REPORTS OF THE COUNCIL ON MEDICAL EDUCATION

The following reports, 1–9, were presented by Mahendr S. Kochar , MD, Chair:

1. ANNUAL REPORT ON AMA MEDICAL EDUCATION ACTIVITIES: 2012

Informational report; no reference committee hearing.

HOUSE ACTION: FILED

This informational report summarizes the major activities of the Council on Medical Education and American Medical Association (AMA) Medical Education Group during 2012. For more information on the Council on Medical Education, see www.ama-assn.org/go/councilmeded.

THE COUNCIL ON MEDICAL EDUCATION

The Council on Medical Education formulates policy on medical education by recommending educational policies to the AMA House of Delegates through the AMA Board of Trustees. The Council's 12 members include a medical student and resident physician representative.

In 2012, the Council submitted 10 reports for consideration by the House of Delegates at the Annual Meeting and two reports at the Interim Meeting along with a memorial resolution. Reports typically are developed with advice and input from other areas in the AMA, especially the Section on Medical Schools, the Resident and Fellow Section, and the Medical Student Section. In addition, the Council continued to work closely with the AMA Board of Trustees and staff in the AMA's Washington, DC office on several key issues, including medical student debt, graduate medical education funding, resident physician duty hours, and physician workforce issues. To proactively formulate policy and address current issues, the Council has two task forces—Maintenance of Certification/Maintenance of Licensure and Physician Workforce—as well as its subcommittees on undergraduate medical education, graduate medical education, and continuing medical education.

In 2012, the Council worked with leaders of other key health care organizations and initiatives:

- Association of American Medical Colleges (AAMC) (including its Physician Workforce Meeting)
- Accreditation Council for Graduate Medical Education (ACGME)
- Accreditation Council for Continuing Medical Education (ACCME)
- Accreditation Review Commission on Education for the Physician Assistant
- Coalition for Physician Accountability
- Commission on Accreditation of Allied Health Education Programs (CAAHEP)
- Commission to End Health Care Disparities
- Council of Deans Administrative Meeting
- Innovative Strategies for Transforming the Education of Physicians (ISTEP)
- Interprofessional Healthcare Conference
- Liaison Committee on Medical Education (LCME)
- National Board of Medical Examiners (and its Advisory Committee for Medical School Programs)
- National Resident Matching Program

One core activity of the Council is to identify and recommend qualified nominees to serve on organizations involved in medical education, accreditation and certification. Nominations are reviewed by the AMA Board of Trustees. The nominations process involves solicitation of qualified AMA members from across the Federation and a careful review to identify knowledgeable individuals who will work to enhance medical education. During 2012, the Council vetted candidates and made recommendations to the BOT for over 30 AMA nominations and reappointments to external boards and committees.

As part of its role in monitoring professional standards in medical education and credentialing, the Council reviews and comments on proposed changes in medical education accreditation, licensure, and certification standards. In 2012, the Council reviewed the LCME's revised standards and proposed rules. In addition, the Council reviewed and commented on the ACCME's proposed bylaws and 74 sets of new or revised program requirements of the

ACGME. The Council also reviewed and provided comments on the draft Report of the Maintenance of Licensure Workgroup on Clinically Inactive Physicians from the Federation of State Medical Boards (FSMB). Finally, the Council approved a revised agreement with the Royal College of Physicians and Surgeons of Canada to award AMA PRA Category 1 Credit™.

The Council also collaborated with other AMA entities:

- Section on Medical Schools (SMS) on stakeholder input to the Council on Long Range Planning and Development for 2014 AMA planning
- BOT on the AMA Task Force on Invasive Procedures
- Council on Ethical and Judicial Affairs on amendments to CEJA Opinion 9.011 on Continuing Medical Education
- Council on Constitution and Bylaws on the joint report pertaining to the bylaws change related to private practitioner requirement/election
- Council on Medical Services on a joint report on physician-led interprofessional teams; a manuscript based on this report is being prepared for publication.

Other Council activities in 2012:

- Implemented new systems/formats for:
  - Vetting and posting virtual testimony for the Annual and Interim Meetings
  - Convening sections to discuss reports/resolutions/issues of common interest
- Hosted Stakeholders Forum during A-12 for 11 organizations and the Section on Medical Schools (SMS) to discuss physician workforce issues
- Conducted required review and made recommendations for changes to the Council's Rules and Regulations
- Served as judges for the AMA Research Symposium during the I-12 meeting

Also in 2012, the Council engaged in a strategic planning process to identify priorities and focus its work for the next three to five years. The four priority strategies that the Council agreed upon as a result of this process are:

1. Interface: Study the impact between residency and undergraduate medical education as well as continuing medical education.
2. Competency-based education (milestones): Work with the ACGME on its milestones project and competencies across the continuum.
3. Enhance inter-professional relationships (team building).
4. Ensure MOC/MOL processes are evidence-based.

SECTION ON MEDICAL SCHOOLS

The SMS (www.ama-assn.org/go/sms) provides the leaders and faculty of all medical schools accredited by the LCME or American Osteopathic Association (AOA) a voice in House of Delegates deliberations and offers a forum for discussing and developing policies on medical education and national research and health care issues.

During the Annual and Interim Meetings, the Section provides education programs on issues of importance to the academic community. In June 2012, the Section held sessions looking at how the "hidden curriculum" can subvert the formal curriculum, and the medical school's mission and values, and lead to a decline in medical student professionalism, empathy and ethics. In November 2012, the meeting's educational focus was the medical student mistreatment vis-à-vis resident physicians.

Increasing AMA membership among academic physicians continues to be a top priority for the AMA-SMS and its governing council. The governing council and staff are assisting in promoting an AMA academic leadership group membership program (which was in place at 10 medical schools by year end) that offers special group membership pricing to the medical school leadership.

Finally, the AMA-SMS Office coordinated a session at the AAMC Annual Meeting highlighting the AMA's new strategic focus to accelerate change in medical education.

MEDICAL EDUCATION GROUP ACTIVITIES

In addition to the work of the Council and the SMS, the AMA is working to transform medical education through the work of the AMA's Center for Transforming Medical Education. In June 2012, the AMA announced that accelerating change in medical education would be one of its three key areas of strategic focus. Through this initiative, the AMA will support eight to 10 medical schools by funding bold innovations in medical education. These projects will:

- Develop new methods for teaching and/or assessing key competencies for medical students, including the use of flexible, individualized learning plans.
- Promote exemplary methods to achieve patient safety, performance improvement and patient-centered, team-based care.
- Improve medical students' understanding of the health care system and health care financing.
- Optimize the learning environment to support development of professional values and ideals.

The Council offered ongoing input and support to the AMA strategic initiative; it identified gaps during the medical education environmental scan and appointed a Council member to serve on the initiative's National Advisory Panel.

In 2012, the AMA also continued its work on a study of the medical education learning environment through a broad consortium of 28 medical schools nationwide and in Canada, with data being collected from approximately 4,800 medical students. Work is ongoing to identify factors in the learning environment that either inhibit or promote the acquisition of professional values and the demonstration of professional behaviors by medical students and resident physicians.

As part of the AMA's work in addressing these and other critical issues in medical education, staff supports and coordinates the work of Reference Committee C at the Annual Meeting of the AMA House of Delegates and Reference Committee K at the Interim Meeting. This work helps ensure that AMA policy and activities reflect the needs of academic physicians as well as medical students, resident/fellow physicians, and patients.

The monthly email newsletter *AMA MedEd Update*, distributed free to 30,000 subscribers, provides news, information, and updates on medical education activities at the AMA and other organizations.

Undergraduate Medical Education

The LCME, sponsored by the AMA and the AAMC, is responsible for accrediting medical education programs in the US and, in collaboration with the Committee on the Accreditation of Canadian Medical Schools, in Canada. During 2012, five additional medical schools received LCME preliminary accreditation, bringing the total number of accredited medical schools in the United States to 141. In addition, three applicant schools are in the pipeline for accreditation by the LCME. Information on developing medical schools is available at www.lcme.org.

During 2012, the LCME received renewed recognition by the United States Department of Education. The LCME also began the process to obtain recognition from the World Federation for Medical Education. In addition, the AMA and the AAMC formalized their partnership as LCME sponsors in a memorandum of understanding (MOU) outlining their joint, ongoing commitment to supporting the medical education accreditation process. The MOU specifies formation of a new nine-member advisory council, with three members from the AMA, three from the AAMC and three from the LCME, charged with enhancing communication, improving planning and facilitating sharing of best practices.

Under the auspices of the LCME, an annual survey is sent to the deans of all LCME-accredited US medical schools. The 2012 survey had a 100% response rate. The survey allows the LCME to track trends related to the curriculum and evaluation methods used in medical schools. Data from the survey are published as Appendix tables in the annual medical education issue of *Journal of the American Medical Association (JAMA)* and shared with members of various stakeholder groups on request.

Graduate Medical Education

The AMA works to ensure the quality of graduate medical education and the appropriate number and mix of physicians. For example, FREIDA Online®, an Internet database with information on more than 9,300 ACGME-accredited and ABMS board-approved GME programs and 1,700 GME teaching institutions, is a popular source of information for medical students. During 2012, FREIDA Online received over 1.5 million visits. Furthermore, the AMA (in collaboration with the AAMC) administered the National GME Census, which collects key residency program and resident/fellow data; these data were published in the medical education issue of *JAMA* and via FREIDA Online. Finally, staff developed and published new editions of the *Graduate Medical Education Directory*, *Electronic State-level GME Data*, *State Medical Licensure Requirements and Statistics*, and *Health Care Careers Directory*.

Through the Council, the AMA also worked to raise awareness of the need to fund GME residency positions to meet the nation's current and coming needs for access to health care services. For example, during the A-12 meeting, the Council hosted a meeting of interested stakeholders to discuss physician workforce issues. On October 15, the AMA sent a letter to Representative Joseph Crowley in support of H.R. 6562, the "Resident Physician Shortage Reduction Act of 2012," which would expand the number of Medicare-supported GME positions by 15 percent (an additional 15,000 positions) over five years. In addition, on December 19, Susan Skochelak, MD, provided testimony on behalf of the Council and the AMA to the Institute of Medicine Committee on Governance and Financing of Graduate Medical Education. (www.ama-assn.org/resources/doc/washington/graduate-medical-education-testimony-19dec2012.pdf).

Continuing Physician Professional Development (CPPD)

The Division of CPPD (www.ama-assn.org/go/cppd) provides support to the Council on Medical Education in relation to continuing medical education (CME) policies and trends. In addition, the Council has delegated responsibility for administering the AMA's accredited CME program to the Division. To ensure effective liaison to key continuing medical education organizations, CPPD staff hold committee appointments for 13 such organizations and serve in defined leadership positions for six organizations.

Nearly 200,000 certificates were awarded to physicians for participating in CME activities offered by the AMA in 2012. The AMA currently awards AMA PRA Category 1 Credit™ for live activities, enduring materials (both print-based and online), journal-based CME activities, manuscript review and Performance Improvement CME activities. In addition, members of the CPPD team took a leadership role in the development of the AMA's new online learning management system. By the end of 2012, 40 CME activities were available via this new online learning center.

The CPPD team presented a webinar on the AMA PRA credit system in March 2012, reaching more than 100 CME professionals. In addition, members of the CPPD team represented the AMA by providing presentations at meetings convened by the ACCME, Association for Hospital Medical Education, Illinois Alliance for Continuing Medical Education and Alliance for Continuing Education in the Health Professions.

CPPD also hosted the fifth annual roundtable meeting with representatives from state medical societies recognized by the ACCME to accredit intrastate providers. This meeting provided an opportunity to discuss several issues related to the AMA PRA credit system, including three current AMA PRA credit system pilots, Maintenance of Licensure progress, PI CME, and updates on the AMA strategic initiatives and AMA House of Delegates resolutions and reports.

In October 2012, nearly 400 participants attended the 22nd Annual Conference of the National Task Force on CME Provider/Industry Collaboration, held in Baltimore, MD. The theme for the conference was "Forces Shaping the Future of CME Collaboration: Solutions for Harnessing the Positive and Mitigating the Negative." The conference focused on four significant forces shaping the future of CME Provider and Industry Collaboration including; cost constraints, quality improvement, risk evaluation and mitigation strategy (REMS), and maintenance of certification.

2. COUNCIL ON MEDICAL EDUCATION SUNSET REVIEW OF 2003 HOUSE POLICIES

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: RECOMMENDATIONS ADOPTED AND REMAINDER OF REPORT FILED

At its 1984 Interim Meeting, the House of Delegates established a sunset mechanism for House policies (Policy G-600.110). Under this mechanism, a policy established by the House ceases to exist after 10 years unless action is taken by the House to retain it. The objective of the sunset mechanism is to help ensure that the AMA Policy Database is current, coherent, and relevant. By eliminating outmoded, duplicative, and inconsistent policies, the sunset mechanism contributes to the ability of the AMA to communicate and promote its policy positions. It also contributes to the efficiency and effectiveness of House of Delegates deliberations.

At its 2012 Annual Meeting, the House amended Policy G-600.110, which now reads as follows:

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

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

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

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

6. Sunset policies will be retained in the AMA historical archives. (BOT Rep. PP, I-84; CLRPD Rep. A, A-89; Reaffirmed:CLRPD Rep. 3 - I-94; Reaffirmed: CLRPD Rep. 2 and 5, I-95; Reaffirmed: Sunset Report, A-00; Consolidated: CLRPD Rep. 3, I-01; Modified: CLRPD Rep. 1, A-02; Modified: CLRPD Rep. 5, A-03; Modified: CCB/CLRPD Rep. 1, A-12)

The Council on Medical Education's recommendations on the disposition of the 2003 House policies that were assigned to it are included in the Appendix to this report.

RECOMMENDATION

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

APPENDIX – Recommended Actions on 2003 and Other Related House of Delegates' Policies

Policy Number	Title	Recommended Action
HOUSE OF DELEGATES' POLICIES		
H-30.952	Education Grant Support From the Licensed Beverage Information Council	Rescind; this organization is no longer in existence.
H-35.978	Education Programs Offered to, for or by Allied Health Professionals Associated with a Hospital	Retain; still relevant.
H-40.973	Support of the Uniformed Services University of the Health Sciences	Rescind; this is replicated by H-40.970 The Uniformed Services University of the Health Sciences: "The AMA fully supports the continuation of the Uniformed Services University of the Health Sciences as an institution and urges the Executive and Legislative Branches of the United States Government to fulfill their responsibility to our armed forces by fully funding the Uniformed Services University of the Health Sciences."
H-45.984	Proposed Excessive Federal Fees for Aviation Medical Examiners	Rescind; no longer relevant.
H-85.969	Preserving the Vital Role of the Autopsy in Medical Education	Retain; still relevant.
H-95.960	MDs/DOs as Medical Review Officers	Retain in part. Recommendation 3 is too limiting; medical schools, for example, or groups like the AMA, among others, could provide such activities. "The AMA (1) reaffirms its policy that only licensed MDs/DOs with knowledge of substance use disorders should serve as Medical Review Officers (MROs); (2) reaffirms its policy that all MDs/DOs who serve as MROs should obtain continuing medical education credit in this subject area; ~~(3) urges that MROs obtain continuing medical education through courses offered by appropriate recognized medical specialty societies;~~ and (3~~4~~) vigorously opposes legislation that is inconsistent with these policies."
H-200.992	Designation of Areas of Medical Need	Retain.
H-200.994	Health Workforce	Retain.
H-235.973	Resident Medical Staffs in US Training Hospitals	Rescind; the AMA no longer takes an active role in establishing collective bargaining among resident/fellow physicians in teaching hospitals.
H-255.970	Employment of Non-Certified IMGs	Retain.
H-255.976	Speech Tests for International Medical Graduates	Retain.
H-255.985	Graduates of Foreign Health Professional Schools	Retain.
H-270.974	Acupuncture	Retain.
H-275.959	Cognitive Exams	Retain. Although AMA Policy H-275.978 (18) reflects this concern, that policy is pertinent to medical licensure, not to certification: Our AMA "urges licensing boards to base endorsement on an assessment of physician competence and not on passing a written examination of cognitive ability, except in those instances when information collected by a licensing board indicates need for such an examination."
H-275.998	Physician Competence	Retain.
H-295.881	Clinical Skills Assessment Exam	Rescind; this examination is already in place.
H-295.927	Medical Student Health and Well-Being	Retain.
H-295.931	Pesticide-Herbicide Toxicity Instruction	Rescind; the AMA is against recommending specific curricular mandates.
H-295.933	Medical School Affiliations With VA Medical Centers	Retain.

Policy Number	Title	Recommended Action
H-295.934	Physician Training in Health Care Management and Administration	Rescind; reflected in H-295.924 Future Directions for Socioeconomic Education.
H-295.937	Medical Students Infected with Bloodborne Pathogens	Rescind; employers and schools are not allowed to discriminate against students with AIDS or HIV under the Americans with Disabilities Act.
H-295.938	Medical Education Accreditation	Rescind; already reflected in H-310.997, Accreditation of Graduate Medical Education Programs, which states, in part, "(b) accreditation and certification programs in graduate medical education should not be administered as a means of regulating or restricting the number of physicians entering any specialty or field of medical practice; and . . . (2) The AMA opposes use of the accreditation and certification process as a means of controlling the number of physicians in any specialty or field of medical practice."
H-295.939	OSHA Regulations for Students	Retain
H-295.940	Recruiting Students of Medicine at the Elementary and High School Levels	Retain.
H-295.941	Policies for the Admission of Students from Underserved Areas to Medical Schools	Rescind; reflected in H-350.960 Underrepresented Student Access to US Medical Schools, H-350.978 Minorities in the Health Professions, and H-350.979 Increase the Representation of Minority and Economically Disadvantaged Populations in the Medical Profession.
H-295.948	Health and Disability Insurance for Medical Students	Rescind; already covered in H-295.942 Providing Dental and Vision Insurance to Medical Students and Resident Physicians.
H-295.984	Family Medicine as a Fundamental Subject in Medical Schools	Retain; still relevant.
H-295.992	Medical Student Education Concerning Physician Impairment	Rescind; reflected in H-295.979 Substance Abuse.
H-300.960	Promoting Physician Access to Quality Continuing Medical Education Programs	Rescind. The ACCME is now an independently incorporated organization. The AMA does not have representatives to ACCME; rather, the AMA nominates individuals to be members of its Board of Directors with fiduciary responsibility to the ACCME.
H-300.964	Medical Ethics and Continuing Medical Education	Retain.
H-300.965	The FDA and Continuing Medical Education Supported by Industry	Rescind; recommendation one refers to an event that occurred in 1992. Further, the "guidelines and clear concepts of independence for activities supported by commercial companies" are currently the AMA's Ethical opinions and the ACCME's Standards for Commercial Support which were originally, in their first iteration, guided by the work of the Task Force. For recommendation two, there are no FDA policies on CME, so there is nothing to monitor.
H-300.966	Continuing Medical Education for Physicians in the Hospital Setting	Retain; still relevant.
H-300.968	Protocol for Recognition of State Medical Society Accreditation Programs	Retain in part; recommendation 1 is outdated, but recommendations 2 and 3 are still of concern. "The AMA ~~(1) reaffirms that proposed changes in the Protocol for the Recognition of State Medical Societies to Accredit Intrastate Continuing Medical Education Sponsors, including Guidelines for the Interpretation of the Criteria, be considered matters subject to the review and approval of the ACCME, in accordance with ACCME Bylaws; (2)~~ (1) urges the ACCME Committee for Review and

Policy Number	Title	Recommended Action
		Recognition of State Medical Societies (CRR) to take into consideration the demographic diversity, geographic differences, and varying resources of states when evaluating state medical society accreditation processes; and (~~3~~2) urges the ACCME and CRR to develop reasonable alternate mechanisms (without lowering essential standards) for creating accreditable CME programs in those states and portions of states designated by the federal government as "rural" and whose resources may vary significantly from the norm."
H-300.988	Restoring Integrity to Continuing Medical Education	Retain in part. Under (1): The second definition is used in the AMA-PRA booklet. Under (3): the revised Essentials have undergone multiple changes since the original language shown here. "The AMA (1) supports retention of the definitions of continuing medical education in the Physicians' Recognition Award ~~("Continuing medical education is composed of any education or training which serves to maintain, develop or increase the knowledge, interpretive and reasoning proficiencies, applicable technical skills, professional performance standards or ability for interpersonal relationships that a physician uses to provide the service needed by patients or the public.") and revised ACCME Essentials~~ ("Continuing medical education consists of educational activities which serve to maintain, develop, or increase the knowledge, skills, and professional performance and relationships that a physician uses to provide services for patients, the public, or the profession. The content of CME is that body of knowledge and skills generally recognized and accepted by the profession as within the basic medical sciences, the discipline of clinical medicine, and the provision of health care to the public."); (2) urges members of the medical profession to be attentive to the distinction between continuing medical education and continuing education which is not related directly to their professional activities; (3) believes that accredited sponsors should designate as continuing medical education only those continuing education activities which meet the definition of continuing medical education ~~in the revised ACCME Essentials~~; (4) encourages the ACCME and state medical associations on the state level to weigh seriously, in considering the sponsor's continued accreditation, instances where an accredited sponsor identifies non-continuing medical education activities as continuing medical education; and (5) encourages state medical boards to accept for credit continuing education which relates directly to the professional activities of physicians, although each state with mandatory continuing medical education for reregistration of license has the prerogative of defining the continuing education it will accept for credit."
H-305.932	State and Local Advocacy on Medical Student Debt	Retain.

