

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 8-A-11

Subject: Residents and Fellows' Bill of Rights
(Resolution 901-I-09)

Presented by: Baretta R. Casey, MD, MPH

Referred to: Reference Committee C
(Robert J. Havlik, MD, Chair)

1 Resolution 901-I-09, introduced by the Resident and Fellow Section and referred to the Board of
2 Trustees, asked:

3
4 1) That our American Medical Association (AMA) adopt a "Residents and Fellows' Bill of
5 Rights" that will serve as a testament to the organization's support for and commitment to the
6 education and training of competent, conscientious residents and fellows by illuminating their
7 rights and advocating for provisions that it believes all residents should be afforded, and that
8 have not yet been designated as rights;

9
10 2) That the "Residents and Fellows' Bill of Rights" shall address the following 10 core themes
11 spanning the aggregate of the graduate medical education experience: Education, Supervision,
12 Evaluations of Trainees and Assessment of Faculty and Training Program, Workplace,
13 Contracts, Compensation, Benefits, Duty Hours, Complaints and Appeals Process and
14 Reporting Violations to Accreditation Council for Graduate Medical Education (ACGME); and
15

16 3) That our AMA work with the ACGME and other professional organizations to distribute this
17 "Residents and Fellows' Bill of Rights" to residents and fellows in training at ACGME-
18 accredited training programs.

19
20 Reference committee testimony strongly supported adoption of this resolution but also called for
21 analysis of provisions to ensure they are both optimal and realistic, as well as applicable to resident
22 physicians not educated in LCME-accredited medical schools. In addition, while almost all of the
23 provisions are supported by ACGME requirements, the ACGME has issued new Common
24 Requirements since Resolution 901 was written; therefore, citations to support the Bill of Rights
25 have been updated. This report transcribes the proposed "Residents and Fellows' Bill of Rights,"
26 consolidates some of the rights, and annotates areas not currently supported by ACGME
27 requirements and/or AMA policy. The report also supports the inclusion of graduates of
28 osteopathic or international medical schools under this proposal.

29
30 *Residents and fellows have a right to:*

- 31
32 1. *An education that fosters professional development, takes priority over service, and leads to*
33 *independent practice.*
34 2. *Appropriate supervision by qualified faculty with progressive resident responsibility toward*
35 *independent practice.*

- 1 3. *Regular and timely feedback and evaluation based on valid assessments of resident*
- 2 *performance.*
- 3 4. *A safe and supportive workplace with appropriate facilities.*
- 4 5. *Adequate compensation and benefits that provide for resident well-being and health.*
- 5 6. *Duty hours that protect patient safety and facilitate resident well-being and education.*
- 6 7. *Due process in cases of allegations of misconduct or poor performance.*
- 7 8. *Access to and protection by institutional and accreditation authorities when reporting*
- 8 *violations.*
- 9

10 Notes on Right 1:

11

12 The provisions are all included in the Common Requirements, with one exception. “Financial

13 support and education leave to attend professional meetings” is supported by AMA Policy H-

14 310.999 [II.H], “Guidelines for Housestaff Contracts or Agreements” (AMA Policy Database).

15 The ACGME requirements support residents’ scholarly activities but do not specify any financial

16 support. Furthermore, based on reference committee testimony, guaranteeing “access to

17 educational programs and curriculum as necessary to facilitate understanding of the US health care

18 system and to increase communication skills” is a potential additional right.^{1,2}

19

20 Notes on Right 3:

21

22 AMA Policies D-310.965, “Credentialing Materials: Timely Submission by Residency and

23 Fellowship Programs,” and H-310.921, “Credentialing Materials: Timely Submission by Residency

24 and Fellowship Programs,” request that the ACGME incorporate into its standards the submission

25 of verification and credentialing information to requesting agencies within 30 days of the request;

26 the ACGME currently requires “timely” submission.

