**Reference Committee C**

**Report(s) of the Council on Medical Education**

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REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 1-I-24

Subject: Medication Reconciliation Education
(Resolution 805-I-23, Resolved 2)

Presented by: Krystal Tomei, MD, MPH, Chair

Referred to: Reference Committee C

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Resolution 805-I-23, "Medication Reconciliation Education," was introduced by the Michigan delegation at the 2023 Interim Meeting of the American Medical Association (AMA). While Resolve 1 was adopted into AMA Policy D-300.973, Medication Reconciliation Education, thus encouraging external parties to more broadly study medication reconciliation separate from this report, the language of Resolve 2 was referred for study. The referred clause asked that our AMA:

> work with other appropriate organizations to determine whether education for physicians-in-training is sufficient to attain the medication reconciliation core competencies necessary to reduce medical errors and ensure patient safety and quality of care and provide recommendations for action as applicable. (Directive to Take Action)

Testimony within Reference Committee J emphasized the importance of the spirit of the resolution and how vital appropriate medication reconciliation is to patient safety. Additionally, testimony indicated that this is not an issue around the education of physicians, but rather the other challenges that can occur even for well-trained physicians working toward medication reconciliation, such as the burdens of dissimilar electronic health records (EHR). The testimony discussed the involvement of many non-physicians in medication reconciliation as well. Council on Medical Education testimony also noted that the AMA as an organization does not make determinations of the adequacy of training as this lies solely with the accrediting body and as such the original language would be inappropriate. Reference Committee J proposed amending language to offer generalized educational support for all relevant health care providers.

The House of Delegates (HOD) rejected this proposed wording. Testimony at full HOD deliberations centered around differing opinions on the adequacy of existing training for medical learners: some academic physicians felt training was sufficient, while some residency program educators felt training was not effective. Other concerns included differing opinions about the potential impacts of additional EHR and medication reconciliation regulations on physicians and patients and uncertainty regarding who bears the responsibility for medication reconciliation. Due to varying and sometimes contradictory concerns, the HOD felt that the language of the directive warranted further study before a decision was made. This report is in response to this referral.

## BACKGROUND

### *Medication Reconciliation: Definitions, Importance, and Existing Policy*

The Centers for Medicare & Medicaid Services (CMS) define medication reconciliation as follows: "The process of identifying the most accurate list of all medications that the patient is taking, including name, dosage, frequency, and route, by comparing the medical record to an external list

of medications obtained from a patient, hospital, or other provider."[1] Adverse drug events are a leading cause of injury and death for patients,[2] and medication reconciliation is one intervention intended to alleviate some of the risks of this potential harm. Medication reconciliation, when compared to usual care, has the potential to reduce dangerous discrepancies, although it is likely insufficient on its own[3] and creates inconsistent results due to being subject to a variety of barriers in resource-limited settings.[4] A reconciled list may also not necessarily be the correct medication list, and understandings of what constitute medication reconciliation and when it has been achieved vary.[5] Though important, evidence indicates medication reconciliation must be paired with a larger set of interventions to improve safety.[6] However, the correct medication list, when achieved, significantly improves patient outcomes.[5]

Existing AMA policy supports medication reconciliation as a means to improve patient safety (Pharmacy Review of First Dose Medication D-120.965), supports implementation of medication reconciliation as part of the hospital discharge process (Hospital Discharge Communications H-160.902), and offers suggestions within these policies to optimize medication reconciliation. AMA also "supports medication reconciliation processes that include confirmation that prescribed discharge medications will be covered by a patient's health plan and resolution of potential coverage and/or prior authorization (PA) issues prior to hospital discharge" (Continuity of Care for Patients Discharged from Hospital Settings H-125.974) and encourages further study of a broad number of issues related to medication reconciliation (Medication Reconciliation Education D-300.973).

Nationally, other major groups incorporate medication reconciliation guidance into their own policies. CMS, a federal agency, provides, regulates, and/or facilitates health coverage through Medicare, Medicaid, the Children's Health Insurance Program, and the Health Insurance Marketplace. They describe medication reconciliation within their Electronic Health Record Incentive Program documentation on Eligible Professional (EP) Meaningful Use Menu Set Measures,[1] with an objective of "The EP who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation" and the qualifying measure of "The EP performs medication reconciliation for more than 50 percent of transitions of care in which the patient is transitioned into the care of the EP." Medication reconciliation is also part of CMS' Merit-Based Incentive Payment System (MIPS) measures for clinicians, listed as high priority under Quality ID #130, "Documentation of Current Medications in the Medical Record."[7] The Joint Commission, a non-profit organization that accredits more than 20,000 health care programs and organizations in the United States,[8] also provides newsletters and National Patient Safety Goals (NPSG) related to medication reconciliation. NPSG.03.06.01 states: "There is evidence that medication discrepancies can affect patient outcomes. Medication reconciliation is intended to identify and resolve discrepancies—it is a process of comparing the medications a patient is taking (or should be taking) with newly ordered medications. The comparison addresses duplications, omissions, and interactions, and the need to continue current medications. The types of information that clinicians use to reconcile medications include (among others) medication name, dose, frequency, route, and purpose. Organizations should identify the information that needs to be collected in order to reconcile current and newly ordered medications and to safely prescribe medications in the future"[9] and lists several elements of performance in this safety goal, including obtaining, documenting, and defining patient medications, comparing other lists and resolving discrepancies, providing appropriate parties with written medication information, and explaining the importance of medication management to patients/caregivers. The Agency for Healthcare Research and Quality also released a toolkit for medical reconciliation with tools for designing or redesigning the process.[10] Finally, globally, the World Health Organization provides a Standard Operating Protocol for "Assuring Medication Accuracy at Transitions in Care: Medication Reconciliation."[2]

*Responsibility*

Significant disagreement exists about who is responsible for each role within medication reconciliation, and workflow processes vary depending on the setting.[11] Although physicians are ultimately held legally accountable in the United States for medication and medication management[12] and AMA policy advocates that prescriptive authority include the responsibility to monitor the effects of the medication and to attend to problems associated with the use of the medication, including liability (Non-Physician Prescribing H-120.955), medication reconciliation, while physician-led, is a team-based interprofessional process, with an absence of shared understanding about the roles physicians, pharmacists, pharmacy technicians, nurses, and other professionals play to reconcile medication lists in any given setting.[13] In fact, pharmacist-based interventions may have a significant positive impact in preventing hospital readmissions.[14] Physician trainees rotate through many different clinical settings during their medical education making the trainees' roles in multiple medical reconciliation processes as transient care team members challenging in many circumstances. The perspectives of the patient and the patient's family also impact the practice of medication reconciliation.[5]

Responsibility for ensuring medication reconciliation takes place within health care is typically enforced via hospital accreditation bodies, although challenges such as difficulty demonstrating tangible positive outcomes and complexities and costs of the process have led to lack of standardization and scaling back of some requirements.[15]

*The Role of Technology*

Although EHR use can reduce medication errors,[7] EHR systems have interoperability gaps across different clinical settings that create additional conditions for errors.[5] AMA policy currently involves working with EHR vendors and other vendors to improve medication reconciliation within the systems (Reducing Polypharmacy as a Significant Contributor to Senior Morbidity D-120.928). Other existing and emerging technologies also impact medication reconciliation—for instance, The Joint Commission warned of the potential dangers of voice recognition technology to patient safety within medication reconciliation.[16]

*Medical Education Core Competencies and Specialty-Specific Competencies*

The Accreditation Council for Graduate Medical Education (ACGME) endorses six core competencies expected of all residents. These are patient care, medical knowledge, professionalism, interpersonal and communication skills, practice-based learning and improvement, and systems-based practice.[17] Though medical reconciliation is not specifically delineated for all specialties in these broad categories, it applies to the requirements within several categories, including patient care, systems-based practice, and the interpersonal and communication skills requirement of communicating effectively with patients and other professionals as well as the need to "maintain comprehensive, timely, and legible medical records."[18] In addition, several specific specialties discuss medication reconciliation within their ACGME Milestones, including within "Patient Care 3: Assessing and Optimizing of Pharmacotherapy" in the Geriatric Medicine Milestones[19] and within "Patient Care 1: History" in the Internal Medicine Milestones.[20]

At the time of this writing, the ACGME, the Association of American Medical Colleges, and the American Association of Colleges of Osteopathic Medicine are engaged in a multi-year initiative to develop a common set of foundational competencies for use in undergraduate medical education programs.[21]

## DISCUSSION

The Agency for Healthcare Research and Quality offers a toolkit for medication reconciliation training,[22] emphasizing a multidisciplinary approach to education, as a multiplicity of disciplines are involved in the medication use process, including physicians, nurses, pharmacists, medical assistants, and others, and therefore, robust communication and cooperation across the continuum of care is required.[23] This multidisciplinary approach is especially highlighted by research that indicates involvement of pharmacists in medication reconciliation tends to lead to better patient outcomes and should therefore not be exclusively related to physician training.[24]

Current research[25] emphasizes the efficacy of using simulation, roleplay, and interactive, skills-based training in teaching interdisciplinary medication reconciliation skills.[26] One interprofessional education session including both pharmacy students and medical students from neighboring institutions elicited themes of: “1) increased awareness of barriers to medication adherence, (2) increased empathy towards adults with polypharmacy, (3) appreciation for the interprofessional team, and (4) realization of the importance of medication reconciliation and patient understanding of their medications.”[27] One study found that even PowerPoint-based instruction within grand rounds improved perceived, self-reported knowledge of medication reconciliation among medical learners, though actual practices and patient outcomes were not assessed.[28]

One 2021 study of pediatric resident physicians in Canada revealed incomplete documentation for 40% of patient charts, with no reason for the incompleteness documented in 68% of these cases. Improved resident education at the institution level was one of the recommended quality improvement strategies, in addition to improved patient education and increased collaboration with pharmacy services.[29] A twice-monthly interactive educational intervention took place among internal medicine residents at the Washington DC VA Medical Center and significantly reduced medication discrepancies when compared to a control group not receiving the educational intervention, although there was no statistical difference between the amount of medication omissions across the two groups.[30] Most studied and effective interventions regarding medication reconciliation education for health care professionals take place at site-specific levels with the entire care team, such as nursing homes in a specific region.[31] Some sites also recommended urgent suggestions for improvement that were not focused around physician training on medication reconciliation specifically, but on improving communication mechanisms between staff and the need for pharmacy involvement, again emphasizing the interdisciplinary nature of the work.[15]

More broadly, away from local contexts, in addition to AMA policy related to medication reconciliation, the AMA also offers continuing medical education in medication reconciliation on the AMA Ed Hub, offering 36 modules at the time of this writing that incorporate mentions of medication reconciliation improvements.

There is an underlying infrastructure for medical learner training within medication reconciliation in several ACGME-accredited specialties, hospital system quality metrics, and wider medical education competencies. The AMA as an organization does not make determinations of the adequacy of training as this lies solely with the accrediting body, but AMA policy does provide robust support for medication reconciliation, including the possibility of additional training. In addition, as discussed above, physician training is only one component of medication reconciliation education, and medication reconciliation itself, though important, is insufficient for patient safety on its own. Each care setting has a unique context, and interventions are often conducted most effectively in the care setting with the entire interdisciplinary team and with the overall promotion of interprofessional communication, as well as improvement of EHR systems. Interventions must also focus on improvements to actual patient outcomes and receiving the correct medications,

rather than simply to the completion of medication reconciliation, which may or may not be correct or helpful to the patient, even if accurately reconciled across multiple sources: “Primary care clinicians and hospitalists currently must attest that medication reconciliation has been completed, but this does not measure accuracy. Currently, no validated measures are available to assess the quality of medication reconciliation. More meaningful measures are needed, and studies can be built upon these measures to assess the value of medication reconciliation across a gradient of how comprehensively it was performed.”[5] AMA policy D-300.973 already advocates toward this goal.

## RELEVANT AMA POLICY

The AMA has extensive policy related to medication reconciliation and physicians-in-training. Some examples are as follows:

- D-300.973, “Medication Reconciliation Education,” encourages the study of current medication reconciliation practices across transitions of care to evaluate the impact on patient safety and quality of care, including when there are dissimilar electronic health records, and to develop strategies, including the potential need for additional training, to reduce medical errors and ensure patient safety and quality of care.
- D-120.965, “Pharmacy Review of First Dose Medication,” supports medication reconciliation as a means to improve patient safety and indicates that (a) systems be established to support physicians in medication reconciliation, and (b) medication reconciliation requirements should be at a level appropriate for a particular episode of care and setting.
- H-160.902, “Hospital Discharge Communications,” supports implementation of medication reconciliation as part of the hospital discharge process.
- D-120.928, “Reducing Polypharmacy as a Significant Contributor to Senior Morbidity,” works with other stakeholders and EHR vendors to address the continuing problem of inaccuracies in medication reconciliation and propagation of such inaccuracies in electronic health records.
- H-125.974, “Continuity of Care for Patients Discharged from Hospital Settings,” supports medication reconciliation processes that include confirmation that prescribed discharge medications will be covered by a patient’s health plan and resolution of potential coverage and/or prior authorization issues prior to hospital discharge.
- H-120.968, “Medication (Drug) Errors in Hospitals,” encourages individual physicians to minimize medication errors by adhering to the following guidelines when prescribing medications: (a) Physicians should stay abreast of the current state of knowledge regarding optimal prescribing through literature review, use of consultations with other physicians and pharmacists, participation in continuing medical education programs, and other means.
- H-120.955, “Non-Physician Prescribing,” advocates that prescriptive authority include the responsibility to monitor the effects of the medication and to attend to problems associated with the use of the medication. This responsibility includes the liability for such actions.
- H-310.929, “Principles for Graduate Medical Education,” states there must be objectives for residency education in each specialty that promote the development of the knowledge, skills, attitudes, and behavior necessary to become a competent practitioner in a recognized medical specialty. Institutions sponsoring residency programs and the director of each program must assure the highest quality of care

for patients and the attainment of the program's educational objectives for the residents.

- D-295.934, "Encouragement of Interprofessional Education Among Health Care Professions Students," recognizes that interprofessional education and partnerships are a priority of the American medical education system and encourages the development of skills for interprofessional education that are applicable to and appropriate for each group of learners.

These policies are listed in full detail in Appendix A.

## SUMMARY AND RECOMMENDATIONS

While support and ongoing improvement can and should be ongoing in the education of physicians-in-training, aligned with the overall goal to reduce errors and improve patient safety, issues associated with medication reconciliation far exceed the domain of education for physicians-in-training, and even appropriate medication reconciliation practices alone[3] do not necessarily improve certain patient outcomes,[6] requiring attention to the full spectrum of medication-related practices. Accrediting bodies for both physician trainees and for hospitals and health systems currently provide guidance and frameworks around medication reconciliation as appropriate for each clinical setting and specialty. The AMA already works to remedy EHR-related medication reconciliation issues via D-120.928 and encourages additional study of medication reconciliation issues via D-300.973, which includes encouraging research on additional training opportunities. Current evidence suggests this training is best done in an interdisciplinary context, which D-295.934 also provides support and guidance for.

The Council on Medical Education therefore recommends that the following recommendations be adopted in lieu of Resolution 805-I-23, Resolve 2, and the remainder of this report be filed:

That our AMA:

1. Amend AMA Policy D-120.965 "Pharmacy Review of First Dose Medication" by addition of a new third clause to read as follows:
   3. Our AMA a) recognizes that medication reconciliation is a multidisciplinary process and b) supports education of physicians-in-training about the physician's role and responsibilities in medication reconciliation and management within a physician-led team in relevant clinical settings, to minimize medical errors and promote patient safety and quality of care.
2. Amend AMA Policy D-120.965 with a change in title to read as follows:
   Medication Reconciliation to Improve Patient Safety
3. Reaffirm AMA Policy H-160.902 "Hospital Discharge Communications"

Fiscal note: $1,000

## APPENDIX A: RELEVANT AMA POLICY

Medication Reconciliation Education D-300.973
Our American Medical Association encourages the study of current medication reconciliation practices across transitions of care to evaluate the impact on patient safety and quality of care, including when there are dissimilar electronic health records, and to develop strategies, including the potential need for additional training, to reduce medical errors and ensure patient safety and quality of care.

