REPORTS OF THE COUNCIL ON MEDICAL EDUCATION

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

1. COUNCIL ON MEDICAL EDUCATION SUNSET REVIEW OF 2014 HOUSE OF DELEGATES' POLICIES

Reference committee hearing: see report of Reference Committee C.

**HOUSE ACTION: RECOMMENDATIONS ADOPTED
REMAINDER OF REPORT FILED**

Policy G-600.110, "Sunset Mechanism for AMA Policy," calls for the decennial review of American Medical Association (AMA) policies to ensure that our AMA's policy database is current, coherent, and relevant:

1. As the House of Delegates adopts policies, a maximum ten-year time horizon shall exist. A policy will typically sunset after ten years unless action is taken by the House of Delegates to retain it. Any action of our AMA House that reaffirms or amends an existing policy position shall reset the sunset "clock," making the reaffirmed or amended policy viable for another 10 years.

2. In the implementation and ongoing operation of our AMA policy sunset mechanism, the following procedures shall be followed: (a) Each year, the Speakers shall provide a list of policies that are subject to review under the policy sunset mechanism; (b) Such policies shall be assigned to the appropriate AMA councils for review; (c) Each AMA council that has been asked to review policies shall develop and submit a report to the House of Delegates identifying policies that are scheduled to sunset; (d) For each policy under review, the reviewing council can recommend one of the following actions: (i) retain the policy; (ii) sunset the policy; (iii) retain part of the policy; or (iv) reconcile the policy with more recent and like policy; (e) For each recommendation that it makes to retain a policy in any fashion, the reviewing council shall provide a succinct, but cogent justification; (f) The Speakers shall determine the best way for the House of Delegates to handle the sunset reports.

3. Nothing in this policy shall prohibit a report to the HOD or resolution to sunset a policy earlier than its 10-year horizon if it is no longer relevant, has been superseded by a more current policy, or has been accomplished.

4. The AMA councils and the House of Delegates should conform to the following guidelines for sunset: (a) when a policy is no longer relevant or necessary; (b) when a policy or directive has been accomplished; or (c) when the policy or directive is part of an established AMA practice that is transparent to the House and codified elsewhere such as the AMA Bylaws or the AMA House of Delegates Reference Manual: Procedures, Policies and Practices.

5. The most recent policy shall be deemed to supersede contradictory past AMA policies.

6. Sunset policies will be retained in the AMA historical archives.

See Appendix for a table of 2014 policies and recommended actions.

RECOMMENDATION

The Council on Medical Education recommends that the House of Delegates policies listed in the appendix to this report be acted upon in the manner indicated and the remainder of this report be filed.

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APPENDIX - RECOMMENDED ACTIONS

Policy Number	Title	Text	Recommendations
D-275.958	USMLE Step 1 Timing	Our AMA will ask the appropriate stakeholders to track United States Medical Licensing Examination (USMLE) Step 1 Exam timing and subsequently publish aggregate data to determine the significance of advanced clinical experience on Step 1 Exam performance. (Res. 911, I-14)	**Sunset - accomplished.** After I-14, the Association of American Medical Colleges (AAMC), National Board of Medical Examiners (NBME), and Federation of State Medical Boards (FSMB) were notified of the HOD directive. It was also communicated via the *MedEd Update* newsletter to each medical school, residency program director, directors of medical education at U.S. teaching hospitals, and other interested groups.
D-275.981	Potential Impact of the USMLE Step 2 CS and COMLEX-PE on Undergraduate and Graduate Medical Education	Our AMA will: (1) continue to closely monitor the USMLE Step 2 CS and the COMLEX-USA Level 2-PE, collecting data on initial and final pass rates, delays in students starting residency training due to scheduling of examinations, economic impact on students, and the potential impact of ethnicity on passing rates; and (2) encourage residency program directors to proactively evaluate their access to resources needed to assist resident physicians who have not passed these examinations to remediate. (CME Rep. 4, A-04; Modified: CME Rep. 2, A-14)	**Sunset – no longer relevant.** USMLE Step 2 CS and the COMLEX-USA Level 2-PE were discontinued in 2021 and 2022 respectively.
D.275.983	Physicians? Right to Reasonable Privacy Protection and the Federation Credentials Verification Service	Our AMA will request the Federation Credentials Verification Service (FCVS) to (1) add to its "Affidavit and Release" and "Authorization for Release of Records" forms appropriate language that: (a) allows physicians to revoke a prior authorization to the FCVS at any time through an affirmative action on the part of the physician (e.g., written notice) and (b) informs physicians their authorization will remain in effect unless and until revoked by the physician in accordance with guidance provided by the FCVS; and (2) clarify its release does not extend to liability which arises from the gross negligence or willful misconduct of FCVS. (BOT Rep. 22, A-04; Reaffirmed: CMS Rep. 1, A-14)	**Retain – still relevant. Amend title to read as follows:** Physicians~~?~~ Right to Reasonable Privacy Protection and the Federation Credentials Verification Service After A-04, the FSMB was notified of this HOD directive. The current FCVS waiver does not contain language contained in the AMA policy. FSMB has shared this AMA policy with their FCVS department and legal staff for review and welcome any AMA language for consideration.
D-275.995	Licensure and Credentialing Issues	Our AMA will: (1) support recognition of the Federation of State Medical Boards' (FSMB) Credentials Verification Service by all licensing jurisdictions; and (2) encourage	**Retain - still relevant. Amend policy with change in title to read as follows**: ~~Licensure and Credentialing Issues~~

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		the National Commission on Quality Assurance (NCQA) and all other organizations to accept the Federation of State Medical Boards' Credentials Verification Service, the Educational Commission for Foreign Medical Graduates' Certification Verification Service, and the AMA Masterfile as primary source verification of credentials. Res. 303, I-00; Reaffirmation A-04; Modified: (CCB/CLRPD Rep. 2, A-14; Reaffirmed: BOT Rep. 3, I-14)	Primary Source Verification of Credentials Our AMA ~~will~~: (1) supports recognition of the Federation of State Medical Boards' (FSMB) Credentials Verification Service by all licensing jurisdictions; and (2) encourages ~~the National Commission on Quality Assurance (NCQA) and all other organizations to accept~~ recognition of the Federation of State Medical Boards' Credentials Verification Service, the Educational Commission for Foreign Medical Graduates' Certification Verification Service, and the AMA Masterfile as primary source verification of credentials.
D-300.984	Physician Reentry	Our AMA: 1. Will continue to collaborate with other appropriate organizations on physician reentry issues including research on the need for and the effectiveness of reentry programs. 2. Will work collaboratively with the American Academy of Pediatrics and other interested groups to convene a conference on physician reentry which will bring together key stakeholders to address the development of reentry programs as well as the educational needs of physicians reentering clinical practice. 3. Will work with interested parties to establish a physician reentry program (PREP) information data base that is publicly accessible to physician applicants and which includes information pertaining to program characteristics. 4. Will support efforts to ensure the affordability and accessibility, and to address the unique liability issues related to PREPs. 5. Will make available to all interested parties the physician reentry program (PREP) system Guiding Principles for use as a basis for all reentry programs: a. Accessible: The PREP system is accessible by geography, time and cost. Reentry programs are available and accessible geographically across the United States and include national and regional pools of reentry positions. Reentering physicians with families or community ties are not burdened by having to relocate to attend a program. The length of time of reentry programs is standardized and is commensurate with the assessed clinical and educational needs of reentering physicians. The cost of reentry programs is not prohibitive to the physician, health care institutions or the health care system. b.	**Retain – in part. Sunset clauses (2) and (3) as having been accomplished and (6) as no longer relevant. Amend policy to read as follows:** Our AMA: 1. Will continue to collaborate with other appropriate organizations on physician reentry issues including research on the need for and the effectiveness of reentry programs. ~~2. Will work collaboratively with the American Academy of Pediatrics and other interested groups to convene a conference on physician reentry which will bring together key stakeholders to address the development of reentry programs as well as the educational needs of physicians reentering clinical practice.~~ ~~3. Will work with interested parties to establish a physician reentry program (PREP) information data base that is publicly accessible to physician applicants and which includes information pertaining to program characteristics.~~ ~~4~~2. Will support efforts to ensure ~~the~~ affordability and accessibility and to address the unique liability issues related to ~~PREPs~~ physician reentry programs. ~~5~~3. Will ~~make available to all interested parties the~~ continue to support ~~physician reentry program (PREP) system~~ these guiding principles for use as a basis for all reentry programs: (a)~~.~~ Accessible: ~~The PREP system is accessible~~ Obtainable by geography, time, and cost. Reentry programs are available and accessible geographically across the United States and include national and regional pools of reentry positions. Reentering physicians with families or community ties are not burdened by having to relocate to attend a program. The length of time of reentry programs is standardized and is commensurate with the assessed clinical and educational needs of reentering physicians. The cost of reentry programs is not prohibitive to the physician, health care institutions, or the health care system. (b)~~.~~ Collaborative: ~~The PREP system is d~~Designed to be collaborative to improve

