Curriculum changes throughout the medical education continuum; c) Expanded financial aid and debt relief options; d) Financial and logistical support for primary care practice, including adequate reimbursement, and enhancements to the practice environment to ensure professional satisfaction and practice sustainability; and e) Support for research and advocacy related to primary care.
4. Admissions and recruitment: The medical school admissions process should reflect the specific institution's mission. Those schools with missions that include primary care should consider those predictor variables among applicants that are associated with choice of these specialties.
5. Medical schools, through continued and expanded recruitment and outreach activities into secondary schools, colleges, and universities, should develop and increase the pool of applicants likely to practice primary care by seeking out those students whose profiles indicate a likelihood of practicing in primary care and underserved areas, while establishing strict guidelines to preclude discrimination.

6. Career counseling and exposure to primary care: Medical schools should provide to students career counseling related to the choice of a primary care specialty, and ensure that primary care physicians are well-represented as teachers, mentors, and role models to future physicians.
7. Financial assistance programs should be created to provide students with primary care experiences in ambulatory settings, especially in underserved areas. These could include funded preceptorships or summer work/study opportunities.
8. Curriculum: Voluntary efforts to develop and expand both undergraduate and graduate medical education programs to educate primary care physicians in increasing numbers should be continued. The establishment of appropriate administrative units for all primary care specialties should be encouraged.
9. Medical schools with an explicit commitment to primary care should structure the curriculum to support this objective. At the same time, all medical schools should be encouraged to continue to change their curriculum to put more emphasis on primary care.
10. All four years of the curriculum in every medical school should provide primary care experiences for all students, to feature increasing levels of student responsibility and use of ambulatory and community-based settings.
11. Federal funding, without coercive terms, should be available to institutions needing financial support to expand resources for both undergraduate and graduate medical education programs designed to increase the number of primary care physicians. Our AMA will advocate for public (federal and state) and private payers to a) develop enhanced funding and related incentives from all sources to provide education for medical students and resident/fellow physicians, respectively, in progressive, community-based models of integrated care focused on quality and outcomes (such as the patient-centered medical home and the chronic care model) to enhance primary care as a career choice; b) fund and foster innovative pilot programs that change the current approaches to primary care in undergraduate and graduate medical education, especially in urban and rural underserved areas; and c) evaluate these efforts for their effectiveness in increasing the number of students choosing primary care careers and helping facilitate the elimination of geographic, racial, and other health care disparities.
12. Medical schools and teaching hospitals in underserved areas should promote medical student and resident/fellow physician rotations through local family health clinics for the underserved, with financial assistance to the clinics to compensate their teaching efforts.
13. The curriculum in primary care residency programs and training sites should be consistent with the objective of training generalist physicians. Our AMA will encourage the Accreditation Council for Graduate Medical Education to (a) support primary care residency programs, including community hospital-based programs, and (b) develop an accreditation environment and novel pathways that promote innovations in graduate medical education, using progressive, community-based models of integrated care focused on quality and outcomes (such as the patient-centered medical home and the chronic care model).
14. The visibility of primary care faculty members should be enhanced within the medical school, and positive attitudes toward primary care among all faculty members should be encouraged.
15. Support for practicing primary care physicians: Administrative support mechanisms should be developed to assist primary care physicians in the logistics of their practices, along with enhanced efforts to reduce administrative activities unrelated to patient care, to help ensure professional satisfaction and practice sustainability.
16. There should be increased financial incentives for physicians practicing primary care, especially those in rural and urban underserved areas, to include scholarship or loan repayment programs, relief of professional liability burdens, and Medicaid case management programs, among others. Our AMA will advocate to state and federal legislative and regulatory bodies, among others, for development of public and/or private incentive programs, and expansion and increased funding for existing programs, to further encourage practice in underserved areas and

decrease the debt load of primary care physicians. The imposition of specific outcome targets should be resisted, especially in the absence of additional support to the schools.
17. Our AMA will continue to advocate, in collaboration with relevant specialty societies, for the recommendations from the AMA/Specialty Society RVS Update Committee (RUC) related to reimbursement for E&M services and coverage of services related to care coordination, including patient education, counseling, team meetings and other functions; and work to ensure that private payers fully recognize the value of E&M services, incorporating the RUC-recommended increases adopted for the most current Medicare RBRVS.
18. Our AMA will advocate for public (federal and state) and private payers to develop physician reimbursement systems to promote primary care and specialty practices in progressive, community-based models of integrated care focused on quality and outcomes such as the patient-centered medical home and the chronic care model consistent with current AMA Policies H-160.918 and H-160.919.
19. There should be educational support systems for primary care physicians, especially those practicing in underserved areas.
20. Our AMA will urge urban hospitals, medical centers, state medical associations, and specialty societies to consider the expanded use of mobile health care capabilities.
21. Our AMA will encourage the Centers for Medicare & Medicaid Services to explore the use of telemedicine to improve access to and support for urban primary care practices in underserved settings.
22. Accredited continuing medical education providers should promote and establish continuing medical education courses in performing, prescribing, interpreting and reinforcing primary care services.
23. Practicing physicians in other specialties--particularly those practicing in underserved urban or rural areas--should be provided the opportunity to gain specific primary care competencies through short-term preceptorships or postgraduate fellowships offered by departments of family medicine, internal medicine, pediatrics, etc., at medical schools or teaching hospitals. In addition, part-time training should be encouraged, to allow physicians in these programs to practice concurrently, and further research into these concepts should be encouraged.
24. Our AMA supports continued funding of Public Health Service Act, Title VII, Section 747, and encourages advocacy in this regard by AMA members and the public.
25. Research: Analysis of state and federal financial assistance programs should be undertaken, to determine if these programs are having the desired workforce effects, particularly for students from disadvantaged groups and those that are underrepresented in medicine, and to gauge the impact of these programs on elimination of geographic, racial, and other health care disparities. Additional research should identify the factors that deter students and physicians from choosing and remaining in primary care disciplines. Further, our AMA should continue to monitor trends in the choice of a primary care specialty and the availability of primary care graduate medical education positions. The results of these and related research endeavors should support and further refine AMA policy to enhance primary care as a career choice.

D-200.982, "Diversity in the Physician Workforce and Access to Care"

Our AMA will: (1) continue to advocate for programs that promote diversity in the US medical workforce, such as pipeline programs to medical schools; (2) continue to advocate for adequate funding for federal and state programs that promote interest in practice in underserved areas, such as those under Title VII of the Public Health Service Act, scholarship and loan repayment programs under the National Health Services Corps and state programs, state Area Health Education Centers, and Conrad 30, and also encourage the development of a centralized database of scholarship and loan repayment programs; and (3) continue to study the factors that support and

those that act against the choice to practice in an underserved area, and report the findings and solutions at the 2008 Interim Meeting.

D-305.983, "Strategies to Combat Mid-year and Retroactive Tuition Increases"

Our AMA will: (1) assist state medical societies in advocacy efforts in opposition to mid-year and retroactive tuition increases, tuition taxes, and any other attendance-based taxes by any government entity at both public and private medical schools; (2) make available, upon request, the judicial precedent that would support a successful legal challenge to mid-year tuition increases; and (3) continue to encourage individual medical schools and universities, federal and state agencies, and others to expand options and opportunities for financial aid to medical students.

H-305.988, "Cost and Financing of Medical Education and Availability of First-Year Residency Positions"

Our AMA:
1. believes that medical schools should further develop an information system based on common definitions to display the costs associated with undergraduate medical education;
2. in studying the financing of medical schools, supports identification of those elements that have implications for the supply of physicians in the future;
3. believes that the primary goal of medical school is to educate students to become physicians and that despite the economies necessary to survive in an era of decreased funding, teaching functions must be maintained even if other commitments need to be reduced;
4. believes that a decrease in student enrollment in medical schools may not result in proportionate reduction of expenditures by the school if quality of education is to be maintained;
5. supports continued improvement of the AMA information system on expenditures of medical students to determine which items are included, and what the ranges of costs are;
6. supports continued study of the relationship between medical student indebtedness and career choice;
7. believes medical schools should avoid counterbalancing reductions in revenues from other sources through tuition and student fee increases that compromise their ability to attract students from diverse backgrounds;
8. supports expansion of the number of affiliations with appropriate hospitals by institutions with accredited residency programs;
9. encourages for profit-hospitals to participate in medical education and training;
10. supports AMA monitoring of trends that may lead to a reduction in compensation and benefits provided to resident physicians;
11. encourages all sponsoring institutions to make financial information available to help residents manage their educational indebtedness; and
12. will advocate that resident and fellow trainees should not be financially responsible for their training.

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

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

2. Our AMA will work to obtain full restoration and protection of federal Title VII funding, and similar state funding programs, for the Centers of Excellence Program, Health Careers Opportunity Program, Area Health Education Centers, and other programs that support physician training, recruitment, and retention in geographically-underserved areas.
3. Our AMA will take a leadership role in efforts to enhance diversity in the physician workforce, including engaging in broad-based efforts that involve partners within and beyond the medical profession and medical education community.
4. Our AMA will encourage the Liaison Committee on Medical Education to assure that medical schools demonstrate compliance with its requirements for a diverse student body and faculty.
5. Our AMA will develop an internal education program for its members on the issues and possibilities involved in creating a diverse physician population.
6. Our AMA will provide on-line educational materials for its membership that address diversity issues in patient care including, but not limited to, culture, religion, race and ethnicity.
7. Our AMA will create and support programs that introduce elementary through high school students, especially those from groups that are underrepresented in medicine (URM), to healthcare careers.
8. Our AMA will create and support pipeline programs and encourage support services for URM college students that will support them as they move through college, medical school and residency programs.
9. Our AMA will recommend that medical school admissions committees use holistic assessments of admission applicants that take into account the diversity of preparation and the variety of talents that applicants bring to their education.
10. Our AMA will advocate for the tracking and reporting to interested stakeholders of demographic information pertaining to URM status collected from Electronic Residency Application Service (ERAS) applications through the National Resident Matching Program (NRMP).
11. Our AMA will continue the research, advocacy, collaborative partnerships and other work that was initiated by the Commission to End Health Care Disparities.
12. Our AMA opposes legislation that would undermine institutions' ability to properly employ affirmative action to promote a diverse student population.
13. Our AMA: (a) supports the publication of a white paper chronicling health care career pipeline programs (also known as pathway programs) across the nation aimed at increasing the number of programs and promoting leadership development of underrepresented minority health care professionals in medicine and the biomedical sciences, with a focus on assisting such programs by identifying best practices and tracking participant outcomes; and (b) will work with various stakeholders, including medical and allied health professional societies, established biomedical science pipeline programs and other appropriate entities, to establish best practices for the sustainability and success of health care career pipeline programs.
14. Our AMA will work with the AAMC and other stakeholders to create a question for the AAMC electronic medical school application to identify previous pipeline program (also known as pathway program) participation and create a plan to analyze the data in order to determine the effectiveness of pipeline programs.

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REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 5-N-21

Subject:	Investigation of Existing Barriers for Osteopathic Medical Students Applying for Away Rotations
Presented by:	Niranjan Rao, MD, Chair
Referred to:	Reference Committee C

American Medical Association (AMA) Policy H-295.876 (3), "Equal Fees for Osteopathic and Allopathic Medical Students," asks that our AMA:

> work with relevant stakeholders to explore reasons behind application barriers that result in discrimination against osteopathic medical students when applying to elective visiting clinical rotations and generate a report with the findings by the 2020 Interim Meeting.

This report is in response to this policy.

Testimony on this topic during the 2019 Interim Meeting noted that U.S. osteopathic medical students are charged fees in excess of those charged to U.S. allopathic medical students for the same clinical rotations at some U.S. allopathic medical schools. These fees represent a financial barrier to career opportunities for osteopathic medical students in that these clinical experiences are often useful to support applications to graduate medical education (GME) programs. Testimony also noted that AMA policy "discourages discrimination against medical students by institutions and programs based on osteopathic or allopathic training…[and]…encourages equitable fees for allopathic and osteopathic medical students in access to clinical electives."

INTRODUCTION

Medical students seek elective clinical experiences at institutions other than their home institution ("away electives") for a number of reasons, including exposure to specialties and subspecialties not available at their home institutions, working with special populations, obtaining letters of reference to support residency applications, and experiencing diverse or different health care systems. Perhaps the most important reason students seek these experiences is to explore the training environment at institutions where they are considering applying for GME positions. In this regard, these away electives have the potential to benefit the student, the specialty program, and the institution hosting the elective, and potentially serve to help both learner and program achieve the best match to meet their respective objectives. Mueller et al, in a study of allopathic medical schools, found that the most common reason for a school to support a visiting medical student program was recruitment into its residency programs, and the most common reason for students to participate is to secure residency positions in those programs.[1]

BACKGROUND

The Association of American Medical Colleges (AAMC) supports students seeking away electives through the online Visiting Student Learning Opportunities (VSLO) program, which includes a Visiting Student Application Service (VSAS) for students and host institutions.[2] Most, if not all, allopathic medical schools utilize VSAS to manage visiting student applications. The fee to use VSAS is $40 for the first three applications and $15 per application thereafter. Institutions are also charged a fee to use the system, but the institutional fee structure is not published. The VSLO website notes that participating host institutions may have their own fee structures and may charge a processing fee or tuition but specifies that only the AAMC may charge fees that are referred to as application fees. Host institutions may charge applicants processing fees, registration fees, or other types of fees, as long as these fees are not labeled as application fees. VSLO also allows host institutions to select the home institutions from which they will accept applications.

The Accreditation Council for Graduate Medical Education (ACGME) reached an agreement with the American Osteopathic Association and American Association of Colleges of Osteopathic Medicine to develop a single accreditation system for GME in early 2014. Transition to the ACGME Single Accreditation System began in 2015, and by June 2020 the transition was complete. One benefit of the Single Accreditation System is to offer all U.S. medical school graduates a uniform GME pathway, allowing them to seek admission into any residency and fellowship program. Any graduate of a college of medicine accredited by the Commission on Osteopathic College Accreditation (COCA), a medical school within the United States or Canada accredited by the Liaison Committee on Medical Education (LCME), or a medical school outside the United States or Canada that meets the established eligibility criteria is eligible to enter an ACGME-accredited program.[3]

Beginning in 2020, the National Resident Matching Program (NRMP) supported the first combined Match for allopathic and osteopathic medical students into programs accredited through the ACGME's Single Accreditation System.

THE ROLE OF ELECTIVE OPPORTUNITIES FOR VISITING MEDICAL STUDENTS IN RESIDENCY PROGRAM DECISIONS

As noted in the introduction, medical students seek away elective experiences to explore programs and make themselves known to the host programs. In this regard, the experiences are often referred to as "audition electives." The literature offers conflicting information about whether audition electives are important in securing a position. Data from the 2014 NRMP Program Director Survey showed that program directors consider the audition elective to be an important factor for deciding whom to interview and rank.[4] Some studies have demonstrated that audition electives are important in the selection of applicants,[5,6] while others have shown that audition electives have no effect on the selection of applicants.[1,7,8,9,10,11]

POTENTIAL BARRIERS IMPOSED UPON OSTEOPATHIC STUDENTS SEEKING ELECTIVE EXPERIENCES AT ALLOPATHIC SCHOOLS IMPOSE BARRIERS

To explore the concerns raised in Policy H-295.876 (3), AMA staff reviewed the websites of allopathic medical schools in six states (California, Florida, Illinois, New York, Ohio, and Texas) and 13 school websites identified by representatives of the AMA Medical Student Section. This sample represented 66 of the 144 allopathic medical schools in the United States that have graduated at least one full class of students. The websites from 15 of these schools indicated that visiting medical students must be from LCME-accredited schools, and four of the 15 explicitly

stated that osteopathic medical students would not be accepted. For 11 of the school websites, either information on visiting medical students was not included or the visiting student websites were suspended due to the COVID-19 pandemic. The remaining 39 school websites indicated that both allopathic and osteopathic medical students could participate as visiting medical students. One of the schools indicated that osteopathic students would be accepted for most, but not all, of the electives. Three schools required passage of United States Medical Licensing Examination (USMLE) Step 1. Of the 39 schools accepting both allopathic and osteopathic medical students, 23 charged a fee. For 19 of these schools, the fee was the same for both allopathic and osteopathic medical students, with a range of $25 to $300 per elective request submitted (mean = $165). The remaining four fee-charging schools in this review charged a differential fee for allopathic and osteopathic student applicants. One school's fees were listed as $125 and $295 for allopathic and osteopathic students, respectively; one school's fees were listed as $150 and $4,150 for allopathic and osteopathic students, respectively; and one school's fees were listed as $500 and $5,000 for allopathic and osteopathic students, respectively. The fourth school listed a $30 processing fee for osteopathic students and $900 per week of elective for osteopathic students, while no fees were listed for allopathic students. The review did not explore the practices of GME programs that operate independently from medical schools but may offer clinical elective experiences for medical students.

Data from an unpublished survey of 182 allopathic schools and GME programs, conducted by the Council of Osteopathic Student Government Presidents, had similar findings. That study found that 24 of the surveyed programs did not accept applications for electives from osteopathic medical students, 35 programs listed "licensing exam disparities" including inequitable class ranking requirements and minimum scores for osteopathic students compared to allopathic students, and 14 programs listed financial disparities between allopathic student applicants and osteopathic student applicants in the application process.[12] (The authors of this study have asked for the following disclaimer: "This is unofficial student-collected information that is not yet submitted for official publication or research.")

HOW SOME FEE STRUCTURES AND OTHER BARRIERS DISADVANTAGE OSTEOPATHIC MEDICAL STUDENTS

The ACGME states that the benefits of the Single Accreditation System include offering all U.S. medical graduates a uniform education pathway, increasing collaboration among the medical education community, providing consistency across all residency and fellowship programs, reducing costs, and increasing opportunities for osteopathic GME. Despite these stated benefits, surveys of allopathic schools demonstrate that osteopathic medical students continue to face barriers in applying for away rotations at allopathic institutions and programs. These barriers include: 1) outright exclusion from participation; 2) the requirement for a passing USMLE score; and 3) inequitable fees. Upon finding these barriers while considering sites for away electives, osteopathic students would be deterred from applying for an elective opportunity, thus potentially decreasing the likelihood of applying to the program for residency or decreasing the likelihood of securing a position after application. Further, the existence of these barriers implies that osteopathic medical students are less welcome, or unwelcome, at the host institution. These barriers also have implications for educational experiences, in that osteopathic medical students may not be able to participate and learn in specialty and subspecialty areas not otherwise available to them at their home institutions.

While it is difficult to determine if these financial and other barriers to away experiences have affected the competitiveness of osteopathic medical students applying for ACGME-accredited residencies, Match data suggest a possible relationship between type of training and securing a

residency position. Although NRMP data show that the match rates for senior osteopathic medical students in the United States have steadily but slowly risen from 82.7 percent in 2015 to 88.1 percent in 2019, during the same period match rates for seniors in allopathic programs were consistently higher, fluctuating between 93.9 percent and 94.3 percent. Beginning in 2020, the ACGME completed the transition to the Single Accreditation System to accredit participating osteopathic residency programs that were previously only accredited by the AOA, thereby offering all U.S. medical school graduates (allopathic and osteopathic) a uniform graduate medical education pathway and allowing them to seek admission into any residency or fellowship program. According to NRMP data for the 2020 match, 90.7 percent of osteopathic senior medical students and 93.7 percent of allopathic senior medical students matched to a PGY-1 position. However, data among specialties demonstrate notable differences between the match rates of allopathic and osteopathic senior student applicants. For example, the unmatched rate for osteopathic senior students ranking only one specialty was approximately double the unmatched rate for allopathic senior students in emergency medicine, neurological surgery, neurology, obstetrics and gynecology, orthopedic surgery, plastic surgery, and general surgery. It should be noted that it is unknown whether financial or other barriers to elective experiences played any role in these outcomes.[13]

Complicating this report are the effects of the COVID-19 pandemic, which has markedly limited away electives for all students and the effects of the increasing use of virtual interviews for residency programs and applicants. The planned conversion of USMLE Step 1 from a scored exam to pass/fail may also have future implications for this issue.

SUMMARY AND RECOMMENDATIONS

The AMA, in a joint statement with the American Osteopathic Association, has described the equivalency of training, licensure, and practice rights of allopathic and osteopathic physicians, and the vital role osteopathic physicians serve in the nation's health care delivery system.[14] Thus, it stands to reason that osteopathic medical students should have equal access to elective training opportunities.

Information collected from allopathic medical school websites indicates that barriers exist for participation of osteopathic medical students in elective experiences at some allopathic medical schools. The barriers include: 1) outright exclusion from participation; 2) the requirement for a passing USMLE score; and 3) inequitable fees. These barriers may deter osteopathic students from applying to or being accepted for a residency position. Programs that lack exposure to potential qualified osteopathic students may rank candidates disparately. These barriers on osteopathic medical students are in contradiction to the goal of the ACGME Single Accreditation System to offer all U.S. medical school graduates a uniform GME pathway.

Further, current AMA Policy H-295.876 discourages discrimination against medical students based on allopathic or osteopathic undergraduate medical education training and encourages equitable fee structures for allopathic and osteopathic medical student applicants to clinical electives.

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

1. That our American Medical Association (AMA) amend Policy H-295.876 (2), "Equal Fees for Osteopathic and Allopathic Medical Students," by addition and deletion as shown below. (Modify Current HOD Policy)

Our AMA encourages equitable access to and equitable fees for clinical electives for allopathic and osteopathic medical students ~~in access to clinical electives~~, while respecting the rights of individual allopathic and osteopathic medical schools to set their own policies related to visiting students.

2. That our AMA encourage the Association of American Medical Colleges to request that its member institutions promote equitable access to clinical electives for allopathic and osteopathic medical students and charge equitable fees to visiting allopathic and osteopathic medical students. (New HOD Policy)

3. That our AMA encourage the Accreditation Council for Graduate Medical Education to require its accredited programs to work with their respective affiliated institutions to ensure equitable access to clinical electives for allopathic and osteopathic medical students and charge equitable fees to visiting allopathic and osteopathic medical students. (New HOD Policy)

Fiscal note: $500.