Pharmacy Review of First Dose Medication D-120.965
1. Our AMA supports medication reconciliation as a means to improve patient safety.
2. It is AMA policy that (a) systems be established to support physicians in medication reconciliation, and (b) medication reconciliation requirements should be at a level appropriate for a particular episode of care and setting.

Hospital Discharge Communications H-160.902
1. Our AMA encourages the initiation of the discharge planning process, whenever possible, at the time patients are admitted for inpatient or observation services and, for surgical patients, prior to hospitalization.
2. Our AMA encourages the development of discharge summaries that are presented to physicians in a meaningful format that prominently highlight salient patient information, such as the discharging physician's narrative and recommendations for ongoing care.
3. Our AMA encourages hospital engagement of patients and their families/caregivers in the discharge process, using the following guidelines:
a. Information from patients and families/caregivers is solicited during discharge planning, so that discharge plans are tailored to each patient's needs, goals of care and treatment preferences.
b. Patient language proficiency, literacy levels, cognitive abilities and communication impairments (e.g., hearing loss) are assessed during discharge planning. Particular attention is paid to the abilities and limitations of patients and their families/caregivers.
c. Specific discharge instructions are provided to patients and families or others responsible for providing continuing care both verbally and in writing. Instructions are provided to patients in layman's terms, and whenever possible, using the patient's preferred language.
d. Key discharge instructions are highlighted for patients to maximize compliance with the most critical orders.
e. Understanding of discharge instructions and post-discharge care, including warning signs and symptoms to look for and when to seek follow-up care, is confirmed with patients and their families/caregiver(s) prior to discharge from the hospital.
4. Our AMA supports making hospital discharge instructions available to patients in both printed and electronic form, and specifically via online portals accessible to patients and their designated caregivers.
5. Our AMA supports implementation of medication reconciliation as part of the hospital discharge process. The following strategies are suggested to optimize medication reconciliation and help ensure that patients take medications correctly after they are discharged:
a. All discharge medications, including prescribed and over-the-counter medications, should be reconciled with medications taken pre-hospitalization.
b. An accurate list of medications, including those to be discontinued as well as medications to be taken after hospital discharge, and the dosage and duration of each drug, should be communicated to patients.
c. Medication instructions should be communicated to patients and their families/caregivers verbally and in writing.

d. For patients with complex medication schedules, the involvement of physician-led multidisciplinary teams in medication reconciliation including, where feasible, pharmacists should be encouraged.
6. Our AMA encourages patient follow-up in the early time period after discharge as part of the hospital discharge process, particularly for medically complex patients who are at high-risk of re-hospitalization.
7. Our AMA encourages hospitals to review early readmissions and modify their discharge processes accordingly.

Reducing Polypharmacy as a Significant Contributor to Senior Morbidity D-120.928
1. Our AMA will work with other organizations e.g., AARP, other medical specialty societies, PhRMA, and pharmacists to educate patients about the significant effects of all medications and most supplements, and to encourage physicians to teach patients to bring all medications and supplements or accurate, updated lists including current dosage to each encounter.
2. Our AMA along with other appropriate organizations encourages physicians and ancillary staff if available to initiate discussions with patients on improving their medical care through the use of only the minimal number of medications (including prescribed or over-the-counter, including vitamins and supplements) needed to optimize their health.
3. Our AMA will work with other stakeholders and EHR vendors to address the continuing problem of inaccuracies in medication reconciliation and propagation of such inaccuracies in electronic health records.
4. Our AMA will work with other stakeholders and EHR vendors to include non-prescription medicines and supplements in medication lists and compatibility screens.

Continuity of Care for Patients Discharged from Hospital Settings H-125.974
Our AMA:
(1) will advocate for protections of continuity of care for medical services and medications that are prescribed during patient hospitalizations, including when there are formulary or treatment coverage changes that have the potential to disrupt therapy following discharge;
(2) supports medication reconciliation processes that include confirmation that prescribed discharge medications will be covered by a patient's health plan and resolution of potential coverage and/or prior authorization (PA) issues prior to hospital discharge;
(3) supports strategies that address coverage barriers and facilitate patient access to prescribed discharge medications, such as hospital bedside medication delivery services and the provision of transitional supplies of discharge medications to patients;
(4) will advocate to the Office of the National Coordinator for Health Information Technology (ONC) and the Centers for Medicare & Medicaid Services (CMS) to work with physician and hospital organizations, and health information technology developers, in identifying real-time pharmacy benefit implementations and published standards that provide real-time or near-time formulary information across all prescription drug plans, patient portals and other viewing applications, and electronic health record (EHR) vendors;
(5) will advocate to the ONC to include proven and established real-time pharmacy benefit criteria within its certification program;
(6) will advocate to the ONC and the CMS that any policies requiring health information technology developers to integrate real-time pharmacy benefit systems (RTPB) within their products do so without disruption to EHR usability and minimal to no cost to physicians and hospitals, providing financial support if necessary; and
(7) supports alignment and real-time accuracy between the prescription drug data offered in physician-facing and consumer-facing RTPB tools.

Medication (Drug) Errors in Hospitals H-120.968

(1) Our AMA encourages individual physicians to minimize medication errors by adhering to the following guidelines when prescribing medications:

(a) Physicians should stay abreast of the current state of knowledge regarding optimal prescribing through literature review, use of consultations with other physicians and pharmacists, participation in continuing medical education programs, and other means.

(b) Physicians should evaluate the patient's total status and review all existing drug therapy before prescribing new or additional medications (e.g., to ascertain possible antagonistic drug interactions).

(c) Physicians should evaluate and optimize patient response to drug therapy by appropriately monitoring clinical signs and symptoms and relevant laboratory data; follow-up and periodically reevaluate the need for continued drug therapy.

(d) Physicians should be familiar with the hospital's medication-ordering system, including the formulary system; the drug use review (DUR) program; allowable delegation of authority; procedures to alert nurses and others to new drug orders that need to be processed; standard medication administration times; and approved abbreviations.

(e) Written drug or prescription orders (including signatures) should be legible. Physicians with poor handwriting should print or type medication orders if direct order entry capabilities for computerized systems are unavailable.

(f) Medication orders should be complete and should include patient name; drug name (generic drug name or trademarked name if a specific product is required); route and site of administration; dosage form (if applicable); dose; strength; quantity; frequency of administration; and prescriber's name. In some cases, a dilution, rate, and time of administration should be specified. Physicians should review all drug orders for accuracy and legibility immediately after they have prescribed them.

(g) Medication orders should be clear and unambiguous. Physicians should: (i) write out instructions rather than use nonstandard or ambiguous abbreviations (e.g., write "daily" rather than "qd" which could be misinterpreted as "qid" or "od"); (ii) not use vague instructions, such as "take as directed"; (iii) specify exact dosage strengths (such as milligrams) rather than dosage form units (such as one vial) (an exception would be combination products, for which the number of dosage form units should be specified); (iv) prescribe by standard nomenclature, using the United States Adopted Names (USAN)-approved generic drug name, official name, or trademarked name (if a specific product is required) and avoid locally coined names, chemical names, unestablished abbreviated drug names (e.g., AZT), acronyms, and apothecary or chemical symbols; (v) always use a leading "0" to precede a decimal expression of less than one (e.g., 0.5 ml), but never use a terminal "0" (e.g., 5.0 ml); (vi) avoid the use of decimals when possible (e.g., prescribe 500 mg instead of 0.5 g); (vii) spell out the word "units" rather than writing "u"; (viii) and use the metric system. Instructions with respect to "hold" orders for medications should be clear.

(h) Verbal medication orders should be reserved only for those situations in which it is impossible or impractical for the prescriber to write the order or enter it in a computer. Verbal orders should be dictated slowly, clearly, and articulately to avoid confusion. The order should be read back to the prescriber by the recipient (e.g., nurse, pharmacist); when read back, the recipient should spell the drug name and avoid abbreviations when repeating the directions. A written copy of the verbal order should be placed in the patient's medical record and later confirmed by the prescriber in accordance with applicable state regulations and hospital policies.

(2) Our AMA encourages the hospital medical staff to take a leadership role in their hospital, and in collaboration with pharmacy, nursing, administration, and others, to develop and improve organizational systems for monitoring, reviewing, and reporting medication errors and, after identification, to eliminate their cause and prevent their recurrence.

Non-Physician Prescribing H-120.955

1. Our AMA advocates that prescriptive authority include the responsibility to monitor the effects of the medication and to attend to problems associated with the use of the medication. This responsibility includes the liability for such actions.
2. Our AMA supports the development of methodologically valid research on the relative impact of non-physician prescribing on the quality of health care.

Principles for Graduate Medical Education H-310.929

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

PURPOSE OF GRADUATE MEDICAL EDUCATION AND ITS RELATIONSHIP TO PATIENT CARE. There must be objectives for residency education in each specialty that promote the development of the knowledge, skills, attitudes, and behavior necessary to become a competent practitioner in a recognized medical specialty. Exemplary patient care is a vital component for any residency/fellowship program. Graduate medical education enhances the quality of patient care in the institution sponsoring an accredited program. Graduate medical education must never compromise the quality of patient care. Institutions sponsoring residency programs and the director of each program must assure the highest quality of care for patients and the attainment of the program's educational objectives for the residents.

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

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

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

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

INSTITUTIONAL RESPONSIBILITY FOR PROGRAMS. Specialty-specific GME must operate under a system of institutional governance responsible for the development and implementation of policies regarding the following; the initial authorization of programs, the appointment of program directors, compliance with the accreditation requirements of the ACGME, the advancement of resident physicians, the disciplining of resident physicians when this is appropriate, the maintenance of permanent records, and the credentialing of resident physicians who successfully complete the program. If an institution closes or has to reduce the size of a residency program, the institution must inform the residents as soon as possible. Institutions must make every effort to allow residents already in the program to complete their education in the affected program. When this is not possible, institutions must assist residents to enroll in another program in which they can

continue their education. Programs must also make arrangements, when necessary, for the disposition of program files so that future confirmation of the completion of residency education is possible. Institutions should allow residents to form housestaff organizations, or similar organizations, to address patient care and resident work environment concerns. Institutional committees should include resident members.
COMPENSATION OF RESIDENT PHYSICIANS. All residents should be compensated. Residents should receive fringe benefits, including, but not limited to, health, disability, and professional liability insurance and parental leave and should have access to other benefits offered by the institution. Residents must be informed of employment policies and fringe benefits, and their access to them. Restrictive covenants must not be required of residents or applicants for residency education.
LENGTH OF TRAINING. The usual duration of an accredited residency in a specialty should be defined in the "Program Requirements." The required minimum duration should be the same for all programs in a specialty and should be sufficient to meet the stated objectives of residency education for the specialty and to cover the course content specified in the Program Requirements. The time required for an individual resident physician's education might be modified depending on the aptitude of the resident physician and the availability of required clinical experiences.
PROVISION OF FORMAL EDUCATIONAL EXPERIENCES. Graduate medical education must include a formal educational component in addition to supervised clinical experience. This component should assist resident physicians in acquiring the knowledge and skill base required for practice in the specialty. The assignment of clinical responsibility to resident physicians must permit time for study of the basic sciences and clinical pathophysiology related to the specialty.
INNOVATION OF GRADUATE MEDICAL EDUCATION. The requirements for accreditation of residency training should encourage educational innovation and continual improvement. New topic areas such as continuous quality improvement (CQI), outcome management, informatics and information systems, and population-based medicine should be included as appropriate to the specialty.
THE ENVIRONMENT OF GRADUATE MEDICAL EDUCATION. Sponsoring organizations and other GME programs must create an environment that is conducive to learning. There must be an appropriate balance between education and service. Resident physicians must be treated as colleagues.
SUPERVISION OF RESIDENT PHYSICIANS. Program directors must supervise and evaluate the clinical performance of resident physicians. The policies of the sponsoring institution, as enforced by the program director, and specified in the ACGME Institutional Requirements and related accreditation documents, must ensure that the clinical activities of each resident physician are supervised to a degree that reflects the ability of the resident physician and the level of responsibility for the care of patients that may be safely delegated to the resident. The sponsoring institution's GME Committee must monitor programs' supervision of residents and ensure that supervision is consistent with:
(A) Provision of safe and effective patient care;
(B) Educational needs of residents;
(C) Progressive responsibility appropriate to residents' level of education, competence, and experience; and
(D) Other applicable Common and specialty/subspecialty specific Program Requirements. The program director, in cooperation with the institution, is responsible for maintaining work schedules for each resident based on the intensity and variability of assignments in conformity with ACGME Review Committee recommendations, and in compliance with the ACGME clinical and educational work hour standards. Integral to resident supervision is the necessity for frequent evaluation of residents by faculty, with discussion between faculty and resident. It is a cardinal principle that responsibility for the treatment of each patient and the education of resident and fellow physicians lies with the physician/faculty to whom the patient is assigned and who

supervises all care rendered to the patient by residents and fellows. Each patient's attending physician must decide, within guidelines established by the program director, the extent to which responsibility may be delegated to the resident, and the appropriate degree of supervision of the resident's participation in the care of the patient. The attending physician, or designate, must be available to the resident for consultation at all times.

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

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

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

<u>Encouragement of Interprofessional Education Among Health Care Professions Students D-295.934</u>

1. Our American Medical Association recognizes that interprofessional education and partnerships are a priority of the American medical education system.
2. Our AMA supports the concept that medical education should prepare students for practice in, and leadership of, physician-led interprofessional health care teams.
3. Our AMA will encourage health care organizations that engage in a collaborative care model to provide access to an appropriate mix of role models and learners.
4. Our AMA will encourage the development of skills for interprofessional education that are applicable to and appropriate for each group of learners.
5. Our AMA supports the concept that interprofessional education include a mechanism by which members of interdisciplinary teams learn about, with, and from each other; and that this education include learning about differences in the depth and breadth of their educational backgrounds, experiences, and knowledge and the impact these differences may have on patient care.
6. Our AMA supports a clear mechanism for medical school and appropriate institutional leaders to intervene when undergraduate and graduate medical education is being adversely impacted by undergraduate, graduate, and postgraduate clinical training programs of non-physicians.

1 REFERENCES

[1] Eligible Professional Meaningful Use Menu Set Measures Measure 6 of 9. Centers for Medicare & Medicaid Services. May 2014. Accessed July 5, 2024. https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/downloads/7_Medication_Reconciliation.pdf.

[2] The High 5s Project Standard Operating Protocol Assuring Medication Accuracy at Transitions in Care: Medication Reconciliation. World Health Organization. September 2014. Accessed June 1, 2024. https://cdn.who.int/media/docs/default-source/integrated-health-services-(ihs)/psf/high5s/h5s-sop.pdf.

[3] Ciapponi A, Fernandez Nievas SE, Seijo M, et al. Reducing medication errors for adults in hospital settings. *Cochrane Libr*. 2021;2021(11). doi:10.1002/14651858.cd009985.pub2

[4] Presley CA, Wooldridge KT, Byerly SH, et al. The rural VA multi-center medication reconciliation quality improvement study (R-VA-MARQUIS). *Am J Health Syst Pharm*. 2020;77(2):128-137. doi:10.1093/ajhp/zxz275

[5] Rose AJ, Fischer SH, Paasche-Orlow MK. Beyond medication reconciliation: The correct medication list. *JAMA*. 2017;317(20):2057. doi:10.1001/jama.2017.4628

[6] Schnipper JL. Medication reconciliation—too much or not enough? *JAMA Netw Open*. 2021;4(9):e2125272. doi:10.1001/jamanetworkopen.2021.25272

[7] Quality ID #130: Documentation of Current Medications in the Medical Record. Centers for Medicare & Medicaid Services. December 2023. Accessed July 5, 2024. https://qpp.cms.gov/docs/QPP_quality_measure_specifications/CQM-Measures/2024_Measure_130_MIPSCQM.pdf.

