

COVID-19 and Graduate Medical Education Trainee Protections and Finances

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The COVID-19 pandemic has brought to the forefront 2 longstanding issues in graduate medical education (GME).^{1,2} The first is the status of a trainee's relationship to their training program as an employee-student hybrid. The second is the precarious nature of GME funding.

Residents as Students and Employees

The employment status of trainees is complex and has evolved over the past century.^{2,3} Residents have been characterized in legal rulings as both student and employee. A 1985 ruling in *Kraft v William Alanson White Psychiatric Foundation* viewed residents as students and cited that there was “no reason to distinguish post-graduate continuing education institutions that choose to have the certificate they award represent satisfactory accomplishment of professional goals” from other “degree-granting institutions.”⁴ In contrast, a 2011 ruling by the Supreme Court in *Mayo Foundation for Medical Education and Research et al v United States*, declared residents as employees, and not students, for tax purposes.⁵ As employees, residents should be allowed the full protections of the National Labor Relations Act of 1935, including the right to unionize and collectively bargain.⁶ The current legal standing of residents is thus a complex hybrid of student for academic purposes and employee for financial purposes.

The relationship between trainees and their training programs is also complicated. A sponsoring institution (SI) is a hybrid of employer and educational institution. In 2003, *Jung v Association of American Medical Colleges* failed in a legal challenge to the National Residency Match Program (NRMP) under federal antitrust laws.⁷ Next, in 2004, the US Congress added Section 207 to the Pension Funding Equity Act,⁸ which fully protected the NRMP from future antitrust litigation. Subsequent to that decision, the Match process, used by the majority of training programs, was converted to an “all-in”

process whereby intuitions agree to exclusively participate in the NRMP for residency recruitment.⁹

After matching, residents enter training at their respective institutions where they may be exposed to substandard working conditions in the clinical learning environment, but subtly encouraged to not report deficiencies.¹⁰ We fear that inadequate work conditions may be exacerbated by COVID-19 exposure health risks. Accordingly, while non-GME employees are free to address grievances by seeking alternate employment in a free market, the limited ability for residents to transfer inhibits free market forces to positively effect work conditions. For example, in the 2017–2018 academic year, fewer than 1% (1099 of 111 570) of residents transferred programs.^{11,12}

In addition to limitations on a resident's ability to seek a new position at another accredited SI, a resident's ability to collectively bargain is also limited. The employee portion of their hybrid status means that residents may unionize, but the power of those unions to affect change is limited in practice. The credible threat of a labor stoppage or slowdown is compromised by the educational component of the mixed student-employee model. The ACGME core competencies for physicians include professionalism and patient care.¹³ Both may be compromised by a work stoppage and result in remediation or disciplinary action against a resident through the student part of their hybrid status. Further, the American Board of Medical Specialties (ABMS) disciplines may have strict training requirements for certification that further restrain trainees' ability to leverage a work stoppage or slowdown.

The ACGME has done much to limit or moderate potential harm to trainees, but there are limits to an accrediting body's ability to intervene. The ACGME's Clinical Learning Environment Review (CLER) program addresses workplace conditions by providing minimum standards, but its recommendations are separate from accreditation decisions. Further, the ACGME does not represent trainees with respect to salary or benefits, such as disability insurance or hazard pay.

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The COVID-19 pandemic has highlighted potential oversight shortcomings despite the ACGME's efforts in areas of trainee well-being and optimal learning environments. Early in the pandemic, the ACGME stated that residents needed to be provided with adequate personal protective equipment (PPE) to protect them from COVID-19 exposure and reiterated its stance on the limitation of work hours without exception.¹⁴ It also warned against the involuntary furloughing of residents by training programs and insisted GME contracts be honored, even where institutions had decreased billing.¹⁵ While the ACGME took these steps to protect residents, it also approved redeployment of trainees from subspecialty training to their primary specialty to support the COVID-19 surge and continued trainee learning.¹⁶ The ACGME also paused program oversight visits and stated programs may determine when a resident can graduate despite a reduction in clinical volume, thus relaxing previously held minimum procedural and clinical experiences standards.¹⁷ These pandemic-related changes expose limits of the ACGME, the sole proprietor of accreditation of medical training in the United States, to protect a vulnerable trainee population.

