ILLINOIS STATE MEDICAL SOCIETY

Resolution 04.2024-03
(A-25)

Introduced by: Divya Meher Surabhi, MD, ISMS Member

Subject: Supporting Medical Student, Resident, and Fellow Research Endeavors

Referred to: Council on Education & Health Workforce

Whereas, the average mean number of research experiences for matched U.S. MD senior medical students and matched U.S. D.O. senior medical students is 4.0[1] and 2.0[2], respectively; and

Whereas, the mean number of research experiences for matched U.S. resident graduates and matched osteopathic resident graduates is 4.7 and 3.1, respectively[3]; and

Whereas, many fellows also participate in research during training; and

Whereas, research advances the field of medicine and medical education; and

Whereas, participating in research as a trainee (i.e., medical student, resident physician, fellow physician) advances an understanding of disciplines within medicine, builds critical thinking skills[4], and supports career advancement; and

Whereas, some medical schools, residency programs, and fellowship programs offer research funding for students to travel to research meetings and conferences or submit articles for journal publications; and

Whereas, however, it is often limited and not enough to cover expenses completely; and

Whereas, students who don't participate in research state that one contributing factor is financial constraints[5]; and

Whereas, this hinders opportunities for career advancement and networking; therefore, be it

RESOLVED, that ISMS support trainees in research endeavors; and be it further

RESOLVED, that the ISMS reaffirms its policy which states: RESOLVED, the Illinois State Medical Society develop or promote resources that assist Illinois physicians and physicians-in-training in submitting scholarly research to medical publications; and be it further

RESOLVED, that the ISMS establish an annual research fund and scholarship to support trainees with the financial burden associated with publishing journal articles and traveling to and attending research meetings and conferences for which trainees have been accepted for poster or oral presentations.

References:

1. Charting Outcomes in the Match: Senior Students of U.S. MD Medical Schools Characteristics of U.S. MD Seniors Who Matched to Their Preferred Specialty in the 2022 Main Residency Match 3rd Edition.; 2022. https://www.nrmp.org/wp-content/uploads/2022/07/Charting-Outcomes-MD-Seniors-2022_Final.pdf
2. Charting Outcomes in the Match: Senior Students of U.S. DO Medical Schools Characteristics of Senior Students of U.S. DO Medical Schools Who Matched to Their Preferred Specialty in the 2022 Main Residency Match 3rd Edition.; 2022. https://www.nrmp.org/wp-content/uploads/2022/07/Charting_Outcomes_DO_Seniors_2022_Final-Updated.pdf
3. Charting Outcomes in the Match Specialties Matching Service®, Appointment Year 2018 Characteristics of Applicants Who Matched to Their Preferred Specialty 2nd Edition.; 2018. Accessed March 17, 2024. https://www.nrmp.org/wp-content/uploads/2021/08/2018-Charting-Outcomes-SMS.pdf
4. Houlden RL, Raja JB, Collier CP, Clark AF, Waugh JM. Medical students' perceptions of an undergraduate research elective. Med Teach. 2004;26:659–61.
5. Agha R, Howell S. Intercalated

Fiscal Note:

n/a

Existing ISMS policy related to this issue:

House of Delegates adopted Substitute Resolution A100 (A-18), Support for Starting a Medical Journal from ISMS, which states: RESOLVED, the Illinois State Medical Society develop or promote resources that assist Illinois physicians and physicians-in-training in submitting scholarly research to medical publications. (HOD 2018)

Board of Trustees approved a one-time funding request of $22,200 from the Educational & Scientific Foundation to fund Illinois residents and fellows to attend the American Medical Association meetings in 2022. (BOT - APR 2022)

Board of Trustees approved using $100,000 for educational programs that benefit students and residents, with 75% being allocated to student programs and 25% to resident programs. (BOT 2007-FEB)

Board of Trustees approved the Committee on Membership and Advocacy working with our Medical Student Section and Resident and Fellow Section to identify and implement activities promoting medical student, resident and fellow membership in ISMS. (BOT 2007-OCT)

