HOD Action: Council on Medical Education Report 3 adopted and the remainder of the report filed.

REPORT 3 OF THE COUNCIL ON MEDICAL EDUCATION (A-25)
Unmatched Graduating Physicians (Resolution 306-A-24)

EXECUTIVE SUMMARY

Resolution 306 was introduced at the 2024 Annual Meeting of the American Medical Association (AMA) House of Delegates. The resolution asked that the "Board of Trustees study the role these unmatched physicians can play in providing care to our patients, their impact of lessening the impact of physician shortages, and provide recommendations on how to enroll these graduating physicians with a uniform title, privileges, geographic restrictions, and collaboration choices, and report to the House of Delegates (HOD) at the next Interim meeting." The Reference Committee received mixed testimony on this item and it was ultimately referred by the HOD.

To examine if unmatched physicians without residency education would contribute meaningfully to addressing a physician workforce shortage and increase access to care, this report will provide background information and data related to physician education standards and graduate medical education as well as the physician workforce shortage. It will also review the quantity of unmatched U.S. medical graduates, reasons for being unmatched, and the Accreditation Council for Graduate Medical Education position on the unmatched.

Finally, this report will discuss concerns and considerations from the resolution author and physician community, implications for international medical graduates, and the AMA's own efforts and resources in this space.

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 3-A-25

Subject: Unmatched Graduating Physicians (Res 306-A-24)

Presented by: Krystal Tomei, MD, MPH, Chair

Referred to: Reference Committee C

INTRODUCTION

At the 2024 Annual Meeting of the American Medical Association (AMA) House of Delegates (HOD), Resolution 306 was referred and asked that our "Board of Trustees study the role these unmatched physicians can play in providing care to our patients, their impact of lessening the impact of physician shortages, and provide recommendations on how to enroll these graduating physicians with a uniform title, privileges, geographic restrictions, and collaboration choices, and report to the HOD at the next Interim meeting."

The author purported many concerns in Resolution 306, demonstrating the complexities of the problem. These concerns include:

- Graduate medical education (GME) shortage (e.g., lack of funding; lack of residency slots)
- Unmatched physicians (e.g., a Missouri state law allowing physicians without residency training to practice and other similar state laws; lack of support/experiences for unmatched medical students so they can go on to match)
- Workforce (e.g., physician shortage in primary and specialty care; a decrease in practicing physicians; not enough medical students, residents, and fellows to meet the needs of patients)
- Scope of practice (e.g., physician assistants [PAs], advanced practice providers [AAPs], and nurse practitioners [NPs] have replaced physicians in shortage areas; state allowances for non-physician extenders to practice)

The reference committee received mixed testimony on this item. Testimony in opposition raised concerns about the multifactorial and nuanced problem of the physician shortage, variances in state laws related to non-physician providers, patient safety, physician education, lack of physician mentors, and circumvention of Accreditation Council for Graduate Medical Education (ACGME) standards by not participating in an accredited GME program. For these reasons, the reference committee recommended that resolution 306 be not adopted; however, the HOD final action moved for referral. This report is written in response to that directive.

BACKGROUND

To examine if unmatched physicians without residency education would contribute meaningfully to addressing a physician workforce shortage and increase access to care, the following issues and facts need to be considered.

Physician workforce shortage

The physician workforce shortage and maldistribution by geography and specialty is impacting access to care. In 2023, the Association of American Medical Colleges (AAMC) conducted a study entitled "The Complexities of Physician Supply and Demand: Projections From 2021 to 2036." The resulting report predicts that by the year 2036, the U.S. will face a physician shortage of up to 86,000 physicians.[1] While the physician shortage is a multifactorial and nuanced problem, the report asserts that the main drivers of the physician shortage are population demographics, retiring physicians, and the needs of groups that have been historically and intentionally excluded.

- Demographics: The study projects the U.S. population will grow by 8.4 percent overall, along with a growth in the aged 65 and older subpopulation by 34.1 percent leading to a significant increase in demand for primary care and for the specialists they most often need.
- Retirement: Currently, 42 percent of the clinical physician workforce is over age 55 (20 percent are aged 65 or older and 22 percent are between age 55 and 64). Thus, a substantial number of physicians will reach retirement age within the next decade.
- Underserved: The U.S. would have already needed 202,800 more physicians (as of 2021) to care for underserved communities in order to provide care at the same rate as other populations.[1]

These forecasts suggest worsening health inequities, particularly for the aging and underserved populations. AAMC offers projected data on physician demand through 2036 by patient race and ethnicity as well as urban-rural location. Of note, the AMA recently issued a brief on "Defining "rural" for the physician workforce."

Physician education standards and graduate medical education

For almost a century, successful completion of GME in the United States has been the established standard for physician education in the United States for independent practice and now for many countries around the world. Beginning in 1914, the AMA published the first list of hospitals approved for GME, and in 1927, the AMA Council on Medical Education and Hospitals began publishing the names of all the approved hospitals with GME programs in various specialties in the "Essentials of Approved Residencies and Fellowships." In the mid-20th century, the AMA played a key role with specialty boards in establishing residency review committees (RRCs), beginning with the RRCs for internal medicine and surgery in 1953. In 1956, the Federation of State Medical Boards recommended GME as a requirement for a full, unrestricted license to practice medicine. In 1972, the AMA helped found the Liaison Committee on Graduate Medical Education to accredit residency programs and, in 1981, was one of the five parent organizations establishing the ACGME.[2] In 2020, osteopathic and allopathic GME were unified into a single accreditation system to standardize GME for all physicians in the United States.[3]

GME is not only a critical part of the education of physicians in preparation for independent practice in a clinical specialty, GME is also a period of assessment for each trainee to ensure they are competent to practice. At completion of a GME program in the U.S., the residency director attests (per the 2024 ACGME Guide to the Common Program Requirements) that the resident has "demonstrated the knowledge, skills, and behaviors necessary to enter autonomous practice."[4] Allowing unmatched physicians to practice without GME would be a significant change in professional standards for patient care.

How many unmatched U.S. medical graduates are there?