RELEVANT AMA POLICY

H-295.876, "Equal Fees for Osteopathic and Allopathic Medical Students"

3. Our AMA, in collaboration with the American Osteopathic Association, discourages discrimination against medical students by institutions and programs based on osteopathic or allopathic training.
4. Our AMA encourages equitable fees for allopathic and osteopathic medical students in access to clinical electives, while respecting the rights of individual allopathic and osteopathic medical schools to set their own policies related to visiting students.
Citation: Res. 809, I-05 Appended: CME Rep. 6, A-07 Modified: CCB/CLRPD Rep. 2, A-14

H-295.867, "Expanding the Visiting Students Application Service for Visiting Student Electives in the Fourth Year"

1. Our American Medical Association strongly encourages the Association of American Medical Colleges (AAMC) to expand eligibility for the Visiting Students Application Service (VSAS) to medical students from Commission on Osteopathic College Accreditation (COCA)-accredited medical schools.
2. Our AMA supports and encourages the AAMC in its efforts to increase the number of members and non-member programs in the VSAS, such as medical schools accredited by COCA and teaching institutions not affiliated with a medical school.
3. Our AMA encourages the AAMC to ensure that member institutions that previously accepted both allopathic and osteopathic applications for fourth year clerkships prior to VSAS implementation continue to have a mechanism for accepting such applications of osteopathic medical students.
Citation: Res. 910, I-09 Reaffirmed: CME Rep. 01, A-19

H-310.909, "ACGME Residency Program Entry Requirements"

Our AMA supports entry into Accreditation Council on Graduate Medical Education (ACGME) accredited residency and fellowship programs from either ACGME-accredited programs or American Osteopathic Association-accredited programs.
Citation: Res. 920, I-12

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 301
(N-21)

Introduced by: Medical Student Section

Subject: Equitable Reporting of USMLE Step 1 Scores

Referred to: Reference Committee C

Whereas, As a result of the slowly-increasing burden of residency applications with only 0.85 positions per applicant in 2020, program directors have become more reliant on quantitative markers for comparison and screening of residency applicants[1]; and

Whereas, The United States Medical Licensing Examination (USMLE) Step 1 exam and Comprehensive Osteopathic Medical Licensing Examination of the United States (COMLEX-USA) Level 1 are psychometric instruments utilized as a top selection criteria by residency programs[2-7]; and

Whereas, There is weak correlation between the 3-digit numerical USMLE Step 1 scores and clinical outcomes related to patient care[8-10]; and

Whereas, Due to perceived adverse impact of the current overemphasis on USMLE performance residency screening and selection, the Federation of State Medical Boards (FSMB) and the National Board of Medical Examiners (NBME) announced a change to a Pass/Fail scoring system for the USMLE Step 1 beginning as early as January of 2022[11-12]; and

Whereas, The National Board of Osteopathic Medical Examiners (NBOME) announced in December 2020 that the COMLEX-USA Level 1 exam will shift to a Pass/Fail scoring system beginning on May 1, 2022[13]; and

Whereas, An estimated 9.2% of all medical students elect to take a leave of absence or participate in dual degree programs, thus taking longer than the standard four years to graduate from undergraduate medical education[14]; and

Whereas, The timing of the change to Pass/Fail will have profound impacts on dual degree students and a significant group of other students who may have received a 3-digit numerical score on USMLE Step 1, but will be applying after the Pass/Fail scoring policy has been implemented[15-16]; and

Whereas, The USMLE announced in July 2020 that all students who have taken Step 1 with 3-digit numerical score report will continue to have this score reported on their USMLE transcript moving forward[17]; and

Whereas, In anticipation of a 3-digit numerical score being removed in favor of a Pass/Fail scoring system for USMLE Step 1, 81% of Residency Program Directors plan to shift emphasis on a scored USMLE Step 2 Clinical Knowledge (CK) following the change in score reporting of USMLE Step 1, resulting in potential inequities with some residency applicants reporting two numerical scored metrics versus some applicants reporting only one[18]; and

Whereas, This imbalance of score reporting within a pool of applicants may lead to inequitable assessment of 3-digit-scoring dual degree students against their Pass/Fail-scored peers[14,19]; therefore be it

RESOLVED, That our American Medical Association work with appropriate stakeholders to release guidance for residency and fellowship program directors on equitably comparing students who received 3-digit United States Medical Licensing Examination Step 1 or Comprehensive Osteopathic Medical Licensing Examination Level 1 scores and students who received Pass/Fail scores. (Directive to Take Action)

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

Date Received: 09/30/21

AUTHORS STATEMENT OF PRIORITY

Given that the FSMB and the NBME announced a change to a Pass/Fail scoring system for the USMLE Step 1 beginning as early as January of 2022, students applying for residency as early as the 2023 residency cycle will be impacted by imbalanced score reporting. This imbalance within a pool of applicants may lead to inequitable assessment of 3-Digit-scoring students against their Pass/Fail-scored peers. These differences in scoring systems will affect dual degree students, students who conducted a research year during their training, and students who take step 1 prior to January of 2022 but still apply during the 2023 application cycle. This is an extremely timely issue and needs to be heard soon so AMA CME has the appropriate time to report back and recommend policy to the AMA before there is a mixed-score residency cycle. Since this will take time for the CME to generate and is crucial for the cohorts of students who will be applying with 3-Digit scores alongside their Pass/Fail-scored peers, this should be heard at the November 2021 meeting.

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RELEVANT AMA POLICY

The Grading Policy for Medical Licensure Examinations H-275.953

1. Our AMA's representatives to the ACGME are instructed to promote the principle that selection of residents should be based on a broad variety of evaluative criteria, and to propose that the ACGME General Requirements state clearly that residency program directors must not use NBME or USMLE ranked passing scores as a screening criterion for residency selection.
2. Our AMA adopts the following policy on NBME or USMLE examination scoring: (a) Students receive "pass/fail" scores as soon as they are available. (If students fail the examinations, they may request their numerical scores immediately.) (b) Numerical scores are reported to the state licensing authorities upon request by the applicant for licensure. At this time, the applicant may request a copy of his or her numerical scores. (c) Scores are reported in pass/fail format for each student to the medical school. The school also receives a frequency distribution of numerical scores for the aggregate of their students.
3. Our AMA will co-convene the appropriate stakeholders to study possible mechanisms for transitioning scoring of the USMLE and COMLEX exams to a Pass/Fail system in order to avoid the inappropriate use of USMLE and COMLEX scores for screening residency applicants while still affording program directors adequate information to meaningfully and efficiently assess medical student applications, and that the recommendations of this study be made available by the 2019 Interim Meeting of the AMA House of Delegates.
4. Our AMA will: (a) promote equal acceptance of the USMLE and COMLEX at all United States residency programs; (b) work with appropriate stakeholders including but not limited to the National Board of Medical Examiners, Association of American Medical Colleges, National Board of Osteopathic Medical Examiners, Accreditation Council for Graduate Medical Education and American Osteopathic Association to educate Residency Program Directors on how to interpret and use COMLEX scores; and (c) work with Residency Program Directors to promote higher COMLEX utilization with residency program matches in light of the new single accreditation system.
CME Rep. G; Reaffirmed by Res. 310, A-98; Reaffirmed: CME Rep. 3, A-04; Reaffirmed: CME Rep. 2, A-14; Appended: Res. 309, A-17; Modified: Res. 318, A-18; Appended: Res. 955, I-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 302
(N-21)

Introduced by: Medical Student Section

Subject: University Land Grant Status in Medical School Admissions

Referred to: Reference Committee C

Whereas, American Indian and Alaska Natives (AI-AN) are defined as “people having origins in any of the original peoples of North America, South America, and Central America, who maintain tribal affiliation or community attachment”[1]; and

Whereas, The United States Department of Interior Bureau of Indian Affairs recognizes 574 American Indian and Alaska Native tribes and villages in the United States, with many more recognized at the state level or in the process of seeking recognition[2]; and

Whereas, AI-AN communities in the U.S. continue to have lower health status and disproportionate disease burden compared with other Americans, secondary to inadequate education, disproportionate poverty, discrimination in the delivery of health services, and cultural differences with healthcare providers[3]; and

Whereas, AI-AN individuals born today have a life expectancy that is 5.5 years less than the U.S. all races population (73.0 years to 78.5 years, respectively)[3]; and

Whereas, The Government Accountability Office reports that 29% of the Indian Health Services’ physician positions are vacant, with some regions operating with up to 46% of their physician positions vacant[4]; and

Whereas, The Association of American Medical Colleges (AAMC) recognizes that the continued underrepresentation of AI-AN physicians should be viewed as a national crisis faced by all medical schools[5]; and

Whereas, Only 0.56% of active physicians identify as AI-AN alone or in combination with another race, far below their national representation of 2%[1,5]; and

Whereas, From 2013-2018, greater than 95% of AI-AN tribes (547 / 574) had fewer than 10 AI-AN applicants to medical school and 99% of AI-AN tribes (567 / 574) had fewer than 10 matriculants to medical school[5]; and

Whereas, AI-AN medical students are more likely to practice medicine in tribal communities, and are more likely than their peers to practice in underserved areas[5]; and

Whereas, In a 2016-2017 Curriculum Inventory, the AAMC reported that only 11% of U.S. MD-granting institutions (14 of 131 participating) had AI-AN health content[5]; and

Whereas, Including AI-AN health content in medical school curricula provides visibility to and acknowledges the importance of the health of [AI-AN] communities and prepares all trainees to work with AI-AN communities[5]; and

Whereas, The AAMC recommends the development of focused AI-AN medical education curricula and medical school admissions policies that consider the political identity, rather than solely the race or ethnicity, of American Indians and Alaska Natives from tribal nations[5-6]; and

Whereas, The U.S. Supreme Court has recognized that membership status in a tribe does not violate laws related to non-discrimination or equal protection under the law (i.e., anti-affirmative action laws), iterating that tribal status is distinct from race[6-7]; and

Whereas, The AAMC has recognized that anti-affirmative action laws have impacted AI-AN application and matriculation rates to medical school despite rulings from the U.S. Supreme Court[8]; and

Whereas, There are professional programs that preferentially consider tribal membership in admissions and funding awards, such as UCLA School of Law, UC San Diego, and UC Davis School of Medicine[6,9-10]; and

Whereas, Our AMA, and other national, state, specialty, and county medical societies recommend special programs for the recruitment and training of American Indians in health careers at all levels and urge that these be expanded to meet the needs of AI-AN communities (H-350.981); and

Whereas, Our AMA opposes legislation and other related efforts that undermine the ability of institutions to employ affirmative action to promote a diverse student population (D-200.985); and

Whereas, As tribal membership is legally distinct from race, then it follows that tribal membership can be affirmatively considered outside of holistic admissions processes, including those that have race-blind admissions (e.g., California, Washington)[5]; and

Whereas, The federal government has a unique legal and political relationship with Tribal governments established through and confirmed by the United States Constitution, treaties, federal statutes, executive orders, and judicial decisions[11]; and

Whereas, Central to this relationship is the Federal Government's trust responsibility to protect the interests of Indian Tribes and communities[11]; and

Whereas, The federal trust responsibility is a legal obligation under which the federal government "has charged itself with moral obligations of the highest responsibility and trust" toward AI-AN tribes, which include healthcare and education[12-13]; and

Whereas, The federal trust responsibility establishes the basis for a variety of federal services provided to federally recognized tribes and villages, including healthcare delivery and the provision of physicians, on the basis of tribal membership, not racial identification[14]; and

Whereas, Land-grant universities are universities built on land transferred to states from the federal government with the enactment of the Morrill Act of 1862[15-16]; and

Whereas, Land-grant universities, many of which house associated medical schools, continue to derive benefit from 10.7 million acres of land expropriated from nearly 250 tribal nations, while being federal and state government-funded entities[15-16]; and

Whereas, As a creation of the federal government and recipient of federal funding, land-grant universities therefore play a role in the fulfillment of the federal trust responsibility; and

Whereas, The rationale for this policy is supported by the following 29 health and policy-related organizations and AI-AN tribes: American Indian Studies Department, CSUSM, San Marcos, CA, American Indian Studies Department, SDSU, San Diego, CA, Association of American Indian Physicians, Oklahoma City, OK, California Consortium for Urban Indian Health, Sacramento, CA, California Democratic Party Native American Caucus, Sacramento, CA, California Indian Culture and Sovereignty Center, San Marcos, CA, California Rural Indian Health Board, Roseville, CA, Center for Native American Youth, Washington, DC, Coyote Valley Band of Pomo Indians, Redwood Valley, CA, Federated Indians of Graton Rancheria, Rohnert Park, CA, Indian Health Center of Santa Clara Valley, San Jose, CA, Indian Health Council, Valley Center, CA, La Jolla Band of Luiseño Indians, Pauma Valley, CA, Latino Medical Student Association, Chicago, IL, Mesa Grande Band of Mission Indians, Santa Ysabel, CA, National Indian Health Board, Washington, DC, Native American Health Center, Oakland, CA, Pala Band of Mission Indians, Pala, CA, Pauma Band of Luiseño Indians, Pauma Valley, CA, Rincon Band of Luiseño Indians, Valley Center, CA, Sacramento Native American Health Center, Sacramento, CA, San Diego American Indian Health Center, San Diego, CA, San Manuel Band of Mission Indians, Highland, CA, San Pasqual Band of Mission Indians, Valley Center, CA Santa Ynez Band of Chumash Indians, Santa Ynez, CA, Student National Medical Association, Washington, DC Sycuan Band of the Kumeyaay Nation, El Cajon, CA, Tolowa Dee-ni' Nation, Smith River, CA, Wilton Rancheria, Elk Grove, CA[17]; and

Whereas, Medical schools are chiefly responsible for the composition of the physician workforce and set their own admissions criteria[5]; therefore be it

RESOLVED, That our American Medical Association work with the Association of American Medical Colleges, Liaison Committee on Medical Education, Association of American Indian Physicians, and Association of Native American Medical Students to design and promulgate medical school admissions recommendations in line with the federal trust responsibility (Directive to Take Action); and be it further

RESOLVED, That our AMA amend Policy H-350.981, "AMA Support of American Indian Health Career Opportunities," by addition to read as follows:

AMA Support of American Indian Health Career Opportunities H-350.981

AMA policy on American Indian health career opportunities is as follows:
(1) Our AMA, and other national, state, specialty, and county medical societies recommend special programs for the recruitment and training of American Indians in health careers at all levels and urge that these be expanded.
(2) Our AMA support the inclusion of American Indians in established medical training programs in numbers adequate to meet their needs. Such training programs for American Indians should be operated for a sufficient period of time to ensure a continuous supply of physicians and other health professionals. These efforts should include, but are not limited to, priority consideration of applicants who self-identify as American Indian or Alaska Native and can provide some form of affiliation with an American Indian or Alaska Native tribe in the United States, and robust mentorship programs that support the successful advancement of these trainees.
(3) Our AMA utilize its resources to create a better awareness among physicians and other health providers of the special problems and needs of American Indians and that particular emphasis be placed on the need for stronger clinical exposure and a greater number of health professionals to work among the American Indian population.
(4) Our AMA continue to support the concept of American Indian self-determination as imperative to the success of American Indian programs, and recognize that enduring acceptable solutions to American Indian health problems can only result from program and project beneficiaries having initial and continued contributions in planning and program operations.
(5) Our AMA acknowledges long-standing federal precedent that membership or lineal descent from an enrolled member in a federally recognized tribe is distinct from racial identification as American Indian or Alaska Native and should be considered in medical school admissions even when restrictions on race-conscious admissions policies are in effect.
(6) Our AMA will engage with the Association of Native American Medical Students and Association of American Indian Physicians to design and disseminate American Indian and Alaska Native medical education curricula that prepares trainees to serve AI-AN communities. (Modify Current HOD Policy)

Fiscal Note: Moderate - between $5,000 - $10,000

Date Received: 09/30/21

AUTHORS STATEMENT OF PRIORITY

While there has been great interest and appropriate action taken to advance all aspects of health equity, the number of American Indian and Alaska Native physicians-in-training is actually, alarmingly, declining. Many contributing factors, from K-12 completion, lack of mentorship, steep financial barriers, and medical school admissions are at play. In 2018, the Association of American Medical Colleges charged academic medicine with examining policies and procedures that may prohibit greater workforce parity for American Indian and Alaska Native physicians. This resolution enables the relevant entities within our AMA to engage with the Association of American Indian Physicians and Association of Native American Physicians to promulgate best practices in admissions and interview considerations for American Indian and Alaska Natives. These efforts would be especially focused at land-grant allopathic and osteopathic training programs given their unique history during periods of Indigenous displacement and assimilation. Further, we direct our AMA to engage in American Indian and Alaska Native-focused medical school didactic and clinical content creation to prepare trainees from all backgrounds to serve rural and urban tribes across the United States.

This resolution aligns with our AMA's consideration of the urgent priority of advancing health equity and redressing the harms of past and present discrimination. Our delegation urges that this issue be considered by our AMA at this meeting, so that the existing and troubling health disparities may be prevented from widening.

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RELEVANT AMA POLICY

AMA Support of American Indian Health Career Opportunities H-350.981

AMA policy on American Indian health career opportunities is as follows: (1) Our AMA, and other national, state, specialty, and county medical societies recommend special programs for

the recruitment and training of American Indians in health careers at all levels and urge that these be expanded.
(2) Our AMA support the inclusion of American Indians in established medical training programs in numbers adequate to meet their needs. Such training programs for American Indians should be operated for a sufficient period of time to ensure a continuous supply of physicians and other health professionals.
(3) Our AMA utilize its resources to create a better awareness among physicians and other health providers of the special problems and needs of American Indians and that particular emphasis be placed on the need for additional health professionals to work among the American Indian population.
(4) Our AMA continue to support the concept of American Indian self-determination as imperative to the success of American Indian programs, and recognize that enduring acceptable solutions to American Indian health problems can only result from program and project beneficiaries having initial and continued contributions in planning and program operations.
CLRPD Rep. 3, I-98; Reaffirmed: Res. 221, A-07; Reaffirmation: A-12

Indian Health Service H-350.977
The policy of the AMA is to support efforts in Congress to enable the Indian Health Service to meet its obligation to bring American Indian health up to the general population level. The AMA specifically recommends: (1) Indian Population: (a) In current education programs, and in the expansion of educational activities suggested below, special consideration be given to involving the American Indian and Alaska native population in training for the various health professions, in the expectation that such professionals, if provided with adequate professional resources, facilities, and income, will be more likely to serve the tribal areas permanently; (b) Exploration with American Indian leaders of the possibility of increased numbers of nonfederal American Indian health centers, under tribal sponsorship, to expand the American Indian role in its own health care; (c) Increased involvement of private practitioners and facilities in American Indian care, through such mechanisms as agreements with tribal leaders or Indian Health Service contracts, as well as normal private practice relationships; and (d) Improvement in transportation to make access to existing private care easier for the American Indian population.
(2) Federal Facilities: Based on the distribution of the eligible population, transportation facilities and roads, and the availability of alternative non-federal resources, the AMA recommends that those Indian Health Service facilities currently necessary for American Indian care be identified and that an immediate construction and modernization program be initiated to bring these facilities up to current standards of practice and accreditation.
(3) Manpower: (a) Compensation for Indian Health Service physicians be increased to a level competitive with other Federal agencies and nongovernmental service; (b) Consideration should be given to increased compensation for service in remote areas; (c) In conjunction with improvement of Service facilities, efforts should be made to establish closer ties with teaching centers, thus increasing both the available manpower and the level of professional expertise available for consultation; (d) Allied health professional staffing of Service facilities should be maintained at a level appropriate to the special needs of the population served; (e) Continuing education opportunities should be provided for those health professionals serving these communities, and especially those in remote areas, and, increased peer contact, both to maintain the quality of care and to avert professional isolation; and (f) Consideration should be given to a federal statement of policy supporting continuation of the Public Health Service to reduce the great uncertainty now felt by many career officers of the corps.
(4) Medical Societies: In those states where Indian Health Service facilities are located, and in counties containing or adjacent to Service facilities, that the appropriate medical societies should explore the possibility of increased formal liaison with local Indian Health Service physicians. Increased support from organized medicine for improvement of health care provided

under their direction, including professional consultation and involvement in society activities should be pursued.
(5) Our AMA also support the removal of any requirement for competitive bidding in the Indian Health Service that compromises proper care for the American Indian population.
CLRPD Rep. 3, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmation: A-12; Reaffirmed: Res. 233, A-13

Improving Health Care of American Indians H-350.976
Our AMA recommends that: (1) All individuals, special interest groups, and levels of government recognize the American Indian people as full citizens of the U.S., entitled to the same equal rights and privileges as other U.S. citizens.
(2) The federal government provide sufficient funds to support needed health services for American Indians.
(3) State and local governments give special attention to the health and health-related needs of non-reservation American Indians in an effort to improve their quality of life.
(4) American Indian religions and cultural beliefs be recognized and respected by those responsible for planning and providing services in Indian health programs.
(5) Our AMA recognize the "medicine man" as an integral and culturally necessary individual in delivering health care to American Indians.
(6) Strong emphasis be given to mental health programs for American Indians in an effort to reduce the high incidence of alcoholism, homicide, suicide, and accidents.
(7) A team approach drawing from traditional health providers supplemented by psychiatric social workers, health aides, visiting nurses, and health educators be utilized in solving these problems.
(8) Our AMA continue its liaison with the Indian Health Service and the National Indian Health Board and establish a liaison with the Association of American Indian Physicians.
(9) State and county medical associations establish liaisons with intertribal health councils in those states where American Indians reside.
(10) Our AMA supports and encourages further development and use of innovative delivery systems and staffing configurations to meet American Indian health needs but opposes overemphasis on research for the sake of research, particularly if needed federal funds are diverted from direct services for American Indians.
(11) Our AMA strongly supports those bills before Congressional committees that aim to improve the health of and health-related services provided to American Indians and further recommends that members of appropriate AMA councils and committees provide testimony in favor of effective legislation and proposed regulations.
CLRPD Rep. 2, I-98; Reaffirmed: Res. 22, A-07; Reaffirmation: A-12; Reaffirmed: Res. 233, A-13

Desired Qualifications for Indian Health Service Director H-440.816
Our AMA supports the following qualifications for the Director of the Indian Health Service:
1. Health profession, preferably an MD or DO, degree and at least five years of clinical experience at an Indian Health Service medical site or facility.
2. Demonstrated long-term interest, commitment, and activity within the field of Indian Health.
3. Lived on tribal lands or rural American Indian or Alaska Native community or has interacted closely with an urban Indian community.
4. Leadership position in American Indian/Alaska Native health care or a leadership position in an academic setting with activity in American Indian/ Alaska Native health care.
5. Experience in the Indian Health Service or has worked extensively with Indian Health Service, Tribal, or Urban Indian health programs.

6. Knowledge and understanding of social and cultural issues affecting the health of American Indian and Alaska Native people.
7. Knowledge of health disparities among Native Americans / Alaska Natives, including the pathophysiological basis of the disease process and the social determinants of health that affect disparities.
8. Experience working with Indian Tribes and Nations and an understanding of the Trust Responsibility of the Federal Government for American Indian and Alaska Natives as well as an understanding of the sovereignty of American Indian and Alaska Native Nations.
9. Experience with management, budget, and federal programs.
Res. 603, I-18

Strong Opposition to Cuts in Federal Funding for the Indian Health Service D-350.987
1. Our AMA will strongly advocate that all of the facilities that serve Native Americans under the Indian Health Service be adequately funded to fulfill their mission and their obligations to patients and providers.
2. Our AMA will ask Congress to take all necessary action to immediately restore full and adequate funding to the Indian Health Service.
3. Our AMA adopts as new policy that the Indian Health Service not be treated more adversely than other health plans in the application of any across the board federal funding reduction.
4. In the event of federal inaction to restore full and adequate funding to the Indian Health Service, our AMA will consider the option of joining in legal action seeking to require the federal government to honor existing treaties, obligations, and previously established laws regarding funding of the Indian Health Service.
5. Our AMA will request that Congress: (A) amend the Indian Health Care Improvement Act to authorize Advanced Appropriations; (B) include our recommendation for the Indian Health Service (HIS) Advanced Appropriations in the Budget Resolution; and (C) include in the enacted appropriations bill IHS Advanced Appropriations.
Res. 233, A-13; Appended: Res. 229, A-14

Plan for Continued Progress Toward Health Equity H-180.944
Health equity, defined as optimal health for all, is a goal toward which our AMA will work by advocating for health care access, research, and data collection; promoting equity in care; increasing health workforce diversity; influencing determinants of health; and voicing and modeling commitment to health equity.
BOT Rep. 33, A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 303
(N-21)

Introduced by: Medical Student Section

Subject: Decreasing Bias in Evaluations of Medical Student Performance

Referred to: Reference Committee C

Whereas, Racism, xenophobia, sexism, homophobia, transphobia, ableism, and other discrimination within medical education manifests through structural, institutional, and interpersonal means, which necessitates a multilevel approach in order to be addressed[1-6]; and

Whereas, The Liaison Committee on Medical Education (LCME) defines a "fair and formal process for taking any action that may affect the status of a medical student" such that a "...student will be assessed by individuals who have not previously formed an opinion of the student's abilities, professionalism, and/or suitability to become a physician"[7]; and

Whereas, Differences by race and ethnicity have been documented in receipt of Honors in various clerkships, Alpha Omega Alpha membership, Medical Student Performance Evaluation (MSPE) comments, and the residency application process[8-13]; and

Whereas, Latinx and Black physicians received a disproportionate number of complaints to the Medical Board of California and had greater odds of complaints escalating to investigations, and Latinx physicians had a greater probability of having an investigation result in disciplinary action in a study of 32,978 complaints to the Medical Board of California between 2003 and 2013[14]; and

Whereas, A study in which fabricated prospective students with names indicative of their gender and race sent emails to professors to discuss research opportunities demonstrated that professors were most responsive to students whose names indicated that they were Caucasian and male, especially professors at private universities and those in more lucrative fields[15]; and

Whereas, A study of medical students in the Netherlands revealed that non-Dutch students were referred to the professional behavior board at a rate 2.86 times that of Dutch students, and noted that "(cultural) differences in communication styles may be a possible explanation for these students' underperformance" and "more subjective grading in clinical training can lead to what is called 'examiner bias', which means that examiners have a more positive view on people who are similar to themselves"[16]; and

Whereas, Blinded peer review of scientific abstracts has been found to resolve statistically-significant bias against non-English speaking authors, international institutions, and less prestigious institutions[17]; and

Whereas, All component groups of the admissions committee of the Ohio State University College of Medicine showed implicit white preference on the Black-White Implicit Association Test, with men and faculty members displaying greater levels of unconscious bias than women and students[18]; and

Whereas, It has been shown implicit bias in grading can be mitigated through the recruitment of diverse disciplinary and grade review committees and through implicit bias awareness training[18-23]; and

Whereas, There is existing literature on the benefits of a two-interval grading system from a wellbeing standpoint, but there are limited published studies delineating the specific impact of this grading schema for minoritized trainees in terms of residency applications and career opportunities[24-26]; and

Whereas, The tiered grading system, often using grades of honors, high pass, pass, fail, or similar, is the most commonly used system for clerkship grading in allopathic US medical schools, while the two-interval, or pass/fail, system is most often used for clerkship grading in osteopathic US medical schools although a number of US allopathic medical schools such as Harvard, University of San Francisco, the David Geffen School of Medicine at UCLA, and the Perelman School of Medicine at the University of Pennsylvania have transitioned to two-tiered systems for at least some of their required clerkships[27-29]; and

Whereas, Inequities present in the tiered grading system have been shown to cascade to subsequent levels of training, leading to the persistent underrepresentation of Black, Latinx/Hispanic, American Indian, Alaska Native, and certain Asian subgroups in medicine[30]; and

Whereas, Two-interval grading and hybrid systems that incorporate pass/fail grades may minimize the disparities in the quantitative aspects of performance evaluations; however, this does not protect from the racial biases codified in the language of medical student performance evaluations as well as other aspects of residency applications, and as such, there is not enough evidence to support or oppose two-interval grading systems for clinical clerkships at this time[31-38]; therefore be it

RESOLVED, That our American Medical Association work with appropriate stakeholders, such as the Liaison Committee on Medical Education and the Commission on Osteopathic College Accreditation to support: 1) increased diversity and implementation of implicit bias training to individuals responsible for assessing medical students' performance, including the evaluation of professionalism and investigating and ruling upon disciplinary matters involving medical students; and 2) that all reviews of medical student professionalism and academic performance be conducted in a blinded manner when doing such does not interfere with appropriate scoring (Directive to Take Action); and be it further

RESOLVED, That our AMA study the impact of two-interval clinical clerkship grading systems on residency application outcomes and clinical performance during residency. (Directive to Take Action)

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

Date Received: 09/30/21

AUTHORS STATEMENT OF PRIORITY

The combined upheaval of the pandemic and reckoning with long-standing racial bias has led to much needed and urgent introspection within the medical community. Importantly, there has been increased recognition of the degree to which bias built into medical training is harming minoritized trainees. Differences by race and ethnicity have been documented in receipt of Honors in various clerkships, Alpha Omega Alpha membership, professionalism reviews, Medical Student Performance Evaluation (MSPE) comments, and the residency application process. These disparities impact individuals during their training and thus go on to affect the rest of their careers. If we in medicine truly aim to eliminate the racism that plagues our history and our present-day practices, we must begin addressing the inequities that arise in training. This resolution gives the AMA concrete ways to do so by giving us the position of supporting increased training for faculty who evaluate, supporting blinded reviews of students, and studying whether two-interval (pass/fail) grading for clerkships may reduce some of the racial bias evident in evaluations. It is imperative that our AMA continue to move forward in examining and alleviating the ways racism, biases, and microaggressions affect trainees' experiences and careers; to do otherwise would be to devalue the difficulties faced and hard work so many have given to overcome these inequities.

