UNITED STATES OF AMERICA
BEFORE THE NATIONAL LABOR RELATIONS BOARD

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In the Matter of

BOSTON MEDICAL CENTER,

Employer Case No. 1-RC-20574

- and -

COMMITTEE OF INTERNS
AND RESIDENTS,

Petitioner,

----------x

Brief of the American Medical Association and the Massachusetts Medical Society, *Amici Curiae*

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Statement of Interest

The American Medical Association (AMA) and the Massachusetts Medical Society (MMS) respectfully submit this brief as amici curiae.

The AMA is a private, nonprofit organization of physicians. The AMA is dedicated to promoting the public welfare through the maintenance of high professional standards and the provision of quality health care. The membership of the AMA exceeds 290,000 physicians nationwide, including 34,000 residents and interns.

The AMA is highly involved in issues relating to undergraduate and graduate medical education through its sponsorship of the Joint Commission on Accreditation of Health Care Organizations, the Liaison Committee on Medical Education, the Accreditation Council on Continuing Medical Education, and the Accreditation Council on Graduate Medical Education (ACGME). These organizations accredit virtually all medical education programs in the United States.

The MMS is the oldest continuously operating non-profit professional medical association in the United States. The MMS is a constituent association of the AMA. Founded in 1781, the MMS represents approximately 17,000 member physicians. The purpose of the MMS is to advance medical knowledge, to develop and maintain the highest professional and ethical standards of medical practice and health care, and to promote medical institutions formed on liberal principles for the health, benefit and

welfare of the citizens of Massachusetts.

The MMS has a Resident Physicians Section which is comprised of over 2,000 resident physician members in the state. Created in 1983, the Resident Physicians Section is led by an elected Governing Council, which meets approximately monthly during the course of the year. The Governing Council elects eight Delegates to the MMS policy making body, the House of Delegates, and one resident physician sits on the MMS Board of Trustees. The Resident Physicians Section is also represented at the AMA by sixteen Delegates to the AMA Resident Physician Section Assembly.

The interest of the AMA and the MMS is to inform the National Labor Relations Board of their position that 1) residents have a unique status as participants in graduate medical education programs and should have the right to negotiate as a group about legitimate issues relating to patient care and resident well-being, but they should not have the right to strike; and 2) the proper forum for developing a model for residents seeking to negotiate with institutions is the ACGME, which accredits and oversees virtually all graduate medical education programs in the United States.

I. Residents should have a right to negotiate as a group on issues of patient care and resident well-being, but they should not have the right to strike.

Resident physicians have a unique status and relationship with the institutions where they receive training. This period in their lives is properly called "graduate medical education," and the justification for their training is education. However, residents also provide valuable patient care services to these institutions. The AMA and MMS strongly

endorse the right of resident physicians to negotiate as a group with their respective training institutions on matters of patient care and resident well being, without fear of retaliation. (AMA Policy H-310-999 (IIB) (3)). For example, legitimate issues for negotiation include adequacy of medical equipment, availability of adequate laboratory and ancillary staff support, availability of adequate call rooms, and security for physicians and patients. Also, the MMS Board of Trustees voted on September 10, 1997 to reaffirm previous policy of the MMS House of Delegates "that the MMS support hospital-based house staff organizations to represent house staff interests, and to negotiate collectively on behalf of their colleagues. ([MMS] policy does not include support for the right to strike nor mandatory membership in such associations.)"

This right is limited by two important principles. First, residents may not strike. AMA Policy 405.998 states that "the AMA reaffirms the tradition of the medical profession of not withholding medical services or performing any act that will interfere with the public welfare as a bargaining mechanism." This flows naturally from bedrock principles of medical ethics that the duty of patient advocacy is a fundamental element of the physician-patient relationship, and physicians must place the needs of their patients first. See AMA Principles of Medical Ethics, AMA Fundamentals of the Patient-Physician Relationship, AMA Council on Ethical and Judicial Affairs Opinion E-8.13. (attached as Exhibit A). Second, the educational concerns of the training program must remain paramount. Therefore, residents may not negotiate over any aspect of the educational requirements of their residency.