[8] Wadhwa R, Boehning AP. *The Joint Commission*. StatPearls Publishing; 2023.

[9] National Patient Safety Goals® Effective January 2023 for the Hospital Program. The Joint Commission. October 2022. Accessed July 5, 2024. https://www.jointcommission.org/-/media/tjc/documents/standards/national-patient-safety-goals/2023/npsg_chapter_hap_jan2023.pdf.

[10] Medications at Transitions and Clinical Handoffs (MATCH) Toolkit for Medication Reconciliation. Chapter 3. Developing Change: Designing the Medication Reconciliation Process. Agency for Healthcare Research and Quality. July 2022. Accessed July 5, 2024. https://www.ahrq.gov/patient-safety/settings/hospital/match/chapter-3.html.

[11] Lee KP, Hartridge C, Corbett K, Vittinghoff E, Auerbach AD. "Whose job is it, really?" physicians', nurses', and pharmacists' perspectives on completing inpatient medication reconciliation: Medication Reconciliation Perspectives. *J Hosp Med*. 2015;10(3):184-186. doi:10.1002/jhm.2289

[12] The physician's role in medication reconciliation: Issues, strategies, and safety principles. American Medical Association. 2007. Accessed July 5, 2024. https://brucelambert.soc.northwestern.edu/book_reviews/med-rec-monograph.pdf.

[13] Rangachari P, Dellsperger KC, Fallaw D, et al. A Mixed-Method Study of Practitioners' Perspectives on Issues Related to EHR Medication Reconciliation at a Health System. Quality Management in Health. April/June 2019;28(2):84-95. doi:10.1097/QMH.0000000000000208

[14] Harris M, Moore V, Barnes M, Persha H, Reed J, Zillich A. Effect of pharmacy-led interventions during care transitions on patient hospital readmission: A systematic review. *J Am Pharm Assoc*. 2022;62(5):1477-1498.e8. doi:10.1016/j.japh.2022.05.017

[15] Holbrook A, Bowen JM, Patel H, et al. Process mapping evaluation of medication reconciliation in academic teaching hospitals: a critical step in quality improvement. *BMJ Open*. 2016;6(12):e013663. doi:10.1136/bmjopen-2016-013663

[16] Quick Safety Issue 12: Speech recognition technology translates to patient risk. The Joint Commission. May 2022. Accessed July 5, 2024. https://www.jointcommission.org/resources/news-and-multimedia/newsletters/newsletters/quick-safety/quick-safety--issue-12-transcription-translates-to-patient-risk/.

[17] Edgar L, McLean S, Hogan SO, Hamstra S, Holmboe ES. *The Milestones Guidebook*. Accreditation Council for Graduate Medical Education; 2020. https://www.acgme.org/globalassets/milestonesguidebook.pdf

[18] IVA5d. Accreditation Council for Graduate Medical Education Competencies. May 2008. Accessed July 5, 2024. https://www.acgme.org/globalassets/PDFs/commonguide/IVA5d_EducationalProgram_ACGMECompetencies_IPCS_Explanation.pdf.

[19] Geriatric Medicine Milestones. Accreditation Council for Graduate Medical Education. July 1, 2021. Accessed July 5, 2024. https://www.acgme.org/globalassets/pdfs/milestones/geriatricmedicinemilestones.pdf.

[20] Internal Medicine Milestones. Accreditation Councl for Graduate Medical Education. July 1, 2021. Accessed July 5, 2024. https://www.acgme.org/globalassets/pdfs/milestones/internalmedicinemilestones.pdf.

[21] Request for Input on First Draft of the Foundational Competencies for Undergraduate Medical Education. Accreditation Council for Graduate Medical Education. January 23, 2024. Accessed July 5, 2024. https://www.acgme.org/newsroom/2024/1/request-for-input-on-first-draft-of-the-foundational-competencies-for-undergraduate-medical-education/.

[22] Medications at Transitions and Clinical Handoffs (MATCH) Toolkit for Medication Reconciliation. Chapter 5. Education and Training. Agency for Healthcare Research and Quality. July 2022. Accessed July 5, 2024. https://www.ahrq.gov/patient-safety/settings/hospital/match/chapter-5.html.

[23] Poon EG. Medication Reconciliation: Whose Job Is It? Agency for Healthcare Research and Quality. September 1, 2007. Accessed July 5, 2024. https://psnet.ahrq.gov/web-mm/medication-reconciliation-whose-job-it.

[24] Splawski J, Minger H. Value of the pharmacist in the medication reconciliation process. *P T*. 2016;41(3):176-178.

[25] Hawley CE, Triantafylidis LK, Phillips SC, Schwartz AW. Brown bag simulation to improve medication management in older adults. *MedEdPORTAL*. 2019;15. doi:10.15766/mep_2374-8265.10857

[26] Stansell P, Paris D, Clark R, Morgan V. Using simulation to teach medication reconciliation and translate didactic to clinical. *Nurse Educ*. 2022;47(1):61-61. doi:10.1097/nne.0000000000001053

[27] Sehgal M, Nassetta KR, Bamdas JAM, Sourial M. First do no 'pharm': Educating medical and pharmacy students on the essentials of medication management. *Curr Pharm Teach Learn*. 2019;11(9):920-927. doi:10.1016/j.cptl.2019.05.006

[28] Lester PE, Sahansra S, Shen M, Becker M, Islam S. Medication reconciliation: An educational module. *MedEdPORTAL*. 2019;15. doi:10.15766/mep_2374-8265.10852

[29] Martin A, McDonald J, Holland J. Completeness of medication reconciliation performed by pediatric resident physicians at hospital admission for asthma. *Can J Hosp Pharm*. 2021;74(1):30-35. Accessed July 5, 2024. https://pubmed.ncbi.nlm.nih.gov/33487652/

[30] Arundel C, Logan J, Ayana R, Gannuscio J, Kerns J, Swenson R. Safe medication reconciliation: An intervention to improve residents' medication reconciliation skills. *J Grad Med Educ*. 2015;7(3):407-411. doi:10.4300/jgme-d-14-00565.1

[31] Mahlknecht A, Krisch L, Nestler N, et al. Impact of training and structured medication review on medication appropriateness and patient-related outcomes in nursing homes: results from the interventional study InTherAKT. *BMC Geriatr*. 2019;19(1). doi:10.1186/s12877-019-1263-3

# REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 2-I-24

Subject: Updates to Recommendations for Future Directions for Medical Education

Presented by: Krystal Tomei, MD, MPH, Chair

Referred to: Reference Committee C

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"Updates to Recommendations for Future Directions for Medical Education" is a self-initiated report by the Council on Medical Education.

## BACKGROUND

*Report Origins and Process*

In July 1980, the AMA House of Delegates (HOD) authorized the establishment of six task forces to review then-current and predicted future issues within medical education. At the 1982 Annual Meeting, the Council on Medical Education released recommendations on "Future Directions for Medical Education," with the following stated purpose: "This report expresses the continual interest of the Council on Medical Education, consistent with its function within the AMA, 'to elevate medical education'."[1] These recommendations are AMA Policy H-295.995, Recommendations for Future Directions for Medical Education, and were last amended by the Council in 2017 with CME Report 1-I-17, Promoting and Reaffirming Domestic Medical School Clerkship Education (Resolution 308-I-16). Most of the current 37 recommendations retain the original language from 1982, despite more than 40 years of changes to medical education.

For this reason, the Council on Medical Education voted in favor of proposing a series of self-initiated reports to reassess and modernize the policy's recommendations, including, when relevant, consolidating some of AMA's other policies on medical education topics. The goal of this self-initiated process is to establish an updated framework for understanding the future of medical education, as well as potentially incorporating innovations and newer understandings from the last several decades of collaboration with medical education stakeholders. This first report seeks to describe a brief history of the important changes in medical education since 1982 and proposes sunsetting out-of-date recommendations within AMA Policy H-295.995. This report also describes a proposed framework for reassessing AMA Policy H-295.995, with the subcategories of 1) mission of medical education, 2) professional regulation, 3) entry into and transition through the medical education continuum, 4) medical education curricula, 5) physician as medical professional, 6) medical education systems, and 7) obligation to students and trainees. This initial report then proposes that the Council conduct future studies in following years based around each of the new framework's categories to overhaul and modernize these aspects of AMA medical education policy. Beyond deleting irrelevant and out-of-date recommendations in AMA Policy H-295.995, this initial report will continue current AMA policies on medical education without revision or reorganization—and will offer these new categories with examples of where the existing recommendations may fit in the body of future reports, with the intention of future restructuring. In future studies, if approved, policy consolidation and/or new policy recommendations will then take place under each of the adopted subcategories.

*40 Years of Changes in Medical Education*

A detailed historical account of all major changes in medical education across more than 40 years is outside the scope of this report; however, major examples of changes include but are not limited to the following.

Mission of medical education

Medical education's mission is to train a competent physician workforce that meets the needs of patients and populations. Though efforts by groups and individuals have been made throughout history to improve conditions for the most marginalized, a heightened awareness of equity concerns within medical education has emerged over the past few decades. In the context of the AMA, since the original 1982 Council report on the future of medical education, the Minority Affairs Consortium was created in 1992, the Commission to End Health Care Disparities began in 2004, and in 2008, the AMA officially apologized for its history of harms against Black physicians and patients.[2] The AMA's Center for Health Equity was launched in 2019, with the AMA's strategic plan to embed racial justice and advance health equity released in 2021.[3] Council on Medical Education Report 05-J-21, "Promising Practices Among Pathway Programs to Increase Diversity in Medicine"[4] discussed the harms of the 1910 Flexner Report and called for an external study focused on reimagining the future of health equity and racial justice in medical education, which was published in 2024.[5] In the greater U.S., milestones such as the 1990 Americans with Disabilities Act (ADA), the 2008 ADA Amendments Act, and the 2015 legalization of same-sex marriage via the *Obergefell v. Hodges* Supreme Court decision have also drawn attention to disability and lesbian, gay, bisexual, transgender, queer, and more (LGBTQ+) rights within medical education.[6]

In recent years, there is an unprecedented demand for health care, with increasing physician workforce shortages nationally as well as in certain underserved areas.[7] There are also current and pending shortages in specific specialties, such as urology.[8] Many of these shortages may be attributed to maldistribution, rather than purely insufficient numbers of physicians nationwide, with certain areas remaining underserved, particularly rural areas, with medical education playing a major role in influencing physicians to meet these needs.[9] The transition toward competency-based medical education (CBME) is one of the most pivotal shifts in medical education in recent years[10] and one of AMA's ChangeMedEd 2023 areas of strategic focus, alongside equity, diversity, and belonging; precision education; and transitions across the continuum.[11]

Professional regulation

Medical education maintains commitment to the concept that the regulation of the medical profession should be guided by physicians. A 2015 memorandum of understanding between the Accreditation Council for Graduate Medical Education (ACGME), American Osteopathic Association, and American Association of Colleges of Osteopathic Medicine began a five-year transition to single U.S. graduate medical education (GME) accreditation, which finalized in 2020,[12] though some express concerns.[13] AMA policy currently supports work toward a single licensure exam (Single Licensing Exam Series for Osteopathic and Allopathic Medical Students D-275.947), and inequities between Doctors of Osteopathic Medicine (DOs) and Doctors of Medicine (MDs) continue to be addressed.[14]

Significant overall shifts in how standardized assessments are designed and discussed have also taken place since the 1980s. This includes the notion of competence as actual competencies linked to patient outcomes rather than personality traits, an understanding that did not develop until the

late 1990s and early 2000s, with awareness of assessor bias and the limitations of assessments emerging in scholarly literature even later.[15] In 2021, the United States Medical Licensing Examination (USMLE) Step 2 Clinical Skills (CS) was permanently discontinued after a COVID-19 related 2020 suspension.[16] In 2022, the USMLE Step 1 exam converted from numeric to pass-fail.[17]

Entry into and transition through the medical education continuum

Application and selection processes have also changed over time. In 1995, the Association of American Medical Colleges (AAMC) developed the Electronic Residency Application Service (ERAS), replacing cumbersome paper mail residency applications with newer technology—first floppy disks, followed by web-based services.[18] In more recent years, specialties have considered and tested alternatives to ERAS, such as the obstetrics and gynecology (OB/GYN) specialty's shift to the Residency Centralized Application Service in 2024.[19] This new platform will still work in conjunction with the National Resident Matching Program (NRMP) for the Match. Although the NRMP was established in 1952,[20] significant changes have also taken place over the years to modernize infrastructure and shift strategic priorities in response to modern needs.[21] The NRMP formalized its Specialty Matching Service and conducted its first fellowship Match in 1984.[22] A single Match for DOs and MDs began in 2020.[6]

The COVID-19 pandemic, declared officially in 2020, sparked both a major crisis within medical education and devastation for many within society at large, prompting opportunities for transformations of existing systems[23] in both education and patient care.[24] AAMC now recommends virtual interviewing for all residency and fellowship programs.[25] On the heels of COVID-19 related upheaval, the Coalition for Physician Accountability commissioned an independent body to review the UME-to-GME transition and provide recommendations. The Undergraduate Medical Education to Graduate Medical Education Review Committee (UGRC) released a report with 34 recommendations in August 2021.[26]

For international medical graduates, the Educational Commission for Foreign Medical Graduates (ECFMG) established the Foundation for Advancement of International Medical Education and Research (FAIMER) in 2000,[27] launched electronic verification of medical credentials in 2012,[28] developed certification Pathways in 2020 following the suspension of USMLE Step 2,[29] and in 2023, ECFMG and FAIMER became divisions of a private nonprofit organization, Intealth.[29] In 2024, the Federation of State Medical Boards (FSMB), Intealth, and the ACGME established an Advisory Commission on Alternate Licensing Models to "provide guidance on alternative pathways for state licensure of physicians who have completed training and/or practiced outside of the United States," with work in progress at the time of this writing.[30]

Medical education curricula

A vast number of technological changes have occurred since 1982, including but not limited to the advent of widely available internet access in the 1990s[31] in addition to more specific technological shifts in medical education over time.[32] Virtual education is now prominent.[33] More recently, the increasing attention to generative artificial intelligence or augmented intelligence (AI) prompted the AMA to release "Principles for Augmented Intelligence Development, Deployment, and Use" in November 2023.[34] AI technology and its opportunities and challenges are increasingly woven into the field of medical education.[35]

From 2013-2022, the AMA's Accelerating Change in Medical Education Consortium[36] made $30 million in grants to 32 medical schools to jumpstart curricular and process changes and disseminate

ideas,[37] and in 2019, AMA launched the Reimagining Residency initiative to support innovations to transform residency training.[38] The consortium became ChangeMedEd in 2023, and lessons from ChangeMedEd are informing ideas on future directions in medical education as intended. Curricular innovations include health systems science,[39] the Master Adaptive Learner model,[40] and a renewed emphasis on equity and social determinants of health.[41]

Physician as medical professional

Due in part to the rapid growth of managed care in health insurance in the late 1980s and early 1990s, a much larger proportion of physicians began seeking board certification.[42] Rapid changes in medicine and the exponential growth of medical knowledge also caused shifts in patient and payer concerns about physician knowledge.[43] In 1990, internal medicine board certification became time-limited rather than one-time, and in 2002, all member boards of the American Board of Medical Specialties agreed on recertification requirements and evaluation of performance in practice.[42] These changes led to continuous assessment programs called maintenance of certification (MOC)[43] in the early 2000s, which offered both benefits and challenges, and translated to varying options for continuing board certification depending on specialty, such as a longitudinal knowledge assessment pathway for the American Board of Internal Medicine (ABIM) in 2022.[43]

With regard to physician lifelong learning, the Accreditation Council for Continuing Medical Education was still new when the 1982 report was written, having been established in 1981, and has evolved over time.[44] AMA's own Physician Recognition Award (PRA) Credit System also shifted over time, including official booklet updates in 2017 and in-progress changes since then.[45] Many factors related to lifelong learning have also emerged into greater awareness, such as ageism and principles to guide physician competence assessment at any age[46] and substance use disorder destigmatization and interventions.[47]

Medical education systems

The overall role of the physician and the practice of medicine in U.S. society has shifted. There has been a shift away from independent practice, influenced by economic, administrative, and regulatory burdens.[48] Due to the increasing complexity of health systems, in 1999, systems-based practice was introduced as one of the core competencies[49] endorsed by the ACGME and the ABMS, with Milestones introduced in 2013 as a developmental framework related to competencies and harmonized across specialties in 2017. There have been other updates since then.[49] Challenges continue to emerge in the clinical learning environment, requiring new approaches.[40] There are increasing concerns about the impact of corporate interests and private equity, as discussed in Council on Medical Education Reports 01-I-22, "The Impact of Private Equity on Medical Training,"[50] and 01-I-20, "Graduate Medical Education and the Corporate Practice of Medicine."[51] Other systems factors also influence medical education, such as high demand for clinical placements,[52] physician workforce disparities,[53] and scope of practice concerns, the latter of which led to the formation of the AMA's Scope of Practice Partnership in 2006.[54]

Obligation to students and trainees

Since 1982, there has been increased attention to the needs of students and trainees, in a variety of forms. Student well-being is now better researched, and a variety of interventions have been tested and implemented on an ongoing basis.[55] Resident working conditions and duty hours have become major issues in GME, particularly after the Libby Zion case in 1984[56] and adoption of ACGME duty hour standards.[57] In 2011, the AMA released the Residents and Fellows' Bill of Rights H-

31.912, last updated in 2023, and there is increasing awareness of the need to address growing stressors and burnout within medical education, both for learners[58] and faculty.[59]

Research is ongoing on how other aspects of the medical education field have shifted over time and how these changes may impact learners and public health.[60]

*Proposal for a New Medical Education Policy Framework*

Given the substantial evolution in medical education over the last 40+ years, the Council on Medical Education proposes, over a series of future reports, to systematically re-evaluate Policy H-295.995 recommendations and other relevant AMA medical education policy to: a) reframe existing policies to match the current context, b) consolidate duplicate or overlapping policies, c) remove outdated policies, and d) propose new policies to address identified gaps. The proposed framework for this project is discussed below.