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RELEVANT AMA POLICY

E-8.5 Disparities in Health Care

Stereotypes, prejudice, or bias based on gender expectations and other arbitrary evaluations of any individual can manifest in a variety of subtle ways. Differences in treatment that are not directly related to differences in individual patients' clinical needs or preferences constitute inappropriate variations in health care. Such variations may contribute to health outcomes that are considerably worse in members of some populations than those of members of majority populations.

This represents a significant challenge for physicians, who ethically are called on to provide the same quality of care to all patients without regard to medically irrelevant personal characteristics.

To fulfill this professional obligation in their individual practices physicians should:

(a) Provide care that meets patient needs and respects patient preferences.

(b) Avoid stereotyping patients.

(c) Examine their own practices to ensure that inappropriate considerations about race, gender identify, sexual orientation, sociodemographic factors, or other nonclinical factors, do not affect clinical judgment.

(d) Work to eliminate biased behavior toward patients by other health care professionals and staff who come into contact with patients.

(e) Encourage shared decision making.

(f) Cultivate effective communication and trust by seeking to better understand factors that can influence patients' health care decisions, such as cultural traditions, health beliefs and health literacy, language or other barriers to communication and fears or misperceptions about the health care system.

The medical profession has an ethical responsibility to:

(g) Help increase awareness of health care disparities.
(h) Strive to increase the diversity of the physician workforce as a step toward reducing health care disparities.
(i) Support research that examines health care disparities, including research on the unique health needs of all genders, ethnic groups, and medically disadvantaged populations, and the development of quality measures and resources to help reduce disparities.
Issued: 2016

Fostering Professionalism During Medical School and Residency Training D-295.983
(1) Our AMA, in consultation with other relevant medical organizations and associations, will work to develop a framework for fostering professionalism during medical school and residency training. This planning effort should include the following elements: (a) Synthesize existing goals and outcomes for professionalism into a practice-based educational framework, such as provided by the AMA's Principles of Medical Ethics.
(b) Examine and suggest revisions to the content of the medical curriculum, based on the desired goals and outcomes for teaching professionalism.
(c) Identify methods for teaching professionalism and those changes in the educational environment, including the use of role models and mentoring, which would support trainees' acquisition of professionalism.
(d) Create means to incorporate ongoing collection of feedback from trainees about factors that support and inhibit their development of professionalism.
(2) Our AMA, along with other interested groups, will continue to study the clinical training environment to identify the best methods and practices used by medical schools and residency programs to fostering the development of professionalism.
CME Rep. 3, A-01; Reaffirmation: I-09; Reaffirmed: CME Rep. 01, A-19; Modified: CME Rep. 01, A-20

11.2.1 Professionalism in Health Care Systems
Containing costs, promoting high-quality care for all patients, and sustaining physician professionalism are important goals. Models for financing and organizing the delivery of health care services often aim to promote patient safety and to improve quality and efficiency. However, they can also pose ethical challenges for physicians that could undermine the trust essential to patient-physician relationships.
Payment models and financial incentives can create conflicts of interest among patients, health care organizations, and physicians. They can encourage undertreatment and overtreatment, as well as dictate goals that are not individualized for the particular patient.
Structures that influence where and by whom care is delivered—such as accountable care organizations, group practices, health maintenance organizations, and other entities that may emerge in the future—can affect patients' choices, the patient-physician relationship, and physicians' relationships with fellow health care professionals.
Formularies, clinical practice guidelines, and other tools intended to influence decision making, may impinge on physicians' exercise of professional judgment and ability to advocate effectively for their patients, depending on how they are designed and implemented.
Physicians in leadership positions within health care organizations should ensure that practices for financing and organizing the delivery of care:
(a) Are transparent.
(b) Reflect input from key stakeholders, including physicians and patients.
(c) Recognize that over reliance on financial incentives may undermine physician professionalism.
(d) Ensure ethically acceptable incentives that:
(i) are designed in keeping with sound principles and solid scientific evidence. Financial incentives should be based on appropriate comparison groups and cost data and adjusted to

reflect complexity, case mix, and other factors that affect physician practice profiles. Practice guidelines, formularies, and other tools should be based on best available evidence and developed in keeping with ethics guidance;
(ii) are implemented fairly and do not disadvantage identifiable populations of patients or physicians or exacerbate health care disparities;
(iii) are implemented in conjunction with the infrastructure and resources needed to support high-value care and physician professionalism;
(iv) mitigate possible conflicts between physicians' financial interests and patient interests by minimizing the financial impact of patient care decisions and the overall financial risk for individual physicians.
(e) Encourage, rather than discourage, physicians (and others) to:
(i) provide care for patients with difficult to manage medical conditions;
(ii) practice at their full capacity, but not beyond.
(f) Recognize physicians' primary obligation to their patients by enabling physicians to respond to the unique needs of individual patients and providing avenues for meaningful appeal and advocacy on behalf of patients.
(g) Are routinely monitored to:
(i) identify and address adverse consequences;
(ii) identify and encourage dissemination of positive outcomes.
All physicians should:
(h) Hold physician-leaders accountable to meeting conditions for professionalism in health care systems.
(i) Advocate for changes in health care payment and delivery models to promote access to high-quality care for all patients.
Issued: 2016

Reducing Racial and Ethnic Disparities in Health Care D-350.995
Our AMA's initiative on reducing racial and ethnic disparities in health care will include the following recommendations:
(1) Studying health system opportunities and barriers to eliminating racial and ethnic disparities in health care.
(2) Working with public health and other appropriate agencies to increase medical student, resident physician, and practicing physician awareness of racial and ethnic disparities in health care and the role of professionalism and professional obligations in efforts to reduce health care disparities.
(3) Promoting diversity within the profession by encouraging publication of successful outreach programs that increase minority applicants to medical schools, and take appropriate action to support such programs, for example, by expanding the "Doctors Back to School" program into secondary schools in minority communities.
BOT Rep. 4, A-03; Reaffirmation: A-11; Reaffirmation: A-16; Reaffirmed: CMS Rep. 10, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 304
(N-21)

Introduced by: Medical Student Section

Subject: Reducing Complexity in the Public Service Loan Forgiveness Program

Referred to: Reference Committee C

Whereas, The number of student borrowers in the United States totals 44.7 million individuals with total indebtedness exceeding $1.5 trillion[1]; and

Whereas, Nearly three-fourths of medical students have financed their education with the use of loans [2-4]; and

Whereas, Median student debt upon graduation from medical school totals $200,000, and the total repayment over a physician's career can total from $365,000 to $440,000 depending on repayment plan[3-4]; and

Whereas, If the increasing trend of median student debt upon graduation from $100,000-$135,000 in 2003 to $200,000 in 2012 continues, then resident physicians could face loan payments comprising up to 50% of their monthly earnings[5-7]; and

Whereas, The majority of surgical residents believe that their loan debt is a significant financial burden and that high debt levels influence their "salary goals, perceptions of financial security, career choices, and practice location"[5]; and

Whereas, High medical school debt has been associated with several adverse outcomes including decreased quality of life, increased stress, lower test scores, and burnout[5,8]; and

Whereas, There are several repayment options for students, including standard repayment programs, income-based repayment programs, and public student loan forgiveness[9-10]; and

Whereas, The Public Service Loan Forgiveness (PSLF) Program was established under the *College Cost Reduction and Access Act of 2007* in an attempt to reduce federal student loan debt burden for indebted professionals working in the public sector[11]; and

Whereas, The Federal Student Aid (FSA) Office of the United States Department of Education introduced the Employment Certification Form (ECF) in 2012 to try and assist borrowers in assuring that their employment qualifies for the PSLF program, 31% of ECFs received were deemed ineligible[12-13]; and

Whereas, The FSA began accepting applications in the Fall of 2017 for individuals seeking to be beneficiaries of this program with 187,053 PSLF applications received and processed through May 2020[13]; and

Whereas, The overwhelming majority of these applications, 183,356 or 98.02%, were deemed ineligible due to ineligible qualifying payments (57%), missing information (24%), or no eligible loans (14%)[13]; and

Whereas, The stringent requirements for qualifying payments have disqualified over 104,000 applications for forgiveness and include that every single one of the 120 payments be under a qualifying repayment plan, be for the full amount as shown on the bill, be no later than 15 days from the due date, be made while employed full-time by a qualifying employer, and be made only during periods when you are required to make a payment[13]; and

Whereas, Missing information on PSLF applications has disqualified over 44,000 individuals from forgiveness with missing information ranging from incorrect employer address on the ECF to failure to recertify repayment plans yearly during the entirety of repayment[13-14]; and

Whereas, Over 25,000 applications were denied due to ineligible loans forcing them to consolidate into a qualifying loan and restart their 120 qualifying payments if they chose to participate in PSLF[13]; and

Whereas, The United States Department of Education sought to address these issues in part by expanding eligibility and reconsideration for loan forgiveness via the Temporary Expanded PSLF (TEPSLF) made possible by a $350-million appropriation through the *Consolidated Appropriations Act of 2018*[15-16]; and

Whereas, Under the TEPSLF program, 93.8% of applicants for forgiveness have been denied with the total amount of discharged funds to approved applicants thus far comprising only 16.1% of the total appropriation by Congress[13]; and

Whereas, AMA policy H-305.925, "Principles of and Actions to Address Medical Education Costs and Student Debt," advocates for increased medical student and physician benefits in PSLF[17], it fails to recognize the TEPSLF and does not acknowledge nor attempt to resolve the bureaucratic complexities that make properly accessing these benefits feasible; therefore be it

RESOLVED, That our American Medical Association amend Policy H-305.925, "Principles of and Actions to Address Medical Education Costs and Student Debt," by addition to read as follows:

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

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

1. Collaborate with members of the Federation and the medical education community, and with other interested organizations, to address the cost of medical education and medical student debt through public- and private-sector advocacy.
2. Vigorously advocate for and support expansion of and adequate funding for federal scholarship and loan repayment programs--such as those from the National Health Service Corps, Indian Health Service, Armed Forces, and Department of Veterans Affairs, and for comparable programs from states and

the private sector--to promote practice in underserved areas, the military, and academic medicine or clinical research.

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

avoid charging any overly broad and ill-defined fees, such as but not limited to professional fees; (h) Use their collective purchasing power to obtain discounts for their students on necessary medical equipment, textbooks, and other educational supplies; (i) Work to ensure stable funding, to eliminate the need for increases in tuition and fees to compensate for unanticipated decreases in other sources of revenue; mid-year and retroactive tuition increases should be opposed.

13. Support and encourage state medical societies to support further expansion of state loan repayment programs, particularly those that encompass physicians in non-primary care specialties.
14. Take an active advocacy role during reauthorization of the Higher Education Act and similar legislation, to achieve the following goals: (a) Eliminating the single holder rule; (b) Making the availability of loan deferment more flexible, including broadening the definition of economic hardship and expanding the period for loan deferment to include the entire length of residency and fellowship training; (c) Retaining the option of loan forbearance for residents ineligible for loan deferment; (d) Including, explicitly, dependent care expenses in the definition of the “cost of attendance”; (e) Including room and board expenses in the definition of tax-exempt scholarship income; (f) Continuing the federal Direct Loan Consolidation program, including the ability to “lock in” a fixed interest rate, and giving consideration to grace periods in renewals of federal loan programs; (g) Adding the ability to refinance Federal Consolidation Loans; (h) Eliminating the cap on the student loan interest deduction; (i) Increasing the income limits for taking the interest deduction; (j) Making permanent the education tax incentives that our AMA successfully lobbied for as part of Economic Growth and Tax Relief Reconciliation Act of 2001; (k) Ensuring that loan repayment programs do not place greater burdens upon married couples than for similarly situated couples who are cohabitating; (l) Increasing efforts to collect overdue debts from the present medical student loan programs in a manner that would not interfere with the provision of future loan funds to medical students.
15. Continue to work with state and county medical societies to advocate for adequate levels of medical school funding and to oppose legislative or regulatory provisions that would result in significant or unplanned tuition increases.
16. Continue to study medical education financing, so as to identify long-term strategies to mitigate the debt burden of medical students, and monitor the short- and long-term impact of the economic environment on the availability of institutional and external sources of financial aid for medical students, as well as on choice of specialty and practice location.
17. Collect and disseminate information on successful strategies used by medical schools to cap or reduce tuition.
18. Continue to monitor the availability of and encourage medical schools and residency/fellowship programs to (a) provide financial aid opportunities and financial planning/debt management counseling to medical students and resident/fellow physicians; (b) work with key stakeholders to develop and disseminate standardized information on these topics for use by medical students, resident/fellow physicians, and young physicians; and (c) share innovative approaches with the medical education community.
19. Seek federal legislation or rule changes that would stop Medicare and Medicaid decertification of physicians due to unpaid student loan debt. The AMA believes that it is improper for physicians not to repay their educational loans, but

assistance should be available to those physicians who are experiencing hardship in meeting their obligations.

20. Related to the Public Service Loan Forgiveness (PSLF) Program, our AMA supports increased medical student and physician benefits the program, and will: (a) Advocate that all resident/fellow physicians have access to PSLF during their training years; (b) Work with the United States Department of Education to ensure that applicants of the PSLF and its supplemental extensions, such as Temporary Expanded Public Service Loan Forgiveness (TEPSLF), are provided with the necessary information to successfully complete the program(s) in a timely manner; (c) Work with the United States Department of Education to ensure individuals who would otherwise qualify for PSLF and its supplemental extensions, such as TEPSLF, are not disqualified from the program(s) due to bureaucratic complexities; (~~b~~d) Advocate against a monetary cap on PSLF and other federal loan forgiveness programs; (~~c~~e) Work with the United States Department of Education to ensure that any cap on loan forgiveness under PSLF be at least equal to the principal amount borrowed; (~~d~~f) Ask the United States Department of Education to include all terms of PSLF in the contractual obligations of the Master Promissory Note; (~~e~~g) Encourage the Accreditation Council for Graduate Medical Education (ACGME) to require residency/fellowship programs to include within the terms, conditions, and benefits of program appointment information on the PSLF program qualifying status of the employer; (~~f~~h) Advocate that the profit status of a physicians training institution not be a factor for PSLF eligibility; (~~g~~i) Encourage medical school financial advisors to counsel wise borrowing by medical students, in the event that the PSLF program is eliminated or severely curtailed; (~~h~~j) Encourage medical school financial advisors to increase medical student engagement in service-based loan repayment options, and other federal and military programs, as an attractive alternative to the PSLF in terms of financial prospects as well as providing the opportunity to provide care in medically underserved areas; (~~i~~k) Strongly advocate that the terms of the PSLF that existed at the time of the agreement remain unchanged for any program participant in the event of any future restrictive changes.
21. Advocate for continued funding of programs including Income-Driven Repayment plans for the benefit of reducing medical student load burden.
22. Formulate a task force to look at undergraduate medical education training as it relates to career choice, and develop new polices and novel approaches to prevent debt from influencing specialty and subspecialty choice.
23. Strongly advocate for the passage of legislation to allow medical students, residents and fellows who have education loans to qualify for interest-free deferment on their student loans while serving in a medical internship, residency, or fellowship program, as well as permitting the conversion of currently unsubsidized Stafford and Graduate Plus loans to interest free status for the duration of undergraduate and graduate medical education. (Modify Current HOD Policy)

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

Date Received: 09/30/21

AUTHORS STATEMENT OF PRIORITY

The COVID-19 pandemic has had immense impacts upon the mental health of healthcare workers. The U.S. is already suffering a physician shortage, and with the early retirements, burnout, and even deaths of physicians due to the pandemic, this shortage is only going to get worse. It is urgent that our AMA begin acting promptly and aggressively to improve conditions that lead to poor mental health and burnout. One of the most important of these is the immeasurable debt that future physicians acquire in medical school and which plagues them throughout their residency training and deep into their medical career. Studies have shown these huge debts to be associated with decreased quality of life and increased stress and burnout for physicians. The Public Service Loan Forgiveness (PSLF) Program was established in an attempt to reduce federal student loan debt burden for indebted professionals working in the public sector. However, the vast majority of applications for this program are deemed ineligible due, simply, to some missing information.

This resolution gives our AMA a tangible advocacy direction to take action to ensure that PSLF applicants have timely access and the necessary support and information to be successful in their applications to this vital tool against debt-induced burnout. Given the effects of this continuing pandemic upon the health and mental health of physicians, it is vital that our AMA commit to concrete action to better protect the rising physician workforce.

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RELEVANT AMA POLICY

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

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

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

indebtedness and payment schedules prior to their graduation; (f) Inform students of all government loan opportunities and disclose the reasons that preferred lenders were chosen; (g) Ensure that all medical student fees are earmarked for specific and well-defined purposes, and avoid charging any overly broad and ill-defined fees, such as but not limited to professional fees; (h) Use their collective purchasing power to obtain discounts for their students on necessary medical equipment, textbooks, and other educational supplies; (i) Work to ensure stable funding, to eliminate the need for increases in tuition and fees to compensate for unanticipated decreases in other sources of revenue; mid-year and retroactive tuition increases should be opposed.

13. Support and encourage state medical societies to support further expansion of state loan repayment programs, particularly those that encompass physicians in non-primary care specialties.

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

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

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

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

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

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

20. Related to the Public Service Loan Forgiveness (PSLF) Program, our AMA supports increased medical student and physician benefits the program, and will: (a) Advocate that all resident/fellow physicians have access to PSLF during their training years; (b) Advocate against a monetary cap on PSLF and other federal loan forgiveness programs; (c) Work with the United States Department of Education to ensure that any cap on loan forgiveness under PSLF be at least equal to the principal amount borrowed; (d) Ask the United States Department of Education to include all terms of PSLF in the contractual obligations of the Master Promissory Note; (e) Encourage the Accreditation Council for Graduate Medical Education (ACGME) to require residency/fellowship programs to include within the terms, conditions, and benefits of program appointment information on the PSLF program qualifying status of the employer; (f) Advocate that the profit status of a physicians training institution not be a factor for PSLF eligibility; (g) Encourage medical school financial advisors to counsel wise borrowing by medical students, in the event that the PSLF program is eliminated or severely curtailed; (h) Encourage medical school financial advisors to increase medical student engagement in service-based loan repayment options, and other federal and military programs, as an attractive alternative to the PSLF in terms of financial prospects as well as providing the opportunity to provide care in medically underserved areas; (i) Strongly advocate that the terms of the PSLF that existed at the time of the agreement remain unchanged for any program participant in the event of any future restrictive changes.
21. Advocate for continued funding of programs including Income-Driven Repayment plans for the benefit of reducing medical student load burden.
22. Formulate a task force to look at undergraduate medical education training as it relates to career choice, and develop new polices and novel approaches to prevent debt from influencing specialty and subspecialty choice.
23. Strongly advocate for the passage of legislation to allow medical students, residents and fellows who have education loans to qualify for interest-free deferment on their student loans while serving in a medical internship, residency, or fellowship program, as well as permitting the conversion of currently unsubsidized Stafford and Graduate Plus loans to interest free status for the duration of undergraduate and graduate medical education.
CME Report 05, I-18; Appended: Res. 953, I-18; Reaffirmation: A-19; Appended: Res. 316, A-19; Appended: Res. 226, A-21; Reaffirmed in lieu of: Res. 311, A-21

Reduction in Student Loan Interest Rates D-305.984
1. Our AMA will actively lobby for legislation aimed at establishing an affordable student loan structure with a variable interest rate capped at no more than 5.0%.
2. Our AMA will work in collaboration with other health profession organizations to advocate for a reduction of the fixed interest rate of the Stafford student loan program and the Graduate PLUS loan program.
3. Our AMA will consider the total cost of loans including loan origination fees and benefits of federal loans such as tax deductibility or loan forgiveness when advocating for a reduction in student loan interest rates.
4. Our AMA will advocate for policies which lead to equal or less expensive loans (in terms of loan benefits, origination fees, and interest rates) for Grad-PLUS loans as this would change the status quo of high-borrowers paying higher interest rates and fees in addition to having a higher overall loan burden.
5. Our AMA will work with appropriate organizations, such as the Accreditation Council for Graduate Medical Education and the Association of American Medical Colleges, to collect

data and report on student indebtedness that includes total loan costs at completion of graduate medical education training.
Res. 316, A-03; Reaffirmed: BOT Rep. 28, A-13; Appended: Res. 302, A-13; Modified and Appended: 301, A-16

Fixing the VA Physician Shortage with Physicians D-510.990
1. Our AMA will work with the VA to enhance its loan forgiveness efforts to further incentivize physician recruiting and retention and improve patient access in the Veterans Administration facilities.
2. Our AMA will call for an immediate change in the Public Service Loan Forgiveness Program to allow physicians to receive immediate loan forgiveness when they practice in a Veterans Administration facility.
3. Our AMA will work with the Veterans Administration to minimize the administrative burdens that discourage or prevent non-VA physicians without compensation (WOCs) from volunteering their time to care for veterans.
4. Our AMA will: (a) continue to support the mission of the Department of Veterans Affairs Office of Academic Affiliations for expansion of graduate medical education (GME) residency positions; and (b) collaborate with appropriate stakeholder organizations to advocate for preservation of Veterans Health Administration funding for GME and support its efforts to expand GME residency positions in the federal budget and appropriations process.
5. Our AMA supports postgraduate medical education service obligations through programs where the expectation for service, such as military service, is reasonable and explicitly delineated in the contract with the trainee.
6. Our AMA opposes the blanket imposition of service obligations through any program where physician trainees rotate through the facility as one of many sites for their training.
Res. 1010, A-16; Appended: Res. 954, I-18; Appended: CME Rep. 6, I-19

Effectiveness of Strategies to Promote Physician Practice in Underserved Areas D-200.980
1. Our AMA, in collaboration with relevant medical specialty societies, will continue to advocate for the following: (a) Continued federal and state support for scholarship and loan repayment programs, including the National Health Service Corps, designed to encourage physician practice in underserved areas and with underserved populations. (b) Permanent reauthorization and expansion of the Conrad State 30 J-1 visa waiver program. (c) Adequate funding (up to at least FY 2005 levels) for programs under Title VII of the Health Professions Education Assistance Act that support educational experiences for medical students and resident physicians in underserved areas.

