

## Reference Committee C

### CME Report(s)

- 01\* Council on Medical Education Sunset Review of 2011 House Policies
- 02\* Licensure for International Medical Graduates Practicing in U.S. Institutions with Restricted Medical Licenses
- 03\* Optimizing Match Outcomes
- 04\* Expediting Entry of Qualified IMG Physicians to U.S. Medical Practice
- 05\* Promising Practices Among Pathway Programs to Increase Diversity in Medicine

### Resolution(s)

- 301 Medical Education Debt Cancellation in the Face of a Physician Shortage During the COVID-19 Pandemic
- 302 Non-Physician Post-Graduate Medical Training
- 303 Improving the Standardization Process for Assessment of Podiatric Medical Students and Residents by Initiating a Process Enabling Them to Take the USMLE
- 304\* Decreasing Financial Burdens on Residents and Fellows
- 305\* Non-Physician Post-Graduate Medical Training
- 306\* Establishing Minimum Standards for Parental Leave During Graduate Medical Education Training
- 307\* Updating Current Wellness Policies and Improving Implementation
- 308\* Rescind USMLE Step 2 CS and COMLEX Level 2 PE Examination Requirement for Medical Licensure
- 309\* Supporting GME Program Child Care Residency Training
- 310\* Unreasonable Fees Charged and Inaccuracies by the American Board of Internal Medicine
- 311\* Student Loan Forgiveness
- 312\* AMA Support for Increased Funding for the American Board of Preventive Medicine Residency Programs
- 313\* Fatigue Mitigation Respite for Faculty and Residents
- 314\* Standard Procedure for Accommodations in USMLE and NBME Exams
- 315\* Representation of Dermatological Pathologies in Varying Skin Tones
- 316\* Improving Support and Access for Medical Students with Disabilities

## REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 1-JUN-21

Subject: Council on Medical Education Sunset Review of 2011 House Policies

Presented by: Liana Puscas, MD, MHS, Chair

Referred to: Reference Committee C

---

- 1 Policy G-600.110, “Sunset Mechanism for AMA Policy,” calls for the decennial review of  
2 American Medical Association policies to ensure that our AMA’s policy database is current,  
3 coherent, and relevant. This policy reads as follows, laying out the parameters for review and  
4 specifying the needed procedures:  
5
- 6 1. As the House of Delegates adopts policies, a maximum ten-year time horizon shall exist. A  
7 policy will typically sunset after ten years unless action is taken by the House of Delegates to  
8 retain it. Any action of our AMA House that reaffirms or amends an existing policy position  
9 shall reset the sunset “clock,” making the reaffirmed or amended policy viable for another 10  
10 years.  
11
  - 12 2. In the implementation and ongoing operation of our AMA policy sunset mechanism, the  
13 following procedures shall be followed: (a) Each year, the Speakers shall provide a list of  
14 policies that are subject to review under the policy sunset mechanism; (b) Such policies shall be  
15 assigned to the appropriate AMA councils for review; (c) Each AMA council that has been  
16 asked to review policies shall develop and submit a report to the House of Delegates identifying  
17 policies that are scheduled to sunset; (d) For each policy under review, the reviewing council  
18 can recommend one of the following actions: (i) retain the policy; (ii) sunset the policy; (iii)  
19 retain part of the policy; or (iv) reconcile the policy with more recent and like policy; (e) For  
20 each recommendation that it makes to retain a policy in any fashion, the reviewing council shall  
21 provide a succinct, but cogent justification (f) The Speakers shall determine the best way for the  
22 House of Delegates to handle the sunset reports.  
23
  - 24 3. Nothing in this policy shall prohibit a report to the HOD or resolution to sunset a policy earlier  
25 than its 10-year horizon if it is no longer relevant, has been superseded by a more current policy,  
26 or has been accomplished.  
27
  - 28 4. The AMA councils and the House of Delegates should conform to the following guidelines for  
29 sunset: (a) when a policy is no longer relevant or necessary; (b) when a policy or directive has  
30 been accomplished; or (c) when the policy or directive is part of an established AMA practice  
31 that is transparent to the House and codified elsewhere such as the AMA Bylaws or the AMA  
32 House of Delegates Reference Manual: Procedures, Policies and Practices.  
33
  - 34 5. The most recent policy shall be deemed to supersede contradictory past AMA policies.  
35
  - 36 6. Sunset policies will be retained in the AMA historical archives.

1 RECOMMENDATION

2

3 The Council on Medical Education recommends that the House of Delegates policies listed in the  
4 appendix to this report be acted upon in the manner indicated and the remainder of this report be  
5 filed. (Directive to Take Action)

Fiscal Note: \$1,000.

## APPENDIX: RECOMMENDED ACTIONS

Policy Number	Title	Texts	Recommendation
<a href="#">H-210.986</a>	Physicians and Family Caregivers - A Model for Partnership	<p>Our AMA (1) encourages residency review committees and residency program directors to consider physician needs for training in evaluation of caregivers. Emphasis at both the undergraduate and graduate level is needed on the development of the physician's interpersonal skills to better facilitate assessment and management of caregiver stress and burden;</p> <p>(2) supports health policies that facilitate and encourage home health care. Current regulatory and financing mechanisms favor institutionalization, often penalizing families attempting to provide lower cost, higher quality-of-life care;</p> <p>(3) reaffirms support for reimbursement for physician time spent in education and counseling of caregivers and/or home care personnel involved in patient care; and</p> <p>(4) supports research that identifies the types of education and support services that most effectively enhance the activities and reduce the burdens of caregivers. Further research is also needed on the role of physicians and others in supporting the family caregiver.</p> <p>Citation: (CSA Rep. I, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11)</p>	<p>Rescind; duplicative of <a href="#">H-210.980</a>, "Physicians and Family Caregivers: Shared Responsibility," which reads: "Our AMA: (1) specifically encourages medical schools and residency programs to prepare physicians to assess and manage caregiver stress and burden; (2) continues to support health policies that facilitate and encourage health care in the home; (3) reaffirm support for reimbursement for physician time spent in educating and counseling caregivers and/or home care personnel involved in patient care; (4) supports research that identifies the types of education, support services, and professional caregiver roles needed to enhance the activities and reduce the burdens of family caregivers, including caregivers of patients with dementia, addiction and other chronic mental disorders; and (5) (a) encourages partner organizations to develop resources to better prepare and support lay caregivers; and (b) will identify and disseminate resources to promote physician understanding of lay caregiver burnout and develop strategies to support lay caregivers and their patients."</p>

<a href="#">D-295.322</a>	Increasing Demographically Diverse Representation in Liaison Committee on Medical Education Accredited Medical Schools	Our AMA will continue to study medical school implementation of the Liaison Committee on Medical Education (LCME) Standard IS-16 and share the results with appropriate accreditation organizations and all state medical associations for action on demographic diversity. (Res. 313, A-09; Modified: CME Rep. 6, A-11)	Retain; remains relevant, especially due to increased attention to the need for diversity in medical education and practice.
<a href="#">H-295.888</a>	Progress in Medical Education: the Medical School Admission Process	<p>1. Our AMA encourages: (A) research on ways to reliably evaluate the personal qualities (such as empathy, integrity, commitment to service) of applicants to medical school and support broad dissemination of the results. Medical schools should be encouraged to give significant weight to these qualities in the admissions process; (B) premedical coursework in the humanities, behavioral sciences, and social sciences, as a way to ensure a broadly-educated applicant pool; and (C) dissemination of models that allow medical schools to meet their goals related to diversity in the context of existing legal requirements, for example through outreach to elementary schools, high schools, and colleges.</p> <p>2. Our AMA: (A) will continue to work with the Association of American Medical Colleges (AAMC) and other relevant organizations to encourage improved assessment of personal qualities in the recruitment process for medical school applicants including types of information to be solicited in applications to medical school; (B) will work with the AAMC and other relevant organizations to explore the range of measures used to assess personal qualities among applicants, including those used by related fields; (C) encourages the development of innovative methodologies to assess personal qualities among medical school applicants; (D) will work with medical schools and other relevant stakeholder groups to review the ways in which medical schools communicate the importance of personal qualities among applicants, including how and when specified personal qualities will be assessed in the admissions process; (E) encourages continued research on the personal qualities most pertinent to success as a medical student and as a physician to assist admissions committees to adequately assess applicants; and (F) encourages continued research on the factors that impact negatively on humanistic and empathetic traits of medical students during medical school. (CME Rep. 8, I-99;</p>	Retain; remains relevant, as the AMA's Accelerating Change in Medical Education initiative and other activities seek to improve the selection process for medical students (and change the composition and diversity of the future physician workforce).

		Reaffirmed: CME Rep. 2, A-09; Appended: CME Rep. 3, A-11)	
<a href="#">H-305.962</a>	Taxation of Federal Student Aid	Our AMA opposes legislation that would make medical school scholarships or fellowships subject to federal income or social security taxes (FICA). (Res. 210, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CME Rep. 2, A-11)	Retain; remains relevant.
<a href="#">H-305.997</a>	Income Tax Exemption for Medical Student Loans and Scholarships	The AMA supports continued efforts to obtain exemption from income tax on amounts received under medical scholarship or loan programs. (Res. 65, I-76; Reaffirmed: Sunset Report, I-98; Reaffirmation A-01; Reaffirmed: CME Rep. 2, A-11)	Rescind; superseded by <a href="#">H-305.962</a> , "Taxation of Federal Student Aid," which reads: "Our AMA opposes legislation that would make medical school scholarships or fellowships subject to federal income or social security taxes (FICA)."
<a href="#">H-40.994</a>	Military Physicians in Graduate Medical Education Programs	Our AMA opposes any arbitrary attempt to limit the percentage of resident physicians in military graduate education or training programs. (Res. 71, I-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CME Rep. 2, A-11)	Rescind; superseded by <a href="#">H-40.995</a> , "Graduate Medical Education in the Military," which reads, in part: "Our AMA: (1) strongly supports and endorses the graduate medical education programs of the military services and recognizes the potential benefit to the military services of recruitment, retention and readiness programs; (2) is gravely concerned that closures of military medical centers and subsequent reduction of graduate medical education programs conducted therein will not only impede the health care mission of the Department of Defense, but also harm the health care of the nation by increasing the drain on trained specialists available to the civilian sector; ... 5) oppose any reductions to military GME residency or fellowship positions without dedicated congressional funding for an equal number of

			civilian residency positions in addition to any other planned increases to civilian GME to avoid further exacerbating the United States' physician shortage."
<a href="#">D-180.995</a>	Physician Privileges Application - Timely Review by Managed Care	Our AMA will work with the American Association of Health Plans (AAHP), the American Hospital Association (AHA), the National Committee on Quality Assurance (NCQA), and other appropriate organizations to allow residents who are within six months of completion of their training to apply for hospital privileges and acceptance by health plans. (Res. 708, A-01; Reaffirmed: CME Rep. 2, A-11)	Retain; still relevant.
<a href="#">D-255.982</a>	Oppose Discrimination in Residency Selection Based on International Medical Graduate Status	<p>Our AMA:</p> <ol style="list-style-type: none"> <li>1. Will request that the Accreditation Council for Graduate Medical Education include in the Institutional Requirements a requirement that will prohibit a program or an institution from having a blanket policy to not interview, rank or accept international medical graduate applicants.</li> <li>2. Recognizes that the assessment of the individual international medical graduate residency and fellowship applicant should be based on his/her education and experience.</li> <li>3. Will disseminate this new policy on opposition to discrimination in residency selection based on international medical graduate status to the graduate medical education community through AMA mechanisms. (Sub. Res. 305, A-08; Reaffirmation I-11)</li> </ol>	<p>Rescind.</p> <p>Clause 1 is reflected in ACGME Institutional Requirement IV.1.5, "Discrimination: The Sponsoring Institution must have policies and procedures, not necessarily GME-specific, prohibiting discrimination in employment and in the learning and working environment, consistent with all applicable laws and regulations. (Core)"</p> <p>Clause 2 is superseded by <a href="#">H-255.988</a> (11), "AMA Principles on International Medical Graduates," which reads, "That AMA representatives to the ACGME, residency review committees and to the ECFMG should support AMA policy opposing discrimination. Medical school admissions officers and directors of residency programs should select applicants on the basis of merit, without considering status as an IMG or an</p>

			<p>ethnic name as a negative factor.”</p> <p>Also reflected in <a href="#">H-255.983</a>, “Graduates of Non-United States Medical Schools,” which reads, “The AMA continues to support the policy that all physicians and medical students should be evaluated for purposes of entry into graduate medical education programs, licensure, and hospital medical staff privileges on the basis of their individual qualifications, skills, and character.”</p> <p>Clause 3 was accomplished at the time of adoption of the resolution.</p>
<a href="#">D-275.993</a>	Reporting of Resident Physicians	<p>Our AMA will: (1) work with appropriate groups, including the Federation of State Medical Boards, to attempt to increase the standardization of information about resident physicians that is reported to state medical licensing boards to obtain or renew the limited educational permit, <del>consistent with existing AMA Policy H-265.934 (#4)</del>; (2) encourage state medical societies to act as a link between state medical licensing boards and medical schools/residency programs to ensure that educational programs are familiar with and have the opportunity to comment on proposed changes in reporting requirements for resident physicians; and (3) make relevant groups-- for example, medical schools, state medical societies, resident physicians--aware of what types of information must be supplied in order for resident physicians to obtain and renew a limited educational permit. (CME Rep. 4-I-01; Reaffirmed CME Rep. 2-A-11)</p>	<p>Retain in part.</p> <p>Policy H-265.934 is no longer AMA policy, hence the deletion in clause 1.</p>
<a href="#">D-305.992</a>	Accounting for GME Funding	<p>Our AMA will encourage: (1) department chairs and residency program directors to learn effective use of the information that is currently available on Medicare funding accounting of GME at the level of individual hospitals to assure appropriate support for their training programs, and publicize sources for this information, including placing links on our</p>	<p>Retain; remains relevant.</p> <p>See also <a href="#">H-305.929</a>, “Proposed Revisions to AMA Policy on the Financing of Medical Education Programs”:</p>



		AMA web site; and (2) hospital administrators to share with residency program directors and department chairs, accounting and budgeting information on the disbursement of Medicare education funding within the hospital to ensure the appropriate use of those funds for Graduate Medical Education. (Sub. Res. 302, I-00; Reaffirmed: CME Rep. 2, A-10; Reaffirmation A-11)	“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 publically 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.”
<a href="#">H-310.911</a>	ACGME Allotted Time Off for Health Care Advocacy and Health Policy Activities	Our AMA: 1) urges the Accreditation Council for Graduate Medical Education (ACGME) to acknowledge that “activities in organized medicine” facilitate competency in professionalism, interpersonal and communication skills, practice-based learning and improvement, and systems-based practice; 2) encourages residency and fellowship programs to support their residents and fellows in their involvement in and pursuit of leadership in organized medicine; and 3) encourages the ACGME and other regulatory bodies to adopt policy that resident and fellow physicians be allotted additional time, beyond scheduled vacation, for scholarly activity time and activities of organized medicine, including but not limited to, health care advocacy and health policy. (Res. 317, A-11)	Retain; remains relevant. See also <a href="#">H-310.905</a> , “Scholarly Activity by Resident and Fellow Physicians.”
<a href="#">H-310.959</a>	In-Service Training Examinations - Final Report	It is the policy of the AMA <del>(1)</del> to encourage entities responsible for in-service examinations and the ACGME to recognize that in-service training examinations should not be used in decisions concerning acceptance, denial, advancement, or retention in residency or fellowship training positions; should not be used by outside regulatory agencies for the purpose of assessing resident knowledge or the quality of training programs; and should not be used as a pretest to sit for specialty boards; <del>(2)</del>	Retain in part.  Clause 1 is still relevant.  For clauses 2 and 3, the Accreditation Council for Graduate Medical Education is using Milestones and multiple measures of evaluation.

		<p><del>to encourage residency program directors to use the results of in-training examinations to counsel residents and as the basis for developing appropriate programs of remediation and also for the purpose of educational program evaluation; and (3) to urge that evaluation of residents for promotion or retention be based on valid and reliable measures of knowledge, skills, and behaviors, applied sequentially over time. In-training examinations should be administered under appropriate testing conditions. Residents should be relieved of on-call duty the night prior to and during the administration of the examination. The results, if used at all, should not be the sole factor in evaluation of residents. (CME Rep. A, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CME Rep. 2, A-11)</del></p>	<p>Relying on one metric is frowned upon. (see <a href="#">Sections V.A.1 Resident Feedback and Evaluation</a> and <a href="#">V.A.2 Resident Final Evaluation</a>.)</p>
<a href="#">H-310.960</a>	Resident Education in Laboratory Utilization	<p>Our AMA endorses the concept of practicing physicians devoting time with medical students and resident physicians for chart reviews focusing on appropriate test ordering in patient care. (Res. 84, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CME Rep. 2, A-11)</p>	<p>Retain; remains relevant.</p>
<a href="#">H-310.996</a>	Residency Review Committee Representation	<p>Our AMA: (1) supports resident membership on Residency Review Committees; (2) requests that the resident representatives to the Residency Review Committees (RRCs) of the Accreditation Council for Graduate Medical Education (ACGME) serve for at least a one-year term as a full and voting participant at all RRC meetings; (3) requests that the resident members of the RRCs be peer-selected; and (4) will advocate for diversity of appointees to RRCs. (Res. 67, I-82; Reaffirmed: Sub. Res. 186, A-87; Reaffirmed: CLRPD Rep. A, I-92; Appended: Res. 306, I-98; Reaffirmed: CME Rep. 2, A-08; Appended: Res. 304, A-11)</p>	<p>Rescind; is now reflected in ACGME documents, including ACGME <a href="#">Policies and Procedures</a>, Subject: 9.00 Review Committees and Recognition Committee: “(8) Member Appointment – Nominating organizations should submit to the ACGME administration the names of two candidates for each vacancy at least 12 months before the date of the appointment. Nominating organizations should consider professional qualifications, geographic distribution, and diversity in nominating their candidates.”</p> <p>Also reflected in <a href="#">Committees and Members Selection</a></p>

			<p><a href="#">Process</a>: “Review Committees have physician members, at least one of whom is a resident at the time of appointment, and a public member.</p> <p>“Appointment of Resident Members to Review Committees</p> <p>“The process takes approximately 12 months from the call for nominations until the member’s term begins. The Review Committee Executive Director requests nominations through the ACGME e-Communication and/or via letter to the specialty-specific professional organizations that have resident groups.”</p>
<a href="#">H-410.986</a>	Resident Involvement in Practice Parameters	Our AMA urges national medical specialty societies to work with resident physicians within their specialty in developing practice parameters. (Res. 52, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CME Rep. 2, A-11)	Rescind. The intent of this policy is being met, as many specialty societies include residents/fellows on committees on development of guidelines for physician practice.
<a href="#">D-140.981</a>	Ethical Guidelines on Gifts to Physicians from Industry	Our AMA shall: (1) communicate to all medical school deans and residency program directors the importance of including education on ethical guidelines regarding gifts to physicians from industry within the ethics curriculum of their medical student and housestaff education programs; (2) communicate to all medical school deans and residency program directors the content of CEJA Opinion E-8.061 and shall recommend that it or another nationally-recognized ethical guideline be used as the basis for educational content on this issue; (3) recommend to all medical school deans and residency program directors that appropriate policies be developed for medical students, housestaff and faculty in their respective institutions regarding the issue of gifts to physicians from industry; (4) work with the Association of American Medical Colleges (AAMC) and the American Association of Colleges of Osteopathic Medicine (AACOM) to encourage the Liaison	Rescind. This directive has been accomplished.

