HOD ACTION: Recommendations in Council on Medical Education Report 5 be adopted and the remainder of the report be filed.

REPORT 5 OF THE COUNCIL ON MEDICAL EDUCATION (I-23)
Organizations to Represent the Interests of Resident and Fellow Physicians (Resolution 304-A-22)
(Reference Committee C)

EXECUTIVE SUMMARY

The American Medical Association (AMA) adopted policy H-310.912, "Residents and Fellows' Bill of Rights" to protect the rights and well-being of medical residents and fellows in the United States. This set of guidelines and principles aims to ensure the professional development, well-being, and rights of medical residents and fellows are safeguarded, allowing them to provide quality care and grow in their medical careers. This bill of rights stems from a history of reforms to improve the training experience for residents and fellows.

As the needs of residents and fellows continue to evolve with the changing medical education ecosystem, it is necessary to understand the entities best suited to protect the rights and well-being of these trainees as detailed in the Residents and Fellows' Bill of Rights. These entities include governmental agencies, resident/fellow forums, resident medical staff organizations, accreditors, associations, and unions. Ultimately, there is no single entity suited to being permanently responsible for the interests of residents and fellows that can hold institutions accountable for fulfilling the Residents and Fellows' Bill of Rights, as described in AMA policy. Residents and fellows need to be empowered as the leading advocates for the Resident and Fellows' Bill of Rights to make this policy a reality.

What is fundamental is representation and organization of residents and fellows to advocate within their institutions and nationally to influence medical education and workplace policies. The AMA and Federation of Medicine can advocate for resident and fellow empowerment both within our profession and at the residents and fellows' sponsoring institutions to facilitate implementation of the rights detailed in this bill of rights. In addition, self-advocacy requires protection from retaliation and threats to livelihood for trainees participating in good faith advocacy.

The Council on Medical Education recommends adopting new policy encouraging the formation of peer-led resident/fellow organizations that can advocate for implementation of the AMA's Resident and Fellows' Bill of Rights at institutions that sponsor graduate medical education (GME), as well as the development of a formal process for resident/fellow physicians to transfer to another GME program without penalty when an employment situation is not sustainable for a trainee and/or program. The Council on Medical Education also recommends amplifying awareness of FREIDA™ as a resource for medical students, residents, and fellows; investigating its current capacity to post open, vacant positions by program directors; and adding the ability for residents and fellows to post positions with program transfers. Lastly, the Council recommends amending Policy H-310.912, "Residents and Fellows' Bill of Rights."

HOD ACTION: Recommendations in Council on Medical Education Report 5 be adopted and the remainder of the report be filed.

REPORT OF THE COUNCIL ON MEDICAL EDUCATION
DRAFT OUTLINE

CME Report 5-I-23

Subject: Organizations to Represent the Interests of Resident and Fellow Physicians (Resolution 304-A-22)

Presented by: Cynthia Jumper, MD, Chair

Referred to: Reference Committee C

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

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

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

Background

AMA Residents and Fellows' Bill of Rights

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

1. An education that fosters professional development, takes priority over service, and leads to independent practice.
2. Appropriate supervision by qualified physician faculty with progressive resident responsibility toward independent practice.

3. Regular and timely feedback and evaluation based on valid assessments of resident performance.
4. A safe and supportive workplace with appropriate facilities.
5. Adequate compensation and benefits that provide for resident well-being and health.
6. Clinical and educational work hours that protect patient safety and facilitate resident well-being and education.
7. Due process in cases of allegations of misconduct or poor performance.
8. Access to and protection by institutional and accreditation authorities when reporting violations.

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

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

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

ACGME Duty Hour Standards

Prior to 2003, the ACGME did not have national standardized duty hour regulations for residents in the United States. Residency programs had flexibility in setting their own work hour policies, resulting in significant variations in duty hour practices across institutions and specialties. The absence of specific ACGME duty hour standards meant that work hour practices were determined by individual residency programs and could vary widely. Some programs implemented more restrictive policies voluntarily, while others adhered to more traditional models with longer work hours and limited time off. In response to mounting concerns about resident well-being, patient safety, and the need for standardized guidelines, the ACGME developed formal duty hour regulations, which were implemented in 2003.[7] These regulations marked a significant shift in the approach to resident work hours and aimed to balance resident well-being, patient safety, educational opportunities, and work hours and mitigate fatigue while maintaining high-quality training experiences. Key reforms that were introduced in 2003 include:

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

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

1. **Limiting Shift Length for First-Year Residents:** Established stricter limits on shift duration for first-year residents (interns). Interns' shifts were capped at a maximum of 16 consecutive hours, recognizing the increased vulnerability of inexperienced residents to fatigue-related errors.
2. **Enhanced Supervision:** Emphasized the importance of appropriate supervision and oversight of resident physicians. Faculty and senior physicians were required to provide direct supervision and be physically present during critical patient care activities and procedures.