Physicians applying for residency or fellowship enter a match to determine in which program they will train. The Council on Medical Education provides greater detail on the match processes and alternatives in their 2024 report, The Current Match Process and Alternatives (CME 2-A-24).

The National Residency Matching Program (NRMP) publishes annual results and reports on various data topics. According to the NRMP's report, "2024 Main Residency Match® By the Numbers," there were 41,503 total positions, and 38,941 of them were filled (93.8 percent), leaving 2,562 unfilled.[5] For PGY-1 positions, there were 38,494 total positions, and 35,984 of them were filled (93.5 percent), leaving 2,510 unfilled. In both instances (total positions and PGY-1 only), the percentages of filled spots went up 0.5 percent from the previous year.[5] See Appendix A for more report highlights or visit the NRMP® website for the complete data. Further Match data shows a match rate of 93.5 percent for U.S. MD seniors (an all-time high), 92.3 percent for U.S. DO seniors, 67 percent match rate for U.S. citizen international medical graduates (IMGs), and 58.5 percent match rate for non-U.S. citizen IMGs.[6]

Regarding IMGs in 2024, "19,050 U.S. citizen and non-U.S. citizen students and graduates of international medical schools (IMGs) registered for the Match, 1,668 more than 2023. Of the 4,751 U.S. IMGs who submitted rank order lists of programs, 3,181 matched to a PGY-1 position for a match rate of 67.0 percent. Of the 10,021 non-U.S. citizen IMGs who submitted rank order lists of programs, 5,864 matched to a PGY-1 position for a match rate of 58.5 percent. In 2024, the overall number of registered applicants was 50,413, the highest in the history of the Match. The number of registered non-U.S. citizen IMGs was 12,787, 1,986 more than last year."[7]

A total of 2,655 positions went unfilled in the 2024 NRMP Match, which included the 2,562 mentioned above as well as 93 additional positions in programs that did not submit a rank order list. Also, some unfilled programs had submitted a rank order list but chose not to participate in the Supplemental Offer and Acceptance Program® (SOAP®)to fill their unfilled positions. Among the 2,655 mentioned above, 97 percent (2,575) were placed in the SOAP offered by the NRMP during Match Week.[7] The SOAP is a process whereby eligible unmatched or partially matched applicants in The Match can apply for and be offered positions that went unfilled after the matching algorithm was processed. At the conclusion of SOAP, 176 positions still remained unfilled from 109 SOAP-participating programs. The matching and SOAP processes combined filled 99.6 percent of positions available through the Match, resulting in 0.4 percent unfilled positions."[7] This data does not include other match processes outside the NRMP. See Appendix A for a graph of NRMP Match data.

Reasons U.S. medical graduates are unmatched

Data provided by medical schools to the Liaison Committee on Medical Education (LCME) in the LCME Part II Annual Medical School Questionnaire offers insight into reasons medical school graduates did not match into a residency program. In 2023, 20,484 graduates accepted a residency position, and the total number of potential graduates who reported not entering residency training in 2023-2024 was 309 and their reasons given were:

- Research/pursuing additional degree or training: 113
- Did not find a residency position: 80
- Changing careers: 56
- Other: 56
- Family responsibilities/childcare: 4[8]

The LCME does not have additional details about the reasons. It is possible that those who "did not find a residency position" may not have found one in their desired specialty or geography even if

other positions were available. Data on osteopathic medical school graduates not entering residency training were not available.

Notably, 80 U.S. LCME medical graduates reported being unable to find a residency position, while the NRMP reported 176 unfilled residency positions after the SOAP. It is likely that the unmatched physicians had preferences for residency positions that were not met by the available vacant positions.

Regarding osteopathic medical schools, American Association of Colleges of Osteopathic Medicine's (AACOM) UME-GME Task Force Residency Match Working Group sent a survey to medical school advisers and deans in 2018-2019 to assess reasons why students did not match. The results indicated low board scores and lack of parallel plans were the main reasons students did not match.[9]

ACGME statement on those who are unmatched

The ACGME issued a statement of note in 2020 regarding "Unmatched US (Domestic, non-IMG) Allopathic and Osteopathic Medical Graduates, and International Medical Graduates with valid Educational Commission for Foreign Medical Graduates (ECFMG) certification Scenarios." It reads, "ACGME-accredited Sponsoring Institutions that permit programs to appoint unmatched/ uncommitted graduates, consistent with their programs'/ Sponsoring Institutions' match participation agreements, must offer at least 1 year of appointment in an ACGME-accredited program (if eligible per ACGME requirements). Any such appointments must be reviewed and approved in advance by the Sponsoring Institution's Graduate Medical Education Committee (GMEC). Enrollment in preliminary year positions, categorical positions, and positions in Transitional Year programs may be appropriate in this circumstance.

1. If the program would be within its approved complement, appointment in an ACGME-accredited program may proceed.
2. If the program would not be within its approved complement, Review Committee approval of a temporary complement increase must be obtained prior to appointment in an ACGME-accredited program. Approval of temporary complement increases, when required, must be obtained by programs of Sponsoring Institutions that have declared pandemic emergency status (Stage 3)."[10]

DISCUSSION

Concerns and considerations

Ultimately, Resolution 306 seeks to determine if unmatched physicians can have a significant impact on the physician shortage by creating opportunities for these physicians to practice.

There is a common misperception that there are not enough GME positions for graduates of U.S. medical schools. However, the data provided in this report proves otherwise, with the number of U.S. medical graduates who are unable to obtain a residency each year being very small (under 100) compared to the overall number of physicians entering GME (almost 40,000) and would have a very small potential impact on the physician workforce. For U.S. medical school graduates who are seeking a residency position but who remain without a residency position, there is likely a mismatch between their preferences and the residency positions available to them. Similarly, unmatched physicians may have preferences that may result in a lack of interest in some practice opportunities.