The COVID pandemic has shown the value, yet vulnerability, of all frontline health care workers. Some non-resident health care workers, such as the nursing staff at the University of Illinois, successfully bargained for hazard pay and better working conditions.¹⁸ Other groups did not fare as well^{19,20}; however, when staff were unable to negotiate for better conditions, they were free to leave. As noted above, trainees face significant obstacles to transferring programs.

Some hospitals acknowledged the burden COVID-19 presented for trainees. New York University moved up scheduled pay increases by several months during the pandemic despite large projected operating losses for the hospital.²¹ George Washington University approved 2% salary increases for residents,²² while enacting major cuts for other employees and health care workers.²³ Trainees at other institutions did not receive similar recognition despite equally formidable COVID-19-related challenges.

GME Funding and COVID-19

The COVID-19 pandemic has also created challenges related to GME funding, which may cause program downsizing or closure. One funding challenge is a potential shortfall in GME funding from the Centers for Medicare & Medicaid Services (CMS) related to extending residents' training times for adequate procedural or other experiences. A second COVID-

19-related funding issue is the diversion of previously earmarked GME funds. The first challenge may occur from a national reduction in procedural volumes, as well as key clinical experiences, due to the cancellation of elective cases and shift of clinical care toward COVID-19. Key index case numbers for residents have decreased in many training programs. Achieving case minimum standards defines an important perceived measure of resident competency in procedural specialties; accordingly, it is unclear if program leaders should permit trainees to graduate with procedural deficiencies. The ACGME has clarified that case minimums were established to determine program accreditation, not individual competence, which implies that residents with case log deficiencies may graduate and not trigger a negative accreditation action against a program.²⁴ Nevertheless, program leaders and their respective specialty boards may judge deficient experiences to merit extension and hold to previous standards. In all specialties, some trainees may not achieve minimal competencies for graduation due to reduced clinical care experiences.

It is too early to know the final effects from reduced clinical care and procedural experiences, but if inadequate training experiences occur, program leaders and specialty boards will need to engage institutions on the issue of large-scale extensions of training in the context of historic financial challenges for academic institutions. Since low patient volume months continued to be fully funded by CMS during COVID-19, and government funding for a trainee is time-limited, extensions of training will require unbudgeted institutional investment. There is currently no congressional legislation or CMS precedent to provide additional funding to support an extension of training programs to ensure the adequacy of procedural or other key clinical competencies. Unable to fund trainee extensions, institutions may pressure programs to graduate trainees regardless of clinical competency determinations. These COVID-19 graduates may find themselves ineligible for certification through their national board until additional experience can be demonstrated.

A second funding challenge is the potential for institutions to divert funds budgeted for GME. CMS indirect funding, clinical revenue, and other sources typically supplement CMS direct funds for GME programs by up to 56%.^{25,26} Our experiences suggest that unspent funds budgeted for activities such as review courses, online medical specialty libraries, simulation, and other expenses unrelated to direct patient care are at risk for diversion during this pandemic. Since some departments already support a significant portion of training program costs, they are likely able to reallocate these funds

without compromising the appropriate use of CMS direct funding. However, GME education may be affected as departmental clinical revenue declines during the pandemic. Further, the Coronavirus Aid, Relief, and Economic Security (CARES) Act funds to offset losses in health care are allocated to hospitals, but without any specific earmarking for COVID-19-related GME needs. As a result, CARES funds will likely be used to meet non-GME shortfalls.

The expansion in GME program deficits may cause program contraction or even closure. In addition to CMS-funded positions being in jeopardy as a result of COVID-19, unfunded positions, which had been growing at a rate of 1.7% annually, are at risk as well.²⁷ The CMS funding to support GME has been capped since 1997 except for congressionally mandated redistributions of slots related to program closures and new positions in primary care and teaching health centers. Many larger academic medical centers are over their CMS cap, and additional trainees are funded entirely without government assistance. With ongoing COVID-19-related revenue losses, these unfunded positions are at highest risk for closure.

Conclusions

The impact of COVID-19 on graduate medical education training has not been fully evaluated and may not be apparent for years. The COVID-19 pandemic demonstrates the vulnerability of residents' student-employee status and their reduced ability to self-advocate. Further, it reveals both the advocacy efforts and limitations of the ACGME. GME budgetary shortfalls may incentivize premature graduation of residents with lingering clinical deficiencies who are unable to gain board certification in the standard time frame. In addition, program contraction may occur and limit GME opportunities for medical school graduates. These concerns have significant potential to impact the physician workforce and patient safety in the United States, and therefore deserve the attention of health policy experts at the highest levels of government.

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