3. **Handover Principles:** Introduced principles for safe and effective handovers of patient care during shift changes. These principles aimed to ensure seamless transitions between resident physicians, minimizing the potential for errors and miscommunication.
4. **Individualized Learning Plans:** Emphasized the development of individualized learning plans for residents. These plans were intended to align with each resident's educational goals and ensure adequate opportunities for professional development and learning.
5. **Enhanced Monitoring and Compliance:** Implemented more robust mechanisms for monitoring and enforcing compliance with the duty hour standards. This included increased oversight, regular program evaluations, and the use of data-driven metrics to assess and address issues related to resident work hours.
6. **Resident Input and Feedback:** Emphasized the importance of resident input and feedback in shaping duty hour policies and ensuring resident well-being. Encouraged open communication channels for residents to voice concerns and provide input on work hour practices and the learning environment.

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

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

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

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

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

A similar event occurred in 2016 at Summa Health™, an integrated nonprofit health care delivery system in the Akron, Ohio area that sponsors 15 ACGME-accredited residency and fellowship programs. A contract dispute between Summa Health™ and Summa Emergency Associates (SEA), an independent physician group that is separate from the health system led to the replacement of

about 60 faculty physicians and 30 residents in Summa's emergency medicine program. The 60 physicians were replaced by a group of emergency physicians paid by Canton-based US Acute Care Solutions.[10] This event led to the loss of accreditation for the institution's emergency medicine residency in 2017, causing displacement to the education of the affected residents and disruption to patient care services. The program acquired new leadership and faculty but remained nonaccredited until 2019.[11] As with HUH, the AMA and other organizations offered financial support to the affected trainees seeking relocation.

Organizations with purview over resident/fellow training and work conditions

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

Governmental agencies

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

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

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

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

CMS primarily oversees the Medicare and Medicaid programs including Medicare GME funding. CMS does not usually set standards on working conditions, although in November 2022, CMS issued a memo on workplace violence and safety requirements in hospitals. Hospitals' failure to

meet CMS regulatory expectations may lead to citations. The full CMS memo is featured as Appendix B of this report.

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

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

Accreditors

An accreditor is a non-governmental or private professional organization that develops professional standards and criteria and conducts peer evaluations and expert visits to assess if the criteria are met. An accreditor is entitled to accord formal status to operate an educational institution, program, or facility following successful examination of the application and evaluation of such entities. Accreditors are often deemed authority by governmental agencies because of their expertise and capacity to encourage compliance with standards.

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

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

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

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

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

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

Resident/fellow forum or resident medical staff organization

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

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

or program specific issues, but without ongoing institutional support and with frequent resident turnover, the resident/fellow forum's ability to address long-term resident concerns can be limited.

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

Associations

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

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

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

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

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

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

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

Unions

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

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

Unions provide three basic functions: collective bargaining, political advocacy, and mutual aid (health insurance and pensions for membership). For physicians, the right to collectively bargain (i.e., negotiating contract terms with an employer on behalf of its employees) is a key driver of physician union development and participation. A study published in the Journal of the American Medical Association in 2022 focused specifically on resident/fellow unions as a tool to address burnout during training and serve as a needed counterweight to deleterious corporate influence in health care.[14] However, unions are not a panacea to the growing trend of corporate influence in medical education and practice. For example, during the mass layoff of all residents at Hahnemann, a collective bargaining agreement would not have prevented the residents from losing their positions. The Worker Adjustment and Retraining Notification (WARN) Act requires advance notice in cases of mass layoffs, but it would not have ensured the residents would have continued their GME during that time. They would still have had to find new positions mid-year. Further, certain states and regions of the country are less hospitable to the development of unions than others. In addition, even with a certified union at their workplace, some residents may opt out of joining the union and paying dues, because of a 2018 Supreme Court ruling banning mandatory union fees for public-sector workers;[15] however, all residents would still fall under the collective bargaining agreement including the wages, benefits, and working and safety conditions the resident union obtained in negotiation. Reaching a collective bargaining agreement can be challenging, and employers may stall for years when employees choose to work without a contract instead of going on strike. While a union can provide some level of protection to its members' employment, a union cannot guarantee that residents' future employability would not be jeopardized by their activism. State labor laws and the composition of the NLRB may also affect the ability of a union to provide its members protection from retribution by employers.

A Comparison of Organizations for Residents

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

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

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

Communicating available residency positions to displaced residents

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

While the Match is designed to place residents starting with first-year positions, it does have subcategories such as Physician-R—meaning, reserved for doctors with previous residency experience—and Advanced, which places residents into PGY-2 positions. These positions may present an avenue to transfer through the Match. Program directors may share information about their residents seeking transfers and vacancies at their program through their program director association or informal networks. The AAMC developed FindAResident that compiles listings of potential residency openings, which is accessible for a subscription fee. ResidentSwap is a website providing anonymous listings of positions currently filled by residents who would like to swap their current location or specialty with another resident.