Residency is mandatory for medical licensure in the U.S. Thus, guidance for unmatched physicians is usually focused on getting them into a residency, which means applying for SOAP to attempt to match into unfilled positions or taking a year to prepare to reapply for The Match. Given AAMC predictions, it would be most advantageous to the health of the public if trainees choose to pursue the specialties of most need and seek employment in areas of most need. Should unmatched physicians decide not to reapply, they can pursue other careers in health care that contribute to the health of patients. Depending on their skills and interests, such employment paths include medical writing, consulting, administration, research, education, entrepreneurship, technology, or government agencies.

For DO students looking to strengthen their application, the National Board of Osteopathic Medical Examiners (NBOME) suggests that unmatched graduates also "consider applying to take COMLEX-USA Level 3 under the alternate pathway attestation, which permits candidates to obtain eligibility with endorsement by their COM dean."[11] Completion of Level 3 may be a way for DO applicants to strength their application while reapplying. Equivalent information for MD students was not available on the National Board of Medical Examiners website, although it is widely accepted that passing Step 3 can strength an application while reapplying.

There is little evidence to suggest that U.S. unmatched physicians can address the physician shortage. Without completing a residency, it is unlikely that they could provide the quality of care of a physician who completed an ACGME-accredited residency program. Residents cannot bill for their services and must be under supervision of fully licensed physicians, including in-person supervision during the first 6 months of residency. Thus, it would seem unmatched physicians should need at least this level of supervision, if not more. Further, hospital medical staff, medical groups, and/or payors should not grant privileges to unmatched physicians without residency training. For privileges, these entities often require completion of ACGME residency training.[12]

While ACGME accreditation standards call for structured supervision and longitudinal assessment in GME, an alternate pathway for unmatched physicians to enter practice lacks detailed guidelines for and enforcement of appropriate clinical supervision to assure patient safety and assess competence. In addition, a shortage of physicians in underserved areas able to supervise may lead to subquality oversight of unmatched physicians in these communities. Related, the AMA recently issued a brief on "The role of supervision in assessment of physician competency."

Also, the resolution implies that unmatched physicians should be granted practice privileges that are potentially greater than those who did match and entered GME. This issue could create distrust between physicians in residency programs and unmatched physicians.

In recent years, there has been movement toward creating positions for these individuals where they may function similarly to a non-physician provider. At least ten states have passed laws to provide this opportunity. For example, the Medical Association of the State of Alabama introduced a bill that was signed into state law in 2023 entitled the "Physician Workforce Act."[13] It creates a Bridge Year Graduate Physician Program. This program allows unmatched physicians to gain experience and skills under the supervision of licensed physicians. These individuals will receive a one-year renewable permit to practice medicine under an Alabama-licensed physician.[14] Since it is a new program, data is limited. While it seems that Alabama seeks to eventually get these individuals into residency positions, some states do not offer an end goal whereby these individuals may remain under supervision much like a non-physician provider. It calls into question the consequences for unmatched physicians who are unable to secure a desired GME position for years. It is unclear if this role is truly transitional, how long they will be allowed to continue in such a role, and how the medical community can prevent exploitation of unmatched physicians.

For example, a St. Louis physician was recently sentenced to prison for employing physician assistants and unmatched physicians to see patients but billing health plans as if he was the one providing direct care. The Department of Justice concluded that "under Missouri law, this is expressly illegal, especially since many of the assistants were not qualified to provide unsupervised care. While they had completed medical school, they did not finish a required residency. …Further, when hiring the assistants, the physician would market the roles as 'residency prep' and a 'stepping stone' toward full qualification."[15]

In 2023, the urology program at Case Western Reserve University School of Medicine in Ohio introduced a pilot program designed to afford an unmatched student a mentored and supervised year as a "Resident Team Assistant (RTA)," with support for research projects, attendance of educational didactic conferences, and experience within their subspecialty that reflects an experience similar to a one-year acting internship. Their responsibilities were limited by the lack of a training permit, but their duties were aligned to the needs of an ACGME-accredited residency program with educational exposure and resources afforded by such a position. This individual successfully matched the next year.[16]

An example of support for DO students who did not initially match into a residency program is a program at the Rocky Vista University (RVU) College of Osteopathic Medicine. In 2021, this institution launched the Predoctoral Internship (PDI) and Master's Predoctoral Internship (MPDI), both designed to aid students who did not match into a residency program to reenter the match process and successfully match. According to RVU, "The PDI and MPDI are rigorous, milestone-based programs designed to develop personalized experiences to meet the individual needs of an unplaced student to prepare them to reenter the match process and successfully match to a residency program. The key difference between the PDI and MPDI, outside of the curriculum structure, is that a student in the MPDI program will also be concurrently enrolled in an accredited master's program of their choice at a different institution. … The successes of these programs have spurred conversations about ways the university can incorporate components of the PDI and MPDI programs into the core curriculum of the COM to mitigate the need for such programs to exist."[17] The programs included 11 participants and achieved a 100 percent success rate for those re-entering the Match, while also helping to reduce anxiety and increase support throughout the process.[17] Additional information about the RVU innovation is available on the school's website and here. AACOM offers a toolkit to aid such students reentering the residency application and match process.[9]

A great concern about creating a pathway for unmatched physicians to enter practice absent completion of an ACGME accredited residency in order to ameliorate the physician shortage would essentially create a two-tiered health care system, further clouding the distinction in training and ability between physicians and non-physician providers. However, examples of successful programs to provide unmatched graduates with structured educational clinical experiences have shown greater success in truly assisting these graduates with a later successful match. Key parties are encouraged to consider the need and utility of programs to support unmatched physicians.

Another potential etiology of unmatched students underlies the decision of some residency programs to choose not to participate in the SOAP. These programs will only accept applicants who matched during the main residency Match. Understanding the decision of these residency programs to keep their positions unfilled rather than considering unmatched applicants for those positions may elucidate opportunities to increase the slots available for unmatched students. Programs need to actively indicate their participation in the SOAP each year; if overlooked it may result in programs with unfilled positions inadvertently not being available in the SOAP. Key

parties are encouraged to investigate processes to enable all unfilled residency positions to be available in the SOAP.