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		Collaborative: The PREP system is designed to be collaborative to improve communication and resource sharing. Information and materials including evaluation instruments are shared across specialties, to the extent possible, to improve program and physician performance. A common nomenclature is used to maximize communication across specialties. Reentry programs share resources and create a common repository for such resources, which are easily accessible. c. Comprehensive: The PREP system is comprehensive to maximize program utility. Physician reentry programs prepare physicians to return to clinical activity in the discipline in which they have been trained or certified and in the practice settings they expect to work including community-based, public health, and hospital-based or academic practice. d. Ethical: The PREP system is based on accepted principles of medical ethics. Physician reentry programs will conform to physician licensure statues. The standards of professionalism, as stated in the AMA Code of Medical Ethics, must be followed. e. Flexible: The PREP system is flexible in structure in order to maximize program relevancy and usefulness. Physician reentry programs can accommodate modifications to program requirements and activities in ways that are optimal to the needs of reentering physicians. f. Modular: Physician reentry programs are modularized, individualized and competency-based. They are tailored to the learning needs of reentering physicians, which prevents the need for large, expensive, and standardized programs. Physicians should only be required to take those modules that allow them to meet an identified educational need. g. Innovative: Innovation is built into a PREP system allowing programs to offer state of the art learning and meet the diverse and changing needs of reentry physicians. Physician reentry programs develop and utilize learning tools including experimenting with innovative and novel curricular methodologies such as distance learning technologies and simulation. h. Accountable: The PREP system has mechanisms for assessment and is open to evaluation. Physician reentry programs have an evaluation component that is comparable among all specialties. Program assessments use objective measures to evaluate	communication and resource sharing. Information and materials including evaluation instruments are shared across specialties, to the extent possible, to improve program and physician performance. A common nomenclature is used to maximize communication across specialties. Reentry programs share resources and create a common repository for such resources, which are easily accessible. <u>(c)</u>~~.~~ Comprehensive: ~~The PREP system is comprehensive~~ <u>Broad</u> to maximize program utility. Physician reentry programs prepare physicians to return to clinical activity in the discipline in which they have been trained or certified and in the practice settings they expect to work including community-based, public health, and hospital-based or academic practice. <u>(d)</u>~~.~~ Ethical: ~~The PREP system is b~~<u>Based</u> on accepted principles of medical ethics. Physician reentry programs will conform to physician licensure statues. The standards of professionalism, as stated in the AMA Code of Medical Ethics, must be followed. <u>(e)</u>~~.~~ Flexible: ~~The PREP system is flexible~~ <u>Pliable</u> in structure in order to maximize program relevancy and usefulness. Physician reentry programs can accommodate modifications to program requirements and activities in ways that are optimal to the needs of reentering physicians. <u>(f)</u>~~.~~ Modular: Physician reentry programs are modularized, individualized, and competency-based. They are tailored to the learning needs of reentering physicians, which prevents the need for large, expensive, and standardized programs. Physicians should only be required to take those modules that allow them to meet an identified educational need. <u>(g)</u>~~.~~ Innovative: ~~Innovation is built into a PREP system allowing~~ <u>Allows</u> programs to offer state of the art learning and meet the diverse and changing needs of reentry physicians. Physician reentry programs develop and utilize learning tools including experimenting with innovative and novel curricular methodologies such as distance learning technologies and simulation. <u>(h)</u>~~.~~ Accountable: ~~The PREP system~~ Has mechanisms for assessment and is open to evaluation. Physician reentry programs have an evaluation component that is comparable among all specialties. Program assessments use objective measures to evaluate physician's competence at time of entry, during the program and at time of completion. Program outcomes are measured. Reliability and validity of the measures are established. Standardization of measures exists across programs to assess whether or not national standards are being met. <u>(i)</u>~~.~~ Stable: A funding scheme is in place to ensure ~~the PREP system is~~ financial~~ly stable~~ <u>stability</u> over the long-term. Adequate funding allows physician reentry

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		physician's competence at time of entry, during the program and at time of completion. Program outcomes are measured. Reliability and validity of the measures are established. Standardization of measures exist across programs to assess whether or not national standards are being met. i. Stable: A funding scheme is in place to ensure the PREP system is financially stable over the long-term. Adequate funding allows physician reentry programs to operate at sufficient and appropriate capacity. j. Responsive: The PREP system makes refinements, updates and other changes when necessary. Physician reentry programs are equipped to address systemic changes such as changes in regulations. Additionally, the PREP system is prepared to respond efficiently to urgent health care needs within society including mobilizing clinically inactive physicians temporarily into the workforce to attend to an acute public health crisis, such as a terrorist, biological, chemical, or natural disaster. 6. Our AMA encourages each state which does not grant a full and unrestricted license to physicians undergoing reentry to develop a non-disciplinary category of licensure for physicians during their reentry process. (CME Rep. 6, A-08; Reaffirmed: CME Rep. 11, A-12; Modified: CCB/CLRPD Rep. 2, A-14; Appended: Res. 310, A-14)	programs to operate at sufficient and appropriate capacity. (j) Responsive: ~~The PREP system m~~Makes refinements, updates, and other changes when necessary. Physician reentry programs are equipped to address systemic changes such as changes in regulations. ~~Additionally, the PREP system~~It is prepared to respond efficiently to urgent health care needs within society including mobilizing clinically inactive physicians temporarily into the workforce to attend to an acute public health crisis, such as a terrorist, biological, chemical, or natural disaster. ~~6. Our AMA Will encourages each states that which does not grant a full and unrestricted license to physicians undergoing reentry to develop a non-disciplinary category of licensure for physicians during their reentry process.~~ Sunset clause (2) as having been accomplished. Records indicate the AMA and the American Academy of Pediatrics hosted joint conferences in 2008 and 2011. They also launched the National Inactive Physicians Survey, which was published in 2011. Plans are underway for a similar study that will ask many of the same questions as the previous study. Sunset clause (3) as having been accomplished. FSMB developed a directory of physician assessment and remedial education programs. Regarding clause (6), state board requirements for reentry are listed on the FSMB website. FSMB's Workgroup on Reentry to Practice developed a draft report that discusses difficulties obtaining licensure based on time away from practice and speaks to differing reentry requirements when absences from practice result from disciplinary action or criminal conviction. Open comment period ended Feb 16, 2024. Remove references to "PREP" as it does not reflect current nomenclature.
D-300.988	Implications of the "Stark II" Regulations for Continuing Medical Education	Our AMA will (1) request that the Centers for Medicare & Medicaid Services develop an explicit exception within the regulations for Section 1877 of the Social Security Act (Stark law) that permits physician compensation without financial limit in the form of continuing medical education that is offered for the purpose of ensuring quality patient care; and (2) monitor the impact of the Section 1877 (Stark II) regulations on the ability of health care institutions to provide continuing medical education to their medical staffs.	**Retain – in part. Amend policy to read as follows:** Our AMA will ~~(1) request that the Centers for Medicare & Medicaid Services develop an explicit exception within the regulations for Section 1877 of the Social Security Act (Stark law) that permits physician compensation without financial limit in the form of continuing medical education that is offered for the purpose of ensuring quality patient care; and (2)~~ monitor the impact of the Section 1877 (Stark II) regulations on the ability of health care institutions to provide continuing medical education to their medical staffs.

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		(CME Rep. 6, I-04; Reaffirmed: CME Rep. 2, A-14)	Sunset clause (1) as having been accomplished. After I-04, Centers for Medicare & Medicaid Services was notified of this HOD directive. Retain clause (2) as there remain situations where health care institutions seek guidance on whether providing certain types of continuing medical education violates section 1877.
D-300.994	Reduced Continuing Medical Education (CME) Fees for Retired Physicians	Our AMA supports reduced registration fees for retired physicians at all continuing medical education (CME) programs and encourages CME providers to consider a reduced fee policy for retired physicians. (Res. 302, I-01; Reaffirmed: CME Rep. 2, A-11; Modified: CME Rep. 2, A-14)	**Retain - still relevant.**
D-310.967	Resident Pay During Orientation	Our AMA will advocate that all resident and fellow physicians should be compensated, and receive benefits, at a level commensurate with the pay that they will receive while in their training program, for all days spent in required orientation activities prior to the onset of their contractual responsibilities. (Res. 302, A-07; Modified: CCB/CLRPD Rep. 2, A-14)	**Retain - still relevant.**
D-310.980	Increase in ACGME Fees	Our AMA will work with the Accreditation Council for Graduate Medical Education to limit the increase of the ACGME fees. (Res. 311, A-04; Reaffirmed: CME Rep. 2, A-14)	**Sunset – not practical.** ACGME has limited increases for many years. It is incumbent on organizations to be able to control their own fees.
D-310.982	Protecting the Privacy of Physician Information Held by the ACGME	Our AMA will request the Accreditation Council for Graduate Medical Education and any other organization with a similar case and procedure log for resident physicians to (1) develop and implement a system to remove or sufficiently protect identifying data from individual physicians? data logs; and (2) adopt a policy not to disseminate any data specific to individual physicians without the written consent of the physician. (Res. 301, A-04; Reaffirmed: CME Rep. 2, A-14)	**Sunset – accomplished.** After A-04, ACGME was notified of this HOD directive. Records of the correspondence state that "in discussing this issue last week with John Nylen, he assured me this is already ACGME policy." The ACGME data systems include the Accreditation Data System (ADS), the Case Log System, the Medical School Portal, and ACGME surveys. Public-facing data is available here. The majority of data are available only to individuals with login credentials. Logins are provided to designated institutional officials (DIOs), program directors, program coordinators, residents, fellows, and designated medical school users. Users have access to the following systems: • Program directors: ADS, including Case Logs for viewing reports. • DIOs: ADS, including Case Logs for viewing reports.