		Committee on Medical Education and the American Osteopathic Association Commission on Osteopathic College Accreditation to require all medical schools to make known to students the existence of the physician-industry financial disclosure databases that exist or will be created by 2013 as required by the Patient Protection and Affordable Care Act; and (5) work with AAMC and AACOM to encourage all medical school faculty to model professional behavior to students by disclosing the existence of financial ties with industry, in accordance with existing disclosure policies at each respective medical school. (Res. 13, A-02; Reaffirmed: Res. 303, A-05; Appended: Res. 308, A-11)	
<a href="#">H-275.993</a>	Examinations for Medical Licensure	Our AMA affirms its recommendation that medical school faculties continue to exercise the responsibilities inherent in their positions for the evaluation of students and residents, respectively. (CME Rep. B, I-81; Reaffirmed: CLRPD Rep. F, I-91; Modified: Sunset Report, I-01; Reaffirmed: CME Rep. 2, A-11)	Rescind. This is in essence the role of medical school faculties, and the essence of medical school accreditation.
<a href="#">H-295.868</a>	Education in Disaster Medicine and Public Health Preparedness During Medical School and Residency Training	<ol style="list-style-type: none"> <li>1. Our AMA recommends that formal education and training in disaster medicine and public health preparedness be incorporated into the curriculum at all medical schools and residency programs.</li> <li>2. Our AMA encourages medical schools and residency programs to utilize multiple methods, including simulation, disaster drills, interprofessional team-based learning, and other interactive formats for teaching disaster medicine and public health preparedness.</li> <li>3. Our AMA encourages public and private funders to support the development and implementation of education and training opportunities in disaster medicine and public health preparedness for medical students and resident physicians.</li> <li>4. Our AMA supports the National Disaster Life Support (NDLS) Program Office's work to revise and enhance the NDLS courses and supporting course materials, in both didactic and electronic formats, for use in medical schools and residency programs.</li> <li>5. Our AMA encourages involvement of the National Disaster Life Support Education Consortium's adoption of training and education standards and guidelines established by the newly created Federal Education and Training Interagency Group (FETIG).</li> <li>6. Our AMA will continue to work with other specialties and stakeholders to coordinate and encourage provision of disaster preparedness education and training in medical schools and in graduate and continuing medical education.</li> </ol>	Retain in part. Still timely, with deletion of clauses 4-7, as these are no longer relevant.

		<p><del>7. Our AMA encourages all medical specialties, in collaboration with the National Disaster Life Support Educational Consortium (NDLSEC), to develop interdisciplinary and inter professional training venues and curricula, including essential elements for national disaster preparedness for use by medical schools and residency programs to prepare physicians and other health professionals to respond in coordinated teams using the tools available to effectively manage disasters and public health emergencies.</del></p> <p>48. Our AMA encourages medical schools and residency programs to use community-based disaster training and drills as appropriate to the region and community they serve as opportunities for medical students and residents to develop team skills outside the usual venues of teaching hospitals, ambulatory clinics, and physician offices.</p> <p>59. Our AMA will make medical students and residents aware of the context (including relevant legal issues) in which they could serve with appropriate training, credentialing, and supervision during a national disaster or emergency, e.g., non-governmental organizations, American Red Cross, Medical Reserve Corps, and other entities that could provide requisite supervision.</p> <p>640. Our AMA will work with the Federation of State Medical Boards to encourage state licensing authorities to include medical students and residents who are properly trained and credentialed to be able to participate under appropriate supervision in a national disaster or emergency.</p> <p>744. Our AMA encourages physicians, residents, and medical students to participate in disaster response activities through organized groups, such as the Medical Response Corps and American Red Cross, and not as spontaneous volunteers.</p> <p>842. Our AMA encourages teaching hospitals to develop and maintain a relocation plan to ensure that educational activities for faculty, medical students, and residents can be continued in times of national disaster and emergency. (CME Rep. 15, A-09; Reaffirmed: CME Rep. 7, A-10; Appended: CME Rep. 7, A-10; Reaffirmed and Appended: CME Rep. 1, I-11)</p>	
<a href="#">H-310.970</a>	Mandatory Helicopter Flight for Emergency Medical Residents in Training	Our AMA urges residency training programs that require helicopter transport as a mandatory part of their residency to notify applicants of that policy prior to and during the interview process. (Res. 239, A-89; Reaffirmed: Sunset	Rescind; superseded by <a href="#">H-295.943</a> , "Issues Regarding Patient and/or Donor Transports by Resident

		Report, A-00; Reaffirmed: CME Rep. 2, A-10; Reaffirmed: CME Rep. 01, A-20)	Physicians and Medical Students.”
<a href="#">H-295.943</a>	Issues Regarding Patient and/or Donor Transports by Resident Physicians and Medical Students	Our AMA (1) urges medical schools not to require medical students to participate in the air or ground transport of patients or organs during required clinical rotations; and (2) encourages all teaching institutions where medical students or resident physicians participate (compulsorily or voluntarily) in the air or ground transport of patients or organs (a) to notify prospective students and residents of all program requirements related to transports; (b) to include accident, disability, and life insurance as part of an available package for participating medical students and resident physicians, and to provide such insurance where participation is mandatory; (c) to include in the educational curriculum formal training on general and safety issues pertaining to emergency transport before students or residents participate in such activity; and (d) to adhere to the Association of Air Medical Services (AAMS) Minimum Quality Standards and Safety Guidelines for transport. (CME Rep. E, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CME Rep. 2, A-11)	Retain; remains relevant.  See also <a href="#">H-310.970</a> , “Mandatory Helicopter Flight for Emergency Medical Residents in Training,” which is being rescinded through this report, as it is superseded by H-295.943.
<a href="#">D-305.990</a>	Impact of Health System Changes on Medical Education	Our AMA will continue to monitor the financial status of academic medical centers and the availability of faculty and patients to support the clinical education of medical students and resident physicians. This should both include collecting information and synthesizing information from other sources on these issues. (CME Rep. 4, A-01; Reaffirmed: CME Rep. 2, A-11)	Rescind; remains relevant, but superseded by <a href="#">H-305.942</a> , “The Ecology of Medical Education: The Infrastructure for Clinical Education,” which reads: “The AMA recommends the following to ensure that access to appropriate clinical facilities and faculty to carry out clinical education is maintained: (1) That each medical school and residency program identify the specific resources needed to support the clinical education of trainees, and should develop an explicit plan to obtain and maintain these resources. This planning should include identification of the types of clinical facilities and the number and specialty

			distribution of full-time and volunteer clinical faculty members needed. (2) That affiliated health care institutions and volunteer faculty members be included in medical school and residency program resource planning for clinical education when appropriate. (3) That medical school planning for clinical network development include consideration of the impact on the education program for medical students and resident physicians. (4) That accrediting bodies for undergraduate and graduate medical education be encouraged to adopt accreditation standards that require notification of changes in clinical affiliations, in order to ensure that changes in the affiliation status of hospitals or other clinical sites do not adversely affect the education of medical students and resident physicians.”
<a href="#">D-405.987</a>	Debilitating Accidents and Accidental Deaths of Physicians in Training	Our AMA: 1) requests modification in the annual survey distributed to medical schools in order to assess the topic of serious accidents and accidental deaths; 2) requests modification of other annual surveys of medical schools, residency directors, and other medical educators in order to assess the topic of serious accidents and accidental deaths among physicians in training. (Res. 323, A-11)	Rescind; this directive was accomplished.
<a href="#">H-435.997</a>	Medical School Malpractice Risk Prevention Curriculum	Our AMA (1) acknowledges the continuing and growing severity of the problem of physician professional liability insurance nationwide and (2) urges medical schools and directors of residency programs to assist students and residents to understand and apply the determinants of sound risk management to clinical practice. (Sub. Res. 48, A-81; Reaffirmed: CLRPD Rep. F, I-91; Reaffirmed:	Rescind; superseded by <a href="#">H-295.924</a> , “Future Directions for Socioeconomic Education,” which reads: “The AMA: (1) asks medical schools and residencies to encourage that basic

		Sunset Report, I-01; Reaffirmed: CMS Rep. 7, A-11)	content related to the structure and financing of the current health care system, including the organization of health care delivery, modes of practice, practice settings, cost effective use of diagnostic and treatment services, practice management, risk management, and utilization review/quality assurance, is included in the curriculum; (2) asks medical schools and residencies to ensure that content related to the environment and economics of medical practice in fee-for-service, managed care and other financing systems is presented at educationally appropriate times during undergraduate and graduate medical education; and (3) will encourage the Liaison Committee on Medical Education (LCME) to ensure that survey teams pay close attention during the accreditation process to the degree to which 'socioeconomic' subjects are covered in the medical curriculum."
<a href="#">G-615.060</a>	CME Activities	Our AMA supports intensified efforts of the Council on Medical Education and other bodies within our AMA to initiate meetings and encourage continuing dialogue with medical students, interns, and residents. (Sub. Res. 22, I-69; CME Rep. I, I-77; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Consolidated: CLRPD Rep. 3, I-01; Modified: CC&B Rep. 2, A-11)	Rescind; this work is already reflected in multiple AMA activities and initiatives, including the Medical Student Section and Resident and Fellow Section (neither of which were in existence in 1969, when this policy was adopted).
<a href="#">H-300.946</a>	Inappropriate Use of Social Security	Our AMA opposes the use of Social Security numbers as: (1) a requirement to obtain	Retain; remains relevant.



	Numbers in CME Accreditation	continuing medical education credit and strongly encourage the use of the AMA Medical Education number for such educational activities; and (2) file identifiers by providers of continuing medical education, certification boards and similar entities, suggesting instead the use of the AMA Medical Education number where such a unique identifier is required and applicable. (Res. 306, A-00; Appended Res. 301, A-01; Reaffirmed: CME Rep. 2, A-11)	See also <a href="#">H-190.963</a> , “Identity Fraud,” which reads: “Our AMA policy is to discourage the use of Social Security numbers to identify insureds, patients, and physicians, except in those situations where the use of these numbers is required by law and/or regulation.”
<a href="#">D-300.980</a>	Opposition to Increased CME Provider Fees	<p>1. Our AMA will <del>(a) communicate its appreciation to the Accreditation Council for Continuing Medical Education (ACCME) Board of Directors for their responsiveness to AMA’s requests this past year;</del> <del>(ab)</del> continue to work with the ACCME to: (i) reduce the financial burden of institutional accreditation and state recognition; (ii) reduce bureaucracy in these processes, (iii) improve continuing medical education, and (iv) encourage the ACCME to show that <del>the updated</del> accreditation criteria improve patient care; and <del>(be)</del> continue to work with the ACCME to (i) mandate meaningful involvement of state medical societies in the policies that affect recognition and (ii) reconsider the fee increases to be paid by the state-accredited providers to ACCME.</p> <p>2. Our AMA will continue to work with the ACCME to accomplish the directives in policy D-300.980, “Opposition to Increased Continuing Medical Education (CME) Provider Fees.”</p> <p><del>3. Our AMA, in collaboration with the ACCME, will do a comprehensive review of the CME process on a national level, with the goal of decreasing costs and simplifying the process of providing CME. (CME Rep. 14, A-10; Appended: CME Rep. 9, A-11; Modified: CCB/CLRPD Rep. 4, A-12; Modified: CCB/CLRPD Rep. 2, A-14; Appended: Res. 302, A-17)</del></p>	<p>Retain in part. Delete 1.(a) and 3, which have been accomplished, and delete “updated” in 1.(b)(iv), in that these criteria were revised in the past.</p> <p>As stated in Council on Medical Education Report 7-A-12, the Council monitored results of the recommendations from Policy D-300.980 for the prior three years, and the Accreditation Council for Continuing Medical Education has been amenable to discussing AMA concerns. In December 2009, the ACCME created a task force to explore strategies for clarifying the requirements, eliminating redundancies, and reducing the documentation requirements for providers. This Task Force reported back to the ACCME Board in November 2010. The ACCME reports that it continues to be actively engaged in ongoing discussions and that some of the “simplification” changes associated with</p>

			the Task Force's work have already been implemented. For the past three years, the AMA has advocated for reduced fees and changes to the existing ACCME accreditation system. The Council on Medical Education will continue to monitor the activities and fees of the ACCME.
<a href="#">H-300.973</a>	Promoting Quality Assurance, Peer Review, and Continuing Medical Education	Our AMA: (1) reaffirms that it is the professional responsibility of every physician to participate in voluntary quality assurance, peer review, and continuing medical education activities; (2) to encourage hospitals and other organizations in which quality assurance, peer review, and continuing medical education activities are conducted to provide recognition to physicians who participate voluntarily; (3) to increase its efforts to make physicians aware that participation in the voluntary quality assurance and peer review functions of their hospital medical staffs and other organizations provides credit toward the AMA's Physicians' Recognition Award; and (4) to continue to study additional incentives for physicians to participate in voluntary quality assurance, peer review, and continuing medical education activities. (BOT Rep. SS, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CME Rep. 2, A-11)	Retain; remains relevant.
<a href="#">H-300.974</a>	Unification of Continuing Education Credits	Our AMA accepts American Academy of Family Physicians prescribed credit hours and American College of Obstetricians and Gynecologists cognate credit hours for formal learning, as equivalent to <i>AMA PRA Category 1 Credit</i> ™. (CME Rep. C, I-91; Reaffirmed: Sunset Report, I-01; Modified: CME Rep. 2, A-11)	Retain; remains relevant.
<a href="#">H-300.975</a>	Fraudulent/Legitimate Continuing Medical Education Activities	Our AMA supports the development and publication of guidelines to assist physicians in identifying continuing medical education of high quality, responsive to their needs, and supports the promulgation of ethical principles regarding the responsibilities of physicians to participate in continuing medical education programs which they claim for continuing medical education recognition, credit or other purposes. (Sub. Res. 64, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CME Rep. 2, A-11)	Retain; remains relevant.
<a href="#">D-300.979</a>	Suggested Revision in	<del>1. Our AMA will: (1) strongly encourage the Accreditation Council for Continuing Medical</del>	Retain in part with the deletion of (1) and

	ACCME Evaluations	<del>Education to recognize the value of gaining knowledge outside a physician's specialty and change the activity evaluation to reflect this;</del> and (2) communicate to the Accreditation Council for Continuing Medical Education that programs on the history of medicine have relevance for improvements in physicians' knowledge and competence. (Sub. Res. 310, A-10; Appended: Res. 320, A-11)	editorial change to (2), along with the number 1., which is unneeded. Both (1) and (2) have been accomplished, but (2) is still relevant.
<a href="#">H-300.992</a>	National Accreditation of AMA as Provider of Continuing Medical Education	Our AMA assigns to the <del>CME Council on Medical Education</del> the responsibility to be the unit of the AMA to become accredited for continuing medical education. (BOT Rep. NN, A-81; CLRPD Rep. F, I-91; Modified: Sunset Report, I-01; Reaffirmed: CME Rep. 2, A-11)	Retain; remains relevant, with editorial change to specify the "Council on Medical Education," to avoid confusion with "continuing medical education."
<a href="#">D-300.995</a>	Reducing Burdens of CME Accreditation and Documentation	Our AMA will work with the Accreditation Council for Continuing Medical Education to simplify the requirements for documentation and administration of accredited CME programs. (Res. 304, I-01; Reaffirmed: CME Rep. 2, A-11)	Rescind; accomplished. In 2017, the AMA and ACCME completed a multi-year process of simplification and alignment of the credit and accreditation systems. The process included multiple avenues of input from the CME community, culminating in a call for comment regarding proposed changes. The recommendations of the AMA/ACCME bridge committee were approved by the AMA Council on Medical Education and the ACCME Board of Directors.
<a href="#">D-300.998</a>	Attendance of Non-Physicians at Courses Teaching Complex Diagnostic, Therapeutic or Surgical Procedures	Our AMA will encourage the Accreditation Council for Continuing Medical Education, the American Academy of Family Physicians, and other groups that accredit providers of continuing medical education to adopt the principle that continuing medical education should be focused on physicians (MDs/DOs). Courses teaching complex diagnostic, therapeutic or surgical procedures should be open only to those practitioners and/or sponsored members of the practitioner's care team who have the appropriate medical education background and preparation to ensure patient safety. This should not be construed to limit access to or apply to programs leading to life support certification, e.g. ATLS, ACLS	Retain; remains relevant.

		(CME Rep. 2, A-01; Reaffirmed: CME Rep. 2, A-11)	
<a href="#">H-250.996</a>	Enhancing Young Physicians' Effectiveness in International Health	It is the policy of the AMA to work with national medical specialty societies and other organizations in preparing materials which guide young physicians in the development of skills necessary for effectively promoting the health of poor populations both in the United States and abroad. (Res. 407, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CME Rep. 2, A-11)	Retain; remains relevant.
<a href="#">H-260.978</a>	Salary Equity for Laboratory Personnel	It is the policy of the AMA to promote adequate compensation for medical technologists, cytotechnologists and other medical laboratory personnel and to promote increased funding for their educational programs. (Sub. Res. 39, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CME Rep. 2, A-11)	Rescind; outside the scope of the AMA.
<a href="#">D-275.964</a>	Principles of Due Process for Medical License Complaints	<p>1. Our AMA will explore ways to establish principles of due process that must be used by a state licensing board prior to the restriction or revocation of a physician's medical license, including strong protections for physicians' rights.</p> <p>2. Our AMA takes the position that: A) when a state medical board conducts an investigation or inquiry of a licensee applicant's quality of care, that the standard of care be determined by physician(s) from the same specialty as the licensee applicant, and B) when a state medical board conducts an investigation or inquiry regarding quality of care by a medical licensee or licensee applicant, that the physician be given: (i) a minimum of 30 days to respond to inquiries or requests from a state medical board, (ii) prompt board decisions on all pending matters, (iii) sworn expert review by a physician of the same specialty, (iv) a list of witnesses providing expert review, and (v) exculpatory expert reports, should they exist. (Res. 238, A-08; Appended: Res. 301, A-11)</p>	Retain; still relevant. Note editorial change to clause 1 to fix error.
<a href="#">D-275.989</a>	Credentialing Issues	<del>1. Our AMA shall: (A) continue to encourage the Federation of State Medical Boards (FSMB) and its licensing jurisdictions to widely disseminate information about the Federation Credentials Verification Service; and (B) encourage the FSMB and the Educational Commission for Foreign Medical Graduates to work together to develop a system for the prompt and reliable verification of the medical education credentials of international medical graduates and to serve as a repository and a body for primary source verification of credentials.</del>	Rescind in part.  Clause 1 has been accomplished through work by the FSMB and ECFMG to replace paper-based processes with an electronic portal for medical school transmission of diplomas and transcripts for IMGs. These technological advances

		<p><del>2-</del> Our AMA encourages state medical licensing boards, the Federation of State Medical Boards, and other credentialing entities to accept the Educational Commission for Foreign Medical Graduates certification as proof of primary source verification of an IMG's international medical education credentials. (CME Rep. 3, A-02; Appended: CME Rep. 10, A-11)</p>	<p>have reduced turnaround time for credentials verification for the majority of applicants.</p> <p>Clause 2 should be retained, in that states should be encouraged to accept the ECMG certification as proof of primary source verification of an IMG's international medical education credentials, to ensure efficiency and reduced processing time for IMGs seeking licensure while protecting the public.</p>
--	--	--	---

# REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 2-JUN-21

Subject: Licensure for International Medical Graduates Practicing in U.S. Institutions with Restricted Medical Licenses (Resolution 311-A-19)

Presented by: Liana Puscas, MD, MHS, Chair

Referred to: Reference Committee C

---

## INTRODUCTION

Resolution 311-A-19, “Licensure for International Medical Graduates Practicing in U.S. Institutions with Restricted Medical Licenses,” introduced by the International Medical Graduates Section (IMGS), and referred by the House of Delegates, asked that our American Medical Association (AMA) work with the Federation of State Medical Boards (FSMB), the Organized Medical Staff Section, and other stakeholders to advocate for state medical boards to support the licensure to practice medicine by physicians who have demonstrated they possess the educational background and technical skills and who are practicing in the U.S. health care system.