Consequently, because of both the ethical responsibility not to strike and the unique educational role of residency training, the model of the traditional labor union has not been appropriate for resident physicians.[1] Residents are in an unique situation, simultaneously serving as students and employees. While the AMA and the MMS support the formation of self-governing, voluntary organizations of residents within the institutions which sponsor their training to negotiate on issues of patient care and resident well-being, the AMA believes that such organizations should operate within the context of the educational standards developed by the ACGME. This will ensure that any negotiations between residents and physicians do not encroach on academic prerogatives or result in the use of any tactic, including a strike, that interferes with the residents' ethical duty to their patients.

II. The standards and procedures of the Accreditation Council for Graduate Medical Education provide the appropriate forum to address the concerns of residents.

The ACGME accredits and develops standards for virtually all residency programs in the United States. The ACGME corporate sponsors are the AMA, the American Board of Medical Specialties, the American Hospital Association, the Association of American Medical Colleges, and the Council of Medical Specialty Societies. Also on the ACGME governing board are a representative from the federal government, two public representatives, a resident representative, and the chair of the Council of Residency

[1] Section 13 of the National Labor Relations Act preserves the right of employees within collective bargaining units to strike. Labor strikes are fundamentally inconsistent with physicians' ethical obligations. Therefore, as outlined below, the AMA policy and MMS supports resident negotiation on legitimate issues of patient care and resident well-being under the standards being developed by the ACGME.

Review Committees (RRCs). The RRCs are composed of a representative from the AMA, the relevant specialty board, and in some cases a national medical specialty society. The RRCs administer the accreditation program and develop standards subject to the approval of the ACGME. Resident physicians participate in the ACGME process at all levels. The setting of educational standards must remain the role of the ACGME and the RRCs and any negotiations regarding educational issues in a resident's training should take place in the context of ACGME and RRC guidelines.

The ACGME clearly provides the appropriate educational context to develop standards for voluntary resident organizations. For example, the Essentials and Information Items of the ACGME 1997-1998, "Institutional Requirements" includes standards that require participating institutions to treat residents appropriately and fairly. These requirements address issues such as financial support for residents and the contents of contracts, including benefits, duty hours, and other matters. A copy of these standards is attached as Exhibit B.

However, the AMA and the MMS also believe that change in the ACGME standards is needed to assure that residents have an opportunity to negotiate as a group on legitimate issues relating to patient care and resident well being. Specifically, Resolution 325, passed at the December 1997 Interim Meeting of the AMA House of Delegates, states as follows:

RESOLVED, That the AMA seek to amend the ACGME Institutional Requirements to prohibit a teaching institution from impeding any efforts by the residents to create a resident organization; and be it further

RESOLVED, That the AMA seek to amend the ACGME Institutional Requirements to require teaching institutions to develop resident physician organizations with substantive empowerment to work with their institutions to address and resolve issues related to patient care and working conditions; and be it further

RESOLVED, That the AMA seek to amend the ACGME Institutional Requirements to forbid teaching institutions from retribution against individual residents for activity related to a resident organization; and be it further

RESOLVED, That the AMA seek means to ensure more timely and vigorous enforcement by the ACGME of its Institutional Requirements.

The AMA, as a sponsor organization of the ACGME, has initiated a process that should result in developing ACGME standards consistent with these principles. Other ACGME sponsors support this process, and the AMA and the MMS are optimistic that this process will result in a model that accommodates the concerns of residents within the educational context.

For its part, the MMS has been working to develop an ACGME model which, utilizing a house staff association approach and due process protections, would address residents' concerns, without jeopardizing the educational aspect of their residency. While no final resolution has yet been realized, a set of suggest principles has been crafted, based on the work of the MMS Resident Physician Section, and others including the MMS' President. This document, which represents a work in progress (and is not meant to constitute official policy of any body) is attached as Exhibit C.

Conclusion

The American Medical Association and the Massachusetts Medical Society have adopted positions which are consistent with the concerns of patient care and with the concerns of residents and the teaching institutions which sponsor them. Standards and procedures for resident organizing and collective negotiation are being developed by the ACGME. Although resident physicians should have the right to organize and bargain collectively, under no circumstances should residents strike or compromise patient care.