## DISCUSSION

In the Council's original 1982 report, medical education topics were divided into the following 10 categories: 1) generalism and specialism, 2) preparation for and admission to medical school, 3) medical schools and undergraduate medical education, 4) evaluation, 5) the transition from undergraduate to graduate medical education, 6) specialism, graduate medical education, and specialty boards, 7) licensure for the practice of medicine, 8) continuing medical education, 9) graduates of foreign medical schools, and 10) the AMA and medical education. To modernize this policy, the Council on Medical Education recommends establishing a new framework with the following seven categories: 1) mission of medical education, 2) professional regulation, 3) entry into and transition through the medical education continuum, 4) medical education curricula, 5) physician as medical professional, 6) medical education systems, and 7) obligations to students and trainees. After receiving input from the House on this report, the Council intends to develop future reports based on a framework as adopted by the House of Delegates.

The Council on Medical Education also recommends sunsetting four out-of-date subsections of H-295.995, seen below.

## RELEVANT AMA POLICY

The current, full text of Recommendations for Future Directions for Medical Education H-295.995 is listed in the Appendix A of this report.

## SUMMARY AND RECOMMENDATIONS

Substantial changes have taken place in medical education since 1982, and AMA Policy H-295.995, "Recommendations for Future Directions for Medical Education," has not been comprehensively reviewed in over 40 years. The Council on Medical Education proposes a future series of self-initiated reports to modernize AMA medical education policy and consolidate relevant medical education policies.

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

That our American Medical Association (AMA):

1. Study the restructuring of AMA Policy H-295.995, “Recommendations for Future Directions for Medical Education” in a series of seven future reports based on the topics of 1) mission of medical education, 2) professional regulation, 3) entry into and transition through the medical education continuum, 4) medical education curricula, 5) physician as medical professional, 6) medical education systems, and 7) obligations to students and trainees, to consolidate existing AMA policies in these areas where appropriate and to recommend new language for the future of medical education. (Directive to Take Action)

2. Policy H-295.995, “Recommendations for Future Directions for Medical Education,” be amended by deletion of items 19, 20, 31 and 33 and appropriately renumbered to read as follows (Modify Current HOD Policy):

    (19) ~~The first year of postdoctoral medical education for all graduates should consist of a broad year of general training. (a) For physicians entering residencies in internal medicine, pediatrics, and general surgery, postdoctoral medical education should include at least four months of training in a specialty or specialties other than the one in which the resident has been appointed. (A residency in family practice provides a broad education in medicine because it includes training in several fields.) (b) For physicians entering residencies in specialties other than internal medicine, pediatrics, general surgery, and family practice, the first postdoctoral year of medical education should be devoted to one of the four above-named specialties or to a program following the general requirements of a transitional year stipulated in the "General Requirements" section of the "Essentials of Accredited Residencies." (c) A program for the transitional year should be planned, designed, administered, conducted, and evaluated as an entity by the sponsoring institution rather than one or more departments. Responsibility for the executive direction of the program should be assigned to one physician whose responsibility is the administration of the program. Educational programs for a transitional year should be subjected to thorough surveillance by the appropriate accrediting body as a means of assuring that the content, conduct, and internal evaluation of the educational program conform to national standards. The impact of the transitional year should not be deleterious to the educational programs of the specialty disciplines.~~

    (20) ~~The ACGME, individual specialty boards, and respective residency review committees should improve communication with directors of residency programs because of their shared responsibility for programs in graduate medical education.~~

    (31) ~~The Educational Commission for Foreign Medical Graduates should be encouraged to study the feasibility of including in its procedures for certification of graduates of foreign medical schools a period of observation adequate for the evaluation of clinical skills and the application of knowledge to clinical problems.~~

    (33) ~~The AMA, when appropriate, supports the use of selected consultants from the public and from the professions for consideration of special issues related to medical education.~~

Fiscal note: $7,000

APPENDIX A: RELEVANT AMA POLICY

<u>Recommendations for Future Directions for Medical Education H-295.995</u>

Our AMA supports the following recommendations relating to the future directions for medical education:
(1) The medical profession and those responsible for medical education should strengthen the general or broad components of both undergraduate and graduate medical education. All medical students and resident physicians should have general knowledge of the whole field of medicine regardless of their projected choice of specialty.
(2) Schools of medicine should accept the principle and should state in their requirements for admission that a broad cultural education in the arts, humanities, and social sciences, as well as in the biological and physical sciences, is desirable.
(3) Medical schools should make their goals and objectives known to prospective students and premedical counselors in order that applicants may apply to medical schools whose programs are most in accord with their career goals.
(4) Medical schools should state explicitly in publications their admission requirements and the methods they employ in the selection of students.
(5) Medical schools should require their admissions committees to make every effort to determine that the students admitted possess integrity as well as the ability to acquire the knowledge and skills required of a physician.
(6) Although the results of standardized admission testing may be an important predictor of the ability of students to complete courses in the preclinical sciences successfully, medical schools should utilize such tests as only one of several criteria for the selection of students. Continuing review of admission tests is encouraged because the subject content of such examinations has an influence on premedical education and counseling.
(7) Medical schools should improve their liaison with college counselors so that potential medical students can be given early and effective advice. The resources of regional and national organizations can be useful in developing this communication.
(8) Medical schools are chartered for the unique purpose of educating students to become physicians and should not assume obligations that would significantly compromise this purpose.
(9) Medical schools should inform the public that, although they have a unique capability to identify the changing medical needs of society and to propose responses to them, they are only one of the elements of society that may be involved in responding. Medical schools should continue to identify social problems related to health and should continue to recommend solutions.
(10) Medical school faculties should continue to exercise prudent judgment in adjusting educational programs in response to social change and societal needs.
(11) Faculties should continue to evaluate curricula periodically as a means of insuring that graduates will have the capability to recognize the diverse nature of disease, and the potential to provide preventive and comprehensive medical care. Medical schools, within the framework of their respective institutional goals and regardless of the organizational structure of the faculty, should provide a broad general education in both basic sciences and the art and science of clinical medicine.
(12) The curriculum of a medical school should be designed to provide students with experience in clinical medicine ranging from primary to tertiary care in a variety of inpatient and outpatient settings, such as university hospitals, community hospitals, and other health care facilities. Medical schools should establish standards and apply them to all components of the clinical educational program regardless of where they are conducted. Regular evaluation of the quality of each experience and its contribution to the total program should be conducted.
(13) Faculties of medical schools have the responsibility to evaluate the cognitive abilities of their students. Extramural examinations may be used for this purpose, but never as the sole criterion for promotion or graduation of a student.
(14) As part of the responsibility for granting the MD degree, faculties of medical schools have the obligation to evaluate as thoroughly as possible the non-cognitive abilities of their medical students.

(15) Medical schools and residency programs should continue to recognize that the instruction provided by volunteer and part-time members of the faculty and the use of facilities in which they practice make important contributions to the education of medical students and resident physicians. Development of means by which the volunteer and part-time faculty can express their professional viewpoints regarding the educational environment and curriculum should be encouraged.
(16) Each medical school should establish, or review already established, criteria for the initial appointment, continuation of appointment, and promotion of all categories of faculty. Regular evaluation of the contribution of all faculty members should be conducted in accordance with institutional policy and practice.
(17a) Faculties of medical schools should reevaluate the current elements of their fourth or final year with the intent of increasing the breadth of clinical experience through a more formal structure and improved faculty counseling. An appropriate number of electives or selected options should be included. (17b) Counseling of medical students by faculty and others should be directed toward increasing the breadth of clinical experience. Students should be encouraged to choose experience in disciplines that will not be an integral part of their projected graduate medical education.
(18) Directors of residency programs should not permit medical students to make commitments to a residency program prior to the final year of medical school.
(19) The first year of postdoctoral medical education for all graduates should consist of a broad year of general training. (a) For physicians entering residencies in internal medicine, pediatrics, and general surgery, postdoctoral medical education should include at least four months of training in a specialty or specialties other than the one in which the resident has been appointed. (A residency in family practice provides a broad education in medicine because it includes training in several fields.) (b) For physicians entering residencies in specialties other than internal medicine, pediatrics, general surgery, and family practice, the first postdoctoral year of medical education should be devoted to one of the four above-named specialties or to a program following the general requirements of a transitional year stipulated in the "General Requirements" section of the "Essentials of Accredited Residencies." (c) A program for the transitional year should be planned, designed, administered, conducted, and evaluated as an entity by the sponsoring institution rather than one or more departments. Responsibility for the executive direction of the program should be assigned to one physician whose responsibility is the administration of the program. Educational programs for a transitional year should be subjected to thorough surveillance by the appropriate accrediting body as a means of assuring that the content, conduct, and internal evaluation of the educational program conform to national standards. The impact of the transitional year should not be deleterious to the educational programs of the specialty disciplines.
(20) The ACGME, individual specialty boards, and respective residency review committees should improve communication with directors of residency programs because of their shared responsibility for programs in graduate medical education.
(21) Specialty boards should be aware of and concerned with the impact that the requirements for certification and the content of the examination have upon the content and structure of graduate medical education. Requirements for certification should not be so specific that they inhibit program directors from exercising judgment and flexibility in the design and operation of their programs.
(22) An essential goal of a specialty board should be to determine that the standards that it has set for certification continue to assure that successful candidates possess the knowledge, skills, and the commitment to upgrade continually the quality of medical care.
(23) Specialty boards should endeavor to develop a consensus concerning the significance of certification by specialty and publicize it so that the purposes and limitations of certification can be clearly understood by the profession and the public.
(24) The importance of certification by specialty boards requires that communication be improved between the specialty boards and the medical profession as a whole, particularly between the

boards and their sponsoring, nominating, or constituent organizations and also between the boards and their diplomates.
(25) Specialty boards should consider having members of the public participate in appropriate board activities.
(26) Specialty boards should consider having physicians and other professionals from related disciplines participate in board activities.
(27) The AMA recommends to state licensing authorities that they require individual applicants, to be eligible to be licensed to practice medicine, to possess the degree of Doctor of Medicine or its equivalent from a school or program that meets the standards of the LCME or accredited by the American Osteopathic Association, or to demonstrate as individuals, comparable academic and personal achievements. All applicants for full and unrestricted licensure should provide evidence of the satisfactory completion of at least one year of an accredited program of graduate medical education in the US. Satisfactory completion should be based upon an assessment of the applicant's knowledge, problem-solving ability, and clinical skills in the general field of medicine. The AMA recommends to legislatures and governmental regulatory authorities that they not impose requirements for licensure that are so specific that they restrict the responsibility of medical educators to determine the content of undergraduate and graduate medical education.
(28) The medical profession should continue to encourage participation in continuing medical education related to the physician's professional needs and activities. Efforts to evaluate the effectiveness of such education should be continued.
(29) The medical profession and the public should recognize the difficulties related to an objective and valid assessment of clinical performance. Research efforts to improve existing methods of evaluation and to develop new methods having an acceptable degree of reliability and validity should be supported.
(30) Methods currently being used to evaluate the readiness of graduates of foreign medical schools to enter accredited programs in graduate medical education in this country should be critically reviewed and modified as necessary. No graduate of any medical school should be admitted to or continued in a residency program if his or her participation can reasonably be expected to affect adversely the quality of patient care or to jeopardize the quality of the educational experiences of other residents or of students in educational programs within the hospital.
(31) The Educational Commission for Foreign Medical Graduates should be encouraged to study the feasibility of including in its procedures for certification of graduates of foreign medical schools a period of observation adequate for the evaluation of clinical skills and the application of knowledge to clinical problems.
(32) The AMA, in cooperation with others, supports continued efforts to review and define standards for medical education at all levels. The AMA supports continued participation in the evaluation and accreditation of medical education at all levels.
(33) The AMA, when appropriate, supports the use of selected consultants from the public and from the professions for consideration of special issues related to medical education.
(34) The AMA encourages entities that profile physicians to provide them with feedback on their performance and with access to education to assist them in meeting norms of practice; and supports the creation of experiences across the continuum of medical education designed to teach about the process of physician profiling and about the principles of utilization review/quality assurance.
(35) Our AMA encourages the accrediting bodies for MD- and DO-granting medical schools to review, on an ongoing basis, their accreditation standards to assure that they protect the quality and integrity of medical education in the context of the emergence of new models of medical school organization and governance.
(36) Our AMA will strongly advocate for the rights of medical students, residents, and fellows to have physician-led (MD or DO as defined by the AMA) clinical training, supervision, and evaluation while recognizing the contribution of non-physicians to medical education.

1 (37) Our AMA will publicize to medical students, residents, and fellows their rights, as per Liaison
2 Committee on Medical Education and Accreditation Council for Graduate Medical Education
3 guidelines, to physician-led education and a means to report violations without fear of retaliation.

1 REFERENCES

[1] AMA House of Delegates Proceedings, Annual Convention 1982. American Medical Association. Accessed July 11, 2024. https://ama.nmtvault.com/jsp/PsImageViewer.jsp?doc_id=1ee24daa-2768-4bff-b792-e4859988fe94%2Fama_arch%2FHOD00001%2F00000114

[2] Washington H. Apology Shines Light on Racial Schism in Medicine. *The New York Times*. Published July 29, 2008. Accessed July 11, 2024. https://www.nytimes.com/2008/07/29/health/views/29essa.html

[3] The history of African Americans and organized medicine. American Medical Association. Published February 2, 2024. Accessed July 11, 2024. https://www.ama-assn.org/about/ama-history/history-african-americans-and-organized-medicine

[4] Council on Medical Education Report 5-J-21, Promising Practices Among Pathway Programs to Increase Diversity in Medicine. American Medical Association. Published June 2021. Accessed July 11, 2024. https://www.ama-assn.org/system/files/2021-05/j21-cme05.pdf

[5] Bonilla-Silva E, Haozous EA, Kayingo G, McDade W, Meeks L, Núñez A, Oyeyemi T, Southerland J, Sukhera J. *Reimagining Medical Education: The Future of Health Equity and Social Justice.* Elsevier; 2024.