Policy Number	Title	Recommended Action
H-310.944	Obstetrics and Gynecology Training in Termination of Pregnancy	Rescind; the specific language is contained in the ACGME Program Requirements for Obstetrics and Gynecology, effective Jan. 1, 2008 (IV.A.2.d): http://acgme.org/acgmeweb/Portals/0/PFAssets/ProgramRequirements/220obstetricsandgynecology01012008.pdf
H-310.946	Training Physicians in Non-Traditional Sites	Retain.
H-310.947	Revision of the "General Requirements" of the Essentials of Accredited Residency Programs	Retain.
H-310.952	Housestaff Input During the ACGME Review Process	Retain.
H-310.953	Practice Options and Skills Curriculum for Residents	Retain.
H-310.997	Accreditation of Graduate Medical Education Programs	Retain.
H-330.950	Post-Licensure Assessment as a Condition for Physician Participation in Medicare	Retain.
H-350.964	Racial Ethnic Disparities in Health Care	Rescind; reflected in H-350.969 Medical Education for Members in Underserved Minority Populations: "Our AMA: (1) actively opposes the reduction of resources and opportunities used to increase the number of minority medical and premedical students in training…."
H-355.986	Peer Review Implications of Adding Allied Health Practitioners to National Practitioner Data Bank	Rescind; this is covered by H.355.990.
H-355.988	Access to National Practitioner Data Bank	Rescind; covered by H.355.999, Minimum Reporting Requirements to National Practitioner Data Bank: "(4) physicians should not be required to turn over copies of their Data Bank file to anyone not authorized direct access to the Data Bank."
H-355.989	Access to National Practitioner Data Bank "Self-Query" Reports	Retain.
H-355.990	National Practitioner Data Bank	Retain.
H-360.983	Registered Nurse Participation in Epidural Analgesia	Retain.
H-360.997	Nursing Education	Retain; still relevant.
HOUSE OF DELEGATES' DIRECTIVES		
D-200.992	US Physician Shortage	Rescind; directive fulfilled, and this is an ongoing AMA priority (reflected in our advocacy for expanded graduate medical education).
D-200.995	Federal Grants to Serve Medically Underserved Areas	Rescind; directive fulfilled.
D-255.990	Nondiscrimination in Residency Selection	Rescind; accomplished.
D-255.992	Opposition to Employment of Non-certified International Medical Graduates	Rescind; the directive has been accomplished, and the rationale behind the directive is reflected in H-255.970, Employment of Non-Certified IMGs.
D-275.966	Eliminating Disparities in Licensure for IMG Physicians	Rescind; reflected in D-275.978 Initial State Licensure: "Our AMA will work with the Federation of State Medical Boards, state medical societies, state medical boards, and state legislatures, to eliminate the additional graduate medical education requirements imposed on IMGs for an unrestricted license, in the earnest hope of implementing AMA Policy H-275.985. (Res. 831, I-04)."
D-275.985	Clinical Skills Assessment Exam and College of Osteopathic Medicine Licensing Exam-Physical Exam Implementation	Rescind. The Council on Medical Education issued two reports at A-04 in response to this resolution. These reports offered updated recommendations that address the concerns of this policy, and, therefore, make this policy outdated (See D-275.981 Potential Impact of the USMLE Step 2 CS and COMLEX-PE on Undergraduate and Graduate Medical Education).

Policy Number	Title	Recommended Action
D-275.986	Developing Rational Role for USMLE Step Exams	Rescind; this directive called for a specific study, which has already occurred.
D-295.959	Musculoskeletal Care in Graduate Medical Education	Rescind.
D-295.961	Proposed Consolidation of Liaison Committee on Medical Education Offices	Rescind; the AMA/Association of American Medical Colleges memorandum of understanding confirms the dual structure.
D-300.991	Web-Based System for Registering CME Credits	Rescind; the Council on Medical Education is examining this issue through an A-13 report on retention and availability of CME participation records.
D-300.992	Internet-Based Continuing Medical Education	Rescind; has been accomplished, and these activities will continue without the need for an AMA directive.
D-305.979	State and Local Advocacy on Medical Student Debt	Retain in part. "Our AMA will: (1) support and encourage our state medical societies to support further expansion of state loan repayment programs, and in particular expansion of those programs to cover physicians in non-primary care specialties; and (2) urge state medical societies to actively solicit funds (either directly or through their Foundations) for the establishment and expansion of medical student scholarships, and that our AMA develop a set of guidelines and suggestions to assist states in carrying out such initiatives.~~; and (3) study the merits of an annual tuition cap (adjusted for inflation) at public and private medical schools within their states.~~"
D-305.983	Strategies to Combat Mid-year and Retroactive Tuition Increases	Retain in part. Rescind recommendation (3)—which is already reflected in D-305.978—and recommendation (5), as this report already occurred (CME 3-I-04). "Our AMA will: (1) assist state medical societies in advocacy efforts in opposition to mid-year and retroactive tuition increases; (2) make available, upon request, the judicial precedent that would support a successful legal challenge to mid-year tuition increases; ~~(3) identify and disseminate information about model financial aid programs for medical students that have the potential to reduce student debt;~~ and (4) continue to encourage individual medical schools and universities, federal and state agencies, and others to expand options and opportunities for financial aid to medical students.~~; and (5) study the funding of medical education programs, to identify: (a) The status of revenue sources used to support undergraduate and graduate medical education programs, including current constraints on these revenue sources; (b) Strategies to reduce these financial constraints; and (c) Mechanisms to ensure that funding for undergraduate and graduate medical education programs is maintained, so as to reduce the financial burden on medical students and resident physicians.~~
D-305.986	Recognizing Spouse and Dependent Care Expenses in Determining Medical Education Financial Aid	Retain in part. Rescind (3), which has been fulfilled; the AMA is now actively lobbying in Congress on this matter. Rescind (4), as the 2004 Annual meeting has already occurred. "Our AMA will: (1) work with the Liaison Committee on Medical Education to require, as part of the accreditation standards for medical schools, that

Policy Number	Title	Recommended Action
		dependent health insurance, dependent care, and dependent living expenses be included both as part of the "cost of attendance" and as an educational expense for the purposes of student budgets and financial aid in medical schools; and (2) encourage medical schools to include spouse and dependent health insurance, dependent care, and dependent living expenses as part of the "cost of attendance" and as an educational expense for the purposes of student budgets and financial aid.; ~~(3) ask its Council on Medical Education, Section on Medical Schools, and Women Physicians Congress to consider options to carry out the intentions of current House of Delegates' policy on the issue of spouse and dependent health insurance, dependent care, and dependent living expenses; and (4) report back on actions taken on this resolution, and their results, to the House of Delegates at the 2004 Annual Meeting.~~
D-310.999	Clinical Supervision of Resident Physicians by Non-Physicians	Rescind; these issues have been addressed in the duty hours' regulations subsequent to the passing and reaffirmation of the resolution.
D-350.994	Continued Support for Diversity in Medical Education	Rescind; reflected in H-350.969 Medical Education for Members in Underserved Minority Populations: "Our AMA: (1) actively opposes the reduction of resources and opportunities used to increase the number of minority medical and premedical students in training…."
D-360.995	Clinical Skills For Labor and Delivery Nurses	Rescind; accomplished.
D-360.998	The Growing Nursing Shortage in the United States	Retain; still relevant.

H-30.952 Education Grant Support From the Licensed Beverage Information Council
The AMA will: (1) not accept funding directly from beer, wine, and distilled spirits companies for the support of any AMA program; (2) continue to accept educational grants from the Licensed Beverage Information Council (LBIC) in order to augment its current educational activities designed to protect the health of the public, provided that the following criteria are followed: (a) the AMA continues to apply the Standards for Commercial Support of Continuing Medical Education of the ACCME, but in the selection of topics and faculty, and in program development, the AMA will be independent of LBIC input; (b) the AMA maintains complete control of the promotion and distribution of the CME materials produced and accepts no accompanying informational materials to its programs without prior review and approval; and (c) all AMA video or printed continuing education programs must contain a message to physicians that explains the AMA policy regarding alcohol abuse and dependence. (BOT Rep. AAA, A-93; Reaffirmed: CLRPD Rep. 5, A-03)

H-35.978 Education Programs Offered to, for or by Allied Health Professionals Associated with a Hospital
The AMA encourages hospital medical staffs to have a process whereby physicians will have input to and provide review of education programs provided by their hospital for the benefit of allied health professionals working in that hospital, for the education of patients served by that hospital, and for outpatient educational programs provided by that hospital. (BOT Rep. B, A-93; Adopts Res. 317, A-92; Reaffirmed: CME Rep. 2, A-03)

H-40.973 Support of the Uniformed Services University of the Health Sciences
The AMA vigorously supports the continuance of the Uniformed Services University of the Health Sciences as vital to the continued strength, morale, and operational readiness of the military services. (Sub. Res. 306, I-93; Reaffirmed: CME Rep. 2, A-03)

H-45.984 Proposed Excessive Federal Fees for Aviation Medical Examiners
The AMA opposes any regulation requiring aviation medical examiners (AMEs) to attend seminars with excessive registration fees and opposes any legislation imposing a fee for serving as an AME for the Federal Aviation Administration. (Res. 209, I-93; Reaffirmed: CME Rep. 2, A-03)

H-85.969 Preserving the Vital Role of the Autopsy in Medical Education
(1) The AMA representatives to the Liaison Committee on Medical Education ask that autopsy rates and student participation in autopsies continue to be monitored periodically and that the reasons that schools do or do not require attendance be collected. (2)

The AMA will continue to work with other interested groups to increase the rate of autopsy attendance. (CME Rep. A, I-92; Reaffirmed: CME Rep. 2, A-03)

H-95.960 MDs/DOs as Medical Review Officers
The AMA (1) reaffirms its policy that only licensed MDs/DOs with knowledge of substance use disorders should serve as Medical Review Officers (MROs); (2) reaffirms its policy that all MDs/DOs who serve as MROs should obtain continuing medical education credit in this subject area; (3) urges that MROs obtain continuing medical education through courses offered by appropriate recognized medical specialty societies; and (4) vigorously opposes legislation that is inconsistent with these policies. (Res. 312, A-92; Reaffirmed: CME Rep. 2, A-03)

H-200.992 Designation of Areas of Medical Need
The AMA urges the federal government to: (1) consolidate the federal designation process for identifying areas of medical need; (2) coordinate the federal designation process with state agencies to obviate duplicative activities; and (3) ask for state and local medical society approval of said designated underserved areas. (Res. 24, A-82; Amended: CLRPD Rep. A, I-92; Reaffirmed: CME Rep. 2, A-03)

H-200.994 Health Workforce
The AMA endorses the following principle on health manpower: Both physicians and allied health professionals have legal and ethical responsibilities for patient care, even though ultimate responsibility for the individual patient's medical care rests with the physician. To assure quality patient care, the medical profession and allied health professionals should have continuing dialogue on patient care functions that may be delegated to allied health professionals consistent with their education, experience and competency. (BOT Rep. C, I-81; Reaffirmed: Sunset Report, I-98; Modified: CME Rep. 2, I-03)

H-235.973 Resident Medical Staffs in US Training Hospitals
The AMA will work with the AMA Resident and Fellow Section, the AMA Organized Medical Staff Section, state resident and fellow sections, state medical societies, and state and national medical staff services organizations toward the goal of establishing Resident and Fellow Organizations in all U.S. training hospitals. (Res. 835, A-93; Modified: CME Rep. 2, A-03)

H-255.970 Employment of Non-Certified IMGs
Our AMA will: (1) oppose efforts to employ graduates of foreign medical schools who are neither certified by the Educational Commission for Foreign Medical Graduates, nor have met state criteria for full licensure; and (2) encourage states that have difficulty recruiting doctors to underserved areas to explore the expanded use of incentive programs such as the National Health Service Corps or J1 or other visa waiver programs. (Res. 309, A-03)

H-255.976 Speech Tests for International Medical Graduates
The AMA encourages state licensing boards to accept ECFMG certification in satisfaction of requirements for demonstrating English language competence. (CME Rep. B, A-93; Reaffirmed: CME Rep. 2, A-03)

H-255.985 Graduates of Foreign Health Professional Schools
(1) Any United States or alien graduate of a foreign health professional education program must, as a requirement for entry into graduate education and/or practice in the United States, demonstrate entry-level competence equivalent to that required of graduates of United States' programs. Agencies recognized to license or certify health professionals in the United States should have mechanisms to evaluate the entry-level competence of graduates of foreign health professional programs. The level of competence and the means used to assess it should be the same or equivalent to those required of graduates of U.S. accredited programs. (2) All health care facilities, including governmental facilities, should adhere to the same or equivalent licensing and credentialing requirements in their employment practices. (BOT Rep. NN, A-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: Res. 320 and Res. 305, A-03; Reaffirmed: CME Rep. 1, I-03)

H-270.974 Acupuncture
It is the policy of the AMA that nonphysician boards should not regulate the clinical practice of medicine. (CME Rep. M, A-93; Modified: CME Rep. 2, A-03)

H-275.959 Cognitive Exams
It is the policy of the AMA to oppose the use of cognitive exams as the major means of evaluating a physician's clinical competence. (Sub. Res. 205, A-90; Modified: Sunset Report, I-00; Reaffirmed: CME Rep. 2, A-10)

H-275.998 Physician Competence
Our AMA urges: (1) The members of the profession of medicine to discover and rehabilitate if possible, or to exclude if necessary, the physicians whose practices are incompetent. (2) All physicians to fulfill their responsibility to the public and to their profession by reporting to the appropriate authority those physicians who, by being impaired, need help, or whose practices are incompetent. (3) The appropriate committees or boards of the medical staffs of hospitals which have the responsibility to do so, to restrict or remove the privileges of physicians whose practices are known to be incompetent, or whose capabilities are impaired, and to restore such physicians to limited or full privileges as appropriate when corrective or rehabilitative measures have been successful. (4) State governments to provide to their state medical licensing boards resources adequate to the proper

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

H-295.881 Clinical Skills Assessment Exam
Our American Medical Association opposes the implementation of the Clinical Skills Assessment Exam as part of the United States Medical Licensing Examination by any means, including possible legal action. (Res. 304, A-03)

H-295.927 Medical Student Health and Well-Being
The AMA encourages the Association of American Medical Colleges, Liaison Committee on Medical Education, medical schools, and teaching hospitals to address issues related to the health and well-being of medical students, with particular attention to issues such as HIV infection that may have long-term implications for health, disability and medical practice, and consider the feasibility of financial assistance for students with disabilities. (BOT Rep. 1, I-934; Modified with Title Change: CSA Rep. 4, A-03)

H-295.931 Pesticide-Herbicide Toxicity Instruction
The AMA encourages education in pesticide and herbicide toxicity to be provided at all levels of medical education. (Res. 304, A-93; Reaffirmed: CME Rep. 2, A-03)

H-295.933 Medical School Affiliations With VA Medical Centers
The AMA will work to ensure that the successful relationships between VA academic medical centers and the nation's medical schools are maintained. (Sub. Res. 313, A-93; Modified: CME Rep. 2, A-03)

H-295.934 Physician Training in Health Care Management and Administration
The AMA encourages the development of programs for physician education in health care administration and management. (Sub. Res. 311, A-93; Reaffirmed: CME Rep. 2, A-03)

H-295.937 Medical Students Infected with Bloodborne Pathogens
A medical student who becomes infected with human immunodeficiency virus (HIV) or other bloodborne infectious diseases should not be prevented from completing their course of study and receiving their MD/DO degree based solely on their seropositivity. (Res. 413, I-92; Reaffirmed: CME Rep. 2, A-03; Modified with Title Change: CSA Rep. 4, A-03)

H-295.938 Medical Education Accreditation
The AMA charges its representatives to medical education accrediting bodies to ensure that program accreditation not be used to address specialty distribution of physicians. (Res. 322, I-92; Reaffirmed: CME Rep. 2, A-03)

H-295.939 OSHA Regulations for Students
The AMA, working in conjunction with its Medical School Section, encourages all health care related educational institutions to apply existing Occupational Safety and Health Administration Blood Borne Pathogen Standards equally to employees and students. (Sub. Res. 229, I-92; Reaffirmed: CME Rep. 2, A-03)

H-295.940 Recruiting Students of Medicine at the Elementary and High School Levels
The AMA will work with state and local medical societies to encourage teachers at primary and secondary schools to alert their students to the potential for professional and personal satisfaction from service to others through a career in medicine. (Res. 319, A-92; Reaffirmed: CME Rep. 2, A-03)

H-295.941 Policies for the Admission of Students from Underserved Areas to Medical Schools
The AMA encourages all U.S. medical schools to develop admissions procedures that will facilitate the admission of students from underserved areas to medical schools, without compromising current admission standards. (Res. 302, A-92; Reaffirmed: CME Rep. 2, A-03)

H-295.948 Health and Disability Insurance for Medical Students
The AMA (1) takes the position that all medical schools and residency programs provide insurance policy options that include a reasonable definition of "sickness" or "disability" that includes HIV infection, and require enrollment in such health and disability insurance plans for all their medical students and residents, and (2) encourages other health professions to provide similar health and disability insurance policies for their students. (BOT Rep. Q, A-91; Amended: BOT Rep. J, I-92; Reaffirmed: CME Rep. 2, A-03)

H-295.984 Family Medicine as a Fundamental Subject in Medical Schools
The AMA recommends that U.S. medical schools include family medicine as a clinical subject. (Res. 14, I-84; Reaffirmed: CMS Rep. L, A-93; Reaffirmed: CME Rep. 2, A-03)

H-295.992 Medical Student Education Concerning Physician Impairment
The AMA (1) supports the teaching of the prevention of physician impairment to medical students and residents; and (2) encourages state medical society physician impairment committees and institutions offering medical education to address student and resident problems with substance abuse. (Sub. Res. 80, I-82; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmed: CME Rep. 2, A-03)