Testimony on this item during the 2019 Annual Meeting from an international medical graduate (IMG) academic physician who has trained many residents and fellows in the United States, but who is ineligible to obtain a medical license, reflected the impetus for this item. A physician from Florida testified how that state continues to grapple with the issue of physician immigrants from Cuba and other countries who do not meet state licensure requirements yet seek to find a way in which to put their (often considerable) skills to work in their new country in service to patients and society.

## BACKGROUND

All state medical boards require physicians to have completed at least one year of graduate medical education (GME) in a residency program accredited by the Accreditation Council for Graduate Medical Education (ACGME) to be eligible for a full, unrestricted medical license.<sup>1</sup> Some states do issue limited, restricted licenses that allow a physician to practice, under supervision, in specific institutions. Some of these physicians are IMGs who not only received their medical education outside the U.S. but also trained in a specialty and practiced abroad. After immigrating to the U.S., these physicians have been able to establish themselves in an institution utilizing one of these limited, restricted licenses, despite being ineligible for full licensure. Some institutions, however, have instituted changes to require that all physicians employed by the institution be board certified or board eligible. This has excluded physicians with restricted, limited licenses who may have been serving their community for years while contributing to patient care and the medical education of students and residents.

## RESTRICTED LICENSES

Medical boards issue a variety of licenses other than full, unrestricted licenses. Of relevance, 40 medical boards issue “faculty/educational” licenses; 44 issue “limited/special purpose” licenses, and 19 issue “institutional practice” licenses.<sup>1</sup> Medical boards may determine the limitations or conditions of practice under these licenses differently, as well as the educational and/or training requirements. In addition, the boards use different names for possibly similar types of licenses, making it challenging to quantify less common license types at the national level. For example, according to a requested analysis provided by the FSMB, 163 physicians nationwide possess a license categorized as “teaching.” These licenses are labeled variously, such as “Foreign Teaching Physicians” or “Distinguished Faculty.” This count could be low considering the variability in how medical boards categorize and share data for these less common license types.

For example, in Washington state, the Washington Medical Commission may “issue a limited license to a physician applicant invited to serve as a teaching-research member of the institution’s instructional staff if the sponsoring institution and the applicant give evidence that he or she has graduated from a recognized medical school and has been licensed or otherwise privileged to practice medicine at his or her location of origin. Such license shall permit the recipient to practice medicine only within the confines of the instructional program specified in the application.”<sup>2</sup>

Texas offers a faculty temporary license, with similar requirements as Washington, with specific restrictions concerning the institution that can hire the physician (i.e., certain medical centers, Texas medical schools, or GME sponsors).<sup>3</sup> The District of Columbia specifically offers licenses “for foreign doctors of eminence and authority.”<sup>4</sup> New York offers a limited permit that can allow an IMG without U.S. GME to practice in a nursing home; state-operated psychiatric, developmental or alcohol treatment center; or incorporated, nonprofit institution for the treatment of the chronically ill, but only for up to four years.<sup>5</sup>

Florida offers a “house physician” license and provides a detailed description of the work that can be done, all under the supervision of a physician with an active, unrestricted Florida license. The license for house physicians does not require U.S. GME and seems to have relatively few requirements, i.e., types of institutions are not specified, nor time limits.<sup>6</sup>

## BOARD CERTIFICATION REQUIREMENTS

The American Board of Medical Specialties (ABMS) acknowledges that there may be acceptable alternative pathways to initial certification for candidates who have not completed U.S. GME. Some ABMS member boards recognize alternative pathways, but others do not, due to the challenges associated with assessing equivalency of training for these medical specialties.<sup>7</sup>

The ABMS Position Statement on Alternative Pathways to initial certification defines the guiding principles for acceptable alternative pathways that do not meet the standard pathway (i.e., ACGME-accredited or Canadian-accredited GME). An ABMS workgroup is currently reviewing the ABMS Position Statement to determine if additional changes are required to ensure continued clarity.<sup>7</sup>

The ABMS stipulates that alternative pathway policies and procedures for initial certification should:

1. Be transparent, objective, equitable, and readily available to interested candidates and stakeholders;

2. Not be arbitrary or capricious to interested candidates and stakeholders;
3. Include the assessment of all six of the ABMS/ACGME core competencies;
4. Include the assessment of professional standing in adherence with the ABMS Professional Standing Policy; and
5. Adhere to Member Boards' existing Board Eligibility policies for both specialties and subspecialties, provided those policies adhere to the ABMS Board Eligibility Policies.

Sixteen boards offer pathways for internationally trained physicians; in particular, ten boards offer pathways for physicians practicing in the United States at an ACGME-accredited institution who are faculty at an ACGME-accredited program and may have achieved a specified academic rank (from associate to full professor); two boards will accept international training as meeting all of the training requirements on a case-by-case basis; and four boards will accept international training as meeting some of the training requirements on a case-by-case basis. Two boards have established that training in Australia and New Zealand is equivalent to ACGME-accredited training; these boards will accept candidates who trained in those countries.

Twenty-two member boards accept all of a candidate's training in Canada (either accredited by the Royal College of Physicians and Surgeons of Canada [RCPSC], or by another body acceptable to the board). Of these, eleven further require that a candidate be certified by the RCPSC or other Canadian certifying body. Three boards will accept some of a candidate's training in Canada (either accredited by the RCPSC or by another body acceptable to the board).

Regardless of a member board's position on alternative pathways, it is the policy of the ABMS that, to be eligible for certification in any specialty or subspecialty and to maintain certification, a physician must have a full and unrestricted license to practice medicine in at least one jurisdiction in the United States, its territories, or Canada.

## EXPLORATION OF ALTERNATIVE PATHWAYS IN MINNESOTA

Minnesota's International Medical Graduate Assistance Program, operational since 2016, helps IMGs in the state obtain residency positions. One aspect of the program includes study of possible licensure changes that would allow qualified IMGs to practice in Minnesota. The Minnesota Department of Health, working with the Minnesota Board of Medical Practice and other stakeholders, proposed two possible strategies in 2018: the creation of an IMG Primary Care Integration license and an amendment to the medical practice act to include an exemption for practice in primary care in a rural or underserved area. Objectively qualified IMGs would be able to practice in areas experiencing primary care shortages without entering U.S. GME. The process includes passage of all licensure exams, demonstrating at least seven years of medical practice, participation in a six-month clinical experience, and an assessment that would culminate in a certificate that would allow work under supervision.

The program would require the commitment of an accredited assessor. Another concern is that these physicians would not be eligible for board certification and may encounter employment restrictions. Two major stakeholders—the Minnesota Academy of Physician Assistants and the Minnesota Medical Association—have raised objections, citing concerns over professional role confusion and a tiered licensure system. The Minnesota Department of Health continues to research possible licensure changes.<sup>8,9</sup>



## 1 CURRENT AMA POLICY

2  
3 As shown in the appendix, the AMA has substantial policy that supports full licensure for  
4 practicing physicians, whether U.S. medical school graduates or IMGs, only after completion of at  
5 least one year of GME in the U.S. (see H-255.988 [12] and H-275.934 [2]).

6  
7 Policy H-160.949 (6) specifies as well that the AMA “opposes special licensing pathways for  
8 physicians who are not currently enrolled in an [accredited]...training program.” This policy was  
9 adopted at the 2014 Annual Meeting in response to development in Missouri of a special licensure  
10 pathway for practice by “assistant physicians” who have not had any GME in the U.S. (see  
11 [https://www.aapa.org/news-central/2014/06/american-medical-association-house-of-delegates-](https://www.aapa.org/news-central/2014/06/american-medical-association-house-of-delegates-rejects-assistant-physician-concept/)  
12 [rejects-assistant-physician-concept/](https://www.aapa.org/news-central/2014/06/american-medical-association-house-of-delegates-rejects-assistant-physician-concept/)). Meanwhile, Policy H-275.978 (5) states that the AMA “urges  
13 those licensing boards that have not done so to develop regulations permitting the issuance of  
14 special purpose licenses. It is recommended that these regulations permit special purpose licensure  
15 with the minimum of educational requirements consistent with protecting the health, safety and  
16 welfare of the public.” It would seem that these two policies are contradictory; accordingly, they  
17 are proposed for modification in the recommendations below.

18  
19 In addition, the AMA both recognizes the value of board certification but advocates against  
20 discrimination against physicians based on a lack of board certification. Policy H-220.960 asks The  
21 Joint Commission to “support retention of important medical staff structural standards in its  
22 hospital accreditation programs, including, but not limited to, standards...that board certification is  
23 an excellent benchmark for the delineation of clinical privileges.” At the same time, H-275.926  
24 states that the AMA “(4) Opposes discrimination against physicians based solely on lack of ABMS  
25 or equivalent AOA-BOS board certification, or where board certification is one of the criteria  
26 considered for purposes of measuring quality of care, determining eligibility to contract with  
27 managed care entities, eligibility to receive hospital staff or other clinical privileges, ascertaining  
28 competence to practice medicine, or for other purposes. Our AMA also opposes discrimination that  
29 may occur against physicians involved in the board certification process, including those who are  
30 in a clinical practice period for the specified minimum period of time that must be completed prior  
31 to taking the board certifying examination.”

## 32 SUMMARY AND RECOMMENDATIONS

33  
34  
35 Existing AMA policy is of two minds in terms of the requirements for full licensure and board  
36 certification. Indeed, the need for an expanded workforce, to meet the growing needs of patients for  
37 access to health care services, must be balanced with requisite caution in awarding licensure for  
38 practice, given the need to protect the public and ensure the quality of the medical workforce.  
39 Given, however, that physicians who have been serving their communities for years may have their  
40 careers jeopardized as a result of employers adopting new employment standards, the Council on  
41 Medical Education recommends that the following recommendations be adopted in lieu of  
42 Resolution 311-A-19 and the remainder of this report be filed:

- 43  
44 1. That our American Medical Association (AMA) encourage state medical licensing boards and  
45 the member boards of the American Board of Medical Specialties to develop criteria that allow  
46 1) completion of medical school and residency training outside the U.S., 2) extensive U.S.  
47 medical practice, and 3) evidence of good standing within the local medical community to  
48 serve as a substitute for U.S. graduate medical education requirement for physicians seeking  
49 full unrestricted licensure and board certification. (Directive to Take Action)

- 1 2. That our AMA amend Policy H-255.988 (12), “AMA Principles on International Medical  
2 Graduates,” by addition to read as follows:  
3  
4 Our AMA supports ...12. The requirement that all medical school graduates complete at least  
5 one year of graduate medical education in an accredited U.S. program in order to qualify for  
6 full and unrestricted licensure. State medical licensing boards are encouraged to allow an  
7 alternate set of criteria for granting licensure in lieu of this requirement: 1) completion of  
8 medical school and residency training outside the U.S., 2) extensive U.S. medical practice, and  
9 3) evidence of good standing within the local medical community. (Modify Current HOD  
10 Policy)  
11
- 12 3. That our AMA amend Policy H-275.934 (2), “Alternatives to the Federation of State Medical  
13 Boards Recommendations on Licensure,” by addition to read as follows:  
14  
15 2. All applicants for full and unrestricted licensure, whether graduates of U.S. medical schools  
16 or international medical graduates, must have completed one year of accredited graduate  
17 medical education (GME) in the U.S., have passed all state-required licensing examinations  
18 (USMLE or COMLEX USA), and must be certified by their residency program director as  
19 ready to advance to the next year of GME and to obtain a full and unrestricted license to  
20 practice medicine. State medical licensing boards are encouraged to allow an alternate set of  
21 criteria for granting licensure in lieu of this requirement for completing one year of accredited  
22 GME in the U.S.: 1) completion of medical school and residency training outside the U.S., 2)  
23 extensive U.S. medical practice, and 3) evidence of good standing within the local medical  
24 community. (Modify Current HOD Policy)  
25
- 26 4. That our AMA amend Policy H-160.949 (6), “Practicing Medicine by Non-Physicians,” by  
27 addition and deletion to read as follows:  
28  
29 Our AMA ... (6) opposes special licensing pathways for “assistant physicians” (i.e., those who  
30 are not currently enrolled in an Accreditation Council for Graduate Medical Education of  
31 American Osteopathic Association training program, or have not completed at least one year of  
32 accredited post-graduate US medical education in the U.S). (Modify Current HOD Policy)  
33
- 34 5. That our AMA amend Policy H-275.978 (5), “Medical Licensure,” by addition to read as  
35 follows:  
36  
37 Our AMA ... (5) urges those licensing boards that have not done so to develop regulations  
38 permitting the issuance of special purpose licenses, with the exception of special licensing  
39 pathways for “assistant physicians.” It is recommended that these regulations permit special  
40 purpose licensure with the minimum of educational requirements consistent with protecting the  
41 health, safety and welfare of the public; (Modify Current HOD Policy)

Fiscal Note: \$1,000.

## APPENDIX

### *H-160.949, "Practicing Medicine by Non-Physicians"*

Our AMA . . . (6) opposes special licensing pathways for physicians who are not currently enrolled in an Accreditation Council for Graduate Medical Education of American Osteopathic Association training program, or have not completed at least one year of accredited post-graduate US medical education.

### *H-220.960, "The Joint Commission Hospital Accreditation Program Standards"*

Our AMA requests its trustees who serve as Commissioners to The Joint Commission to support retention of important medical staff structural standards in its hospital accreditation programs, including, but not limited to, standards requiring that medical staff operate as a self-governing entity - as defined in medical staff bylaws; that physician directors of hospital departments be board certified or possess equivalent qualifications; and that board certification is an excellent benchmark for the delineation of clinical privileges....

### *H-255.966, "Abolish Discrimination in Licensure of IMGs"*

1. Our AMA supports the following principles related to medical licensure of international medical graduates (IMGs):

A. State medical boards should ensure uniformity of licensure requirements for IMGs and graduates of U.S. and Canadian medical schools, including eliminating any disparity in the years of graduate medical education (GME) required for licensure and a uniform standard for the allowed number of administrations of licensure examinations.

B. All physicians seeking licensure should be evaluated on the basis of their individual education, training, qualifications, skills, character, ethics, experience and past practice.

C. Discrimination against physicians solely on the basis of national origin and/or the country in which they completed their medical education is inappropriate.

D. U.S. states and territories retain the right and responsibility to determine the qualifications of individuals applying for licensure to practice medicine within their respective jurisdictions.

E. State medical boards should be discouraged from a) using arbitrary and non-criteria-based lists of approved or unapproved foreign medical schools for licensure decisions and b) requiring an interview or oral examination prior to licensure endorsement. More effective methods for evaluating the quality of IMGs' undergraduate medical education should be pursued with the Federation of State Medical Boards and other relevant organizations. When available, the results should be a part of the determination of eligibility for licensure.

2. Our AMA will continue to work with the Federation of State Medical Boards to encourage parity in licensure requirements for all physicians, whether U.S. medical school graduates or international medical graduates.

3. Our AMA will continue to work with the Educational Commission for Foreign Medical Graduates and other appropriate organizations in developing effective methods to evaluate the clinical skills of IMGs.

4. Our AMA will work with state medical societies in states with discriminatory licensure requirements between IMGs and graduates of U.S. and Canadian medical schools to advocate for parity in licensure requirements, using the AMA International Medical Graduate Section licensure parity model resolution as a resource.

*H-255.970, "Employment of Non-Certified IMGs"*

Our AMA will: (1) oppose efforts to employ graduates of foreign medical schools who are neither certified by the Educational Commission for Foreign Medical Graduates, nor have met state criteria for full licensure.

*H-255.988, "AMA Principles on International Medical Graduates"*

Our AMA supports:

6. Working with the Accreditation Council for Graduate Medical Education (ACGME) and the Federation of State Medical Boards (FSMB) to assure that institutions offering accredited residencies, residency program directors, and U.S. licensing authorities do not deviate from established standards when evaluating graduates of foreign medical schools.

7. In cooperation with the ACGME and the FSMB, supports only those modifications in established graduate medical education or licensing standards designed to enhance the quality of medical education and patient care.

12. The requirement that all medical school graduates complete at least one year of graduate medical education in an accredited U.S. program in order to qualify for full and unrestricted licensure.

*H-275.926, "Medical Specialty Board Certification Standards"*

Our AMA: (4) Opposes discrimination against physicians based solely on lack of ABMS or equivalent AOA-BOS board certification, or where board certification is one of the criteria considered for purposes of measuring quality of care, determining eligibility to contract with managed care entities, eligibility to receive hospital staff or other clinical privileges, ascertaining competence to practice medicine, or for other purposes. Our AMA also opposes discrimination that may occur against physicians involved in the board certification process, including those who are in a clinical practice period for the specified minimum period of time that must be completed prior to taking the board certifying examination.

*H-275.934, "Alternatives to the Federation of State Medical Boards Recommendations on Licensure"*

Our AMA adopts the following principles: (2) All applicants for full and unrestricted licensure, whether graduates of U.S. medical schools or international medical graduates, must have completed one year of accredited graduate medical education (GME) in the U.S., have passed all licensing examinations (USMLE or COMLEX USA), and must be certified by their residency program director as ready to advance to the next year of GME and to obtain a full and unrestricted license to practice medicine.

*H-275.936, "Mechanisms to Measure Physician Competency"*

Our AMA: (1) continues to work with the American Board of Medical Specialties and other relevant organizations to explore alternative evidence-based methods of determining ongoing clinical competency; (2) reviews and proposes improvements for assuring continued physician competence, including but not limited to performance indicators, board certification and recertification, professional experience, continuing medical education, and teaching experience....