[6] Edje L, Casillas C, O'Toole JK. Strategies to counteract impact of harmful bias in selection of medical residents. *Acad Med*. 2023;98(8S):S75-S85. doi:10.1097/acm.0000000000005258

[7] Zhang X, Lin D, Pforsich H, Lin VW. Physician workforce in the United States of America: forecasting nationwide shortages. *Hum Resour Health*. 2020;18(1). doi:10.1186/s12960-020-0448-3

[8] Goroll AH. The future of the US physician workforce—challenges and opportunities. *JAMA Netw Open*. 2021;4(11):e2134464. doi:10.1001/jamanetworkopen.2021.34464

[9] Elma A, Nasser M, Yang L, Chang I, Bakker D, Grierson L. Medical education interventions influencing physician distribution into underserved communities: a scoping review. *Hum Resour Health*. 2022;20(1). doi:10.1186/s12960-022-00726-z

[10] Majumder MAA, Haque M, Razzaque MS. Editorial: Trends and challenges of medical education in the changing academic and public health environment of the 21st century. *Front Commun*. 2023;8. doi:10.3389/fcomm.2023.1153764

[11] Catalyzing change in medical education. American Medical Association. Published March 4, 2024. Accessed July 11, 2024. https://www.ama-assn.org/education/changemeded-initiative/catalyzing-change-medical-education

[12] Transition to a single GME accreditation system history. Accreditation Council for Graduate Medical Education. Accessed July 11, 2024. https://www.acgme.org/about/transition-to-a-single-gme-accreditation-system-history/

[13] Cummings M. The Single Accreditation System: Risks to the osteopathic profession. *Acad Med*. 2021;96(8):1108-1114. doi:10.1097/acm.0000000000004109

[14] Discrimination Against DO Students in Medical Residency. American Medical Association. Published June 2022. Accessed July 11, 2024. https://www.ama-assn.org/system/files/cme-issue-brief-discrimination-against-DO-students-in-medical-residency.pdf

[15] Schuwirth LWT, van der Vleuten CPM. A history of assessment in medical education. *Adv Health Sci Educ Theory Pract*. 2020;25(5):1045-1056. doi:10.1007/s10459-020-10003-0

[16] Work to relaunch USMLE Step 2 CS discontinued. United States Medical Licensing Examination. Published January 26, 2021. Accessed July 11, 2024. https://www.usmle.org/work-relaunch-usmle-step-2-cs-discontinued

[17] Murphy B. How the switch to pass-fail scoring for USMLE Step 1 is going. American Medical Association. Published April 5, 2023. Accessed July 11, 2024. https://www.ama-assn.org/medical-students/usmle-step-1-2/how-switch-pass-fail-scoring-usmle-step-1-going

[18] AAMC history. Association of American Medical Colleges. Accessed July 11, 2024. https://www.aamc.org/who-we-are/aamc-history

[19] Murphy B. What to know about the new ob-gyn physician residency application. American Medical Association. Published February 8, 2024. Accessed July 11, 2024. https://www.ama-assn.org/medical-students/preparing-residency/what-know-about-new-ob-gyn-physician-residency-application

[20] About the National Resident Matching Program. National Resident Matching Program. Accessed July 11, 2024. https://www.nrmp.org/about/

[21] Annual Report 2022-2023. National Resident Matching Program. Accessed July 11, 2024. https://annualreport.nrmp.org/#strategicpriorities

[22] NRMP® Publishes Comprehensive Data Book for Fellowship Matches. National Resident Matching Program. Published April 5, 2023. Accessed August 8, 2024. https://www.nrmp.org/about/news/2023/04/nrmp-publishes-comprehensive-data-book-for-fellowship-matches/

[23] Lucey CR, Davis JA, Green MM. We have no choice but to transform: The future of medical education after the COVID-19 pandemic. *Acad Med*. 2022;97(3S):S71-S81. doi:10.1097/acm.0000000000004526

[24] Guo MZ, Allen J, Sakumoto M, Pahwa A, Santhosh L. Reimagining undergraduate medical education in a post-COVID-19 landscape. *J Gen Intern Med*. 2022;37(9):2297-2301. doi:10.1007/s11606-022-07503-7

[25] Interviews in GME: Where do we go from here? Association of American Medical Colleges. Accessed July 11, 2024. https://www.aamc.org/about-us/mission-areas/medical-education/interviews-gme-where-do-we-go-here

[26] Knickrehm J. Coalition for Physician Accountability Accepts Report and Recommendations from UME-to-GME Review Committee. Coalition for Physician Accountability. Published August 26, 2021. Accessed July 11, 2024. https://physicianaccountability.org/wp-content/uploads/2021/08/UGRC-Submits-Final-Report-and-Recommendations.pdf

[27] History. Educational Commission for Foreign Medical Graduates. Published February 10, 2023. Accessed August 13, 2024. https://www.ecfmg.org/about/history.html

[28] Kelly, B. ECFMG® Launches Electronic Verification of Medical Credentials. Educational Commission for Foreign Medical Graduates. Published February 28, 2012. Accessed August 13, 2024. https://www.ecfmg.org/annc/ECFMG-release-Feb-28-2012.pdf

[29] About Us. Intealth. Published June 24, 2024. Accessed August 13, 2024. https://www.intealth.org/about-us/

[30] FSMB, Intealth, ACGME Establish Advisory Commission to Guide Alternate Pathways for State Licensure of International Medical Graduates. Intealth. Published March 27, 2024. Accessed August 13, 2024. https://www.intealth.org/news/2024/03/27/fsmb-intealth-acgme-establish-advisory-commission-to-guide-alternate-pathways-for-state-licensure-of-international-medical-graduates/

[31] A short history of the internet. National Science and Media Museum. Published December 3, 2020. Accessed July 11, 2024. https://www.scienceandmediamuseum.org.uk/objects-and-stories/short-history-internet

[32] Tokuç B, Varol G. Medical education in the era of advancing technology. *Balkan Med J*. 2023;40(6):395-399. doi:10.4274/balkanmedj.galenos.2023.2023-7-79

[33] Park A, Awan OA. COVID-19 and virtual medical student education. *Acad Radiol*. 2023;30(4):773-775. doi:10.1016/j.acra.2022.04.011

[34] AMA issues new principles for AI development, deployment & use. American Medical Association. Published November 28, 2023. Accessed July 11, 2024. https://www.ama-assn.org/press-center/press-releases/ama-issues-new-principles-ai-development-deployment-use

[35] Nagi F, Salih R, Alzubaidi M, et al. Applications of artificial Intelligence (AI) in medical education: A scoping review. In: *Studies in Health Technology and Informatics*. Vol 305. IOS Press; 2023.

[36] Accelerating change in medical education consortium: 2013-2022. American Medical Association. Published May 18, 2023. Accessed July 11, 2024. https://www.ama-assn.org/education/changemeded-initiative/accelerating-change-medical-education-consortium-2013-2022

[37] Smith, TM. Medical education in 2020: How we got here, where we're headed. American Medical Association. Published March 17, 2020. Accessed July 11, 2024. https://www.ama-assn.org/education/changemeded-initiative/medical-education-2020-how-we-got-here-where-we-re-headed

[38] AMA Reimagining Residency initiative. American Medical Association. Published April 26, 2024. Accessed July 11, 2024. https://www.ama-assn.org/education/changemeded-initiative/ama-reimagining-residency-initiative

[39] Richardson J, Gordon M, Pacis R, Wurster C, Hammoud MM. Health systems science: Insights from 155 U.S. allopathic medical schools, 2020–2021. Acad Med. 2023;98(11S):S214-S215. doi:10.1097/acm.0000000000005416

[40] Smith, TM. Why the physician of the future is a master adaptive learner. American Medical Association. Published October 5, 2020. Accessed August 13, 2024. https://www.ama-assn.org/education/changemeded-initiative/why-physician-future-master-adaptive-learner

[41] Onchonga D, Abdalla ME. Integrating social determinants of health in medical education: a bibliometric analysis study. *Public Health*. 2023;224:203-208. doi:10.1016/j.puhe.2023.09.005

[42] Cassel CK, Holmboe ES. Professionalism and accountability: the role of specialty board certification. *Trans Am Clin Climatol Assoc*. 2008;119:295-303; discussion 303-4.

[43] Cuenca AE. Board certification maintenance: History and evolution. *Fam Pract Manag*. 2022;29(5):6-11. Accessed July 11, 2024. https://www.aafp.org/pubs/fpm/issues/2022/0900/board-recertification.html

[44] History. Accreditation Council for Continuing Medical Education. Accessed July 11, 2024. https://www.accme.org/history

[45] The AMA PRA Credit System. American Medical Association. Published November 2023. Accessed July 11, 2024. https://www.ama-assn.org/system/files/cme-issue-brief-pra-credit-system.pdf

[46] Smith TM. 9 principles to guide physician competence assessment at all ages. American Medical Association. Published March 15, 2022. Accessed July 11, 2024. https://www.ama-assn.org/delivering-care/health-equity/9-principles-guide-physician-competence-assessment-all-ages

[47] Oreskovich MR, Shanafelt T, Dyrbye LN, et al. The prevalence of substance use disorders in American physicians. *Am J Addict*. 2015;24(1):30-38. doi:10.1111/ajad.12173

[48] AMA examines decade of change in physician practice ownership and organization. American Medical Association. Published July 12, 2023. Accessed July 11, 2024. https://www.ama-assn.org/press-center/press-releases/ama-examines-decade-change-physician-practice-ownership-and

[49] Edgar L, Hogan SO, Yamazaki K, Nasca TJ, Holmboe ES. Systems-based practice 20 years on: Navigating the system for better care. *Acad Med*. 2024;99(4):351-356. doi:10.1097/acm.0000000000005640

[50] Council on Medical Education Report 1-I-22, The Impact of Private Equity on Medical Training. American Medical Association. Published November 2022. Accessed July 11, 2024. https://councilreports.ama-assn.org/councilreports/downloadreport?uri=/councilreports/CME_01_I_22_final_annotated.pdf

[51] Council on Medical Education Report 2-N-20, Graduate Medical Education and the Corporate Practice of Medicine. American Medical Association. Published November 2020. Accessed July 11, 2024. https://councilreports.ama-assn.org/councilreports/downloadreport?uri=/councilreports/CME_02_I_20_annotated.pdf

[52] Nyoni CN, Dyk LHV, Botma Y. Clinical placement models for undergraduate health professions students: a scoping review. *BMC Med Educ*. 2021;21(1). doi:10.1186/s12909-021-03023-w

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[53] Silver JK, Bean AC, Slocum C, et al. Physician workforce disparities and patient care: A narrative review. *Health Equity*. 2019;3(1):360-377. doi:10.1089/heq.2019.0040

[54] AMA successfully fights scope of practice expansions that threaten patient safety. American Medical Association. Published May 15, 2023. Accessed August 13, 2024. https://www.ama-assn.org/practice-management/scope-practice/ama-successfully-fights-scope-practice-expansions-threaten

[55] Klein HJ, McCarthy SM. Student wellness trends and interventions in medical education: a narrative review. *Humanit Soc Sci Commun*. 2022;9(1):1-8. doi:10.1057/s41599-022-01105-8

[56] Patel N. Learning lessons. *J Am Coll Cardiol*. 2014;64(25):2802-2804. doi:10.1016/j.jacc.2014.11.007

[57] Imrie KR, Frank JR, Parshuram CS. Resident duty hours: past, present, and future. *BMC Med Educ*. 2014;14(S1):S1. doi:10.1186/1472-6920-14-s1-s1

[58] Amir M, Dahye K, Duane C, Wendy L W. Medical student and resident burnout: A review of causes, effects, and prevention. *J Fam Med Dis Prev*. 2018;4(4). doi:10.23937/2469-5793/1510094

[59] Ko S, Guck A, Williamson M, Buck K, Young R. Family medicine faculty time allocation and burnout: A residency research network of Texas study. *J Grad Med Educ*. 2020;12(5):620-623. doi:10.4300/jgme-d-19-00930.1

[60] Buja LM. Medical education today: all that glitters is not gold. *BMC Med Educ*. 2019;19(1). doi:10.1186/s12909-019-1535-9

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 302
(I-24)

Introduced by: Resident and Fellow Section, LGBTQ+ Section, Minority Affairs Section

Subject: Strengthening Parental Leave Policies for Medical Trainees and Recent Graduates

Referred to: Reference Committee C

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1 Whereas, supporting trainees with adequate parental leave is associated with improved resident
2 wellness and productivity, as well as long-term maternal and child health outcomes;[1-3] and
3
4 Whereas, as of October 2020, all federal employees including members of the military are
5 eligible for 12 weeks of paid parental leave for the birth or adoption of a child;[4] and
6
7 Whereas, both the American Academy of Pediatrics (AAP) and the American Academy of
8 Family Physicians (AAFP) recommend that up to 12 weeks of paid parental leave should be
9 available during residency training;[8] and
10
11 Whereas, a study of top-ranked hospitals and cancer centers found that the mean paid
12 maternity and parental leave is 7.8 and 3.6 weeks, respectively, well below the 12-week paid
13 family leave recommendation of the American Academy of Pediatrics and the mean of
14 18.6 weeks afforded by other Organization for Economic Co-operation and Development
15 countries;[5] and
16
17 Whereas, the Family and Medical Leave Act of 1993 gives “eligible” employees of large
18 employers and all government agencies regardless of size to take unpaid leave if it has been
19 earned (defined as after 12 months of work) for a period of up to 12 weeks in any 12 month
20 period;[6] and
21
22 Whereas, there are state-based parental leave laws that also require employees to have worked
23 at least 12 months, which poses a burden for new graduates from residency and fellowship;[7]
24 and
25
26 Whereas, in survey responses many residents do not feel supported in taking parental leave
27 due to perceived or actual lack of support from faculty/peers, strain on residency program, and
28 lack of flexibility of programs;[8] and
29
30 Whereas, in one survey, ⅔ of medical trainees who were parents felt that childcare contributed
31 to their burnout especially when compounded by short parental leave and the difficulties of a
32 relatively low trainee salary;[9] and
33
34 Whereas, in one survey of trainees in an institution and state offering only unpaid parental
35 leave, the leading factor influencing length of parental leave time was financial;[10] and
36
37 Whereas, in one survey, nearly 40% of surgical trainees reported considering leaving residency
38 during or after pregnancy for reasons including dissatisfaction with leave options;[11] and

1 Whereas, many women physicians delay childbearing until after training which often overlaps
2 with periods of peak fertility such that approximately ¼ of women physicians report infertility, up
3 to double the rate of the general US population;[12-14] and
4
5 Whereas, even if residencies and fellowships support paid leave, there is limited flexibility to
6 support residents finishing residency on time, including limited board licensing exam dates;
7 therefore be it
8
9 RESOLVED, that our American Medical Association amend Policies for Parental, Family and
10 Medical Necessity Leave H-405.960 by addition to read as follows:
11
12 5. Our AMA recommends that medical practices, departments and training programs strive to
13 provide 12 weeks of paid parental, family and medical necessity leave in a 12-month period for
14 their attending and trainee physicians as needed with eligibility beginning at the start of
15 employment without a waiting period. (Modify Current HOD Policy)