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

Discussion

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

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

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

Summary and Recommendations

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

1. That Our AMA will encourage the formation of peer-led resident/fellow organizations that can advocate for trainees' interests, as outlined by the AMA's Residents and Fellows' Bill of Rights, at sponsoring institutions. (New HOD Policy)

2. That Our AMA will encourage the development of a formal process for resident/fellow physicians to transfer to another graduate medical education program, without penalty, when an employment situation is not sustainable for a trainee and/or program. (New HOD Policy)

3. That Our AMA will investigate promoting the current capacity of FREIDA™ to post open positions and adding the ability for FREIDA™ to facilitate the process of residents and fellows who wish to transfer programs. (Directive to Take Action)

4. That AMA Policy H-310.912, "Residents and Fellows' Bill of Rights," be amended by addition, to read as follows (Modify Current HOD Policy):

"12. Our AMA will distribute and promote the Residents and Fellows' Bill of Rights online and individually to residency and fellowship training programs and encourage changes to institutional processes that embody these principles, including resident/fellow empowerment and peer-selected representation in institutional leadership.

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

Fiscal note: $1000

APPENDIX A: RELEVANT AMA POLICIES

Residents and Fellows' Bill of Rights H-310.912

1. Our AMA continues to advocate for improvements in the ACGME Institutional and Common Program Requirements that support AMA policies as follows: a) adequate financial support for and guaranteed leave to attend professional meetings; b) submission of training verification information to requesting agencies within 30 days of the request; c) adequate compensation with consideration to local cost-of-living factors and years of training, and to include the orientation period; d) health insurance benefits to include dental and vision services; e) paid leave for all purposes (family, educational, vacation, sick) to be no less than six weeks per year; and f) stronger due process guidelines.

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

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

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

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

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

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

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

RESIDENT/FELLOW PHYSICIANS' BILL OF RIGHTS
Residents and fellows have a right to:

A. An education that fosters professional development, takes priority over service, and leads to independent practice.
With regard to education, residents and fellows should expect: (1) A graduate medical education experience that facilitates their professional and ethical development, to include regularly scheduled didactics for which they are released from clinical duties. Service obligations should not interfere with educational opportunities and clinical education should be given priority over service obligations; (2) Faculty who devote sufficient time to the educational program to fulfill their teaching and supervisory responsibilities; (3) Adequate clerical and clinical support services that minimize the extraneous, time-consuming work that draws attention from patient care issues and offers no educational value; (4) 24-hour per day access to information resources to educate themselves further about appropriate patient care; and (5) Resources that will allow them to pursue scholarly activities to include financial support and education leave to attend professional meetings.
B. Appropriate supervision by qualified physician faculty with progressive resident responsibility toward independent practice.
With regard to supervision, residents and fellows must be ultimately supervised by physicians who are adequately qualified and allow them to assume progressive responsibility appropriate to their level of education, competence, and experience. In instances where clinical education is provided by non-physicians, there must be an identified physician supervisor providing indirect supervision, along with mechanisms for reporting inappropriate, non-physician supervision to the training program, sponsoring institution or ACGME as appropriate.
C. Regular and timely feedback and evaluation based on valid assessments of resident performance.
With regard to evaluation and assessment processes, residents and fellows should expect: (1) Timely and substantive evaluations during each rotation in which their competence is objectively assessed by faculty who have directly supervised their work; (2) To evaluate the faculty and the program confidentially and in writing at least once annually and expect that the training program will address deficiencies revealed by these evaluations in a timely fashion; (3) Access to their training file and to be made aware of the contents of their file on an annual basis; and (4) Training programs to complete primary verification/credentialing forms and recredentialing forms, apply all required signatures to the forms, and then have the forms permanently secured in their educational files at the completion of training or a period of training and, when requested by any organization involved in credentialing process, ensure the submission of those documents to the requesting organization within thirty days of the request.
D. A safe and supportive workplace with appropriate facilities.
With regard to the workplace, residents and fellows should have access to: (1) A safe workplace that enables them to fulfill their clinical duties and educational obligations; (2) Secure, clean, and comfortable on-call rooms and parking facilities which are secure and well-lit; (3) Opportunities to participate on committees whose actions may affect their education, patient care, workplace, or contract.
E. Adequate compensation and benefits that provide for resident well-being and health.
(1) With regard to contracts, residents and fellows should receive: a. Information about the interviewing residency or fellowship program including a copy of the currently used contract clearly outlining the conditions for (re)appointment, details of remuneration, specific responsibilities including call obligations, and a detailed protocol for handling any grievance; and b. At least four months advance notice of contract non-renewal and the reason for non-renewal.
(2) With regard to compensation, residents and fellows should receive: a. Compensation for time at orientation; and b. Salaries commensurate with their level of training and experience.
Compensation should reflect cost of living differences based on local economic factors, such as housing, transportation, and energy costs (which affect the purchasing power of wages), and include appropriate adjustments for changes in the cost of living.