H-300.960 Promoting Physician Access to Quality Continuing Medical Education Programs
The AMA will instruct its representatives to the ACCME to advocate: (1) an extensive review and evaluation of the ACCME accreditation review process and criteria, including procedures for training and oversight of accreditation survey team members to assure review quality and continuity; (2) the development of specific documentation criteria which will be expected of accredited institutions and clearly communicate these to the accredited institutions; (3) the emphasis on physician access to quality continuing medical education programming rather than deterring providers with an over-emphasis on unnecessary bureaucratic detail; and (4) that the accreditation process be conducted as a mentoring and constructive process, as well as a quality assurance process. (Res. 313, I-93; Reaffirmed: CME Rep. 2, A-03)

H-300.964 Medical Ethics and Continuing Medical Education
The AMA encourages accredited continuing medical education sponsors to plan and conduct programs and conferences emphasizing ethical principles in medical decision making. (Res. 323, I-92; Reaffirmed: CME Rep. 2, A-03)

H-300.965 The FDA and Continuing Medical Education Supported by Industry
The AMA commends the activities of all parties, including the Food and Drug Administration (FDA), who have worked diligently through the Task Force on CME Provider-Industry Collaboration in CME, to develop guidelines and clear concepts of independence for activities supported by commercial companies. The AMA will continue to monitor the implementation of FDA policies in accredited CME activities. (Sub. Res. 307, I-92; Reaffirmed: CME Rep. 2, A-03)

H-300.966 Continuing Medical Education for Physicians in the Hospital Setting
It is the policy of the AMA that the continuing medical educational programs offered physicians in the hospital setting be the responsibility of the hospital medical staff and directed by the medical staff as defined in the hospital bylaws. (Res. 318, A-92; Reaffirmed: CME Rep. 2, A-03)

H-300.968 Protocol for Recognition of State Medical Society Accreditation Programs
The AMA (1) reaffirms that proposed changes in the Protocol for the Recognition of State Medical Societies to Accredit Intrastate Continuing Medical Education Sponsors, including Guidelines for the Interpretation of the Criteria, be considered matters subject to the review and approval of the ACCME, in accordance with ACCME Bylaws; (2) urges the ACCME Committee for Review and Recognition of State Medical Societies (CRR) to take into consideration the demographic diversity, geographic differences, and varying resources of states when evaluating state medical society accreditation processes; and (3) urges the ACCME and CRR to develop reasonable alternate mechanisms (without lowering essential standards) for creating accreditable CME programs in those states and portions of states designated by the federal government as "rural" and whose resources may vary significantly from the norm. (CME Rep. A, A-92; Reaffirmed: CME Rep. 2, A-03)

H-300.988 Restoring Integrity to Continuing Medical Education
The AMA (1) supports retention of the definitions of continuing medical education in the Physicians' Recognition Award ("Continuing medical education is composed of any education or training which serves to maintain, develop or increase the knowledge, interpretive and reasoning proficiencies, applicable technical skills, professional performance standards or ability for interpersonal relationships that a physician uses to provide the service needed by patients or the public.") and revised ACCME Essentials ("Continuing medical education consists of educational activities which serve to maintain, develop, or increase the knowledge, skills, and professional performance and relationships that a physician uses to provide services for patients, the public, or the profession. The content of CME is that body of knowledge and skills generally recognized and accepted by the profession as within the basic medical sciences, the discipline of clinical medicine, and the provision of health care to the public."); (2) urges members of the medical profession to be attentive to the distinction between continuing medical education and continuing education which is not related directly to their professional activities; (3) believes that accredited sponsors should designate as continuing medical education only those continuing education activities which meet the definition of continuing medical education in the revised ACCME Essentials; (4) encourages the ACCME and state medical associations on the state level to weigh seriously, in considering the sponsor's continued accreditation, instances where an accredited sponsor identifies non-continuing medical education activities as continuing medical education; and (5) encourages state medical boards to accept for credit continuing education which relates directly to the professional activities of physicians, although each state with mandatory continuing medical education for reregistration of license has the prerogative of defining the continuing education it will accept for credit. (CME Rep. A, A-82; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmed: CME Rep. 2, A-03)

H-305.932 State and Local Advocacy on Medical Student Debt
Our AMA: (1) opposes the charging of broad and ill-defined student fees by medical schools, such as but not limited to professional fees, encouraging in their place fees that are earmarked for specific and well-defined purposes; (2) encourages medical schools to use their collective purchasing power to obtain discounts for their students on necessary medical equipment,

textbooks, and other educational supplies; and (3) encourages medical schools to cooperate with undergraduate institutions to establish collaborative debt counseling for entering first-year medical students. (Res. 847, I-03)

H-310.944 Obstetrics and Gynecology Training in Termination of Pregnancy
The AMA supports the Residency Review Committee for Obstetrics and Gynecology in its current efforts to revise language of the Special Requirements for Obstetrics-Gynecology to provide for specific educational standards for the knowledge and skills associated with the termination of pregnancy that will allow an exclusion for individuals or residency programs with religious/moral objections or legal restrictions, provided that the residents receive a satisfactory knowledge of the principles associated with the termination of pregnancy rather than the actual procedures, and that these exempt residency programs must establish a protocol to allow residents who wish to learn termination of pregnancy procedures to obtain this training in another institution. (Res. 321, I-93; Reaffirmed: CME Rep. 2, A-03)

H-310.946 Training Physicians in Non-Traditional Sites
It is the policy of the AMA to promote and support the training of physicians in non-traditional sites, including nursing homes. (Res. 301, I-93; Reaffirmed: CME Rep. 2, A-03)

H-310.947 Revision of the "General Requirements" of the Essentials of Accredited Residency Programs
The AMA supports the following principles of the ACGME Institutional Requirements: Candidates for residencies must be fully informed of benefits including financial support, vacations, professional leave, parental leave, sick leave, professional liability insurance, hospital and health insurance, disability insurance, and other insurance benefits for the residents and their family and the conditions under which living quarters, meals and laundry or their equivalent are to be provided. Institutions sponsoring graduate medical education must provide access to insurance, where available, to all residents for disabilities resulting from activities that are part of the educational program. Institutions should have a written policy and an educational program regarding physician impairment, including substance abuse. (CME Rep. Q, A-93; Modified: CME Rep. 2, A-03)

H-310.952 Housestaff Input During the ACGME Review Process
The AMA asks its representatives to the Accreditation Council for Graduate Medical Education to support a requirement that site visitors to both residency training programs and institutions conduct interviews with residents, including peer-selected residents, as well as with administrators and faculty. (Res. 314, I-92; Reaffirmed: CME Rep. 2, A-03)

H-310.953 Practice Options and Skills Curriculum for Residents
The AMA will assist medical societies and residency programs in the development of model curricula for resident physicians and those entering practice regarding practice options and management skills, including information on CPT and ICD coding. (Sub. Res. 311, I-92; Reaffirmed: CME Rep. 2, A-03)

H-310.997 Accreditation of Graduate Medical Education Programs
(1) The AMA believes that (a) accreditation and certification programs in graduate medical education should be designed and operated to objectively evaluate the educational quality and content of such programs and to assure a high level of professional training, achievement, and competence; (b) accreditation and certification programs in graduate medical education should not be administered as a means of regulating or restricting the number of physicians entering any specialty or field of medical practice; and (c) qualified physicians who possess the essential prerequisites are entitled to compete for training and subsequently to practice in the specialty or type of practice of their choice upon successful completion of their training. (2) The AMA opposes use of the accreditation and certification process as a means of controlling the number of physicians in any specialty or field of medical practice. (Res. 14, A-82; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmed: CME Rep. 2, A-03)

H-330.950 Post-Licensure Assessment as a Condition for Physician Participation in Medicare
The AMA opposes proposals for periodic post-licensure assessment as a condition for physician participation in the Medicare program or other health-related entitlement program. (Res. 231, I-93; Reaffirmed: BOT Rep. 28, A-03)

H-350.964 Racial Ethnic Disparities in Health Care
Our AMA opposes the elimination of programs or mechanisms designed to increase the number of minority physicians. (BOT Rep. 4, A-03)

H-355.986 Peer Review Implications of Adding Allied Health Practitioners to National Practitioner Data Bank
The AMA will continue to pursue vigorously remedial action to correct all operational problems with the National Practitioner Data Bank. (Res. 817, A-93; Reaffirmed: BOT Rep. 28, A-03)

H-355.988 Access to National Practitioner Data Bank
The AMA will inform its members that entities who are authorized to query the National Practitioner Data Bank should not request physicians to self-query on the entities' behalf. (Res. 804, A-93; Reaffirmed: BOT Rep. 28, A-03)

H-355.989 Access to National Practitioner Data Bank "Self-Query" Reports
(1) The AMA again requests a written opinion from the Health Resources and Services Administration's Bureau of Health Professions and/or the HHS Office of the Inspector General, as to the confidentiality of National Practitioner Data Bank (NPDB)

information that is received directly or indirectly from the NPDB. (2) The AMA recommends that physicians who are compelled to release information received from the NPDB to entities not authorized to access the NPDB require that such entity provide them with written documentation that: information disclosed to the entity will be protected from further disclosure under the relevant state peer review immunity statute(s); that the requirements that the physician self-query the NPDB and disclose the information to the entity is in compliance with the intent and protections of the Health Care Quality Improvement Act of 1986; that the information will be used only for and maintained only for those purposes, such as quality assurance activities, that are protected under the relevant state peer review immunity statute(s); and that the entity will protect the confidentiality of the information to the fullest extent permitted by both state law and the Health Care Quality Improvement Act of 1986. (3) The AMA will provide model language until such legislation is enacted that physicians can use to protect confidentiality when they release information received from the NPDB to entities not authorized to access the NPDB. The AMA urges state and county medical societies to develop a mechanism physicians can use to report problems they encounter with these entities. (BOT Rep. L, I-92; Reaffirmed: BOT Rep. 28, A-03)

H-355.990 National Practitioner Data Bank
(1) The AMA shall continue to pursue vigorously remedial action to correct all operational problems with the National Practitioner Data Bank (NPDB). (2) The AMA requests that the Health Resources and Services Administration (a) prepare and disseminate to physician and hospital organizations a white paper addressing its plans to enhance the confidentiality/security provisions of the reporting and querying process no later than December 1992; (b) conduct a statistically valid sample of health care entities, other than hospitals, on the entity file to determine if entities that are not eligible to query under the statute and regulation have gained access to the NPDB information, and disseminate the results to the NPDB Executive Committee no later than December 1992; (c) implement appropriate steps to ensure and maintain the confidentiality of the practitioner's self-query reports no later than December 1992; (d) recommend to the Congress that small claims payments, less than $30,000, no longer be reported to the NPDB and provide the Executive Committee members the opportunity to attach their comments on the report that goes to the Congress; (e) allow by January 1, 1993, the practitioner to append an explanatory statement to the disputed report; and (f) release the evaluation report, prepared by Dr. Mohammad Akhter, on the NPDB's first year of operation to the AMA by July 1992. (3) The AMA will reevaluate at the 1992 Interim Meeting the progress on these issues. If the preceding requests are not met by the established due date and the House of Delegates is not satisfied with the progress on these issues, the AMA will again reevaluate the implementation of Policy H-355.991. (BOT Rep. QQ, A-92; Reaffirmed: BOT Rep. 28, A-03)

H-360.983 Registered Nurse Participation in Epidural Analgesia
Our AMA, consistent with the American Society of Anesthesiologists position statement adopts the following statement on the administration of epidural analgesia: In order to provide optimum patient care, it is essential that registered nurses participate in the management of analgesic modalities. A registered nurse--qualified by education, experience and credentials--who follows a patient-specific protocol written by a qualified physician should be allowed to adjust and discontinue catheter infusions. (Res. 530, A-03)

H-360.997 Nursing Education
The AMA (1) supports all levels of nursing education, including baccalaureate, diploma, associate degree and practical nursing in order that individuals may be able to choose from a number of alternatives, each of which legitimately fulfills the purpose of meeting the health care needs of the nation; (2) affirms that there is no substitute for bedside teaching and practical learning in any education program for nurses; and (3) recommends strong support of multiple levels of nursing education in order to make available career ladders in the various levels of nursing education without dead-ends or repetitions of education. (Res. 4, A-82; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmed: CME Rep. 2, A-03)

D-200.992 US Physician Shortage
Our AMA will draft a report outlining policy options to address the US physician supply. (Res. 807, I-03)

D-200.995 Federal Grants to Serve Medically Underserved Areas
Our AMA will encourage physicians interested in the availability of federal grants available for service in medically underserved areas, to review the information on the US Department of Health and Human Services web site at www.hhs.gov/grantsnet. (CMS Rep. 2, I-03)

D-255.990 Nondiscrimination in Residency Selection
Policy H-255.983 will be communicated to the Accreditation Council for Graduate Medical Education and to all residency program directors. (Sub. Res. 314, A-04)

D-255.992 Opposition to Employment of Non-certified International Medical Graduates
Our AMA, in conjunction with the California Medical Association, will recommend to the California legislature and the California Hispanic Healthcare Association, other solutions to the California physician shortage including (1) maximizing their use of existing programs such as the National Health Service Corps and the J-1 visa waiver program, and (2) recruiting Spanish-speaking physicians who have recently retired by assisting them with state licensing and liability concerns. Our AMA, in conjunction with state medical societies, will respond to attempts by states to employ non-certified physicians for patient care by recommending solutions to those states such as (1) maximizing their use of existing programs such as the National Health

Service Corps and the J-1 visa waiver program, and (2) recruiting physicians who have recently retired by assisting them with state licensing and liability concerns. (Res. 320, A-03)

D-275.966 Eliminating Disparities in Licensure for IMG Physicians
Our AMA will advocate and assist the state medical societies to seek legislative action eliminating any disparity in the years of graduate medical education training required for full and unrestricted licensure between IMG and LCME graduates. (Res. 327, A-08; Reaffirmation A-10)

D-275.985 Clinical Skills Assessment Exam and College of Osteopathic Medicine Licensing Exam-Physical Exam Implementation
Our AMA will: (1) study mechanisms for providing feedback to medical students on their performance on the proposed United States Medical Licensing Exam Clinical Skills Assessment Examination (CSAE) and College of Osteopathic Medicine Licensing Exam-Physical Exam (COMLEX-PE) including but not limited to written narrative feedback, and access to video recording of the exam for possible review with their medical school and communicate these findings to the National Board of Medical Examiners (NBME) and National Board of Osteopathic Medical Examiners (NBOME); (2) encourage medical schools to develop mechanisms to assist medical students to meet financial obligations associated with the requirements for participation in the CSAE and COMLEX-PE; (3) encourage medical schools to avoid linking passage of the CSAE and COMLEX-PE to graduation requirements for at least the first five years after the implementation of the proposed exam; (4) in conjunction with the National Resident Matching Program, the American Osteopathic Association, the Accreditation Council for Graduate Medical Education, and other interested organizations, study the potential impact of the CSAE and COMLEX-PE on undergraduate and graduate medical education and report back at the 2004 Annual Meeting; (5) strongly encourage the NBME and NBOME to develop policies to ensure adequate capacity for registration and administration of the proposed CSAE and COMLEX-PE in order to accommodate all students testing for the initial time as well ensuring students failing the exam can retest within 60 days; (6) monitor in an ongoing fashion, the proposed implementation of the CSAE and COMLEX-PE and its impact on the medical education continuum; and (7) involve all interested groups at the AMA in any AMA deliberations regarding the CSAE as well as utilization of this or a similar test for recertification purposes, to ensure that the perspectives of all physicians are reflected. (Res. 324, A-03)

D-275.986 Developing Rational Role for USMLE Step Exams
Our American Medical Association, with appropriate partners, will study what role, if any, scaled and scored national, standardized examinations like the USMLE Steps I and II should have in evaluation of applicants for residency, and propose appropriate changes to the examination(s) in order to serve that role. (Res. 303, A-03)

D-295.959 Musculoskeletal Care in Graduate Medical Education
Our AMA will: (1) strongly urge our medical schools to formally reevaluate the musculoskeletal curriculum; (2) strongly urge our medical schools to make changes that ensure medical school students have the appropriate education and training in musculoskeletal care, and make competence in basic musculoskeletal principles a graduation requirement for medical school; and (3) encourage its representatives to the Liaison Committee on Medical Education, the Accreditation Council for Graduate Medical Education, and the various Residency Review Committees to promote higher standards in basic competence in musculoskeletal care in accreditation standards. (Res. 310, A-03)

D-295.961 Proposed Consolidation of Liaison Committee on Medical Education Offices
Our AMA will continue to support the current dual Secretariat structure for the management of the Liaison Committee on Medical Education. (CME Rpt. 7, A-03)

D-300.991 Web-Based System for Registering CME Credits
(1) Our American Medical Association, through the Division of Continuing Physician Professional Development, will perform a new feasibility analysis to determine if reinitiating the CME Credit Tracker project is possible. (2) The Council on Medical Education will monitor the progress of the analysis and facilitate constructive dialogue with all interested stakeholders. (CME Rep. 5, A-03)

D-300.992 Internet-Based Continuing Medical Education
(1) Our AMA will express its appreciation to the Accreditation Council for Continuing Medical Education and to the AMA PRA program for anticipating issues associated with Internet-based CME, and for developing clear policy to guide physicians and accredited CME providers in this area. (2) The Council on Medical Education will remain closely involved with the evaluation processes of the current AMA PRA Internet CME Pilot Project and develop appropriate new language for the certification of AMA PRA category 1 credit for self-directed, self-initiated, Internet-based CME. (3) The AMA PRA program will continue to monitor the area of Internet-based CME and report back to the House of Delegates as major changes occur. (CME Rep. 4, A-03)

D-305.979 State and Local Advocacy on Medical Student Debt
Our AMA will: (1) support and encourage our state medical societies to support further expansion of state loan repayment programs, and in particular expansion of those programs to cover physicians in non-primary care specialties; (2) urge state medical societies to actively solicit funds (either directly or through their Foundations) for the establishment and expansion of medical student scholarships, and that our AMA develop a set of guidelines and suggestions to assist states in carrying out such

initiatives; and (3) study the merits of an annual tuition cap (adjusted for inflation) at public and private medical schools within their states. (Res. 847, I-03)

D-305.983 Strategies to Combat Mid-year and Retroactive Tuition Increases
Our AMA will: (1) assist state medical societies in advocacy efforts in opposition to mid-year and retroactive tuition increases; (2) make available, upon request, the judicial precedent that would support a successful legal challenge to mid-year tuition increases; (3) identify and disseminate information about model financial aid programs for medical students that have the potential to reduce student debt; (4) continue to encourage individual medical schools and universities, federal and state agencies, and others to expand options and opportunities for financial aid to medical students; and (5) study the funding of medical education programs, to identify: (a) The status of revenue sources used to support undergraduate and graduate medical education programs, including current constraints on these revenue sources; (b) Strategies to reduce these financial constraints; and (c) Mechanisms to ensure that funding for undergraduate and graduate medical education programs is maintained, so as to reduce the financial burden on medical students and resident physicians. (CME Rep. 3, I-03)

D-305.986 Recognizing Spouse and Dependent Care Expenses in Determining Medical Education Financial Aid
Our AMA will: (1) work with the Liaison Committee on Medical Education to require, as part of the accreditation standards for medical schools, that dependent health insurance, dependent care, and dependent living expenses be included both as part of the "cost of attendance" and as an educational expense for the purposes of student budgets and financial aid in medical schools; (2) encourage medical schools to include spouse and dependent health insurance, dependent care, and dependent living expenses as part of the "cost of attendance" and as an educational expense for the purposes of student budgets and financial aid; (3) ask its Council on Medical Education, Section on Medical Schools, and Women Physicians Congress to consider options to carry out the intentions of current House of Delegates' policy on the issue of spouse and dependent health insurance, dependent care, and dependent living expenses; and (4) report back on actions taken on this resolution, and their results, to the House of Delegates at the 2004 Annual Meeting. (Res. 301, A-03)

D-310.999 Clinical Supervision of Resident Physicians by Non-Physicians
In light of the concerns of the AMA Resident Physician Section and the adoption of amended Principle 16, the ACGME be asked to clarify ACGME Institutional and Program Requirements regarding the responsibility for resident supervision. (CME Rep. 3, A-99; Reaffirmed: Res. 322, A-03)

D-350.994 Continued Support for Diversity in Medical Education
Our AMA will publicly state and reaffirm its strong opposition to the reduction of opportunities used to increase the number of minority and premedical students in training. (Res. 325, A-03)

D-360.995 Clinical Skills For Labor and Delivery Nurses
Our AMA will encourage the National League of Nursing Accrediting Commission and the Commission on Collegiate Nursing Education to emphasize education and certificate training programs that assure the necessary clinical skills for labor and delivery nurses to be able to adjust the rate of epidural infusion for patients. (Res. 530; A-03)

D-360.998 The Growing Nursing Shortage in the United States
Our AMA: (1) recognizes the important role nurses and other allied health professionals play in providing quality care to patients, and participate in activities with state medical associations, county medical societies, and other local health care agencies to enhance the recruitment and retention of qualified individuals to the nursing profession and the allied health fields; (2) encourages physicians to be aware of and work to improve workplace conditions that impair the professional relationship between physicians and nurses in the collaborative care of patients; (3) encourages hospitals and other health care facilities to collect and analyze data on the relationship between staffing levels, nursing interventions, and patient outcomes, and to use this data in the quality assurance process; (4) will work with nursing, hospital, and other appropriate organizations to enhance the recruitment and retention of qualified individuals to the nursing and other allied health professions; (5) will work with nursing, hospital, and other appropriate organizations to seek to remove administrative burdens, e.g., excessive paperwork, to improve efficiencies in nursing and promote better patient care. (CMS Rep. 7, A-01; Modified: Res. 708, A-03)

3. IMPLEMENTATION OF ACCREDITATION STANDARDS RELATED TO MEDICAL SCHOOL DIVERSITY

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: RECOMMENDATIONS ADOPTED AND REMAINDER OF REPORT FILED
See Policy D-295.963

Policy D-295.963, Continued Support for Diversity in Medical Education paragraphs #2 and #3, calls on our American Medical Association (AMA) to:

> Request that the Liaison Committee on Medical Education (LCME) regularly share statistics related to compliance with accreditation standards IS-16 (Institutional Diversity) and MS-8 (Pipeline Programs) with medical schools and other stakeholders; and
>
> In collaboration with the Association of American Medical Colleges (AAMC), continue to monitor medical school implementation of processes to enhance the diversity of medical students, residents, and medical school faculty and report back on the results at the 2013 Annual Meeting of the AMA House of Delegates.