27

28 Notes on Right 5:

29

30 AMA policy advocates for compensation during orientation and recommends that compensation

31 overall be based on years of experience (Policies H-310.999 [II.E.1-3], “Guidelines for Housestaff

32 Contracts or Agreements,” H-310.988, “Adequate Resident Compensation,” H-305-930,

33 “Residents’ Salaries,” and D-310.967, “Resident Pay During Orientation”). AMA policy does not

34 specify compensation adjusted to cost of living differences based on geographic differences,

35 although this may be covered by H-310.988, which calls for “adequate compensation.” The

36 ACGME requires “appropriate financial support” but does not provide for differing levels of

37 experience or region of the country.

38

39 AMA Policy H-295.942, “Providing Dental and Vision Insurance to Medical Students and

40 Resident Physicians,” specifically covers dental and vision services for residents and fellows, while

41 ACGME requirements do not. The ACGME does not mention guaranteed predetermined

42 educational leave, paid or otherwise. The total amount for all leave is not included in ACGME

43 requirements, although they do specify that leave policies must comply with applicable laws.

44

45 Notes on Right 6:

46

47 Council on Medical Education Report 7-A-11 updates all AMA and ACGME actions on duty

48 hours.

1 Notes on Right 7:

2

3 There are ACGME requirements addressing grievance procedures and due process; however, they
4 are not as extensive as AMA due process guidelines.

5

6 Notes on Right 8:

7

8 The original language in this section requested “anonymous channels” of communication for
9 reporting violations. The AMA does not have policy to support “anonymous” reporting, but has
10 strong policy supporting “confidential” reporting, which is in congruence with Accreditation
11 Council for Graduate Medical Education requirements that residents can address concerns “in a
12 confidential and protected manner.”

13

14 RECOMMENDATIONS

15

16 The Council of Medical Education recommends that the following recommendations be adopted in
17 lieu of Resolution 901-I-09 and that the remainder of this report be filed.

18

19 1. That our American Medical Association (AMA) continue to advocate for improvements in
20 the ACGME Institutional and Common Program Requirements that support AMA policies
21 as follows: a) adequate financial support for and guaranteed leave to attend professional
22 meetings; b) submission of training verification information to requesting agencies within
23 30 days of the request; c) adequate compensation with consideration to local cost-of-living
24 factors and years of training, and to include the orientation period; d) health insurance
25 benefits to include dental and vision services; e) paid leave for all purposes (family,
26 educational, vacation, sick) to be no less than six weeks per year; and f) stronger due
27 process guidelines. (Directive to Take Action)

28

29 2. That our AMA encourage the ACGME to ensure access to educational programs and
30 curricula as necessary to facilitate a deeper understanding by resident physicians of the US
31 health care system and to increase their communication skills. (Directive to Take Action)

32

33 3. That our AMA regularly communicate to residency and fellowship programs and other
34 GME stakeholders through various publication methods (e.g., the AMA GME e-letter) this
35 Residents and Fellows’ Bill of Rights. (Directive to Take Action)

36

37 4. That our AMA adopt the following “Residents and Fellows’ Bill of Rights” as applicable
38 to all resident and fellow physicians in ACGME-accredited training programs. (New HOD
39 Policy)

40

41 RESIDENTS AND FELLOWS’ BILL OF RIGHTS

42

43 *Residents and fellows have a right to:*

44

45 1. *An education that fosters professional development, takes priority over service, and*
46 *leads to independent practice.*

47

48 With regard to education, residents and fellows should expect:

49

50 • A graduate medical education experience that facilitates their professional and ethical
51 development, to include regularly scheduled didactics for which they are released from

1 clinical duties. Service obligations should not interfere with educational opportunities
2 and clinical education should be given priority over service obligations;³

- 3 • Faculty who devote sufficient time to the educational program to fulfill their teaching
4 and supervisory responsibilities;⁴
5 • Adequate clerical and clinical support services that minimize the extraneous, time-
6 consuming work that draws attention from patient care issues and offers no educational
7 value;⁵
8 • 24-hour per day access to information resources to educate themselves further about
9 appropriate patient care;⁶ and
10 • Resources that will allow them to pursue scholarly activities to include financial
11 support and education leave to attend professional meetings.^{7,8}

12
13 2. *Appropriate supervision by qualified faculty with progressive resident responsibility*
14 *toward independent practice.*