Accordingly, the AMA and the MMS request that the National Labor Relations Board rule consistently with the aforesaid positions.

Date: January 29, 1998

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E-Principles of Medical Ethics

"Preamble:"

The medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient. As a member of this profession, a physician must recognize responsibility not only to patients, but also to society, to other health professionals, and to self. The following Principles adopted by the American Medical Association are not laws, but standards of conduct which define the essentials of honorable behavior for the physician.

I. A physician shall be dedicated to providing competent medical service with compassion and respect for human dignity.

II. A physician shall deal honestly with patients and colleagues, and strive to expose those physicians deficient in character or competence, or who engage in fraud or deception.

III. A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient.

IV. A physician shall respect the rights of patients, of colleagues, and of other health professionals, and shall safeguard patient confidences within the constraints of the law.

V. A physician shall continue to study, apply and advance scientific knowledge, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.

VI. A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical services.

VII. A physician shall recognize a responsibility to participate in activities contributing to an improved community.

E-Fundamental Elements of the Patient - Physician Relationship

From ancient times, physicians have recognized that the health and well-being of patients depends upon a collaborative effort between physician and patient. Patients share with physicians the responsibility for their own health care. The patient-physician relationship is of greatest benefit to patients when they bring medical problems to the attention of their physicians in a timely fashion, provide information about their medical condition to the best of their ability, and work with their physicians in a mutually respectful alliance. Physicians can best contribute to this alliance by serving as their patients' advocate and by fostering these rights:

1. The patient has the right to receive information from physicians and to discuss the benefits, risks, and costs of appropriate treatment alternatives. Patients should receive guidance from their physicians as to the optimal course of action. Patients are also entitled to obtain copies or summaries of their medical records, to have their questions answered, to be advised of potential conflicts of interest that their physicians might have, and to receive independent professional opinions.

2. The patient has the right to make decisions regarding the health care that is recommended by his or her physician. Accordingly, patients may accept or refuse any recommended medical treatment.

3. The patient has the right to courtesy, respect, dignity, responsiveness, and timely attention to his or her needs.

4. The patient has the right to confidentiality. The physician should not reveal confidential communications or information without the consent of the patient, unless provided for by law or by the need to protect the welfare of the individual or the public interest.

5. The patient has the right to continuity of health care. The physician has an obligation to cooperate in the coordination of medically indicated care with other health care providers treating the patient. The physician may not discontinue treatment of a patient as long as further treatment is medically indicated, without giving the patient reasonable assistance and sufficient opportunity to make alternative arrangements for care.

6. The patient has a basic right to have available adequate health care. Physicians, along with the rest of society, should continue to work toward this goal. Fulfillment of this right is dependent on society providing resources so that no patient is deprived of necessary care because of an inability to pay for the care. Physicians should continue their traditional assumption of a part of the responsibility for the medical care of those who cannot afford essential health care. Physicians should advocate for patients in dealing with third parties when appropriate. Report of the Council on Ethical and Judicial Affairs of the American Medical Association. Originally adopted June 1990; updated June 1994.

E-8.13 Managed Care.

The expansion of managed care has brought a variety of changes to medicine including new and different reimbursement systems for physicians with complex referral restrictions and benefits packages for patients. Some of these changes have raised concerns that a physician's ability to practice ethical medicine will be adversely affected by the modifications in the system. In response to these concerns, the following points were developed to provide physicians with general guidelines that will assist them in fulfilling their ethical responsibilities to patients given the changes heralded by managed care.

(1) The duty of patient advocacy is a fundamental element of the physician-patient relationship that should not be altered by the system of health care delivery in which physicians practice. Physicians must continue to place the interests of their patients first.

(2) When managed care plans place restrictions on the care that physicians in the plan may provide to their patients, the following principles should be followed:

A. Any broad allocation guidelines that restrict care and choices - which go beyond the cost/benefit judgments made by physicians as a part of their normal professional responsibilities - should be established at a policy making level so that individual physicians are not asked to engage in bedside rationing.

B. Regardless of any allocation guidelines or gatekeeper directives, physicians must advocate for any care they believe will materially benefit their patients.