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			• Residents and fellows: Case Logs and ACGME Surveys. • Faculty members: ACGME Surveys • Medical school users: Medical School Portal. • Others: ADS Public.
D-310.992	Limits on Training Opportunities for J-1 Residents	Our AMA will request that the Bureau of Educational and Cultural Affairs, Accreditation Council for Graduate Medical Education (ACGME), American Board of Medical Specialties and the Educational Commission for Foreign Medical Graduates develop criteria by which J-1 exchange visitor physicians could seek extension of the length of their visa beyond the 7-year limit in order to participate in fellowship or subspecialty programs accredited by the ACGME. (Res. 303, A-01; Reaffirmed: CME Rep. 2, A-11; Reaffirmation A-14)	**Sunset – accomplished.** After A-01, the Bureau of Educational and Cultural Affairs and the Educational Commission for Foreign Medical Graduates were notified of this HOD directive. It was also communicated to each residency program director and directors of medical education at U.S. teaching hospitals via the *Medical Education Bulletin*. According to ECFMG's (now a member of Intealth) Exchange Visitor Sponsor Program (EVSP), "any international medical graduate seeking to extend his/her participation in ECFMG-sponsored training beyond seven years must file a formal extension request with the Department of State (DOS) through ECFMG." In addition to the ECFMG fee and DOS fee, documentation must include: complete application for ECFMG sponsorship, letter of support from applicant's current and proposed program directors, statement of educational objectives from applicant, and letter of "exceptional need" from the home country government; this letter must be signed by either the home country's ambassador to the United States or the home country's minister of health confirming an "exceptional need" for the applicant to be trained in the field of medicine being pursued.
D-373.999	Informed Patient Choice and Shared Decision Making	1. Our AMA will work with state and specialty societies, medical schools, and others as appropriate to educate and communicate to medical students and to physicians about the importance of shared decision-making guidance through publications and other educational methods and assist the medical community in moving towards patient-centered care. (Res. 817, I-08; Modified: Res. 301, A-14)	**Retain - still relevant.**
D-480.999	State Authority and Flexibility in Medical Licensure for Telemedicine	Our AMA will continue its opposition to a single national federalized system of medical licensure. (CME Rep. 7, A-99; Reaffirmed and Modified: CME Rep. 2, A-09; Reaffirmed in lieu of Res. 920, I-13; Reaffirmed: BOT Rep. 3, I-14)	**Retain - still relevant.** This policy is central to Advocacy's work on telehealth licensure.

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G-620.065	Dues Exemption/ Adjustment for Physicians Unable to Attain Residency Training Program	Our AMA urges state societies to offer membership at significantly discounted rates for example, equal to the charge for medical students or residents, to physicians who have graduated from American medical schools or who have successfully completed Educational Commission on Foreign Medical Graduate (ECFMG) and United States Medical Licensing Examination (USMLE) examinations but have been unable to obtain American residency positions. (Res. 611, A-14)	**Retain - still relevant.**
H-40.977	Pay Equity for Physicians in Active and Reserve Uniformed Services	For reservists called to active duty or on short-term mobilization assignments, the AMA supports the adjustment of pay and allowances upwards to approach pay and allowances for those with similar rank and qualifications in regular and long-term reserve status. (Sub. Res. 233, I-92; Reaffirmed: CMS Rep. 10, A-03; Reaffirmed: CME Rep. 2, I-04; Reaffirmed: CMS Rep. 1, A-14)	**Retain - still relevant.**
H-40.983	Active and Reserve Physicians and Physicians-In-Training	(1) Our AMA requests the Residency Review Committees and Specialty Boards to develop flexible policies to ensure that (a) resident physicians and fellows who are members of the active or reserve components of the uniformed services of the United States retain their academic and training status within their respective training programs during periods of reserve activation or active duty with the uniformed services; and (b) active duty or deployment time with the uniformed services during a residency or fellowship should be credited toward the usual training period for eligibility for matriculation and Board examinations when the trainee's experiences have been educationally appropriate. (2) Our AMA strongly encourages state licensing boards to waive requirements for continuing medical education credits for physicians during periods of reserve or national guard activation or active duty with the uniformed services. (3) Our AMA supports the position that, at the time of national emergency, residents and fellows called to support their country in military service should be placed, when possible, in positions consistent with their specialty and level of training.	**Retain – still relevant.** ACGME works closely with the Department of Defense around issues with deployment of both residents and faculty. The institutional review group is revising their requirements, which will likely be released in fall 2024 with an open comment period.

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		(Res. 187, I-90; Modified: Sunset Report, I-00; Reaffirmed: CME Rep. 2, I-04; Modified: CME Rep. 2, A-14)	
H-95.943	MDs/DOs as Medical Review Officers	Our AMA: (1) reaffirms its policy that only licensed MDs/DOs with knowledge of substance use disorders should serve as Medical Review Officers (MROs); (2) reaffirms its policy that all MDs/DOs who serve as MROs should obtain continuing medical education credit in this subject area; (3) vigorously advocates that any legislation concerning drug testing in the workplace include a provision for a Medical Review Officer (MRO) who will review all positive test results and further that only a licensed physician may serve as the MRO and further that this physician MRO has knowledge of substance abuse disorders and has appropriate medical training to interpret and evaluate an individual's positive test results together with his or her medical history and any other relevant biomedical information ; and (4) vigorously opposes legislation that is inconsistent with these policies. (CCB/CLRPD Rep. 3, A-14)	**Retain – still relevant. Amend policy to read as follows:** Our AMA: (1) ~~reaffirms its policy~~ affirms that only licensed MDs/DOs with knowledge of substance use disorders should serve as Medical Review Officers (MROs); (2) ~~reaffirms its policy~~ affirms that all MDs/DOs who serve as MROs should obtain continuing medical education credit in this subject area; (3) ~~vigorously advocates~~ affirms that any legislation concerning drug testing in the workplace include a provision for a Medical Review Officer (MRO) who will review all positive test results ~~and further that only a licensed physician may serve as the MRO~~ and further that this physician MRO ~~has knowledge of substance abuse disorders and~~ has appropriate medical training to interpret and evaluate an individual's positive test results together with their medical history and any other relevant biomedical information-; and (4) ~~vigorously~~ opposes legislation that is inconsistent with these policies. Clauses (1) and (2) are consistent with ACOEM's MRO training. Language in clause (3) is redundant.
H-275.929	Additions to United States Medical Licensure Examination and Comprehensive Osteopathic Medical Licensure Examination	Our AMA opposes additions to the United States Medical Licensing Examination and Comprehensive Osteopathic Medical Licensure Examination that lack predictive validity for future performance as a physician. (Res. 308, A-04; Reaffirmed: CME Rep. 2, A-14)	**Retain - still relevant. Amend policy with change in title to read as follows:** Oppose Additions to United States Medical Licensure Examination and Comprehensive Osteopathic Medical Licensure Examination
H-275.930	Opposition to Clinical Skills Examinations for Physician Medical Relicensure	Our AMA: (1) opposes clinical skills examinations for the purpose of physician medical relicensure; (2) reaffirms its support for continuous quality improvement of practicing physicians, and supports research into methods to improve clinical practice, including practice guidelines; and (3) continues to support the implementation of quality improvement through local professional, non-governmental oversight. (Res. 307, A-04; Reaffirmed: CME Rep. 2, A-14)	**Retain- in part. Amend policy to read as follows:** Our AMA: (1) opposes clinical skills examinations for the purpose of physician medical relicensure; and (2) ~~reaffirms its supports for continuous quality improvement of practicing physicians, and supports; research into methods to improve clinical practice, including practice guidelines; and (3) continues to~~ supports the implementation of quality improvement through local professional, non-governmental oversight. Retain clause (1) as still relevant.

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			Sunset clause (2) which is addressed in policies H-450.970, H-450.965, and D-478.984. Retain clause (3) and append to H-450.970 where it better aligns with the content and title.
H-275.945	Self-Incriminating Questions on Applications for Licensure and Specialty Boards	The AMA will: (1) encourage the Federation of State Medical Boards and its constituent members to develop uniform definitions and nomenclature for use in licensing and disciplinary proceedings to better facilitate the sharing of information; (2) seek clarification of the application of the Americans with Disabilities Act to the actions of medical licensing and medical specialty boards; and (3) until the applicability and scope of the Americans with Disabilities Act are clarified, will encourage the American Board of Medical Specialties and the Federation of State Medical Boards and their constituent members to advise physicians of the rationale behind inquiries on mental illness, substance abuse or physical disabilities in materials used in the licensure, reregistration, and certification processes when such questions are asked. (BOT Rep. 13, I-93; Reaffirmed: CME Rep. 10-I-94; Reaffirmed: CME Rep. 2, A-04; Reaffirmed: CME Rep. 2, A-14)	**Sunset – accomplished.** Sunset clause (1) as having been accomplished. FSMB Physician Data Center (PDC) and Disciplinary Alert Service (DAS) foster the appropriate sharing of information and uniformity of definitions and nomenclature. Sunset clause (2) as having been accomplished. FSMB adopted policy Physician Wellness and Burnout (2018) that addresses the ADA related to licensing. Sunset clause (3), as it is addressed in policy H-275.970.
H-275.973	State Control of Qualifications for Medical Licensure	(1) The AMA firmly opposes the imposition of federally mandated restrictions on the ability of individual states to determine the qualifications of physician candidates for licensure by endorsement. (2) The AMA actively opposes the enactment of any legislation introduced in Congress that promotes these objectives. (Res. 84, I-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CME Rep. 2, A-07; Reaffirmed: BOT Rep. 3, I-14)	**Retain - still relevant. Amend policy with change in title to read as follows:** Support State Control of Qualifications for Medical Licensure
H-275.977	Verifying Physicians' Credentials	The AMA endorses the use of pluralistic approaches to the verification and validation of physicians' credentials. The AMA will seek legislation that managed care companies be required to request credentialing information in a uniform standardized format which all groups involved in credentialing would accept. (Sub. Res. 91, A-87; Amended by Res. 736, A-97; Reaffirmed: Sunset Report, I-97;	**Sunset – duplicative.** Sunset the first sentence as superseded by policy D-275.995 that supports primary source verification of credentials via the AMA Masterfile, FSMB's Federation Credentials Verification Service, and the Educational Commission for Foreign Medical Graduates' Certification Verification Service. Sunset the second sentence, which is already addressed by policy H-285.979.