IMGs

Resolution 306 did not specify "U.S." unmatched physicians. Thus, it can be interpreted to include IMGs and open the door to broader implications. Regarding IMGs, the AMA is an active member of the newly formed Advisory Commission on Additional Licensing Models, co-chaired by the Federation of State Medical Boards (FSMB), Intealth™, and the ACGME. This Commission, established in March 2024, released draft preliminary recommendations on eligibility requirements for public comment through December 6, 2024. Notably, requiring GME training is recommended for the IMGs in any additional licensing pathway. More information is expected in 2025.

AMA efforts and resources

GME, matching, and the physician shortage are areas of significant concern of the AMA and often addressed in its Advocacy efforts. See Appendix B for a list of relevant accomplishments in the last two years alone.

In addition to the report cited earlier, the Council on Medical Education has actively addressed concerns related to GME and the physician workforce in reports such as:

- Guiding Principles and Appropriate Criteria for Assessing the Competency of Physicians Across the Professional Continuum, CME 1-I-21
- Optimizing Match Outcomes, CME 3-A-21
- Expanding UME Without Concurrent GME Expansion, CME 3-A-18
- Options for Unmatched Medical Students, CME 5-A-17
- Standardizing the Allopathic Residency Match System and Timeline, CME 6-A-17
- Addressing the Increasing Number of Unmatched Medical Students, CME 3-A-16

FREIDA™ is the AMA's Residency & Fellowship Database® that enables unmatched students to research residencies from more than 13,000 programs both during and following SOAP.

AMA media coverage and educational resources in the last two years include:

- Powerful Senate committee takes up physician shortage (Aug 2024)
- AMA president sounds alarm on national physician shortage (Oct 2023)
- Match: Which specialties place most residents through SOAP (Feb 2024)
- What if you don't match? 4 things you should do (March 2024)
- What's exacerbating the physician shortage crisis—and what's needed to fix it (May 2024).

REVANT AMA POLICIES

The AMA has strong policy in support of GME, medical licensure, board certification, and competent patient care – all of which illuminate the importance of completion of a residency. See Appendix C for full policies. To support an alternative to residency training that allows for insufficiently supervised patient care would go against longstanding AMA policy.

AMA policy D-310.977 entitled "National Resident Matching Program Reform" addresses the unmatched in clauses 11-15 and 17 to read as follows:

11. Our AMA will work with the Association of American Medical Colleges (AAMC), American Osteopathic Association (AOA), American Association of Colleges of Osteopathic Medicine (AACOM), and National Resident Matching Program (NRMP) to evaluate the current available data or propose new studies that would help us learn how many students graduating from US medical schools each year do not enter into a US residency program; how many never enter into a US residency program; whether there is disproportionate impact on individuals of minority racial and ethnic groups; and what careers are pursued by those with an MD or DO degree who do not enter residency programs.
12. Our AMA will work with the AAMC, AOA, AACOM and appropriate licensing boards to study whether US medical school graduates and international medical graduates who do not enter residency programs may be able to serve unmet national health care needs;
13. Our AMA will work with the AAMC, AOA, AACOM and the NRMP to evaluate the feasibility of a national tracking system for US medical students who do not initially match into a categorical residency program.
14. Our AMA will discuss with the National Resident Matching Program, Association of American Medical Colleges, American Osteopathic Association, Liaison Committee on Medical Education, Accreditation Council for Graduate Medical Education, and other interested bodies potential pathways for reengagement in medicine following an unsuccessful match and report back on the results of those discussions.
15. Our AMA encourages the Association of American Medical Colleges to work with U.S. medical schools to identify best practices, including career counseling, used by medical schools to facilitate successful matches for medical school seniors, and reduce the number who do not match.
17. Our AMA encourages the Educational Commission for Foreign Medical Graduates (ECFMG) and other interested stakeholders to study the personal and financial consequences of ECFMG-certified U.S. IMGs who do not match in the National Resident Matching Program and are therefore unable to get a residency or practice medicine.

Also, AMA Policy H-200.954 entitled "US Physician Shortage" addresses the underlying issue of this resolution — the physician shortage. Additional related policies are located in the AMA Policy Finder and include:

- Educational Strategies for Meeting Rural Health Physician Shortage H-465.988
- Proposed Revisions to AMA Policy on the Financing of Medical Education Programs H-305.929
- Evaluation of DACA-Eligible Medical Students, Residents and Physicians in Addressing Physician Shortages D-350.986
- Financing of Medical Education Programs D-305.973
- Fixing the VA Physician Shortage with Physicians D-510.990
- The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education D-305.967
- Residents and Fellows' Bill of Rights H-310.912

SUMMARY

This report examined issues surrounding physicians who do not secure entry into an accredited residency program by graduation. It addressed concerns related to competency to perform patient care as well as the growing physician shortage, both of which were raised by the resolution author. Based on the data and analysis in this report, changing professional standards to permit the small number of unmatched physicians without GME training to practice is a problematic and negligible response to physician workforce shortages and lack of access to care. Successful completion of a

residency is a key tenant of medical education and licensure and is highly supported by AMA policy. However, there may be more that key parties can do to support and prepare applicants to succeed is securing a GME position in their residency applications and The Match (or other match processes). Such parties should evaluate their roles and efforts.