2. Our AMA encourages medical schools and their associated teaching hospitals, as well as state medical societies and other private sector groups, to develop or enhance loan repayment or scholarship programs for medical students or physicians who agree to practice in underserved areas or with underserved populations.

3. Our AMA will advocate to states in support of the introduction or expansion of tax credits and other practice-related financial incentive programs aimed at encouraging physician practice in underserved areas.

4. Our AMA will advocate for the creation of a national repository of innovations and experiments, both successful and unsuccessful, in improving access to and distribution of physician services to government-insured patients (National Access Toolbox).

5. Our AMA supports elimination of the tax liability when employers provide the funds to repay student loans for physicians who agree to work in an underserved area.

CME Rep. 1, I-08; Modified: CME Rep. 4, A-10; Reaffirmation I-11; Appended: Res. 110, A-12; Reaffirmation A-13; Reaffirmation A-14; Appended: Res. 312, I-16; Appended: Res 312, I-16

Educational Strategies for Meeting Rural Health Physician Shortage H-465.988
1. In light of the data available from the current literature as well as ongoing studies being conducted by staff, the AMA recommends that:
A. Our AMA encourage medical schools and residency programs to develop educationally sound rural clinical preceptorships and rotations consistent with educational and training requirements, and to provide early and continuing exposure to those programs for medical students and residents.
B. Our AMA encourage medical schools to develop educationally sound primary care residencies in smaller communities with the goal of educating and recruiting more rural physicians.
C. Our AMA encourage state and county medical societies to support state legislative efforts toward developing scholarship and loan programs for future rural physicians.
D. Our AMA encourage state and county medical societies and local medical schools to develop outreach and recruitment programs in rural counties to attract promising high school and college students to medicine and the other health professions.
E. Our AMA urge continued federal and state legislative support for funding of Area Health Education Centers (AHECs) for rural and other underserved areas.
F. Our AMA continue to support full appropriation for the National Health Service Corps Scholarship Program, with the proviso that medical schools serving states with large rural underserved populations have a priority and significant voice in the selection of recipients for those scholarships.
G. Our AMA support full funding of the new federal National Health Service Corps loan repayment program.
H. Our AMA encourage continued legislative support of the research studies being conducted by the Rural Health Research Centers funded by the National Office of Rural Health in the Department of Health and Human Services.
I. Our AMA continue its research investigation into the impact of educational programs on the supply of rural physicians.
J. Our AMA continue to conduct research and monitor other progress in development of educational strategies for alleviating rural physician shortages.
K. Our AMA reaffirm its support for legislation making interest payments on student debt tax deductible.
L. Our AMA encourage state and county medical societies to develop programs to enhance work opportunities and social support systems for spouses of rural practitioners.
2. Our AMA will work with state and specialty societies, medical schools, teaching hospitals, the Accreditation Council for Graduate Medical Education (ACGME), the Centers for Medicare and Medicaid Services (CMS) and other interested stakeholders to identify,

encourage and incentivize qualified rural physicians to serve as preceptors and volunteer faculty for rural rotations in residency.
3. Our AMA will: (a) work with interested stakeholders to identify strategies to increase residency training opportunities in rural areas with a report back to the House of Delegates; and (b) work with interested stakeholders to formulate an actionable plan of advocacy with the goal of increasing residency training in rural areas.
4. Our AMA will undertake a study of issues regarding rural physician workforce shortages, including federal payment policy issues, and other causes and potential remedies (such as telehealth) to alleviate rural physician workforce shortages.
CME Rep. C, I-90; Reaffirmation A-00; Reaffirmation A-01; Reaffirmation I-01; Reaffirmed: CME Rep. 1, I-08; Reaffirmed: CEJA Rep. 06, A-18; Appended: Res. 956, I-18; Appended: Res. 318, A-19

Principles of and Actions to Address Primary Care Workforce H-200.949
1. Our patients require a sufficient, well-trained supply of primary care physicians--family physicians, general internists, general pediatricians, and obstetricians/gynecologists--to meet the nation's current and projected demand for health care services.
2. To help accomplish this critical goal, our American Medical Association (AMA) will work with a variety of key stakeholders, to include federal and state legislators and regulatory bodies; national and state specialty societies and medical associations, including those representing primary care fields; and accreditation, certification, licensing, and regulatory bodies from across the continuum of medical education (undergraduate, graduate, and continuing medical education).
3. Through its work with these stakeholders, our AMA will encourage development and dissemination of innovative models to recruit medical students interested in primary care, train primary care physicians, and enhance both the perception and the reality of primary care practice, to encompass the following components: a) Changes to medical school admissions and recruitment of medical students to primary care specialties, including counseling of medical students as they develop their career plans; b) Curriculum changes throughout the medical education continuum; c) Expanded financial aid and debt relief options; d) Financial and logistical support for primary care practice, including adequate reimbursement, and enhancements to the practice environment to ensure professional satisfaction and practice sustainability; and e) Support for research and advocacy related to primary care.
4. Admissions and recruitment: The medical school admissions process should reflect the specific institution's mission. Those schools with missions that include primary care should consider those predictor variables among applicants that are associated with choice of these specialties.
5. Medical schools, through continued and expanded recruitment and outreach activities into secondary schools, colleges, and universities, should develop and increase the pool of applicants likely to practice primary care by seeking out those students whose profiles indicate a likelihood of practicing in primary care and underserved areas, while establishing strict guidelines to preclude discrimination.
6. Career counseling and exposure to primary care: Medical schools should provide to students career counseling related to the choice of a primary care specialty, and ensure that primary care physicians are well-represented as teachers, mentors, and role models to future physicians.

7. Financial assistance programs should be created to provide students with primary care experiences in ambulatory settings, especially in underserved areas. These could include funded preceptorships or summer work/study opportunities.
8. Curriculum: Voluntary efforts to develop and expand both undergraduate and graduate medical education programs to educate primary care physicians in increasing numbers should be continued. The establishment of appropriate administrative units for all primary care specialties should be encouraged.
9. Medical schools with an explicit commitment to primary care should structure the curriculum to support this objective. At the same time, all medical schools should be encouraged to continue to change their curriculum to put more emphasis on primary care.
10. All four years of the curriculum in every medical school should provide primary care experiences for all students, to feature increasing levels of student responsibility and use of ambulatory and community-based settings.
11. Federal funding, without coercive terms, should be available to institutions needing financial support to expand resources for both undergraduate and graduate medical education programs designed to increase the number of primary care physicians. Our AMA will advocate for public (federal and state) and private payers to a) develop enhanced funding and related incentives from all sources to provide education for medical students and resident/fellow physicians, respectively, in progressive, community-based models of integrated care focused on quality and outcomes (such as the patient-centered medical home and the chronic care model) to enhance primary care as a career choice; b) fund and foster innovative pilot programs that change the current approaches to primary care in undergraduate and graduate medical education, especially in urban and rural underserved areas; and c) evaluate these efforts for their effectiveness in increasing the number of students choosing primary care careers and helping facilitate the elimination of geographic, racial, and other health care disparities.
12. Medical schools and teaching hospitals in underserved areas should promote medical student and resident/fellow physician rotations through local family health clinics for the underserved, with financial assistance to the clinics to compensate their teaching efforts.
13. The curriculum in primary care residency programs and training sites should be consistent with the objective of training generalist physicians. Our AMA will encourage the Accreditation Council for Graduate Medical Education to (a) support primary care residency programs, including community hospital-based programs, and (b) develop an accreditation environment and novel pathways that promote innovations in graduate medical education, using progressive, community-based models of integrated care focused on quality and outcomes (such as the patient-centered medical home and the chronic care model).
14. The visibility of primary care faculty members should be enhanced within the medical school, and positive attitudes toward primary care among all faculty members should be encouraged.
15. Support for practicing primary care physicians: Administrative support mechanisms should be developed to assist primary care physicians in the logistics of their practices, along with enhanced efforts to reduce administrative activities unrelated to patient care, to help ensure professional satisfaction and practice sustainability.
16. There should be increased financial incentives for physicians practicing primary care, especially those in rural and urban underserved areas, to include scholarship or loan repayment programs, relief of professional liability burdens, and Medicaid case management programs, among others. Our AMA will advocate to state and federal legislative and regulatory bodies, among others, for development of public and/or private incentive programs, and expansion and increased funding for existing programs, to further

encourage practice in underserved areas and decrease the debt load of primary care physicians. The imposition of specific outcome targets should be resisted, especially in the absence of additional support to the schools.
17. Our AMA will continue to advocate, in collaboration with relevant specialty societies, for the recommendations from the AMA/Specialty Society RVS Update Committee (RUC) related to reimbursement for E&M services and coverage of services related to care coordination, including patient education, counseling, team meetings and other functions; and work to ensure that private payers fully recognize the value of E&M services, incorporating the RUC-recommended increases adopted for the most current Medicare RBRVS.
18. Our AMA will advocate for public (federal and state) and private payers to develop physician reimbursement systems to promote primary care and specialty practices in progressive, community-based models of integrated care focused on quality and outcomes such as the patient-centered medical home and the chronic care model consistent with current AMA Policies H-160.918 and H-160.919.
19. There should be educational support systems for primary care physicians, especially those practicing in underserved areas.
20. Our AMA will urge urban hospitals, medical centers, state medical associations, and specialty societies to consider the expanded use of mobile health care capabilities.
21. Our AMA will encourage the Centers for Medicare & Medicaid Services to explore the use of telemedicine to improve access to and support for urban primary care practices in underserved settings.
22. Accredited continuing medical education providers should promote and establish continuing medical education courses in performing, prescribing, interpreting and reinforcing primary care services.
23. Practicing physicians in other specialties--particularly those practicing in underserved urban or rural areas--should be provided the opportunity to gain specific primary care competencies through short-term preceptorships or postgraduate fellowships offered by departments of family medicine, internal medicine, pediatrics, etc., at medical schools or teaching hospitals. In addition, part-time training should be encouraged, to allow physicians in these programs to practice concurrently, and further research into these concepts should be encouraged.
24. Our AMA supports continued funding of Public Health Service Act, Title VII, Section 747, and encourages advocacy in this regard by AMA members and the public.
25. Research: Analysis of state and federal financial assistance programs should be undertaken, to determine if these programs are having the desired workforce effects, particularly for students from disadvantaged groups and those that are underrepresented in medicine, and to gauge the impact of these programs on elimination of geographic, racial, and other health care disparities. Additional research should identify the factors that deter students and physicians from choosing and remaining in primary care disciplines. Further, our AMA should continue to monitor trends in the choice of a primary care specialty and the availability of primary care graduate medical education positions. The results of these and related research endeavors should support and further refine AMA policy to enhance primary care as a career choice.
CME Rep. 04, I-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 305
(N-21)

Introduced by: Medical Student Section

Subject: Increase Awareness Among Residency, Fellowship, and Academic Programs on the United States-Puerto Rico Relationship Status

Referred to: Reference Committee C

Whereas, There are four allopathic medical schools in Puerto Rico accredited by the Liaison Committee on Medical Education (LCME) and the Middle States Commission on Higher Education (MSCHE) and members of the Association of American Medical Colleges (AAMC); and

Whereas, Most medical students from Puerto Rican schools are United States citizens and are evaluated by the same standards and examinations administered by the United States Medical Licensing Examination (USMLE) and National Board of Medical Examiners (NBME) as other medical students in the United States[1]; and

Whereas, Based on total medical school enrollment during the 2019-2020 academic year, Puerto Rico ranked 22nd out of 46 states with medical schools with 1,494 enrolled medical students[2,3]; and

Whereas, Just like all other U.S. medical graduates, students from Puerto Rican schools utilize the Visiting Student Learning Opportunities (VSLO/VSAS) portal, the Electronic Residency Application Service (ERAS), and the National Resident Matching Program (NRMP) to apply for clinical rotations and residency programs in the continental U.S.; and

Whereas, Medical students attending Puerto Rican medical schools have historically faced many hurdles in their away rotations and residency application process as they are commonly misperceived as International Medical Graduate (IMG) students by other medical students, physicians, and healthcare professionals from the continental US[4] ; and

Whereas, A study in progress shows that recently graduated physicians from Puerto Rican medical schools have reported that during the process of away rotations and residency interviews, they had to explain their citizenship, the accreditation status of Puerto Rican medical schools, the board exams taken, clarify about not being an IMG and their application being denied due to misinformation regarding these topics[5]; and

Whereas, The AMA has strong policy supporting parity in access to away rotations for D.O. students, (D-295.309) and policy supporting access to IMGs by abolishing discrimination in licensure (H-255.966**)**, protecting IMGs from unfair discrimination (H-255.978), and opposing discrimination in residency selection based on IMG status (D-255.982), but notably no policy in support of Puerto Rican medical school students who face similar barriers to IMGs despite being classified as U.S. graduates; and

Whereas, The AMA is interested in evaluating students based on merit (H-255.988, H-255.983) and eliminating discrimination (H-310.919), but lacks policy addressing the importance in merit-based evaluation of medical students from Puerto Rican medical schools; therefore be it

RESOLVED, That our American Medical Association issue an official public statement regarding the academic status of Puerto Rican medical students and schools to inform residency, fellowship, and academic programs in the continental United States that all medical schools from Puerto Rico are Liaison Committee on Medical Education (LCME), Association of American Medical Colleges (AAMC), and Middle States Commission on Higher Education (MSCHE) accredited, and their medical students are not considered international medical graduates (Directive to Take Action); and be it further

RESOLVED, That our AMA support policies that ensure equity and parity in the undergraduate and graduate educational and professional opportunities available to medical students and graduates from Puerto Rican medical schools. (New HOD Policy)

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

Date Received: 09/30/21

AUTHORS STATEMENT OF PRIORITY

Medical students attending Puerto Rican medical schools have historically faced many hurdles in their away rotations and residency application process as they are commonly misperceived as International Medical Graduate (IMG) students by other medical students, physicians, and healthcare professionals from the continental U.S. Residents and young physicians who have recently graduated from Puerto Rican medical schools report often having to explain their citizenship, the accreditation status of Puerto Rican medical schools, the board exams taken, clarify about not being an IMG and their application being denied due to misinformation regarding these topics. These issues represent significant barriers to trainees at the very beginning of their career as physicians. Given the physician shortage the U.S. Is already facing, and given the natural disasters that have so severely impacted Puerto Rico in recent years, and given the AMA's stated commitments to equity in health and healthcare, it should be an urgent AMA priority to ensure that Puerto Rican students and physicians have equal rights and equal opportunity to their counterparts from elsewhere throughout the U.S.

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RELEVANT AMA POLICY

Abolish Discrimination in Licensure of IMGs H-255.966
1. Our AMA supports the following principles related to medical licensure of international medical graduates (IMGs):
A. State medical boards should ensure uniformity of licensure requirements for IMGs and graduates of U.S. and Canadian medical schools, including eliminating any disparity in the years of graduate medical education (GME) required for licensure and a uniform standard for the allowed number of administrations of licensure examinations.
B. All physicians seeking licensure should be evaluated on the basis of their individual education, training, qualifications, skills, character, ethics, experience and past practice.
C. Discrimination against physicians solely on the basis of national origin and/or the country in which they completed their medical education is inappropriate.
D. U.S. states and territories retain the right and responsibility to determine the qualifications of individuals applying for licensure to practice medicine within their respective jurisdictions.
E. State medical boards should be discouraged from a) using arbitrary and non-criteria-based lists of approved or unapproved foreign medical schools for licensure decisions and b) requiring an interview or oral examination prior to licensure endorsement. More effective methods for evaluating the quality of IMGs' undergraduate medical education should be pursued with the Federation of State Medical Boards and other relevant organizations. When available, the results should be a part of the determination of eligibility for licensure.
2. Our AMA will continue to work with the Federation of State Medical Boards to encourage parity in licensure requirements for all physicians, whether U.S. medical school graduates or international medical graduates.
3. Our AMA will continue to work with the Educational Commission for Foreign Medical Graduates and other appropriate organizations in developing effective methods to evaluate the clinical skills of IMGs.
4. Our AMA will work with state medical societies in states with discriminatory licensure requirements between IMGs and graduates of U.S. and Canadian medical schools to advocate for parity in licensure requirements, using the AMA International Medical Graduate Section licensure parity model resolution as a resource.
5. Our AMA will: (a) encourage states to study existing strategies to improve policies and processes to assist IMGs with credentialing and licensure to enable them to care for patients in underserved areas; and (b) encourage the FSMB and state medical boards to evaluate the progress of programs aimed at reducing barriers to licensure--including successes, failures, and barriers to implementation.
BOT Rep. 25, A-15; Appended: CME Rep. 4, A-21

Unfair Discrimination Against International Medical Graduates H-255.978
It is the policy of the AMA to take appropriate action, legal or legislative, against implementation of Section 4752(d) of the OBRA of 1990 that requires international medical graduates, in order to obtain a Medicaid UPIN number, to have held a license in one or more states continuously since 1958, or pass the Foreign Medical Graduate Examination in Medical Sciences (FMGEMS), or pass the Educational Commission for Foreign Medical Graduates (ECFMG) Examination, or be certified by ECFMG.
Res. 123, I-90; Reaffirmation: A-00; Reaffirmed: CME Rep. 2, A-10; Reaffirmed: CME Rep. 01, A-20

Graduates of Non-United States Medical Schools H-255.983
The AMA continues to support the policy that all physicians and medical students should be evaluated for purposes of entry into graduate medical education programs, licensure, and hospital medical staff privileges on the basis of their individual qualifications, skills, and character. Sub. Res. A-88; Reaffirmed: Res. 311, A-96; Reaffirmed: CMS Rep. 10, A-03; Reaffirmed: CME Rep.

1, I-03; Reaffirmed: CME Rep. 7, A-04; Reaffirmed: Sub. Res. 314, A-04; Reaffirmed: CME Rep. 11, A-10; Reaffirmed: BOT Rep. 25, A-15

AMA Principles on International Medical Graduates H-255.988
Our AMA supports:
1. Current U.S. visa and immigration requirements applicable to foreign national physicians who are graduates of medical schools other than those in the United States and Canada.
2. Current regulations governing the issuance of exchange visitor visas to foreign national IMGs, including the requirements for successful completion of the USMLE.
3. The AMA reaffirms its policy that the U.S. and Canada medical schools be accredited by a nongovernmental accrediting body.
4. Cooperation in the collection and analysis of information on medical schools in nations other than the U.S. and Canada.
5. Continued cooperation with the ECFMG and other appropriate organizations to disseminate information to prospective and current students in foreign medical schools. An AMA member, who is an IMG, should be appointed regularly as one of the AMA's representatives to the ECFMG Board of Trustees.
6. Working with the Accreditation Council for Graduate Medical Education (ACGME) and the Federation of State Medical Boards (FSMB) to assure that institutions offering accredited residencies, residency program directors, and U.S. licensing authorities do not deviate from established standards when evaluating graduates of foreign medical schools.
7. In cooperation with the ACGME and the FSMB, supports only those modifications in established graduate medical education or licensing standards designed to enhance the quality of medical education and patient care.
8. The AMA continues to support the activities of the ECFMG related to verification of education credentials and testing of IMGs.
9. That special consideration be given to the limited number of IMGs who are refugees from foreign governments that refuse to provide pertinent information usually required to establish eligibility for residency training or licensure.
10. That accreditation standards enhance the quality of patient care and medical education and not be used for purposes of regulating physician manpower.
11. That AMA representatives to the ACGME, residency review committees and to the ECFMG should support AMA policy opposing discrimination. Medical school admissions officers and directors of residency programs should select applicants on the basis of merit, without considering status as an IMG or an ethnic name as a negative factor.
12. The requirement that all medical school graduates complete at least one year of graduate medical education in an accredited U.S. program in order to qualify for full and unrestricted licensure. State medical licensing boards are encouraged to allow an alternate set of criteria for granting licensure in lieu of this requirement: (a) completion of medical school and residency training outside the U.S.; (b) extensive U.S. medical practice; and (c) evidence of good standing within the local medical community.
13. Publicizing existing policy concerning the granting of staff and clinical privileges in hospitals and other health facilities.
14. The participation of all physicians, including graduates of foreign as well as U.S. and Canadian medical schools, in organized medicine. The AMA offers encouragement and assistance to state, county, and specialty medical societies in fostering greater membership among IMGs and their participation in leadership positions at all levels of organized medicine, including AMA committees and councils and state boards of medicine, by providing guidelines and non-financial incentives, such as recognition for outstanding achievements by either individuals or organizations in promoting leadership among IMGs.