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		Reaffirmed: CME Rep. 2, A-07; Reaffirmed: BOT Rep. 3, I-14)	
H-275.988	Identifying Persons with Illegally Obtained Medical Degrees	The AMA supports appropriate efforts of private and governmental agencies in identification of persons possessing illegally obtained medical degrees. (Res. 43, A-84; Reaffirmed by CLRPD Rep. 3 - I-94; Reaffirmed: CME Rep. 2, A-04; Reaffirmed: CME Rep. 2, A-14)	**Retain- still relevant.**
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)	**Sunset – accomplished.** Sunset clause (1) as having been accomplished. According to the ABMS, "member board certification is a voluntary specialty credential that indicates a physician or medical specialist's proficiency in a particular specialty area of medicine." Sunset clause (2) as having been accomplished, given the FSMB was notified of this policy after A-80. In 2012, the FSMB House of Delegates adopted a policy that states "The Federation of State Medical Boards (FSMB) supports the use of, and encourages state boards to recognize, a licensee's participation in an ABMS MOC and/or AOA BOS OCC program as an acceptable means of meeting CME requirements for license renewal." FSMB is aware of a small but growing number of state medical boards that accept participation in continuing certification as evidence of substantive compliance with CME requirements. Sunset clause (3) as duplicative. Addressed in AMA policy Support for Continuing Medical Education H-300.958.
H-295.863	Impairment Prevention and Treatment in the Training Years	Our AMA: (1) reaffirms the importance of preventing and treating psychiatric illness, alcoholism and substance abuse in medical students, residents and fellows; (2) strongly encourages medical schools and teaching hospitals to develop and maintain impairment prevention and treatment programs with confidential services for medical students, residents and fellows; (3) urges medical schools, hospitals with graduate medical education programs, and state and county medical societies to initiate active liaison with local impaired physician committees in order to more effectively diagnose and treat medical student and resident substance abuse; (4) advocates (a) further study (and continued monitoring of other studies) concerning the problem of	**Retain - still relevant. Amend policy to read as follows:** Our AMA: (1) ~~re~~affirms the importance of preventing and treating psychiatric illness, alcoholism, and substance ~~abuse~~ use in medical students, residents, and fellows; (2) ~~strongly~~ encourages medical schools and teaching hospitals to develop and maintain impairment prevention and treatment programs with confidential services for medical students, residents, and fellows; (3) urges medical schools, hospitals with graduate medical education programs, and state and county medical societies to initiate active liaison with local impaired physician committees in order to more effectively diagnose and treat medical student and resident substance ~~abuse~~ use; (4) advocates (a) further study (and continued

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		substance abuse among students, residents, and faculty in U.S. medical schools, and (b) development of model policy and programmatic guidelines which might assist in the establishment of programs for medical students, residents and faculty and which could significantly impact this problem and potentially reduce the risk of future impairment among physicians. (CCB/CLRPD Rep. 3, A-14)	monitoring of other studies) concerning the problem of substance ~~abuse~~ use among students, residents, and faculty in U.S. medical schools, and (b) development of model policy and programmatic guidelines which might assist in the establishment of programs for medical students, residents, and faculty and which could significantly impact this problem and potentially reduce the risk of future impairment among physicians. Change from "abuse to "use" in keeping with policy Destigmatizing the Language of Addiction H-95.917.
H-295.880	Service Learning in Medical Education	Our AMA will support the concept of service learning as a key component in medical school and residency curricula, and that these experiences should include student and resident collaboration with a community partner to improve the health of the population. (Res. 321, A-04; Reaffirmed: CME Rep. 2, A-14)	**Retain - still relevant.**
H-295.929	Faculty/Staff Appointments at More Than One Medical School	The AMA encourages medical schools that currently do not permit volunteer faculty members to hold appointments at more than one medical school to review this policy, to ensure that it is in the best interests of medical education and program integrity. Nonsalaried faculty members of medical schools should be allowed to hold concurrent appointments at more than one medical school as long as the individual physician agrees to carry out all responsibilities assigned by each medical school. (CME Rep. 3, I-93; Reaffirmed: CME Rep. 2, A-05; Modified: CME Rep. 2, A-14)	**Retain - still relevant.**
H-295.983	Extramural Clerkships and Early Career Decisions	The AMA (1) recognizes the essential role of the medical school faculty in the determination of the core clinical education of medical students; and (2) opposes resident recruitment practices which would interfere with scheduled core clinical clerkships at the student's medical school. (Res. 77, I-84; CLRPD Rep. 3 - I-94; Reaffirmed: CME Rep. 2, A-04; Reaffirmed: CME Rep. 2, A-14)	**Retain - still relevant.**
H-295.985	Humanism in Graduate Medical Education	The AMA encourages medical schools and teaching hospitals to strengthen educational programs for undergraduates and resident physicians in recognizing and meeting the emotional needs of patients and their families.	**Retain - still relevant.**

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		(Sub. Res. 154, A-84; Reaffirmed by CLRPD Rep. 3 - I-94; Reaffirmed: CME Rep. 2, A-04; Reaffirmed: CME Rep. 2, A-14)	
H-305.950	Fairness in Publication of Names of Loan Defaulters	The AMA opposes the selective publication of names of defaulters on federally funded student loans. (Res. 309, A-94; Reaffirmed: CME Rep. 2, A-04; Reaffirmed: CME Rep. 2, A-14)	**Retain - still relevant.**
H-310.990	Shared Residency Positions	The AMA supports the concept of shared residency positions and the continued collection and publication of data on these positions, and encourages residency program directors to offer such positions where feasible. (Res. 81, I-84; Reaffirmed by CLRPD Rep. 3 - I-94; Reaffirmed: CME Rep. 2, A-04; Modified: CME Rep. 2, A-14)	**Retain – still relevant. Amend policy to read as follows:** The AMA supports the concept of shared residency positions and the continued collection and publication of data on these positions~~, and encourages residency program directors to offer such positions where feasible~~.
H-355.977	Reporting of Resident Physicians to the National Practitioner Data Bank	1. Our AMA: (A) seeks opportunities to limit reports concerning residents to the National Practitioner Data Bank to only those situations where a final adverse action has been taken by a medical licensing jurisdiction; (B) opposes attempts to extend reports concerning residents to the National Practitioner Data Bank beyond those covered in Item 1 of this policy; and (C) advocates for legislation amending, as appropriate, the NPDB reporting requirements regarding resident physicians to be consistent with this policy, and opposes the expansion of existing reporting requirements. (CCB/CLRPD Rep. 3, A-14)	**Retain - still relevant. Amend policy to read as follows:** ~~1.~~ Our AMA: (A) ~~seeks opportunities to~~ supports the limiting of reports concerning residents to the National Practitioner Data Bank to only those situations where a final adverse action has been taken by a medical licensing jurisdiction; and (B) opposes attempts to extend reports concerning residents to the National Practitioner Data Bank ~~beyond those covered in Item 1 of this policy; and (C) advocates for legislation amending, as appropriate, the NPDB reporting requirements regarding resident physicians to be consistent with this policy, and opposes the expansion of existing reporting requirements~~.

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2. THE CURRENT MATCH PROCESS AND ALTERNATIVES

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS
REMAINDER OF REPORT FILED
See Policies H-310.900, H-310.912 and H-310.977

INTRODUCTION

At the 2023 Annual Meeting of the House of Delegates, Resolution 302-A-23 entitled "Antitrust Legislation Regarding the AAMC, ACGME, NRMP and Other Relevant Associations or Organizations" asked "that our American Medical Association study alternatives to the current residency and fellowship Match process which would be less restrictive on free market competition for applicants." The Resident and Fellow Section (RFS), authors of the resolution, noted concerns related to preservation of the process of free market competition, antitrust laws, and The Match®. Their resolution stated, "The Match poses significant anticompetition concerns and the procompetitive effect of streamlining residency job applications and increasing percentage of position filled needs to be outweighed by the anticompetitive effect of the lack of negotiation power of residents."[1.]

The resolution, now American Medical Association (AMA) Policy D-310.944, was referred for study. This report seeks to address this directive by providing historical context, differentiating between the application process versus The Match, explaining aspects of The Match process as well as independent match processes, and offering perspective from the National Resident Matching Program® (NRMP®). It seeks to illuminate what can be done within the confines of The Match to make it better and clarify that there are no currently identified "alternatives" other than the free market approach. To provide context, The Match is defined by the NRMP as "a computerized mathematical algorithm, 'the matching algorithm,' to place applicants into the most preferred residency and fellowship positions at programs that also prefer them."[2] It is intended to favor the rank list of the applicant.

BACKGROUND

History of The Match

The trainee internship experience began in the late 1800s and was formalized shortly thereafter. Such positions began to outnumber the students available. "In the early 1900s, competition among hospitals for interns and among medical students for good internships led to increasingly early offers of internships to students. By the 1940s, appointments were often made as early as the beginning of the junior year of medical school. ...From 1945 through 1951, efforts were made to enforce a uniform date for accepting offers. However, students were still faced with offers having very short deadlines, compelling them to accept or reject offers without knowing what other offers might be forthcoming."[3] Such challenges led to the creation of a centralized clearinghouse to allow for students to benefit from uniform appointment dates while reducing congestion and pressure. The clearinghouse was created by the National Interassociation Committee on Internships, who later changed its name to the National Intern Matching Program (NIMP). It included national organizations such as the AMA (Council on Medical Education), American Hospital Association, Association of American Medical Colleges (AAMC) and federal hospitals involved in resident training.[4] Dissatisfaction among students led to proposals of algorithms that were felt to be more equitable.