15
16 With regard to supervision, residents and fellows should expect supervision by physicians
17 and non-physicians who are adequately qualified and which allows them to assume
18 progressive responsibility appropriate to their level of education, competence, and
19 experience.⁹

20
21 3. *Regular and timely feedback and evaluation based on valid assessments of resident*
22 *performance.*

23
24 With regard to evaluation and assessment processes, residents and fellows should expect:¹⁰

- 25
26 • Timely and substantive evaluations during each rotation in which their competence is
27 objectively assessed by faculty who have directly supervised their work;
28 • To evaluate the faculty and the program confidentially and in writing at least once
29 annually and expect that the training program will address deficiencies revealed by
30 these evaluations in a timely fashion;
31 • Access to their training file and to be made aware of the contents of their file on an
32 annual basis; and
33 • Training programs to complete primary verification/credentialing forms and
34 recredentialing forms, apply all required signatures to the forms, and then have the
35 forms permanently secured in their educational files at the completion of training or a
36 period of training and, when requested by any organization involved in credentialing
37 process, ensure the submission of those documents to the requesting organization
38 within thirty days of the
39 request.^{11,12}

40
41 4. *A safe and supportive workplace with appropriate facilities.*

42
43 With regard to the workplace, residents and fellows should have access to:

- 44
45 • A safe workplace that enables them to fulfill their clinical duties and educational
46 obligations;¹³
47 • Secure, clean, and comfortable on-call rooms and parking facilities which are secure
48 and
49 well-lit;¹⁴
50 • Opportunities to participate on committees whose actions may affect their education,

1 patient care, workplace, or contract.¹⁵

2
3 *5. Adequate compensation and benefits that provide for resident well-being and health.*

4
5 A) With regard to contracts, residents and fellows should receive:

- 6
7 • Information about the interviewing residency or fellowship program including a
8 copy of the currently used contract clearly outlining the conditions for (re)appointment,
9 details of remuneration, specific responsibilities including call obligations, and a
10 detailed protocol for handling any grievance;¹⁶ and
11 • At least four months advance notice of contract non-renewal and the reason for non-
12 renewal.¹⁷

13
14 B) With regard to compensation, residents and fellows should receive:

- 15
16 • Compensation to begin during orientation;¹⁸ and
17 • Salaries commensurate with their level of training and experience, and that reflect cost
18 of living differences based on geographical differences.^{19,20,21,22,23}

19
20 C) With Regard to Benefits, Residents and Fellows Should Receive:

- 21
22 • Quality and affordable comprehensive medical,²⁴ mental health, dental, and vision
23 care;^{25,26,27}
24 • Education on the signs of excessive fatigue, clinical depression, and substance abuse
25 and dependence;^{28,29,30}
26 • Confidential access to mental health and substance abuse services;³¹
27 • A guaranteed, predetermined amount of paid vacation leave, sick leave, maternity and
28 paternity leave and educational leave during each year in their training program³² the
29 total amount of which should not be less than six weeks;³³ and
30 • Leave in compliance with the Family and Medical Leave Act.³⁴

31
32 *6. Duty hours that protect patient safety and facilitate resident well-being and education.*

33
34 With regard to duty hours, residents and fellows should experience:

- 35
36 • A reasonable work schedule that is in compliance with duty-hour requirements set
37 forth by the ACGME or other relevant accrediting body;³⁵ and
38 • At-home call that is not so frequent or demanding such that rest periods are
39 significantly diminished³⁶ or that duty-hour requirements are effectively
40 circumvented.³⁷

41
42 *7. Due process in cases of allegations of misconduct or poor performance.*

43
44 With regard to the complaints and appeals process, residents and fellows should have the
45 opportunity to defend themselves against any allegations presented against them by a
46 patient, health professional, or training program in accordance with the due process
47 guidelines established by the AMA.³⁸

1 8. *Access to and protection by institutional and accreditation authorities when reporting*
2 *violations.*

3
4 With regard to reporting violations to the ACGME, residents and fellows should:

- 5
6 • Be informed by their program at the beginning of their training and again at each semi-
7 annual review of the resources and processes available within the residency program
8 for addressing resident concerns or complaints, including the program director,
9 Residency Training Committee, and the designated institutional official;³⁹
10 • Be able to file a formal complaint with the ACGME to address program violations of
11 residency training requirements without fear of recrimination and with the guarantee of
12 due process;^{40,41} and
13 • Have the opportunity to address their concerns about the training program through
14 confidential channels, including the ACGME concern process and/or the annual
15 ACGME Resident Survey.⁴²

Fiscal Note: \$500 for staff time.