15. Support studying the feasibility of conducting peer-to-peer membership recruitment efforts aimed at IMGs who are not AMA members.
16. AMA membership outreach to IMGs, to include a) using its existing publications to highlight policies and activities of interest to IMGs, stressing the common concerns of all physicians; b) publicizing its many relevant resources to all physicians, especially to nonmember IMGs; c) identifying and publicizing AMA resources to respond to inquiries from IMGs; and d) expansion of its efforts to prepare and disseminate information about requirements for admission to accredited residency programs, the availability of positions, and the problems of becoming licensed and entering full and unrestricted medical practice in the U.S. that face IMGs. This information should be addressed to college students, high school and college advisors, and students in foreign medical schools.
17. Recognition of the common aims and goals of all physicians, particularly those practicing in the U.S., and support for including all physicians who are permanent residents of the U.S. in the mainstream of American medicine.
18. Its leadership role to promote the international exchange of medical knowledge as well as cultural understanding between the U.S. and other nations.
19. Institutions that sponsor exchange visitor programs in medical education, clinical medicine and public health to tailor programs for the individual visiting scholar that will meet the needs of the scholar, the institution, and the nation to which he will return.
20. Informing foreign national IMGs that the availability of training and practice opportunities in the U.S. is limited by the availability of fiscal and human resources to maintain the quality of medical education and patient care in the U.S., and that those IMGs who plan to return to their country of origin have the opportunity to obtain GME in the United States.
21. U.S. medical schools offering admission with advanced standing, within the capabilities determined by each institution, to international medical students who satisfy the requirements of the institution for matriculation.
22. The Federation of State Medical Boards, its member boards, and the ECFMG in their willingness to adjust their administrative procedures in processing IMG applications so that original documents do not have to be recertified in home countries when physicians apply for licenses in a second state.
BOT Rep. Z, A-86; Reaffirmed: Res. 312, I-93; Modified: CME Rep. 2, A-03; Reaffirmation; I-11; Reaffirmed: CME Rep. 1, I-13; Modified: BOT Rep. 25, A15; Modified: CME Rep. 01, A-16; Appended: Res. 304, A-17; Modified: CME Rep. 01, I-17; Reaffirmation: A-19; Modified: CME Rep. 2, A-21

Promoting and Reaffirming Domestic Medical School Clerkship Education D-295.309
1. Our American Medical Association:
A. Will work with the Association of American Medical Colleges, American Association of Colleges of Osteopathic Medicine, and other interested stakeholders to encourage local and state governments and the federal government, as well as private sector philanthropies, to provide additional funding to support: (1) infrastructure and faculty development and capacity for medical school expansion; and (2) delivery of clinical clerkships and other educational experiences.
B. Encourages clinical clerkship sites for medical education (to include medical schools and teaching hospitals) to collaborate with local, state, and regional partners to create additional clinical education sites and resources for students.
C. Advocates for federal and state legislation/regulations to: (1) Oppose any extraordinary compensation granted to clinical clerkship sites that would displace or otherwise limit the education/training opportunities for medical students in clinical rotations enrolled in medical school programs accredited by the Liaison Committee on Medical Education (LCME) or Commission on Osteopathic College Accreditation (COCA); (2) Ensure that priority for clinical clerkship slots be given first to students of LCME- or COCA-accredited medical school programs;

and (3) Require that any institution that accepts students for clinical placements ensure that all such students are trained in programs that meet requirements for educational quality, curriculum, clinical experiences and attending supervision that are equivalent to those of programs accredited by the LCME and COCA.
D. Encourages relevant stakeholders to study whether the "public service community benefit" commitment and corporate purposes of not for profit, tax exempt hospitals impose any legal and/or ethical obligations for granting priority access for teaching purposes to medical students from medical schools in their service area communities and, if so, advocate for the development of appropriate regulations at the state level.
E. Will work with interested state and specialty medical associations to pursue legislation that ensures the quality and availability of medical student clerkship positions for U.S. medical students.
2. Our AMA supports the practice of U.S. teaching hospitals and foreign medical schools entering into appropriate relationships directed toward providing clinical educational experiences for advanced medical students who have completed the equivalent of U.S. core clinical clerkships. Policies governing the accreditation of U.S. medical education programs specify that core clinical training be provided by the parent medical school; consequently, the AMA strongly objects to the practice of substituting clinical experiences provided by U.S. institutions for core clinical curriculum of foreign medical schools. Moreover, it strongly disapproves of the placement of medical students in teaching hospitals and other clinical sites that lack appropriate educational resources and experience for supervised teaching of clinical medicine, especially when the presence of visiting students would disadvantage the institution's own students educationally and/or financially and negatively affect the quality of the educational program and/or safety of patients receiving care at these sites.
3. Our AMA supports agreements for clerkship rotations, where permissible, for U.S. citizen international medical students between foreign medical schools and teaching hospitals in regions that are medically underserved and/or that lack medical schools and clinical sites for training medical students, to maximize the cumulative clerkship experience for all students and to expose these students to the possibility of medical practice in these areas.
4. AMA policy is that U.S. citizens should have access to factual information on the requirements for licensure and for reciprocity in the various U.S. medical licensing jurisdictions, prerequisites for entry into graduate medical education programs, and other relevant factors that should be considered before deciding to undertake the study of medicine in schools not accredited by the LCME or COCA.
5. AMA policy is that existing requirements for foreign medical schools seeking Title IV Funding should be applied to those schools that are currently exempt from these requirements, thus creating equal standards for all foreign medical schools seeking Title IV Funding.
CME Rep. 01, I-17

Eliminating Questions Regarding Marital Status, Dependents, Plans for Marriage or Children, Sexual Orientation, Gender Identity, Age, Race, National Origin and Religion During the Residency and Fellowship Application Process H-310.919
Our AMA:
1. Opposes questioning residency or fellowship applicants regarding marital status, dependents, plans for marriage or children, sexual orientation, gender identity, age, race, national origin, and religion;
2. Will work with the Accreditation Council for Graduate Medical Education, the National Residency Matching Program, and other interested parties to eliminate questioning about or discrimination based on marital and dependent status, future plans for marriage or children, sexual orientation, age, race, national origin, and religion during the residency and fellowship application process;

3. Will continue to support efforts to enhance racial and ethnic diversity in medicine. Information regarding race and ethnicity may be voluntarily provided by residency and fellowship applicants;
4. Encourages the Association of American Medical Colleges (AAMC) and its Electronic Residency Application Service (ERAS) Advisory Committee to develop steps to minimize bias in the ERAS and the residency training selection process; and
5. Will advocate that modifications in the ERAS Residency Application to minimize bias consider the effects these changes may have on efforts to increase diversity in residency programs.
Res. 307, A-09; Appended: Res. 955, I-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 306
(N-21)

Introduced by: Medical Student Section

Subject: Support for Standardized Interpreter Training

Referred to: Reference Committee C

Whereas, There are more than 6,900 known living languages spoken in the world[1]; and

Whereas, More than 66 million Americans speak at least one of over 350 languages other than English at home and more than 25 million Americans speak English "less than very well"[2-4]; and

Whereas, Language barriers can have major adverse effects on health such as suboptimal health status; lower likelihood of having regular care providers; lower rates of mammograms, pap smears, and other preventative services; greater likelihood of diagnosis of more severe psychopathology; leaving the hospital against medical advice; and increased risk of drug complications[1,3,5]; and

Whereas, Ad hoc interpreters have been shown to engage in "false fluency", where substandard interpretation skills leads to inadequate translation, thereby compromising the integrity of the patient-provider interaction[6-8]; and

Whereas, Errors in medical interpretation are not uncommon, and translation errors made by ad hoc interpreters are more likely to result in clinical consequences than errors made by professionally trained medical interpreters[9]; and

Whereas, Underuse of a valuable health care resource, professional medical interpretation, can result in these adverse effects and inappropriate care[4]; and

Whereas, Professional medical interpreter services can facilitate effective communication across language differences and increase the delivery of health care to Limited English Proficiency (LEP) patients, yet remain underutilized in health care[3,10]; and

Whereas, Language assistance is a legal right of patients under Title VI of the 1964 Civil Rights Act, therefore hospitals have policies and processes in place, but how they are communicated to front-line staff is variable[5,11]; and

Whereas, One potential contributor is the lack of a designated place within medical training curricula to address language barriers, which calls for a more recognizable and accessible resource for training[5,11]; and

Whereas, In recent studies, only 19% of emergency department (ED) staff had reported prior training on working with interpreters, regardless of the source of training[7], and most ED providers and staff who have little training in the use of language assistance were unaware of hospital policy in this area[11,12]; and

Whereas, Only 28% of medical schools offer students on clerkships training involving a language interpreter[13]; and

Whereas, Dissemination of best practices for the provision of language assistance and the clinical use of non-English language skills has the potential to improve communication with LEP patients[11]; and

Whereas, Healthcare organizations should ensure that medical professionals across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery or have access to training[14]; and

Whereas, Providing training to physicians and medical students about the proper use of medical interpreter services increases the correct use of those services[15-18]; and

Whereas, Teaching medical professionals to emphasize the appropriate use of an interpreter is warranted to improve cross-language clinical encounters, and could be executed through a Continuing Medical Education (CME) module[12]; and

Whereas, It has been recommended that healthcare organizations should either verify that staff at all levels and in all disciplines participate in ongoing CME-accredited education or other training in Culturally and Linguistically Appropriate Services delivery, or arrange for such education and training to be made available to staff[14]; and

Whereas, CME is a cornerstone of improving competencies and ensuring high-quality patient care by nurses and physicians[19]; and

Whereas, Although the AMA Education Hub (EdHub) has produced a series of modules related to Health Disparities and the Health Care Workforce, such as Disparities in Research and Health Equity to Bias in Artificial Intelligence, it does not currently have any modules covering the correct use of interpreter services; and

Whereas, The American Association of Medical Colleges (AAMC) has published “Guidelines on the Use of Medical Interpreter Services,” which describe best practices for assessing English proficiency, use of an interpreter, additional considerations for ad hoc interpreters, conflicts of interest and privacy, and considerations for telephonic interpreter services[20]; and

Whereas, Though AMA policy reimbursement for and calls for further research regarding interpreter services (D-385.957, H-160.924, H-385.928, H-382.929, D-385.978), it does not recognize the importance of interpreter services for providing appropriate care or call upon physicians to use them with patients with LEP, and the AMA Ed Hub does not currently provide any resources addressing how to correctly use interpreter services; therefore be it

RESOLVED, That our American Medical Association recognize the importance of using medical interpreters as a means of improving quality of care provided to patients with Limited English Proficiency (LEP) including patients with sensory impairments (New HOD Policy); and

RESOLVED, That our AMA encourage physicians and physicians in training to improve interpreter-use skills and increase education through publicly available resources such as the American Association of Medical College’s “Guidelines for Use of Medical Interpreter Services” (New HOD Policy); and be it further

RESOLVED, That our AMA work with the Commission for Medical Interpreter Education, National Hispanic Medical Association, National Council of Asian Pacific Islander Physicians, National Medical Association, Association of American Indian Physicians, and other relevant stakeholders to develop a cohesive Continuing Medical Education module offered through the AMA Ed Hub for physicians to effectively and appropriately use interpreter services to ensure optimal patient care. (Directive to Take Action)

Fiscal Note: Moderate - between $5,000 - $10,000

Date Received: 09/30/21

AUTHORS STATEMENT OF PRIORITY

The COVID-19 pandemic revealed the particular vulnerability of individuals with limited English proficiency (LEP). People with LEP have struggled to receive adequate and proper care, and the outcomes for this population have been drastically worse than those who are proficient in English. Disparities in outcomes for people with LEP have been a known problem in healthcare, but the pandemic has made this an even more urgent problem. Lack of adequate training for using interpreter services has immense impacts on health outcomes. Our AMA recognizes the urgent priority of health equity, and should make the protection of vulnerable communities with LEP a priority. This resolution addresses that priority by recognizing the importance of and providing solutions to the problem of lacking interpreter training, which so often leads to preventable poor health and healthcare outcomes.

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RELEVANT AMA POLICY

Certified Translation and Interpreter Services D-385.957
Our AMA will: (1) work to relieve the burden of the costs associated with translation services implemented under Section 1557 of the Affordable Care Act; and (2) advocate for legislative and/or regulatory changes to require that payers including Medicaid programs and Medicaid managed care plans cover interpreter services and directly pay interpreters for such services, with a progress report at the 2017 Interim Meeting of the AMA House of Delegates.
Res. 703, A-17; Reaffirmed: CMS Rep. 7, A-21

Use of Language Interpreters in the Context of the Patient-Physician Relationship H-160.924
AMA policy is that: (1) further research is necessary on how the use of interpreters--both those who are trained and those who are not--impacts patient care; (2) treating physicians shall respect and assist the patients' choices whether to involve capable family members or friends to provide language assistance that is culturally sensitive and competent, with or without an interpreter who is competent and culturally sensitive; (3) physicians continue to be resourceful in their use of other appropriate means that can help facilitate communication--including print materials, digital and other electronic or telecommunication services with the understanding, however, of these tools' limitations--to aid LEP patients' involvement in meaningful decisions about their care; and (4) physicians cannot be expected to provide and fund these translation services for their patients, as the Department of Health and Human Services' policy guidance currently requires; when trained medical interpreters are needed, the costs of their services shall be paid directly to the interpreters by patients and/or third party payers and physicians shall not be required to participate in payment arrangements.
BOT Rep. 8, I-02; Reaffirmation: I-03; Reaffirmed in lieu of Res. 722, A-07; Reaffirmation: A-09; Reaffirmed: CMS Rep. 5, A-11; Reaffirmed in lieu of Res. 110, A-13; Reaffirmation: A-17

Patient Interpreters H-385.928
Our AMA supports sufficient federal appropriations for patient interpreter services and will take other necessary steps to assure physicians are not directly or indirectly required to pay for interpreter services mandated by the federal government.
Res. 219, I-01; Reaffirmed: BOT Rep. 8, I-02; Reaffirmation: I-03; Reaffirmed in lieu of Res .722, A-07; Reaffirmation: A-09; Reaffirmation: A-10; Reaffirmation A-14

Availability and Payment for Medical Interpreters Services in Medical Practices H-385.929
It is the policy of our AMA to: (1) the fullest extent appropriate, to actively oppose the inappropriate extension of the OCR LEP guidelines to physicians in private practice; and (2) continue our proactive, ongoing efforts to correct the problems imposed on physicians in private practice by the OCR language interpretation requirements.
BOT Rep. 25, I-01; Reaffirmation: I-03; Reaffirmed: Res. 907, I-03; Reaffirmation: A-09; Reaffirmation: A-17

Language Interpreters D-385.978
Our AMA will: (1) continue to work to obtain federal funding for medical interpretive services;(2) redouble its efforts to remove the financial burden of medical interpretive services from physicians;(3) urge the Administration to reconsider its interpretation of Title VI of the Civil Rights Act of 1964 as requiring medical interpretive services without reimbursement;(4) consider the feasibility of a legal solution to the problem of funding medical interpretive services; and(5)

work with governmental officials and other organizations to make language interpretive services a covered benefit for all health plans inasmuch as health plans are in a superior position to pass on the cost of these federally mandated services as a business expense.
Res. 907, I-03; Reaffirmed in lieu of Res. 722, A-07; Reaffirmation: A-09; Reaffirmation: A-10; Reaffirmed: CMS Rep. 5, A-11; Reaffirmed in lieu of Res. 110, A-13; Reaffirmation: A-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 307
(N-21)

Introduced by: Medical Student Section

Subject: Support for Institutional Policies for Personal Days for Undergraduate Medical Students

Referred to: Reference Committee C

Whereas, Burnout is a multifactorial occupational syndrome characterized by emotional exhaustion, depersonalization, and cynicism or professional dissatisfaction as a result of prolonged stress[1,2]; and

Whereas, Burnout can not only undermine professional development, but also contribute to mental health disorders including suicidal ideal and substance use[2]; and

Whereas, Over half of U.S. medical students report experiencing burnout at some point in their medical education, along with greater prevalence of depressive symptoms (27.2%) and suicidal ideation (11.1%) compared to the general population (7.1% and 4%, respectively)[2-4]; and

Whereas, A lack of protected time remains the prominent barrier preventing medical students from accessing mental health treatment[5]; and

Whereas, Institutional policies and initiatives to address burnout and improve mental wellness vary widely, including the implementation of “sick days” which may require proof of illness or be restricted in how they can be utilized[6,7]; and

Whereas, Students may not feel comfortable sharing mental health concerns due to professional stigma, shame, or fear or repercussions on professional development[8]; and

Whereas, Personal days are defined as excused absences that may require advance notice but without an explanation for the absence, and may be also be utilized for mental wellness, physical wellness, and self-care[9]; and

Whereas, Personal days have been increasingly prevalent in workplace or corporate policies, and are now offered in over one third of workplaces and in companies such as Netflix, Best Buy, and Virgin America[10,11]; and

Whereas, The implementation of personal days in medical schools would allow students to address their health needs—including mental health and routine appointments—without compromising their privacy to clerkship directors or administrators; and

Whereas, A number of medical schools have started providing personal days, though policies continue to vary widely due to lack of standardization[12-31]; and

Whereas, Our AMA has policy supporting existing programs in identification and management of stress (H-405.957), prioritizing self-care among medical students and the maintenance of a healthy lifestyle (H-405.957), and promoting the recognition of burnout in students by institutional officials, program directors, resident physicians, and attending faculty (H-295.858); therefore be it

RESOLVED, That our American Medical Association encourage medical schools to accept flexible uses for excused absences from clinical clerkships (New HOD Policy); and be it further

RESOLVED, That our AMA support a clearly defined number of easily accessible personal days for medical students per academic year, which should be explained to students at the beginning of each academic year and a subset of which should be granted without requiring an explanation on the part of the students. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

Date Received: 09/30/21

AUTHORS STATEMENT OF PRIORITY

The impact of the pandemic on the mental health of healthcare workers cannot be overstated. This devastating impact, however, helped illuminate some of the ways in which the field of medicine and medical training are set up to cause emotional trauma and damage mental health. One particularly harmful practice is the way personal days off of training are handled for medical students. Sick days for medical students may require extensive and invasive documentation, and personal days off may require notice weeks to months in advance. The days off system is often rigid, and the institution's policies may be opaque, and the burden is placed on the student to prove why they should not be harshly penalized for missing a day of schooling they are paying for. All of this contributes to burnout, and all of it has been significantly worsened during the pandemic, as students continue to feel pressure to show up even when potentially ill and face confusing systems when they need time off to mourn friends and family lost to COVID.

Even before the pandemic, over half of medical students reported experiencing burnout, which will doubtless be exacerbated by pandemic conditions. This is an urgent problem that is already at crisis magnitude, and it is imperative that the AMA begin taking large, bold steps if it wants to protect the healthcare workforce of the future.

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RELEVANT AMA POLICY

Access to Confidential Health Services for Medical Students and Physicians H-295.858

1. Our AMA will ask the Liaison Committee on Medical Education, Commission on Osteopathic College Accreditation, American Osteopathic Association, and Accreditation Council for Graduate Medical Education to encourage medical schools and residency/fellowship programs, respectively, to:

A. Provide or facilitate the immediate availability of urgent and emergent access to low-cost, confidential health care, including mental health and substance use disorder counseling

services, that: (1) include appropriate follow-up; (2) are outside the trainees' grading and evaluation pathways; and (3) are available (based on patient preference and need for assurance of confidentiality) in reasonable proximity to the education/training site, at an external site, or through telemedicine or other virtual, online means;
B. Ensure that residency/fellowship programs are abiding by all duty hour restrictions, as these regulations exist in part to ensure the mental and physical health of trainees;
C. Encourage and promote routine health screening among medical students and resident/fellow physicians, and consider designating some segment of already-allocated personal time off (if necessary, during scheduled work hours) specifically for routine health screening and preventive services, including physical, mental, and dental care; and
D. Remind trainees and practicing physicians to avail themselves of any needed resources, both within and external to their institution, to provide for their mental and physical health and well-being, as a component of their professional obligation to ensure their own fitness for duty and the need to prioritize patient safety and quality of care by ensuring appropriate self-care, not working when sick, and following generally accepted guidelines for a healthy lifestyle.

2. Our AMA will urge state medical boards to refrain from asking applicants about past history of mental health or substance use disorder diagnosis or treatment, and only focus on current impairment by mental illness or addiction, and to accept "safe haven" non-reporting for physicians seeking licensure or relicensure who are undergoing treatment for mental health or addiction issues, to help ensure confidentiality of such treatment for the individual physician while providing assurance of patient safety.
3. Our AMA encourages medical schools to create mental health and substance abuse awareness and suicide prevention screening programs that would:
A. be available to all medical students on an opt-out basis;
B. ensure anonymity, confidentiality, and protection from administrative action;
C. provide proactive intervention for identified at-risk students by mental health and addiction professionals; and
D. inform students and faculty about personal mental health, substance use and addiction, and other risk factors that may contribute to suicidal ideation.
4. Our AMA: (a) encourages state medical boards to consider physical and mental conditions similarly; (b) encourages state medical boards to recognize that the presence of a mental health condition does not necessarily equate with an impaired ability to practice medicine; and (c) encourages state medical societies to advocate that state medical boards not sanction physicians based solely on the presence of a psychiatric disease, irrespective of treatment or behavior.
5. Our AMA: (a) encourages study of medical student mental health, including but not limited to rates and risk factors of depression and suicide; (b) encourages medical schools to confidentially gather and release information regarding reporting rates of depression/suicide on an opt-out basis from its students; and (c) will work with other interested parties to encourage research into identifying and addressing modifiable risk factors for burnout, depression and suicide across the continuum of medical education.
6. Our AMA encourages the development of alternative methods for dealing with the problems of student-physician mental health among medical schools, such as: (a) introduction to the concepts of physician impairment at orientation; (b) ongoing support groups, consisting of students and house staff in various stages of their education; (c) journal clubs; (d) fraternities; (e) support of the concepts of physical and mental well-being by heads of departments, as well as other faculty members; and/or (f) the opportunity for interested students and house staff to work with students who are having difficulty. Our AMA supports making these alternatives available to students at the earliest possible point in their medical education.

7. Our AMA will engage with the appropriate organizations to facilitate the development of educational resources and training related to suicide risk of patients, medical students, residents/fellows, practicing physicians, and other health care professionals, using an evidence-based multidisciplinary approach.
CME Rep. 01, I-16Appended: Res. 301, A-17Appended: Res. 303, A-17Modified: CME Rep. 01, A-18Appended: Res. 312, A-18Reaffirmed: BOT Rep. 15, A-19

Programs on Managing Physician Stress and Burnout H-405.957
1. Our American Medical Association supports existing programs to assist physicians in early identification and management of stress and the programs supported by the AMA to assist physicians in early identification and management of stress will concentrate on the physical, emotional and psychological aspects of responding to and handling stress in physicians' professional and personal lives, and when to seek professional assistance for stress-related difficulties.
2. Our AMA will review relevant modules of the STEPs Forward Program and also identify validated student-focused, high quality resources for professional well-being, and will encourage the Medical Student Section and Academic Physicians Section to promote these resources to medical students.
Res. 15, A-15; Appended: Res. 608, A-16; Reaffirmed: BOT Rep. 15, A-19

Study of Medical Student, Resident, and Physician Suicide D-345.983
Our AMA will: (1) explore the viability and cost-effectiveness of regularly collecting National Death Index (NDI) data and confidentially maintaining manner of death information for physicians, residents, and medical students listed as deceased in the AMA Physician Masterfile for long-term studies; (2) monitor progress by the Association of American Medical Colleges and the Accreditation Council for Graduate Medical Education (ACGME) to collect data on medical student and resident/fellow suicides to identify patterns that could predict such events; (3) support the education of faculty members, residents and medical students in the recognition of the signs and symptoms of burnout and depression and supports access to free, confidential, and immediately available stigma-free mental health and substance use disorder services; and (4) collaborate with other stakeholders to study the incidence of and risk factors for depression, substance misuse and addiction, and suicide among physicians, residents, and medical students.
CME Rep. 06, A-19

Physician and Medical Student Burnout D-310.968
1. Our AMA recognizes that burnout, defined as emotional exhaustion, depersonalization, and a reduced sense of personal accomplishment or effectiveness, is a problem among residents, fellows, and medical students.
2. Our AMA will work with other interested groups to regularly inform the appropriate designated institutional officials, program directors, resident physicians, and attending faculty about resident, fellow, and medical student burnout (including recognition, treatment, and prevention of burnout) through appropriate media outlets.
3. Our AMA will encourage partnerships and collaborations with accrediting bodies (e.g., the Accreditation Council for Graduate Medical Education and the Liaison Committee on Medical Education) and other major medical organizations to address the recognition, treatment, and prevention of burnout among residents, fellows, and medical students and faculty.
4. Our AMA will encourage further studies and disseminate the results of studies on physician and medical student burnout to the medical education and physician community.
5. Our AMA will continue to monitor this issue and track its progress, including publication of peer-reviewed research and changes in accreditation requirements.