The NIMP was established as a 501c(3) and operated through the 1960s. In 1966, the Millis Commission Report, authorized by the AMA Council on Medical Education, examined medical education in the U.S., particularly the length and quality of graduate medical education. It supported a broader move to integrated residency training.[5] The NIMP became the NIRMP in 1968. The organization, in 1972, revised its participation requirements such that The Match expanded to include all first-year resident positions and required all institutions participating in The Match to select U.S. senior students in allopathic medical schools through it. By 1975, the NIRMP had become the NRMP.

The NRMP oversees The Match, which is the mathematical algorithm to match applicants and programs to their most preferred ranked choices. In 2012, researchers Lloyd Shapley and Alvin Roth won the Nobel Prize in Economics for developing the "theory of stable allocations and the practice of market design" which led to the development of the algorithm used for The Match. They "pioneered theoretical concepts to understand and solve the matching problem and clarified those ideas and applied them to engineer algorithms that are now widely used in the

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real world."[6] The current algorithm has been used since 1998. The Match continues to be updated to address the changing needs of applicants and to yield a favorable match while producing a stable outcome.

In the past, osteopathic medical students could also participate in the American Osteopathic Association (AOA) national match process through the National Matching Services (NMS). Starting in July 2015, the AOA and the Accreditation Council for Graduate Medical Education (ACGME) began a transition to a single accreditation system (SAS) to combine the AOA and NRMP match programs. Between 2015 and 2020, AOA programs applied for accreditation to the ACGME, and if granted, these programs could take residents through the NRMP match. By 2020, most AOA programs had transitioned to the SAS or had withdrawn and were no longer taking new residents but were allowed to complete the training of the residents remaining in their programs under AOA accreditation until the last resident finished. The intent of the SAS was to foster inclusion for osteopathic medical students as well as residents at former AOA programs. Data from 2020-2023 indicates that Doctor of Osteopathic Medicine (DO) applicants have an increased match rate from 90.7% to 91.6%, which also correlates with the opening of more DO schools.[7]

The Match process

The intention of The Match is to make the best possible match for all participants and ensure the uniform process is fair, efficient, transparent, and reliable. Referred to as the Main Residency Match, it is part of a larger undertaking that begins with applying to and interviewing with training programs. Most applicants use the Electronic Residency Application Service® (ERAS®), a product of the AAMC, to apply to programs per their chosen specialty. This centralized online application service delivers applications and supporting documents to residency programs. Next, applicants register for The Match in the NRMP's Registration, Ranking, and Results® (R3®) system. Applicants are invited to interview per the criteria set by each program. Both applicants and programs submit their rank order preferences in the R3 system by a predetermined deadline, usually in early March. The NRMP runs their matching algorithm according to the preferences submitted and all parties are notified of the results later that month. Matched applicants and programs enter into an agreement. Unmatched applicants and programs may elect to participate in the NRMP's Supplemental Offer and Acceptance Program (SOAP) during Match Week. See Appendix A for an infographic of this process. The NRMP website provides data on the Main Residency Match (including 2023) as well as research reports, survey reports, and research briefs.

The NRMP's Main Residency All In Policy asserts that if a program is registering for the Main Residency Match®, then they must register and attempt to fill all positions through the Match (or another national matching plan).[8] This policy only applies to those positions a program wishes to fill. Programs planning to participate in The Match cannot offer positions outside The Match. If that were to happen prior to program registration and activation, then the program is ineligible to enroll in The Match (unless the NRMP grants an exception). Per the Fellowship Match All In Policy, Specialties Matching Service® (SMS®) Match sponsors may *voluntarily* implement the All In Policy for their fellowship matches. AMA Policy D-310.977(6) "does not support the current 'All-In' policy for the Main Residency Match to the extent that it eliminates flexibility within the match process."[9]

In its current form, the NRMP contends that The Match process is uncongested, defers acceptance, promotes true preferences, and establishes a thick market "which allows for multi-specialty applications and couple matching (including for mixed-specialty couples)."[10] It is built upon the following core components:

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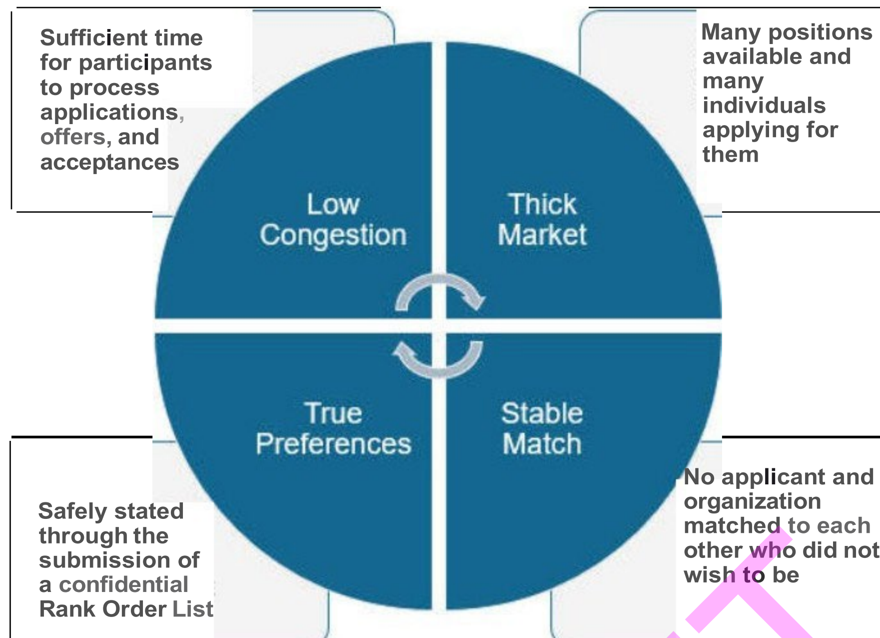

Principles of Market Design. Copyright National Resident Matching Program. Reprinted with permission.

Independent match processes

According to the NRMP, "U.S. medical school graduates and students and graduates of international medical schools can be offered positions outside of the Main Residency Match provided it is in a program that does not participate in the Match and thus not subject to the All In Policy. No applicant can accept a position outside of the Match after the Rank Order List Certification Deadline."[11] Some programs choose to participate in an early match process, and the percentage of outside-the-match offers varies by specialty.[12] Not all are affiliated with the NRMP. For example, students in the Health Professions Scholarship Program and the Uniformed Services University of the Health Sciences who wish to apply for military PGY-1 positions go through a similar process overseen by the Joint Service Graduate Medical Education Selection Board. While they still use the ERAS system, military medical students complete a different application that includes ranking programs. Deadlines also differ, as materials are submitted late August through mid-October, and results are announced in mid-December. The military does not use a computer-generated algorithm, rather it is a process of discussions and negotiations. An applicant can be placed in a program that they did not even rank.[13] Other examples include:

- Preventive Medicine and Public Health: First implemented in 2017, the American College of Preventive Medicine (ACPM) oversees their own match called the Residency Standardized Acceptance Process (SAP).[14]

- Plastic Surgery and Ophthalmology: The San Francisco Residency Match, more commonly referred to as SF Match, is a residency and fellowship matching service that has been used by several specialties and subspecialties for over 40 years. It includes residencies in plastic surgery and ophthalmology, overseen by the American Council of Academic Plastic Surgeons and Association of University Professors of Ophthalmology respectively. It also currently includes 25 fellowship matches, ranging from abdominal transplant surgery to rhinology.

- Urology: For over 30 years, the American Urological Association , in conjunction with the Society of Academic Urologists, has overseen the Urology Residency Match Program.

- Neuromuscular medicine: Starting in 2020, the American Association of Neuromuscular & Electrodiagnostic Medicine started its own standardized match process called the Neuromuscular Fellowship Application Portal that uses an online hub through which residents submit application materials, communicate with programs, and receive offers.[15] The first cycle hosted a partial match process, whereby

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programs submitted rank lists but applicants did not rank programs. The following cycle was a full match process.[15]

DISCUSSION

Before The Match and other match processes

The time before The Match and other match processes presented real challenges, added stress to the residency application process, and fueled unequal treatment. One reflection written about the time before The Match noted, "Medical students and hospitals once negotiated directly with each other. Competition for talent was fierce amid a tight labor market, with residency programs extending offers to medical students up to two years before graduation. This process had significant downsides: Students had to deal with exploding offers and felt pressure to commit to a program before getting sufficient exposure to different medical specialties. Medical students, residents, and hospitals all backed reform."[16] While The Match offered solutions to those who experienced life before it, a new generation of residency applicants has questioned its efficacy.

Perceived challenges faced by residency applicants

As summarized in the introduction, the RFS, as authors of the original resolution, noted concerns about lack of negotiation power of residents. Consternations were also raised regarding the possibility of residency/fellowship out-of-match offers being better than those in The Match; however, there is no data to support this notion. Discussions of these concerns among trainees are evident on social media platforms and the internet. For example, The Student Doctor Network, "a non-profit educational website dedicated to building a diverse doctor workforce," has hosted forums that debate this very issue.[16] In a 2021 forum called "What are the alternatives to the Match? What do you think would happen if it were abolished?", trainees raised several points for consideration. They shared that it is within the realm of possibility that programs would have zero incentive to increase wages to be more competitive if The Match went away. Without The Match or some unified system of application, programs could try to fill their spots earlier and such timing may not align with the applicant's desired specialty training. In the non-physician job market, a candidate often has to make a decision about accepting a position without knowing the full extent of the employment details.[17] The NRMP and other matches are not involved in any negotiations or agreements between programs and applicants, and if what a program is willing to offer to an applicant is unacceptable to the applicant, the applicant can simply not include that program in their rank list.