RECOMMENDATIONS

The Council on Medical Education recommends that the following be adopted in lieu of Resolution 306-A-24, and the remainder of the report be filed:

1. Encourage relevant parties to examine the root causes for physicians who do not secure entry into an accredited residency program by graduation and evaluate each of their efforts to address them including informing medical students and their advisers how to obtain GME training opportunities. Such parties include but are not limited to medical schools, residency programs, Association of American Medical Colleges, American Association of Colleges of Osteopathic Medicine, National Resident Matching Program , Intealth, and Accreditation Council for Graduate Medical Education . (New HOD Policy)

2. Encourage relevant parties to evaluate opportunities that have successfully matched previously unmatched physicians into residency positions, so students can be better counselled on opportunities that improve their chances of matching into a residency program. (New HOD Policy)

3. Reaffirm AMA policies D-310.977 "National Resident Matching Program Reform" and H-200.954 "U.S. Physician Shortage." (Reaffirm HOD Policy)

Fiscal note: $1,000

APPENDIX A:

PGY-1 Match and Placement Rates by Applicant Type, 2024

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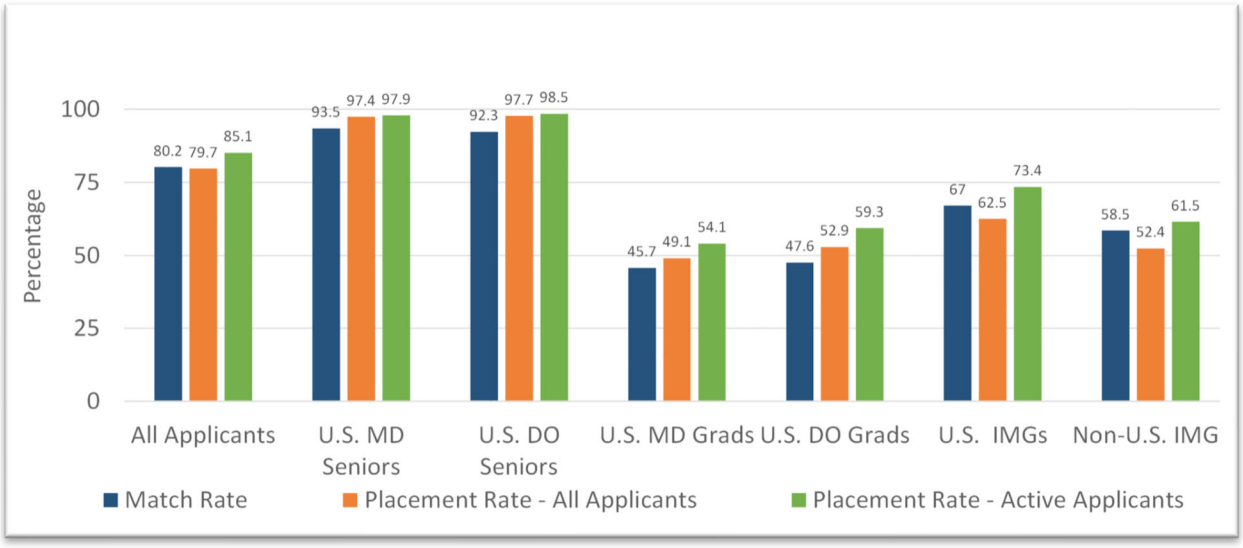

National Resident Matching Program, Results and Data: 2024 Main Residency Match. Reprinted with permission from NRMP, 2025.

APPENDIX B: AMA ADVOCACY EFFORTS IN LAST TWO YEARS

- June 24, 2024: comments were submitted on the Senate Finance Committee's draft policy proposal and specific questions for consideration on policies related to the Medicare Graduate Medical Education (GME) program. If workforce barriers for physicians are reduced and additional investments in GME are made, it will help to increase the number of physicians in the U.S., which will lead to healthier communities and ultimately a healthier country as access to much-needed medical care increases.
- June 10, 2024: comments were submitted to the Centers for Medicare & Medicaid Services (CMS) on the Fiscal Year 2025 Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals (IPPS) and the Long-Term Care Hospital Prospective Payment System (LTCH PPS), supporting the expansion of resources and the removal of barriers to the training and retention of obstetric care physicians, especially in rural and underserved areas. We also recommended that CMS consider increasing support for programs that integrate comprehensive approaches to maternity care and highlight the importance of social determinants of health (SODH) in maternal and infant outcomes. The AMA also supported the allocation of Graduate Medical Education (GME) slots to strategically address the most pressing needs within the health care system, including the shortage of mental health professionals. We urged CMS to adopt a distribution framework that considers the specific needs of communities and the capacity of institutions to provide high quality education and training to residents.
- May 16, 2024: Statement for the Record was submitted to the U.S. Senate Committee on Finance as part of the hearing entitled, "Rural Health Care: Supporting Lives and Improving Communities." The statement covered a number of issues, including recommendations on ways to increase and retain the physician workforce, especially in rural communities.
- October 19, 2023: Statement for the Record was submitted to the U.S. House of Representatives Committee on Energy and Commerce Subcommittee on Health as part of the hearing entitled "What's the Prognosis? Examining Medicare Proposals to Improve Patient Access to Care & Minimize Red Tape for Doctors." This statement covers a number of issues including GME and workforce issues that the AMA would like addressed to strengthen the physician workforce.
- October 5, 2023: letter was sent by request from the House Committee on Ways and Means' for information (RFI) commenting on ways to improve health care in rural and underserved areas. A number of subject areas were covered including needed improvements for workforce issues and scope of practice considerations.
- March 20, 2023: comments were submitted to the Senate Committee on Health, Education, Labor and Pensions responding to their request for comment concerning health care workforce shortages. We discussed rural hospitals, physician burnout, prior authorization, loan repayment and scholarship programs, support for physician led teams, and physician payment.
- On July 29, 2022: information was provided regarding the Department of Health and Human Services' (HHS) Initiative To Strengthen Primary Health Care.
- May 22, 2023: letter was signed in support of the Resident Physician Shortage Reduction Act of 2023 (S. 1302). This bipartisan legislation is crucial to expanding the physician workforce and to ensuring that patients across the country are able to access quality care from physicians.
- On May 9, 2023: letter was sent in strong support of H.R. 2389, the "Resident Physician Shortage Reduction Act of 2023." This bipartisan legislation would gradually raise the number of Medicare-supported graduate medical education (GME) positions by 2,000 per

year for seven years, for a total of 14,000 new slots. A share of these positions would be targeted to hospitals with diverse needs including hospitals in rural areas, hospitals serving patients from health professional shortage areas (HPSAs), hospitals affiliated with historically Black medical schools, hospitals in states with new medical schools or branch campuses, and hospitals already training over their caps.