REFERENCES

- ¹ Common Program Requirements. ACGME. Sections VI.A.5.e. and IV.A.5.g.
- ² ECFMG. ECFMG Acculturation Program. <http://www.ecfm.org/acculturation/index.html>. Accessed January 25, 2011.
- ³ Common Program Requirements. Accreditation Council for Graduate Medical Education (ACGME). Section VI.A.4.
- ⁴ Common Program Requirements. ACGME. Section II.B.1.
- ⁵ Common Program Requirements. ACGME. Section II.C.
- ⁶ Common Program Requirements. ACGME. Section II.E.
- ⁷ Common Program Requirements. ACGME. Section IV.B.3.
- ⁸ American Medical Association. Policy Compendium. HOD Policy H-310.999 (II.H).
- ⁹ Common Program Requirements. ACGME. Sections IV.A.4, V.A.1.b.2, and VI.D.2.
- ¹⁰ Common Program Requirements. ACGME. Sections V.A., V.C.
- ¹¹ American Medical Association. Policy Compendium. HOD Policy D-310.965.
- ¹² American Medical Association. Policy Compendium. HOD Policy H-310.921.
- ¹³ Institutional Requirements. ACGME. Section II.F.3.
- ¹⁴ Institutional Requirements. ACGME. Sections II.F.3.b. and II.F.3.c.
- ¹⁵ Institutional Requirements. ACGME. Section II.E.2.a.
- ¹⁶ Institutional Requirements. ACGME. Section II.D.4.
- ¹⁷ Institutional Requirements. ACGME. Section II.D.4.d.1.
- ¹⁸ American Medical Association. Policy Compendium. HOD Policy D-310.967.
- ¹⁹ Institutional Requirements. ACGME. Section II.B.
- ²⁰ American Medical Association. Policy Compendium. HOD Policy H-310.999 (II.E.1-3).
- ²¹ American Medical Association. Policy Compendium. HOD Policy H-310.988.
- ²² American Medical Association. Policy Compendium. HOD Policy D-310.967.
- ²³ American Medical Association. Policy Compendium. HOD Policy H-305.930.
- ²⁴ Institutional Requirements. ACGME. Section II.D.4.g.
- ²⁵ American Medical Association. Policy Compendium. HOD Policy H-310.999 (II.I.1-3).
- ²⁶ Institutional Requirements. ACGME. Section II.D.4.k.
- ²⁷ American Medical Association. Policy Compendium. HOD Policy H-295.942.
- ²⁸ Institutional Requirements. ACGME. Section II.D.4.l.
- ²⁹ Common Program Requirements. ACGME. Section VI.C.
- ³⁰ American Medical Association. Policy Compendium. HOD Policy H-295.979.
- ³¹ Institutional Requirements. ACGME. Section II.D.4.k.
- ³² Institutional Requirements. ACGME. Section II.D.4.h.
- ³³ American Medical Association. Policy Compendium. HOD Policy D-310.963.
- ³⁴ Institutional Requirements. ACGME. Section II.D.4.h.
- ³⁵ Common Program Requirements. ACGME. Section VI.G.
- ³⁶ Common Program Requirements. ACGME. Section VI.G.8.
- ³⁷ American Medical Association. Policy Compendium. RFS Policy 310.572R.
- ³⁸ American Medical Association. Policy Compendium. HOD Policy H-265.998.
- ³⁹ Institutional Requirements. ACGME. Section II.D.4.e.
- ⁴⁰ ACGME Complaint Process, http://www.acgme.org/acWebsite/resInfo/ri_formalcomplaint.asp.
- ⁴¹ American Medical Association. Policy Compendium. HOD Policy H-310.999 (II.L. and II.M.).
- ⁴² American Medical Association. Policy Compendium. HOD Policy D-310.973.