The impact of The Match on competition for residency positions

Another concern raised by the RFS is alleged lack of competition. In 1890, Congress passed The Sherman Act, the first antitrust law, followed in 1914 by two additional antitrust laws—the Federal Trade Commission Act (which formed the FTC) and the Clayton Act. Challenges to The Match were brought forth in a class-action lawsuit in 2002, alleging The Match as violating the Sherman Antitrust Act as described in the AMA Journal of Ethics.[18] However, U.S. Code 37b was passed into law in 2004, entitled "Confirmation of antitrust status of graduate medical resident matching programs," to "confirm that the antitrust laws do not prohibit sponsoring, conducting, or participating in a graduate medical education residency matching program, or agreeing to do so; and ensure that those who sponsor, conduct or participate in such matching programs are not subjected to the burden and expense of defending against litigation that challenges such matching programs under the antitrust laws."[19]

Concern was also raised about The Match possibly having a negative impact on resident salaries. A 2006 economic study by Bulow and Levin is frequently cited to support this claim[20]. However, Bulow and Levin also noted that The Match "was developed for efficiency reasons, and on that score, it appears to do quite well."[20] Research published since the Bulow-Levin paper does not support their conclusions. Agarwal noted that "The Match is not the likely cause of low salaries."[21] According to Konishi & Sapozhnikov, "competitive salary vector is the best-case scenario for applicants in the decentralized market. [… T]he reference salary vector adopted by Bulow and Levin (2006) for the decentralized market outcome might not have a strong justification and could be regarded as rather optimistic."[22] Also, it is important to consider that most resident salaries are funded by clinical revenues from the sponsoring institution and federal government sources, particularly Medicare graduate medical education funds from a budget set by Congress. Since clinical revenue and institutional funding can vary by specialty and setting, disparities in pay may result, even across residency programs at the same institution unfortunately.

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Resolution 308 implied that a free-market approach may be more beneficial for trainees. As described earlier in this report regarding the history of The Match and the era before its implementation, the free market posed many problems. Returning to such a process would not likely improve the challenges experienced previously. Economists agree that a free-market approach is not without flaws.[23,24] For example, "Apart from agriculture, few real-world markets are perfectly competitive."[25] Roth asserts that a centralized matching system can improve the welfare of all participants in that market and, depending on its design, can address the problems of unraveling and the congestion.[26] It seems that further analysis of what works well and what does not work well is warranted in order to improve The Match process. As described in this report, the NRMP and others are committed to continued review and improvement.

The Council on Medical Education recently addressed mechanisms to advocate for the needs of residents in its report, "Organizations to Represent the Interests of Resident and Fellow Trainees" (CME 5-I-23), which was adopted at the Interim 2023 Meeting. It also reviewed duty hour standards; work conditions; the impact of private equity; and the roles of government agencies, accreditors, medical staff organizations, associations, and unions. The adoption of that report signifies renewed efforts to advocate for the interests of trainees.

Coalition for Physician Accountability recommendations

The Coalition for Physician Accountability (CPA) is comprised of representatives from national organizations (including the AMA) responsible for the oversight, education, and assessment of medical students and physicians throughout their medical careers. In April 2021, the CPA's Undergraduate Medical Education-Graduate Medical Education Review Committee (UGRC) released 28 recommendations for comprehensive improvement of the UME-GME transition. The UGRC was comprised of several workgroups, one of which focused on the mechanics of the application/selection process from the graduate medical education perspective. The final recommendations were categorized according to themes and refer to the residency application process as well as The Match and other matching processes. Two themes of note address an equitable, mission-driven application review (Recommendations #14-20) as well as optimization of the application, interview, and selection processes (Recommendations #21-24). Specifically, Recommendation #23 states that "Innovations to the residency application process should be piloted to reduce application numbers and concentrate applicants at programs where mutual interest is high, while maximizing applicant placement into residency positions. Well-designed pilots should receive all available support from the medical community and be implemented as soon as the 2022-2023 application cycle; successful pilots should be expanded expeditiously toward a unified process."[27]

Recent NRMP proposals

The NRMP maintains that it is committed to considering ways to inform the transition to residency or improve the matching process. In 2021, the NRMP issued a statement on the feasibility of an early match. Specifically, NRMP was asked to pilot the Early Result and Acceptance Program (ERAP) proposed for obstetrics and gynecology. This pilot program was created through a grant provided by the AMA's Reimagining Residency program. The NRMP concluded that an early match would disadvantage applicants, and that changes to the process could potentially cause behavior changes that could negatively affect outcomes for all participants.[10]

To consider the feasibility of a proposed Two-Phase Main Residency Match (that would replace The Match and SOAP), the NRMP Board of Directors opened a call for comment period in August-September 2022. The goal was to "alleviate some of the stressors inherent in the current transition to residency based on available evidence."[28] After considering the over 8,000 responses to the call, the NRMP Board of Directors decided to not pursue the proposal as written, stating that "Although the benefits/advantages articulated by the community are significant, the risks/disadvantages are considered of greater consequence."[29] The AAMC hosted several listening sessions with their constituency to discuss this two-phase proposal and issued a statement concluding that a long-term evaluation plan would be needed with a focus on "learners and equity."[30] The AAMC also noted that ERAS would still play a role in a two-phase match and recommended further discussions.

AMA ENGAGEMENT

The AMA has been actively engaged in monitoring this process, is in regular communication with the NRMP, and actively participates in the CPA. The AMA Medical Student Section (MSS) and RFS each offer to their members the opportunity to apply to represent the AMA on the NRMP Board. Both AMA sections have solicited for or nominated members every year for at least the last ten years. The NRMP board offers three seats for student

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directors and three seats for resident physician directors. The NRMP no longer has designated AMA seats for students or residents due to a change in their bylaws in 2017. To promote effective communication, fostering relationships among key parties is vital. The AMA will continue to look for opportunities to collaborate with the NRMP and other matching organizations.

Through the AMA's ChangeMedEd initiative, efforts are underway across the continuum with visionary partners to create bold innovations. Specifically, Reimagining Residency is a grant program dedicated to promoting systemic change in graduate medical education (GME). "It supports bold and innovative projects that provide a meaningful and safe transition from undergraduate medical education to graduate medical education."[31] Several Reimagining Residency projects directly address the transition from undergraduate medical education (UME) to GME. "Right Resident, Right Program, Ready Day One," a collaboration with the Association of Professors of Gynecology & Obstetrics (APGO), raises cross-specialty standards for the residency application and interview process. It promotes signaling to reduce the number of applications submitted by formalizing communication about true preferences. APGO has also developed an Alignment Check Index (ACI). This adjunct to AMA's FREIDA platform seeks to better align applicant preferences and characteristics with those being sought by specific residency programs. A project at New York University (NYU), called the "Transition to Residency Advantage," builds on experience with UME coaching to train a cadre of GME coaches and then effect a learner-driven warm handoff from UME to GME. Two additional projects, the "California Oregon Medical Partnership to Address Rural Disparities in Rural Education and Health" (COMPADRE) and the University of North Carolina's "Fully Integrated Readiness for Service Training" (FIRST) are creating pathways to rural practice that entail dedicated pathways from medical school to residency that meet the needs of those areas. Also, the AMA helps to inform future GME advocacy by addressing concerns regarding the challenges faced by the current GME system. A 2023 compendium of such GME advocacy initiatives is available for review.

Council on Medical Education efforts

Since 2012, the Council on Medical Education has offered several reports that address residency and The Match as listed below. Additional Council reports can be accessed in the AMA Council Report Finder database.

- Organizations to Represent the Interests of Resident and Fellow Trainees" (CME 5-I-23)
- Optimizing Match Outcomes (CME Report 3-A-21)
- Standardizing the Residency Match System and Timeline (CME Report 3-A-19)
- The Transition from Undergraduate Medical Education to Graduate Medical Education (CME Report 5-I-19)
- Options for Unmatched Medical Students (CME Report 5-A-17)
- Standardizing the Allopathic Residency Match System and Timeline (CME Report 6-A-17)
- Resident and Fellow Compensation and Health Care System Value (CME Report 4-A-16)
- Transparency in the National Resident Matching Program Match Agreement (CME Report 12-A-12)

Relevant AMA Policy

The AMA has ample policy in support of trainees that address such topics as The Match, other match processes, residency application process, and graduate medical education. These policies exemplify the AMA's commitment to closely monitor these issues and engage with the NRMP and others to optimize successful, equitable matching. See Appendix B for the following full policies:

- Study of the Current Match Process and Alternatives D-310.944
- Residents and Fellows' Bill of Rights H-310.912
- Preliminary Year Program Placement H-310.910
- Closing of Residency Programs H-310.943
- Protection of Resident and Fellow Training in the Case of Hospital or Training Program Closure D-310.948
- Residency Interview Schedules H-310.998

Of note, Policy D-310.977 "National Resident Matching Program Reform" includes the following clauses that state the AMA:

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

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(5) will work with the Accreditation Council for Graduate Medical Education (ACGME) and other appropriate agencies to assure that the terms of employment for resident physicians are fair and equitable and reflect the unique and extensive amount of education and experience acquired by physicians;
(6) does not support the current the "All-In" policy for the Main Residency Match to the extent that it eliminates flexibility within the match process;
(7) will work with the NRMP, and other residency match programs, in revising Match policy, including the secondary match or scramble process to create more standardized rules for all candidates including application timelines and requirements;
(8) will work with the NRMP and other external bodies to develop mechanisms that limit disparities within the residency application process and allow both flexibility and standard rules for applicants;

Additional related policies, such as those listed below, can be accessed in the AMA Policy Finder database:

- Strengthening Interview Guidelines for American Indian and Alaska Native Medical School, Residency, and Fellowship Applicants H-295.852
- Mitigating Demographic and Socioeconomic Inequities in the Residency and Fellowship Selection Process D-310.945
- 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
- Strategies for Enhancing Diversity in the Physician Workforce D-200.985
- US Physician Shortage H-200.954
- Collective Bargaining: Antitrust Immunity D-383.983
- AMA's Aggressive Pursuit of Antitrust Reform D-383.990
- Antitrust Relief for Physicians Through Federal Legislation H-383.990
- Antitrust Relief H-383.992

SUMMARY AND RECOMMENDATIONS

The Council on Medical Education understands the concerns presented by the authors of Resolution 302-A-23 and their frustrations related to lack of control over their own destinies. This report describes the origins of The Match and its current state as well as information about independent match processes. It also clarifies the difference between the AAMC's ERAS application process versus NRMP's Match process, acknowledges challenges, and summarizes recent considerations and recommendations. This report illuminates the importance of ongoing communication and transparency by the NRMP as well as collaboration among all invested parties. Further, this report makes clear that there are no currently identified alternatives other than an unstructured, open market approach, which the Council believes would be detrimental to the majority of trainees in comparison to the current Match process. Accordingly, attention should be focused on what can be done to improve The Match and other specialty matches rather than focusing on its replacement, as a match process continues to be the best solution for trainees at this time.