This report: 1) summarizes the status of implementation of the LCME diversity standards and describes the steps taken by the LCME to assist schools in achieving compliance; 2) provides data on trends in medical student, resident, and faculty diversity; and 3) describes current strategies to enhance medical school diversity.

Accreditation standards IS-16 and MS-8 are included as an attachment to this report.

STATUS OF COMPLIANCE WITH DIVERSITY STANDARDS

LCME diversity standards IS-16 and MS-8 went into effect in July 2009 for medical schools with accreditation reviews in the 2009-2010 academic year. Since that time, medical schools must provide evidence of how they are addressing the expectations of the two standards.

Requirements of the Standards

In summary, accreditation standard IS-16, institutional diversity, requires that there be policies and practices aimed at achieving institutional diversity. Institutions must explicitly define the categories of diversity that will add value to the learning environment; implement focused efforts to attract and retain medical students, faculty, and staff from the value-added categories; and evaluate the results of their efforts. Accreditation standard MS-8, pipeline programs, states the expectation that medical schools, alone or in partnership, develop outreach activities aimed at broadening the pool of diverse medical school applicants.

Current Level of Compliance with the Diversity Standards

Of the 25 schools with full reviews by the LCME between October 2011 and June 2012, IS-16 (institutional diversity) was the most commonly-cited standard. There were 13 schools reviewed by the LCME during that period that received a citation for IS-16. Of these, 10 schools were identified as not being in compliance with the standard and three were in compliance but required follow-up to assure that compliance would be maintained and/or efforts made to date would be successful.

The LCME reviewed the reasons for the citations, which were one or more of the following: 1) the absence of specified diversity categories that the school believes add value to the learning environment; 2) the lack of processes and practices focused on the recruitment and/or retention of individuals (students and/or faculty) from the identified diversity categories; 3) the absence of a process to collect data on diversity outcomes; and 4) the inability of the school to meet its own diversity goals.

Standard MS-8 (pipeline programs) was not cited as a separate area of noncompliance between October 2011 and June 2012, in that all medical schools could document the presence of one or more programs. Collectively, there are

a variety of types of pipeline programs. For example, programs differ in the age group that is targeted. For example, some programs reach back to primary or middle school, while others are directed at high school or college students. Programs also differ in the content that is included. Programs for younger students may attempt to create an interest in the sciences or in health careers, while programs for college students and postbaccalaureate programs aim to provide the skills necessary to be a competitive applicant.

LCME Actions to Support Compliance

The LCME has engaged in a variety of actions to inform schools of the expectations of the diversity standards and to share the data (cited above) on the reasons for noncompliance. These include presentations at national meetings, development of written documentation to describe the expectations of the standards, consultations with individual schools, and open question and answer sessions involving administrators and faculty from groups of schools. The LCME plans to continue to collect data on the extent of and reasons for noncompliance and will make this information widely available.

MEDICAL STUDENT, RESIDENT, AND FACULTY DIVERSITY

Data for this section are derived from publications of the Association of American Medical Colleges (AAMC) and the AMA.

Medical Students

Data will provide comparisons between the 2003 and 2011 entering classes. In 2002, the AAMC changed the way data on race and ethnicity were collected, allowing multiple responses from a given individual (for example, an individual could select a Hispanic ethnicity alone or in combination with any race). This new way of categorizing data does not allow comparisons with earlier years.

The percentage of women among medical school applicants and matriculants reached an all-time high for the entering class in 2003 (50.8% of applicants and 49.6% of matriculants) and has decreased slightly since that time. For the 2011 entering class, 47.3% of applicants and 47.0% of matriculants were women.[1] These percentages must be considered in the context of the national increase in medical school enrollment. The number of medical students in the 2003 entering class was 17,118 and in the 2011 entering class was 19,719.[2] The absolute number of women applying to medical school (34,792 in 2003 and 43,919 in 2011) and the number of matriculants (8,212 in 2003 and 9,037 in 2011) have increased.[1]

The following table compares the number and percentage of applicants and of first-year students by race and Hispanic ethnicity for the 2003 and 2011 entering classes. Note that the data for the entering class includes students repeating the year.

US Medical School Applicants and First-year Students by Race and Ethnicity, 2003 and 2011[1]				
Race, Alone or in Combination, Non-Hispanic – Number (% of Total)				
	2003		2011	
	Applicants	First-Year	Applicants	First-Year
Black/African-American	2,963 (8.5%)	1,277 (7.5%)	3,407 (7.8%)	1,384 (6.9%)
American Indian/Alaskan Native	342 (1%)	160 (0.9%)	308 (0.7%)	129 (0.6%)
Asian/Pacific Islander	6,834 (19.6%)	3,515 (20.6%)	9,818 (22.4%)	4,442 (22.3%)
Native Hawaiian/Other Pacific Islanders (OPI)	98 (0.3%)	37 (0.2%)	139 (0.3%)	52 (0.2%)
Hispanic, of any Race – Number (% of Total)				
US Hispanic	2,491 (7.2%)	1,157 (6.8%)	3.459 (7.9%)	1.707 (8.6%)

Residents

As with medical students, the number of residents increased between 2003 and 2011. There were 99,694 residents on duty in Accreditation Council for Graduate Medical Education-accredited programs in 2003 and 113,427 residents on duty in 2011. In 2003, 41% of residents in ACGME-accredited programs were women.[3] In 2011, the percent of women was 46.3%.[4]

The following table compares the number of and percentage of resident physicians by race and Hispanic ethnicity for the 2003 and 2011 years.

US Resident Physicians in ACGME-Accredited Programs by Race and Ethnicity, 2003 and 2011[3,4]		
	2003	2011
	Race, Alone or in Combination, Non-Hispanic – Number (% of Total)	
Black/African-American	5,359 (5.4%)	6,901 (6.1%)
American Indian/Alaskan Native	225 (0.2%)	413 (0.4%)
Asian/Pacific Islander	25,623 (26.5%)	31,975 (28.2%)
	Hispanic of any Race – Number (% of Total)	
Hispanic	6,578 (6.6%)	9.013 (7.9%)

Medical School Faculty

In 2011, there were 136,373 full-time faculty members in US medical schools. Of these, 49,017 (35.9%) were women. Women were more highly represented in lower academic ranks. In the basic science departments, 22.0% of the faculty at the professor level were women and in the clinical departments, 18.9% were women. In contrast, 40.0% of faculty at the assistant professor level in the basic science departments and 42.4% of the faculty in the clinical departments were women.[5]

Also in 2011, 12.5% of medical school faculty of all ranks were Asian, 2.9% were Black/African American, 0.1% were Native American/Alaskan Native, and 0.1% were Native Hawaiian/OPI and 4% were Hispanic. Faculty data on race and ethnicity have gaps, in that 17.1% of faculty are of unknown race. The racial and ethnic composition of the faculty has been relatively constant over the past five years.[1]

ACTIONS TO ENHANCE DIVERSITY AT THE BEGINNING OF THE PIPELINE

This section will focus on processes that are being used to build a diverse pipeline into the medical profession, starting with medical school admissions.

Creating a Pipeline to Medical School

As specified in LCME accreditation standard MS-8, medical schools are expected to participate in outreach programs to enhance the pool of medical school applicants and to monitor the success of their efforts. The LCME requires that medical schools monitor the outcomes of pipeline programs, including the success of students in gaining entry to medical school. Success is defined as contributing to the national pool of medical students from diverse backgrounds, not just increasing the applicants to the specific medical school responsible for the program.

Programs may be supported through *institutional* funds or through national funding programs. For example, the Summer Medical and Dental Education Program (SMDEP), funded by the Robert Wood Johnson Foundation and managed through the AAMC and the American Dental Education Association, provides college students with academic enrichment in the basic sciences and mathematics, clinical experiences, learning and study skills, and career development activities. Outcome data indicate that the program has a good record of preparing its graduates for entry into the health field.[6]

Categories of Diversity and Race Neutral Admissions

As a result of various court opinions and state legislation, the ability to use criteria such as race, gender, color, or ethnicity as explicit factors in admission has been limited in certain regions. Replacement variables have included

socioeconomic factors (e.g., socioeconomic disadvantage, educational disadvantage), adversity indices (e.g., distance traveled), or institutional mission-based practices.[7]

Holistic Review Admissions Process

Holistic review has been defined as a flexible, individualized process in which consideration is given to multiple ways that applicants can demonstrate suitability as medical students and future physicians. In this context, applicants for admission are evaluated through institution-specific criteria that are mission-driven.[8] Diversity, as defined by the institution, is one element that can be taken into account in the admissions process. Diversity, as noted above, may be defined in a variety of ways.

AMA POLICY

The policy of our AMA strongly supports the concept that a racially and ethnically diverse educational experience results in a better educational process H-200.952. In that context, the AMA will continue to advocate for programs that promote diversity in the medical workforce, such as pipeline programs, financial aid programs for students from groups underrepresented in medicine, and diversity affairs offices in medical schools D-200.982; D-200.985. In addition, our AMA recognizes the importance of a diverse faculty in the recruitment and retention of a diverse student body H-350.968. Policy suggests financial support programs to recruit and retain a diverse faculty D-200.985.

CONCLUSIONS AND RECOMMENDATIONS

The standards of the LCME focus on creating a diverse medical school environment. The desired outcomes of this attention to diversity are twofold: 1) to enhance the educational experience for all students; and 2) to support the development of a workforce that will lead to a mitigation of health disparities.[9] Standards IS-16 and MS-8 are relatively recent and outcomes are, to date, unavailable. Therefore, the Council on Medical Education recommends that the following statements be adopted and the remainder of this report be filed:

1. That American Medical Association Policy D-295.963(2) be reaffirmed.

2. That AMA Policy D-295.963(3) be rescinded.

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9. Coleman A, Palmer S, Winnick S et al., Roadmap to Diversity: Key Legal and Educational Policy Foundations to Medical Schools. AAMC, Washington, DC, 2008.

APPENDIX – Accreditation Standards IS-16 and MS-8

(From: *Functions and Structure of a Medical School*, May 2012 edition)

IS-16. An institution that offers a medical education program must have policies and practices to achieve appropriate diversity among its students, faculty, staff, and other members of its academic community, and must engage in ongoing, systematic, and focused efforts to attract and retain students, faculty, staff, and others from demographically diverse backgrounds.

Explanatory annotation:
The LCME and the CACMS believe that aspiring future physicians will be best prepared for medical practice in a diverse society if they learn in an environment characterized by, and supportive of, diversity and inclusion. Such an environment will facilitate physician training in:

- Basic principles of culturally competent health care.
- Recognition of health care disparities and the development of solutions to such burdens.
- The importance of meeting the health care needs of medically underserved populations.
- The development of core professional attributes (e.g., altruism, social accountability) needed to provide effective care in a multidimensionally diverse society.

The institution should articulate its expectations regarding diversity across its academic community in the context of local and national responsibilities, and regularly assess how well such expectations are being achieved. The institution should consider in its planning elements of diversity including, but not limited to, gender, racial, cultural, and economic factors. The institution should establish focused, significant, and sustained programs to recruit and retain suitably diverse students, faculty members, staff, and others.

MS-8. A medical education program must develop programs or partnerships aimed at broadening diversity among qualified applicants for medical school admission.

Explanatory annotation:
Because graduates of U.S. and Canadian medical schools may practice anywhere in their respective countries, it is expected that an institution that offers a medical education program will recognize its collective responsibility for contributing to the diversity of the profession as a whole. To that end, a medical education program should work within its own institutions and/or collaborate with other institutions to make admission to medical education programs more accessible to potential applicants of diverse backgrounds. Institutions can accomplish that aim through a variety of approaches, including, but not limited to, the development and institutionalization of pipeline programs, collaborations with institutions and organizations that serve students from disadvantaged backgrounds, community service activities that heighten awareness of and interest in the profession, and academic enrichment programs for applicants who may not have taken traditional premedical coursework.

4. AN UPDATE ON MAINTENANCE OF CERTIFICATION, OSTEOPATHIC CONTINUOUS CERTIFICATION, AND MAINTENANCE OF LICENSURE (RESOLUTION 917-I-12)

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS IN LIEU OF RESOLUTION 917-A-12 AND RESOLUTIONS 308, 309, 311, 315 AND 319 AND REMAINDER OF REPORT FILED
See Policies H-275.923, H-275.924 and D-275.960

Resolution 917-I-12, Accreditation/Certification Cost and Convenience, introduced by the Indiana Delegation and referred by the House of Delegates, asked that our American Medical Association (AMA) adopt the following principles related to certifying and accrediting entities:

1. There should be full transparency related to the costs of preparing, administering, scoring, and reporting the results of board certifying exams.
2. There should be full transparency on the costs of facility documentation, review, facility inspection, scoring, and reporting of accreditation results.
3. There is the expectation that timely and multiple board exam sites will be available so as to minimize the need for physicians to travel long distances or wait long times for exam dates.
4. The accreditation process should be timely and efficient.
5. There is the expectation that certification and accreditation services should not be a source of substantial profit for these entities.

Resolution 917-I-12 was referred for further study because many of these issues are being addressed by the Council on Medical Education, which issued three reports on Maintenance of Certification (MOC), Osteopathic Continuous Certification (OCC), and Maintenance of Licensure (MOL) and is continuing to monitor these activities.

Policy D-275.960, "An Update on Maintenance of Certification, Osteopathic Continuous Certification, and Maintenance of Licensure," calls on our AMA to continue to monitor the evolution of MOC, OCC, and MOL, continue its active engagement in the discussions regarding their implementation, and report back to the House of Delegates on these issues at the 2013 Annual Meeting.

INTRODUCTION

The AMA has extensive policy on MOC and OCC as well as policy to support the principles of MOL. The AMA advocates for balancing these requirements with a sensitivity to physicians' valuable time and resources, ensuring physician input into the ongoing development of MOC, OCC, and MOL, and making these processes as efficient, effective, and evidence-based as possible.

This report builds on information provided in three previous Council reports to the House of Delegates on this topic (Council on Medical Education Reports 10-A-12, 3-A-10, and 16-A-09) and addresses the resolution and policies above by providing updates on:

1. Progress that has been made in developing MOC, OCC, and the policies and framework for MOL, which is intended to provide guidance to the state medical and osteopathic boards as they consider the results of the MOL pilot projects.
2. Expanded models that boards are using for secured examinations.
3. References that point to evidence of the benefits of specialty board certification.
4. How knowledgeable the public may be about MOC.
5. The impact of MOC, OCC, and MOL on the physician workforce.

PROGRESS REPORT ON MOC, OCC, AND THE MOL INITIATIVE

The Council on Medical Education is committed to monitoring the development of MOC, OCC, and the MOL initiative on a regular basis. Since June 2012, Board of Trustees, Council members, and AMA staff have participated in meetings that include the Special Committee on Maintenance of Licensure, Maintenance of Licensure Implementation Group, MOL Workgroup on Non-Clinical Physicians, Joint Working Group on MOC-CME, and CEO Advisory Council conference calls.

Future Direction for the ABMS MOC

The MOC Committee of the ABMS and its member boards has continued to develop the conceptual framework for MOC 2015 program standards with the goal of aligning with other professional accountability requirements by professional and regulatory organizations that share the same goal of promoting patient-care safety and quality. Alignment would facilitate the use of MOC for meeting the requirements of pay-for-quality, institutional privileging, MOL, and other professional obligations. A summary of the individual member boards' requirements for MOC Part II *Lifelong Learning and Self Assessment* and MOC Part IV *Practice Performance Assessment*, are shown in Attachments A and B.

Update on MOC Continuing Medical Education (CME)

The MOC Committee established a Joint Working Group on MOC-CME. This was not a call for, or intent to form, a new credit, certifying, or accreditation system for CME, but was intended to identify CME that best fits into the continuing professional development framework for MOC 2015. The goal is to standardize the CME requirements of individual ABMS member boards and streamline the process for physicians who hold multiple board certifications and to facilitate understanding of MOC requirements by external stakeholders.

The Joint Working Group presented its final report to the MOC Committee that recommended guidelines for evaluating the quality and the quantity of MOC-CME. Some of the questions raised by the Group with regard to quality included how often is clinical content as well as the educational format evidence based, how often is

learning/improvement demonstrated, and are the six competencies (professionalism, patient care and procedural skills, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, and systems-based practice) adequately covered in current CME programming. Questions raised with regard to quantity included how much CME is appropriate for MOC, is the "credit" the right metric or would a point system be better, and where do learning/improvement outcomes fit. The Group recommended that the characteristics of MOC-CME include evidence-based clinical content, evidence-based learning formats (i.e., interactive, multimedia), span the six competencies, and support diplomates' needs in demonstrating and documenting practice-based learning and improvement.

The ABMS has also developed a tool kit to advance the state medical boards' adoption of the FSMB's policy encouraging the state medical boards to accept MOC participation as meeting a state's CME requirements for license renewal. The MOC4CME Tool Kit includes information about state requirements on CME, frequently asked questions, and key messages. As of December 2012, four states (Idaho, Minnesota, North Carolina, and Oregon) have adopted this policy, and four states (California, Missouri, Washington, and West Virginia) are in varying stages of discussion about the policy change.