(3) With regard to benefits, residents and fellows must be fully informed of and should receive: a. Quality and affordable comprehensive medical, mental health, dental, and vision care for residents and their families, as well as retirement plan options, professional liability insurance and disability insurance to all residents for disabilities resulting from activities that are part of the educational program; b. An institutional written policy on and education in the signs of excessive fatigue, clinical depression, substance abuse and dependence, and other physician impairment issues; c. Confidential access to mental health and substance abuse services; d. A guaranteed, predetermined amount of paid vacation leave, sick leave, family and medical leave and educational/professional leave during each year in their training program, the total amount of which should not be less than six weeks; e. Leave in compliance with the Family and Medical Leave Act; and f. The conditions under which sleeping quarters, meals and laundry or their equivalent are to be provided.
F. Clinical and educational work hours that protect patient safety and facilitate resident well-being and education.
With regard to clinical and educational work hours, residents and fellows should experience: (1) A reasonable work schedule that is in compliance with clinical and educational work hour requirements set forth by the ACGME; and (2) At-home call that is not so frequent or demanding such that rest periods are significantly diminished or that clinical and educational work hour requirements are effectively circumvented. Refer to AMA Policy H-310.907, "Resident/Fellow Clinical and Educational Work Hours," for more information.
G. Due process in cases of allegations of misconduct or poor performance.
With regard to the complaints and appeals process, residents and fellows should have the opportunity to defend themselves against any allegations presented against them by a patient, health professional, or training program in accordance with the due process guidelines established by the AMA.
H. Access to and protection by institutional and accreditation authorities when reporting violations.
With regard to reporting violations to the ACGME, residents and fellows should: (1) Be informed by their program at the beginning of their training and again at each semi-annual review of the resources and processes available within the residency program for addressing resident concerns or complaints, including the program director, Residency Training Committee, and the designated institutional official; (2) Be able to file a formal complaint with the ACGME to address program violations of residency training requirements without fear of recrimination and with the guarantee of due process; and (3) Have the opportunity to address their concerns about the training program through confidential channels, including the ACGME concern process and/or the annual ACGME Resident Survey.

9. Our AMA will work with the ACGME and other relevant stakeholders to advocate for ways to defray additional costs related to residency and fellowship training, including essential amenities and/or high cost specialty-specific equipment required to perform clinical duties.

10. Our AMA believes that health care trainee salary, benefits, and overall compensation should, at minimum, reflect length of pre-training education, hours worked, and level of independence and complexity of care allowed by an individual's training program (for example when comparing physicians in training and midlevel providers at equal postgraduate training levels).

11.The Residents and Fellows' Bill of Rights will be prominently published online on the AMA website and disseminated to residency and fellowship programs.

12. Our AMA will distribute and promote the Residents and Fellows' Bill of Rights online and individually to residency and fellowship training programs and encourage changes to institutional processes that embody these principles.

Resident Physicians, Unions and Organized Labor H-383.998

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

1.2.10 Political Action by Physicians

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

Physicians who participate in advocacy activities should:

(a) Ensure that the health of patients is not jeopardized and that patient care is not compromised.

(b) Avoid using disruptive means to press for reform. Strikes and other collection actions may reduce access to care, eliminate or delay needed care, and interfere with continuity of care and should not be used as a bargaining tactic. In rare circumstances, briefly limiting personal availability may be appropriate as a means of calling attention to the need for changes in patient care. Physicians should be aware that some actions may put them or their organizations at risk of violating antitrust laws or laws pertaining to medical licensure or malpractice.

(c) Avoid forming workplace alliances, such as unions, with workers who do not share physicians' primary and overriding commitment to patients.

(d) Refrain from using undue influence or pressure colleagues to participate in advocacy activities and should not punish colleagues, overtly or covertly, for deciding not to participate.

AMA Principles of Medical Ethics: I,III,VI

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

APPENDIX B: CMS Memo on Workplace Violence in Hospitals

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-16
Baltimore, Maryland 21244-1850

CENTERS FOR MEDICARE & MEDICAID SERVICES

Center for Clinical Standards and Quality

Ref: QSO-23-04-Hospitals

DATE: **November 28, 2022**

TO: State Survey Agency Directors

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

SUBJECT: Workplace Violence-Hospitals

Memorandum Summary

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

Background

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

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

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

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

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

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

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

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

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

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

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

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

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

/s/

Karen L. Tritz
Director, Survey & Operations Group

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

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

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