6. Our AMA encourages the utilization of mindfulness education as an effective intervention to address the problem of medical student and physician burnout.
7. Our AMA will encourage medical staffs and/or organizational leadership to anonymously survey physicians to identify local factors that may lead to physician demoralization.
8. Our AMA will continue to offer burnout assessment resources and develop guidance to help organizations and medical staffs implement organizational strategies that will help reduce the sources of physician demoralization and promote overall medical staff well-being.
9. Our AMA will continue to: (a) address the institutional causes of physician demoralization and burnout, such as the burden of documentation requirements, inefficient work flows and regulatory oversight; and (b) develop and promote mechanisms by which physicians in all practices settings can reduce the risk and effects of demoralization and burnout, including implementing targeted practice transformation interventions, validated assessment tools and promoting a culture of well-being.
CME Rep. 8, A-07; Modified: Res. 919, I-11; Modified: BOT Rep. 15, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 308
(N-21)

Introduced by: Medical Student Section

Subject: Modifying Eligibility Criteria for the Association of American Medical Colleges' Financial Assistance Program

Referred to: Reference Committee C

Whereas, The American College Application Service (AMCAS) is the American Association of Medical College's (AAMC) centralized medical school application processing service and is used by most US medical schools as the primary application method for their entering class[1]; and

Whereas, The 2019 medical school application fee through AMCAS is $170 for the first application and an additional $40 for each application after[2]; and

Whereas, It is estimated that the average cost of secondary applications is $80 per application, and pre-medical applicants apply to an average of 16 medical schools per cycle[3,4]; and

Whereas, Pre-medical students without AAMC Fee Assistance Program (FAP) benefits spend at least $2,800 on application fees alone, not including travel costs for interviews[5]; and

Whereas, Spending $2,800 on application fees alone would be four times greater than the amount the median US household saves for miscellaneous fees in their budget[6]; and

Whereas, The Medical College Admission Test (MCAT), developed and administered by the AAMC, is a standardized, multiple-choice examination created to help medical school admissions offices assess students[7]; and

Whereas, The cost of MCAT registration is $315, with additional fees for late registration and changing test dates, not including test-prep materials recommended to most students which are offered by the AAMC and other test-prep companies[9]; and

Whereas, The University of California Berkeley Career Center estimates a total cost of approximately $7,520 total for the medical school application process as of 2014, and notes that the cost is higher for those applying to both allopathic and osteopathic programs[10]; and

Whereas, The AAMC generated over $70 million dollars in revenue by administering the MCAT and AMCAS alone in 2016[8]; and

Whereas, The Fee Assistance Program (FAP), offered by AAMC, exists to assist those who, without financial assistance, would not be able to apply to medical schools who use the AMCAS application and would not be able to afford the MCAT registration fee[9]; and

Whereas, In order to qualify for the 2019 FAP, the applicants' total family income in 2018 must be 300% or less than the 2018 national poverty level for that family size[11]; and

Whereas, In contrast to other federally funded programs, the FAP does not distinguish between independent or dependent tax statuses, and therefore, parental financial information and tax documents are required and must also fall within eligibility guidelines; This requirement is not waived based on marital status, age or tax filing status[11]; and

Whereas, An applicant having an income that meets the eligibility requirements for fee assistance themselves, are denied based on parental income[11]; and

Whereas, The Free Application for Federal Student Aid (FAFSA) provided for by the U.S. Department of Education does not require an applicant to report parental income if they file taxes as an independent[12]; and

Whereas, The Expected Family Contribution (EFC) is an index number used by the FAFSA based on family's taxed and untaxed income, assets, and benefits to generate a sliding-scale model in which a lower EFC indicates eligibility for more financial aid[13]; and

Whereas, Offering additional need-based aid to students increases the odds of obtaining their degree, thus helping to reduce inequality in higher education[14]; and

Whereas, In 2017, less than 5% of entering medical students came from the lowest quintile of family income while 51% came from the highest quintile[15]; and

Whereas, Despite several efforts to make medical education attainable to low-income students, the cost of attending medical school continues to rise, making it even more difficult for low-income students and families to afford in the future[16]; and

Whereas, Our AMA has pledged to take action on the rising cost of medical education and its contribution to student debt (H-305.925); and

Whereas, Our AMA has established support for increasing the representation of minority and economically disadvantaged populations in the medical profession (H-350.979) and has committed to working with the AAMC to achieve this goal (D-200.985); therefore be it

RESOLVED, That our American Medical Association encourage the Association of American Medical Colleges to conduct a study of the financial impact of the current Fee Assistance Program policy to medical school applicants. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

Date Received: 09/30/21

AUTHORS STATEMENT OF PRIORITY

The COVID-19 pandemic has been a massive crisis for healthcare workers, resulting in losses of our physician workforce through early retirements, hour reduction due to burnout, and deaths. The U.S. faced a physician shortage before the pandemic, and the pandemic will only serve to greatly exacerbate that pre-existing crisis. A large pre-existing factor for the crisis of a physician shortage is the incomprehensible debt with which young doctors start and, increasingly commonly, spend much of their careers. The U.S. particularly faces a shortage of physicians from traditionally marginalized backgrounds: Black, Latinx, Indigenous, some Asian groups, LGBTQ+, low-SES, and disabled people remain underrepresented in medicine.

This resolution aims to address this combined crisis--physician shortage, increasing burnout, and unequal representation in medicine--by addressing a barrier at the initiation of a medical career. Medical school applicants who do not have AAMC Fee Assistance Program benefits spend an average of $2,800 on application fees alone, not including travel costs for interviews. This huge burden, especially for applicants from underprivileged backgrounds, starts all applicants into the path of medicine by experiencing one of the strongest contributors to burnout. Our resolution asks the AMA to take a stand for medical students and future physician colleagues by encouraging the AAMC to investigate the impact of fee assistance. We hope the AMA joins us in considering as priority the reduction of burnout starting before medical school, to begin to address the physician workforce crisis that has been so worsened by the pandemic.

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RELEVANT AMA POLICY

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

Our AMA supports increasing the representation of minorities in the physician population by:
(1) Supporting efforts to increase the applicant pool of qualified minority students by:
(a) Encouraging state and local governments to make quality elementary and secondary education opportunities available to all; (b) Urging medical schools to strengthen or initiate programs that offer special premedical and precollegiate experiences to underrepresented minority students; (c) urging medical schools and other health training institutions to develop new and innovative measures to recruit underrepresented minority students, and (d) Supporting legislation that provides targeted financial aid to financially disadvantaged students at both the collegiate and medical school levels.
(2). Encouraging all medical schools to reaffirm the goal of increasing representation of underrepresented minorities in their student bodies and faculties.
(3) Urging medical school admission committees to consider minority representation as one factor in reaching their decisions.
(4) Increasing the supply of minority health professionals.
(5) Continuing its efforts to increase the proportion of minorities in medical schools and medical school faculty.
(6) Facilitating communication between medical school admission committees and premedical counselors concerning the relative importance of requirements, including grade point average and Medical College Aptitude Test scores.
(7) Continuing to urge for state legislation that will provide funds for medical education both directly to medical schools and indirectly through financial support to students.
(8) Continuing to provide strong support for federal legislation that provides financial assistance for able students whose financial need is such that otherwise they would be unable to attend medical school.
CLRPD Rep. 3, I-98, Reaffirmed: CLRPD Rep. 1, A-08, Reaffirmed: CME Rep. 1, A-18

Strategies for Enhancing Diversity in the Physician Workforce D-200.985

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

4. Our AMA will encourage the Liaison Committee on Medical Education to assure that medical schools demonstrate compliance with its requirements for a diverse student body and faculty.
5. Our AMA will develop an internal education program for its members on the issues and possibilities involved in creating a diverse physician population.
6. Our AMA will provide on-line educational materials for its membership that address diversity issues in patient care including, but not limited to, culture, religion, race and ethnicity.
7. Our AMA will create and support programs that introduce elementary through high school students, especially those from groups that are underrepresented in medicine (URM), to healthcare careers.
8. Our AMA will create and support pipeline programs and encourage support services for URM college students that will support them as they move through college, medical school and residency programs.
9. Our AMA will recommend that medical school admissions committees use holistic assessments of admission applicants that take into account the diversity of preparation and the variety of talents that applicants bring to their education.
10. Our AMA will advocate for the tracking and reporting to interested stakeholders of demographic information pertaining to URM status collected from Electronic Residency Application Service (ERAS) applications through the National Resident Matching Program (NRMP).
11. Our AMA will continue the research, advocacy, collaborative partnerships and other work that was initiated by the Commission to End Health Care Disparities.
12. Our AMA opposes legislation that would undermine institutions' ability to properly employ affirmative action to promote a diverse student population.
13. Our AMA will work with the AAMC and other stakeholders to create a question for the AAMC electronic medical school application to identify previous pipeline program (also known as pathway program) participation and create a plan to analyze the data in order to determine the effectiveness of pipeline programs.
CME Rep, 1, I-06, Reaffirmation: I-10, Reaffirmation: A-13, Modified: CCB/CLRPD Rep. 2, A-14, Reaffirmation: A-16, Appended: Res. 313, A-17, Appended: Res. 314, A-17, Modified: CME Rep. 1, A-18, Appended: Res. 207, I-18, Appended: Res. 304, A-19, Appended: Res. 319, A-19; Modified: CME Rep. 5, A-21

Principles of and Actions to Address Medical Education Costs and Student Debt H-305.925
The costs of medical education should never be a barrier to the pursuit of a career in medicine nor to the decision to practice in a given specialty. To help address this issue, our American Medical Association (AMA) will:
1. Collaborate with members of the Federation and the medical education community, and with other interested organizations, to address the cost of medical education and medical student debt through public- and private-sector advocacy.
2. Vigorously advocate for and support expansion of and adequate funding for federal scholarship and loan repayment programs--such as those from the National Health Service Corps, Indian Health Service, Armed Forces, and Department of Veterans Affairs, and for comparable programs from states and the private sector--to promote practice in underserved areas, the military, and academic medicine or clinical research.
3. Encourage the expansion of National Institutes of Health programs that provide loan repayment in exchange for a commitment to conduct targeted research.
4. Advocate for increased funding for the National Health Service Corps Loan Repayment Program to assure adequate funding of primary care within the National Health Service Corps, as well as to permit: (a) inclusion of all medical specialties in need, and (b) service in clinical settings that care for the underserved but are not necessarily located in health professions shortage areas.

5. Encourage the National Health Service Corps to have repayment policies that are consistent with other federal loan forgiveness programs, thereby decreasing the amount of loans in default and increasing the number of physicians practicing in underserved areas.
6. Work to reinstate the economic hardship deferment qualification criterion known as the "20/220 pathway," and support alternate mechanisms that better address the financial needs of trainees with educational debt.
7. Advocate for federal legislation to support the creation of student loan savings accounts that allow for pre-tax dollars to be used to pay for student loans.
8. Work with other concerned organizations to advocate for legislation and regulation that would result in favorable terms and conditions for borrowing and for loan repayment, and would permit 100% tax deductibility of interest on student loans and elimination of taxes on aid from service-based programs.
9. Encourage the creation of private-sector financial aid programs with favorable interest rates or service obligations (such as community- or institution-based loan repayment programs or state medical society loan programs).
10. Support stable funding for medical education programs to limit excessive tuition increases, and collect and disseminate information on medical school programs that cap medical education debt, including the types of debt management education that are provided.
11. Work with state medical societies to advocate for the creation of either tuition caps or, if caps are not feasible, pre-defined tuition increases, so that medical students will be aware of their tuition and fee costs for the total period of their enrollment.
12. Encourage medical schools to (a) Study the costs and benefits associated with non-traditional instructional formats (such as online and distance learning, and combined baccalaureate/MD or DO programs) to determine if cost savings to medical schools and to medical students could be realized without jeopardizing the quality of medical education; (b) Engage in fundraising activities to increase the availability of scholarship support, with the support of the Federation, medical schools, and state and specialty medical societies, and develop or enhance financial aid opportunities for medical students, such as self-managed, low-interest loan programs; (c) Cooperate with postsecondary institutions to establish collaborative debt counseling for entering first-year medical students; (d) Allow for flexible scheduling for medical students who encounter financial difficulties that can be remedied only by employment, and consider creating opportunities for paid employment for medical students; (e) Counsel individual medical student borrowers on the status of their indebtedness and payment schedules prior to their graduation; (f) Inform students of all government loan opportunities and disclose the reasons that preferred lenders were chosen; (g) Ensure that all medical student fees are earmarked for specific and well-defined purposes, and avoid charging any overly broad and ill-defined fees, such as but not limited to professional fees; (h) Use their collective purchasing power to obtain discounts for their students on necessary medical equipment, textbooks, and other educational supplies; (i) Work to ensure stable funding, to eliminate the need for increases in tuition and fees to compensate for unanticipated decreases in other sources of revenue; mid-year and retroactive tuition increases should be opposed.
13. Support and encourage state medical societies to support further expansion of state loan repayment programs, particularly those that encompass physicians in non-primary care specialties.
14. Take an active advocacy role during reauthorization of the Higher Education Act and similar legislation, to achieve the following goals: (a) Eliminating the single holder rule; (b) Making the availability of loan deferment more flexible, including broadening the definition of economic hardship and expanding the period for loan deferment to include the entire length of residency and fellowship training; (c) Retaining the option of loan forbearance for residents ineligible for loan deferment; (d) Including, explicitly, dependent care expenses in the definition of the "cost of attendance"; (e) Including room and board expenses in the definition of tax-exempt scholarship income; (f) Continuing the federal Direct Loan Consolidation program, including the ability to

“lock in” a fixed interest rate, and giving consideration to grace periods in renewals of federal loan programs; (g) Adding the ability to refinance Federal Consolidation Loans; (h) Eliminating the cap on the student loan interest deduction; (i) Increasing the income limits for taking the interest deduction; (j) Making permanent the education tax incentives that our AMA successfully lobbied for as part of Economic Growth and Tax Relief Reconciliation Act of 2001; (k) Ensuring that loan repayment programs do not place greater burdens upon married couples than for similarly situated couples who are cohabitating; (l) Increasing efforts to collect overdue debts from the present medical student loan programs in a manner that would not interfere with the provision of future loan funds to medical students.

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

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

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

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

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

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

21. Advocate for continued funding of programs including Income-Driven Repayment plans for the benefit of reducing medical student load burden.

22. Formulate a task force to look at undergraduate medical education training as it relates to career choice, and develop new polices and novel approaches to prevent debt from influencing specialty and subspecialty choice.

23. Strongly advocate for the passage of legislation to allow medical students, residents and fellows who have education loans to qualify for interest-free deferment on their student loans while serving in a medical internship, residency, or fellowship program, as well as permitting the conversion of currently unsubsidized Stafford and Graduate Plus loans to interest free status for the duration of undergraduate and graduate medical education.
CME Rep. 5, I-18, Appended: Res. 953, I-18, Reaffirmation: A-19, Appended: Res. 316, A-19

Cost and Financing of Medical Education and Availability of First Year Residency Positions H-305.988
Our AMA:
1. believes that medical schools should further develop an information system based on common definitions to display the costs associated with undergraduate medical education;
2. in studying the financing of medical schools, supports identification of those elements that have implications for the supply of physicians in the future;
3. believes that the primary goal of medical school is to educate students to become physicians and that despite the economies necessary to survive in an era of decreased funding, teaching functions must be maintained even if other commitments need to be reduced;
4. believes that a decrease in student enrollment in medical schools may not result in proportionate reduction of expenditures by the school if quality of education is to be maintained;
5. supports continued improvement of the AMA information system on expenditures of medical students to determine which items are included, and what the ranges of costs are;
6. supports continued study of the relationship between medical student indebtedness and career choice;
7. believes medical schools should avoid counterbalancing reductions in revenues from other sources through tuition and student fee increases that compromise their ability to attract students from diverse backgrounds;
8. supports expansion of the number of affiliations with appropriate hospitals by institutions with accredited residency programs;
9. encourages for profit-hospitals to participate in medical education and training;
10. supports AMA monitoring of trends that may lead to a reduction in compensation and benefits provided to resident physicians;
11. encourages all sponsoring institutions to make financial information available to help residents manage their educational indebtedness; and
12. will advocate that resident and fellow trainees should not be financially responsible for their training.
CME Rep. A, I-83, Reaffirmed: CLRPD Rep. 1, I-93, Res. 313, I-95, Reaffirmed: CME Rep. 13, A-97, Modified: CME Rep. 7, A-05, Modified: CME Rep. 13, A-06, Appended: Res. 321, A-15, Reaffirmed: CME Rep. 5, A-16, Modified: CME Rep. 4, A-16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 309
(N-21)

Introduced by: Medical Student Section

Subject: Protecting Medical Student Access to Abortion Education and Training

Referred to: Reference Committee C

Whereas, Abortion is a legal medical procedure in the United States as a result of the 1973 U.S. Supreme Court decision in *Roe v. Wade* recognizing a woman's constitutional right to an abortion[1]; and

Whereas, The U.S. Supreme Court has reaffirmed the right to an abortion in subsequent decisions holding that a state cannot ban abortion before viability, the point at which a fetus can survive outside the uterus, and that any restriction on abortion after viability must contain exceptions to protect the life and health of the woman[2]; and

Whereas, Following the national legalization of abortion with *Roe v. Wade* and the resultant increase in physician education and skill regarding pregnancy termination procedures, deaths from legal abortions declined fivefold[3]; and

Whereas, Nearly half (45%) of all pregnancies among U.S. women are unintended, and about 4 in 10 of these unintended pregnancies were terminated by abortion[4]; and

Whereas, Sixteen percent of all pregnancies (excluding miscarriages) in 2015 ended in abortion[5]; and

Whereas, Approximately 638,169 abortions were reported to the CDC in 2015[5]; and

Whereas, The abortion rate in 2015 was 11.8 abortions per 1,000 women aged 15–44[5]; and

Whereas, It is estimated one in 20 U.S. women (5%) will have an abortion by age 20, about one in five women (19%) will have an abortion by age 30, and about one in four women (24%) will have an abortion by age 45[6]; and

Whereas, These numbers may be even higher given that underreporting of abortions is common in nationally representative surveys[7]; and

Whereas, Pregnancy options counseling, which is defined as providing non-directive, evidence-based information to newly diagnosed pregnant women about their options for continuing or terminating a pregnancy and referrals as necessary, is an integral part of the public health prevention framework for addressing unintended pregnancy and is considered a clinical best practice in the United States[8,9]; and

Whereas, A study analyzing data from the Medical Expenditure Panel Survey from 2002-2011 found that among reproductive-age women, 42.6% were found to receive care including, but not limited to, pregnancy care from solely a family physician, an additional 21.5% received care from a family physician or general internist in addition to receiving care from an OB/GYN, and 28.6% received their care from solely an OB/GYN[10]; and

Whereas, A 2018 study analyzing data from the Nationwide Emergency Department Sample Survey from 2009-2013 found that among all Emergency Department (ED) visits by women aged 15–49 (189,480,685), 0.01% (27,941) were abortion-related[11]; and

Whereas, The large number of abortion-related ED visits demonstrates that many different types of physicians, not just abortion providers, may have to counsel patients on abortion options and/or care for patients whose health has been affected by an abortion[11]; and

Whereas, Recent studies have found U.S. medical students may be under-prepared to address essential sexual health issues in future clinical practice and have recommended increased integration of sexual health curricula into medical schools' curriculum specifically in the area of family planning[12-14]; and

Whereas, A 2009 study found that only 60% of U.S. medical schools surveyed reported any type of preclinical abortion-related education[15]; and

Whereas, A 2005 study found that 17% of clerkship directors surveyed reported no formal education regarding abortion either in the preclinical or clinical years and 23% reported no formal abortion education provided during third-year OB-GYN rotations[16]; and

Whereas, A 2011 survey of 131 third-year medical students at the University of Colorado found that while 80% wanted didactic training on abortion, 57% reported no formal didactic training on abortion, only 24% had rotated through a clinic that provided abortion, and 45% reported unsatisfactory clinical opportunities with regards to abortion training[17]; and

Whereas, A 2015 study of 4th year medical students taking a family planning elective found that 72% of the students reported taking the elective due to a need for greater exposure to family planning care, 48% indicated the elective was necessary to obtain knowledge not available to them during their third-year clerkships, and 21% reported taking the elective in order to learn about abortions and how to perform them as they were not previously given this education[18]; and

Whereas, A 2014 study found that among 362 OB-GYN residents, representing 161 of the 240 OBGYN residency programs within the U.S., 54% reported routine training on abortion, 30% reported opt-in training, and 16% reported that no abortion training was available[19]; and

Whereas, A 2018 study surveying 190 OBGYN residency program directors representing 79% of all OBGYN residency directors found that 64% reported routine abortion training with dedicated time was offered within their residency program, 31% reported only optional abortion training being offered, and 5% reported abortion training was not available[20]; and

Whereas, The American College of Obstetricians and Gynecologists formally recommends integrated medical education on abortion and universal opt-out training policies for medical students and residents[21]; and

Whereas, The ACGME Review Committee for Obstetrics and Gynecology has stated "All programs must have an established curriculum for family planning, including for complications of abortions and provisions for the opportunity for direct procedural training in terminations of pregnancy for those residents who desire it"[22]; and

Whereas, The ACGME Review Committee for Obstetrics and Gynecology stated in a 2017 report that programs must allow residents to "opt out" rather than "opt in" to family planning curriculum, education, and training which includes abortions and that the Committee would consider a program with an "opt out" curriculum to be in substantial compliance with the requirements whereas a program with an "opt in" curriculum would be non-compliant with the requirements[22]; and

Whereas, The Association of American Medical Colleges (AAMC) which sponsors, in partnership with the AMA, the Liaison Committee on Medical Education (LCME) has affirmed its support for comprehensive options counseling in regard to reproductive care and its support of the ACGME's guidelines for offering opt-out abortion education[23]; and

Whereas, The AMA sued the Trump Administration over a new executive order that prevents clinics from receiving Title X funding if they provide, counsel patients regarding, or refer patients out for abortions, which demonstrates the AMA's consistent support for access to abortion and comprehensive options counseling that includes abortion[24]; therefore be it

RESOLVED, That our American Medical Association amend policy H-295.923, "Medical Training and Termination of Pregnancy," by addition and deletion to read as follows:

H-295.923 – MEDICAL TRAINING AND TERMINATION OF PREGNANCY

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

2.~~,~~ ~~a~~ Although observation of, attendance at, or any direct or indirect participation in ~~an~~ abortion procedures should not be required~~.~~, our AMA does support opt-out curriculum on abortion education. Further, the AMA supports the opportunity for medical students and residents to learn procedures for termination of pregnancy and opposes efforts to interfere with or restrict the availability of this training.

~~2~~3. Our AMA encourages the Accreditation Council for Graduate Medical Education to better enforce compliance with the standardization of abortion training opportunities as per the requirements set forth by the Review Committee for Obstetrics and Gynecology and the American College of Obstetricians and Gynecologists' recommendations. (Modify Current HOD Policy)

Fiscal Note: Minimal - less than $1,000

Date Received: 09/30/21

AUTHORS STATEMENT OF PRIORITY

Recent legislative changes have made essentially all abortion illegal in Texas with bounties and imprisonment for physicians who perform this medical procedure for their patients, and several other states have plans to enact similar legislation. Not only does this legislation violate the privacy of the patient-physician relationship and take away the rights of patients and physicians to decide the best healthcare, it also prevents residents and students in those states from being able to learn this medical procedure. Medical students and residents training in women's health will be behind their peers in understanding this procedure, and Texas, and states following suit, may become an undesirable place for training for aspiring women's health physicians.

This is a pivotal moment for women's healthcare, and we need to be able to respond adequately with policy stances that encompass all of the harms of Texas' anti-abortion laws. This resolution gives our AMA policy protecting the rights of trainees who wish to do so to learn about this medical procedure. Given the current circumstances, we believe this is a high-priority resolution which should be heard at this meeting.

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RELEVANT AMA POLICY

Medical Training and Termination of Pregnancy H-295.923

1. Our AMA supports the education of medical students, residents and young physicians about the need for physicians who provide termination of pregnancy services, the medical and public health importance of access to safe termination of pregnancy, and the medical, ethical, legal and psychological principles associated with termination of pregnancy, although observation of, attendance at, or any direct or indirect participation in an abortion should not be required. Further, the AMA supports the opportunity for residents to learn procedures for termination of pregnancy and opposes efforts to interfere with or restrict the availability of this training.
2. Our AMA encourages the Accreditation Council for Graduate Medical Education to better enforce compliance with the standardization of abortion training opportunities as per the requirements set forth by the Review Committee for Obstetrics and Gynecology and the American College of Obstetricians and Gynecologists' recommendations.

Res. 315, I-94; Reaffirmed: CME Rep. 2, A-04; Modified: CME Rep. 2, A-14; Modified: CME Rep. 1, A-15; Appended: Res. 957, I-17

Abortion H-5.995

Our AMA reaffirms that: (1) abortion is a medical procedure and should be performed only by a duly licensed physician and surgeon in conformance with standards of good medical practice and the Medical Practice Act of his state; and (2) no physician or other professional personnel shall be required to perform an act violative of good medical judgment. Neither physician, hospital, nor hospital personnel shall be required to perform any act violative of personally held moral principles. In these circumstances, good medical practice requires only that the physician or other professional withdraw from the case, so long as the withdrawal is consistent with good medical practice.

Sub. Res. 43, A-73; Reaffirmed: I-86; Reaffirmed: Sunset Report, I-96; Reaffirmed by Sub. Res. 208, I-96; Reaffirmed by BOT Rep. 26, A-97; Reaffirmed: CMS Rep. 1, I-00; Reaffirmed: CEJA Rep. 6, A-10; Reaffirmed: CEJA Rep. 01, A-20

E-4.2.7 Abortion

The Principles of Medical Ethics of the AMA do not prohibit a physician from performing an abortion in accordance with good medical practice and under circumstances that do not violate the law.

Issued: 2016

Oppose the Criminalization of Self-Induced Abortion H-5.980

Our AMA: (1) opposes the criminalization of self-induced abortion as it increases patients' medical risks and deters patients from seeking medically necessary services; and (2) will advocate against any legislative efforts to criminalize self-induced abortion.