Fiscal Note: Minimal – less than $1,000

Received: 9/24/2024

**REFERENCES:**

1. Stack SW, McKinney CM, Spiekerman C, Best JA. Childbearing and maternity leave in residency: determinants and well-being outcomes. Postgrad Med J. 2018;94(1118):694-699. doi:10.1136/postgradmedj-2018-135960PubMedGoogle ScholarCrossref
2. Avendano M, Berkman LF, Brugiavini A, Pasini G. The long-run effect of maternity leave benefits on mental health: evidence from European countries. Soc Sci Med. 2015;132:45-53. doi:10.1016/j.socscimed.2015.02.037PubMedGoogle ScholarCrossref
3. Staehelin K, Bertea PC, Stutz EZ. Length of maternity leave and health of mother and child—a review. Int J Public Health. 2007;52(4):202-209. doi:10.1007/s00038-007-5122-1PubMedGoogle ScholarCrossref
4. Paid Parental Leave for Federal Employees. https://www.commerce.gov/hr/paid-parental-leave-federal-employees
5. Lu DJ, King BK, Sandler HM, Tarbell NJ, Kamrava M, Atkins KM. Paid parental leave policies among U.S. News & World Report 2020-2021 best hospitals and best hospitals for cancer. JAMA Netw Open 2021;4:e218518.Google Scholar
6. Code of Federal Regulations. https://www.ecfr.gov/current/title-29/subtitle-B/chapter-V/subchapter-C/part-825
7. Expanded Family and Medical Leave in California. https://calcivilrights.ca.gov/wp-content/uploads/sites/32/2023/02/Expanded-Family-And-Medical-Leave_ENG.pdf
8. Tobin-Tyler, Elizabeth, and Eli Y. Adashi. "The ACGME's new paid family and medical leave policy: just the beginning." *The Journal of the American Board of Family Medicine* 36.1 (2023): 190-192.
9. Marguerite W Spruce, Alicia A Gingrich, Amanda Phares, Carl A Beyer, Edgardo S Salcedo, Susan Guralnick, Margaret M Rea, Child-rearing During Postgraduate Medical Training and Its Relation to Stress and Burnout: Results From a Single-institution Multispecialty Survey, Military Medicine, Volume 187, Issue 3-4, March/April 2022, Pages e518–e526, https://doi.org/10.1093/milmed/usab029
10. Shobha W Stack, Christy M McKinney, Charles Spiekerman, Jennifer A Best, Childbearing and maternity leave in residency: determinants and well-being outcomes, Postgraduate Medical Journal, Volume 94, Issue 1118, December 2018, Pages 694–699, https://doi.org/10.1136/postgradmedj-2018-135960
11. Rangel EL, Smink DS, Castillo-Angeles M, Kwakye G, Changala M, Haider AH, Doherty GM. Pregnancy and Motherhood During Surgical Training. JAMA Surg. 2018 Jul 1;153(7):644-652. doi: 10.1001/jamasurg.2018.0153. PMID: 29562068; PMCID: PMC5875346.
12. Willett, Lisa L., et al. "Do women residents delay childbearing due to perceived career threats?." Academic Medicine 85.4 (2010): 640-646.
13. Natalie Clark Stentz, Kent A. Griffith, Elena Perkins, Rochelle DeCastro Jones, and Reshma Jagsi. Fertility and Childbearing Among American Female Physicians. Journal of Women's Health.Oct 2016.1059-1065.http://doi.org/10.1089/jwh.2015.5638
14. Carson SA, Kallen AN. Diagnosis and Management of Infertility: A Review. JAMA. 2021 Jul 6;326(1):65-76. doi: 10.1001/jama.2021.4788. PMID: 34228062; PMCID: PMC9302705.

**RELEVANT AMA POLICY:**

**Policies for Parental, Family and Medical Necessity Leave H-405.960**
AMA adopts as policy the following guidelines for, and encourages the implementation of, Parental, Family and Medical Necessity Leave for Medical Students and Physicians:
1. Our AMA urges residency training programs, medical specialty boards, the Accreditation Council for Graduate Medical Education, and medical group practices to incorporate and/or encourage development of leave policies, including parental, family, and medical leave policies, as part of the physician's standard benefit agreement.
2. Recommended components of parental leave policies for physicians include: (a) duration of leave allowed before and after delivery; (b) category of leave credited; (c) whether leave is paid or unpaid; (d) whether provision is made for continuation of insurance benefits during leave, and who pays the premium; (e) whether sick leave and vacation time may be accrued from year to year or used in advance; (f) how much time must be made up in order to be considered board eligible; (g) whether make-up time will be paid; (h) whether schedule accommodations are allowed; and (i) leave policy for adoption.
3. AMA policy is expanded to include physicians in practice, reading as follows: (a) residency program directors and group practice administrators should review federal law concerning maternity leave for guidance in developing policies to assure that pregnant physicians are allowed the same sick leave or disability benefits as those physicians who are ill or disabled; (b) staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in other physicians' workloads, particularly in residency programs; and (c) physicians should be able to return to their practices or training programs after taking parental leave without the loss of status.
4. Our AMA will study the impact on and feasibility of medical schools, residency programs, specialty boards, and medical group practices incorporating into their parental leave policies a 12-week minimum leave allowance, with the understanding that no parent be required to take a minimum leave.
5. Our AMA recommends that medical practices, departments and training programs strive to provide 12 weeks of paid parental, family and medical necessity leave in a 12-month period for their attending and trainee physicians as needed.
6. Residency program directors should review federal and state law for guidance in developing policies for parental, family, and medical leave.
7. Medical students and physicians who are unable to work because of pregnancy, childbirth, abortion or stillbirth, and other related medical conditions should be entitled to such leave and other benefits on the same basis as other physicians who are temporarily unable to work for other medical reasons.
8. Residency programs should develop written policies on leave for physicians. Such written policies should include the following elements: (a) leave policy for birth or adoption; (b) duration of leave allowed before and after delivery; (c) duration of leave allowed after abortion or stillbirth; (d) category of leave credited (e.g., sick, vacation, parental, unpaid leave, short term disability); (e) whether leave is paid or unpaid; (f) whether provision is made for continuation of insurance benefits during leave and who pays for premiums; (g) whether sick leave and vacation time may be accrued from year to year or used in advance; (h) extended leave for resident physicians with extraordinary and long-term personal or family medical tragedies for periods of up to one year, without loss of previously accepted residency positions, for devastating conditions such as terminal illness, permanent disability, or complications of pregnancy that threaten maternal or fetal life; (i) how time can be made up in order for a resident physician to be considered board eligible; (j) what period of leave would result in a resident physician being required to complete an extra or delayed year of training; (k) whether time spent in making up a leave will be paid; and (l) whether schedule accommodations are allowed, such as reduced hours, no night call, modified rotation schedules, and permanent part-time scheduling.
9. Medical schools should develop written policies on parental leave, family leave, and medical leave for medical students. Such written policies should include the following elements: (a) leave policy for birth or adoption; (b) duration of leave allowed before and after delivery; (c) extended leave for medical students with extraordinary and long-term personal or family medical tragedies, without loss of previously accepted medical school seats, for devastating conditions such as terminal illness, permanent disability, or complications of pregnancy that threaten maternal or fetal life; (d) how time can be made up in order for a medical students to be eligible for graduation with minimal or no delays; (e) what period of leave would result in a medical student being required to complete an extra or delayed year of training; and (f) whether schedule accommodations are allowed, such as modified rotation schedules, no night duties, and flexibility with academic testing schedules.

10. Our AMA endorses the concept of equal parental leave for birth and adoption as a benefit for resident physicians, medical students, and physicians in practice regardless of gender or gender identity.
11. Staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in the workloads of other physicians, particularly those in residency programs.
12. Physicians should be able to return to their practices or training programs after taking parental leave, family leave, or medical leave without the loss of status.
13. Residency program directors must assist residents in identifying their specific requirements (for example, the number of months to be made up) because of leave for eligibility for board certification and must notify residents on leave if they are in danger of falling below minimal requirements for board eligibility. Program directors must give these residents a complete list of requirements to be completed in order to retain board eligibility.
14. Our AMA encourages flexibility in residency programs and medical schools incorporating parental leave and alternative schedules for pregnant trainees.
15. In order to accommodate leave protected by the federal Family and Medical Leave Act, our AMA encourages all specialties within the American Board of Medical Specialties to allow graduating residents to extend training up to 12 weeks after the traditional residency completion date while still maintaining board eligibility in that year.
16. Our AMA will work with appropriate stakeholders to encourage that residency programs annually publish and share with FREIDA and other appropriate stakeholders, self-identified and other demographic data, including but not limited to the composition of their program over the last 5 years by age; historically marginalized, minoritized, or excluded status; sexual orientation and gender identity.
17. Our AMA will encourage the Accreditation Council for Graduate Medical Education and other relevant stakeholders to annually collect data on childbirth and parenthood from all accredited US residency programs and publish this data with disaggregation by gender identity and specialty.
18. These policies as above should be freely available online through FREIDA and in writing to all current trainees and applicants to medical school, residency or fellowship. [CCB/CLRPD Rep. 4, A-13; Modified: Res. 305, A-14; Modified: Res. 904, I-14; Modified: Res. 307, A-22; Modified: Res. 302, I-22; Modified: Res. 312, I-22; Modified: CME Rep. 01 and Res. 306, I-23]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 304
(I-24)

Introduced by: Resident and Fellow Section, LGBTQ+ Section, Minority Affairs Section

Subject: Payment and Benefit Parity for Fellows

Referred to: Reference Committee C

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1 Whereas, Graduate Medical Education (GME) is funded through both private and public
2 sources[1-4]; and
3
4 Whereas, the largest source of funding for GME, specifically for residency positions, is through
5 Medicare, both through direct (DGME) and indirect (IME) payments[1-4]; and
6
7 Whereas, additional federal funding comes from HRSA grants, the VA, and Department of
8 Defense[1-4]; and
9
10 Whereas, Medicare payments cover residents in approved programs, accredited by the
11 Accreditation Council on Graduate Medical Education (ACGME), the American Osteopathic
12 Association (AOA), the American Dental Association (ADA), or the American Podiatric Medical
13 Association (APMA)[3,5]; and
14
15 Whereas, Medicare will pay 1.0 FTE for each resident within their initial residency period, or the
16 minimum number of years required for a resident to become board eligible in the specialty in
17 which the resident first begins training, as determined by the ACGME[3,6]; and
18
19 Whereas, Medicare GME may have indirect effects on fellowship funding through various
20 mechanisms such as hospital budget allocation, and contributing to infrastructure, resources
21 and workforce development initiatives that can then support fellowship training[3,4]; and
22
23 Whereas, fellowships rely on private foundations, direct funding from the institution, government
24 grants, endowments and donations, and/or other funding sources (often a combination of
25 funding sources) to fund the fellowship[3,4]; and
26
27 Whereas, this difference in funding structure or pool can allow institutions to provide inferior
28 benefits and salaries for fellows as compared to residents; and
29
30 Whereas, one can complete residency at an institution and have fringe benefits such as having
31 subsidized parking, a 403b match, and/or gym membership, only to lose those benefits once
32 they transition to fellowship at the same institution; and
33
34 Whereas, fellows often are older, carry more clinical responsibility, and may be more likely to
35 have dependents compared to residents, and despite this, may receive fewer/inferior benefits
36 compared to residents at the same institution; and
37
38 Whereas, all resident and fellow trainees deserve to be eligible for the same benefits, no matter
39 what the funding source is for their program; therefore be it

1 RESOLVED, that our American Medical Association amend Residents and Fellows' Bill of
2 Rights H-310.912 by addition to read as follows:
3
4 5. Our AMA will partner with ACGME and other relevant stakeholders to encourage
5 training programs to reduce financial burdens on residents and fellows by providing
6 employee benefits including, but not limited to, on-call meal allowances, transportation
7 support, relocation stipends, and childcare services, and will encourage institutions to
8 provide parity in salary and benefits between residents and fellows at a level that is at
9 minimum commensurate with their postgraduate year. (Modify Current HOD Policy)

Fiscal Note: Minimal – less than $1,000

Received: 9/24/2024

**REFERENCES:**

1. ACGME. Funding for Graduate Medical Education. 2022. https://www.acgme.org/globalassets/pdfs/funding-for-graduate-medical-education-5.3.2022.pdf
2. Heisler, E., Mendez, B., Mitchell, A., Panangala, S.V, Villagrana, M. (2018) Federal Support for Graduate Medical Education: An Overview (CRS Report No. R44376) Retrieved from Congressional Research Service Website: Federal Support for Graduate Medical Education: An Overview (congress.gov)
3. AAMC. Medicare Payments for Graduate Medical Education: What Every Medical Student, Resident and Advisor needs to know. 2019. https://www.aamc.org/media/71701/download?attachment
4. Committee on the Governance and Financing of Graduate Medical Education; Board on Health Care Services; Institute of Medicine; Eden J, Berwick D, Wilensky G, editors. Graduate Medical Education That Meets the Nation's Health Needs. Washington (DC): National Academies Press (US); 2014 Sep 30. 3, GME Financing. Available from: https://www.ncbi.nlm.nih.gov/books/NBK248024/
5. 42 CFR 413.78 Direct GME payments: Determination of the total number of FTE residents; 42 CFR 413.75(b) Direct GME payments: General requirements.
6. 42 CFR 413.75(b) Direct GME payments: General requirements

**RELEVANT AMA POLICY:**

**Onsite and Subsidized Childcare for Medical Students, Residents and Fellows H-200.948**
Our AMA recognizes: (1) the unique childcare challenges faced by medical students, residents and fellows, which result from a combination of limited negotiating ability (given the matching process into residency), non-traditional work hours, extended or unpredictable shifts, and minimal autonomy in selecting their work schedules; and (2) the fiscal challenges faced by medical schools and graduate medical education institutions in providing onsite and/or subsidized childcare to students and employees, including residents and fellows. [CME Rep. 3, A-22]

**Medical and Mental Health Services for Medical Students and Resident and Fellow Physicians H-345.973**
Our AMA promotes the availability of timely, confidential, accessible, and affordable medical and mental health services for medical students and resident and fellow physicians, to include needed diagnostic, preventive, and therapeutic services. Information on where and how to access these services should be readily available at all education/training sites, and these services should be provided at sites in reasonable proximity to the sites where the education/training takes place. [Res. 915, I-15; Revised: CME Rep. 01, I-16]

**Financial Protections for Doctors in Training H-310.903**
Our AMA supports the availability of retirement plans for residents and fellows at all teaching institutions that are no less favorable than those offered to other institution employees. [BOT Rep. 18, I-21]