*H-275.978, "Medical Licensure"*

Our AMA: (5) urges those licensing boards that have not done so to develop regulations permitting the issuance of special purpose licenses. It is recommended that these regulations permit special purpose licensure with the minimum of educational requirements consistent with protecting the health, safety and welfare of the public;

## REFERENCES

- <sup>1</sup> U.S. Medical Regulatory Trends and Actions 2018. Federation of State Medical Boards: 2018.
- <sup>2</sup> Washington State Legislature, RCW 18.71.095. Limited licenses.  
<https://app.leg.wa.gov/rcw/default.aspx?cite=18.71.095>. Accessed January 7, 2020.
- <sup>3</sup> Texas Medical Board. Faculty Temporary License. [www.tmb.state.tx.us/page/licensing-faculty-temporary-licenses](http://www.tmb.state.tx.us/page/licensing-faculty-temporary-licenses). Accessed September 16, 2019.
- <sup>4</sup> Code of the District of Columbia, § 3–1205.09a. Licenses for foreign doctors of eminence and authority.  
<https://code.dccouncil.us/dc/council/code/sections/3-1205.09a.html>. Accessed September 16, 2019.
- <sup>5</sup> New York State Education Department. License Requirements. Physician. Limited Permits.  
[www.op.nysed.gov/prof/med/medlic.htm](http://www.op.nysed.gov/prof/med/medlic.htm). Accessed September 16, 2019.
- <sup>6</sup> Florida Board of Medicine. Resident Physicians, Interns, Fellows, and House Physicians.  
<https://flboardofmedicine.gov/licensing/resident-physicians-interns-fellows-and-house-physicians/>. Accessed September 16, 2019.
- <sup>7</sup> American Board of Medical Specialties Committee on Certification (COCERT). December, 2020.
- <sup>8</sup> Minnesota Department of Health. International Medical Graduate (IMG) Program.  
<https://www.health.state.mn.us/facilities/ruralhealth/img/index.html>. Accessed September 16, 2019.
- <sup>9</sup> Hirs I. Could the state-funded International Medical Graduate Assistance Program do more for immigrant doctors — and help address Minnesota’s looming doctor shortage? MinnPost. May 11, 2018.  
<https://www.minnpost.com/new-americans/2018/05/could-state-funded-international-medical-graduate-assistance-program-do-more-i/>. Accessed December 30, 2019.

REPORT 3 OF THE COUNCIL ON MEDICAL EDUCATION (June 2021)  
Optimizing Match Outcomes  
(Resolution 304-I-19)  
(Reference Committee C)

EXECUTIVE SUMMARY

For many years there have been concerns that the system for entry into U.S. residency training programs has barriers that stymie the efforts of qualified applicants to achieve their goal of practicing medicine in the U.S., often at great personal financial cost. These concerns have led to the development of American Medical Association (AMA) policy and advocacy to increase residency training positions, and policy that promotes systems and programs to guide applicants to choose specialties and apply and match to residency training programs effectively. Recent technological problems with the application service used by unmatched applicants and unfilled training programs, the Supplemental Offer and Acceptance Program<sup>®</sup> or SOAP<sup>®</sup>, have increased the apprehension of medical students and physicians concerning their ability to enter graduate medical education.

Many medical education stakeholders, most notably the Association of American Medical Colleges (AAMC), but also the National Resident Matching Program (NRMP) and the AMA, have developed numerous tools and informational guides to help students select a specialty and then apply to, interview with, rank, and match to programs. In addition, U.S. medical schools have dedicated staff eager to help students successfully match into residency programs, providing accessible online advice as well as personal counseling. To further improve the system, pilots are currently being tested to provide optimal matching opportunities with the intent of decreasing anxiety during the application/interview/matching season, reducing superfluous applications, and increasing transparency between applicants and programs.

In the interim, key stakeholder organizations, such as the NRMP and AAMC, can consolidate information that can assist students and their advisers to create effective application strategies. Those applicants without an adviser should also have easy access to such information. All applicants, however, will need to use this information consistently and rationally if the desire is to successfully match to a program.

# REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 3-JUN-21

Subject: Optimizing Match Outcomes  
(Resolution 304-I-19)

Presented by: Liana Puscas, MD, MHS, Chair

Referred to: Reference Committee C

---

## INTRODUCTION

Resolution 304-I-19, “Issues with the Match, the National Residency Matching Program (NRMP),” introduced by the Indiana Delegation, asked the AMA to:

1. continue working to promote an increase in residency program positions in the U.S.;
2. study how residency programs can expand in novel ways;
3. determine what strategies can increase an applicant’s ability to match into a residency program;
4. support the option of permitting those who failed to obtain a position during the Supplemental Offer and Acceptance Program® (SOAP®) in 2019 to participate in a future matching opportunity at no cost; and
5. encourage the National Resident Matching Program (NRMP) and the Electronic Residency Application Service (ERAS) to conduct an audit to identify opportunities for lowering the financial burden on applicants and to promote and disseminate strategies to mitigate issues that interfere with successfully matching. The full resolution is in the Appendix.

Online and in-person testimony during the 2019 Interim Meeting suggested that this resolution, which calls for a broad investigation into several different aspects of the resident match, has already been addressed in the recent past by the Council on Medical Education (CME Report 3-A-16, “Addressing the Increasing Number of Unmatched Medical Students”). It was noted that the AMA has extensive policy on expanding graduate medical education (see for example D-305.967, “The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education”). Testimony also noted that the NRMP and the Association of American Medical Colleges (AAMC) release yearly authoritative reports on match outcomes with granular data for medical students to aid in their decision making. Others, however, expressed concern that current efforts to address this issue have been insufficient. The reference committee initially considered reaffirmation of existing policy in lieu of Resolves 1 and 2, and deletion of Resolve 3, but ultimately recommended referral of the entire resolution. The House of Delegates (HOD) subsequently agreed; this report is in response to that referral.

## BACKGROUND

For many years there have been concerns that the system for entry into U.S. residency training programs has barriers that stymie the efforts of qualified applicants to achieve their goal of practicing medicine in the U.S., often at great personal financial cost. These concerns have led to many resolutions presented to the AMA HOD and subsequent reports and policies generated to



address those concerns. This report: a) summarizes the AMA's recent efforts to increase residency training positions and assist applicants in applying to residency programs; b) describes the technological problems of SOAP in 2019 and what has been done to prevent future problems; and c) describes resources for applicants on effective program application and matching.

## AMA REPORTS, POLICY, AND ADVOCACY

The AMA Council on Medical Education (CME) has prepared several reports for the HOD addressing the process of matching into residency programs, as well as the need to increase funding for graduate medical education (GME). For example, CME Report 3-A-18, "Expanding UME Without Concurrent GME Expansion," included three recommendations that were adopted as policy and recorded in D-305.967, "The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education:"

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

CME Report 5-A-17, "Options for Unmatched Medical Students," outlined a number of key points related to unmatched medical students, including the long-term stability of match rates, common reasons for an unsuccessful match, options for students who do not match, and tools/initiatives from medical schools and medical organizations (including the AMA) to ensure an effective, efficient, and equitable match process that balances the interests of applicants and programs and promotes rational, strategic decision making by all parties. This report also highlighted AMA resources, including the AMA's Career Planning Resource, which includes guidance on applying for residency, choosing a specialty, interviewing for residency, writing a C.V., and finding residency programs through FREIDA™. Another tool described in this report is the AAMC's Careers in Medicine (CiM) online guide, which helps students make strategic decisions about residency training and beyond and provides self-assessment tools and specialty-specific data to inform those decisions.

CME Report 3-A-16, "Addressing the Increasing Number of Unmatched Medical Students," recommended reaffirming existing policy, namely D-305.967 (4) and (22), "The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education;" H-200.954 (4) (5) (6) and (7), "US Physician Shortage," and D-310.977 (11), "National Resident Matching Program Reform." These various policies direct the AMA to advocate for increasing GME positions; encourage research and data that support the value of GME; and encourage medical schools and residency programs to consider policies to attract physicians to practice in and care for patients in underserved and rural areas. Other policy encourages the AMA to work with other major stakeholders in medical education to evaluate data and propose new research that would describe how many students graduating from U.S. medical schools each year do not enter into a U.S. residency program; how many never enter into a U.S. residency program; whether there is

disproportionate impact on individuals of minoritized racial and ethnic groups; and what careers are pursued by those with an MD or DO degree who do not enter residency programs.

The AMA has long advocated for advancing GME, including increasing funding for residency positions, developing innovative funding models, and creating residency positions that reflect patient and societal needs. The AMA launched the Reimagining Residency Initiative in 2019 with \$15 million in grants to projects promoting systemic change in GME. Recently the AMA offered technical assistance in the drafting of the Health Heroes 2020 Act (H.R. 6650), which proposes to bolster the National Health Service Corps (NHSC) by providing an additional \$25 billion for both the loan repayment and scholarship programs to increase the number of medical professionals in underserved communities. The Act would also increase the mandatory NHSC funding level from \$310M to \$690M for fiscal years 2021-2026 to increase scholarship and loan forgiveness awards. The AMA offered assistance in the drafting of the Rural America Health Corps Act (S.2406) which builds upon the existing NHSC model by proposing up to five years of loan forgiveness (versus two) to help pay down medical school debt and increase the number of individuals that can enter the NHSC.

The AMA continues to voice its support for federal bills to increase residency positions, including the Resident Physician Shortage Reduction Act of 2021 (S. 834), which would expand Medicare funding for 15,000 additional residency positions. Earlier legislative proposals from 2019 that garnered AMA support and advocacy would close a loophole in GME cap-setting criteria affecting hospitals that temporarily host small numbers of residents (H.R. 1358), and provide 1,000 additional Medicare-supported GME positions over five years in hospitals that have, or are establishing, accredited residency programs in addiction medicine, addiction psychiatry, or pain management (H.R. 2439).

Most recently, there were multiple provisions in the new Appropriations Act that provide benefits for GME, variations of which AMA has advocated for, including:

- Increased funding (\$310 million) from 2021-2023 for the National Health Service Corps, and extended funding through 2023 for teaching health centers that operate GME programs. (Sec. 301)
- Hospitals will be allowed to host a limited number of residents for short-term rotations without being negatively impacted by a set permanent full time equivalent (FTE) resident cap or a per resident amount (PRA). A hospital must report full-time equivalent residents on its cost report for a cost reporting period if the hospital trains at least 1.0 full-time-equivalent residents in an approved medical residency training program or programs in such period. (Sec. 131)
- A thousand additional Medicare-funded GME residency positions (200 per year for 5 years), to be distributed to rural hospitals, hospitals that are already above their Medicare cap for residency positions, hospitals in states with new medical schools or new locations and branch campuses, and hospitals that serve Health Professional Shortage Areas. However, a hospital may not receive more than 25 additional full-time equivalent residency positions. (Sec. 126)

#### TECHNOLOGICAL PROBLEMS FOR SOAP

SOAP is a joint service of the NRMP and ERAS. Through SOAP, qualified applicants who do not obtain a position through the NRMP Match are privy to a list of participating programs that did not fill all their positions through the Match. Applicants submit applications to programs of interest. Programs review the applications and select candidates to interview (via phone, video, or in-person

if local), and positions are then offered to successful applicants. This occurs over a compressed timeframe, with three rounds over two days.

In 2019 the ERAS system experienced technical issues during the SOAP process, which affected applicants and program directors. The system was taken offline to correct the problem, resulting in a shortened time frame to complete the process; therefore, the NRMP reduced the number of rounds from three to two. The AAMC conducted an internal root-cause analysis and had an external review completed by an industry expert to evaluate technology and processes. Those reviews identified immediate and long-term steps that were implemented to mitigate future risk and to improve systems and operations.<sup>1</sup> Similar technical issues also occurred during the first day of the SOAP process in 2021. The cause of these issues was not known at the time this report was prepared, but the AAMC has apologized for the situation and promised another thorough investigation to understand the poor performance and identify and implement solutions to improve the process. The Council on Medical Education will continue to monitor the situation.

Typically, around 600 U.S. MD seniors are without a position at the conclusion of SOAP. In 2019, there were 623 without a position versus 620 in 2018. In 2020, there were 522. Overall, all applicants accepted offers with roughly the same frequency: the percent of offers accepted was 64.1 in 2018, 62.5 in 2019, and 61.8 in 2020.<sup>2,3,4</sup> Data from the 2021 Match were not available at the time this report was prepared. Although the compressed schedule caused additional anxiety during a period that is normally stressful, the resulting proportions of applicants with positions are much the same. However, the NRMP has become concerned that in the past few years there has been a decrease in the number of SOAP-eligible applicants at the conclusion of the Match, compared to an increasing number of unfilled positions placed in SOAP, and an increasing number of unfilled positions at the end of SOAP. Coupled with the uncertainty surrounding the upcoming application and match season due to the COVID-19 pandemic, the NRMP has decided to add an additional, fourth offer round to the SOAP process.<sup>5</sup>

## EFFECTIVE STRATEGIES FOR APPLYING AND MATCHING

The AAMC has numerous tools and informational guides developed to help students select a specialty and then apply to, interview with, and rank programs, all through the CiM website (<https://www.aamc.org/cim/>). Users of most CiM material need a subscription. Students of U.S. MD-granting schools have a subscription through their schools as a result of their school's membership in the AAMC. Students of DO-granting schools and international medical students may have subscriptions through their schools or may need to purchase an individual subscription for \$75. Medical school advisers also have access to CiM material.

The AAMC launched the Apply Smart website in 2016 to assist students in determining the optimal number of residency programs to which they should apply. The website provides information on the relationship between the number of applications submitted and the likelihood of entry into a residency program, highlighting the point at which the likelihood does not increase as the number of applications increase. Apply Smart also provides ranges of United States Medical Licensing Examination® (USMLE®) Step 1 scores as a comparison metric and suggests that students should consider limiting their applications at the point of diminishing returns.<sup>6</sup> Although relatively easy to use and understand, there are some caveats to the tool's utility. The tool relies on USMLE 3-digit Step 1 scores, so students who do not have a Step 1 score, e.g., some students at DO-granting medical schools, will not find the tool useful. Future use of the tool when Step 1 results are reported as pass/fail (proposed to occur in January 2022) will also be in doubt, unless another valid metric is provided. Further, the tool's methodology has been questioned, in that the data uses the number of applications submitted through ERAS, which does not distinguish between

1 preferred specialties and backup specialties. Therefore, for example, a student may submit 10  
 2 applications to a specialty that is not the preferred one and ultimately choose not to enter it. This  
 3 datapoint will contribute to a low likelihood of entering that specialty with only 10 applications.<sup>7</sup>  
 4 One suggestion is to pair ERAS applications data with interviews offered data, which, with the  
 5 support of residency programs, is available through ERAS, thus creating a probability that a given  
 6 number of applications results in an interview offer. Also suggested is pairing ERAS application  
 7 data with NRMP data, to filter preferred specialties from backup specialties.<sup>7</sup>

8  
 9 The AAMC has also developed the Residency Explorer tool, which uses Step 1 scores as well as  
 10 Step 2CK and COMLEX-USA Level 1 and Level 2-CE scores. Offered free to U.S. medical and  
 11 international students, Residency Explorer has benefited by creating a consortium of data  
 12 providers. Users create a profile based on their test scores and academic achievements, and  
 13 Residency Explorer will provide a list of programs in a chosen specialty with statistics on current  
 14 and recent residents. Users can then compare where they stand in relation to matched residents at a  
 15 given program. In addition, other characteristics about the program are provided for students to  
 16 consider. Programs that have few residents or have been accredited for only a few years will not  
 17 have test score information available and may also have few program characteristics to report. As  
 18 with the Apply Smart tool, Step 1 three-digit scores will not be available once score reporting  
 19 transitions to pass/fail; therefore, students of MD-granting schools will have one less metric.

20  
 21 The NRMP produces several reports that can be helpful in guiding applicants' decision-making.  
 22 The "Results from the Program Director Survey" describes what factors are considered by program  
 23 directors, as well as their importance, when deciding which applicants to interview, and then the  
 24 same for deciding how to rank applicants. The report is broken down by specialty. Unfortunately,  
 25 the response rate by program directors to this survey is low, averaging 18 percent in 2019.<sup>8</sup>  
 26 Similarly, the NRMP surveys applicants and asks about the program characteristics that influenced  
 27 both application and ranking choices as well as the relative importance of those characteristics. In  
 28 the "Results of the 2019 NRMP Applicant Survey by Preferred Specialty and Applicant Type"  
 29 report, applying, interviewing, and ranking behavior is available by whether the applicant  
 30 successfully matched or not. These data are also available by specialty. This report has a response  
 31 rate of 42.3 percent, and specialties with fewer than 50 respondents are excluded.<sup>9</sup>

32  
 33 More data on applicant characteristics and applying, interviewing, ranking, and matching success  
 34 are available in the Charting Outcomes in the Match reports, available for U.S. MD seniors,<sup>10</sup> U.S.  
 35 DO seniors,<sup>11</sup> and graduates of international medical schools (IMGs).<sup>12</sup> All data are self-reported,  
 36 with the exception of match data. These reports are also segmented into specialties. In addition, the  
 37 NRMP used 2018 match data to create an interactive tool, the Interactive Charting Outcomes in the  
 38 Match, which allows users to enter their own values, such as number of publications, and assess the  
 39 percentage of applicants who matched or did not match, by Step 1 or Level 1 score range.<sup>13</sup> Given  
 40 the similarity to Residency Explorer, the NRMP has not further developed the interactive charts  
 41 and collaborates with the AAMC on Residency Explorer.

42  
 43 The AMA provides general guidance offered by experts in the field on choosing a specialty and  
 44 effective applying and matching strategies, most of which can be found on the AMA website ("The  
 45 Match journey made simple," at <https://www.ama-assn.org/residents-students/match/match-journey-made-simple>). The AMA has also developed a new residency calculator tool to help  
 46 students estimate the costs of applying to programs (<https://freidaresidencycalculator.com/>).  
 47

48  
 49 Aside from the AAMC and the AMA, other websites provide advice on residency program  
 50 applications and interviews. Many of these are geared in particular to IMGs, but not always, and  
 51 may charge a fee for assistance. Specialty societies also present information on program locations

1 and characteristics and advice on how to apply to programs in the specialty, such as family  
 2 medicine (<https://www.aafp.org/medical-school-residency/residency/process.html>).  
 3

4 Finally, U.S. medical schools have dedicated staff that are eager to help students successfully  
 5 match into residency programs, providing accessible online advice as well as personal counseling.  
 6 The most commonly reported reason why a student does not successfully match is that the  
 7 student's academic performance (e.g., clinical grades) and/or USMLE scores are below the norm  
 8 for the desired specialty. Other commonly cited reasons are 1) applications in a single specialty, 2)  
 9 lack of a backup plan, and 3) application to too few programs. These issues could be mitigated with  
 10 advice, but some advisers report that some students do not make themselves available for career  
 11 counseling.<sup>14</sup>  
 12

### 13 *Pilots for 2021*

14  
 15 The Otolaryngology Program Directors Organization, the Society of University Otolaryngologists,  
 16 and the Association of Academic Departments in Otolaryngology created a voluntary signal  
 17 preference program in advance of the 2021 match, modeled after the preference signaling program  
 18 developed by the American Economic Association (AEA) to facilitate interview offers for  
 19 economics graduate students. In the AEA model, students can send signals to up to two employers  
 20 to indicate their interest in receiving an interview. Signals were found to increase probability of  
 21 interviews, especially for niche scenarios (e.g., an applicant whose academic and personal  
 22 background is limited to a single state or region may be viewed as unlikely to move to a different  
 23 geographic region and therefore an interview may not be offered despite excellent qualifications of  
 24 the applicant. A signal in this scenario changes the program's erroneous perception of applicant  
 25 disinterest). The otolaryngology pilot allows applicants to signal up to 5 programs. The signals will  
 26 be sent to participating programs around the time programs download applications from ERAS.  
 27 Participating programs are advised to consider signals of interest as one factor in a holistic review  
 28 of all applications and should not rely on signals to screen applications. In addition, programs  
 29 should expect many non-signaled applications from interested and highly qualified applicants.  
 30 Applicants were instructed not to signal their home institution or any programs at which they have  
 31 completed a clinical subinternship in the current calendar year, and programs were advised not to  
 32 expect to receive a signal from applicants in these scenarios.<sup>15</sup> Examining ERAS data does not  
 33 suggest a reduction in the number of applications per applicant to otolaryngology programs  
 34 compared to previous years.<sup>16</sup> It is not known publicly at this time how many programs and  
 35 applicants participated in the pilot.  
 36

37 The Association of Professors of Gynecology and Obstetrics and the Council on Resident  
 38 Education in Obstetrics and Gynecology have created the "Right Resident, Right Program, Ready  
 39 Day One" pilot program for the obstetrics and gynecology specialty. The program received a  
 40 \$1.75M grant from the AMA's Reimagining Residency Initiative. Aspects of the program include a  
 41 uniform application deadline date across all programs, limiting interview invitations to the number  
 42 of interview slots available, allowing a minimum of 72 hours for applicants to respond to an  
 43 interview invitation, and providing interview status (invited, waitlisted, or rejected) to all applicants  
 44 by November 22, 2020.<sup>17</sup> In addition, the pilot program will develop an applicant compatibility  
 45 index mobile device application that facilitates alignment between applicants' profiles and  
 46 residency program offerings, and develop additional application review metrics for programs to use  
 47 in screening. The goal is to increase transparency and efficiency in the process to reduce costs and  
 48 anxiety and ultimately to increase individuals' success in training.<sup>18</sup>

## CURRENT AMA POLICY

AMA policies related to this topic are listed in the Appendix.