C. Physicians should be given an active role in contributing their expertise to any allocation process and should advocate for guidelines that are sensitive to differences among patients. Managed care plans should create structures similar to hospital medical staffs that allow physicians to have meaningful input into the plan's development of allocation guidelines. Guidelines for allocating health care should be reviewed on a regular basis and updated to reflect advances in medical knowledge and changes in relative costs.

D. Adequate appellate mechanisms for both patients and physicians should be in place to address disputes regarding medically necessary care. In some circumstances, physicians have an obligation to initiate appeals on behalf of their patients. Cases may arise in which a health plan has an allocation guideline that is generally fair but in particular circumstances results in unfair denials of care, i.e., denial of care that, in the physician's judgment, would materially benefit the patient. In such cases, the physician's duty as patient advocate requires that the physician challenge the denial and argue for the provision of treatment in the specific case. Cases may also arise when a health plan has an allocation guideline that is generally unfair in its operations. In such cases, the physician's duty as patient advocate requires not only a challenge to any denials of treatment from the guideline but also advocacy at the health plan's policy-making level to seek an elimination or modification of the guideline.

Physicians should assist patients who wish to seek additional, appropriate care outside the plan when the physician believes the care is in the patient's best interests.

E. Managed care plans must adhere to the requirement of informed consent that patients be given full disclosure of material information. Full disclosure requires that managed care plans inform potential subscribers of limitations or restrictions on the benefits package when they are considering entering the plan.

F. Physicians also should continue to promote full disclosure to patients enrolled in managed care organizations. The physician's obligation to disclose treatment alternatives to patients is not altered by any limitations in the coverage provided by the patient's managed care plan. Full disclosure includes informing patients of all of their treatment options, even those that may not be covered under the terms of the managed care plan. Patients may then determine whether an appeal is appropriate, or whether they wish to seek care outside the plan for treatment alternatives that are not covered.

G. Physicians should not participate in any plan that encourages or requires care at below minimum professional standards.

(3) When physicians are employed or reimbursed by managed care plans that offer financial incentives to limit care, serious potential conflicts are created between the physicians' personal financial interests and the needs of their patients. Efforts to contain health care costs should not place patient welfare at risk. Thus, financial incentives are permissible only if they promote the cost-effective delivery of health care and not the withholding of medically necessary care.

A. Any incentives to limit care must be disclosed fully to patients by plan administrators upon enrollment and at least annually thereafter.

B. Limits should be placed on the magnitude of fee withholds, bonuses and other financial incentives to limit care.

Calculating incentive payments according to the performance of a sizable group of physicians rather than on an individual basis should be encouraged.

C. Health plans or other groups should develop financial incentives based on quality of care. Such incentives should complement financial incentives based on the quantity of services used.

(4) Patients have an individual responsibility to be aware of the benefits and limitations of their health care coverage. Patients should exercise their autonomy by public participation in the formulation of benefits packages and by prudent selection of health care coverage that best suits their needs. Issued June 1996 based on the report "Ethical Issues in Managed Care," issued June 1994.

6. Disability Insurance: Institutions sponsoring GME must provide access to insurance, where available, to all residents for disabilities resulting from activities that are part of the educational program.
7. Leave of Absence: There must be a written institutional policy on leave (with or without pay) for residents that complies with applicable laws. The institution must provide residents with a written policy concerning the effect of leaves of absence, for any reason, on satisfying the criteria for completion of a residency program.
8. Counseling Services: GME places increasing responsibilities on residents and requires sustained intellectual and physical effort. Therefore, institutions should facilitate resident access to appropriate and confidential counseling, medical, and psychological support services.
9. Physician Impairment: Institutions must have written policies that describe how physician impairment, including that due to substance abuse, will be handled. In addition, institutions should provide an educational program for residents regarding physician impairment, including substance abuse.
10. Residency Closure/Reduction: If an institution intends to reduce the size of a residency program or to close a residency program, the institution should inform the residents as soon as possible. In the event of such a reduction or closure, institutions should make every effort to allow residents already in the program to complete their education. If any residents are displaced by the closure of a program or a reduction in the number of residents, the institution should make every effort to assist the residents in identifying a program in which they can continue their education.