Additional ABMS Member Boards Drop End Dates

Three additional ABMS member boards—the American Board of Family Medicine (ABFM), American Board of Psychiatry and Neurology (ABPN), and American Board of Radiology (ABR)—are now emphasizing continuous involvement in their respective MOC programs. Ongoing certification with each board is contingent upon meeting the MOC requirements for the specific board. Three boards have eliminated specific "end dates" for the physicians they certify, and have joined the American Board of Pediatrics, which piloted this approach in 2010, in emphasizing the continuous nature of the ABMS MOC program.

For family physicians who are board certified by the ABFM and who enter MOC in 2012 or later, and for physicians who were initially board certified by ABPN or ABR in 2012 or later, maintaining certification is contingent upon their meeting the requirements for the specific board's MOC program, and therefore no specific end date to certification will be provided. To maintain certification by ABFM, ABPN, or ABR, their respective board certified physicians must successfully complete specialty-specific requirements throughout their ongoing MOC cycles. Implementation details will be determined by each board for physicians who are board certified earlier than 2012. More information on MOC no- "end dates" is available at www.abms.org.

Time Limits for Becoming Board Certified

The ABMS and its member boards have also set time limits to the number of years that can elapse between a physician's completion of residency training and achievement of board certification. Board eligibility and transition dates, the ABMS Board Eligibility Policy, and an updated Board Eligibility Fact Sheet are available at www.abms.org.

ABMS Educational Programs

In 2012, the ABMS sponsored educational activities for its associate members and all representatives from the ABMS member boards. The ABMS Board Congress, titled "Professionalism: What are the Implications for the ABMS Board Community?" outlined the role and charge of the new ABMS Ethics and Professionalism Committee, and the "ABMS Workshop on Professionalism and Certification Examinations" focused on best practices and communication with examinees and other parties before, during, and after an examination.

ABMS Participation Costs

ABMS acknowledges that participation in MOC programs places expectations on physicians. Physicians participating in MOC commit to, and complete, a substantive program of learning, assessment, and quality improvement in order to remain current in their specialty and provide up-to-date care for patients. The investment of time and effort in MOC activities is expected to yield tangible dividends for patients—better health care, fewer medical errors, and improved patient safety. For physicians, it is expected to yield improvement in all the competency domains targeted and developed throughout a physician's training: professionalism, patient care, procedural skill, medical knowledge, practice-based learning and improvement, interpersonal communication skill,

and system-based practice. The average cost of participation in an MOC program across the 24 ABMS member boards is $500 per year. These fees are determined at the discretion of each of the 24 boards, based on the needs of their physician specialists.[1]

AMA Policy H-275.923 (3), "Maintenance of Certification/Maintenance of Licensure," states that our AMA will encourage rigorous evaluation of the impact on physicians of future proposed changes to the MOC and MOL processes including cost, staffing, and time. AMA Policy
H-275.924 (4), "Maintenance of Certification," states that any changes in the MOC process should not result in significantly increased cost or burden to physician participants (such as systems that mandate continuous documentation or require annual milestones).

American Osteopathic Association's Bureau of Osteopathic Specialists Board Certification

Each of the 18 specialty certifying member boards of the American Osteopathic Association's Bureau of Osteopathic Specialists (AOA-BOS) has implemented OCC, effective January 1, 2013. All osteopathic physicians who hold a time-limited certificate are required to participate in the following five components of the OCC process in order to maintain osteopathic board certification:

- Component 1 - Unrestricted Licensure: requires that physicians who are board certified by the AOA hold a valid, unrestricted license to practice medicine in one of the 50 states, and adhere to the AOA's Code of Ethics.
- Component 2 - Life Long Learning/CME: requires that all recertifying diplomates fulfill a minimum of 120 hours of CME credit during each three-year CME cycle (some certifying boards have higher requirements). Of these 120 plus CME credit hours, a minimum of 50 credit hours must be in the specialty area of certification. Self-assessment activities will be designated by each of the 18 specialty certification boards. If an osteopathic physician holds a Certificate of Added Qualifications (CAQ), a percentage of their specialty credit hours must be in their CAQ area.
- Component 3 - Cognitive Assessment: requires provision of one (or more) psychometrically valid and proctored examinations that assess a physician's specialty medical knowledge as well as core competencies in the provision of healthcare.
- Component 4 - Practice Performance Assessment and Improvement: requires that physicians engage in continuous quality improvement through comparison of personal practice performance measured against national standards for his or her medical specialty. The Standards Review Committee of the AOA-BOS has specific criteria for each component 4 activity.
- Component 5 - Continuous AOA Membership.

Osteopathic physicians who hold non-time-limited certificates (non-expiring) are not required to participate in OCC. However, in order to maintain their certification, they must continue to meet licensure, CME (120-150 credits every three-year CME cycle, 30 of which are in AOA CME category 1A) and membership requirements.

The AOA has developed policies for clinically inactive diplomates, and, for dually-boarded (AOA/ABMS) diplomates, each board is developing mechanisms to partially accept ABMS MOC Part IV activities for the AOA Component 4 requirements; an osteopathic activity will still be required.

The AOA is encouraging all physicians to participate in OCC, because the FSMB has agreed to recommend the acceptance of OCC for MOL requirements. Physicians who do not participate may have additional requirements for MOL as prescribed by the state(s) where physicians are licensed. In addition, the AOA has applied for its OCC process to be approved for the CMS Maintenance of Certification incentive program on behalf of all specialty certifying boards; four boards (Radiology, Pediatrics, Internal Medicine, and Obstetrics/Gynecology) were approved in 2012.

Federation of State Medical Boards – MOL Initiative

Pilot Projects

The FSMB is currently engaged in a series of pilot projects, in collaboration with the ABMS and NBME, to advance understanding of the process, structure and resources necessary to develop an effective and comprehensive MOL system. Nine state medical boards are participating in pilot projects: Osteopathic Medical Board of California,

Colorado Medical Board, Delaware Board of Medical Practice, Iowa Board of Medicine, Massachusetts Board of Registration in Medicine, Mississippi State Board of Medical Licensure, Oregon Medical Board, Virginia Board of Medicine, and Wisconsin Medical Examining Board.

The first pilot project, a State Readiness Inventory survey, was distributed to participating pilot state medical boards in October 2012. The pilot consisted of an electronic survey designed to facilitate discussion of implementation of MOL and to identify issues state boards need to consider and possibly resolve to ensure successful implementation of MOL. The survey results are currently being collated and analyzed. The second pilot to be implemented will be a Physician Acceptability Survey to collect opinions from licensed physicians about the potential features of a comprehensive MOL system. Additional pilots will be undertaken throughout 2013.

MOL Workgroup on Clinically Inactive Physicians

In 2011, then-FSMB chair, Janelle Rhyne, MD, established an MOL Workgroup on Clinically Inactive Physicians to define the non-clinical physician and develop pathway(s) that non-clinical physicians may follow to successfully participate in a state medical board's MOL program. Given the complexity of the issue, the Workgroup delayed issuing a report to the FSMB House of Delegates in 2012 in order to take additional time to identify, review, and discuss all relevant components of clinically inactive physicians' participation in MOL. A draft of the committee's report was distributed to the state medical boards and other stakeholders, including the AMA.

In December 2012, the AMA provided a constructive critique of the FSMB draft report of the MOL Workgroup on Clinically Inactive Physicians. In general, the AMA agrees with the FSMB that the options and processes for MOL should be similar for clinically active and clinically inactive physicians. The AMA also agrees with the responsibilities and guidelines outlined in the report that would require clinically inactive physicians to understand and engage in a process of practice-relevant lifelong learning, participate in activities that reflect their day-to-day professional activities and maintain appropriate documentation of participation in such activities, and provide an accurate reflection of clinical status to the licensing authority for licensure purposes and to the specialty certification board for eligibility for MOC/OCC.

The FSMB's MOL Workgroup on Non-Clinical Physicians is developing policy intended to ensure an MOL framework that is effective and efficient for all physicians. A final report was presented to the FSMB House of Delegates in April 2013 for adoption as formal FSMB policy.

Communications

The FSMB is continuing to provide updates on the development of MOL to the state medical boards and key stakeholders, including the AMA, and has established an information center with up-to-date information on the development of MOL (www.fsmb.org/mol.html). In addition, recent articles about MOL have been published in *Annals of Internal Medicine*, the *New England Journal of Medicine*, and the FSMB's *Journal of Medical Regulation*.[2, 3]

EXPANDED MODELS USED FOR SECURED EXAMINATIONS

Traditional assessment methods have relied significantly on multiple-choice examinations or continuing medical education activities. However, the certification boards are beginning to incorporate simulation-based educational and assessment formats into MOC that more closely represent how practicing physicians diagnose and treat patients.

Approximately one-third of the ABMS member boards who responded to an ABMS survey conducted in October 2011 said that they use a modular examination approach to accommodate for relevancy to practice. These boards administer an MOC Part III examination that represents the practice content of that particular specialty and includes a combination of core content of their specialty and modules that focus on specific practice area(s). The number of modules incorporated into the MOC Part III examination varies among the member boards that utilize the modular approach. In some cases, the number of modules incorporated into one MOC examination may be dependent on the subspecialty characteristics of a diplomate's practice. Modules may vary in length dependent upon the number of questions needed to satisfy reliability and validity requirements. Some of the boards offering modular examination choices allow diplomates to choose which modules to take along with the core exam.

BENEFITS OF SPECIALTY BOARD CERTIFICATION

The value of specialty board certification has been demonstrated by the ongoing public interest in seeking out board-certified physicians and by the number of hospitals and other health care organizations that make board certification a key qualification for medical staff privileges. Few practices will hire physicians who are not board certified.[4]

A summary of the evidence and theory about the role of a physician's board certification status, compiled by Brennan et al., noted that "the value of specialty board certification and MOC takes three forms: the internal validity of the testing process, the correlation of examination scores with other measures of physician quality, and the correlation of certification status with practice outcomes."[5] All ABMS member boards develop cognitive examinations that are composed of questions developed by experts in the discipline and selected to fulfill a blueprint for the overall examination based on the importance and frequency with which problems are faced in clinical practice. The Boards also set standards for passing the secure examinations using widely accepted, credible standard-setting methods.[5]

The Boards are developing MOC requirements that are supported by evidence-based guidelines, national clinical and quality standards, and specialty best practices. Because the MOC program has been introduced gradually during the last decade, the evidence that results from longitudinal data collection is not available. However, data are beginning to emerge. The ABMS has compiled an annotated bibliography that highlights research studies and articles supporting the value of board certification and MOC (Attachment C).

The ABMS studies reinforce prior research that has shown a positive link between initial ABMS board certification and the quality of care. Early studies show a link between MOC and improved clinical performance and outcomes by participating physicians. Physician engagement in MOC activities has been associated with enhancement in clinical competence, improvement in care processes, and the gathering of valuable patient feedback. Many of the learning and assessment methods used in MOC programs have a firm grounding in research and a demonstrated ability to address physician competencies. The Boards are incorporating the latest principles in adult learning into MOC activities, such as self-directed practice improvement modules (PIMs) and interactive workshops. Many of the Boards use PIMs or incorporate similar approaches in their performance improvement activities. The latter studies range from lower mortality rates for patients with acute myocardial infarction and colorectal surgery to improved preventive care services for Medicare patients when such care is delivered by a board certified specialist.

PUBLIC AWARENESS OF MOC AND OCC

Studies have shown that the public values physician participation in a board certification program. A 2004 Gallup poll showed that physician certification and MOC are highly valued by the public.[5] More recently, a 2010 consumer survey commissioned by ABMS showed that most patients (95%) said it's important to them that their physicians participate in a program to maintain their board certification, with two-thirds (66 percent) saying it is "very important." The ABMS survey also showed that 84 percent of respondents would take some form of action if they found out their physician did not participate in an MOC program, out of which 45 percent would look for a new physician and 41 percent would stop referring their family and friends to that physician.[6]

In August 2011, the ABMS began to display the MOC status of member board certified physicians online (www.CertificationMatters.org). The information displayed includes the physician's name, certifying boards and "yes" or "no" as to whether the physician is meeting MOC standards. As of August 2012, 11 additional ABMS Member Boards joined seven other Boards in reporting publicly whether the physicians they certify are meeting their MOC requirements. The American Board of Anesthesiology, American Board of Radiology, and American Board of Orthopaedic Surgery plan to make their information available in 2013, and the American Board of Pathology anticipates providing its information in early 2014. The American Board of Internal Medicine and American Board of Pediatrics are expected to announce the date their information will be available in the near future.

The AOA also provides information about the OCC status of member board certified physicians upon request through its online DO Directory (www.doprofiles.org/).

IMPACT OF MOC, OCC, AND MOL ON THE PHYSICIAN WORKFORCE

The MOC, OCC, and MOL processes will be unfolding over the next decade, and their impact on the physician workforce is still unknown. Depending on the physician's professional activities, some physicians may have chosen not to proceed with specialty board certification even though they may have fulfilled all requirements to do so.[7] Lack of certification might reflect a delay or break in training or the fact that some boards require documentation of actual practice before board certification. For some physicians, participation in MOC and OCC will likely fulfill requirements for MOL and avoid unnecessary duplication of work.[8] Published studies on the impact of MOC on an older physician's decision to retire are limited.

AMA Policy H-275.924, Maintenance of Certification, states that MOC requirements should not reduce the capacity of the overall physician workforce. It further states that it is important to retain a structure of MOC programs that permits physicians to complete modules with temporal flexibility, compatible with the practice responsibilities. AMA Policy H-275.920 (2), Impact of Maintenance of Certification, Osteopathic Continuous Certification, Maintenance of Licensure on the Physician Workforce, states that our AMA encourages the ABMS to use data from maintenance of certification to track whether physicians are maintaining certification and share this data with the AMA.

DISCUSSION

The AMA has extensive policy on MOC, OCC, and the principles of MOL and supports the intent of these programs. AMA policy states that any changes in the MOC process should not result in significantly increased cost or burden to physician participants or reduce the capacity of the overall physician workforce. The Council on Medical Education is committed to monitoring the development of MOC, OCC, and the MOL initiative on a regular basis.

MOC, OCC, and MOL are distinctly different processes, designed by independent organizations with different purposes and mandates. Currently the guiding principles for MOL, adopted by the FSMB, recognize the value of active engagement in meeting MOC and OCC requirements. MOC and OCC are not intended to become mandatory requirements for medical licensure but should be recognized as meeting some or all of a state's requirements for MOL to avoid unnecessary duplication of work.[9] Pilot testing of the FSMB's guiding principles and framework developed for MOL is currently underway. The pilots will determine and identify multiple options and pathways by which physicians, including those who are not specialty-certified or not engaged in MOC or OCC, may fulfill a state board's MOL requirements.[9]

In the United States, there is a shared responsibility for physician performance through a combination of state regulation and professional self-regulation. Although the state medical boards provide an overall safety net for medical care to provide greater assurance of the quality of physician practice, the medical profession launched the specialty board movement to assist the public in the identification of highly qualified health professionals in specialty-based practice.[4] Board certification assures the public that an independent third party has evaluated a physician's skills and abilities, and that a physician conducts his or her practice according to a professional code of ethics and remains current with medical practices and procedures. Studies show that the public values physicians' participation in a board certification program.[5]

Specialty board certification is also becoming a frequent requirement for credentialing by hospitals, health systems, and health insurance plans. Physicians without specialty board certification have difficulty obtaining hospital privileges and are usually precluded from serving on medical school faculties.[7, 10] As MOC gains acceptance among health care agencies, state medical boards, medical associations, private health care organizations and health plans, there will be a need to create synergy in health care improvement efforts and minimize overlap of requirements providers must meet.

RECOMMENDATIONS

The Council on Medical Education recommends that the following recommendations be adopted in lieu of Resolution 917-I-12, and that the remainder of the report be filed.

1. That our American Medical Association (AMA) Reaffirm Policy H-275.923, Maintenance of Certification/Maintenance of Licensure, to reinforce that our AMA encourages rigorous evaluation of the impact on physicians of future proposed changes to the MOC and MOL processes including cost, staffing, and time.

2. That our AMA Reaffirm Policy H-275.924, Maintenance of Certification, to reinforce that any changes in the MOC process should not result in significantly increased cost or burden to physician participants (such as systems that mandate continuous documentation or require annual milestones).

3. That our AMA will continue to monitor the evolution of Maintenance of Certification (MOC), Osteopathic Continuous Certification (OCC), and Maintenance of Licensure (MOL), continue its active engagement in the discussions regarding their implementation, and report back to the House of Delegates on these issues.

4. That our AMA will 1) work with the American Board of Medical Specialties (ABMS) and ABMS specialty boards to continue to examine the evidence supporting the value of specialty board certification and MOC and to determine the continued need for the mandatory high-stakes examination; and 2) work with the ABMS to explore alternatives to the mandatory high-stakes examination.

5. That our AMA encourage the ABMS to ensure that all ABMS specialty boards provide full transparency related to the costs of preparing, administering, scoring, and reporting MOC and certifying/recertifying examinations and ensure that MOC and certifying/recertifying examinations do not result in significant financial gain to the ABMS specialty boards.

6. That our AMA work with the ABMS to lessen the burden of MOC on physicians with multiple board certifications, in particular to ensure that MOC is specifically relevant to the physician's current practice.

7. That our AMA solicit an independent entity to commission and pay for a study to evaluate the impact that MOL and MOC requirements have on physicians' practices, including but not limited to: physician workforce, physicians' practice costs, patient outcomes, patient safety and patient access. Such study will look at the examination processes of the ABMS, the American Osteopathic Association, and the Federation of State Medical Boards. Such study is to be presented to the AMA HOD, for deliberation and consideration before any entity, agency, board or governmental body requires physicians to sit for MOL licensure examinations. Progress report is to be presented at Annual 2014; complete report by Annual 2015.

8. That our AMA 1) support ongoing ABMS specialty board efforts to allow other physician educational and quality improvement activities to count for MOC; 2) support specialty board activities in facilitating the use of MOC quality improvement activities to count for other accountability requirements or programs such as pay for quality/performance or PQRS reimbursement; 3) encourage the ABMS specialty boards to enhance the consistency of such programs across all boards; and 4) work with specialty societies and specialty boards to develop tools and services that facilitate the physician's ability to meet MOC requirements.

9. That our AMA Rescind Policy D-275.960(2), An Update on Maintenance of Certification, Osteopathic Continuous Certification, and Maintenance of Licensure, since that has been accomplished through this report.

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APPENDIX

Editor's note: Council on Medical Education Report 4 included three appendices taken from the website of the American Board of Medical Specialties (ABMS), which is at www.abms.org. That material is not included here because it is subject to regular updates.

Appendix A provided summary and contact information for each of the ABMS member boards on the subject of Maintenance of Certification Part II Lifelong Learning & Self-Assessment. It is available at: www.abms.org/Maintenance_of_Certification/competencies_pdf/ABMS_MemberBoardsRequirementsProject_MOC_PartII_Final.pdf

Appendix B provided summary and contact information for each of the ABMS member boards on the subject of Maintenance of Certification Part IV Practice Performance Assessment. It is available on the ABMS website at: www.abms.org/Maintenance_of_Certification/competencies_pdf/ABMS_MemberBoardsRequirementsProject_MOC_PartIV_FINAL.pdf.

Appendix C provided a bibliography on Maintenance of Certification. It is available at: www.abms.org/about_board_certification/pdfs/ABMS_MOCAnnotated%20Bibliography_12_12_2012.pdf.

5. PHYSICIAN WORKFORCE SHORTAGE, GOING FORWARD WITH REFORMING GME FINANCING (RESOLUTIONS 317-A-12 AND 329-A-12)

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS IN LIEU OF RESOLUTIONS 317-A-12 AND 329-A-12 AND REMAINDER OF REPORT FILED
See Policies H-305.929, H-310.917, D-305.958, D-305.967 and D-305.973

Resolution 317-A-12, Physician Workforce Shortages, introduced by the Oklahoma Delegation and referred to the Board of Trustees, asked that our American Medical Association (AMA) work diligently with the Centers for Medicare and Medicaid Services (CMS) and the US Congress to create a supplemental private funding opportunity in addition to current funding sources to help develop additional residency training positions with private donations to cope with the critical shortage of primary care physicians in our country.