Board of Trustees adopted Substitute Resolution 60 (A-04), which requested that the ISMS Board of Trustees form an educational panel with representation from the ISMS Medical Student and Resident & Fellow sections, to develop criteria and procedures, and oversee an educational assistance program that effectively uses an appropriate portion of available ESF funds for the benefit of member students, residents and fellows. (BOT 2005-APR)

Board of Trustees approved the availability, on an annual basis as part of the ISMS budget process, of up to $150,000 for the funding of ISMS educational or scientific-related programs and activities as needed, and that up to $100,000 each year be designated for the purpose of providing some form of educational assistance to medical students and residents. Approved the formation of an educational panel to develop criteria and procedures, and oversee an educational assistance program subject to the endorsement of the ISMS Medical Student Section, the ISMS Resident & Fellow Section, and the ISMS Executive Committee, and subsequent ratification by the ISMS and Educational and Scientific (ESF) boards. (BOT 2004-OCT)

Board of Trustees approved that The Educational and Scientific Foundation of the Illinois State Medical Society create a Student and Resident Leadership account, with donations solicited from members of the Illinois Delegation, Board of Trustees, and perhaps others. The funds collected would be used to fund students and residents to attend their respective AMA Section meetings, which are held twice a year. (BOT - OCT 2023)

Board of Trustees approved that, based upon the annual funds available from the ESF Student and Resident Leadership Account, to establish a per person reimbursement cap per student/resident per year, not per meeting. The allocation of such funds be capped at one representative from each Illinois medical school campus and up to five resident physicians, all of whom must demonstrate active involvement within the ISMS. (BOT - OCT 2023)

Existing AMA policy related to this issue:

Principles for Graduate Medical Education H-310.929

Our AMA urges the Accreditation Council for Graduate Medical Education (ACGME) to incorporate these principles in its Institutional Requirements, if they are not already present.
(1) PURPOSE OF GRADUATE MEDICAL EDUCATION AND ITS RELATIONSHIP TO PATIENT CARE. There must be objectives for residency education in each specialty that promote the development of the knowledge, skills, attitudes, and behavior necessary to become a competent practitioner in a recognized medical specialty.

Exemplary patient care is a vital component for any residency/fellowship program. Graduate medical education enhances the quality of patient care in the institution sponsoring an accredited program. Graduate medical education must never compromise the quality of patient care. Institutions sponsoring residency programs and the director of each program must assure the highest quality of care for patients and the attainment of the program's educational objectives for the residents.

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

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

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

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

(6) INSTITUTIONAL RESPONSIBILITY FOR PROGRAMS. Specialty-specific GME must operate under a system of institutional governance responsible for the development and implementation of policies regarding the following; the initial authorization of programs, the appointment of program directors, compliance with the accreditation requirements of the ACGME, the advancement of resident physicians, the disciplining of resident physicians when this is appropriate, the maintenance of permanent records, and the credentialing of resident physicians who successfully complete the program. If an institution closes or has to reduce the size of a residency program, the institution must inform the residents as soon as possible. Institutions must make every effort to allow residents already in the program to complete their education in the affected program. When this is not possible, institutions must assist residents to enroll in another program in which they can continue their education. Programs must also make arrangements, when necessary, for the disposition of program files so that future confirmation of the completion of residency education is possible. Institutions should allow residents to form house staff organizations, or similar organizations, to address patient care and resident work environment concerns. Institutional committees should include resident members.

(7) COMPENSATION OF RESIDENT PHYSICIANS. All residents should be compensated. Residents should receive fringe benefits, including, but not limited to, health, disability, and professional liability insurance and parental leave and should have access to other benefits offered by the institution. Residents must be informed of employment policies and fringe benefits, and their access to them. Restrictive covenants must not be required of residents or applicants for residency education.

(8) LENGTH OF TRAINING. The usual duration of an accredited residency in a specialty should be defined in the "Program Requirements." The required minimum duration should be the same for all programs in a specialty and should be sufficient to meet the stated objectives of residency education for the specialty and to cover the course content specified in the Program Requirements. The time required for an individual resident physician's education might be modified depending on the aptitude of the resident physician and the availability of required clinical experiences.