APPENDIX C: RELEVANT AMA POLICIES

National Resident Matching Program Reform D.310.977

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

13. Our AMA will work with the AAMC, AOA, AACOM and the NRMP to evaluate the feasibility of a national tracking system for US medical students who do not initially match into a categorical residency program.
14. Our AMA will discuss with the National Resident Matching Program, Association of American Medical Colleges, American Osteopathic Association, Liaison Committee on Medical Education, Accreditation Council for Graduate Medical Education, and other interested bodies potential pathways for reengagement in medicine following an unsuccessful match and report back on the results of those discussions.
15. Our AMA encourages the Association of American Medical Colleges to work with U.S. medical schools to identify best practices, including career counseling, used by medical schools to facilitate successful matches for medical school seniors, and reduce the number who do not match.
16. Our AMA supports the movement toward a unified and standardized residency application and match system for all non-military residencies.
17. Our AMA encourages the Educational Commission for Foreign Medical Graduates (ECFMG) and other interested stakeholders to study the personal and financial consequences of ECFMG-certified U.S. IMGs who do not match in the National Resident Matching Program and are therefore unable to get a residency or practice medicine.
18. Our AMA encourages the AAMC, AACOM, NRMP, and other key stakeholders to jointly create a no-fee, easily accessible clearinghouse of reliable and valid advice and tools for residency program applicants seeking cost-effective methods for applying to and successfully matching into residency.
19. Our AMA will work with appropriate stakeholders to study options for improving transparency in the resident application process.
20. Our AMA encourages the piloting of innovations to the residency application process with aims to reduce application numbers per applicant, focus applicants on programs with reciprocal interest, and maximize residency placement. With support from the medical education community, successful pilots should be expanded to enhance the standardized process.
21. Our AMA will continue to engage the National Resident Matching Program® (NRMP®) and other matching organizations on behalf of residents and medical students to further develop ongoing relationships, improve communications, and seek additional opportunities to collaborate including the submission of suitable nominees for their governing bodies as appropriate.

US Physician Shortage H-200.954

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

7. Our AMA will continue to advocate for funding from public and private payers for educational programs that provide experiences for medical students in rural and other underserved areas.
8. Our AMA will continue to advocate for funding from all payers (public and private sector) to increase the number of graduate medical education positions in specialties leading to first certification.
9. Our AMA will work with other groups to explore additional innovative strategies for funding graduate medical education positions, including positions tied to geographic or specialty need.
10. Our AMA continues to work with the Association of American Medical Colleges (AAMC) and other relevant groups to monitor the outcomes of the National Resident Matching Program; and
11. Our AMA continues to work with the AAMC and other relevant groups to develop strategies to address the current and potential shortages in clinical training sites for medical students.
12. Our AMA will:
    a. promote greater awareness and implementation of the Project ECHO (Extension for Community Healthcare Outcomes) and Child Psychiatry Access Project models among academic health centers and community-based primary care physicians;
    b. work with stakeholders to identify and mitigate barriers to broader implementation of these models in the United States; and
    c. monitor whether health care payers offer additional payment or incentive payments for physicians who engage in clinical practice improvement activities as a result of their participation in programs such as Project ECHO and the Child Psychiatry Access Project; and if confirmed, promote awareness of these benefits among physicians.
13. Our AMA will work to augment the impact of initiatives to address rural physician workforce shortages.
14. Our AMA supports opportunities to incentivize physicians to select specialties and practice settings which involve delivery of health services to populations experiencing a shortage of providers, such as women, LGBTQ+ patients, children, elder adults, and patients with disabilities, including populations of such patients who do not live in underserved geographic areas.

Educational Strategies for Meeting Rural Health Physician Shortage H-465.988

1. In light of the data available from the current literature as well as ongoing studies being conducted by staff, our American Medical Association recommends that:
    a. Our AMA encourage medical schools and residency programs to develop educationally sound rural clinical preceptorships and rotations consistent with educational and training requirements, and to provide early and continuing exposure to those programs for medical students and residents.
    b. Our AMA encourage medical schools to develop educationally sound primary care residencies in smaller communities with the goal of educating and recruiting more rural physicians.
    c. Our AMA encourage state and county medical societies to support state legislative efforts toward developing scholarship and loan programs for future rural physicians.
    d. Our AMA encourage state and county medical societies and local medical schools to develop outreach and recruitment programs in rural counties to attract promising high school and college students to medicine and the other health professions.
    e. Our AMA urge continued federal and state legislative support for funding of Area Health Education Centers (AHECs) for rural and other underserved areas.
    f. Our AMA continue to support full appropriation for the National Health Service Corps Scholarship Program, with the proviso that medical schools serving states with large rural underserved populations have a priority and significant voice in the selection of recipients for those scholarships.

g. Our AMA support full funding of the new federal National Health Service Corps loan repayment program.
h. Our AMA encourage continued legislative support of the research studies being conducted by the Rural Health Research Centers funded by the National Office of Rural Health in the Department of Health and Human Services.
i. Our AMA continue its research investigation into the impact of educational programs on the supply of rural physicians.
j. Our AMA continue to conduct research and monitor other progress in development of educational strategies for alleviating rural physician shortages.
k. Our AMA reaffirm its support for legislation making interest payments on student debt tax deductible.
l. Our AMA encourage state and county medical societies to develop programs to enhance work opportunities and social support systems for spouses of rural practitioners.

2. Our AMA will work with state and specialty societies, medical schools, teaching hospitals, the Accreditation Council for Graduate Medical Education (ACGME), the Centers for Medicare and Medicaid Services (CMS) and other interested stakeholders to identify, encourage and incentivize qualified rural physicians to serve as preceptors and volunteer faculty for rural rotations in residency.
3. Our AMA will:
   a. work with interested stakeholders to identify strategies to increase residency training opportunities in rural areas with a report back to the House of Delegates; and
   b. work with interested stakeholders to formulate an actionable plan of advocacy with the goal of increasing residency training in rural areas.
4. Our AMA will encourage ACGME review committees to consider adding exposure to rural medicine as appropriate, to encourage the development of rural program tracks in training programs and increase physician awareness of the conditions that pose challenges and lack of resources in rural areas.
5. Our AMA will encourage adding educational webinars, workshops and other didactics via remote learning formats to enhance the educational needs of smaller training programs.