Resolution 329-A-12, Going Forward with Reforming GME Financing, introduced by the Mississippi Delegation and referred to the Board of Trustees, asked that our AMA:

1. Work with all available internal data and other available sources to craft a new national model for sustainable funding of graduate medical education (GME) programs, which includes not only the CMS funding, but also private funding sources as well, and

2. Urgently work to implement via legislation and other means this new model for funding GME programs in the United States.

This report provides an update on AMA efforts to improve GME funding at the federal, state, and regional levels.

BACKGROUND

Many experts agree that a predicted shortage of physicians in the coming years is a serious issue facing the nation. The Association of American Medical Colleges (AAMC) Center for Workforce Studies projects that the United

States faces a shortage of physicians that may begin as early as 2015 and reach 130,000 across all specialties by 2025. Contributing to the physician shortage is continued growth of the US population; a projected 36% increase in the Medicare population; and an increased demand for physician services as 30 million Americans request more health care services due to the passage of the Patient Protection and Affordable Care Act (ACA) (P.L. 111-148). Furthermore, nearly one-third (250,000) of currently practicing physicians will reach age 60 and likely retire in the next 10 years.[1]

The number of medical school enrollments has risen in response to this anticipated shortfall of physicians. However, the training of resident physicians is heavily dependent upon funding through the Medicare system. Medicare has historically paid for its share of the costs of training through the highly sophisticated health services provided by teaching hospitals, but the 1997 Balanced Budget Act capped the number of Medicare-funded GME positions at 1996 levels for almost all teaching hospitals. As a result, growth in the number of core GME programs, a prerequisite for medical licensure, has been minimal.[2]

While debate continues about how best to fund and structure GME, many agree that proposals such as the Medicare Payment Advisory Commission (MedPAC) proposal to cut GME funding as much as 50% would impact the entire nation.[3] Residents and fellows continue learning while providing direct patient care in hospitals and clinics under the direct supervision of a teaching physician. They render care to medically underserved, indigent, and elderly patients who otherwise might not have access to health care services.[4] In 2011, the Accreditation Council for Graduate Medical Education conducted a survey of GME programs and reported that a 50% reduction in Medicare GME funding would result in the closing of 2,551 (28.7%) residency and fellowship programs nationwide and the loss of 33,023 (29.2%) GME positions.[5]

The ACA authorized redistribution of some unused GME residency slots and has provided a few new residency positions in primary care and general surgery, but these changes will not be enough to build an appropriately sized and fully trained medical workforce. Given the long pipeline for physician training (7 years post-college at a minimum), combined with the years required to build and accredit new residency programs, expansion of GME should be approached with some urgency.

AMA ADVOCACY REGARDING GME

The AMA continues to collaborate with the AAMC and other key stakeholders to advocate for GME funding and alert Congress that cuts to GME funding would jeopardize the ability of medical schools and teaching hospitals to train physicians, as well as limit critical services to patients. The following is a summary of important federal legislative activity in the 112th Congress and AMA advocacy efforts on GME.

- On April 20, 2011, the AMA supported H.R. 1852, the "Children's Hospital GME Support Reauthorization Act of 2011," which would reauthorize federal funding to support GME positions for freestanding children's hospitals.

- On October 3, 2011, the AMA issued strong support for S. 1627, the "Resident Physician Shortage Reduction Act of 2011," a federal bill introduced by Senators Bill Nelson (D-FL), Harry Reid (D-NV), and Charles Schumer (D-NY) which would expand the number of Medicare-supported GME training positions by 15 percent (approximately 15,000 additional positions) over five years.

- On October 3, 2011, the AMA joined the AAMC and 38 other physician, hospital, and educational associations urging the Congressional Committee on Deficit Reduction to protect Medicare GME funding from cuts.

- On October 15, 2012, the AMA sent a letter to Representative Crowley (D-NY) in support of H.R. 6562, the "Resident Physician Shortage Reduction Act of 2012," which would expand the number of Medicare-supported GME positions by 15 percent (an additional 15,000 positions) over five years.

- The Josiah Macy Jr. Foundation designed a series of two conferences to develop recommendations regarding the future of GME in the United States. The AMA participated in the first conference held on October 24, 2010. The first published report, "Ensuring an Effective Physician Workforce for America: Recommendations for an Accountable GME System," embraces an all-payer model for GME funding.6 Following the second conference, the Foundation published a second report, "Ensuring an Effective Physician Workforce for the United States:

Recommendations for Reforming GME to Meet the Needs of the Public," which focused on the content, structure, and format of the GME system.[7]

- On December 19, 2012, the AMA testified before the Institute of Medicine (IOM) Committee on the Governance and Financing of Graduate Medical Education (the AMA's written testimony is available at: www.ama-assn.org/resources/doc/washington/graduate-medical-education-testimony-19dec2012.pdf). By the Spring of 2014, the IOM committee will: (1) assess current regulation, financing, content, governance, and organization of US GME; and (2) recommend how to modify GME to produce a physician workforce for a 21st century US health care system that provides high quality preventive, acute, and chronic care, and meets the needs of an aging and more diverse population.[8]

- Starting in December 2012, the AMA launched a new grassroots campaign to raise awareness in Congress of the need to preserve funding for residency training in the federal budget. Physicians and medical students were called on to urge their members of Congress to support GME funding by sending an email through the AMA Physicians Grassroots Network (www.SaveGME.org). On February 11, 2013, medical students from across the nation talked with Members of Congress on this topic. Physicians attending the 2013 National Advocacy Conference also raised the need to protect GME funding during conversations with their representatives and senators.

- On March 7, 2013, AMA provided background material to the Government Accountability Office (GAO) for their study on physician and health care workforce supply and demand and how provisions in the ACA may affect estimates of future needs. The GAO is expecting to issue their findings later this year.

The AMA continues to pursue its GME advocacy campaign with the 113th Congress. On January 29, 2013, the AMA supported H.R. 297, the "Children's Hospital GME Support Reauthorization Act of 2013," which would reauthorize federal funding to support GME for free-standing children's hospitals. On March 19, the AMA also supported S.577 and H.R. 1180, the "Resident Physician Shortage Reduction Act," which would expand the number of GME slots by 15 percent (an additional 15,000 GME slots).

The AMA has also been closely monitoring the activities of the following organizations that are studying GME financing:

- The Council on Graduate Medical Education (COGME), the entity mandated by Congress to study and advise the federal government about the nation's physician workforce, convened twice in 2012 to prepare its upcoming 21st report on "Restructuring Graduate Medical Education." COGME has recommended that funded GME positions be increased by a minimum of 15% to directly support innovative training models that address community needs and reflect emerging, evolving, and contemporary models of health care delivery, e.g., the patient-centered medical home. COGME has also recommended the adoption of an all-payer GME system.[9]

- MedPAC has been reviewing ways to improve GME through Medicare's teaching payments with the goal of creating a payment system that fosters greater accountability for Medicare's GME dollars and rewards education and training that will improve the health care delivery system. MedPAC's proposed performance-based funding system does not address the supply, mix, and geographic distribution of physicians.[10]

While several federal bills introduced during the 112th Congress would increase GME funding to address physician shortages, other federal bills tied GME payments to an accountability and transparency program. With an accountability and transparency program, teaching hospitals that do not meet performance standards would face reduced Indirect Medical Education (IME) payments. As federal policymakers continue to discuss the budget and reducing the federal deficit in recent years, funding for federally funded programs including GME are under scrutiny. In December 2010, the Simpson-Bowles Commission put forth a plan to reduce Medicare funding for residency training programs by $60 billion over a 10-year period. President Obama recommended a cut of $11 billion over 10 years in his FY 2014 budget plan. Moreover, federal funding for GME is currently being reduced by the 2 percent sequestration cut that went into effect on April 1.

As the AMA continues with its mission at the federal level to ensure that adequate GME opportunities exist, state and local-based strategies to justify and support GME funding are also becoming more critical. At a November 2010 summit, the AMA, in collaboration with leaders from GME programs, state medical societies, and national medical

organizations discussed state-based GME funding options. The summit's goal was to develop successful strategies that state and regional stakeholders could embrace for political action to expand GME funding to meet state and regional medical workforce needs. A brochure, which was published following the summit, contains recommendations and policies supported by the AMA (Appendix A).

AMA EFFORTS IN EDUCATION ACROSS THE CONTINUUM

The AMA has set forth a multi-year strategy, defined during a period in which the state and future of health care appear particularly unsettled.[11] The AMA outlined a long-range strategic plan that focuses on three core areas that include improving patients' health outcomes while reducing health care costs, accelerating change in medical education to align physician training and education with the future needs of patients and the health care system, and enhancing professional satisfaction and practice sustainability by helping physicians navigate delivery and payment models.

The AMA plans to accelerate change in undergraduate medical education in part to align with the changes that are occurring with the restructuring of the GME accreditation system. In January 2013, the AMA released a request for proposals to US medical schools to submit proposals for funding that embrace bold change in medical education programs to better meet the needs of an evolving health care system. As part of the RFP process, schools are encouraged to consider innovations that support new, flexible, and outcomes-based education across the continuum. In addition, the AMA will convene a learning collaborative of participating medical schools and additional partners to evaluate and promote adoption of successful innovations.

AMA POLICY

AMA Policies H-305.929, "Proposed Revisions to AMA Policy on the Financing of Medical Education Programs," H-310.917, "Securing Funding for Graduate Medical Education," D-305.967, "The Preservation, Stability, and Expansion of Full Funding for Graduate Medical Education," D-305.958, "Increasing Graduate Medical Education Positions as a Component to any Federal Health Care Reform Policy," and D-305.973, "Proposed Revisions to AMA Policy on the Financing of Medical Education Programs" (Appendix B) are relevant to this discussion.

AMA policy supports maintaining adequate and stable Medicare and Medicaid GME funding levels, advocating for the contribution by all payers for health care to fund the cost of GME (e.g. the federal government, states, and private payers), actively exploring additional sources of GME funding and their potential impact on the quality of residency training and patient care, and making new funding available to support increases in the number of medical school and residency training positions, preferably in or adjacent to physician shortage/underserved areas and in undersupplied specialties.

Policy H-305.929 (4) states that diversified sources of funding should be available to support medical schools' multiple missions, including education, research, and clinical service. Reliance on any particular revenue source should not jeopardize the balance among a medical school's missions.

Policy D-305.967 (11) states that the AMA 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; and directs the AMA to 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.

DISCUSSION

Medicare is still the single largest funding source for GME, and CMS funding helps offset some of the costs associated with educating residents, caring for patients in teaching hospitals who often require more intense and complex care, and other special missions of teaching hospitals. Medicare pays approximately $9.5 billion annually for direct and indirect costs of GME programs throughout the country, but this funding does not come close to the cost of maintaining teaching programs (approximately $27 billion per year).[12] Sponsoring institutions have found it difficult to maintain their net income, which has depended in part on revenue generated by resident service and CMS funding.[13, 14]

It will be important now more than ever to continue pressing policymakers to protect or increase GME funding. Such support is essential to ensuring teaching hospitals' ability to provide patient care as well as preventing a worsening of the physician shortages that have already been identified by 33 states and 22 physician specialty organizations.[15] In this regard, the AMA will continue to collaborate with the AAMC and other key stakeholders to advocate for GME funding.

AMA has long-standing policy to advocate for the contribution by all payers for health care (including the federal government, states, and private payers) to fund both the direct and indirect costs of GME. Pulling in other payers for GME could increase the number of training positions without placing additional financial burden on Medicare. An all-payer system could also be an important contribution to deficit reduction by spreading the responsibility for funding GME to all who benefit from it instead of the federal government bearing a disproportionate share of the cost, as it currently does. However, private insurers have consistently opposed mandates that would require them to pay a portion of GME expenses.[16] Given the number of stakeholders involved in GME, it is of critical importance that the AMA continues to work with all stakeholders to explore and agree upon proposals for GME governance and financing. Proposed changes in GME should be carefully considered and crafted and agreed upon to avoid exacerbating projected shortages of physicians across all specialties including primary care. As the AMA continues to work with GME stakeholders on assessing a secure, rational, and fiscally sound GME funding model, AMA policy that supports new sources of funding for GME including private payers should also be considered.

In the long run, reimbursement reform may begin to reward accountable health care organizations (ACOs) that have the ability to manage complex chronic diseases efficiently and prevent unnecessary hospitalizations.[17] Broad participation in this model, however, may be constrained by the loss of payments for advanced clinical care, care to the underserved, and medical education payments associated with hospital stays.[17] The Teaching Health Center Graduate Medical Education (THCGME) program, created and funded under the ACA, offers opportunities to explore alternative solutions to GME funding, such as institutional indirect educational costs, variations in trainee-related productivity gains, and the program cost of GME innovations in non-hospital settings and in primary care.[18]

SUMMARY AND RECOMMENDATIONS

The Council on Medical Education envisions a health care system based on an adequate number of highly trained physicians who can work efficiently and effectively to provide high-quality care to all US citizens. The AMA is working with the AAMC and other stakeholders to advocate for the expansion of the graduate medical education (GME) workforce.

Therefore, the Council on Medical Education recommends that the following statements be adopted in lieu of Resolutions 317-A-12 and 329-A-12 and the remainder of this report be filed:

1. That our AMA reaffirm Policies H-305.929, "Proposed Revisions to AMA Policy on the Financing of Medical Education Programs," H-310.917, "Securing Funding for Graduate Medical Education," D-305.967, "The Preservation, Stability, and Expansion of Full Funding for Graduate Medical Education," D-305.958, "Increasing Graduate Medical Education Positions as a Component to any Federal Health Care Reform Policy," and D-305.973, "Proposed Revisions to AMA Policy on the Financing of Medical Education Programs." which support adequate and stable funding as well as new sources of funding for graduate medical education from all payers for health care including the federal government, the states, and private payers.

2. That our AMA reaffirm Policy H-305.929 (4), "Proposed Revisions to AMA Policy on the Financing of Medical Education Programs," which states that diversified sources of funding should be available to support medical schools' multiple missions, including education, research, and clinical service. Reliance on any particular revenue source should not jeopardize the balance among a medical school's missions.

3. That our AMA reaffirm Policy D-305.967 (11), "The Preservation, Stability, and Expansion of Full Funding for Graduate Medical Education," to recognize 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; and to direct AMA to 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.

4. That our AMA work with the Association of American Medical Colleges and other key stakeholders to continue to examine alternative models of funding for graduate medical education, with a report back at the 2014 Annual Meeting.

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APPENDIX A – AMA Brochure with Recommendations and Policies on Graduate Medical Education Funding

Visit www.ama-assn.org/resources/doc/med-ed-products/graduate-medical-education-funding.pdf for information on AMA's advocacy efforts on gradate medical education.

APPENDIX B – AMA Policies on GME Financing and Medical Workforce

H-305.929 Proposed Revisions to AMA Policy on the Financing of Medical Education Programs
It is AMA policy that: (1) Since quality medical education directly benefits the American people, there should be public support for medical schools and graduate medical education programs and for the teaching institutions in which medical education occurs. Such support is required to ensure that there is a continuing supply of well-educated, competent physicians to care for the American public. (2) Planning to modify health system organization or financing should include consideration of the effects on medical education, with the goal of preserving and enhancing the quality of medical education and the quality of and access to care in teaching institutions are preserved. (3) Adequate and stable funding should be available to support quality undergraduate

and graduate medical education programs. Our AMA and the federation should advocate for medical education funding. (4) Diversified sources of funding should be available to support medical schools' multiple missions, including education, research, and clinical service. Reliance on any particular revenue source should not jeopardize the balance among a medical school's missions. (5) All payers for health care, including the federal government, the states, and private payers, benefit from graduate medical education and should directly contribute to its funding. (6) Full Medicare direct medical education funding should be available for the number of years required for initial board certification. For combined residency programs, funding should be available for the longest of the individual programs plus one additional year. There should be opportunities to extend the period of full funding for specialties or subspecialties where there is a documented need, including a physician shortage. (7) Medical schools should develop systems to explicitly document and reimburse faculty teaching activity, so as to facilitate faculty participation in medical student and resident physician education and training. (8) Funding for graduate medical education should support the training of resident physicians in both hospital and non-hospital (ambulatory) settings. Federal and state funding formulas must take into account the resources, including volunteer faculty time and practice expenses, needed for training residents in all specialties in non-hospital, ambulatory settings. Funding for GME should be allocated to the sites where teaching occurs. (9) New funding should be available to support increases in the number of medical school and residency training positions, preferably in or adjacent to physician shortage/underserved areas and in undersupplied specialties. (CME Rep. 7, A-05; Reaffirmation I-06; Reaffirmed: Sub. Res. 314, A-07; Reaffirmation I-07; Reaffirmed: CME Rep. 4, I-08; Reaffirmed: Sub. Res. 314, A-09; Reaffirmed: CME Rep. 3, I-09; Reaffirmed: CME Rep. 15, A-10; Reaffirmation A-11)

H-310.917 Securing Funding for Graduate Medical Education
Our American Medical Association will: (1) continue to be vigilant while monitoring pending legislation that may change the financing of medical services (health system reform) and advocate for expanded and broad-based funding for graduate medical education (from federal, state, and commercial entities); and (2) continue to advocate for graduate medical education funding that reflects the physician workforce needs of the nation. (CME Rep. 3, I-09; Modified: CME Rep. 15, A-10; Reaffirmed in lieu of Res. 324, A-12)

D-305.967 The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education
1. Our AMA will actively collaborate with appropriate stakeholder organizations, (including Association of American Medical Colleges, American Hospital Association, state medical societies, medical specialty societies/associations) to advocate for the preservation, stability and expansion of full funding for the direct and indirect costs of graduate medical education (GME) positions from all existing sources (e.g. Medicare, Medicaid, Veterans Administration, CDC and others). 2. Our AMA will actively advocate for the stable provision of matching federal funds for state Medicaid programs that fund GME positions. 3. Our AMA will actively seek congressional action to remove the caps on Medicare funding of GME positions for resident physicians that were imposed by the Balanced Budget Amendment of 1997 (BBA-1997). 4. Our AMA will strenuously advocate for increasing the number of GME positions to address the future physician workforce needs of the nation. 5. Our AMA will oppose efforts to move federal funding of GME positions to the annual appropriations process that is subject to instability and uncertainty. 6. Our AMA will oppose regulatory and legislative efforts that reduce funding for GME from the full scope of resident educational activities that are designated by residency programs for accreditation and the board certification of their graduates (e.g. didactic teaching, community service, off-site ambulatory rotations, etc.). 7. Our AMA will actively explore additional sources of GME funding and their potential impact on the quality of residency training and on patient care. 8. Our AMA will vigorously advocate for the contribution by all payers for health care, (including the federal government, the states and private payers), to funding 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. (Sub. Res. 314, A-07; Reaffirmation I-07; Reaffirmed: CME Rep. 4, I-08; Reaffirmed: Sub. Res. 314, A-09; Reaffirmed: CME Rep. 3, I-09; Reaffirmation A-11; Appended: Res. 910, I-11; Reaffirmed in lieu of Res. 303, A-12; Reaffirmed in lieu of Res. 324, A-12)

D-305.958 Increasing Graduate Medical Education Positions as a Component to any Federal Health Care Reform Policy
1. Our AMA will ensure that actions to bolster the physician workforce must be part of any comprehensive federal health care reform. 2. Our AMA will work with the Centers for Medicare and Medicaid Services to explore ways to increase graduate medical education slots to accommodate the need for more physicians in the US. 3. Our AMA will work actively and in collaboration with the Association of American Medical Colleges and other interested stakeholders to rescind funding caps for GME imposed by the Balanced Budget Act of 1997. 4. Our AMA will actively advocate for expanded funding for entry and continued training positions in specialties and geographic regions with documented medical workforce shortages. 5. Our AMA will lobby Congress to find ways to increase graduate medical education funding to accommodate the projected need for more

physicians. 6. Our AMA will work with key organizations, such as the US Health Resources and Services Administration, the Robert Graham Center, and the Cecil G. Sheps Center for Health Services Research, to: (A) support development of reports on the economic multiplier effect of each residency slot by geographic region and specialty; and (B) investigate the impact of GME funding on each state and its impact on that state's health care workforce and health outcomes. (Sub. Res. 314, A-09; Appended: Res. 316, A-12)

D-305.973 Proposed Revisions to AMA Policy on the Financing of Medical Education Programs
Our AMA will work with: (1) the federal government, including the Centers for Medicare and Medicaid Services, and the states, along with other interested parties, to bring about the following outcomes: (a) ensure adequate Medicaid and Medicare funding for graduate medical education; (b) ensure adequate Disproportionate Share Hospital funding; (c) make the Medicare direct medical education per-resident cost figure more equitable across teaching hospitals while assuring adequate funding of all residency positions; (d) revise the Medicare and Medicaid funding formulas for graduate medical education to recognize the resources utilized for training in non-hospital settings; (e) stabilize funding for pediatric residency training in children's hospitals; (f) explore the possibility of extending full direct medical education per-resident payment beyond the time of first board eligibility for specialties/subspecialties in shortage/defined need; (g) identify funding sources to increase the number of graduate medical education positions, especially in or adjacent to physician shortage/underserved areas and in undersupplied specialties; and (h) act on existing policy by seeking federal legislation requiring all health insurers to support graduate medical education through an all-payer trust fund created for this purpose; and (2) other interested parties to ensure adequate funding to support medical school educational programs, including creating mechanisms to fund additional medical school positions. (CME Rep. 7, A-05; Reaffirmation I-06; Reaffirmation I-07)

6. CURRICULA FOR PAIN EDUCATION (RESOLUTION 325-A-12)

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: RECOMMENDATIONS ADOPTED IN LIEU OF RESOLUTION 325-A-12 AND REMAINDER OF REPORT FILED
See Policies D-295.982 and D-300.996

Resolution 325-A-12, Curricula for Pain Education, introduced by the American Academy of Pain Medicine and referred by the House of Delegates, asked that our American Medical Association (AMA):

> Work with all agencies, government bodies and other stakeholder organizations associated with developing, coordinating, and maintaining curricula for pain education, in cooperation with relevant medical specialty societies, to provide education about pain neurobiology, evaluation and treatment to all medical students.