## SUMMARY AND RECOMMENDATIONS

Resolution 304-I-19 contained a wide variety of requests for action, including some in which the AMA is currently engaged. The AMA continues to advocate for an increase in GME positions, innovative models of GME training, and greater accountability overall in the funding for and outcomes of GME. The AMA has studied the causes of failures to match into a residency program—as have many medical education stakeholders—and has made resources available to students that can reduce the risk of failure (again, as have many medical education stakeholders). Other actions requested in the resolution are already reflected in material and tools prepared by the AAMC and NRMP. This information, however, is not all in one location. Furthermore, availability and ease of access to known successful strategies will not help applicants who do not avail themselves of advice that runs counter to their own sense of identity as a practitioner of a particular specialty.

Current proposals in the literature to improve the process of applying to, interviewing with, and matching to residency programs include, among many, signaling program preference in the application,<sup>19</sup> multi-phase matches,<sup>20,21</sup> and capping the number of applications so that each applicant can be considered more holistically.<sup>22</sup> The recent decisions of the Federation of State Medical Boards and the National Board of Medical Examiners, and the National Board of Osteopathic Medical Examiners, to report results of the USMLE Step 1 and the COMLEX-USA Level 1 examinations, respectively, as pass/fail rather than a three-digit score will remove metrics relied on by many individual program directors and application tools as a measure easily obtained and understood, although questionable in its ability to predict clinical performance. The application and interview season for the 2021 Match presented its own challenges, as programs were encouraged to interview applicants through video to reduce exposure to COVID-19. Few programs are experienced using virtual interviews, and most that have, have used them as adjunct to in-person interviews.<sup>23</sup> Programs were also encouraged to provide more information on the type of resident they are looking for, beyond academic statistics and overused adjectives. This is essential insight for students, who need to know when making their decisions to apply as to how well they would fit a given program.

Movement is afoot to revise the current system for program application, interviewing, and matching. In the interim, key stakeholder organizations, like the NRMP and AAMC, can consolidate information that can assist students and their advisers to create effective application strategies. Those applicants without an adviser should also have easy access to such information. All applicants, however, will need to use this information rationally if the desire is to successfully match to a program without unnecessary financial cost.

The Council on Medical Education therefore recommends that the following recommendations be adopted in lieu of Resolution 304-I-19 and the remainder of this report be filed:

1. That our AMA reaffirm Policies D-310.977, “National Resident Matching Program Reform,” H-200.954, “US Physician Shortage,” and D-305.967, “The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education.” (Reaffirm HOD Policy)

- 1        2. That our AMA encourage the Association of American Medical Colleges, American  
2        Association of Colleges of Osteopathic Medicine, National Resident Matching Program,  
3        and other key stakeholders to jointly create a no-fee, easily accessible clearinghouse of  
4        reliable and valid advice and tools for residency program applicants seeking cost-effective  
5        methods for applying to and successfully matching into residency. (Directive to Take  
6        Action)

Fiscal note: \$1,000.

## APPENDIX: RELEVANT AMA POLICY

### *D-310.977, "National Resident Matching Program Reform"*

Our AMA:

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



- (13) will work with the AAMC, AOA, AACOM and the NRMP to evaluate the feasibility of a national tracking system for US medical students who do not initially match into a categorical residency program;
- (14) will discuss with the National Resident Matching Program, Association of American Medical Colleges, American Osteopathic Association, Liaison Committee on Medical Education, Accreditation Council for Graduate Medical Education, and other interested bodies potential pathways for reengagement in medicine following an unsuccessful match and report back on the results of those discussions;
- (15) encourages the Association of American Medical Colleges to work with U.S. medical schools to identify best practices, including career counseling, used by medical schools to facilitate successful matches for medical school seniors, and reduce the number who do not match;
- (16) supports the movement toward a unified and standardized residency application and match system for all non-military residencies; and
- (17) encourages the Educational Commission for Foreign Medical Graduates (ECFMG) and other interested stakeholders to study the personal and financial consequences of ECFMG-certified U.S. IMGs who do not match in the National Resident Matching Program and are therefore unable to get a residency or practice medicine.

*H-200.954, "US Physician Shortage"*

Our AMA:

- (1) explicitly recognizes the existing shortage of physicians in many specialties and areas of the US;
- (2) supports efforts to quantify the geographic maldistribution and physician shortage in many specialties;
- (3) supports current programs to alleviate the shortages in many specialties and the maldistribution of physicians in the US;
- (4) encourages medical schools and residency programs to consider developing admissions policies and practices and targeted educational efforts aimed at attracting physicians to practice in underserved areas and to provide care to underserved populations;
- (5) encourages medical schools and residency programs to continue to provide courses, clerkships, and longitudinal experiences in rural and other underserved areas as a means to support educational program objectives and to influence choice of graduates' practice locations;
- (6) encourages medical schools to include criteria and processes in admission of medical students that are predictive of graduates' eventual practice in underserved areas and with underserved populations;
- (7) will continue to advocate for funding from public and private payers for educational programs that provide experiences for medical students in rural and other underserved areas;
- (8) will continue to advocate for funding from all payers (public and private sector) to increase the number of graduate medical education positions in specialties leading to first certification;
- (9) will work with other groups to explore additional innovative strategies for funding graduate medical education positions, including positions tied to geographic or specialty need;
- (10) continues to work with the Association of American Medical Colleges (AAMC) and other relevant groups to monitor the outcomes of the National Resident Matching Program; and
- (11) continues to work with the AAMC and other relevant groups to develop strategies to address the current and potential shortages in clinical training sites for medical students.
- (12) will: (a) promote greater awareness and implementation of the Project ECHO (Extension for Community Healthcare Outcomes) and Child Psychiatry Access Project models among academic health centers and community-based primary care physicians; (b) work with stakeholders to identify and mitigate barriers to broader implementation of these models in the United States; and

(c) monitor whether health care payers offer additional payment or incentive payments for physicians who engage in clinical practice improvement activities as a result of their participation in programs such as Project ECHO and the Child Psychiatry Access Project; and if confirmed, promote awareness of these benefits among physicians.

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

1. Our AMA will actively collaborate with appropriate stakeholder organizations, (including Association of American Medical Colleges, American Hospital Association, state medical societies, medical specialty societies/associations) to advocate for the preservation, stability and expansion of full funding for the direct and indirect costs of graduate medical education (GME) positions from all existing sources (e.g. Medicare, Medicaid, Veterans Administration, CDC and others).
2. Our AMA will actively advocate for the stable provision of matching federal funds for state Medicaid programs that fund GME positions.
3. Our AMA will actively seek congressional action to remove the caps on Medicare funding of GME positions for resident physicians that were imposed by the Balanced Budget Amendment of 1997 (BBA-1997).
4. Our AMA will strenuously advocate for increasing the number of GME positions to address the future physician workforce needs of the nation.
5. Our AMA will oppose efforts to move federal funding of GME positions to the annual appropriations process that is subject to instability and uncertainty.
6. Our AMA will oppose regulatory and legislative efforts that reduce funding for GME from the full scope of resident educational activities that are designated by residency programs for accreditation and the board certification of their graduates (e.g. didactic teaching, community service, off-site ambulatory rotations, etc.).
7. Our AMA will actively explore additional sources of GME funding and their potential impact on the quality of residency training and on patient care.
8. Our AMA will vigorously advocate for the continued and expanded contribution by all payers for health care (including the federal government, the states, and local and private sources) to fund both the direct and indirect costs of GME.
9. Our AMA will work, in collaboration with other stakeholders, to improve the awareness of the general public that GME is a public good that provides essential services as part of the training process and serves as a necessary component of physician preparation to provide patient care that is safe, effective and of high quality.
10. Our AMA staff and governance will continuously monitor federal, state and private proposals for health care reform for their potential impact on the preservation, stability and expansion of full funding for the direct and indirect costs of GME.
11. Our AMA: (a) recognizes that funding for and distribution of positions for GME are in crisis in the United States and that meaningful and comprehensive reform is urgently needed; (b) will immediately work with Congress to expand medical residencies in a balanced fashion based on expected specialty needs throughout our nation to produce a geographically distributed and appropriately sized physician workforce; and to make increasing support and funding for GME programs and residencies a top priority of the AMA in its national political agenda; and (c) will continue to work closely with the Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, American Osteopathic Association, and other key stakeholders to raise awareness among policymakers and the public about the importance of expanded GME funding to meet the nation's current and anticipated medical workforce needs.
12. Our AMA will collaborate with other organizations to explore evidence-based approaches to quality and accountability in residency education to support enhanced funding of GME.

13. Our AMA will continue to strongly advocate that Congress fund additional graduate medical education (GME) positions for the most critical workforce needs, especially considering the current and worsening maldistribution of physicians.
14. Our AMA will advocate that the Centers for Medicare and Medicaid Services allow for rural and other underserved rotations in Accreditation Council for Graduate Medical Education (ACGME)-accredited residency programs, in disciplines of particular local/regional need, to occur in the offices of physicians who meet the qualifications for adjunct faculty of the residency program's sponsoring institution.
15. Our AMA encourages the ACGME to reduce barriers to rural and other underserved community experiences for graduate medical education programs that choose to provide such training, by adjusting as needed its program requirements, such as continuity requirements or limitations on time spent away from the primary residency site.
16. Our AMA encourages the ACGME and the American Osteopathic Association (AOA) to continue to develop and disseminate innovative methods of training physicians efficiently that foster the skills and inclinations to practice in a health care system that rewards team-based care and social accountability.
17. Our AMA will work with interested state and national medical specialty societies and other appropriate stakeholders to share and support legislation to increase GME funding, enabling a state to accomplish one or more of the following: (a) train more physicians to meet state and regional workforce needs; (b) train physicians who will practice in physician shortage/underserved areas; or (c) train physicians in undersupplied specialties and subspecialties in the state/region.
18. Our AMA supports the ongoing efforts by states to identify and address changing physician workforce needs within the GME landscape and continue to broadly advocate for innovative pilot programs that will increase the number of positions and create enhanced accountability of GME programs for quality outcomes.
19. Our AMA will continue to work with stakeholders such as Association of American Medical Colleges (AAMC), ACGME, AOA, American Academy of Family Physicians, American College of Physicians, and other specialty organizations to analyze the changing landscape of future physician workforce needs as well as the number and variety of GME positions necessary to provide that workforce.
20. Our AMA will explore innovative funding models for incremental increases in funded residency positions related to quality of resident education and provision of patient care as evaluated by appropriate medical education organizations such as the Accreditation Council for Graduate Medical Education.
21. Our AMA will utilize its resources to share its content expertise with policymakers and the public to ensure greater awareness of the significant societal value of graduate medical education (GME) in terms of patient care, particularly for underserved and at-risk populations, as well as global health, research and education.
22. Our AMA will advocate for the appropriation of Congressional funding in support of the National Healthcare Workforce Commission, established under section 5101 of the Affordable Care Act, to provide data and healthcare workforce policy and advice to the nation and provide data that support the value of GME to the nation.
23. Our AMA supports recommendations to increase the accountability for and transparency of GME funding and continue to monitor data and peer-reviewed studies that contribute to further assess the value of GME.
24. Our AMA will explore various models of all-payer funding for GME, especially as the Institute of Medicine (now a program unit of the National Academy of Medicine) did not examine those options in its 2014 report on GME governance and financing.
25. Our AMA encourages organizations with successful existing models to publicize and share strategies, outcomes and costs.

26. Our AMA encourages insurance payers and foundations to enter into partnerships with state and local agencies as well as academic medical centers and community hospitals seeking to expand GME.

27. Our AMA will develop, along with other interested stakeholders, a national campaign to educate the public on the definition and importance of graduate medical education, student debt and the state of the medical profession today and in the future.

28. Our AMA will collaborate with other stakeholder organizations to evaluate and work to establish consensus regarding the appropriate economic value of resident and fellow services.

29. Our AMA will monitor ongoing pilots and demonstration projects, and explore the feasibility of broader implementation of proposals that show promise as alternative means for funding physician education and training while providing appropriate compensation for residents and fellows.

30. Our AMA will monitor the status of the House Energy and Commerce Committee's response to public comments solicited regarding the 2014 IOM report, Graduate Medical Education That Meets the Nation's Health Needs, as well as results of ongoing studies, including that requested of the GAO, in order to formulate new advocacy strategy for GME funding, and will report back to the House of Delegates regularly on important changes in the landscape of GME funding.

31. Our AMA will advocate to the Centers for Medicare & Medicaid Services to adopt the concept of "Cap-Flexibility" and allow new and current Graduate Medical Education teaching institutions to extend their cap-building window for up to an additional five years beyond the current window (for a total of up to ten years), giving priority to new residency programs in underserved areas and/or economically depressed areas.

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

33. Our AMA encourages the Secretary of the U.S. Department of Health and Human Services to coordinate with federal agencies that fund GME training to identify and collect information needed to effectively evaluate how hospitals, health systems, and health centers with residency programs are utilizing these financial resources to meet the nation's health care workforce needs. This includes information on payment amounts by the type of training programs supported, resident training costs and revenue generation, output or outcomes related to health workforce planning (i.e., percentage of primary care residents that went on to practice in rural or medically underserved areas), and measures related to resident competency and educational quality offered by GME training programs.

## REFERENCES

- <sup>1</sup> Amy Mathias, personal communication. June 2020.
- <sup>2</sup> National Resident Matching Program, Results and Data: 2018 Main Residency Match®. National Resident Matching Program, Washington, DC. 2018.
- <sup>3</sup> National Resident Matching Program, Results and Data: 2019 Main Residency Match®. National Resident Matching Program, Washington, DC. 2019.
- <sup>4</sup> National Resident Matching Program, Results and Data: 2020 Main Residency Match®. National Resident Matching Program, Washington, DC. 2020.
- <sup>5</sup> Match Update: Fourth Offer Round Added To The 2021 SOAP Process. <http://www.nrmp.org/soap-fourth-round/> Accessed June 26, 2020.
- <sup>6</sup> Apply Smart for Residency. <https://students-residents.aamc.org/applying-residency/filteredresult/apply-smart-data-consider-when-applying-residency/>. Accessed June 16, 2020.
- <sup>7</sup> J. Bryan Carmody (2020) Applying Smarter: A Critique of the AAMC Apply Smart Tools. Journal of Graduate Medical Education: February 2020, Vol. 12, No. 1, pp. 10-13. <https://doi.org/10.4300/JGME-D-19-00495.1>
- <sup>8</sup> National Resident Matching Program, Data Release and Research Committee: Results of the 2020 NRMP Program Director Survey. National Resident Matching Program, Washington, DC. 2020.
- <sup>9</sup> National Resident Matching Program, Data Release and Research Committee: Results of the 2019 NRMP Applicant Survey by Preferred Specialty and Applicant Type. National Resident Matching Program, Washington, DC. 2019.
- <sup>10</sup> National Resident Matching Program, Charting Outcomes in the Match: U.S. Allopathic Seniors, 2018. National Resident Matching Program, Washington, DC 2018. [https://mk0nrmp3oyqui6wqfm.kinstacdn.com/wp-content/uploads/2019/10/Charting-Outcomes-in-the-Match-2018\\_Seniors-1.pdf](https://mk0nrmp3oyqui6wqfm.kinstacdn.com/wp-content/uploads/2019/10/Charting-Outcomes-in-the-Match-2018_Seniors-1.pdf). Accessed June 16, 2020.
- <sup>11</sup> National Resident Matching Program, Charting Outcomes in the Match: Senior Students of U.S. Osteopathic Medical Schools, 2018. National Resident Matching Program, Washington, DC 2018. <https://mk0nrmp3oyqui6wqfm.kinstacdn.com/wp-content/uploads/2018/06/Charting-Outcomes-in-the-Match-2018-Osteo.pdf>. Accessed June 16, 2020.
- <sup>12</sup> National Resident Matching Program, Charting Outcomes in the Match: International Medical Graduates, 2018. National Resident Matching Program, Washington, DC 2018. <https://mk0nrmp3oyqui6wqfm.kinstacdn.com/wp-content/uploads/2018/06/Charting-Outcomes-in-the-Match-2018-IMGs.pdf>. Accessed June 16, 2020.
- <sup>13</sup> Interactive Charting Outcomes in the Match. <https://www.nrmp.org/interactive-charting-outcomes-in-the-match/#:~:text=Interactive%20Charting%20Outcomes%20in%20the%20Match%20has%20been%20built%20using,Charting%20Outcomes%20in%20the%20Match.&text=PDF%20copies%20of%20the%202018,Residency%20Data%20and%20Reports%20page>. Accessed June 16, 2020.
- <sup>14</sup> AMA Council on Medical Education. Report 5-A-17 Options for Unmatched Medical Students.
- <sup>15</sup> Otolaryngology Preference Signaling. <https://opdo-hns.org/mpage/signaling>. Accessed January 10, 2021.

<sup>16</sup> Association of American Medical Colleges. ERAS Statistics. <https://www.aamec.org/data-reports/interactive-data/eras-statistics-data>. Accessed January 9, 2021.

<sup>17</sup> Murphy B. The Match process is packed with stress. Ob-gyns aim to fix it. <https://www.ama-assn.org/education/improve-gme/match-process-packed-stress-ob-gyns-aim-fix-it>. Accessed January 10, 2021.

<sup>18</sup> Winkel AF, Morgan HK, Burk-Rafel J, et al. A model for exploring compatibility between applicants and residency programs: Right Resident, Right Program. *Obstet Gynecol* 2021;137:164–9.DOI: 10.1097/AOG.0000000000004179.

<sup>19</sup> Whipple ME, Law AB, Bly RA. A computer simulation model to analyze the application process or competitive residency programs. *J Grad Med Educ*. 2019 Feb;11(1):30-35. doi: 10.4300/JGME-D-18-00397.1.

<sup>20</sup> Monir JG. Reforming the Match: A proposal for a new 3-phase system. *J Grad Med Educ*. 2020 Feb;12(1):7-9. doi: 10.4300/JGME-D-19-00425.1.

<sup>21</sup> Hammoud MM, Andrews J, Skochelak SE. Improving the residency application and selection process: An optional early result acceptance program. *JAMA*. 2020;323(6):503-504. doi:10.1001/jama.2019.21212.