D. Resident Supervision, Duty Hours, and Work Environment

Institutions must ensure that their GME programs provide appropriate supervision for all residents, as well as a duty hour schedule and a work environment, that is consistent with proper patient care, the educational needs of residents, and the applicable Program Requirements.

1. Supervision: There must be sufficient institutional oversight to assure that residents are appropriately supervised. Residents must be supervised by teaching staff in such a way that the residents assume progressively increasing responsibility according to their level of education, ability, and experience. On-call schedules for teaching staff must be structured to ensure that supervision is readily available to residents on duty. The level of responsibility accorded to each resident must be determined by the teaching staff.
2. Duty Hours: The sponsoring institution must ensure that each residency program establishes formal policies governing resident duty hours that foster resident education and facilitate the care of patients.
   a. The educational goals of the program and learning objectives of residents must not be compromised by excessive reliance on residents to fulfill institutional service obligations. Duty hours, however, must reflect the fact that responsibilities for continuing patient care are not automatically discharged at specific times. Programs must ensure that residents are provided appropriate backup support when patient care responsibilities are especially difficult or prolonged.
   b. Resident duty hours and on-call time periods must not be excessive. The structuring of duty hours and on-call schedules must focus on the needs of the patient, continuity of care, and the educational needs of the resident. Duty hours must be consistent with the Institutional and Program Requirements that apply to each program.
3. Work Environment: Sponsoring institutions must provide services and develop systems to minimize the work of residents that is extraneous to their educational programs, ensuring that the following conditions are met:
   a. Residents on duty in the hospital must be provided adequate and appropriate food services and sleeping quarters.
   b. Patient support services, such as intravenous services, phlebotomy services, and laboratory services, as well as messenger and transporter services, must be provided in a manner appropriate to and consistent with educational objectives and patient care.
   c. An effective laboratory, medical records, and radiologic information retrieval system must be in place to provide for appropriate conduct of the educational programs and quality and timely patient care.
   d. Appropriate security measures must be provided to residents in all locations including but not limited to parking facilities, on-call quarters, hospital and institutional grounds, and related clinical facilities (eg, medical office building).

ACGME: March 1996 Effective: July 1997

II. Residents

A. Resident Eligibility and Selection

The sponsoring institution must have written policies and procedures for the recruitment and appointment of residents that comply with the requirements listed below, and it must monitor the compliance of each program with these procedures.

1. Resident Eligibility
   Applicants with one of the following qualifications are eligible for appointment to accredited residency programs:
   a. Graduates of medical schools in the United States and Canada accredited by the Liaison Committee on Medical Education (LCME).
   b. Graduates of colleges of osteopathic medicine in the United States accredited by the American Osteopathic Association (AOA).
   c. Graduates of medical schools outside the United States and Canada who meet one of the following qualifications:
      (1) Have received a currently valid certificate from the Educational Commission for Foreign Medical Graduates or
      (2) Have a full and unrestricted license to practice medicine in a US licensing jurisdiction.
   d. Graduates of medical schools outside the United States who have completed a Fifth Pathway program provided by an LCME-accredited medical school. [*Note:* A Fifth Pathway program is an academic year of supervised clinical education provided by an LCME-accredited medical school to students who meet the following conditions: (1) have completed, in an accredited college or university in the United States, undergraduate premedical education of the quality acceptable for matriculation in an accredited United States medical school; (2) have studied at a medical school outside the United States and Canada but listed in the *World Health Organization Directory of Medical Schools*; (3) have completed all of the formal requirements of the foreign medical school except internship and/or social service; (4) have attained a score satisfactory to the sponsoring medical school on a screening examination; and (5) have passed either the Foreign Medical Graduate Examination in the Medical Sciences, Parts I and II of the examination of the National Board of Medical Examiners, or Steps 1 and 2 of the United States Medical Licensing Examination (USMLE).]
2. Resident Selection
   a. The sponsoring institution must ensure that programs select from among eligible applicants on the basis of their preparedness, ability, aptitude, academic credentials, communication skills, and personal qualities such as motivation and integrity. Programs must not discriminate with regard to sex, race, age, religion, color, national origin, disability, or veteran status.
   b. In selecting from among qualified applicants, it is strongly suggested that institutions and all of their sponsored programs participate in an organized matching program, where available, such as the National Resident Matching Program (NRMP).
3. Enrollment of Noneligibles
   The enrollment of noneligible residents may be a cause for withdrawal of accreditation of the involved program.