(9) PROVISION OF FORMAL EDUCATIONAL EXPERIENCES. Graduate medical education must include a formal educational component in addition to supervised clinical experience. This component should assist resident physicians in acquiring the knowledge and skill base required for practice in the specialty. The assignment of clinical responsibility to resident physicians must permit time for study of the basic sciences and clinical pathophysiology related to the specialty.

(10) INNOVATION OF GRADUATE MEDICAL EDUCATION. The requirements for accreditation of residency training should encourage educational innovation and continual improvement. New topic areas such as continuous quality improvement (CQI), outcome management, informatics and information systems, and population-based medicine should be included as appropriate to the specialty.

(11) THE ENVIRONMENT OF GRADUATE MEDICAL EDUCATION. Sponsoring organizations and other GME programs must create an environment that is conducive to learning. There must be an appropriate balance between education and service. Resident physicians must be treated as colleagues.

(12) SUPERVISION OF RESIDENT PHYSICIANS. Program directors must supervise and evaluate the clinical performance of resident physicians. The policies of the sponsoring institution, as enforced by the program director, and specified in the ACGME Institutional Requirements and related accreditation documents, must ensure that the clinical activities of each resident physician are supervised to a degree that reflects the ability of the resident physician and the level of responsibility for the care of patients that may be safely delegated to the resident. The sponsoring institution's GME Committee must monitor programs' supervision of residents and ensure that supervision is consistent with: (A) Provision of safe and effective patient care; (B)

Educational needs of residents; (C) Progressive responsibility appropriate to residents' level of education, competence, and experience; and (D) Other applicable Common and specialty/subspecialty specific Program Requirements. The program director, in cooperation with the institution, is responsible for maintaining work schedules for each resident based on the intensity and variability of assignments in conformity with ACGME Review Committee recommendations, and in compliance with the ACGME clinical and educational work hour standards. Integral to resident supervision is the necessity for frequent evaluation of residents by faculty, with discussion between faculty and resident. It is a cardinal principle that responsibility for the treatment of each patient and the education of resident and fellow physicians lies with the physician/faculty to whom the patient is assigned and who supervises all care rendered to the patient by residents and fellows. Each patient's attending physician must decide, within guidelines established by the program director, the extent to which responsibility may be delegated to the resident, and the appropriate degree of supervision of the resident's participation in the care of the patient. The attending physician, or designate, must be available to the resident for consultation at all times.

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

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

(15) VERIFICATION OF RESIDENT PHYSICIAN EXPERIENCE. The program director must document a resident physician's specific experiences and demonstrated knowledge, skills, attitudes, and behavior, and a record must be maintained within the institution.
CME Rep. 9, A-99; Reaffirmed: CME Rep. 2, A-09; Reaffirmed: CME Rep. 14, A-09; Modified: CME Rep. 06, I-18; Reaffirmed: CME Rep. 01, I-22.

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.
CME Rep. 7, A-05; Reaffirmation I-06; Reaffirmed: Sub. Res. 314, A-07; Reaffirmation I-07; Reaffirmed: CME Rep. 4, I-08; Reaffirmed: Sub. Res. 314, A-09; Reaffirmed: CME Rep. 3, I-09; Reaffirmed: CME Rep. 15, A-10; Reaffirmation A-11; Reaffirmation A-13; Reaffirmed: CME Rep. 5, A-13; Appended: CME 05, A-16; Appended: Res. 319, A-16; Reaffirmation A-16

Support for Careers in Research H-460.995

Our AMA: (1) recognizes the serious decline in the number of physicians seeking to prepare for a career in research, which is fundamental to the advancement of the practice of medicine, and urges that: (a) medical students be made aware of the challenging and important career option of biomedical research, and (b) schools of medicine be made aware of the impending shortage and provide increased opportunities for students to participate in research; and (2) supports policies and legislation designed to increase the number of physician-investigators. Such support should include encouragement for training of physicians in careers in biomedical research and for supportive legislation to make physician-investigators eligible for forgiveness in certain government scholarship and loan programs for qualified candidates in numbers consistent with national needs.
Sub. Res. 79, I-79; Reaffirmed: CLRPD Rep. B, I-89; Reaffirmed: Sunset Report, A-00; Reaffirmation A-09; Reaffirmed: CSSAPH Rep. 01, A-19