<sup>22</sup> Weissbart SJ, Kim SJ, Feinn RS, Stock JA. Relationship between the number of residency applications and the yearly Match rate: Time to start thinking about an application limit? *J Grad Med Educ*. 2015 Mar;7(1):81-5. doi: 10.4300/JGME-D-14-00270.1.

<sup>23</sup> Wolff M, Burrows H. Planning for virtual interviews: Residency recruitment during a pandemic. *Acad Pediatr*. 2021;21:24–31.

REPORT 4 OF THE COUNCIL ON MEDICAL EDUCATION (June 2021)  
Expediting Entry of Qualified IMG Physicians to U.S. Medical Practice  
(Resolution 308-I-19)  
(Reference Committee C)

EXECUTIVE SUMMARY

International medical graduates (IMGs) currently represent a quarter of the physician workforce and physicians-in-training in the United States. They have long been an integral part of the U.S. health care system, contributing substantially to primary care disciplines and providing care to underserved populations, and their foreign language proficiency can be invaluable when communicating with patients from the same country of origin. The diversity of IMGs contributes to the many ethnicities and cultures represented in the health care workforce. This diversity is likely to be a factor enhancing health outcomes, considering the equally diverse nature of the U.S. patient population. In addition, IMGs are serving on the front lines of patient care during the COVID-19 pandemic.

IMGs are subject to the same rigorous credentialing standards as any other U.S. physician, which assures the quality of the medical workforce and protects the public. That said, some licensing regulations, such as attaining source documents to verify one's medical education or other schooling, may be more challenging for IMGs than for physicians who graduated from medical schools in the U.S. Improving and streamlining licensing and credentialing policies and processes, where appropriate, can ensure that IMGs can help address health care inequities and improve health care access through service in federally designated health care shortage areas.

The goal of this report, which is in response to American Medical Association (AMA) House of Delegates (HOD) Policy D-255.978, "Study Expediting Entry of Qualified IMG Physicians to U.S. Medical Practice," is to "study and make recommendations for the best means for evaluating, credentialing, and expediting entry of competently trained international medical graduate (IMG) physicians of all specialties into medical practice in the USA."

This report provides information on state legislatures that have begun to implement strategies to assist IMGs with credentialing, licensure, and certification requirements in order to increase access to primary care in rural and underserved areas. This report also provides information on AMA efforts to assist non-U.S. citizen IMGs, who are severely restricted as to where they can practice under the terms of their visas. This includes some physicians who could not work as a result of being furloughed when the facilities at which they were working closed.

The AMA continues to assist IMGs through its International Medical Graduates Section and advocacy efforts. New models, such as those described in this report, may enable physicians to be credentialed and licensed in a more efficient and timely manner in an effort to address national or international pandemics or medical emergencies at a state or regional level. The Council on Medical Education believes that states remain best positioned to evaluate the relative success of these programs in addressing their needs. In addition, successful efforts to reduce medical licensing barriers should be shared as best practices across states.

## REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 4-JUN-21

Subject: Expediting Entry of Qualified IMG Physicians to U.S. Medical Practice  
(Resolution 308-I-19)

Presented by: Liana Puscas, MD, MHS, Chair

Referred to: Reference Committee C

---

American Medical Association (AMA) House of Delegates (HOD) Policy D-255.978, “Study Expediting Entry of Qualified IMG Physicians to U.S. Medical Practice,” asks that our AMA “study and make recommendations for the best means for evaluating, credentialing, and expediting entry of competently trained international medical graduate (IMG) physicians of all specialties into medical practice in the USA.” This report is in response to that policy.

### INTRODUCTION

There is a projected shortage of physicians in the United States, given the aging of the present physician and general civilian populations, as well as potential and ongoing crisis situations, such as the COVID-19 pandemic, which has spiked the need for patient care and hospital beds across the country.<sup>1</sup> Compared with U.S. medical school graduates, IMGs provide care to a disproportionate number of socioeconomically disadvantaged patients, and certain states and specialties disproportionately depend on these physicians. IMGs represent nearly one-quarter of the U.S. physician workforce. They often practice at institutions that are on the front line of the COVID-19 pandemic, and these physicians play a critical role in providing health care in areas of the country with higher rates of poverty and chronic disease. Appendix A displays the U.S. map indicating medically underserved areas/populations (MAU/P) and practicing IMGs by state.

The continued steady influx of immigrants from strife-torn regions of the world to the U.S. includes highly trained physicians fleeing their country because of political or religious persecution. These immigrant physicians may have beneficial skills, such as professional experience and language proficiency. However, IMGs often face licensing barriers beyond those of physicians who graduated from a U.S. medical school. IMGs often are required to repeat complete cycles of training, including medical school, residency, and subspecialty training. This report provides information on state legislatures that have begun to implement strategies to assist IMGs with credentialing, licensure, and certification requirements in order to increase access to primary care in rural and underserved areas.

This report also provides information on AMA efforts to assist non-U.S. citizen IMGs, who are severely restricted as to where they can practice under the terms of their visas. This includes some physicians who could not work as a result of being furloughed when the facilities at which they were working closed.



## CREDENTIALING REQUIREMENTS

Certification by the Educational Commission for Foreign Medical Graduates (ECFMG) is the standard for evaluating the qualifications of IMGs before they enter U.S. residency and fellowship programs accredited by the Accreditation Council for Graduate Medical Education (ACGME). ECFMG requirements include examinations in the medical sciences, evaluation of English language proficiency, and documentation of medical education credentials.<sup>2</sup>

Non-U.S. citizen IMGs who seek entry into U.S. graduate medical education (GME) programs must obtain a visa permitting clinical training to provide medical services. The ECFMG / Foundation for Advancement of International Medical Education and Research Exchange Visitor Sponsorship Program (EVSP) serves as the visa sponsor for approximately 12,000 IMGs at teaching hospitals in the U.S.<sup>3-4</sup> All non-U.S. citizen IMGs enter the U.S. in one of two broad immigration categories—either under a temporary, nonimmigrant visa or as a permanent resident. The two most common temporary, nonimmigrant classifications for IMGs are the J-1 Exchange Visitor program and the H-1B temporary worker classification. Both classifications limit a physician's duration of residence in the U.S. and impose strict controls over the range of employment authorized. In contrast, permanent residence provides a foreign national with both an unlimited duration of residence in the U.S. and authorization of full, unrestricted employment. However, the lead time required to qualify for permanent residence status is usually substantially longer than the lead time required to obtain temporary worker status.<sup>4</sup> Additional information about visa options for IMGs is provided in Appendix B.

Certification from the ECFMG is a requirement for medical licensing, and it is a prerequisite for taking the United States Medical Licensing Examination (USMLE) Step 3. However, state licensure requirements vary from state to state.<sup>5</sup> All state licensing jurisdictions require IMGs to complete at least one year of accredited U.S. or Canadian GME before licensure. However, 21 states require two years, and 27 states require three years of accredited GME.<sup>5</sup>

Some states issue limited, restricted licenses that allow IMGs who have not entered U.S. GME to practice in the U.S. under supervision and in specific institutions. To qualify, IMGs must have been trained in a specialty and practiced medicine abroad. After immigrating to the U.S., these physicians have been able to establish themselves in an institution, despite being ineligible for full licensure. (Refer to CME Report 2, June 2021, "Licensure for International Medical Graduates Practicing in U.S. Institutions with Restricted Medical Licenses," for more information about states that issue restricted licenses.)

Many institutions also require that physicians be board-certified or board eligible. However, it is the policy of the American Board of Medical Specialties (ABMS) that to be eligible for certification in any specialty or subspecialty and to maintain certification a physician must: 1) complete ACGME-accredited or Royal College of Physicians and Surgeons of Canada (RCPSC)-accredited GME; and 2) hold a full and unrestricted license to practice medicine in at least one jurisdiction in the U.S., its territories, or Canada. Some of the ABMS member boards recognize alternative pathways that may meet eligibility requirements for initial board certification for candidates who have not completed U.S. or Canadian-accredited GME.

Recognized alternative pathways for international trainees that may meet eligibility requirements include Canadian and international training. Twenty ABMS member boards accept all of a candidate's training in Canada (either accredited by the RCPSC or by another body acceptable to the board) and of these, seven further require that a candidate be certified by the RCPSC or other Canadian certifying body. Three boards will accept some of a candidate's training in Canada

(either accredited by the RCPSC or by another body acceptable to the board). Fifteen boards offer pathways for non-Canadian internationally trained physicians. Of these, nine boards offer pathways for physicians practicing in the U.S. at an ACGME-accredited institution who are faculty at an ACGME-accredited program and may have achieved a specified academic rank (from associate to full professor). Two boards will accept international training as meeting all training requirements on a case-by-case basis, and four boards will accept international training as meeting some of the training requirements on a case-by-case basis. (Refer to CME Report 2, June 2021, “Licensure for International Medical Graduates Practicing in U.S. Institutions with Restricted Medical Licenses,” for more information about board certification pathways.)

On January 26, 2021, the Federation of State Medical Boards (FSMB) and National Board of Medical Examiners (NBME), co-sponsors of the USMLE, [announced](#) the discontinuation of work to relaunch a modified Step 2 Clinical Skills examination (Step 2 CS) and henceforth the discontinuation of Step 2 CS, while continuing to seek innovative and sensible ways to assess medical licensing eligibility. ECFMG continues to oversee requirements for its certification of IMGs and [announced](#) an expansion of its pathways allowing qualified IMGs to meet the requirements for ECFMG Certification and continue to pursue U.S. graduate medical education.

#### AMA ADVOCACY ACTIVITIES DURING COVID-19 RELATED TO IMGs

The AMA has been especially active in its federal level advocacy efforts on behalf of IMG physicians during the COVID-19 pandemic. Some of the areas in which AMA advocacy has been most significant include visas, labor condition applications, work surrounding last year’s presidential proclamations, and the HEROES Act.

##### *Visa Processing, Allocation, and Extensions*

On March 20, 2020, U.S. Citizenship and Immigration Services (USCIS) suspended premium processing for visas. As such, IMG physicians were concerned about being able to obtain visas in a timely manner. In response, on March 24, 2020, the AMA sent a [letter](#) to USCIS urging USCIS to reconsider the suspension and instead expand premium processing for H-1B visas. USCIS reopened its offices and resumed citizenship ceremonies in June 2020. Additionally, it restarted premium processing for certain visa petitions, including H-1B visas, in phases throughout June. Moreover, companies were allowed request accelerated processing for immigrant worker visas, and employers who had pending H-1B temporary worker visas could ask for their applications to be fast-tracked. Per the [USCIS website](#), premium processing for H-1B visa holders is available.

As the severity of the COVID-19 pandemic increased, embassies and consulates around the world stopped processing visas, including J-1 physician visas. As such, J-1 physicians were concerned that they would not be able to obtain or maintain a valid visa. Additionally, due to visa restrictions, J-1 physicians were concerned about being able to continue their training during the pandemic. In response, the AMA sent a [letter](#) to the U.S. Department of State (DoS) and the U.S. Department of Homeland Security (DHS) requesting opening of visa processing at embassies and consulates for physicians joining U.S. residency programs on July 1, 2020. Additionally, the AMA requested that J-1 physicians be allowed to engage in extended training activities and asked for confirmation concerning J-1 physician redeployment to new rotations to respond to the pandemic. As a result of AMA advocacy, in concert with ECFMG, the DoS agreed to begin [processing visa applications](#) for foreign-born medical professionals and announced that J-1 physicians may consult with their program sponsor to extend their programs in the U.S. The AMA also confirmed that J-1 physicians can engage in revised clinical training rotations/assignments, in keeping with the ACGME’s [“Response to Pandemic Crisis.”](#)

1 IMG physicians were also concerned about alterations in work schedules and the visa  
2 consequences of being laid off due to the impact of the COVID-19 pandemic. To help ease these  
3 concerns, on April 14, 2020, the AMA sent a [letter](#) urging USCIS to recognize the COVID-19  
4 pandemic as an extraordinary circumstance beyond the control of non-U.S. citizen IMG applicants  
5 or their employers. The AMA consequently asked to expedite approvals of extensions and changes  
6 of status for non-U.S. citizen IMGs practicing, or otherwise lawfully present, in the U.S. In  
7 addition, the AMA urged the Administration to extend the 60-day maximum grace period to a 180-  
8 day grace period to allow any non-U.S. citizen IMG who had been furloughed or laid off as a result  
9 of the pandemic to remain in the U.S. and find new employment. Moreover, the AMA asked  
10 USCIS to protect the spouses and dependent children of H-1B physicians by automatically granting  
11 a one-year extension of their H-4 visas. Due in part to the advocacy efforts of the AMA, USCIS  
12 [announced](#) that it is temporarily waiving certain immigration consequences for failing to meet the  
13 full-time work requirement due to quarantine, illness, travel restrictions, or other consequences of  
14 the pandemic.

15  
16 Throughout the pandemic, the AMA has not lost sight of the need for long term policy change,  
17 especially change surrounding the need for an increase in visas for additional physicians. As such,  
18 on May 8, 2020, the AMA sent letters to the U.S. [House of Representatives](#) and the U.S. [Senate](#)  
19 supporting the “Healthcare Workforce Resilience Act” and urging the Congress to quickly pass the  
20 legislation so that the U.S. can recapture 15,000 unused employment-based physician immigrant  
21 visas from prior fiscal years. The bill was not enacted.

#### 22 23 *Labor Condition Applications*

24  
25 Labor Condition Application restrictions have made it difficult for IMGs to practice in areas where  
26 they are most needed during the pandemic. As such, on April 3, 2020, the AMA wrote a [letter](#) to  
27 then Vice President Pence and USCIS urging the Administration to permit non-citizen IMG  
28 physicians currently practicing in the U.S. with an active license and an approved immigrant  
29 petition to apply and quickly receive authorization to work at multiple locations and facilities, with  
30 a broader range of medical services, for the duration of the COVID-19 pandemic. The AMA also  
31 urged the Administration to expedite work permits and renewal applications for all IMG physicians  
32 who are beginning their residencies or fellowships or are currently in training. Due in part to the  
33 advocacy efforts of the AMA, USCIS [announced](#) that IMGs can deliver telehealth services during  
34 the current public health emergency without having to apply for a new or amended Labor  
35 Condition Application. At the time of the writing of this report, the AMA is not planning additional  
36 follow up on the Labor Condition Application.

#### 37 38 *Presidential Proclamation*

39  
40 As a result of the April 22, 2020 Presidential [Proclamation, Suspending Entry of Immigrants Who](#)  
41 [Present Risk to the U.S. Labor Market During the Economic Recovery Following the COVID-19](#)  
42 [Outbreak](#), the AMA sent a [letter](#) to then-Vice President Pence urging the Administration to allow  
43 IMGs with J-1, H-1B, and O-1 (individuals with extraordinary ability or achievement) visas to be  
44 exempt from any future immigration bans or limitations, so that these physicians can maintain their  
45 lawful non-immigrant status while responding to the pandemic.

46  
47 On June 22, 2020, President Trump issued a [Proclamation, Suspending Entry of Aliens Who](#)  
48 [Present a Risk to the U.S. Labor Market Following the Coronavirus Outbreak](#). In response to the  
49 proclamation, the DoS issued a [statement](#) that “as resources allow, embassies and consulates may  
50 continue to provide emergency and mission-critical visa services. Mission-critical immigrant visa  
51 categories include applicants who may be eligible for an exception under these presidential

proclamations, such as...certain medical professionals.” As such, on June 26, 2020, the AMA sent a [letter](#) to the DHS and the DoS strongly urging the Administration to consider J-1 and H-1B IMGs and their families’ entry into the U.S. to be in the national interest of the country, so that families could remain together and IMG physicians could immediately begin to provide health care services to U.S. patients. The AMA understands that every physician is mission-critical, especially at this time.

Moreover, on July 8, 2020, the AMA initiated a sign-on [letter](#) for medical specialty societies. The letter urges the DoS and DHS to issue clarifying guidance pertaining to the June 22, 2020, proclamation by directing Consular Affairs to advise embassies and consulates that H-1B physicians and their dependent family members’ entry into the U.S. is in the national interest.

During his first day in office, President Biden issued a [Proclamation on Ending Discriminatory Bans on Entry to The United States](#) to revoke Executive Order 13780 of March 6, 2017 (Protecting the Nation From Foreign Terrorist Entry Into the United States), Proclamation 9645 of September 24, 2017 (Enhancing Vetting Capabilities and Processes for Detecting Attempted Entry Into the United States by Terrorists or Other Public-Safety Threats), Proclamation 9723 of April 10, 2018 (Maintaining Enhanced Vetting Capabilities and Processes for Detecting Attempted Entry Into the United States by Terrorists or Other Public-Safety Threats), and Proclamation 9983 of January 31, 2020 (Improving Enhanced Vetting Capabilities and Processes for Detecting Attempted Entry Into the United States by Terrorists or Other Public-Safety Threats).

On January 25, 2021, President Biden issued a [Proclamation on the Suspension of Entry as Immigrants and Non-Immigrants of Certain Additional Persons Who Pose a Risk of Transmitting Coronavirus Disease](#) to further examine certain current public health precautions for international travel and take additional appropriate regulatory action, to the extent feasible and consistent with Centers for Disease Control and Prevention guidelines and applicable law.

#### *HEROES Act*

H.R. 6800, the “Health and Economic Recovery Omnibus Emergency Solutions Act” (HEROES ACT), is the U.S. House of Representatives’ next proposed coronavirus relief fund package and incorporates many of the IMG advocacy requests, including authorization of the Conrad 30 Program, expedited visa processing, and employment authorization cards for IMGs. For more information, see [sections](#) 191201 and 191204 of the HEROES Act or the AMA HEROES Act [Summary](#). The AMA has worked with members of the U.S. House of Representatives to help ensure that favorable measures for IMGs are included in this proposed legislation. At the time of the writing of this Council report, the HEROES ACT had been passed in the House and was sent to the Senate. It was assigned to the Committee on Small Business and Entrepreneurship and hearings were held but no action was taken. The Continuing [Appropriations Act](#) (H.R. 8337) was passed; however, it had very little in it concerning IMGs. The most recent stimulus bill, the [American Rescue Plan](#), does not include anything related to IMGs.

#### *Additional Rule Changes*

In the latter part of 2020, the AMA commented on related rule changes/proposed rule changes. Information regarding these rules and comments are located in Appendix C.