This report provides an overview of issues relevant to pain management in the US, highlights relevant AMA policy, and provides a recommendation.

BACKGROUND

Pain is one of the most common reasons for patients to seek medical attention and one of the most prevalent medical complaints in the US.[1-3] According to the 2010 Institute of Medicine Report Relieving Pain in America, more than 116 million Americans are burdened with chronic pain.[4] Three in five of those 65 years or older said that they experienced pain that lasted a year or more; more than 60% of US nursing home residents report pain, most commonly attributable to arthritis, and 17% have substantial daily pain.[2,4] More than one-quarter of adults said they had experienced low back pain, and 15% of adults experienced migraine or severe headache in the past three months. For the millions of Americans who experience persistent pain, the impact on function and quality of life can be profound.[2-5]

Pain is associated with high utilization of health care, and the societal costs related to treatment are compounded by the loss in productivity associated with persistent pain.[6] Lost productive time from common pain conditions among workers costs an estimated $61.2 billion per year; most of this is related to reduced performance while at work.[7] The annual economic cost associated with chronic pain most likely exceeds $560 billion.[4]

Additionally, in recent years, national attention has focused on the escalating problem of prescription drug misuse and abuse—particularly of opioid medications. Drug overdose deaths in the United States exceed 36,000 annually with prescription drugs involved in more than 55% of such deaths. In 2008, opioid prescription pain killers played a role in 14,800 drug overdose deaths in the United States.[8] Unintentional poisoning deaths from these medications now exceed those attributable to car accidents in many states and show no signs of abating.

Federal actions such as requiring education on FDA-mandated Risk Evaluation and Mitigation Strategy (REMS) for extended-release and long-acting opioids, tracking and monitoring of prescription drugs at the retail level, developing standards on proper medication disposal, and enforcing laws to prevent practitioners illegally prescribing and/or dispensing prescription controlled substances and other prescriptions under the banner of medical care have emerged. State-based initiatives designed to more tightly regulate opioid use have followed these federal actions. Physicians and other clinicians would benefit from current, state-of-the-art education to assist them in developing the necessary skills to evaluate and safely manage patients with persistent pain.

DISCUSSION

Reference committee testimony from the American Academy of Pain Medicine argued for new policy, indicating that current AMA policy on this topic is more than 10 years old. However, the AMA House of Delegates has recognized this need for education related to pain, most recently in its reaffirmation (A-11) of the following AMA policies:

> D-295.982, Model Pain Management Program for Medical School Curricula
> Our AMA will collect, synthesize, and disseminate information about effective educational programs in pain management and palliative care in medical schools and residency programs.
>
> D-300.996, Voluntary Continuing Education for Physicians in Pain Management
> Our AMA will encourage appropriate organizations to support voluntary continuing education for physicians based on effective guidelines in pain management.

In addition to supporting these policies, the AMA House of Delegates at its 2012 Interim Meeting reaffirmed the Association's commitment to continuing to promote training of physicians on competent use of controlled substances and encourage use of screening tools to identify patients at risk of abusing prescription drugs.[8]

While the AMA does not support mandating medical education curricula, the Association recognizes that physician education is key to ensuring appropriate pain management of patients. One component of the AMA's strategy for fighting opioid abuse is a comprehensive CME activity on pain management, first developed by the AMA in 2003, with content revisions released in 2007 and 2010. Over 155,000 certificates were issued to physicians for participation in this 12-module series since its initial online release. In addition to physician participation, nearly 10,000 medical students participated in one or more of the modules between 2007 and 2012. The next revision of this series is scheduled to be released in 2013.

RECOMMENDATION

The Council of Medical Education recommends the following statement be adopted in lieu of Resolution 325-A-12 and the remainder of this report be filed:

> That our American Medical Association (AMA) reaffirm policies D-295.982, "Model Pain Management Program for Medical School Curricula, and D-300.996, Voluntary Continuing Education for Physicians in Pain Management.

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7. RETENTION AND AVAILABILITY OF CONTINUING MEDICAL EDUCATION PARTICIPATION RECORDS (RESOLUTION 327-A-12)

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: RECOMMENDATIONS ADOPTED IN LIEU OF RESOLUTION 327-A-12 AND REMAINDER OF REPORT FILED
See Policy D-300.999

Resolution 327-A-12, Retention and Availability of Continuing Medical Education Participation Records, introduced by the Michigan Delegation and referred by the House of Delegates, asked that our American Medical Association (AMA):

> Work with the Accreditation Council for Continuing Medical Education (ACCME) and continuing medical education (CME) providers that it accredits to ensure that each CME provider will make available to a central data repository a transcript of all CME credits earned by a physician from the CME provider, including date, credits earned, and program title; and
>
> Work with the ACCME to make physician CME transcripts available to the physician online and in real time in a format suitable for submission to licensing and other organizations without cost to the physician.

During testimony it was noted that a central data repository service would potentially be very useful for physicians and could expand the member value of AMA by tracking CME as well as maintenance of certification (MOC) and osteopathic continuous certification (OCC) as noted in CME Report 10-A-12. However, the cost of such a service would almost invariably be borne by physicians, and the AMA could be duplicating similar services already provided by state and specialty societies, hospitals, and area health education centers.

BACKGROUND

There are three major credit systems in the United States: 1) the AMA Physician Recognition Award (PRA), 2) The American Academy of Family Physician (AAFP) credit system, and 3) the American Osteopathic Association (AOA) credit system. The three established credit systems facilitate physician credentialing and the renewal of licensure by providing metrics to demonstrate that a physician has maintained a commitment to study, apply, and advance scientific knowledge through participation in appropriate CME activities. There is strong communication and cooperation among the AMA, AOA, and AAFP, and although there are differences in how they categorize credits, their CME rules are similar in many ways. However, there is no central data repository to track all CME credits earned by a physician.

RELATIONSHIP BETWEEN THE ACCME AND AMA PRA CREDIT SYSTEM

The ACCME accredits organizations that are CME providers, including medical schools; nonprofit physician membership organizations, such as medical specialty and state medical societies; hospitals/health care delivery systems; publishing and education companies; government and military organizations; and insurance and managed-care companies. The ACCME also recognizes 43 state and territory medical societies as accreditors for local organizations, such as community hospitals, state specialty societies, and county medical societies, offering CME. In

total, as of January 9, 2013, there were 1,980 accredited CME providers, including organizations accredited by the ACCME and by ACCME-recognized accreditors.[1]

Within the United States, the AMA authorizes organizations that are accredited by the ACCME or by a state medical society recognized by the ACCME, referred to as "accredited CME providers," to designate and award *AMA PRA Category 1 Credit*™ to physicians. With the exception of those activities directly certified by the AMA, individual educational activities must be offered by accredited CME providers, in accordance with AMA PRA credit system requirements, to be certified for *AMA PRA Category 1 Credit*™. The AMA reserves the right to withdraw an accredited CME provider's privilege to certify activities for *AMA PRA Category 1 Credit*™ should the accredited CME provider fail to bring the program and activities into compliance with AMA PRA policies, regardless of accreditation status.

EVIDENCE OF CME PARTICIPATION

It is a physician's professional responsibility to participate in CME activities in order to continue to learn and improve the care they provide to patients. Often CME credits can be used to meet the CME requirements of state medical boards, medical specialty societies, specialty boards, hospital medical staffs, and insurance companies. Physicians can choose from a wide variety of CME offerings through many venues, including live meetings and courses, medical journals, and the Internet, developed by accredited CME providers.

CME providers accredited by the ACCME and state/territory medical societies produced 132,768 CME activities in 2011 that were certified for *AMA PRA Category 1 Credit*™. AMA PRA requirements mandate that all accredited CME providers maintain records for each physician that participates in their CME activities and verify this participation if requested by the physician. CME providers do not report to the AMA, the ACCME, or the state medical societies the actual number of credits that they have awarded to individual physicians. Physicians are responsible for tracking their earned CME credits, and when CME credit verification is required for licensure or other credentialing purposes, physicians must produce documentation of participation in CME activities from the primary source. AMA PRA policy encourages physicians to report to the AMA any accredited CME provider that fails to provide documentation to a physician of his or her earned AMA PRA credits.[2]

AMA Policy D-300.999, Registration of Accredited CME Sponsors, states that the AMA will continue cooperative efforts to assure that accredited sponsors of continuing medical education adhere to AMA Physician's Recognition Award (PRA) policy when designating AMA PRA credit.

The AOA works with approximately 157 AOA-accredited sponsors who provide AOA Category 1 credit. It is the responsibility of the sponsor to report all CME credit earned by individual physicians to the AOA. For non-osteopathic-sponsored CME activities, it is the responsibility of the physician to provide documentation to the AOA. A certificate of attendance or a letter of verification from the CME sponsor must be provided. The AOA tracks earned CME credits for individual physicians in a centralized repository, the AOA "DO CME Online" system. AOA members may view their CME profile/activity report online or contact the AOA for a written report, and there is no fee.[3]

The AAFP members usually self-report their CME credits to the AAFP. However, this is strictly voluntary. The AAFP does not require CME providers to give certificates to their CME participants; however, the AAFP encourages CME providers to offer certificates since many members need one for state licensing and credentialing. CME providers are required to have a mechanism in place to document learner participation.[4]

ORGANIZATIONS THAT CURRENTLY TRACK CME CREDIT

Policy D-300.991, Web-Based System for Registering CME Credits, states: 1) Our AMA, through the Division of Continuing Physician Professional Development (CPPD), will perform a new feasibility analysis to determine if reinitiating the CME Credit Tracker project is possible; and 2) The Council on Medical Education will monitor the progress of the analysis and facilitate constructive dialogue with all interested stakeholders.

Since 2003, the AMA CPPD Division has studied the feasibility and considered the development of a CME Tracker system that would track individual physician CME credits and provide a number of other services. However, due to its complexity and concerns related to security issues and economics, this project has not been approved for

implementation. There is also concern that such a service would compete with and duplicate other services that are currently available to assist physicians with tracking CME.

A recent survey of CME directors conducted by the Council of Medical Specialty Societies showed that the majority of specialty societies who manage a database of CME credits earned by their physician members would not prefer a centralized database of CME credits in lieu of their services. They consider their CME tracking services valuable member benefits. Specialty societies are also concerned about the potential data integrity/ownership/security issues that could arise with the development of a centralized database.

Although there is no centralized data repository for specialty-focused CME activities there are organizations that have developed services to assist physicians with tracking their CME credits. The American Society of Clinical Oncology (www.asco.org) and the American Academy of Family Physicians (www.aafp.org/online/en/home/publications/news/news-now/cme-lifelonglearning/20100330learningportal.html) offer their members online CME tracking services. The American Board of Radiology and CME Gateway (www.CMEgateway.org), developed by the American College of Radiology, Society of Nuclear Medicine, and American Roentgen Ray Society, allows members to view, print and generate reports of their CME credits from these organizations from a single online access point.

State societies are also assisting physicians with tracking CME to meet state licensure requirements. The Pennsylvania Medical Society (PMS) (www.pamedsoc.org/MainMenuCategories/CME/CMETracker) allows physicians to enter their CME credits into an electronic tracking system; the tracker shows physicians when they have met the state licensing requirements and the PMS's CME certificate requirements. The California Medical Association (CMA) (www.cmanet.org/membership/membership-benefits/professional-development/cme-tracking-credentialing) has been designated by the ACCME as California's intrastate accrediting agency. CMA's Institute for Medical Quality's (IMQs) CME Certification Program records and verifies Category 1 CME credit/hours for California licensed physicians to meet California Medical Board's requirements for re-licensure. Physicians who participate in this program are not required to undergo an independent audit of their CME activities by the California Medical Board. The Florida Department of Health, Medical Quality Assurance and CE Broker (www.doh.state.fl.us/mqa/publications/cebroker.htm) will verify a practitioner's CME in its electronic tracking system at the time of licensure renewal.

Mobile apps are also available to track CME credit. Epocrates CME (www.epocrates.com) is a free mobile app and online resource that allows physicians to participate in activities for CME credit on an Android or iOS device (iPhone, iPod touch, iPad), or on the web from a personal computer and has a tool set that allows its users to track their CME credits. CME Easy (itunes.apple.com/us/app/cmeasy/id514211622?mt=8) is an inexpensive iPhone app that allows physicians to create templates for frequently used sources of CME.

FACILITATING INDIVIDUAL PHYSICIAN EFFORTS TO COMPLETE MOC AND OCC

As noted in CME Report 10-A-12 (www.ama-assn.org/resources/doc/council-on-med-ed/a-12cmerpt10.pdf), the American Board of Medical Specialties (ABMS) and many of the certification boards have developed tools to assist physicians with completing MOC Part IV Practice Performance Assessment.

DISCUSSION

The current CME system in the United States allows for physicians to choose from approximately 133,000 certified *AMA PRA Category 1 Credit*™ CME activities offered through a wide variety of venues as well as CME activities certified for AAFP or AOA credit. CME providers make high quality certified CME activities available to ensure the continuous professional development of physicians. Many of these CME providers, like the AMA, offer physicians CME through a learning management system that tracks their CME participation. Resources are also available to assist physicians with tracking their earned CME credits. The AMA continues to work actively with the ABMS, ACCME, the CME provider community and CME stakeholders to address issues related to CME and the various components of the MOC program.

The AMA has long recognized that a central repository and online reporting system that could allow a physician to track and store his or her CME credit would be very useful for meeting the requirements for certification, licensure, and credentialing. However, state medical and specialty societies and other organizations already provide similar

services, and a central repository would duplicate these services. Some CME providers might resist requirements to report information to a central repository since they already provide this service to their members. Some specialty societies have also developed working relationships with their certifying boards as a member service. In addition, each CME provider is required to keep records of the credits it issues to meet the requirements for the AMA PRA, and this could create more administrative work for their staff.

In order to create a central repository, all CME providers would have to agree upon technical and data security proposals and determine who would pay for the database development. Although the AMA has previously considered the development of a central repository impractical due to its complexity and expense, the appropriate departments within the AMA will continue to monitor advancements in technology and the changing environment that may make this project feasible in the future.

RECOMMENDATIONS

The Council on Medical Education recommends that the following recommendations be adopted in lieu of Resolution 327-A-12 and that the remainder of the report be filed.

1. That our American Medical Association (AMA) reaffirm Policy D-300.999, Registration of Accredited CME Sponsors, to reinforce that the AMA will continue cooperative efforts to assure that accredited sponsors of continuing medical education adhere to AMA Physician's Recognition Award (PRA) policy when designating AMA PRA credit.

2. That our AMA remind all accredited CME providers of their responsibility, as stated in the AMA PRA requirements, to provide documentation to participating physicians of the credit awarded at the request of the physician.

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8. THE CHANGING TRAINING ENVIRONMENT: ACCESS TO PROCEDURAL TRAINING FOR RESIDENTS AND FELLOWS (RESOLUTION 328-A-12)

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS IN LIEU OF RESOLUTION 328-A-12 AND REMAINDER OF REPORT FILED
See Policies H-310.913 and D-310.964

Resolution 328-A-12, The Changing Training Environment: Access to Procedural Training for Residents and Fellows, introduced by the Minnesota Delegation, Minority Affairs Section, and Nebraska Delegation and referred by the House of Delegates, asked that our American Medical Association (AMA):

1. Study the trends in numbers of residency training sites that also employ mid-level providers and/or concurrently train students of these mid-level programs;

2. Define a physician-in-training's role in the hospital and specifically make it a high educational priority for trainees to receive the needed exposure to procedures required for them to master competency in their specialty and that these exposures are not delegated to mid-level providers and mid-level provider trainees; and

3. Study the financial impact for institutional training sites of hiring more mid-level providers versus investing in a physician training program.

There was mixed testimony heard during Reference Committee C. While it is possible that the hiring of mid-level providers may have had an adverse effect or deprived medical students and residents in some needed training opportunities, their presence has also enhanced the education of students and residents and contributed to a better understanding of team-based care and coordination.

BACKGROUND

In July 2011, the Accreditation Council for Graduate Medical Education (ACGME) implemented new resident duty hour standards.[1] The standards retain the 80-hour limit per week (averaged over 4 weeks) implemented by the ACGME in 2003, but reduce shift lengths for first-year residents to no more than 16 hours and set stricter requirements for duty hour exceptions. In addition, the standards specify in greater detail the levels of supervision necessary for first-year residents; set higher requirements for teamwork, clinical responsibilities, communication, professionalism, personal responsibility, and transitions of care; establish graduated requirements for minimum time off between scheduled duty periods; expand requirements regarding patient care hand-offs; and call for alertness management and fatigue mitigation strategies to promote continuity of patient care and resident safety.[2] Although Public Citizen has repeatedly called for the Occupational Safety and Health Administration (OSHA) to regulate resident physician duty hours,[3] AMA policy (D-310.964) supports oversight and enforcement of resident/fellow physician duty hours by the ACGME and believes that the ACGME is the most appropriate body to regulate and monitor resident duty hours in the context of multiple other factors including supervision, professionalism, and patient care quality. The AMA Council on Medical Education continues to monitor the enforcement and impact of the ACGME duty hour standard as it relates to patient safety and the optimal learning environment for residents.