**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 in this Resident/Fellows Physicians' Bill of Rights.
4. Our AMA: a) will promote residency and fellowship training programs to evaluate their own institution's process for repayment and develop a leaner approach. This includes disbursement of funds by direct deposit as opposed to a paper check and an online system of applying for funds; b) encourages a system of expedited repayment for purchases of $200 or less (or an equivalent institutional threshold), for example through payment directly from their residency and fellowship programs (in contrast to following traditional workflow for reimbursement); and c) encourages training programs to develop a budget and strategy for planned expenses versus unplanned expenses, where planned expenses should be estimated using historical data, and should include trainee reimbursements for items such as educational materials, attendance at conferences, and entertaining applicants. Payment in advance or within one month of document submission is strongly recommended.
5. Our AMA will partner with ACGME and other relevant stakeholders to encourage training programs to reduce financial burdens on residents and fellows by providing employee benefits including, but not limited to, on-call meal allowances, transportation support, relocation stipends, and childcare services.
6. Our AMA will work with the Accreditation Council for Graduate Medical Education (ACGME) and other relevant stakeholders to amend the ACGME Common Program Requirements to allow flexibility in the specialty-specific ACGME program requirements enabling specialties to require salary reimbursement or "protected time" for resident and fellow education by "core faculty," program directors, and assistant/associate program directors.
7. Our AMA encourages teaching institutions to offer retirement plan options, retirement plan matching, financial advising and personal finance education.
8. Our AMA adopts the following "Residents and Fellows' Bill of Rights" as applicable to all resident and fellow physicians in ACGME-accredited training programs:
RESIDENT/FELLOW PHYSICIANS' BILL OF RIGHTS
Residents and fellows have a right to:
A. An education that fosters professional development, takes priority over service, and leads to independent practice.
With regard to education, residents and fellows should expect: (1) A graduate medical education experience that facilitates their professional and ethical development, to include regularly scheduled didactics for which they are released from clinical duties. Service obligations should not interfere with educational opportunities and clinical education should be given priority over service obligations; (2) Faculty who devote sufficient time to the educational program to fulfill their teaching and supervisory responsibilities; (3) Adequate clerical and clinical support services that minimize the extraneous, time-consuming work that draws attention from patient care issues and offers no educational value; (4) 24-hour per day access to information resources to educate themselves further about appropriate patient care; and (5) Resources that will allow them to pursue scholarly activities to include financial support and education leave to attend professional meetings.
B. Appropriate supervision by qualified physician faculty with progressive resident responsibility toward independent practice.
With regard to supervision, residents and fellows must be ultimately supervised by physicians who are adequately qualified and allow them to assume progressive responsibility appropriate to their level of education, competence, and experience. In instances where clinical education is provided by non-physicians, there must be an identified physician supervisor providing indirect supervision, along with mechanisms for reporting inappropriate, non-physician supervision to the training program, sponsoring institution or ACGME as appropriate.
C. Regular and timely feedback and evaluation based on valid assessments of resident performance.
With regard to evaluation and assessment processes, residents and fellows should expect: (1) Timely and substantive evaluations during each rotation in which their competence is objectively assessed by faculty who have directly supervised their work; (2) To evaluate the faculty and the program confidentially and in writing at least once annually and expect that the training program will address deficiencies revealed by these evaluations in a timely fashion; (3) Access to their training file and to be made aware of the contents of their file on an annual basis; and (4) Training programs to complete primary

verification/credentialing forms and recredentialing forms, apply all required signatures to the forms, and then have the forms permanently secured in their educational files at the completion of training or a period of training and, when requested by any organization involved in credentialing process, ensure the submission of those documents to the requesting organization within thirty days of the request.
D. A safe and supportive workplace with appropriate facilities.
With regard to the workplace, residents and fellows should have access to: (1) A safe workplace that enables them to fulfill their clinical duties and educational obligations; (2) Secure, clean, and comfortable on-call rooms and parking facilities which are secure and well-lit; (3) Opportunities to participate on committees whose actions may affect their education, patient care, workplace, or contract.
E. Adequate compensation and benefits that provide for resident well-being and health.
(1) With regard to contracts, residents and fellows should receive: a. Information about the interviewing residency or fellowship program including a copy of the currently used contract clearly outlining the conditions for (re)appointment, details of remuneration, specific responsibilities including call obligations, and a detailed protocol for handling any grievance; and b. At least four months advance notice of contract non-renewal and the reason for non-renewal.
(2) With regard to compensation, residents and fellows should receive: a. Compensation for time at orientation; and b. Salaries commensurate with their level of training and experience. Compensation should reflect cost of living differences based on local economic factors, such as housing, transportation, and energy costs (which affect the purchasing power of wages), and include appropriate adjustments for changes in the cost of living.
(3) With regard to benefits, residents and fellows must be fully informed of and should receive: a. Quality and affordable comprehensive medical, mental health, dental, and vision care for residents and their families, as well as retirement plan options, professional liability insurance and disability insurance to all residents for disabilities resulting from activities that are part of the educational program; b. An institutional written policy on and education in the signs of excessive fatigue, clinical depression, substance abuse and dependence, and other physician impairment issues; c. Confidential access to mental health and substance abuse services; d. A guaranteed, predetermined amount of paid vacation leave, sick leave, family and medical leave and educational/professional leave during each year in their training program, the total amount of which should not be less than six weeks; e. Leave in compliance with the Family and Medical Leave Act; and f. The conditions under which sleeping quarters, meals and laundry or their equivalent are to be provided.
F. Clinical and educational work hours that protect patient safety and facilitate resident well-being and education.
With regard to clinical and educational work hours, residents and fellows should experience: (1) A reasonable work schedule that is in compliance with clinical and educational work hour requirements set forth by the ACGME; and (2) At-home call that is not so frequent or demanding such that rest periods are significantly diminished or that clinical and educational work hour requirements are effectively circumvented. Refer to AMA Policy H-310.907, “Resident/Fellow Clinical and Educational Work Hours,” for more information.
G. Due process in cases of allegations of misconduct or poor performance.
With regard to the complaints and appeals process, residents and fellows should have the opportunity to defend themselves against any allegations presented against them by a patient, health professional, or training program in accordance with the due process guidelines established by the AMA.
H. Access to and protection by institutional and accreditation authorities when reporting violations.
With regard to reporting violations to the ACGME, residents and fellows should: (1) Be informed by their program at the beginning of their training and again at each semi-annual review of the resources and processes available within the residency program for addressing resident concerns or complaints, including the program director, Residency Training Committee, and the designated institutional official; (2) Be able to file a formal complaint with the ACGME to address program violations of residency training requirements without fear of recrimination and with the guarantee of due process; and (3) Have the opportunity to address their concerns about the training program through confidential channels, including the ACGME concern process and/or the annual ACGME Resident Survey.
9. Our AMA will work with the ACGME and other relevant stakeholders to advocate for ways to defray additional costs related to residency and fellowship training, including essential amenities and/or high cost specialty-specific equipment required to perform clinical duties.
10. Our AMA believes that healthcare trainee salary, benefits, and overall compensation should, at minimum, reflect length of pre-training education, hours worked, and level of independence and

complexity of care allowed by an individual's training program (for example when comparing physicians in training and midlevel providers at equal postgraduate training levels).
11.The Residents and Fellows' Bill of Rights will be prominently published online on the AMA website and disseminated to residency and fellowship programs.
12. Our AMA will distribute and promote the Residents and Fellows' Bill of Rights online and individually to residency and fellowship training programs and encourage changes to institutional processes that embody these principles, including resident/fellow empowerment and peer-selected representation in institutional leadership.
13. Our AMA encourages development of accreditation standards and institutional policies designed to facilitate and protect residents/fellows who seek to exercise their rights.
14. Our AMA encourages the formation of peer-led resident/fellow organizations that can advocate for trainees' interests, as outlined by the AMA's Residents and Fellows' Bill of Rights, at sponsoring institutions. [CME Rep. 8, A-11; Appended: Res. 303, A-14; Reaffirmed: Res. 915, I-15; Appended: CME Rep. 04, A-16; Modified: CME Rep. 06, I-18; Appended: Res. 324, A-19; Modified: Res. 304, A-21; Modified: Res. 305, A-21; Modified: BOT Rep. 18, I-21; Reaffirmation: A-22; Reaffirmed in lieu of: Res. 307, I-22; Modified: CME Rep. 05, I-23]

**Resident and Fellow Access to Fertility Preservation H-310.902**
Our AMA: (1) encourages insurance coverage for fertility preservation and infertility treatment within health insurance benefits for residents and fellows offered through graduate medical education programs; and (2) supports the accommodation of residents and fellows who elect to pursue fertility preservation and infertility treatment, including but not limited to, the need to attend medical visits to complete the gamete preservation process and to administer medications in a time-sensitive fashion. [Res. 302, A-22]

**The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education D-305.967**
1. Our AMA will actively collaborate with appropriate stakeholder organizations, (including Association of American Medical Colleges, American Hospital Association, state medical societies, medical specialty societies/associations) to advocate for the preservation, stability and expansion of full funding for the direct and indirect costs of graduate medical education (GME) positions from all existing sources (e.g. Medicare, Medicaid, Veterans Administration, CDC and others).
2. Our AMA will actively advocate for the stable provision of matching federal funds for state Medicaid programs that fund GME positions.
3. Our AMA will actively seek congressional action to remove the caps on Medicare funding of GME positions for resident physicians that were imposed by the Balanced Budget Amendment of 1997 (BBA-1997).
4. Our AMA will strenuously advocate for increasing the number of GME positions to address the future physician workforce needs of the nation.
5. Our AMA will oppose efforts to move federal funding of GME positions to the annual appropriations process that is subject to instability and uncertainty.
6. Our AMA will oppose regulatory and legislative efforts that reduce funding for GME from the full scope of resident educational activities that are designated by residency programs for accreditation and the board certification of their graduates (e.g. didactic teaching, community service, off-site ambulatory rotations, etc.).
7. Our AMA will actively explore additional sources of GME funding and their potential impact on the quality of residency training and on patient care.
8. Our AMA will vigorously advocate for the continued and expanded contribution by all payers for health care (including the federal government, the states, and local and private sources) to fund both the direct and indirect costs of GME.
9. Our AMA will work, in collaboration with other stakeholders, to improve the awareness of the general public that GME is a public good that provides essential services as part of the training process and serves as a necessary component of physician preparation to provide patient care that is safe, effective and of high quality.
10. Our AMA staff and governance will continuously monitor federal, state and private proposals for health care reform for their potential impact on the preservation, stability and expansion of full funding for the direct and indirect costs of GME.
11. Our AMA: (a) recognizes that funding for and distribution of positions for GME are in crisis in the United States and that meaningful and comprehensive reform is urgently needed; (b) will immediately

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

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

27. Our AMA will develop, along with other interested stakeholders, a national campaign to educate the public on the definition and importance of graduate medical education, student debt and the state of the medical profession today and in the future.
28. Our AMA will collaborate with other stakeholder organizations to evaluate and work to establish consensus regarding the appropriate economic value of resident and fellow services.
29. Our AMA will monitor ongoing pilots and demonstration projects, and explore the feasibility of broader implementation of proposals that show promise as alternative means for funding physician education and training while providing appropriate compensation for residents and fellows.
30. Our AMA will monitor the status of the House Energy and Commerce Committee's response to public comments solicited regarding the 2014 IOM report, Graduate Medical Education That Meets the Nation's Health Needs, as well as results of ongoing studies, including that requested of the GAO, in order to formulate new advocacy strategy for GME funding, and will report back to the House of Delegates regularly on important changes in the landscape of GME funding.
31. Our AMA will advocate to the Centers for Medicare & Medicaid Services to adopt the concept of “Cap-Flexibility” and allow new and current Graduate Medical Education teaching institutions to extend their cap-building window for up to an additional five years beyond the current window (for a total of up to ten years), giving priority to new residency programs in underserved areas and/or economically depressed areas.
32. Our AMA will: (a) encourage all existing and planned allopathic and osteopathic medical schools to thoroughly research match statistics and other career placement metrics when developing career guidance plans; (b) strongly advocate for and work with legislators, private sector partnerships, and existing and planned osteopathic and allopathic medical schools to create and fund graduate medical education (GME) programs that can accommodate the equivalent number of additional medical school graduates consistent with the workforce needs of our nation; and (c) encourage the Liaison Committee on Medical Education (LCME), the Commission on Osteopathic College Accreditation (COCA), and other accrediting bodies, as part of accreditation of allopathic and osteopathic medical schools, to prospectively and retrospectively monitor medical school graduates’ rates of placement into GME as well as GME completion.
33. Our AMA encourages the Secretary of the U.S. Department of Health and Human Services to coordinate with federal agencies that fund GME training to identify and collect information needed to effectively evaluate how hospitals, health systems, and health centers with residency programs are utilizing these financial resources to meet the nation’s health care workforce needs. This includes information on payment amounts by the type of training programs supported, resident training costs and revenue generation, output or outcomes related to health workforce planning (i.e., percentage of primary care residents that went on to practice in rural or medically underserved areas), and measures related to resident competency and educational quality offered by GME training programs.
34. Our AMA will publicize best practice examples of state-funded Graduate Medical Education positions and develop model state legislation where appropriate.
[Appended: Res. 202, I-22]

**Insurance Coverage for Medical Students and Resident Physicians H-295.942**
1. Our AMA urges (1) all medical schools to pay for or offer affordable policy options and, assuming the rates are appropriate, require enrollment in disability insurance plans by all medical students; (2) all residency programs to pay for or offer affordable policy options for disability insurance, and strongly encourage the enrollment of all residents in such plans; (3) medical schools and residency training programs to pay for or offer comprehensive and affordable health insurance coverage, including but not limited to medical, dental, and vision care, to medical students and residents which provides no less than the minimum benefits currently recommended by the AMA for employer-provided health insurance and to require enrollment in such insurance; (4) carriers offering disability insurance to: (a) offer a range of disability policies for medical students and residents that provide sufficient monthly disability benefits to defray any educational loan repayments, other living expenses, and an amount sufficient to continue payment for health insurance providing the minimum benefits recommended by the AMA for employer-provided health insurance; and (b) include in all such policies a rollover provision allowing continuation of student disability coverage into the residency period without medical underwriting. (5) Our AMA: (a) actively encourages medical schools, residency programs, and fellowship programs to provide access to portable group health and disability insurance, including human immunodeficiency virus positive indemnity insurance, for all medical students and resident and fellow physicians; (b) will work with the ACGME and the LCME, and other interested state medical societies or specialty organizations, to

develop strategies and policies to ensure access to the provision of portable health and disability insurance coverage, including human immunodeficiency virus positive indemnity insurance, for all medical students, resident and fellow physicians; and (c) will prepare informational material designed to inform medical students and residents concerning the need for both disability and health insurance and describing the available coverage and characteristics of such insurance.
2. Our AMA encourages medical schools to allow students and their families who qualify for and enroll in health insurance plans other than the institutionally offered health insurance plans, to be exempt from an otherwise mandatory student health insurance plan requirement, provided that the alternative plan has comparable care coverage and is accepted at the primary geographic locations of training.
3. Our AMA supports the continuation of comprehensive medical insurance benefits for inactive students taking an approved leave of absence during their time of degree completion and encourage medical schools to publicize their policies regarding the continuation of insurance benefits during leaves of absence. [Appended: Res. 304, I-23]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 305
(I-24)

Introduced by: New York

Subject: Removing Board Certification as a Requirement for Billing for Home Sleep Studies

Referred to: Reference Committee C

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1 Whereas, 25-30% of men at 9-13% of women in the United States suffer from sleep apnea; and
2
3 Whereas, there is a shortage of board certified Sleep physicians to address this unmet public
4 health threat; and
5
6 Whereas, the Center for Medicare and Medicaid Services (CMS) require onerous requirements
7 for centers and physicians to even provide basic at home sleep testing[1]; and
8
9 Whereas, the American Academy of Sleep Medicine offers an alternative pathway for
10 cardiologists not board certified in Sleep Medicine to seek accreditation in sleep apnea
11 screening for OSA for $4500 for 5 years[2]; and
12
13 Whereas, this pathway is not offered to other licensed physicians and pathways for
14 grandfathering of sleep certification were closed years ago and no post graduate pathway has
15 been made available except leaving practice for a one year fellowship; and
16
17 Whereas, it has never been demonstrated that board certification in sleep apnea results in
18 improved outcomes; therefore be it
19
20 RESOLVED, that our American Medical Association advocate that the appropriate bodies in
21 United States government to remove Sleep Board Certification and facility accreditation as a
22 requirement for the approval of and payment for home sleep studies. (Directive to Take Action)

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

Received: 9/24/2024

**REFERENCES**

1. https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?LCDId=34040
Physician and Technician Requirements for Sleep Studies and Polysomnography Testing:
1. The physician performing the service must meet one of the following:
be a diplomate of the American Board of Sleep Medicine (ABSM);
OR
has a Sleep Certification issued by ONE of the following Boards:
American Board of Internal Medicine (ABIM),
American Board of Family Medicine (ABFM),
American Board of Pediatrics (ABP),
American Board of Psychiatry and Neurology (ABPN),
American Board of Otolaryngology (ABOto),
American Osteopathic Board of Neurology and Psychiatry (AOBNP),
American Osteopathic Board of Family Medicine, (AOBFP)
American Osteopathic Board of Internal Medicine, (AOBIM)
American Osteopathic Board of Ophthalmology and
Otorhinolaryngology (AOBOO);
OR
be an active physician staff member of a credentialed sleep center or laboratory that have active physician staff members meeting the criteria above in a or b.
2. Technician Credentials
The technician performing the service must meet one of the following:
American Board of Sleep Medicine (ABSM),
Registered Sleep Technologist (RST);
Board of Registered Polysomnographic Technologists (BRPT),
Registered Polysomnographic Technologist (RPSGT)
National Board for Respiratory Care (NBRC)
Certified Pulmonary Function Technologist (CPFT)
Registered Pulmonary Function Technologist (RPFT)
Certified Respiratory Therapist (CRT)
Registered Respiratory Therapist (RRT)