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

1. AMA Policy D-310.977, "National Resident Matching Program Reform" be amended by addition to read as follows. Our AMA:

    (20) Encourages the piloting of innovations to the residency application process with aims to reduce application numbers per applicant, focus applicants on programs with reciprocal interest, and maximize residency placement. With support from the medical education community, successful pilots should be expanded to enhance the standardized process.
    (21) Continues to engage the National Resident Matching Program® (NRMP®) and other matching organizations on behalf of residents and medical students to further develop ongoing relationships, improve communications, and seek additional opportunities to collaborate including the submission of suitable nominees for their governing bodies as appropriate.

2. Reaffirm AMA Policies H-310.900 "Resident and Fellow Physicians Seeking to Transfer GME Program" and H-310.912 "Residents and Fellows' Bill of Rights."

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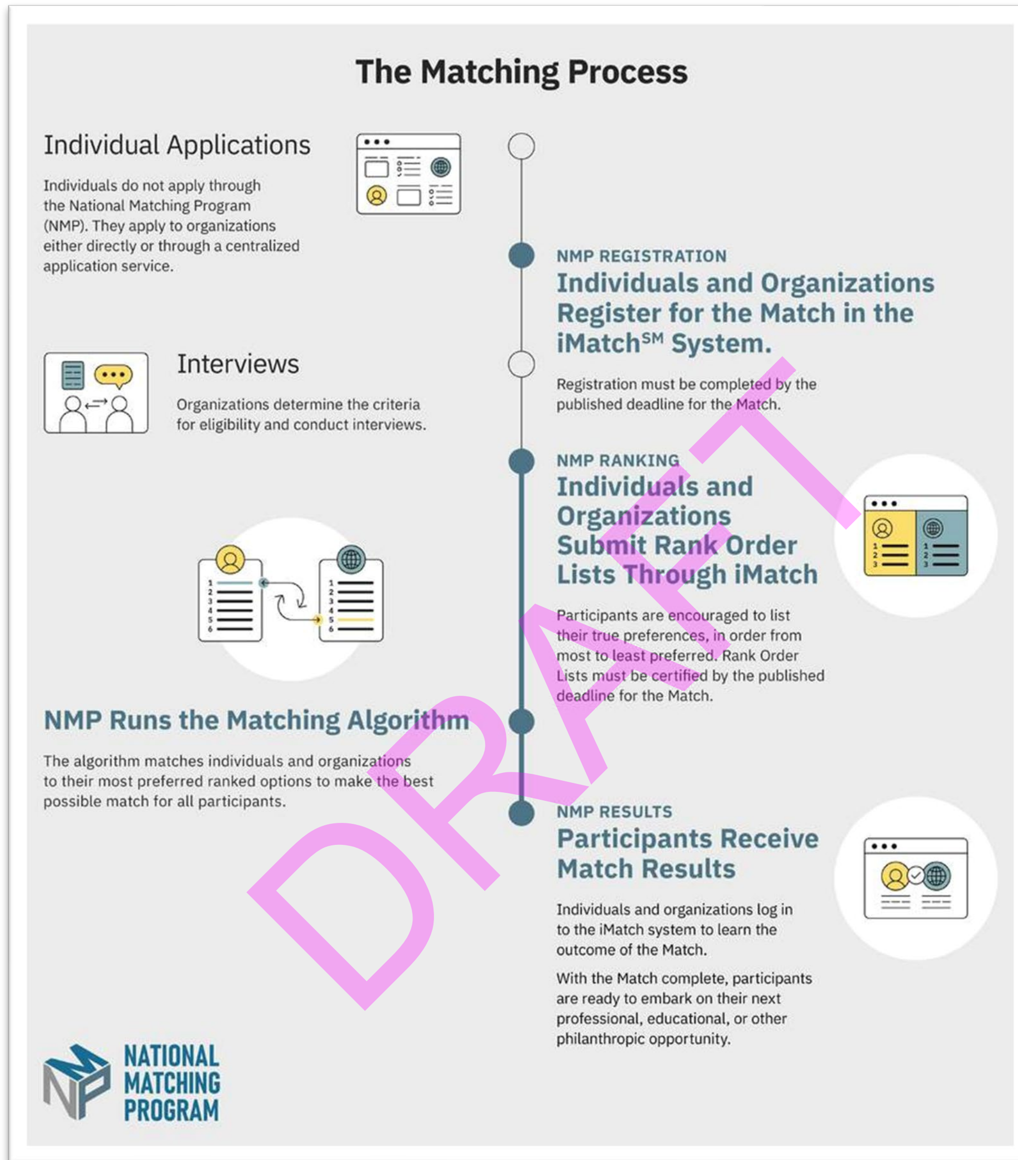
3. Rescind AMA policy D-310.944, "Study of the Current Match Process and Alternatives," as having been accomplished by this report.

APPENDIX A: THE MATCH PROCESS



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APPENDIX B: RELEVANT AMA POLICY

National Resident Matching Program Reform D-310.977

Our AMA:
(1) will work with the National Resident Matching Program (NRMP) to develop and distribute educational programs to better inform applicants about the NRMP matching process, including the existing NRMP waiver and violations review policies;
(2) will actively participate in the evaluation of, and provide timely comments about, all proposals to modify the NRMP Match;
(3) will request that the NRMP explore the possibility of including the Osteopathic Match in the NRMP Match;
(4) will continue to review the NRMP's policies and procedures and make recommendations for improvements as the need arises, to include making the conditions of the Match agreement more transparent while assuring the confidentiality of the match;
(5) will work with the Accreditation Council for Graduate Medical Education (ACGME) and other appropriate agencies to assure that the terms of employment for resident physicians are fair and equitable and reflect the unique and extensive amount of education and experience acquired by physicians;
(6) does not support the current the "All-In" policy for the Main Residency Match to the extent that it eliminates flexibility within the match process;
(7) will work with the NRMP, and other residency match programs, in revising Match policy, including the secondary match or scramble process to create more standardized rules for all candidates including application timelines and requirements;
(8) will work with the NRMP and other external bodies to develop mechanisms that limit disparities within the residency application process and allow both flexibility and standard rules for applicants;
(9) encourages the National Resident Matching Program to study and publish the effects of implementation of the Supplemental Offer and Acceptance Program on the number of residency spots not filled through the Main Residency Match and include stratified analysis by specialty and other relevant areas;
(10) will work with the NRMP and ACGME to evaluate the challenges in moving from a time-based education framework toward a competency-based system, including: a) analysis of time-based implications of the ACGME milestones for residency programs; b) the impact on the NRMP and entry into residency programs if medical education programs offer variable time lengths based on acquisition of competencies; c) the impact on financial aid for medical students with variable time lengths of medical education programs; d) the implications for interprofessional education and rewarding teamwork; and e) the implications for residents and students who achieve milestones earlier or later than their peers;
(11) will work with the Association of American Medical Colleges (AAMC), American Osteopathic Association (AOA), American Association of Colleges of Osteopathic Medicine (AACOM), and National Resident Matching Program (NRMP) to evaluate the current available data or propose new studies that would help us learn how many students graduating from US medical schools each year do not enter into a US residency program; how many never enter into a US residency program; whether there is disproportionate impact on individuals of minority racial and ethnic groups; and what careers are pursued by those with an MD or DO degree who do not enter residency programs;
(12) will work with the AAMC, AOA, AACOM and appropriate licensing boards to study whether US medical school graduates and international medical graduates who do not enter residency programs may be able to serve unmet national health care needs;
(13) will work with the AAMC, AOA, AACOM and the NRMP to evaluate the feasibility of a national tracking system for US medical students who do not initially match into a categorical residency program;
(14) will discuss with the National Resident Matching Program, Association of American Medical Colleges, American Osteopathic Association, Liaison Committee on Medical Education, Accreditation Council for Graduate Medical Education, and other interested bodies potential pathways for reengagement in medicine following an unsuccessful match and report back on the results of those discussions;
(15) encourages the Association of American Medical Colleges to work with U.S. medical schools to identify best practices, including career counseling, used by medical schools to facilitate successful matches for medical school seniors, and reduce the number who do not match;
(16) supports the movement toward a unified and standardized residency application and match system for all non-military residencies;
(17) encourages the Educational Commission for Foreign Medical Graduates (ECFMG) and other interested stakeholders to study the personal and financial consequences of ECFMG-certified U.S. IMGs who do not match in the National Resident Matching Program and are therefore unable to get a residency or practice medicine;

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(18) encourages the AAMC, AACOM, NRMP, and other key stakeholders to jointly create a no-fee, easily accessible clearinghouse of reliable and valid advice and tools for residency program applicants seeking cost-effective methods for applying to and successfully matching into residency; and
(19) will work with appropriate stakeholders to study options for improving transparency in the resident application process.