The AMA also recognizes that institutions that sponsor residency training programs have found it difficult to maintain their net income, which has depended in part on revenue generated by resident service and Medicare-funded graduate medical education (GME) programs.[4, 5] The 1997 Balanced Budget Act capped the number of Medicare-funded GME positions at 1996 levels for almost all teaching hospitals.[6] While new US allopathic and osteopathic medical schools are opening and many medical schools are expanding their enrollments to meet the need for more physicians, core residency training programs are experiencing minimal growth due to limited federal funding.

There is mounting concern about the ability of the health care profession to handle the expected surge in demand for health care services due to the passage of the Patient Protection and Affordable Care Act (ACA) (P.L. 111-148) and the projected shortage of physicians (including primary care, general surgeons, and many other specialties) in the near future.[7, 8] In that regard, the AMA has continued to collaborate with the Association of American Medical Colleges and other key stakeholders to advocate for GME funding and alert Congress that cuts to GME funding will jeopardize the ability of medical schools and teaching hospitals to train physicians, as well as limit critical services to patients.[9]

EMPLOYMENT OF MID-LEVEL PROVIDERS

Many resident physicians train at teaching hospitals where they provide complex and acute care for the underserved, indigent, and elderly. Restrictions on resident work hours and minimal growth in residency training positions have decreased patients' access to medical services provided by residents.[10] This has impacted the ability for resident physicians to provide the same amount of patient care as in prior years, and this gap has been offset by expanding the number of non-physicians to care for patients. Advanced practice nurses (APNs) and physician assistants (PAs) have assumed increasing responsibility and independence in a variety of health care settings and are making significant and important contributions to patient care. There is substantial variation in the allocation of their clinical services by specialty, geography, employment setting, and other factors. There are also considerable gaps in the data describing their distribution and participation compared to physicians.[11]

Individual state licensing boards are responsible for ensuring, through licensure and certification, that health care professionals provide services commensurate with their training. The Joint Commission establishes medical staff and other credentialing procedures for non-physician practitioners in its Hospital Accreditation Standards. Hospitals can extend medical staff membership to APNs and PAs, and any other category of practitioner deemed eligible by the hospital so long as it complies with federal and state laws and accreditation standards. Current rules and regulations governing APN and PA qualifications, practice and prescription authority, and reimbursement vary greatly across states as well as in hospitals that may choose to exercise all the skills the law permits them to exercise or limit the privileges of independent practitioners.[12]

DEFINING THE "PHYSICIAN-IN-TRAINING" ROLE IN THE HOSPITAL

The AMA's role in defining the role of physicians-in-training is accomplished through AMA representation on the ACGME Board of Directors. The AMA and the appropriate medical specialty boards and specialty organizations also appoint about 6 to 15 volunteer physicians to the ACGME's 28 Residency Review Committees (RRCs). The function of the RRCs is to establish accreditation standards and to provide a peer evaluation of residency programs and subspecialties (or, in the case of the Institutional Review Committee, to provide a peer evaluation of sponsoring institutions). This includes preparing or revising the Common Program, specialty specific and Institutional Requirements to reflect current educational and clinical practice. The RRCs also initiate discussion in matters of policy, best practice, and innovation relating to GME.[13]

To maintain its accreditation, a medical training institution must establish how physicians will be trained to perform certain procedures. For example, the ACGME's Program Requirements for GME in General Surgery (Int.B.) provide the Definition and Scope of the Specialty and state:

> The goal of a surgical residency program is to prepare the resident to function as a qualified practitioner of surgery at the advanced level of performance expected of a board-certified specialist. The education of surgeons in the practice of general surgery encompasses both didactic instruction in the basic and clinical sciences of surgical diseases and conditions, as well as education in procedural skills and operative techniques. The educational process must lead to the acquisition of an appropriate fund of knowledge and technical skills, the ability to integrate the acquired knowledge into the clinical situation, and the development of surgical judgment.[13]

The ACGME currently has requirements in place that require residents to maintain a log of procedures that they are required to perform for their particular specialty. The RRCs are responsible for establishing the minimum number of procedures required, and residency programs are responsible for documenting that residents have performed a sufficient breadth of complex procedures to graduate qualified physicians. The ACGME also has requirements that prevent residents' progression through training if they are not receiving adequate clinical experiences.[13]

In July 2013, the ACGME will implement its next accreditation system (NAS) for 7 of the 26 ACGME-accredited residency core specialties (emergency medicine, internal medicine, neurological surgery, orthopedic surgery, pediatrics, diagnostic radiology, and urology), and the remaining specialties and the transitional year will be implemented in 2014.[14] The RRCs in these specialties will begin to collect milestones (developmentally based, specialty-specific achievements that residents are expected to demonstrate at established intervals as they progress through training) data. The milestones that are being developed within the NAS will include a procedural competency as part of the evaluation. Under this new system, theoretically, residents should perform the procedure until the required level of competency is achieved, at which point having a mid-level provider perform this procedure would be less detrimental to the resident's education. If the program cannot demonstrate that their residents are achieving competency in procedures, this would be noted in their evaluations.

In addition to milestones, other data elements that will be reviewed annually include ACGME resident and faculty surveys and operative and case-log data. This ongoing data collection and trend analysis will allow the ACGME to base its accreditation in part on the educational outcomes of programs and enhance its ongoing oversight to ensure that programs meet standards for high-quality education and a safe and effective learning environment.[14]

DISCUSSION

Residents and fellows learn while providing direct patient care in hospitals and clinics under the direct supervision of a teaching physician. While on duty, residents are the first-line contact for patient care issues and emergencies pertaining to patients on their service. Many types of residents (e.g., surgery, radiology, obstetrics, family medicine) also learn and perform surgical procedures under supervision and are engaged in the pre- and postoperative medical and surgical care of their patients.

It is becoming common practice in some institutions to shift procedural work to mid-level providers as residents comply with new duty hour restrictions. APNs and PAs are being trained to perform operating room and bedside procedures such as placement of central lines, catheters, intracranial pressure monitors, etc. However, in some cases, limited training has been available to residents and fellows who need to become proficient at performing these procedures.[15]

In its position statement to the Institute of Medicine, the American College of Surgeons states, "Optimum training of resident physicians, especially surgical residents, requires a longitudinal, comprehensive curriculum that focuses on the cognitive elements, technical skills, and judgment that are critical to providing safe patient care." The ACS also states, "Achievement of expertise requires sustained deliberate practice, and retention of skills requires periodic reinforcement."[16]

It has been argued that less time spent in the hospital will ultimately lead to less experienced and less competent physicians than in the era preceding work-hour restrictions.[17] A recent longitudinal study showed that half of all general surgery interns felt that the duty hour changes have decreased their coordination of patient care (53%), their ability to achieve continuity with hospitalized patients (70%), and their time spent in the operating room (57%).[15]

In another study among neurological surgeons, board certification test scores and levels of participation in national conferences declined after implementation of duty hour limits in 2003. The study also found that 96 percent of chief residents and residency program directors believed that the 80-hour limit had compromised resident training, and 98 percent believed that it had led to a decrease in surgical experience.[10]

Published studies on the impact of duty hour restrictions on surgery residents' ability to perform a sufficient number of surgical procedures to make them proficient and well qualified for independent practice are limited. Additional study is needed to evaluate the impact of reductions in duty hours on a physician's ability to train and perform the necessary procedures established by the RRCs.

RECOMMENDATIONS

The Council on Medical Education recommends that the following recommendations be adopted in lieu of Resolution 328-A-12, and the remainder of this report be filed.

1. That our American Medical Association (AMA) support the concept that procedural training is a critical portion of resident education and the augmentation of patient care by non-physician practitioners should not interfere with a resident's ability to achieve competence in the performance of required procedures.

2. That our AMA ask the Accreditation Council for Graduate Medical Education to evaluate the trend in the number of cases, and roles in these cases, of graduating residents since the implementation and revision of duty hour restrictions to determine whether duty hour standards may have adversely impacted residents' ability to participate in a sufficient number of cases to make them proficient and well qualified for independent practice, and that this information be used to further refine change in resident education under the Next Accreditation System.

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9. STUDENT MISTREATMENT

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: RECOMMENDATIONS ADOPTED AND REMAINDER OF REPORT FILED
See Policies H-295.900 and H-295.955

Perceived mistreatment by medical students is pervasive and consistent in medical education even after interventions to remedy it. Types of mistreatment include verbal abuse, sexual harassment, racial and ethnic insensitivity, abuse of power and physical abuse. Although public humiliation and belittlement are the most common forms of mistreatment, instances of physical abuse continue to occur.[1-3]

Mistreatment of students has been associated with lack of confidence in clinical skills, decreased empathy, increased cynicism about medicine, anxiety, depression, post-traumatic stress, drinking and suicidal ideation. Of concern is the potential for mistreatment to have long-lasting negative effects on students' professionalism and quality of patient care. [3-7]

Interventions to reduce mistreatment have included zero-tolerance policies, improved reporting structure such as the ability to file anonymous concerns, no statute of limitations, rewarding good behavior, focusing on maintaining a positive learning environment and disseminating best practices. Despite implementing these strategies, a culture of mistreatment persists. Recent findings from a study on student mistreatment at a US medical school found that

despite interventions to eliminate mistreatment over a 13-year time period, students continued to report experiencing mistreatment during clerkships.[2]

DEFINITION OF MISTREATMENT

Mistreatment, either intentional or unintentional, occurs when behavior shows disrespect for the dignity of others and unreasonably interferes with the learning process. Examples of mistreatment include sexual harassment; discrimination or harassment based on race, religion, ethnicity, gender, or sexual orientation; humiliation, psychological or physical punishment; and the use of grading and other forms of assessment in a punitive manner.[8]

PREVALENCE OF MISTREATMENT

According to the 2012 Association of American Medical Colleges (AAMC) Graduation Questionnaire (GQ), almost half (47%) of medical students reported experiencing mistreatment. About one-third (34%) of respondents reported that they had been publicly humiliated at least once during medical school. About 16 percent (N = 1,935) were subjected to offensive sexist remarks and twelve percent (N = 243) were physically harmed.[1] Respondents to the 2012 GQ were 79 percent (N = 13,681) of medical students graduating from 126 LCME-accredited medical schools in the US in the 2011-2012 academic year.

The study further showed that students most often cited clerkship faculty (31%) in clinical settings, residents/interns (28%) and nurses (11%) as the perpetrators of mistreatment. The majority (85%) of medical students are aware that their school has a policy on mistreatment; about two-thirds (67%) know the procedures for reporting mistreatment at their schools. A relatively low percentage of students reported the incident, either when experienced personally (17%) or when witnessed happening to others (8%). The main reason for not reporting in both cases was "the incident did not seem important enough to report" (59% and 43% respectively). Among students who did report the behavior (either experienced personally or witnessed), over half reported the incident to a faculty member (52% and 55% respectively).[1]

It should be noted that between 2007 and 2011 about 17 percent of medical students reported being mistreated. The apparent reason for the large increase to 47 percent of students who reported being mistreated was a substantial revision to the questions regarding students' experiences of the various types of mistreatment in the 2012 GQ.

Before 2012, students were asked: Have you personally been mistreated during medical school? Students who answered "no" did not answer questions on whether or not they had personally experienced specific types of mistreatment. In 2012, this "gateway" question was removed and students were asked to respond to individual questions that pertained to specific behaviors associated with mistreatment. This change was implemented in part due to literature that indicates that questions on specific behaviors yields more accurate data than questions that require respondents to identify the behavior through the lens of a label, such as mistreatment.

Due to the changes made to the 2012 GQ questions on mistreatment, data from 2012 should not be compared to data from previous years of the GQ. For a detailed description of the changes and the specific questions on mistreatment see the section entitled "Changes to the GQ in 2012" and pages 41-44 respectively in the 2012 GQ All Schools Summary available online at: www.aamc.org/download/300448/data/2012gqallschoolssummaryreport.pdf.

LCME STANDARDS MS-31-A AND MS-32

MS-31-A, the LCME accreditation standard on the medical education learning environment, went into effect in July 2009. In summary, the intent of the standard is for a medical school to:

1. Define the professional attributes that medical students are expected to develop;
2. Include education and student assessment related to these attributes as part of the educational program;
3. Evaluate the learning environment to identify positive and negative influences; and
4. Work with its partners to mitigate negative influences on medical students' development of desired professional attributes.

The wording of standard MS-31-A and its explanatory annotation are available online at: www.ama-assn.org/resources/doc/council-on-med-ed/cmereport4a11.pdf (see pages 20-21).

The LCME has an additional standard on the medical education learning environment, MS-32 that expects medical schools to define and publicize the standards for the teacher-learner relationship and to develop written policies for addressing violations. The wording of standard MS-32 and its explanatory annotation is available online at: www.ama-assn.org/resources/doc/council-on-med-ed/cmereport4a11.pdf (see page 21).

The LCME monitors compliance with this standard in part through responses to the AAMC GQ. The LCME co-chairs also wrote to the AMA and AAMC to ask for assistance in addressing mistreatment of medical students.

ACTIVITIES OF THE AMA

In response to the request from the LCME to participate in addressing problems related to medical student mistreatment, the AMA Council on Medical Education (CME), the Section on Medical Schools, and the Medical Student Section held a joint education session entitled *Optimizing the Learning Environment: Exploring the Issue of Medical Student Mistreatment* during the 2011 Annual Meeting of the AMA House of Delegates. The AMA's commitment to reducing student mistreatment and promoting a positive medical education learning environment has led to three other AMA-sponsored activities: 1) Strategies for Addressing Medical Student and Resident Mistreatment Conference; 2) Medical Student Mistreatment: The Residency Connection educational session; and 3) the Learning Environment Study. For AMA activities that focus more broadly on the learning environment, refer to CME Report 4-A-11: Progress in Transforming the Medical Education Learning Environment. This report is available online at: www.ama-assn.org/resources/doc/council-on-med-ed/cmereport4a11.pdf.

Optimizing the Learning Environment: Exploring the Issue of Medical Student Mistreatment

The AMA Council on Medical Education, Section on Medical Schools and the Medical Student Section (MSS) held a joint education program at the 2011 Annual Meeting. Speakers included representatives from medical schools, LCME and AAMC as well as members of the MSS and Resident and Fellow Section. The session brought together the perspectives of medical school deans, resident physicians, and medical students for the purpose of outlining the problem and suggesting potential solutions. A summary of the education session is available online at: www.ama-assn.org/resources/doc/medical-schools/sms-a11-mistreatment.pdf.

Strategies for Addressing Medical Student and Resident Mistreatment Conference

The medical education learning environment including the relationship between teachers and learners is a long-standing interest of the CME. To further the AMA's commitment to reducing student mistreatment, the CME Subcommittee on Undergraduate Medical Education called for a conference.

This invitational conference was held November 30 – December 1, 2011. Participants were 30 experts in medical education, medical students, residents and AMA staff. Participants provided valuable feedback to the AAMC on enhancing the questions on mistreatment in the GQ. As a result of the conference, a new MSS listserv devoted to the topic of medical student mistreatment was created. The main purpose of the listserv was to provide specific feedback and suggestions to the AAMC on restructuring mistreatment questions on the GQ.

Medical Student Mistreatment: the Residency Connection

The AMA also sponsored the educational session "Medical Student Mistreatment: The Residency Connection" at its 2012 Interim Meeting. The session highlighted the importance of addressing mistreatment of residents in the clinical setting before they enter unsupervised practice. Participants noted that the lack of a clear definition of mistreatment was a concern as this impacted the quality of data on mistreatment. Further, it was noted that what constituted mistreatment varied across individuals making efforts to reduce mistreatment more complex. A summary of presentations from this educational session is available online at: www.ama-assn.org/resources/doc/medical-schools/i-12-sms-presentations.pdf.

Learning Environment Study (LES)

The AMA-led LES is a prospective longitudinal cohort study of the medical education learning environment. The LES includes approximately 4,800 medical students from 2 consecutive classes (2014 and 2015) representing 28 medical schools in the US and Canada. Students are being followed throughout the four years of undergraduate

medical education. To measure the medical education learning environment, students complete the Medical School Learning Environment Scale (MSLES). Students complete a demographics questionnaire and four trait scales: Patient-Practitioner Orientation Scale (PPOS), Jefferson Scale of Physician Empathy, Ways of Coping Questionnaire, and Tolerance of Ambiguity Scale. Additionally, a representative from each participating school will complete the Structural Attributes of Schools Survey (SASS) to assess institutional-level factors that may influence students' perceptions of the learning environment including mistreatment.

The SASS includes the following two questions on mistreatment: 1) Is there a school policy to address student mistreatment? and; 2) What services are available to students who experience mistreatment and may wish to report it? Respondents are given the following list of services and are asked to check all that apply: a) Peer counseling; b) Support group for students who have experienced mistreatment; c) Ombudsman; d) Resolution mechanism at local level; e) Can report directly to a Dean /Associate Dean; and f) Other. Data collection for the SASS is scheduled for spring of 2013.

AMA POLICY ON MISTREATMENT

The recommendations and viewpoints stemming from the literature and AMA-sponsored meetings are highly consistent with existing AMA policy. The AMA recommends that each medical education institution have a widely disseminated policy that: (1) sets forth the expected standards of behavior of the teacher and the learner; (2) delineates procedures for dealing with breaches of that standard, including: (a) avenues for complaints; (b) procedures for investigation; (c) protection and confidentiality; (d) sanctions; and (3) outlines a mechanism for prevention and education. The AMA also urges all medical education programs to regard the code of behavior as a guide in developing standards of behavior for both teachers and learners in their own institutions, with appropriate provisions for grievance procedures, investigative methods, and maintenance of confidentiality (Policy H-295.955). The AMA specifically encourages the development of a model student orientation program that addresses standards of behavior for teachers and learners (Policy H-295.900).

The AMA has other related policies that address behavior in the educational context. Policy on professional behavior is detailed in the AMA's Principles of Medical Ethics (Policy E-1.001). The AMA has adopted principles to guide physician leaders of health care teams including fostering a respectful team culture (Policy H-160.912). Additionally, the AMA urges medical schools and residency programs to teach about ethics and the doctor-patient relationship (Policy H-295.961) as well as to promote professionalism, maintain a positive learning environment and provide appropriate role models for learners throughout medical school and residency training (Policies H-295.961, H-295.975, D-295.983).

SUMMARY AND RECOMMENDATIONS

Reducing mistreatment must be addressed by a broad set of interventions. These include instituting polices, regulations or procedures to reduce behaviors associated with mistreatment, maintaining a positive learning environment, changing the culture of the medical profession, developing and rewarding models of good behavior and disseminating best practices, among others. Support from leadership is critical to creating and maintaining a positive learning environment. Changes in medical school culture to reduce mistreatment must include students. The AMA is committed to addressing the problem of student mistreatment and promoting a positive learning environment.

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

1. That our American Medical Association (AMA) reaffirm Policy H-295.955, which recommends that each medical education institution have a widely disseminated policy that sets forth the expected standards of behavior of the teacher and learner and delineates procedures for dealing with breaches of that standard and specifies a Code of Behavior for all medical programs to utilize as a guide in developing standards of behavior for both teachers and learners.

2. That our AMA reaffirm Policy H-295.900, which encourages the development of a model student orientation program that addresses standards of behavior for teachers and learners.

3. That our AMA ask the Liaison Committee on Medical Education to ensure that medical schools have policies to protect medical students from retaliation based on reporting incidents of mistreatment.

4. That our AMA, through the Learning Environment Study, conduct research and disseminate findings on the medical education learning environment including the positive and negative elements of that environment that impact the teacher-learner relationship.

5. That our AMA encourage the Association of American Medical Colleges and the American Association of Colleges of Osteopathic Medicine to identify best practices and strategies to assure an appropriate learning environment for medical students.

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