Proposed Revisions to AMA Policy on the Financing of Medical Education Programs H-305.929

1. It is AMA policy that:

A. 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.

B. 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.

C. 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.

D. 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.

E. 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.

F. 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.
G. 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.
H. 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.
I. 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.

2. Our AMA endorses the following principles of social accountability and promotes their application to GME funding: (a) Adequate and diverse workforce development; (b) Primary care and specialty practice workforce distribution; (c) Geographic workforce distribution; and (d) Service to the local community and the public at large.
3. Our AMA encourages transparency of GME funding through models that are both feasible and fair for training sites, affiliated medical schools and trainees.
4. Our AMA believes that financial transparency is essential to the sustainable future of GME funding and therefore, regardless of the method or source of payment for GME or the number of funding streams, institutions should publicly report the aggregate value of GME payments received as well as what these payments are used for, including: (a) Resident salary and benefits; (b) Administrative support for graduate medical education; (c) Salary reimbursement for teaching staff; (d) Direct educational costs for residents and fellows; and (e) Institutional overhead.
5. Our AMA supports specialty-specific enhancements to GME funding that neither directly nor indirectly reduce funding levels for any other specialty.

Evaluation of DACA-Eligible Medical Students, Residents and Physicians in Addressing Physician Shortages D-350.986

1. Our American Medical Association will study the issue of Deferred Action for Childhood Arrivals-eligible medical students, residents, and physicians and consider the opportunities for their participation in the physician profession and report its findings to the House of Delegates.
2. Our AMA will issue a statement in support of current US healthcare professionals, including those currently training as medical students or residents and fellows, who are Deferred Action for Childhood Arrivals recipients.

Financing of Medical Education Programs D-305.973

1. Our American Medical Association will work with 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.
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.

2. Our AMA will work with other interested parties to ensure adequate funding to support medical school educational programs, including creating mechanisms to fund additional medical school positions.

Fixing the VA Physician Shortage with Physicians D-510.990

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

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

1. Our American Medical Association will actively collaborate with appropriate stakeholder organizations, (including Association of American Medical Colleges, American Hospital Association, state medical societies, medical specialty societies/associations) to advocate for the preservation, stability and expansion of full funding for the direct and indirect costs of graduate medical education (GME) positions from all existing sources (e.g. Medicare, Medicaid, Veterans Administration, CDC and others).
2. Our AMA will actively advocate for the stable provision of matching federal funds for state Medicaid programs that fund GME positions.
3. Our AMA will actively seek congressional action to remove the caps on Medicare funding of GME positions for resident physicians that were imposed by the Balanced Budget Amendment of 1997 (BBA-1997).
4. Our AMA will strenuously advocate for increasing the number of GME positions to address the future physician workforce needs of the nation.
5. Our AMA will oppose efforts to move federal funding of GME positions to the annual appropriations process that is subject to instability and uncertainty.
6. Our AMA will oppose regulatory and legislative efforts that reduce funding for GME from the full scope of resident educational activities that are designated by residency programs for accreditation and the board certification of their graduates (e.g. didactic teaching, community service, off-site ambulatory rotations, etc.).

7. Our AMA will actively explore additional sources of GME funding and their potential impact on the quality of residency training and on patient care.
8. Our AMA will vigorously advocate for the continued and expanded contribution by all payers for health care (including the federal government, the states, and local and private sources) to fund both the direct and indirect costs of GME.
9. Our AMA will work, in collaboration with other stakeholders, to improve the awareness of the general public that GME is a public good that provides essential services as part of the training process and serves as a necessary component of physician preparation to provide patient care that is safe, effective and of high quality.
10. Our AMA staff and governance will continuously monitor federal, state and private proposals for health care reform for their potential impact on the preservation, stability and expansion of full funding for the direct and indirect costs of GME.
11. Our AMA:
    a. recognizes that funding for and distribution of positions for GME are in crisis in the United States and that meaningful and comprehensive reform is urgently needed.
    b. will immediately work with Congress to expand medical residencies in a balanced fashion based on expected specialty needs throughout our nation to produce a geographically distributed and appropriately sized physician workforce; and to make increasing support and funding for GME programs and residencies a top priority of the AMA in its national political agenda.
    c. will continue to work closely with the Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, American Osteopathic Association, and other key stakeholders to raise awareness among policymakers and the public about the importance of expanded GME funding to meet the nation's current and anticipated medical workforce needs.
12. Our AMA will collaborate with other organizations to explore evidence-based approaches to quality and accountability in residency education to support enhanced funding of GME.
13. Our AMA will continue to strongly advocate that Congress fund additional graduate medical education (GME) positions for the most critical workforce needs, especially considering the current and worsening maldistribution of physicians.
14. Our AMA will advocate that the Centers for Medicare and Medicaid Services allow for rural and other underserved rotations in Accreditation Council for Graduate Medical Education (ACGME)-accredited residency programs, in disciplines of particular local/regional need, to occur in the offices of physicians who meet the qualifications for adjunct faculty of the residency program's sponsoring institution.
15. Our AMA encourages the ACGME to reduce barriers to rural and other underserved community experiences for graduate medical education programs that choose to provide such training, by adjusting as needed its program requirements, such as continuity requirements or limitations on time spent away from the primary residency site.
16. Our AMA encourages the ACGME and the American Osteopathic Association (AOA) to continue to develop and disseminate innovative methods of training physicians efficiently that foster the skills and inclinations to practice in a health care system that rewards team-based care and social accountability.
17. Our AMA will work with interested state and national medical specialty societies and other appropriate stakeholders to share and support legislation to increase GME funding, enabling a state to accomplish one or more of the following: (a) train more physicians to meet state and regional workforce needs; (b) train physicians who will practice in physician shortage/underserved areas; or (c) train physicians in undersupplied specialties and subspecialties in the state/region.
18. Our AMA supports the ongoing efforts by states to identify and address changing physician workforce needs within the GME landscape and continue to broadly advocate for innovative

pilot programs that will increase the number of positions and create enhanced accountability of GME programs for quality outcomes.