Study of the Current Match Process and Alternatives D-310.944
Our American Medical Association will study alternatives to the current residency and fellowship Match process which would be less restrictive on free market competition for applicants.

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

RESIDENT/FELLOW PHYSICIANS' BILL OF RIGHTS

Residents and fellows have a right to:

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

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

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B. Appropriate supervision by qualified physician faculty with progressive resident responsibility toward independent practice.
With regard to supervision, residents and fellows must be ultimately supervised by physicians who are adequately qualified and allow them to assume progressive responsibility appropriate to their level of education, competence, and experience. In instances where clinical education is provided by non-physicians, there must be an identified physician supervisor providing indirect supervision, along with mechanisms for reporting inappropriate, non-physician supervision to the training program, sponsoring institution or ACGME as appropriate.
C. Regular and timely feedback and evaluation based on valid assessments of resident performance.
With regard to evaluation and assessment processes, residents and fellows should expect: (1) Timely and substantive evaluations during each rotation in which their competence is objectively assessed by faculty who have directly supervised their work; (2) To evaluate the faculty and the program confidentially and in writing at least once annually and expect that the training program will address deficiencies revealed by these evaluations in a timely fashion; (3) Access to their training file and to be made aware of the contents of their file on an annual basis; and (4) Training programs to complete primary verification/credentialing forms and recredentialing forms, apply all required signatures to the forms, and then have the forms permanently secured in their educational files at the completion of training or a period of training and, when requested by any organization involved in credentialing process, ensure the submission of those documents to the requesting organization within thirty days of the request.
D. A safe and supportive workplace with appropriate facilities.
With regard to the workplace, residents and fellows should have access to: (1) A safe workplace that enables them to fulfill their clinical duties and educational obligations; (2) Secure, clean, and comfortable on-call rooms and parking facilities which are secure and well-lit; (3) Opportunities to participate on committees whose actions may affect their education, patient care, workplace, or contract.
E. Adequate compensation and benefits that provide for resident well-being and health.
(1) With regard to contracts, residents and fellows should receive: a. Information about the interviewing residency or fellowship program including a copy of the currently used contract clearly outlining the conditions for (re)appointment, details of remuneration, specific responsibilities including call obligations, and a detailed protocol for handling any grievance; and b. At least four months advance notice of contract non-renewal and the reason for non-renewal.
(2) With regard to compensation, residents and fellows should receive: a. Compensation for time at orientation; and b. Salaries commensurate with their level of training and experience. Compensation should reflect cost of living differences based on local economic factors, such as housing, transportation, and energy costs (which affect the purchasing power of wages), and include appropriate adjustments for changes in the cost of living.
(3) With regard to benefits, residents and fellows must be fully informed of and should receive: a. Quality and affordable comprehensive medical, mental health, dental, and vision care for residents and their families, as well as retirement plan options, professional liability insurance and disability insurance to all residents for disabilities resulting from activities that are part of the educational program; b. An institutional written policy on and education in the signs of excessive fatigue, clinical depression, substance abuse and dependence, and other physician impairment issues; c. Confidential access to mental health and substance abuse services; d. A guaranteed, predetermined amount of paid vacation leave, sick leave, family and medical leave and educational/professional leave during each year in their training program, the total amount of which should not be less than six weeks; e. Leave in compliance with the Family and Medical Leave Act; and f. The conditions under which sleeping quarters, meals and laundry or their equivalent are to be provided.
F. Clinical and educational work hours that protect patient safety and facilitate resident well-being and education.
With regard to clinical and educational work hours, residents and fellows should experience: (1) A reasonable work schedule that is in compliance with clinical and educational work hour requirements set forth by the ACGME; and (2) At-home call that is not so frequent or demanding such that rest periods are significantly diminished or that clinical and educational work hour requirements are effectively circumvented. Refer to AMA Policy H-310.907, "Resident/Fellow Clinical and Educational Work Hours," for more information.
G. Due process in cases of allegations of misconduct or poor performance.
With regard to the complaints and appeals process, residents and fellows should have the opportunity to defend themselves against any allegations presented against them by a patient, health professional, or training program in accordance with the due process guidelines established by the AMA.
H. Access to and protection by institutional and accreditation authorities when reporting violations.

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

9. Our AMA will work with the ACGME and other relevant stakeholders to advocate for ways to defray additional costs related to residency and fellowship training, including essential amenities and/or high cost specialty-specific equipment required to perform clinical duties.
10. Our AMA believes that healthcare trainee salary, benefits, and overall compensation should, at minimum, reflect length of pre-training education, hours worked, and level of independence and complexity of care allowed by an individual's training program (for example when comparing physicians in training and midlevel providers at equal postgraduate training levels).
11.The Residents and Fellows' Bill of Rights will be prominently published online on the AMA website and disseminated to residency and fellowship programs.
12. Our AMA will distribute and promote the Residents and Fellows' Bill of Rights online and individually to residency and fellowship training programs and encourage changes to institutional processes that embody these principles.

Preliminary Year Program Placement H-310.910

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

Closing of Residency Programs H-310.943

1. Our AMA: (a) encourages the Accreditation Council for Graduate Medical Education (ACGME) to address the problem of non-educational closing or downsizing of residency training programs; (b) reminds all institutions involved in educating residents of their contractual responsibilities to the resident; (c) encourages the ACGME and the various Residency Review Committees to reexamine requirements for "years of continuous training" to determine the need for implementing waivers to accommodate residents affected by non-educational closure or downsizing; (d) will work with the American Board of Medical Specialties Member Boards to encourage all its member boards to develop a mechanism to accommodate the discontinuities in training that arise from residency closures, regardless of cause, including waiving continuity care requirements and granting residents credit for partial years of training; (e) urges residency programs and teaching hospitals be monitored by the applicable Residency Review Committees to ensure that decreases in resident numbers do not place undue stress on remaining residents by affecting work hours or working conditions, as specified in Residency Review Committee requirements; (f) opposes the closure of residency/fellowship programs or reductions in the number of current positions in programs as a result of changes in GME funding; and (g) will work with the Centers for Medicare and Medicaid Services

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(CMS), ACGME, and other appropriate organizations to advocate for the development and implementation of effective policies to permit graduate medical education funding to follow the resident physician from a closing to the receiving residency program (including waivers of CMS caps), in the event of temporary or permanent residency program closure.
2. Our AMA will work with the Centers for Medicare and Medicaid Services (CMS) to establish regulations that protect residents and fellows impacted by program or hospital closure, which may include recommendations for:
A. Notice by the training hospital, intending to file for bankruptcy within 30 days, to all residents and fellows primarily associated with the training hospital, as well as those contractually matched at that training institution who may not yet have matriculated, of its intention to close, along with provision of reasonable and appropriate procedures to assist current and matched residents and fellows to find and obtain alternative training positions that minimize undue financial and professional consequences, including but not limited to maintenance of specialty choice, length of training, initial expected time of graduation, location and reallocation of funding, and coverage of tail medical malpractice insurance that would have been offered had the program or hospital not closed;
B. Revision of the current CMS guidelines that may prohibit transfer of funding prior to formal financial closure of a teaching institution;
C. Improved provisions regarding transfer of GME funding for displaced residents and fellows for the duration of their training in the event of program closure at a training institution; and
D. Protections against the discrimination of displaced residents and fellows consistent with H-295.969.
3. Our AMA will work with the Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, National Resident Matching Program, Educational Commission for Foreign Medical Graduates, Centers for Medicare and Medicaid Services, and other relevant stakeholders to identify a process by which displaced residents and fellows may be directly represented in proceedings surrounding the closure of a training hospital or program.
4. Our AMA will work with the Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, National Resident Matching Program, Educational Commission for Foreign Medical Graduates, Centers for Medicare and Medicaid Services, and other relevant stakeholders to:
A. Develop a stepwise algorithm for designated institutional officials and program directors to assist residents and fellows with finding and obtaining alternative training positions;
B. Create a centralized, regulated process for displaced residents and fellows to obtain new training positions; and
C. Develop pathways that ensure that closing and accepting institutions provide liability insurance coverage to residents, at no cost to residents.

Protection of Resident and Fellow Training in the Case of Hospital or Training Program Closure D-310.948
Our AMA will:
1. ask the Centers for Medicare & Medicaid Services (CMS) to stipulate in its regulations that residency slots are not assets that belong to the teaching institution;
2. encourage the Association of American Medical Colleges (AAMC), American Association of Colleges of Osteopathic Medicine (AACOM), and National Resident Matching Program (NRMP) to develop a process similar to the Supplemental Offer and Acceptance Program (SOAP) that could be used in the event of a sudden teaching institution or program closure;
3. encourage the Accreditation Council for Graduate Medical Education (ACGME) to specify in its Institutional Requirements that sponsoring institutions are to provide residents and residency applicants information regarding the financial health of the institution, such as its credit rating, or if it has recently been part of an acquisition or merger;
4. work with AAMC, AACOM, ACGME, and relevant state and specialty societies to coordinate and collaborate on the communication with sponsoring institutions, residency programs, and resident physicians in the event of a sudden institution or program closure to minimize confusion, reduce misinformation, and increase clarity;
5. encourage ACGME to revise its Institutional Requirements, under section IV.E., Professional Liability Insurance, to state that sponsoring institutions must create and maintain a fund that will ensure professional liability coverage for residents in the event of an institution or program closure; and
6. continue to work with ACGME, interested specialty societies, and others to monitor issues, collect data, and share information related to training programs run by nonprofit and for-profit entities and their effect on medical education.

Residency Interview Schedules H-310.998
1. Our AMA encourages residency and fellowship programs to incorporate in their interview dates increased flexibility, whenever possible, to accommodate applicants' schedules. Our AMA encourages the ACGME and other

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

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