Res. 007, A-18

Training in Reproductive Health Topics as a Requirement for Accreditation of Family Residencies D-310.954
Our AMA: (1) will work with the Accreditation Council for Graduate Medical Education to protect patient access to important reproductive health services by advocating for all family medicine residencies to provide comprehensive women's health including training in contraceptive counseling, family planning, and counseling for unintended pregnancy; and (2) encourages the ACGME to ensure greater clarity when making revisions to the educational requirements and expectations of family medicine residents in comprehensive women's health topics.
Res. 317, A-13

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 310
(N-21)

Introduced by: Resident and Fellow Section

Subject: Resident and Fellow Access to Fertility Preservation

Referred to: Reference Committee C

Whereas, The average age at completion of medical training in the United States is approximately 31.6 years overall[1] and 36.8 years for surgical trainees[2]; and

Whereas, Female fertility is known to decrease substantially after age 35,[3,4] with a nearly 50% drop from the early 20s to late 30s[5]; and

Whereas, Female physicians have a chance of infertility that is twice that of the general population (24.1% vs. 10.9%), with an average age at diagnosis of 33.7 years[1]; and

Whereas, The demands of residency increase the risk of pregnancy complications, with a higher rate of gestational hypertension, placental abruption, preterm labor, and intrauterine growth restriction among female residents[6–8]; and

Whereas, A majority of recent trainees perceive a stigma associated with pregnancy during training[9] and have concerns about workplace support,[10] which may deter medical students from choosing a career in a surgical or other field with longer and demanding training; and

Whereas, Approximately one third of program directors have reported discouraging pregnancy among residents in surgical training programs[10]; and

Whereas, Oocyte cryopreservation is an established method of preserving fertility[11] that can cost $10,000 per cycle, often with multiple cycles required, and $500 per year for storage,[12] in addition to requiring timely injection of ovarian stimulation medications and numerous outpatient visits for cycle monitoring and egg retrieval[13]; and

Whereas, Companies such as Google, Apple, and Facebook have been offering oocyte cryopreservation benefits to their workforce, who are similarly largely of reproductive age, for several years[14]; therefore be it

RESOLVED, That our American Medical Association support education for residents and fellows regarding the natural course of female fertility in relation to the timing of medical education, and the option of fertility preservation and infertility treatment (New HOD Policy); and be it further

RESOLVED, That our AMA advocate inclusion of insurance coverage for fertility preservation and infertility treatment within health insurance benefits for residents and fellows offered through graduate medical education programs (Directive to Take Action); and be it further

RESOLVED, That our AMA support the accommodation of residents and fellows who elect to pursue fertility preservation and infertility treatment, including the need to attend medical visits to complete the oocyte preservation process and to administer medications in a time-sensitive fashion. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 10/12/21

AUTHORS STATEMENT OF PRIORITY

Every extra year of training is a sacrifice when it comes to fertility. Recent news stories, including in the New York Times, have highlighted the emotional and physical difficulties affecting our colleagues. As policies are changing around the country regarding trainee benefits, bills of rights, and compensation, a discussion of this resolution by the HOD would be timely and guide the AMA with policy it does not currently have. This policy applies to most current trainees and future physicians.

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RELEVANT AMA POLICY

Disclosure of Risk to Fertility with Gonadotoxic Treatment H-425.967
Our AMA: (1) supports as best practice the disclosure to cancer and other patients of risks to fertility when gonadotoxic treatment is used; and (2) supports ongoing education for providers who counsel patients who may benefit from fertility preservation.
Citation: Res. 512, A-19

Infertility and Fertility Preservation Insurance Coverage H-185.990
1. Our AMA encourages third party payer health insurance carriers to make available insurance benefits for the diagnosis and treatment of recognized male and female infertility.
2. Our AMA supports payment for fertility preservation therapy services by all payers when iatrogenic infertility may be caused directly or indirectly by necessary medical treatments as determined by a licensed physician and will lobby for appropriate federal legislation requiring payment for fertility preservation therapy services by all payers when iatrogenic infertility may be

caused directly or indirectly by necessary medical treatments as determined by a licensed physician.
Citation: Res. 150, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CMS Rep. 4, A-08; Appended: Res. 114, A-13; Modified: Res. 809, I-14

Infertility Benefits for Veterans H-510.984
1. Our AMA supports lifting the congressional ban on the Department of Veterans Affairs (VA) from covering in vitro fertilization (IVF) costs for veterans who have become infertile due to service-related injuries.
2. Our AMA encourages interested stakeholders to collaborate in lifting the congressional ban on the VA from covering IVF costs for veterans who have become infertile due to service-related injuries.
3. Our AMA encourages the Department of Defense (DOD) to offer service members fertility counseling and information on relevant health care benefits provided through TRICARE and the VA at pre-deployment and during the medical discharge process.
4. Our AMA supports efforts by the DOD and VA to offer service members comprehensive health care services to preserve their ability to conceive a child and provide treatment within the standard of care to address infertility due to service-related injuries. Citation: CMS Rep. 01, I-16Appended: Res. 513, A-19

Right for Gamete Preservation Therapies H-65.956
1. Fertility preservation services are recognized by our AMA as an option for the members of the transgender and non-binary community who wish to preserve future fertility through gamete preservation prior to undergoing gender affirming medical or surgical therapies.
2. Our AMA supports the right of transgender or non-binary individuals to seek gamete preservation therapies. Citation: Res. 005, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 311
(N-21)

Introduced by: Resident and Fellow Section

Subject: Improving Access to Physician Health Programs for Physician Trainees

Referred to: Reference Committee C

Whereas, It is now commonly accepted that burnout is a significant issue among US physicians who experience higher levels of burnout than other US workers and groups that attain a similar higher-level of education[1]; and

Whereas, A study that further looked at burnout among medical students, residents, and early career physicians suggested an even higher risk among physician trainees[2]; and

Whereas, The authors reported that medical students were most susceptible to depression and suicidal ideation while residents had the highest fatigue. Medical students and residents/fellows had higher emotional exhaustion in comparison to early career physicians, with burnout and depersonalization reaching a peak during residency and lowest in early career[3-5]; and

Whereas, Burnout has far-reaching negative effects that can eventually lead to physician impairment through its association with alcohol abuse/dependence, worsened suicidal ideation, and increased self-perception of medical errors[3-5]; and

Whereas, Maintaining mental health and wellness across the entire lifespan of a physician's career is important but can be especially critical in the stages of training from medical school to fellowship; and

Whereas, The main governing bodies of medical education have implemented measures to address the poor mental health reported among physicians-in-training; and

Whereas, There is a need to expand advocacy for physician trainee mental health by promoting and protecting resident and fellow access to physician health programs; and

Whereas, PHPs are unique and evidence-based solutions to rehabilitate and manage impairment for licensed physicians; therefore be it

RESOLVED, That our American Medical Association work with the Accreditation Council for Graduate Medical Education and other relevant stakeholders to ensure physician health programs (PHPs) are promoted by training programs and transparent information is disseminated by programs to their trainees about PHP reporting requirements, benefits of participation, and limitations of such programs (Directive to Take Action); and be it further

RESOLVED, That our AMA recognize PHPs as one of many resources available to support physician trainee mental health. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000
Received: 10/12/21

AUTHORS STATEMENT OF PRIORITY

Physician trainees, including medical students, residents and fellows, are at increased risk of burnout even compared to practicing physicians, who are at increased risk compared to the rest of the population. Residents and fellows, who are at the early stage of the career, could benefit from established physician health programs to support their mental health. AMA advocacy on this important topic will have long-standing benefits for trainees, now and in the future and expand existing policy in important ways.

References:
1. Shanafelt, T., Boone, S., Tan, L., Dyrbye, L., Sotile, W., Satele, D., West, C., Sloan, J. and Oreskovich, M., 2012. Burnout and Satisfaction With Work-Life Balance Among US Physicians Relative to the General US Population. Archives of Internal Medicine, 172(18), p.1377.
2. Dyrbye, L., West, C., Satele, D., Boone, S., Tan, L., Sloan, J. and Shanafelt, T., 2014. Burnout Among U.S. Medical Students, Residents, and Early Career Physicians Relative to the General U.S. Population. Academic Medicine, 89(3), pp.443-451.
3. Jackson, E., Shanafelt, T., Hasan, O., Satele, D. and Dyrbye, L., 2016. Burnout and Alcohol Abuse/Dependence Among U.S. Medical Students. Academic Medicine, 91(9), pp.1251-1256.
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5. West, C., Huschka, M., Novotny, P., Sloan, J., Kolars, J., Habermann, T. and Shanafelt, T., 2006. Association of Perceived Medical Errors With Resident Distress and Empathy. JAMA, 296(9), p.1071.

RELEVANT AMA POLICY

H-405.961 Physician Health Programs

1. Our AMA affirms the importance of physician health and the need for ongoing education of all physicians and medical students regarding physician health and wellness.
2. Our AMA encourages state medical societies to collaborate with the state medical boards to: (a) develop strategies to destigmatize physician burnout; and (b) encourage physicians to participate in the state's physician health program without fear of loss of license or employment.
Citation: CSAPH Rep. 2, A-11; Reaffirmed in lieu of Res. 412, A-12; Reaffirmed: BOT action in response to referred for decision Res. 403, A-12; Modified: BOT Rep. 15, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 312
(N-21)

Introduced by: Resident and Fellow Section

Subject: Accountable Organizations to Resident and Fellow Trainees

Referred to: Reference Committee C

Whereas, The stated mission of the Accreditation Council for Graduate Medical Education (ACGME) is to, "improve healthcare and population health by assessing and advancing the quality of resident physicians' education through accreditation"[1]; and

Whereas, To achieve its mission the ACGME has determined that it has two main purposes: "(1) to establish and maintain accreditation standards that promote the educational quality of residency and subspecialty training programs; and (2) to promote conduct of the residency educational mission with sensitivity to the safety of care rendered to patients and in a humane environment that fosters the welfare, learning, and professionalism of residents,"[1]; and

Whereas, While the ACGME has taken steps to advocate for residents, its ability to effectively and timely work on their behalf is limited by "blunt tools" related to removal of accreditation and delay in providing feedback to programs[3]; and

Whereas, Our AMA Residents and Fellows' Bill of Rights (H-310.912) establishes that residents and fellows have rights to: (1) have a safe workspace that enables them to fulfill their clinical duties and educational obligations; (2) defend themselves against any allegations presented by a patient, health professional, or training program in accordance with due process guidelines established by the AMA; (3) 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 (4) confidentially evaluate faculty and programs and expect that the training program will address deficiencies by these evaluations in a timely fashion[4]; and

Whereas, Resident and fellow trainees still endure suboptimal training conditions, with recourse to address these issues limited by multiple factors including a high debt burden and fear of their program losing accreditation thus affecting future career prospects, which ultimately makes reporting even gross ACGME guideline infractions difficult to encourage[5,6]; and

Whereas, During the COVID-19 pandemic, residents and fellow trainees have been particularly susceptible to poor conditions including limited availability of personal protective equipment (PPE), longer work hours, lack of hazard pay or similar programs, redeployment into other specialties which may or may not be relevant to education in their own specialty, and difficulty in securing workers' compensation in the event of severe illness, with many programs revoking promised stipend increases[6]; and

Whereas, The rate of closure of family medicine residency programs is increasing, and the Federation of State Medical Boards (FSMB) has records of over 50 hospitals with accredited training programs that have closed, with indications that more closures can be expected across the country in multiple specialties[7,8]; and

Whereas, As exemplified by the Hahnemann University Hospital closure, residents and fellow trainees are vulnerable to the negative effects of hospital closures that threaten the quality and completion of their graduate medical education, financial wellbeing, and legal status within the United States,[9,10]; and

Whereas, Numerous organizations such as the ACGME, AMA, American Osteopathic Association (AOA), American Board of Medical Specialties (ABMS), Association of American Medical Colleges (AAMC), Council of Medical Specialty Societies, National Board of Medical Examiners (NBME), Pennsylvania Medical Society (PAMED), Philadelphia County Medical Society (PCMS), and Educational Commission for Foreign Medical Graduates (ECFMG) responded to the Hahnemann closure as well as other residency closures with offers of legal assistance, grants, visa assistance, tail-insurance coverage, and other forms of support[11]; and

Whereas, The majority of funding for Graduate Medical Education (GME) is through Medicare and Medicaid, with additional funding through the U.S. Department of Veteran Affairs (VA) and Health Resources and Services Administration (HRSA), as well as private hospital funding[12]; and

Whereas, The Centers for Medicare & Medicaid Services (CMS) is tasked with distributing the majority of GME funding, but is not responsible for overseeing the quality of training programs nor the wellness or treatment of trainees[12]; and

Whereas, None of the organizations that responded to the Hahnemann residency closures were required to by law, nor was the response coordinated, regulated, or monitored by any type of oversight organization with regards to resident and fellow interests, and an ACGME investigation of the closure of the Hahnemann University Hospital found that no existing organizations represented resident and fellow interests to the exclusion of other stakeholder interests.[3,11]; therefore be it

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 wellbeing 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 2022 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. (Directive to Take Action)

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

Received: 10/12/21

AUTHORS STATEMENT OF PRIORITY

The closure of the Hahnemann University Hospital and the residencies there highlighted the vulnerability of residents and fellows, particularly given the effect on their ability to complete their training, financial wellbeing, and legal status. While many organizations, including the AMA, stepped in to support residents, there is no single permanent accountable organization to represent resident and fellow interests without additional conflicts of interest. This resolution asks the AMA to take a leadership role in supporting residents and fellows by identifying such an organization and recommend strategies that can help in these situations in the future.

References:
1. *ACGME Manual Of Policies And Procedures*. Originally published 06/1992, Updated 06/2020. Online. <https://www.acgme.org/Portals/0/PDFs/ab_ACGMEPoliciesProcedures.pdf> Accessed 30 August 2020.
2. Nasca T, Johnson PF, Weiss KB, Brigham TP. Elevating Resident Voices in Health Systems Change: Lessons From the Closure of Hahnemann University Hospital. *Acad Med*. 2020;95(4):506-508. doi:10.1097.
3. Lypson M, Hamstra S, Colletti L. Is the Accreditation Council for Graduate Medical Education a Suitable Proxy for Resident Unions? Acad Med. 2009;84(3)296-300. doi: 10.1097/ACM.0b013e3181971f77
4. *Residents and Fellows' Bill of Rights H-310.912*. AMA Policy. <https://policysearch.ama-assn.org/policyfinder/detail/bill%20of%20rights?uri=%2FAMADoc%2FHOD.xml-0-2496.xml> Accessed 10 March 2021.
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11. O'Reilly, Kevin. Grants will help residents displaced by record hospital closure. AMA news. https://www.ama-assn.org/residents-students/residency/grants-will-help-residents-displaced-record-hospital-closure. Published August 27, 2019. Accessed September 11, 2020.
12. Direct Graduate Medical Education (DGME). https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/DGME. CMS.gov. Last modified on 05/12/2020. Accessed September 11, 2020.

RELEVANT AMA POLICY

Residents and Fellows' Bill of Rights H-310.912

1. Our AMA continues to advocate for improvements in the ACGME Institutional and Common Program Requirements that support AMA policies as follows: a) adequate financial support for and guaranteed leave to attend professional meetings; b) submission of training verification information to requesting agencies within 30 days of the request; c) adequate compensation with consideration to local cost-of-living factors and years of training, and to include the orientation period; d) health insurance benefits to include dental and vision services; e) paid leave for all purposes (family, educational, vacation, sick) to be no less than six weeks per year; and f) stronger due process guidelines.
2. Our AMA encourages the ACGME to ensure access to educational programs and curricula as necessary to facilitate a deeper understanding by resident physicians of the US health care system and to increase their communication skills.
3. Our AMA regularly communicates to residency and fellowship programs and other GME stakeholders this Resident/Fellows Physicians' Bill of Rights.
4. Our AMA: a) will promote residency and fellowship training programs to evaluate their own institution's process for repayment and develop a leaner approach. This includes disbursement of funds by direct deposit as opposed to a paper check and an online system of applying for

funds; b) encourages a system of expedited repayment for purchases of $200 or less (or an equivalent institutional threshold), for example through payment directly from their residency and fellowship programs (in contrast to following traditional workflow for reimbursement); and c) encourages training programs to develop a budget and strategy for planned expenses versus unplanned expenses, where planned expenses should be estimated using historical data, and should include trainee reimbursements for items such as educational materials, attendance at conferences, and entertaining applicants. Payment in advance or within one month of document submission is strongly recommended.
5. Our AMA encourages teaching institutions to explore benefits to residents and fellows that will reduce personal cost of living expenditures, such as allowances for housing, childcare, and transportation.
6. Our AMA will work with the Accreditation Council for Graduate Medical Education (ACGME) and other relevant stakeholders to amend the ACGME Common Program Requirements to allow flexibility in the specialty-specific ACGME program requirements enabling specialties to require salary reimbursement or “protected time” for resident and fellow education by “core faculty,” program directors, and assistant/associate program directors.
7. Our AMA adopts the following ‘Residents and Fellows’ Bill of Rights’ as applicable to all resident and fellow physicians in ACGME-accredited training programs:
RESIDENT/FELLOW PHYSICIANS’ BILL OF RIGHTS
Residents and fellows have a right to:
A. An education that fosters professional development, takes priority over service, and leads to independent practice.
With regard to education, residents and fellows should expect: (1) A graduate medical education experience that facilitates their professional and ethical development, to include regularly scheduled didactics for which they are released from clinical duties. Service obligations should not interfere with educational opportunities and clinical education should be given priority over service obligations; (2) Faculty who devote sufficient time to the educational program to fulfill their teaching and supervisory responsibilities; (3) Adequate clerical and clinical support services that minimize the extraneous, time-consuming work that draws attention from patient care issues and offers no educational value; (4) 24-hour per day access to information resources to educate themselves further about appropriate patient care; and (5) Resources that will allow them to pursue scholarly activities to include financial support and education leave to attend professional meetings.
B. Appropriate supervision by qualified faculty with progressive resident responsibility toward independent practice.
With regard to supervision, residents and fellows should expect supervision by physicians and non-physicians who are adequately qualified and which allows them to assume progressive responsibility appropriate to their level of education, competence, and experience. It is neither feasible nor desirable to develop universally applicable and precise requirements for supervision of residents.
C. Regular and timely feedback and evaluation based on valid assessments of resident performance.
With regard to evaluation and assessment processes, residents and fellows should expect: (1) Timely and substantive evaluations during each rotation in which their competence is objectively assessed by faculty who have directly supervised their work; (2) To evaluate the faculty and the program confidentially and in writing at least once annually and expect that the training program will address deficiencies revealed by these evaluations in a timely fashion; (3) Access to their training file and to be made aware of the contents of their file on an annual basis; and (4) Training programs to complete primary verification/credentialing forms and recredentialing forms, apply all required signatures to the forms, and then have the forms permanently secured in their educational files at the completion of training or a period of training and, when requested

by any organization involved in credentialing process, ensure the submission of those documents to the requesting organization within thirty days of the request.
D. A safe and supportive workplace with appropriate facilities.
With regard to the workplace, residents and fellows should have access to: (1) A safe workplace that enables them to fulfill their clinical duties and educational obligations; (2) Secure, clean, and comfortable on-call rooms and parking facilities which are secure and well-lit; (3) Opportunities to participate on committees whose actions may affect their education, patient care, workplace, or contract.
E. Adequate compensation and benefits that provide for resident well-being and health.
(1) With regard to contracts, residents and fellows should receive: a. Information about the interviewing residency or fellowship program including a copy of the currently used contract clearly outlining the conditions for (re)appointment, details of remuneration, specific responsibilities including call obligations, and a detailed protocol for handling any grievance; and b. At least four months advance notice of contract non-renewal and the reason for non-renewal.
(2) With regard to compensation, residents and fellows should receive: a. Compensation for time at orientation; and b. Salaries commensurate with their level of training and experience. Compensation should reflect cost of living differences based on local economic factors, such as housing, transportation, and energy costs (which affect the purchasing power of wages), and include appropriate adjustments for changes in the cost of living.
(3) With Regard to Benefits, Residents and Fellows Must Be Fully Informed of and Should Receive: a. Quality and affordable comprehensive medical, mental health, dental, and vision care for residents and their families, as well as professional liability insurance and disability insurance to all residents for disabilities resulting from activities that are part of the educational program; b. An institutional written policy on and education in the signs of excessive fatigue, clinical depression, substance abuse and dependence, and other physician impairment issues; c. Confidential access to mental health and substance abuse services; d. A guaranteed, predetermined amount of paid vacation leave, sick leave, family and medical leave and educational/professional leave during each year in their training program, the total amount of which should not be less than six weeks; e. Leave in compliance with the Family and Medical Leave Act; and f. The conditions under which sleeping quarters, meals and laundry or their equivalent are to be provided.
F. Clinical and educational work hours that protect patient safety and facilitate resident well-being and education.
With regard to clinical and educational work hours, residents and fellows should experience: (1) A reasonable work schedule that is in compliance with clinical and educational work hour requirements set forth by the ACGME; and (2) At-home call that is not so frequent or demanding such that rest periods are significantly diminished or that clinical and educational work hour requirements are effectively circumvented. Refer to AMA Policy H-310.907, “Resident/Fellow Clinical and Educational Work Hours,” for more information.
G. Due process in cases of allegations of misconduct or poor performance.
With regard to the complaints and appeals process, residents and fellows should have the opportunity to defend themselves against any allegations presented against them by a patient, health professional, or training program in accordance with the due process guidelines established by the AMA.
H. Access to and protection by institutional and accreditation authorities when reporting violations.
With regard to reporting violations to the ACGME, residents and fellows should: (1) Be informed by their program at the beginning of their training and again at each semi-annual review of the resources and processes available within the residency program for addressing resident concerns or complaints, including the program director, Residency Training Committee, and the designated institutional official; (2) Be able to file a formal complaint with the ACGME to address program violations of residency training requirements without fear of recrimination and with the

guarantee of due process; and (3) Have the opportunity to address their concerns about the training program through confidential channels, including the ACGME concern process and/or the annual ACGME Resident Survey.
Citation: CME Rep. 8, A-11Appended: Res. 303, A-14Reaffirmed: Res. 915, I-15Appended: CME Rep. 04, A-16Modified: CME Rep. 06, I-18Appended: Res. 324, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 313
(N-21)

Introduced by: Resident and Fellow Section

Subject: Establishing Minimum Standards for Parental Leave During Graduate Medical Education Training

Referred to: Reference Committee C

Whereas, A substantial number of trainees become parents during their training as a resident or fellow; and

Whereas, PGY-1 trainees will not meet eligibility for the Family Medical Leave Act, which has a 12-month employment eligibility threshold; and

Whereas, Unlike other industries, such as technology and law, "there is no standardized approach to parental leave across GME programs" [1]; and

Whereas, The Accreditation Council for Graduate Medical Education (ACGME) does not establish minimum standards for duration of parental leave for trainees; and

Whereas, A lack of minimum national standards may result in some trainees receiving substandard resources and benefits[2]; and

Whereas, Current AMA policy (H-405.960) encourages residency programs, among other stakeholders, to incorporate a "six-week minimum leave allowance;" therefore be it

RESOLVED, That our American Medical Association support current efforts by the Accreditation Council for Graduate Medical Education (ACGME), the American Board of Medical Specialties (ABMS), and other relevant stakeholders to develop and align minimum requirements for parental leave during residency and fellowship training and urge these bodies to adopt minimum requirements in accordance with policy H-405.960 (New HOD Policy); and be it further

RESOLVED, That our AMA petition the ACGME to recommend strategies to prevent undue burden on trainees related to parental leave; (Directive to Take Action)

RESOLVED, That our AMA petition the ACGME, ABMS, and other relevant stakeholders to develop specialty specific pathways for residents and fellows in good standing, who take maximum allowable parental leave, to complete their training within the original time frame. (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000

Received: 10/12/21

AUTHORS STATEMENT OF PRIORITY

As conversations are actively occurring around the country regarding trainee compensation, bills of rights, and benefits, discussion of this resolution by the HOD would be timely and guide the AMA with policy it does not currently have. Specifically, the ACGME is actively working on this and not having AMA policy on an issue that affects a significant number of trainees while discussions are actively being had by decision makers makes this policy particularly relevant and timely. This policy applies to current and all future physician trainees.