B. Resident Participation in Educational Activities

Institutions must ensure that residents have the opportunity to

1. develop a personal program of learning to foster continued professional growth with guidance from the teaching staff;
2. participate in safe, effective, and compassionate patient care, under supervision, commensurate with their level of advancement and responsibility;
3. participate fully in the educational and scholarly activities of their program and, as required, assume responsibility for teaching and supervising other residents and students;
4. participate as appropriate in institutional programs and medical staff activities and adhere to established practices, procedures, and policies of the institution;
5. have appropriate representation on institutional committees and councils whose actions affect their education and/or patient care; and,
6. submit to the program director at least annually confidential written evaluations of the faculty and of the educational experiences.

C. Resident Support, Benefits, and Conditions of Employment

Sponsoring and participating institutions should provide all residents with appropriate financial support and benefits. Compensation of residents and distribution of resources for the support of education should be carried out with the advice of the GMEC.

1. Financial Support: Adequate financial support of residents is necessary to ensure that residents are able to fulfill the responsibilities of their educational programs.
2. Applicants: Applicants for GME programs must be informed in writing of the terms and conditions of employment and benefits including financial support, vacations, professional leave, parental leave, sick leave, professional liability insurance, hospital and health insurance, disability insurance, and other insurance benefits for the residents and their family, and the conditions under which living quarters, meals, and laundry or their equivalents are to be provided.
3. Contracts: Sponsoring institutions must provide residents with a written agreement or contract outlining the terms and conditions of their appointment to an educational program, and the institutions must monitor the implementation of these terms and conditions by the program directors.
   The agreement should contain or reference at least the following:
   a. Financial support
   b. Vacation policies
   c. Professional liability insurance in conformity with II.C.5, below
   d. Disability insurance and other hospital and health insurance benefits for the residents and their family in conformity with II.C.6, below
   e. Professional, parental, and sick-leave benefits in conformity with II.C.7, below
   f. Conditions under which living quarters, meals, and laundry or their equivalents are to be provided
   g. Counseling, medical, psychological, and other support services in conformity with II.C.8 and 9, below.
4. The agreement should also delineate or reference specific policies regarding
   a. resident's responsibilities
   b. duration of appointment and conditions for reappointment
   c. professional activities outside the educational program
   d. grievance procedures, including those covering gender or other forms of harassment.
5. Liability Insurance: Residents in GME must be provided with professional liability coverage for the duration of training. Such coverage must provide legal defense and protection against awards from claims reported or filed after the completion of GME if the alleged acts or omissions of the residents are within the scope of the education program. The coverage to be provided should be consistent with the institution's coverage for other medical/professional practitioners. Each institution must provide current residents and applicants for residency with the details of the institution's professional liability coverage for residents.

Draft:

Suggested Principles and Recommendations for Strengthening the Accreditation Council for Graduate Medical Education (ACGME) Institutional Requirements to Address House Staff Concerns and Protect Residency Education

Note: This document has been prepared by resident members of the Massachusetts Medical Society (MMS) and modestly edited by Drs. M. Rabkin and A. Goroll. It is meant to further development of improved ACGME institutional requirements that address resident concerns, but it does not represent the official policy of the Massachusetts Medical Society or the MMS Resident Physician Section or the AMA.

Principle I

Resident concerns can usually be addressed locally at each sponsoring teaching institution through a self-governing resident organization that represents the interests of all residents at the sponsoring institution.

Recommendation:

Institutions sponsoring graduate medical education programs should support formation of self-governing resident organizations with democratically-elected leadership that voices and advocates for resident interests regarding patient care, working conditions, and medical education. This organization may take different forms, such as a house officers' association or a resident medical staff. Residents should have membership on all hospital committees that address resident education, patient care, and working conditions, including the Graduate Medical Education Committee (GMEC) and hospital medical staff executive committee. This role would be mandated by the ACGME Institutional Requirements. The role of the GMEC also needs to be strengthened in the language of ACGME Institutional Requirements and their greater enforcement.