2. https://aasm.org/cardiology-practice-accreditation/

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 306
(I-24)

Introduced by: American College of Surgeons

Subject: Streamlining Continuing Medical Education Across States and Medical Specialties

Referred to: Reference Committee C

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1 Whereas, continuing medical education (CME) is a requirement for maintaining licensure in
2 almost every state and for maintenance of certification (MOC), Continuing Certification, or
3 Continuous Certification across multiple medical and surgical specialty boards; and
4
5 Whereas, state medical licensing boards have differing CME requirements for licensure—
6 without a common standard—while over 1 in 5 physicians hold an active license in more than
7 one state; and
8
9 Whereas, federal entities, states, and medical specialty boards may require overlapping CME
10 (e.g., U.S. Drug Enforcement Administration (DEA) opioid education along with state-specific
11 opioid education mandates); and
12
13 Whereas, state and medical specialty boards may additionally require a proportion of CME to be
14 of a specific type (e.g., contain a self-assessment component or be category 1 or 2); and
15
16 Whereas, CME across multiple state or medical specialty boards may require individual entry for
17 each board, which can be repetitive, time consuming, and come at the expense of losing
18 licensure; and
19
20 Whereas, simplified and central reporting of CME exists, such as the Program and Activity
21 Reporting System (PARS) administered by the Accreditation Council for Continuing Medical
22 Education (ACCME); and
23
24 Whereas, central reporting of CME is not universally implemented across all states and medical
25 specialties requiring CME; therefore be it
26
27 RESOLVED, that our American Medical Association work with relevant stakeholders to
28 minimize the financial and time burden of reporting continuing medical education, including but
29 not limited to participation in a common reporting standard (Directive to Take Action); and be it
30 further
31
32 RESOLVED, that our AMA advocate for medical specialty and state medical boards to continue
33 to allow manual entry of continuing medical education until all boards and continuing medical
34 education providers participate in a common reporting standard (Directive to Take Action); and
35 be it further
36
37 RESOLVED, that our AMA work with relevant stakeholders to examine the feasibility of a single
38 common continuing medical education requirement for maintaining state licensure (Directive to
39 Take Action); and be it further

1 RESOLVED, that our AMA advocate any continuing medical education that requires answering
2 questions to be categorized as "Self-Assessment continuing medical education." (Directive to
3 Take Action

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

Received: 9/19/2024

**References:**

Young A., Chaudhry H.J., Pei A., Arnhart K., Dugan M., Simons K.B., (2021) "FSMB Census of Licensed Physicians in the United States, 2020" Journal of Medical Regulation 107(2), 58–59. N

**Relevant AMA Policy:**

**H-300.969 Uniform Standards for Continuing Medical Education**
The AMA (1) will continue its efforts to develop uniform standards for continuing medical education, and (2) will solicit input from all state medical associations, medical licensure boards, and national specialty organizations concerning the development of the most appropriate uniform standards for continuing medical education. [Res. 313, A-92; Reaffirmed: CME Rep. 2, A-03; Reaffirmed in lieu of Res. 901, I-05; Reaffirmed: CME Rep. 1, A-15]

**An Update on Maintenance of Licensure D-275.957**
Our American Medical Association will: 1. Continue to monitor the evolution of Maintenance of Licensure (MOL), continue its active engagement in discussions regarding MOL implementation, and report back to the House of Delegates on this issue.
2. Continue to review, through its Council on Medical Education, published literature and emerging data as part of the Council's ongoing efforts to critically review MOL issues.
3. Work with the Federation of State Medical Boards (FSMB) to study whether the principles of MOL are important factors in a physician's decision to retire or have a direct impact on the U.S. physician workforce.
4. Work with interested state medical societies and support collaboration with state specialty medical societies and state medical boards on establishing criteria and regulations for the implementation of MOL that reflect AMA guidelines for implementation of state MOL programs and the FSMB's Guiding Principles for MOL.
5. Explore the feasibility of developing, in collaboration with other stakeholders, AMA products and services that may help shape and support MOL for physicians.
6. Encourage the FSMB to continue to work with state medical boards to accept physician participation in the American Board of Medical Specialties maintenance of certification (MOC) and the American Osteopathic Association Bureau of Osteopathic Specialists (AOA-BOS) osteopathic continuous certification (OCC) as meeting the requirements for MOL and to develop alternatives for physicians who are not certified/recertified, and advocate that MOC or OCC not be the only pathway to MOL for physicians.
7. Continue to work with the FSMB to establish and assess MOL principles, with the AMA to assess the impact of MOL on the practicing physician and the FSMB to study its impact on state medical boards.
8. Encourage rigorous evaluation of the impact on physicians of any future proposed changes to MOL processes, including cost, staffing, and time. [CME Rep. 3, A-15 Modified: CME Rep. 2, I-15]

**An Update on Maintenance of Licensure H-275.917**
AMA Principles on Maintenance of Licensure (MOL):
1. Our American Medical Association (AMA) established the following guidelines for implementation of state MOL programs:
A. Any MOL activity should be able to be integrated into the existing infrastructure of the health care environment.
B. Any MOL educational activity under consideration should be developed in collaboration with physicians, should be evidence-based and should be practice-specific. Accountability for physicians should be led by physicians.

C. Any proposed MOL activity should undergo an in-depth analysis of the direct and indirect costs, including physicians' time and the impact on patient access to care, as well as a risk/benefit analysis, with particular attention to unintended consequences.
D. Any MOL activity should be flexible and offer a variety of compliance options for all physicians, practicing or non-practicing, which may vary depending on their roles (e.g., clinical care, research, administration, education).
E. Any MOL activity should be designed for quality improvement and lifelong learning.
F. Participation in quality improvement activities, such as chart review, should be an option as an MOL activity.

2. Our AMA supports the Federation of State Medical Boards Guiding Principles for MOL (current as of June 2015), which state that:
A. Maintenance of licensure should support physicians' commitment to lifelong learning and facilitate improvement in physician practice.
B. Maintenance of licensure systems should be administratively feasible and should be developed in collaboration with other stakeholders. The authority for establishing MOL requirements should remain within the purview of state medical boards.
C. Maintenance of licensure should not compromise patient care or create barriers to physician practice.
D. The infrastructure to support physician compliance with MOL requirements must be flexible and offer a choice of options for meeting requirements.
E. Maintenance of licensure processes should balance transparency with privacy protections (e.g., should capture what most physicians are already doing, not be onerous, etc.).

3. Our AMA will:
A. Continue to support and promote the AMA Physician's Recognition Award (PRA) Credit system as one of the three major CME credit systems that comprise the foundation for continuing medical education in the U.S., including the Performance Improvement CME (PICME) format, and continue to develop relationships and agreements that may lead to standards accepted by all U.S. licensing boards, specialty boards, hospital credentialing bodies, and other entities requiring evidence of physician CME as part of the process for MOL.
B. Advocate that if state medical boards move forward with a more intense or rigorous MOL program, each state medical board be required to accept evidence of successful ongoing participation in the ABMS MOC and AOA-Bureau of Osteopathic Specialists Osteopathic Continuous Certification to have fulfilled all three components of the MOL, if performed,
C. Advocate that state medical boards accept programs created by specialty societies as evidence that the physician is participating in continuous lifelong learning and allow physicians to choose which programs they participate in to fulfill their MOL criteria.
D. Oppose any MOL initiative that creates barriers to practice, is administratively unfeasible, is inflexible with regard to how physicians practice (clinically or not), does not protect physician privacy, or is used to promote policy initiatives about physician competence. [CME Rep. 3, A-15Modified: CME Rep. 2, I-15]

**Continuing Board Certification D-275.954**
1. Our American Medical Association will continue to monitor the evolution of Continuing Board Certification (CBC), continue its active engagement in discussions regarding their implementation, encourage specialty boards to investigate and/or establish alternative approaches for CBC, and prepare a report regarding the CBC process at the request of the House of Delegates or when deemed necessary by the Council on Medical Education.
2. Our AMA will continue to review, through its Council on Medical Education, published literature and emerging data as part of the Council’s ongoing efforts to critically review CBC issues.
3. Our AMA will continue to monitor the progress by the American Board of Medical Specialties (ABMS) and its member boards on implementation of CBC, and encourage the ABMS to report its research findings on the issues surrounding certification and CBC on a periodic basis.
4. Our AMA will encourage the ABMS and its member boards to continue to explore other ways to measure the ability of physicians to access and apply knowledge to care for patients, and to continue to examine the evidence supporting the value of specialty board certification and CBC.
5. Our AMA will work with the ABMS to streamline and improve the Cognitive Expertise (Part III) component of CBC, including the exploration of alternative formats, in ways that effectively evaluate acquisition of new knowledge while reducing or eliminating the burden of a high-stakes examination.

6. Our AMA will work with interested parties to ensure that CBC uses more than one pathway to assess accurately the competence of practicing physicians, to monitor for exam relevance and to ensure that CBC does not lead to unintended economic hardship such as hospital de-credentialing of practicing physicians.
7. Our AMA will recommend that the ABMS not introduce additional assessment modalities that have not been validated to show improvement in physician performance and/or patient safety.
8. Our AMA will work with the ABMS to eliminate practice performance assessment modules, as currently written, from CBC requirements.
9. Our AMA will encourage the ABMS to ensure that all ABMS member boards provide full transparency related to the costs of preparing, administering, scoring and reporting CBC and certifying examinations.
10. Our AMA will encourage the ABMS to ensure that CBC and certifying examinations do not result in substantial financial gain to ABMS member boards, and advocate that the ABMS develop fiduciary standards for its member boards that are consistent with this principle.
11. Our AMA will work with the ABMS to lessen the burden of CBC on physicians with multiple board certifications, particularly to ensure that CBC is specifically relevant to the physician's current practice.
12. Our AMA will work with key stakeholders to
a. support ongoing ABMS member board efforts to allow multiple and diverse physician educational and quality improvement activities to qualify for CBC.
b. support ABMS member board activities in facilitating the use of CBC quality improvement activities to count for other accountability requirements or programs, such as pay for quality/performance or PQRS reimbursement.
c. encourage ABMS member boards to enhance the consistency of quality improvement programs across all boards.
d. work with specialty societies and ABMS member boards to develop tools and services that help physicians meet CBC requirements.
13. Our AMA will work with the ABMS and its member boards to collect data on why physicians choose to maintain or discontinue their board certification.
14. Our AMA will work with the ABMS to study whether CBC is an important factor in a physician's decision to retire and to determine its impact on the US physician workforce.
15. Our AMA will encourage the ABMS to use data from CBC to track whether physicians are maintaining certification and share this data with the AMA.
16. Our AMA will encourage AMA members to be proactive in shaping CBC by seeking leadership positions on the ABMS member boards, American Osteopathic Association (AOA) specialty certifying boards, and CBC Committees.
17. Our AMA will continue to monitor the actions of professional societies regarding recommendations for modification of CBC.
18. Our AMA will encourage medical specialty societies' leadership to work with the ABMS, and its member boards, to identify those specialty organizations that have developed an appropriate and relevant CBC process for its members.
19. Our AMA will continue to work with the ABMS to ensure that physicians are clearly informed of the CBC requirements for their specific board and the timelines for accomplishing those requirements.
20. Our AMA will encourage the ABMS and its member boards to develop a system to actively alert physicians of the due dates of the multi-stage requirements of continuous professional development and performance in practice, thereby assisting them with maintaining their board certification.
21. Our AMA will recommend to the ABMS that all physician members of those boards governing the CBC process be required to participate in CBC.
22. Our AMA will continue to participate in the Coalition for Physician Accountability, formerly known as the National Alliance for Physician Competence forums.
23. Our AMA will encourage the PCPI Foundation, the ABMS, and the Council of Medical Specialty Societies to work together toward utilizing Consortium performance measures in Part IV of CBC.
24. Our AMA will continue to assist physicians in practice performance improvement.
25. Our AMA encourage all specialty societies to grant certified CME credit for activities that they offer to fulfill requirements of their respective specialty board's CBC and associated processes.
26. Our AMA will support the American College of Physicians as well as other professional societies in their efforts to work with the American Board of Internal Medicine (ABIM) to improve the CBC program.
27. Our AMA will oppose those maintenance of certification programs administered by the specialty boards of the ABMS, or of any other similar physician certifying organization, which do not appropriately adhere to the principles codified as AMA Policy on Continuing Board Certification.

28. Our AMA will ask the ABMS to encourage its member boards to review their maintenance of certification policies regarding the requirements for maintaining underlying primary or initial specialty board certification in addition to subspecialty board certification, if they have not yet done so, to allow physicians the option to focus on continuing board certification activities relevant to their practice.
29. Our AMA will call for the immediate end of any mandatory, secured recertifying examination by the ABMS or other certifying organizations as part of the recertification process for all those specialties that still require a secure, high-stakes recertification examination.
30. Our AMA will support a recertification process based on high quality, appropriate Continuing Medical Education (CME) material directed by the AMA recognized specialty societies covering the physician's practice area, in cooperation with other willing stakeholders, that would be completed on a regular basis as determined by the individual medical specialty, to ensure lifelong learning.
31. Our AMA will continue to work with the ABMS to encourage the development by and the sharing between specialty boards of alternative ways to assess medical knowledge other than by a secure high stakes exam.
32. Our AMA will continue to support the requirement of CME and ongoing, quality assessments of physicians, where such CME is proven to be cost-effective and shown by evidence to improve quality of care for patients.
33. Our AMA , through legislative, regulatory, or collaborative efforts, will work with interested state medical societies and other interested parties by creating model state legislation and model medical staff bylaws while advocating that Continuing Board Certification not be a requirement for:
a. medical staff membership, privileging, credentialing, or recredentialing.
b. insurance panel participation.
c. state medical licensure.
34. Our AMA will increase its efforts to work with the insurance industry to ensure that continuing board certification does not become a requirement for insurance panel participation.
35. Our AMA will advocate that physicians who participate in programs related to quality improvement and/or patient safety receive credit for CBC Part IV.
36. Our AMA will continue to work with the medical societies and the American Board of Medical Specialties (ABMS) member boards that have not yet moved to a process to improve the Part III secure, high-stakes examination to encourage them to do so.
37. Our AMA, through its Council on Medical Education, will continue to work with the American Board of Medical Specialties (ABMS), ABMS Committee on Continuing Certification (3C), and ABMS Stakeholder Council to pursue opportunities to implement the recommendations of the Continuing Board Certification: Vision for the Future Commission and AMA policies related to continuing board certification.
38. Our AMA, through its Council on Medical Education, will continue to work with the American Board of Medical Specialties (ABMS) and ABMS member boards to implement key recommendations outlined by the Continuing Board Certification: Vision for the Future Commission in its final report, including the development and release of new, integrated standards for continuing certification programs that will address the Commission's recommendations for flexibility in knowledge assessment and advancing practice, feedback to diplomates, and consistency.
39. Our AMA will work with the ABMS and its member boards to reduce financial burdens for physicians holding multiple certificates who are actively participating in continuing certification through an ABMS member board, by developing opportunities for reciprocity for certification requirements as well as consideration of reduced or waived fee structures.
40. Our AMA will continue to publicly report its work on enforcing AMA Principles on Continuing Board Certification.[CME Rep. 2, I-15 Appended: Res. 911, I-15 Appended: Res. 309, A-16 Appended: CME Rep. 02, A-16 Appended: Res. 307, I-16 Appended: Res. 310, I-16 Modified: CME Rep. 02, A-17 Reaffirmed: Res. 316, A-17 Reaffirmed in lieu of: Res. 322, A-17 Appended: CME Rep. 02, A-18 Appended: Res. 320, A-18 Appended: Res. 957, I-18 Reaffirmation: A-19 Modified: CME Rep. 02, A-19 Appended: CME Rep. 1, I-20 Appended: Res. 310, A-21 Modified: CME Rep. 2, A-22 Appended: Res. 310, I-22 Reaffirmed in lieu of: Res. 302, A-24 Reaffirmed in lieu of: Res. 316, A-24]