19. Our AMA will continue to work with stakeholders such as Association of American Medical Colleges (AAMC), ACGME, AOA, American Academy of Family Physicians, American College of Physicians, and other specialty organizations to analyze the changing landscape of future physician workforce needs as well as the number and variety of GME positions necessary to provide that workforce.
20. Our AMA will explore innovative funding models for incremental increases in funded residency positions related to quality of resident education and provision of patient care as evaluated by appropriate medical education organizations such as the Accreditation Council for Graduate Medical Education.
21. Our AMA will utilize its resources to share its content expertise with policymakers and the public to ensure greater awareness of the significant societal value of graduate medical education (GME) in terms of patient care, particularly for underserved and at-risk populations, as well as global health, research and education.
22. Our AMA will advocate for the appropriation of Congressional funding in support of the National Healthcare Workforce Commission, established under section 5101 of the Affordable Care Act, to provide data and healthcare workforce policy and advice to the nation and provide data that support the value of GME to the nation.
23. Our AMA supports recommendations to increase the accountability for and transparency of GME funding and continue to monitor data and peer-reviewed studies that contribute to further assess the value of GME.
24. Our AMA will explore various models of all-payer funding for GME, especially as the Institute of Medicine (now a program unit of the National Academy of Medicine) did not examine those options in its 2014 report on GME governance and financing.
25. Our AMA encourages organizations with successful existing models to publicize and share strategies, outcomes and costs.
26. Our AMA encourages insurance payers and foundations to enter into partnerships with state and local agencies as well as academic medical centers and community hospitals seeking to expand GME.
27. Our AMA will develop, along with other interested stakeholders, a national campaign to educate the public on the definition and importance of graduate medical education, student debt and the state of the medical profession today and in the future.
28. Our AMA will collaborate with other stakeholder organizations to evaluate and work to establish consensus regarding the appropriate economic value of resident and fellow services.
29. Our AMA will monitor ongoing pilots and demonstration projects, and explore the feasibility of broader implementation of proposals that show promise as alternative means for funding physician education and training while providing appropriate compensation for residents and fellows.
30. Our AMA will monitor the status of the House Energy and Commerce Committee's response to public comments solicited regarding the 2014 IOM report, Graduate Medical Education That Meets the Nation's Health Needs, as well as results of ongoing studies, including that requested of the GAO, in order to formulate new advocacy strategy for GME funding, and will report back to the House of Delegates regularly on important changes in the landscape of GME funding.
31. Our AMA will advocate to the Centers for Medicare & Medicaid Services to adopt the concept of “Cap-Flexibility” and allow new and current Graduate Medical Education teaching institutions to extend their cap-building window for up to an additional five years beyond the current window (for a total of up to ten years), giving priority to new residency programs in underserved areas and/or economically depressed areas.
32. Our AMA will:

a. encourage all existing and planned allopathic and osteopathic medical schools to thoroughly research match statistics and other career placement metrics when developing career guidance plans.
b. strongly advocate for and work with legislators, private sector partnerships, and existing and planned osteopathic and allopathic medical schools to create and fund graduate medical education (GME) programs that can accommodate the equivalent number of additional medical school graduates consistent with the workforce needs of our nation.
c. encourage the Liaison Committee on Medical Education (LCME), the Commission on Osteopathic College Accreditation (COCA), and other accrediting bodies, as part of accreditation of allopathic and osteopathic medical schools, to prospectively and retrospectively monitor medical school graduates' rates of placement into GME as well as GME completion.

33. Our AMA encourages the Secretary of the U.S. Department of Health and Human Services to coordinate with federal agencies that fund GME training to identify and collect information needed to effectively evaluate how hospitals, health systems, and health centers with residency programs are utilizing these financial resources to meet the nation's health care workforce needs. This includes information on payment amounts by the type of training programs supported, resident training costs and revenue generation, output or outcomes related to health workforce planning (i.e., percentage of primary care residents that went on to practice in rural or medically underserved areas), and measures related to resident competency and educational quality offered by GME training programs.
34. Our AMA will publicize best practice examples of state-funded Graduate Medical Education positions and develop model state legislation where appropriate.
35. Our American Medical Association will ask federal agencies that fund graduate medical education (including but not limited to the Centers for Medicare and Medicaid Services, the Department of Veterans Affairs, the Department of Defense, the Health Resources and Services Administration, and others) to issue an annual report detailing the quantity of total GME funding for each year including how Direct GME funds are allocated on a per resident or fellow basis, for the previous year.

Residents and Fellows' Bill of Rights H-310.912

1. Our American Medical Association 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.
   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).
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.
   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.
   b. Compensation, including salary and benefits, 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.

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.
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.
3. Have the opportunity to address their concerns about the training program through confidential channels, including the ACGME concern process and/or the annual ACGME Resident Survey.

9. Our AMA will work with the ACGME and other relevant stakeholders to advocate for ways to defray additional costs related to residency and fellowship training, including essential amenities and/or high cost specialty-specific equipment required to perform clinical duties.
10. Our AMA believes that healthcare trainee salary, benefits, and overall compensation should, at minimum, reflect length of pre-training education, hours worked, and level of independence and complexity of care allowed by an individual's training program (for example when comparing physicians in training and midlevel providers at equal postgraduate training levels).
11. The Residents and Fellows' Bill of Rights will be prominently published online on the AMA website and disseminated to residency and fellowship programs.
12. Our AMA will distribute and promote the Residents and Fellows' Bill of Rights online and individually to residency and fellowship training programs and encourage changes to institutional processes that embody these principles, including resident/fellow empowerment and peer-selected representation in institutional leadership.
13. Our AMA encourages development of accreditation standards and institutional policies designed to facilitate and protect residents/fellows who seek to exercise their rights.
14. Our AMA encourages the formation of peer-led resident/fellow organizations that can advocate for trainees' interests, as outlined by the AMA's Residents and Fellows' Bill of Rights, at sponsoring institutions.

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