## 1 *IMG Resource Guide*

2  
3 Due to the uncertainty that IMGs are experiencing during this time, the AMA has created an IMG  
4 resource guide, [“FAQs: Guidance for international medical graduates during COVID-19.”](#) This  
5 guide answers some of the most pressing questions IMGs have surrounding their ability to practice  
6 and visas. It also lists available resources for assistance.  
7

## 8 REVISIONS TO STATE LICENSURE REQUIREMENTS DURING COVID-19

9  
10 In areas where physicians were acutely needed to address the needs of the patient surges during the  
11 pandemic, state agencies created stratification processes for those non-U.S. citizen IMG physicians  
12 most easily integrated into the system. These were IMGs working under direct supervision of  
13 licensed physicians and identified on the basis of education, training, certification as a medical  
14 specialist, English proficiency, and experience in direct patient care in countries other than the U.S.  
15 For example, in 2020 the New Jersey Division of Consumer Affairs had been authorized to issue  
16 temporary state medical licenses to IMGs who are licensed and in good standing in other countries,  
17 along with other workforce measures. In January 2021, it was announced they were no longer  
18 accepting new applications and pending applications were put on hold per review of the program.<sup>6</sup>  
19 In New York, a March 23, 2020 executive order from Governor Cuomo allows non-US citizen  
20 IMGs who are not licensed in the state but have completed at least one year of GME in the U.S., to  
21 provide patient care in hospitals, under the supervision of a New York State-licensed and registered  
22 physician, by way of a limited permit. This order was extended until May 6, 2021.<sup>7-8</sup>  
23

## 24 PROGRAMS THAT SERVE AS MODELS FOR ACCELERATED TRAINING AND 25 CREDENTIALING

26  
27 Programs such as the National Health Service (NHS) of Scotland show it is possible to retrain  
28 immigrant physicians in 18 to 24 months, and that these physicians are able to demonstrate  
29 proficiency in language, medicine, and the culture of the host country. Immigrant physicians in  
30 Scotland who have been retrained on an accelerated path and who have demonstrated proficiency  
31 in language, medicine, and Scottish culture are obligated by the NHS of Scotland to practice in the  
32 NHS specific areas of need.<sup>9</sup>  
33

34 Similarly, the following states are studying and developing pathways for qualified IMGs to  
35 expeditiously enter practice in the U.S.  
36

### 37 *Minnesota*

38  
39 The Minnesota Department of Health (MDH) has supported the integration of IMGs through the  
40 state’s International Medical Graduate Assistance Program.<sup>10</sup> As the first program of its kind in the  
41 U.S., the Minnesota Legislature established this program in 2015 to address barriers to practice and  
42 facilitate pathways for immigrant IMGs to integrate into the Minnesota health care delivery system,  
43 with the goal of increasing access to primary care in rural and underserved areas of the state. It has  
44 achieved considerable success, including forming grant agreements with nonprofits to provide  
45 career support to IMGs and working with residency directors to carve out pathways for IMGs to  
46 demonstrate the clinical expertise required to enter into residency programs. The program requires  
47 that participants be legal residents who have lived in Minnesota for at least two years, graduated  
48 from an accredited medical school outside the U.S., and are willing to practice primary care in the  
49 state’s underserved communities in rural and urban areas.



In its [2018 report](#), the MDH reported that the program has developed a database comprised of immigrant IMG physicians in Minnesota. The program also identified barriers to residency, and it is taking steps to address those barriers with the following interventions: funding dedicated residency positions for immigrant IMGs, supporting clinical readiness assessment and preparation programs, and providing career guidance and support. The MDH report includes data on IMGs who received career guidance and support as well as those who were selected by the University of Minnesota Medical School to participate in the clinical experience component, which began in September 2017.

The MDH met with the Minnesota Board of Medical Practice and other stakeholders to study possible changes to the Medical Practice Act. The group proposed two possible strategies: an IMG Primary Care Integration License and an amendment to the Medical Practice Act, which would include an exemption for practicing primary care in a rural or underserved area. As noted in the 2018 MDH report, the creation of this alternate license would be beneficial because it would allow objectively qualified IMGs into the system quickly to address issues of health disparities and primary care shortages. It would not require additional residency positions and thus would be cost-effective. The process would require that IMGs pass all licensure exams, demonstrate previous work of at least seven years in medical practice, participate in a six-month clinical experience, and undergo an assessment. This process would culminate in a certificate allowing work under supervision.

Implementation of this proposal raised several concerns. This effort is based on identifying and securing the commitment of an accredited assessor. In addition, these IMGs would not be eligible for board certification and may encounter employment restrictions. Key stakeholders, including the Minnesota Medical Association and Minnesota Academy of Physician Assistants, have raised objections, citing concerns over a tiered licensure system and professional role confusion. The MDH continues to research possible licensure changes.<sup>11-13</sup>

#### THE CONRAD 30 J-1 VISA WAIVER

IMGs who graduate from U.S. residency and fellowship programs may be in search of hospitals and practice groups that will support them in continuing their careers in the U.S. If these physicians held a J-1 Exchange Visitor visa during their GME in the U.S., they are required to return to their home countries for a two-year period before they can continue their careers in the U.S., but this provision can be waived in specific instances. One common way to do so is through the Conrad 30 Program, whereby a hospital or health center makes an application to a state department of health, requesting that the two-year home residency requirement be waived in exchange for the physician's three years of service in a medically underserved or health professional shortage area. The program currently allows for 30 waivers per state per year. However, the details of this annual program differ by state. States collectively recruit approximately 800 to 1,000 IMGs annually through the Conrad 30 program to practice in underserved communities.<sup>17</sup>

A study conducted by the Washington, Wyoming, Alaska, Montana, Idaho (WWAMI) Rural Health Research Center, University of Washington, showed that Conrad 30 program staff generally valued the J-1 visa waiver as one of several important tools for recruitment of physicians to rural and underserved communities.<sup>17</sup> Since at least 2013, there have been efforts to make the Conrad 30 J-1 visa waiver program for physicians permanent; as this has yet to occur, it has been necessary to reauthorize the program every year. In 2019, bill was introduced in Congress to improve and extend the program until 2021—the *Conrad State 30 and Physician Access Reauthorization Act*.<sup>18</sup> The bill was not enacted.

The AMA has been vocal in its support for the Conrad 30 program over the years. Recently, the AMA worked with U.S. Senator Amy Klobuchar and a bipartisan list of other U.S. Senators to show the impact of the Administration's immigration policy changes during the pandemic to IMGs, reiterating the value of the Conrad 30 program and the need for its reauthorization.

## RELEVANT AMA POLICY

The AMA has extensive policy regarding the requirements to practice medicine in the United States. AMA Policy H-255.983 states that "the AMA continues to support the policy that all physicians and medical students should be evaluated for purposes of entry into graduate medical education programs, licensure, and hospital medical staff privileges on the basis of their individual qualifications, skills, and character." Policy H-275.934 (2) states, "All applicants for full and unrestricted licensure, whether graduates of U.S. medical schools or international medical graduates, must have completed one year of accredited graduate medical education (GME) in the U.S., have passed all licensing examinations (USMLE or COMLEX USA), and must be certified by their residency program director as ready to advance to the next year of GME and to obtain a full and unrestricted license to practice medicine." Policy H-255.966 (1.D.) notes, "U.S. states and territories retain the right and responsibility to determine the qualifications of individuals applying for licensure to practice medicine within their respective jurisdictions." Policy H-255.985 (1) states, "Any United States or alien graduate of a foreign health professional education program must, as a requirement for entry into graduate education and/or practice in the United States, demonstrate entry-level competence equivalent to that required of graduates of United States programs." Policy H-255.988 states that the AMA "continues to support the activities of the ECFMG related to verification of education credentials and testing of IMGs."

At the Special Meeting of the AMA House of Delegates in November 2020, Policy D-275.950 "Retirement of the National Board of Medical Examiners Step 2 Clinical Skills Exam for US Medical Graduates: Call for Expedited Action by the American Medical Association" was adopted. In part it asks that the AMA "in collaboration with the Educational Commission for Foreign Medical Graduates (ECFMG), advocate for an equivalent, equitable, and timely pathway for international medical graduates to demonstrate clinical skills competency." Other related policies are shown in Appendix D.

## SUMMARY AND RECOMMENDATIONS

IMGs currently represent a quarter of the physician workforce and physicians-in-training. They have long been an integral part of the U.S. health care system, contributing substantially to primary care disciplines and providing care to underserved populations. The diversity of IMGs contributes to the many ethnicities and cultures represented in the health care workforce.<sup>19</sup> This is likely to be a factor enhancing health outcomes, considering the equally diverse nature of the U.S. patient population. In addition, IMGs are serving on the front lines of patient care during the COVID-19 pandemic.

IMGs are subject to the same rigorous credentialing standards as any other U.S. physician, but some licensing regulations may be more challenging for IMGs than for U.S.-educated physicians. There are, however, ways to improve and streamline licensing and credentialing policies and processes to ensure that IMGs can be recruited to federally designated health care shortage areas to address health care inequities and improve health care access. The AMA continues to assist IMGs through its International Medical Graduates Section and advocacy efforts. Proposed and enacted state models, such as those described in this report, may enable physicians to be quickly credentialed and licensed in an effort to address national or international pandemics or state/

1 regional medical emergencies. States remain best positioned to evaluate the relative success of  
2 these programs in addressing their needs; however successful efforts to reduce medical licensing  
3 barriers should be shared among state licensing boards as best practices.

4  
5 The Council on Medical Education therefore recommends that the following recommendations be  
6 adopted and that the remainder of the report be filed:

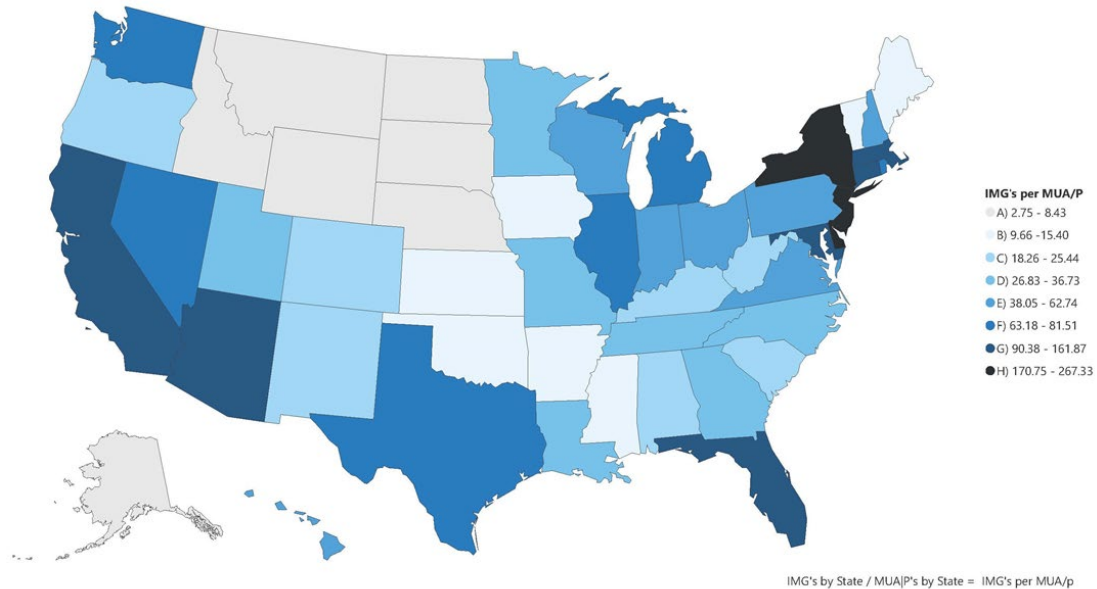
- 7  
8 1. That American Medical Association (AMA) Policy D-255.980 (1), “Impact of Immigration  
9 Barriers on the Nation’s Health,” that reads, “Our AMA recognizes the valuable contributions  
10 and affirms our support of international medical students and international medical graduates  
11 and their participation in U.S. medical schools, residency and fellowship training programs and  
12 in the practice of medicine” be reaffirmed. (Reaffirm HOD Policy)  
13  
14 2. That our AMA encourage states to study existing strategies to improve policies and processes  
15 to assist IMGs with credentialing and licensure to enable them to care for patients in  
16 underserved areas. (Directive to Take Action)  
17  
18 3. That our AMA encourage the Federation of State Medical Boards and state medical boards to  
19 evaluate the progress of programs aimed at reducing barriers to licensure—including successes,  
20 failures, and barriers to implementation. (Directive to Take Action)  
21  
22 4. That Policy D-255.978, “Study Expediting Entry of Qualified IMG Physicians to US Medical  
23 Practice,” be rescinded, as having been fulfilled by this report. (Rescind HOD Policy)

Fiscal Note: \$1,000.



## Appendix A. U.S. map indicating medically underserved areas/populations (MAU/P) and practicing IMGs by state

IMG's per MUA/P by State



Data sources;

Health Resources & Services Administration (HRSA), Medically Underserved Areas/Populations (MUA/P) data: 2021. Available at: <https://data.hrsa.gov/maps/map-tool/>. Accessed 1-14-21.

Association of American Medical Colleges (AAMC), 2019 State Physician Workforce Data Report. Available at: <https://www.aamc.org/data-reports/workforce/report/state-physician-workforce-data-report>. Accessed 1-12-21.

Map created with Microsoft Power BI.

**Appendix B. Visa Options for Non-U.S. Citizen International Medical Graduate Physicians**

<b>Visa Option</b>	<b>Purpose</b>	<b>Requirements</b>
J-1 Exchange Visitor program <sup>1-2</sup>	<p>Intended to provide a broad range of foreign nationals with educational, employment, and training opportunities in the U.S. Allows International Medical Graduate (IMG) physicians to attend residency and fellowship programs in the U.S.</p> <p><i>Physicians wishing to stay in the U.S. after completion of training (or applying for a Green Card), must first return to their home country for a period of two years.</i></p>	<p>Educational Commission for Foreign Medical Graduates (ECFMG) Certification* including:</p> <ol style="list-style-type: none"> <li>1. Passage of United States Medical Licensing Examination (USMLE) Steps 1 and 2 examinations or the Visa Qualifying Examination (VQE) prepared by the National Board of Medical Examiners, and administered by the ECFMG to establish medical competence</li> <li>2. Passage of the ECFMG English language examination</li> <li>3. Possession of an MD degree** from a foreign medical school listed in the International Medical Education Directory of the Foundation for Advancement of International Medical Education and Research (FAIMER®)</li> </ol> <p>A statement of need from the government of the country of the physician's nationality or last legal permanent residence to provide written assurance to the Secretary of Health and Human Services of the need in that country for persons with the skills the physician seeks to acquire and that the physician has filed a written assurance with the government of this country that he/she will return upon completion of the training</p> <p>An agreement or contract from a U.S. accredited medical school, an affiliated hospital, or a scientific institution to provide the accredited graduate medical education (GME), signed by the physician and the official responsible for the training</p> <p><i>Upon entry to the U.S., an IMG is authorized to pursue GME training for a period of up to seven years. Each year, the training program in conjunction with the IMG must file an extension application with the ECFMG.</i></p>
J-1 Waiver <sup>3</sup>	<p>Can be granted for the J-1 two-year requirement.</p> <p><i>The most common waiver options are those granted by: 1) obtaining an official recommendation from an interested government agency in need of the physician's services, or 2) through the</i></p>	<p>Grounds under law to obtain a waiver of home residence obligation:</p> <ul style="list-style-type: none"> <li>• If the physician will suffer from persecution in his/her home country or country of last permanent residence</li> <li>• If fulfillment of the two-year home residence obligation will subject a U.S.</li> </ul>

	<i>Conrad 30 Waiver Program offered by states in exchange for three years of service in a qualifying medically underserved area.</i>	<p>citizen spouse or child to exceptional hardship</p> <ul style="list-style-type: none"> <li>Based on a recommendation issued by a government agency interested in the physician's continued residence or employment in the U.S.</li> </ul>
H-1B Temporary Worker classification <sup>4</sup>	<p>Enables a foreign national to enter the U.S. to accept professional level employment for a period of up to six years.</p> <p><i>IMG physicians must have an existing job offer for full-time employment with a U.S. employer. This can be a hospital, university, clinic, a doctor's office, or an assisted living community.</i></p>	<p>A certified Labor Condition Application covering each location where the physician will perform services as required under Department of Labor regulations</p> <p>Completion of a medical degree from either a U.S. based school or an acceptable school in a foreign country</p> <p>Possession of a full, unrestricted state medical license or the "appropriate authorization" for the position</p> <p>Completion of the USMLE (Steps I, II, and III) or be eligible for the limited exceptions to this requirement</p> <p>English language competence as established through graduation from an accredited medical school or by passing the ECFMG English language examination</p>
O-1 Visa: Individuals with Extraordinary Ability or Achievement <sup>5</sup>	<p>Option for well-established doctors who are looking to come to the U.S. to practice.</p> <p><i>Significant amount of documentation needed to qualify</i></p>	<p>Must demonstrate (through awards, publications, or other evidence) extraordinary accomplishments in the medical field</p> <p>The position for which the physician is going to work must require someone with well-above average skills and experience</p> <p>Abilities must be corroborated with consultation letters (detailed letters of recommendation) from other respected experts in the applicant's specific field</p> <p>May be exempted from the USMLE examination requirement (some state medical boards may still require USMLE passage)</p>

\*All IMGs, regardless of country of citizenship, are required to complete ECFMG Certification to be eligible for J-1 visa sponsorship for clinical GME in the U.S. The location of the medical school, not the citizenship of the physician, determines whether the graduate is an IMG. U.S. and Canadian citizens who graduate from medical schools located outside the U.S. and Canada are considered IMGs and must be certified by ECFMG.<sup>1</sup>

\*\*The [ECFMG Reference Guide for Medical Education Credentials](#) lists the exact name of the final medical diploma that these applicants must have earned (and must provide).

1. Exchange Visitor Sponsorship Program (EVSP). Educational Commission for Foreign Medical Graduates. Available at: <https://www.ecfm.org/evsp/> (Accessed 7-20-20).
2. Exchange Visitor Program. U.S. Department of State. Available at: <https://j1visa.state.gov/programs> (Accessed 7-16-20).
3. Waiver of the Exchange Visitor Two-Year Home-Country Physical Presence Requirement. U.S. Department of State-Bureau of Consular Affairs. Available at: <https://travel.state.gov/content/travel/en/us-visas/study/exchange/waiver-of-the-exchange-visitor.html> (Accessed 7-20-20).
4. H-1B Specialty Occupations, DOD Cooperative Research and Development Project Workers, and Fashion Models. U.S. Citizenship and Immigration Services. Available at: <https://www.uscis.gov/working-united-states/temporary-workers/h-1b-specialty-occupations-dod-cooperative-research-and-development-project-workers-and-fashion-models> (Accessed 7-16-20).
5. O-1 Visa: Individuals with Extraordinary Ability or Achievement. U.S. Citizenship and Immigration Services. Available at: <https://www.uscis.gov/working-united-states/temporary-workers/o-1-visa-individuals-extraordinary-ability-or-achievement> (Accessed 7-20-20).

## Appendix C. Rule Changes/ Proposed Rule Changes

### J-1's

- In October 2020, the U.S. Department of Homeland Security (DHS) released a proposed rule titled “[Establishing a Fixed Time Period of Admission and an Extension of Stay Procedure for Nonimmigrant Academic Students, Exchange Visitors, and Representatives of Foreign Information Media](#).” The proposed administrative change to eliminate “duration of status” as an authorized period of stay would significantly disrupt the medical specialty and subspecialty training of thousands of foreign national physicians in the United States in J-1 visa status, which in turn will have severe implications for patient care.
- DHS is proposing to eliminate the duration of status in favor of only admitting J-1 physicians until the program end date noted in their Form I-20 or DS-2019, not to exceed four years, unless they are subject to a more limited two-year admission, plus a period of 30 days following their program end date. Individuals who need time beyond their period of admission would have to timely file a complete extension of stay (EOS) with U.S. Citizenship and Immigration Services (USCIS) before their prior admission expires. As such, under the proposed rule, J-1 physicians applying for EOS would need to file a Form I-539 with the required fee, provide biometrics, and possibly undergo an interview. While the rule provides an admission period of two to four years, this timeframe will not be applicable to J-1 physicians because they are required to undergo an annual application process.
  - On October 23, 2020, the AMA [commented](#) on a DHS proposed rule concerning “Establishing a Fixed Time Period of Admission and an Extension of Stay Procedure for Nonimmigrant Academic Students, Exchange Visitors, and Representatives of Foreign Information Media.”
  - The AMA urged DHS to withdraw the proposed rule as it relates to J-1 IMGs.
  - The AMA signed onto two letters, one that was circulated around the [Hill](#) and one that was submitted as a [formal comment](#) that asked that IMGs be exempt from the proposed rule.
  - The AMA spearheaded a [letter](#) that was sent by Representatives Brad Schneider (D-IL), Abby Finkenauer (D-IA), and David McKinley (R-WV) to the Department of Homeland Security (DHS) in opposition to the regulatory changes to duration of status for J-1 physicians. The letter also opposes the regulation because it will disrupt the Conrad 30 Program. The letter was co-signed by 36 bipartisan members of Congress and sent to DHS’ Legislative Affairs Department.