The Institutional Requirements and their review would incorporate the following recommendations:

- Residents must be free to form and participate in a self-governing resident organization at their institution without impediment from their program or sponsoring institution and without retribution from their program or sponsoring institution for participating in resident organizational activities.
- Peer-selected residents should have voting membership on institutional committees and councils whose actions affect resident education and/or patient care, including the GMEC and the hospital medical staff executive committee.
- There must be at least two voting resident members on the GMEC, who are elected or appointed by the resident organization.
- The GMEC should meet at least quarterly, address resident-education issues and maintain minutes which include dates, attendance, and recorded votes. ACGME institutional review must include examination of GMEC minutes.

- Regular, substantive meetings directly between the institution's administration and the resident organization should also be required at least quarterly, be it as part of the GMEC meeting or separately.
- The GMEC must be given the authority to review and approve all terms and conditions of written agreements or contracts between the sponsoring institution and residents. The components of a contract delineated by the ACGME Institutional Requirements as a "should" are now to be required and changed to a "must."
- The GMEC should review all actions regarding dismissal, discipline, and the adjudication of complaints and grievances involving residents as an institutional policy.
- Institutional review should include statements from both the resident organization and the sponsoring institution on relations between residents and the sponsoring institution, including a list of concerns brought by residents to the institution and how these concerns were addressed. Institutions should be required to demonstrate good faith efforts to address resident concerns and there should be in place a well defined and fair procedure for timely resolution of difficult disputes between residents and the sponsoring institution.

Principle II

The quality of residency education needs to be maintained through the application of sound educational principles, open access to information about individual programs and institutions, and compliance with ACGME accreditation standards.

Recommendations:

As educational bodies, residency programs should apply sound educational principles in evaluating residents, including establishment of specific criteria for performance at each level of training. Each program should be required to provide regular feedback (at least every 4 months) on the resident's educational and professional progress. The criteria should be based on nationally recognized performance standards. These criteria should be presented to residents at the beginning of training, and evaluations should include the resident's progress toward attaining these goals. These evaluations should be documented in writing and shared with the resident in a timely fashion, with opportunity for the resident to respond in writing to the evaluator if there is disagreement with the evaluation or a desire to submit an explanation or other comment for the record.

Resident participation in accreditation bodies contributes an essential perspective, that of the learner, and is essential to defining and maintaining accreditation standards.
It is strongly recommended that the current pilot program for resident representation on Residency Review Committees (RRCs) be converted to constitutive resident representation on all RRCs. The resident members should be selected through representative national resident organizations by their peers.

Compliance of institutions and programs with ACGME standards is essential to assure the quality of medical education. Students and residents should have access to

accreditation information when selecting programs. The following actions are strongly recommended:

- A renewed commitment of the ACGME parent organizations to support efforts of the ACGME for more timely action on accreditation violations.
- In all accreditation reviews of programs and/or institutions, the use of anonymous surveys of all affected residents regarding compliance with standards.
- Interviews with peer- and accreditor-selected residents as part of all accreditation reviews.
- Investigations by the ACGME and RRCs of accreditation violations that are reported by a resident organization or resident, without identification to the institution of the source of the complaint.
- Publication of ACGME Institutional and Program Requirements on the Internet and other electronic and print publications.
- Publication of the current accreditation status of all residency programs in FREIDA and other electronic and print publications.
- Distribution of representative housestaff contracts or written agreements to applicants prior to the date of submission of National Residency Match Program match lists.

Principle III

Residents must have due process and protection from retribution when filing complaints and grievances.

Recommendation:

The ACGME Institutional Requirements must require due process for individual residents who file complaints and grievances. Mechanisms to assure fair treatment and protection of residents filing grievances needs to be developed by the ACGME.

STATEMENT OF SERVICE

I, Leonard A. Nelson, an attorney, hereby certify that on January 29, 1998 a copy of the *Amicus Curiae* Brief of the American Medical Association and Massachusetts Medical Society was served by mailing a copy, postage prepaid, on the following:

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