References:
1. Vassallo P, Jeremiah J, Forman L, et al. Parental Leave in Graduate Medical Education: Recommendations for Reform. *Am J Med*. 2019;132(3):385-389. doi:10.1016/j.amjmed.2018.11.006
2. Baril N. Parenting during Graduate Medical Training — Practical Policy. 2019:995-997. doi:10.1056/NEJMp1902966

RELEVANT AMA POLICY:

Principles for Graduate Medical Education H-310.929

Our AMA urges the Accreditation Council for Graduate Medical Education (ACGME) to incorporate these principles in its Institutional Requirements, if they are not already present.
(1) PURPOSE OF GRADUATE MEDICAL EDUCATION AND ITS RELATIONSHIP TO PATIENT CARE. There must be objectives for residency education in each specialty that promote the development of the knowledge, skills, attitudes, and behavior necessary to become a competent practitioner in a recognized medical specialty.
Exemplary patient care is a vital component for any residency/fellowship program. Graduate medical education enhances the quality of patient care in the institution sponsoring an accredited program. Graduate medical education must never compromise the quality of patient care. Institutions sponsoring residency programs and the director of each program must assure the highest quality of care for patients and the attainment of the program's educational objectives for the residents.
(2) RELATION OF ACCREDITATION TO THE PURPOSE OF RESIDENCY TRAINING. Accreditation requirements should relate to the stated purpose of a residency program and to the knowledge, skills, attitudes, and behaviors that a resident physician should have on completing residency education.
(3) EDUCATION IN THE BROAD FIELD OF MEDICINE. GME should provide a resident physician with broad clinical experiences that address the general competencies and professionalism expected of all physicians, adding depth as well as breadth to the competencies introduced in medical school.
(4) SCHOLARLY ACTIVITIES FOR RESIDENTS. Graduate medical education should always occur in a milieu that includes scholarship. Resident physicians should learn to appreciate the importance of scholarly activities and should be knowledgeable about scientific method. However, the accreditation requirements, the structure, and the content of graduate medical education should be directed toward preparing physicians to practice in a medical specialty. Individual educational opportunities beyond the residency program should be provided for resident physicians who have an interest in, and show an aptitude for, academic and research pursuits. The continued development of evidence-based medicine in the graduate medical education curriculum reinforces the integrity of the scientific method in the everyday practice of clinical medicine.
(5) FACULTY SCHOLARSHIP. All residency faculty members must engage in scholarly activities and/or scientific inquiry. Suitable examples of this work must not be limited to basic biomedical research. Faculty can comply with this principle through participation in scholarly meetings, journal club, lectures, and similar academic pursuits.
(6) INSTITUTIONAL RESPONSIBILITY FOR PROGRAMS. Specialty-specific GME must operate under a system of institutional governance responsible for the development and

implementation of policies regarding the following; the initial authorization of programs, the appointment of program directors, compliance with the accreditation requirements of the ACGME, the advancement of resident physicians, the disciplining of resident physicians when this is appropriate, the maintenance of permanent records, and the credentialing of resident physicians who successfully complete the program. If an institution closes or has to reduce the size of a residency program, the institution must inform the residents as soon as possible. Institutions must make every effort to allow residents already in the program to complete their education in the affected program. When this is not possible, institutions must assist residents to enroll in another program in which they can continue their education. Programs must also make arrangements, when necessary, for the disposition of program files so that future confirmation of the completion of residency education is possible. Institutions should allow residents to form 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.
Citation: CME Rep. 9, A-99; Reaffirmed: CME Rep. 2, A-09; Reaffirmed: CME Rep. 14, A-09; Modified: CME Rep. 06, I-18

Policies for Parental, Family and Medical Necessity Leave H-405.960
AMA adopts as policy the following guidelines for, and encourages the implementation of, Parental, Family and Medical Necessity Leave for Medical Students and Physicians:
1. Our AMA urges medical schools, residency training programs, medical specialty boards, the Accreditation Council for Graduate Medical Education, and medical group practices to incorporate and/or encourage development of leave policies, including parental, family, and medical leave policies, as part of the physician's standard benefit agreement.
2. Recommended components of parental leave policies for medical students and physicians include: (a) duration of leave allowed before and after delivery; (b) category of leave credited; (c) whether leave is paid or unpaid; (d) whether provision is made for continuation of insurance benefits during leave, and who pays the premium; (e) whether sick leave and vacation time may be accrued from year to year or used in advance; (f) how much time must be made up in order to be considered board eligible; (g) whether make-up time will be paid; (h) whether schedule accommodations are allowed; and (i) leave policy for adoption.
3. AMA policy is expanded to include physicians in practice, reading as follows: (a) residency program directors and group practice administrators should review federal law concerning maternity leave for guidance in developing policies to assure that pregnant physicians are allowed the same sick leave or disability benefits as those physicians who are ill or disabled; (b)

staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in other physicians' workloads, particularly in residency programs; and (c) physicians should be able to return to their practices or training programs after taking parental leave without the loss of status.
4. Our AMA encourages residency programs, specialty boards, and medical group practices to incorporate into their parental leave policies a six-week minimum leave allowance, with the understanding that no parent should be required to take a minimum leave.
5. Residency program directors should review federal and state law for guidance in developing policies for parental, family, and medical leave.
6. Medical students and physicians who are unable to work because of pregnancy, childbirth, and other related medical conditions should be entitled to such leave and other benefits on the same basis as other physicians who are temporarily unable to work for other medical reasons.
7. Residency programs should develop written policies on parental leave, family leave, and medical leave for physicians. Such written policies should include the following elements: (a) leave policy for birth or adoption; (b) duration of leave allowed before and after delivery; (c) category of leave credited (e.g., sick, vacation, parental, unpaid leave, short term disability); (d) whether leave is paid or unpaid; (e) whether provision is made for continuation of insurance benefits during leave and who pays for premiums; (f) whether sick leave and vacation time may be accrued from year to year or used in advance; (g) extended leave for resident physicians with extraordinary and long-term personal or family medical tragedies for periods of up to one year, without loss of previously accepted residency positions, for devastating conditions such as terminal illness, permanent disability, or complications of pregnancy that threaten maternal or fetal life; (h) how time can be made up in order for a resident physician to be considered board eligible; (i) what period of leave would result in a resident physician being required to complete an extra or delayed year of training; (j) whether time spent in making up a leave will be paid; and (k) whether schedule accommodations are allowed, such as reduced hours, no night call, modified rotation schedules, and permanent part-time scheduling.
8. Our AMA endorses the concept of equal parental leave for birth and adoption as a benefit for resident physicians, medical students, and physicians in practice regardless of gender or gender identity.
9. Staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in the workloads of other physicians, particularly those in residency programs.
10. Physicians should be able to return to their practices or training programs after taking parental leave, family leave, or medical leave without the loss of status.
11. Residency program directors must assist residents in identifying their specific requirements (for example, the number of months to be made up) because of leave for eligibility for board certification and must notify residents on leave if they are in danger of falling below minimal requirements for board eligibility. Program directors must give these residents a complete list of requirements to be completed in order to retain board eligibility.
12. Our AMA encourages flexibility in residency training programs, incorporating parental leave and alternative schedules for pregnant house staff.
13. In order to accommodate leave protected by the federal Family and Medical Leave Act, our AMA encourages all specialties within the American Board of Medical Specialties to allow graduating residents to extend training up to 12 weeks after the traditional residency completion date while still maintaining board eligibility in that year.
14. These policies as above should be freely available online and in writing to all applicants to medical school, residency or fellowship. Citation: CCB/CLRPD Rep. 4, A-13; Modified: Res. 305, A-14; Modified: Res. 904, I-14

Parental Leave H-405.954

1. Our AMA encourages the study of the health implications among patients if the United States were to modify one or more of the following aspects of the Family and Medical Leave Act (FMLA): a reduction in the number of employees from 50 employees; an increase in the number of covered weeks from 12 weeks; and creating a new benefit of paid parental leave.
2. Our AMA will study the effects of FMLA expansion on physicians in varied practice environments.
3. Our AMA: (a) encourages employers to offer and/or expand paid parental leave policies; (b) encourages state medical associations to work with their state legislatures to establish and promote paid parental leave policies; (c) advocates for improved social and economic support for paid family leave to care for newborns, infants and young children; and (d) advocates for federal tax incentives to support early child care and unpaid child care by extended family members. Citation: Res. 215, I-16; Appended: BOT Rep. 11, A-19;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 314
(N-21)

Introduced by: Resident and Fellow Section

Subject: Updating Current Wellness Policies and Improving Implementation

Referred to: Reference Committee C

Whereas, Previous AMA-RFS policy asked our AMA to study resident burnout prevention and wellness strategies (291.015R); and

Whereas, This same policy was reaffirmed at I-18 (291.036R); and

Whereas, Current Accreditation Council for Graduate Medical Education (ACGME) policy does include program requirements for specific aspects, but is unclear about what satisfies those requirements[1]; and

Whereas, New data exists regarding the efficacy of various specific burnout prevention strategies[2-7]; and

Whereas, Some organizations such as Stanford Medicine have been leaders in the field of physician wellness and burnout prevention through research, novel approaches and curriculum and support such as House Staff Wellbeing Panel and it may be prudent to apply these strategies into ACGME common requirements of residency programs[8]; and

Whereas, These specific strategies may be a more effective way to mitigate burnout than the current ACGME policy as listed; therefore be it

RESOLVED, That our American Medical Association work with the Accreditation Council on Graduate Medical Education and other appropriate stakeholders in the creation of an evidence-based best practices reference to address trainee burnout prevention and mitigation. (Directive to Take Action)

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

Received: 10/12/21

AUTHORS STATEMENT OF PRIORITY

This policy is lower priority. Although there is much focus on wellness in the era of COVID-19, this has been a long-standing concern for which too little has been done to affect change, and it is now taking its toll. Although this is less urgent due to the declining pandemic, medicine has struggled with how to address burnout and sustain wellness for years and there is no better place to begin to address this than at the GME level.

References:
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8. https://wellmd.stanford.edu/

RELEVANT AMA POLICY

Code of Medical Ethics
9.3.1 Physician Health & Wellness
When physician health or wellness is compromised, so may the safety and effectiveness of the medical care provided. To preserve the quality of their performance, physicians have a responsibility to maintain their health and wellness, broadly construed as preventing or treating acute or chronic diseases, including mental illness, disabilities, and occupational stress.
To fulfill this responsibility individually, physicians should:
(a) Maintain their own health and wellness by:
(i) following healthy lifestyle habits;
(ii) ensuring that they have a personal physician whose objectivity is not compromised.
(b) Take appropriate action when their health or wellness is compromised, including:
(i) engaging in honest assessment of their ability to continue practicing safely;
(ii) taking measures to mitigate the problem;
(iii) taking appropriate measures to protect patients, including measures to minimize the risk of transmitting infectious disease commensurate with the seriousness of the disease;
(iv) seeking appropriate help as needed, including help in addressing substance abuse.
Physicians should not practice if their ability to do so safely is impaired by use of a controlled substance, alcohol, other chemical agent or a health condition.
Collectively, physicians have an obligation to ensure that colleagues are able to provide safe and effective care, which includes promoting health and wellness among physicians.
Citation: Issued: 2016

Physician and Medical Student Burnout D-310.968
1. Our AMA recognizes that burnout, defined as emotional exhaustion, depersonalization, and a reduced sense of personal accomplishment or effectiveness, is a problem among residents, fellows, and medical students.
2. Our AMA will work with other interested groups to regularly inform the appropriate designated institutional officials, program directors, resident physicians, and attending faculty about resident, fellow, and medical student burnout (including recognition, treatment, and prevention of burnout) through appropriate media outlets
3. Our AMA will encourage partnerships and collaborations with accrediting bodies (e.g., the Accreditation Council for Graduate Medical Education and the Liaison Committee on Medical Education) and other major medical organizations to address the recognition, treatment, and prevention of burnout among residents, fellows, and medical students and faculty.
4. Our AMA will encourage further studies and disseminate the results of studies on physician and medical student burnout to the medical education and physician community.

5. Our AMA will continue to monitor this issue and track its progress, including publication of peer-reviewed research and changes in accreditation requirements.
6. Our AMA encourages the utilization of mindfulness education as an effective intervention to address the problem of medical student and physician burnout.
7. Our AMA will encourage medical staffs and/or organizational leadership to anonymously survey physicians to identify local factors that may lead to physician demoralization.
8. Our AMA will continue to offer burnout assessment resources and develop guidance to help organizations and medical staffs implement organizational strategies that will help reduce the sources of physician demoralization and promote overall medical staff well-being.
9. Our AMA will continue to: (a) address the institutional causes of physician demoralization and burnout, such as the burden of documentation requirements, inefficient work flows and regulatory oversight; and (b) develop and promote mechanisms by which physicians in all practices settings can reduce the risk and effects of demoralization and burnout, including implementing targeted practice transformation interventions, validated assessment tools and promoting a culture of well-being.
Citation: CME Rep. 8, A-07; Modified: Res. 919, I-11; Modified: BOT Rep. 15, A-19

Programs on Managing Physician Stress and Burnout H-405.957
1. Our American Medical Association supports existing programs to assist physicians in early identification and management of stress and the programs supported by the AMA to assist physicians in early identification and management of stress will concentrate on the physical, emotional and psychological aspects of responding to and handling stress in physicians' professional and personal lives, and when to seek professional assistance for stress-related difficulties.
2. Our AMA will review relevant modules of the STEPs Forward Program and also identify validated student-focused, high quality resources for professional well-being, and will encourage the Medical Student Section and Academic Physicians Section to promote these resources to medical students.
Citation: Res. 15, A-15; Appended: Res. 608, A-16; Reaffirmed: BOT Rep. 15, A-19;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 315
(N-21)

Introduced by: Resident and Fellow Section

Subject: Reducing Overall Fees and Making Costs for Licensing, Exam Fees, Application Fees, etc., Equitable for IMGS

Referred to: Reference Committee C

Whereas, United States Medical Licensing Examination (USMLE) fees are steep as a US medical student: Step 1 $645, Step 2 $6451,2; and

Whereas, USMLE fees are even higher for International Medical Graduates (IMGs): Step 1 $975, Step 2 $975[3]; and

Whereas, If a medical student takes the USMLE Step 1 or 2 exams outside the US, there is an additional delivery fee of the electronic test of $180 for Step 1 and $200 for Step 2[4]; and

Whereas, In 2020, over 52,000 US MD/DO and IMG applicants applied to residencies (over $38M for US MD/DO med students and over $40M for IMGs in USMLE Step 1 and 2 fees)[5]; and

Whereas, In 2018, 21,393 graduates applied for Educational Commission for Foreign Medical Graduates (ECFMG) certification and only 9,431 were certified[6]; and

Whereas, ECFMG certification ($60 in 2013; $150 in 2021) is required to take USMLE Step 3 for IMGs: primary source of verification of credentials ($60) + passing USMLE exams[3,7]; and

Whereas, In 2019, IMGs constituted 22% of physicians in training in residency, yet their costs to apply to become physicians in the US is much greater than their US counterparts[8]; and

Whereas, During the COVID-19 pandemic and suspension of USMLE Step 2 CS, ECFMG required IMGs to pass an Occupational English Test (OET) ($444) (online courses available for purchase from official OET sites), if students fit within 5 defined pathways ($900)[9,10]; and

Whereas, Prior to the cancellation of the USMLE Step 2 CS exam, examination fees rose year after year, but even more so for IMGs (~ $1600 in 2020, up from ~$1420 in 2013) compared to US counterparts (~ $1280 in 2020, up from ~$1200 in 2013)[11]; and

Whereas, ECFMG also provides an alternative way to verify credentials through Electronic Portfolio of International Credentials (EPIC) that costs $130 ($125 in 2020) and $100 ($90 in 2020) to confirm each credential and costs $50 to deliver each subsequent EPIC report[12]; and

Whereas, The ECFMG net assets in 2018 were $151,818,498[13]; therefore be it

RESOLVED, That our American Medical Association work with all relevant stakeholders to reduce application, exam, licensing fees and related financial burdens for international medical graduates (IMGs) to ensure cost equity with US MD and DO trainees (Directive to Take Action); and be it further

RESOLVED, That our AMA amend current policy H-255.966, "Abolish Discrimination in Licensure of IMGs," by addition to read as follows:

2. Our AMA will continue to work with the Federation of State Medical Boards to encourage parity in licensure requirements, and associated costs, for all physicians, whether U.S. medical school graduates or international medical graduates. (Modify Current HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 10/12/21

AUTHORS STATEMENT OF PRIORITY

This policy is lower priority. Our IMG colleagues, who comprise a significant portion of the physician workforce in the US, face additional financial burdens related to extra licensing, application and exam fees on top of the required fees faced by US medical graduates. Parity in licensing and examination requirements is already part of AMA policy, but ensuring parity in the fees associated should be policy as well.

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4. https://www.ecfmg.org/fees/usmle-surcharge.html. Accessed Mar 26, 2021
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RELEVANT AMA POLICY

Retirement of the National Board of Medical Examiners Step 2 Clinical Skills Exam for US Medical Graduates: Call for Expedited Action by the American Medical Association D-275.950
Our AMA: (1) will take immediate, expedited action to encourage the National Board of Medical Examiners (NBME), Federation of State Medical Boards (FSMB), and National Board of Osteopathic Medical Examiners (NBOME) to eliminate centralized clinical skills examinations used as a part of state licensure, including the USMLE Step 2 Clinical Skills Exam and the Comprehensive Osteopathic Medical Licensing Examination (COMLEX) Level 2 - Performance Evaluation Exam; (2) in collaboration with the Educational Commission for Foreign Medical Graduates (ECFMG), will advocate for an equivalent, equitable, and timely pathway for international medical graduates to demonstrate clinical skills competency; (3) strongly encourages all state delegations in the AMA House of Delegates and other interested member organizations of the AMA to engage their respective state medical licensing boards, the Federation of State Medical Boards, their medical schools and other interested credentialling bodies to encourage the elimination of these centralized, costly and low-value exams; and (4) will advocate that any replacement examination mechanisms be instituted immediately in lieu of resuming existing USMLE Step 2-CS and COMLEX Level 2-PE examinations when the COVID-19 restrictions subside.
Citation: Res. 306, I-20

AMA Principles on International Medical Graduates H-255.988
Our AMA supports:
1. Current U.S. visa and immigration requirements applicable to foreign national physicians who are graduates of medical schools other than those in the United States and Canada.
2. Current regulations governing the issuance of exchange visitor visas to foreign national IMGs, including the requirements for successful completion of the USMLE.
3. The AMA reaffirms its policy that the U.S. and Canada medical schools be accredited by a nongovernmental accrediting body.
4. Cooperation in the collection and analysis of information on medical schools in nations other than the U.S. and Canada.
5. Continued cooperation with the ECFMG and other appropriate organizations to disseminate information to prospective and current students in foreign medical schools. An AMA member, who is an IMG, should be appointed regularly as one of the AMA's representatives to the ECFMG Board of Trustees.
6. Working with the Accreditation Council for Graduate Medical Education (ACGME) and the Federation of State Medical Boards (FSMB) to assure that institutions offering accredited residencies, residency program directors, and U.S. licensing authorities do not deviate from established standards when evaluating graduates of foreign medical schools.
7. In cooperation with the ACGME and the FSMB, supports only those modifications in established graduate medical education or licensing standards designed to enhance the quality of medical education and patient care.
8. The AMA continues to support the activities of the ECFMG related to verification of education credentials and testing of IMGs.
9. That special consideration be given to the limited number of IMGs who are refugees from foreign governments that refuse to provide pertinent information usually required to establish eligibility for residency training or licensure.
10. That accreditation standards enhance the quality of patient care and medical education and not be used for purposes of regulating physician manpower.
11. That AMA representatives to the ACGME, residency review committees and to the ECFMG should support AMA policy opposing discrimination. Medical school admissions officers and directors of residency programs should select applicants on the basis of merit, without considering status as an IMG or an ethnic name as a negative factor.
12. The requirement that all medical school graduates complete at least one year of graduate medical education in an accredited U.S. program in order to qualify for full and unrestricted licensure.
13. Publicizing existing policy concerning the granting of staff and clinical privileges in hospitals and other health facilities.
14. The participation of all physicians, including graduates of foreign as well as U.S. and Canadian medical schools, in organized medicine. The AMA offers encouragement and assistance to state, county, and specialty medical societies in fostering greater membership among IMGs and their participation in leadership positions at all levels of organized medicine, including AMA committees and councils and state boards of medicine, by providing guidelines and non-financial incentives, such as recognition for outstanding achievements by either individuals or organizations in promoting leadership among IMGs.
15. Support studying the feasibility of conducting peer-to-peer membership recruitment efforts aimed at IMGs who are not AMA members.
16. AMA membership outreach to IMGs, to include a) using its existing publications to highlight policies and activities of interest to IMGs, stressing the common concerns of all physicians; b) publicizing its many relevant resources to all physicians, especially to nonmember IMGs; c) identifying and publicizing AMA resources to respond to inquiries from IMGs; and d) expansion

of its efforts to prepare and disseminate information about requirements for admission to accredited residency programs, the availability of positions, and the problems of becoming licensed and entering full and unrestricted medical practice in the U.S. that face IMGs. This information should be addressed to college students, high school and college advisors, and students in foreign medical schools.
17. Recognition of the common aims and goals of all physicians, particularly those practicing in the U.S., and support for including all physicians who are permanent residents of the U.S. in the mainstream of American medicine.
18. Its leadership role to promote the international exchange of medical knowledge as well as cultural understanding between the U.S. and other nations.
19. Institutions that sponsor exchange visitor programs in medical education, clinical medicine and public health to tailor programs for the individual visiting scholar that will meet the needs of the scholar, the institution, and the nation to which he will return.
20. Informing foreign national IMGs that the availability of training and practice opportunities in the U.S. is limited by the availability of fiscal and human resources to maintain the quality of medical education and patient care in the U.S., and that those IMGs who plan to return to their country of origin have the opportunity to obtain GME in the United States.
21. U.S. medical schools offering admission with advanced standing, within the capabilities determined by each institution, to international medical students who satisfy the requirements of the institution for matriculation.
22. The Federation of State Medical Boards, its member boards, and the ECFMG in their willingness to adjust their administrative procedures in processing IMG applications so that original documents do not have to be recertified in home countries when physicians apply for licenses in a second state.
Citation: BOT Rep. Z, A-86Reaffirmed: Res. 312, I-93Modified: CME Rep. 2, A-03Reaffirmation I-11Reaffirmed: CME Rep. 1, I-13Modified: BOT Rep. 25, A-15Modified: CME Rep. 01, A-16Appended: Res. 304, A-17Modified: CME Rep. 01, I-17Reaffirmation: A-19

Abolish Discrimination in Licensure of IMGs H-255.966
Medical Licensure of International Medical Graduates
1. Our AMA supports the following principles related to medical licensure of international medical graduates (IMGs):
A. State medical boards should ensure uniformity of licensure requirements for IMGs and graduates of U.S. and Canadian medical schools, including eliminating any disparity in the years of graduate medical education (GME) required for licensure and a uniform standard for the allowed number of administrations of licensure examinations.
B. All physicians seeking licensure should be evaluated on the basis of their individual education, training, qualifications, skills, character, ethics, experience and past practice.
C. Discrimination against physicians solely on the basis of national origin and/or the country in which they completed their medical education is inappropriate.
D. U.S. states and territories retain the right and responsibility to determine the qualifications of individuals applying for licensure to practice medicine within their respective jurisdictions.
E. State medical boards should be discouraged from a) using arbitrary and non-criteria-based lists of approved or unapproved foreign medical schools for licensure decisions and b) requiring an interview or oral examination prior to licensure endorsement. More effective methods for evaluating the quality of IMGs' undergraduate medical education should be pursued with the Federation of State Medical Boards and other relevant organizations. When available, the results should be a part of the determination of eligibility for licensure.
2. Our AMA will continue to work with the Federation of State Medical Boards to encourage parity in licensure requirements for all physicians, whether U.S. medical school graduates or international medical graduates.

3. Our AMA will continue to work with the Educational Commission for Foreign Medical Graduates and other appropriate organizations in developing effective methods to evaluate the clinical skills of IMGs.
4. Our AMA will work with state medical societies in states with discriminatory licensure requirements between IMGs and graduates of U.S. and Canadian medical schools to advocate for parity in licensure requirements, using the AMA International Medical Graduate Section licensure parity model resolution as a resource.
Citation: BOT Rep. 25, A-15