### H-1B's

- The AMA drafted a [letter](#) in opposition to the interim final rule “[Strengthening Wage Protections for the Temporary and Permanent Employment of Certain Aliens in the United States](#).” In the letter the AMA strongly urged the U.S. Department of Labor (DOL) to rescind the Interim Final Rule (IFR), effective October 8, 2020. If rescission is not possible, we urged the DOL to exempt physicians from the IFR. Additionally, the AMA strongly urged the DOL to continue to approve, and DHS to annually accept, without reservation, the wage data from the Association of American Medical Colleges (AAMC) Survey of Resident/Fellow Stipends and Benefits Report for our foreign medical residents.
  - Currently, the Immigration and Nationality Act (INA) requires employers attempting to hire H-1B physicians to pay the greater of “the actual wage level paid by the employer to all other individuals with similar experience and qualifications for the specific employment in question,” or “the prevailing wage level for the occupational classification in the area of employment.” Without providing evidence-based reasoning, this rule increased wage levels. Specifically,

the entry level wage (Level 1) was increased from representing the 17th wage percentile or higher than 17 percent of all wages for that specific position in that Metropolitan Statistical Area, to representing the 45th percentile. Subsequently, Level 2 (qualified) was increased from the 34th percentile to the 62nd percentile, Level 3 (experienced) from the 50th percentile to the 78th percentile, and Level 4 (fully competent) from the 67th percentile to the 95th percentile.

- Recently ruled to be in violation of the Administrative Procedure Act by a District Court.
- Implementation date has been delayed. [Comment period](#) has been reopened until April 21, 2021. Rescindment of rule also under consideration.
- The AMA commented on proposed rule “[Modification of Registration Requirement for Petitioners Seeking To File Cap-Subject H-1B Petitions.](#)”
  - DHS proposed to amend its regulations governing the process by which U.S. Citizenship and Immigration Services (USCIS) selects H-1B registrations for filing of H-1B cap-subject petitions (or H-1B petitions for any year in which the registration requirement will be suspended), by generally first selecting registrations based on the highest Occupational Employment Statistics (OES) prevailing wage level that the proffered wage equals or exceeds for the relevant Standard Occupational Classification (SOC) code and area(s) of intended employment.
  - On December 2, 2020, the AMA submitted [comments](#) strongly opposing the DHS proposed rule “Modification of Registration Requirement for Petitioners Seeking To File Cap-Subject H-1B Petitions.” This proposed rule seeks to abruptly and unnecessarily change the selection process for H-1B cap-subject petitions by prioritizing registrants based on the highest prevailing wage or highest proffered wage. In our comments, we acknowledge that it is false to assume that higher skilled workers are always paid a higher wage and thus, this conclusion made by DHS devalues physicians practicing in medically underserved areas. AMA strongly urged DHS to withdraw the proposed rule, but if withdrawal is not possible, DHS was urged to exempt physicians from this provision.
  - It was scheduled to go into [effect](#) March 9, 2021 but has been [delayed](#) until December 31, 2021
- The AMA commented on proposed rule “[Strengthening the H-1B Nonimmigrant Visa Classification Program.](#)”
  - DHS is proposing to revise the regulatory definition of and standards for a “specialty occupation.”
  - On December 4, 2020, the AMA [submitted comments](#). The United States District Court of the Northern District of California ruled on December 1, 2020 that the IFR is in violation of the Administrative Procedures Act. For the reasons stated in the court’s ruling, we agree. The AMA strongly urges DHS to rescind the IFR. If this, or a similar rule is implemented in the future, DHS was urged to exempt physicians.

## **Appendix D: Relevant Policy**

### **D-255.978, Study Expediting Entry of Qualified IMG Physicians to US Medical Practice**

Our AMA will study and make recommendations for the best means for evaluating, credentialing and expediting entry of competently trained international medical graduate (IMG) physicians of all specialties into medical practice in the USA.

(Res. 308, I-19)

### **H-255.983, Graduates of Non-United States Medical Schools**

The AMA continues to support the policy that all physicians and medical students should be evaluated for purposes of entry into graduate medical education programs, licensure, and hospital medical staff privileges on the basis of their individual qualifications, skills, and character.

(Sub. Res. 45, A-88 Reaffirmed by Res. 311, A-96 Reaffirmed: CMS Rep. 10, A-03 Reaffirmed: CME Rep. 1, I-03 Reaffirmed: CME Rep. 7, A-04 Reaffirmed: Sub. Res. 314, A-04 Reaffirmed: CME Rep. 11, A-10 Reaffirmed: BOT Rep. 25, A-15)

### **H-275.934, Alternatives to the Federation of State Medical Boards Recommendations on Licensure**

Our AMA adopts the following principles: (1) Ideally, all medical students should successfully complete Steps 1 and 2 of the United States Medical Licensing Examination (USMLE) or Levels 1 and 2 of the Comprehensive Osteopathic Medical Licensing Examination (COMLEX USA) prior to entry into residency training. At a minimum, individuals entering residency training must have successfully completed Step 1 of the USMLE or Level 1 of COMLEX USA. There should be provision made for students who have not completed Step 2 of the USMLE or Level 2 of the COMLEX USA to do so during the first year of residency training. (2) All applicants for full and unrestricted licensure, whether graduates of U.S. medical schools or international medical graduates, must have completed one year of accredited graduate medical education (GME) in the U.S., have passed all licensing examinations (USMLE or COMLEX USA), and must be certified by their residency program director as ready to advance to the next year of GME and to obtain a full and unrestricted license to practice medicine. The candidate for licensure should have had education that provided exposure to general medical content. (3) There should be a training permit/educational license for all resident physicians who do not yet have a full and unrestricted license to practice medicine. To be eligible for an initial training permit/educational license, the resident must have completed Step 1 of the USMLE or Level 1 of COMLEX USA. (4) Residency program directors shall report only those actions to state medical licensing boards that are reported for all licensed physicians. (5) Residency program directors should receive training to ensure that they understand the process for taking disciplinary action against resident physicians, and are aware of procedures for dismissal of residents and for due process. This requirement for residency program directors should be enforced through Accreditation Council for Graduate Medical Education accreditation requirements. (6) There should be no reporting of actions against medical students to state medical licensing boards. (7) Medical schools are responsible for identifying and remediating and/or disciplining medical student unprofessional behavior, problems with substance abuse, and other behavioral problems, as well as gaps in student knowledge and skills. (8) The Dean's Letter of Evaluation should be strengthened and standardized, to serve as a better source of information to residency programs about applicants.

(CME Rep. 8, A-99 Reaffirmed: CME Rep. 4, I-01 Reaffirmed: CME Rep. 2, A-11 Modified: CME Rep. 2, A-12)

### **H-255.966, Abolish Discrimination in Licensure of IMGs**

#### **Medical Licensure of International Medical Graduates**

1. Our AMA supports the following principles related to medical licensure of international medical graduates (IMGs):
    - A. State medical boards should ensure uniformity of licensure requirements for IMGs and graduates of U.S. and Canadian medical schools, including eliminating any disparity in the years of graduate medical education (GME) required for licensure and a uniform standard for the allowed number of administrations of licensure examinations.
    - B. All physicians seeking licensure should be evaluated on the basis of their individual education, training, qualifications, skills, character, ethics, experience and past practice.
    - C. Discrimination against physicians solely on the basis of national origin and/or the country in which they completed their medical education is inappropriate.
    - D. U.S. states and territories retain the right and responsibility to determine the qualifications of individuals applying for licensure to practice medicine within their respective jurisdictions.
    - E. State medical boards should be discouraged from a) using arbitrary and non-criteria-based lists of approved or unapproved foreign medical schools for licensure decisions and b) requiring an interview or oral examination prior to licensure endorsement. More effective methods for evaluating the quality of IMGs' undergraduate medical education should be pursued with the Federation of State Medical Boards and other relevant organizations. When available, the results should be a part of the determination of eligibility for licensure.
  2. Our AMA will continue to work with the Federation of State Medical Boards to encourage parity in licensure requirements for all physicians, whether U.S. medical school graduates or international medical graduates.
  3. Our AMA will continue to work with the Educational Commission for Foreign Medical Graduates and other appropriate organizations in developing effective methods to evaluate the clinical skills of IMGs.
  4. Our AMA will work with state medical societies in states with discriminatory licensure requirements between IMGs and graduates of U.S. and Canadian medical schools to advocate for parity in licensure requirements, using the AMA International Medical Graduate Section licensure parity model resolution as a resource.
- (BOT Rep. 25, A-15)

### **H-255.985, Graduates of Foreign Health Professional Schools**

- (1) Any United States or alien graduate of a foreign health professional education program must, as a requirement for entry into graduate education and/or practice in the United States, demonstrate entry-level competence equivalent to that required of graduates of United States' programs. Agencies recognized to license or certify health professionals in the United States should have mechanisms to evaluate the entry-level competence of graduates of foreign health professional programs. The level of competence and the means used to assess it should be the same or equivalent to those required of graduates of U.S. accredited programs. (2) All health care facilities, including governmental facilities, should adhere to the same or equivalent licensing and credentialing requirements in their employment practices.
- (BOT Rep. NN, A-87 Reaffirmed: Sunset Report, I-97 Reaffirmed: Res. 320 and Res. 305, A-03 Reaffirmed: CME Rep. 1, I-03 Reaffirmed: CME Rep. 2, A-13)

### **H-255.988, AMA Principles on International Medical Graduates**

#### **Our AMA supports:**

1. Current U.S. visa and immigration requirements applicable to foreign national physicians who are graduates of medical schools other than those in the United States and Canada.
2. Current regulations governing the issuance of exchange visitor visas to foreign national IMGs, including the requirements for successful completion of the USMLE.



3. The AMA reaffirms its policy that the U.S. and Canada medical schools be accredited by a nongovernmental accrediting body.
4. Cooperation in the collection and analysis of information on medical schools in nations other than the U.S. and Canada.
5. Continued cooperation with the ECFMG and other appropriate organizations to disseminate information to prospective and current students in foreign medical schools. An AMA member, who is an IMG, should be appointed regularly as one of the AMA's representatives to the ECFMG Board of Trustees.
6. Working with the Accreditation Council for Graduate Medical Education (ACGME) and the Federation of State Medical Boards (FSMB) to assure that institutions offering accredited residencies, residency program directors, and U.S. licensing authorities do not deviate from established standards when evaluating graduates of foreign medical schools.
7. In cooperation with the ACGME and the FSMB, supports only those modifications in established graduate medical education or licensing standards designed to enhance the quality of medical education and patient care.
8. The AMA continues to support the activities of the ECFMG related to verification of education credentials and testing of IMGs.
9. That special consideration be given to the limited number of IMGs who are refugees from foreign governments that refuse to provide pertinent information usually required to establish eligibility for residency training or licensure.
10. That accreditation standards enhance the quality of patient care and medical education and not be used for purposes of regulating physician manpower.
11. That AMA representatives to the ACGME, residency review committees and to the ECFMG should support AMA policy opposing discrimination. Medical school admissions officers and directors of residency programs should select applicants on the basis of merit, without considering status as an IMG or an ethnic name as a negative factor.
12. The requirement that all medical school graduates complete at least one year of graduate medical education in an accredited U.S. program in order to qualify for full and unrestricted licensure.
13. Publicizing existing policy concerning the granting of staff and clinical privileges in hospitals and other health facilities.
14. The participation of all physicians, including graduates of foreign as well as U.S. and Canadian medical schools, in organized medicine. The AMA offers encouragement and assistance to state, county, and specialty medical societies in fostering greater membership among IMGs and their participation in leadership positions at all levels of organized medicine, including AMA committees and councils and state boards of medicine, by providing guidelines and non-financial incentives, such as recognition for outstanding achievements by either individuals or organizations in promoting leadership among IMGs.
15. Support studying the feasibility of conducting peer-to-peer membership recruitment efforts aimed at IMGs who are not AMA members.
16. AMA membership outreach to IMGs, to include a) using its existing publications to highlight policies and activities of interest to IMGs, stressing the common concerns of all physicians; b) publicizing its many relevant resources to all physicians, especially to nonmember IMGs; c) identifying and publicizing AMA resources to respond to inquiries from IMGs; and d) expansion of its efforts to prepare and disseminate information about requirements for admission to accredited residency programs, the availability of positions, and the problems of becoming licensed and entering full and unrestricted medical practice in the U.S. that face IMGs. This information should be addressed to college students, high school and college advisors, and students in foreign medical schools.

17. Recognition of the common aims and goals of all physicians, particularly those practicing in the U.S., and support for including all physicians who are permanent residents of the U.S. in the mainstream of American medicine.

18. Its leadership role to promote the international exchange of medical knowledge as well as cultural understanding between the U.S. and other nations.

19. Institutions that sponsor exchange visitor programs in medical education, clinical medicine and public health to tailor programs for the individual visiting scholar that will meet the needs of the scholar, the institution, and the nation to which he will return.

20. Informing foreign national IMGs that the availability of training and practice opportunities in the U.S. is limited by the availability of fiscal and human resources to maintain the quality of medical education and patient care in the U.S., and that those IMGs who plan to return to their country of origin have the opportunity to obtain GME in the United States.

21. U.S. medical schools offering admission with advanced standing, within the capabilities determined by each institution, to international medical students who satisfy the requirements of the institution for matriculation.

22. The Federation of State Medical Boards, its member boards, and the ECFMG in their willingness to adjust their administrative procedures in processing IMG applications so that original documents do not have to be recertified in home countries when physicians apply for licenses in a second state.

(BOT Rep. Z, A-86 Reaffirmed: Res. 312, I-93 Modified: CME Rep. 2, A-03 Reaffirmation I-11 Reaffirmed: CME Rep. 1, I-13 Modified: BOT Rep. 25, A-15 Modified: CME Rep. 01, A-16 Appended: Res. 304, A-17 Modified: CME Rep. 01, I-17 Reaffirmation: A-19)

#### **D-275.989, Credentialing Issues**

1. Our AMA shall: (A) continue to encourage the Federation of State Medical Boards (FSMB) and its licensing jurisdictions to widely disseminate information about the Federation Credentials Verification Service; and (B) encourage the FSMB and the Educational Commission for Foreign Medical Graduates to work together to develop a system for the prompt and reliable verification of the medical education credentials of international medical graduates and to serve as a repository and a body for primary source verification of credentials.

2. Our AMA encourages state medical licensing boards, the Federation of State Medical Boards, and other credentialing entities to accept the Educational Commission for Foreign Medical Graduates certification as proof of primary source verification of an IMG's international medical education credentials.

(CME Rep. 3, A-02 Appended: CME Rep. 10, A-11)

#### **D-255.991, Visa Complications for IMGs in GME**

1. Our AMA will: (A) work with the ECFMG to minimize delays in the visa process for International Medical Graduates applying for visas to enter the US for postgraduate medical training and/or medical practice; (B) promote regular communication between the Department of Homeland Security and AMA IMG representatives to address and discuss existing and evolving issues related to the immigration and registration process required for International Medical Graduates; and (C) work through the appropriate channels to assist residency program directors, as a group or individually, to establish effective contacts with the State Department and the Department of Homeland Security, in order to prioritize and expedite the necessary procedures for qualified residency applicants to reduce the uncertainty associated with considering a non-citizen or permanent resident IMG for a residency position.

2. Our AMA International Medical Graduates Section will continue to monitor any H-1B visa denials as they relate to IMGs' inability to complete accredited GME programs.

3. Our AMA will study, in collaboration with the Educational Commission on Foreign Medical Graduates and the Accreditation Council for Graduate Medical Education, the frequency of such J-1 Visa reentry denials and its impact on patient care and residency training.
  4. Our AMA will, in collaboration with other stakeholders, advocate for unfettered travel for IMGs for the duration of their legal stay in the US in order to complete their residency or fellowship training to prevent disruption of patient care.
- (Res. 844, I-03 Reaffirmation A-09 Reaffirmation I-10 Appended: CME Rep. 10, A-11 Appended: Res. 323, A-12 Reaffirmation: A-19)

#### **D-255.985, Conrad 30 - J-1 Visa Waivers**

1. Our AMA will: (A) lobby for the reauthorization of the Conrad 30 J-1 Visa Waiver Program; (B) advocate that the J-1 Visa waiver slots be increased from 30 to 50 per state; (C) advocate for expansion of the J-1 Visa Waiver Program to allow IMGs to serve on the faculty of medical schools and residency programs in geographic areas or specialties with workforce shortages; (D) publish on its website J-1 visa waiver (Conrad 30) statistics and information provided by state Conrad 30 administrators along with a frequently asked questions (FAQs) document about the Conrad 30 program; (E) advocate for solutions to expand the J-1 Visa Waiver Program to increase the overall number of waiver positions in the US in order to increase the number of IMGs who are willing to work in underserved areas to alleviate the physician workforce shortage; (F) work with the Educational Commission for Foreign Medical Graduates and other stakeholders to facilitate better communication and information sharing among Conrad 30 administrators, IMGs, US Citizenship and Immigration Services and the State Department; and (G) continue to communicate with the Conrad 30 administrators and IMGs members to share information and best practices in order to fully utilize and expand the Conrad 30 program.
  2. Our AMA will continue to monitor legislation and provide support for improvements to the J-1 Visa Waiver program.
  3. Our AMA will continue to promote its educational or other relevant resources to IMGs participating or considering participating in J-1 Visa waiver programs.
  4. As a benefit of membership, our AMA will provide advice and information on Federation and other resources (but not legal opinions or representation), as appropriate to IMGs in matters pertaining to work-related abuses.
  5. Our AMA encourages IMGs to consult with their state medical society and consider requesting that their state society ask for assistance by the AMA Litigation Center, if it meets the Litigation Center's established case selection criteria.
- (Res. 233, A-06 Appended: CME Rep. 10, A-11 Appended: Res. 303, A-11 Reaffirmation I-11 Modified: BOT Rep. 5, I-12 Appended: BOT Rep. 27, A-13 Reaffirmation A-14)

#### **D-255.980, Impact of Immigration Barriers on the Nation's Health**

1. Our AMA recognizes the valuable contributions and affirms our support of international medical students and international medical graduates and their participation in U.S. medical schools, residency and fellowship training programs and in the practice of medicine.
2. Our AMA will oppose laws and regulations that would broadly deny entry or re-entry to the United States of persons who currently have legal visas, including permanent resident status (green card) and student visas, based on their country of origin and/or religion.
3. Our AMA will oppose policies that would broadly deny issuance of legal visas to persons based on their country of origin and/or religion.
4. Our AMA will advocate for the immediate reinstatement of premium processing of H-1B visas for physicians and trainees to prevent any negative impact on patient care.
5. Our AMA will advocate for the timely processing of visas for all physicians, including residents, fellows, and physicians in independent practice.

6. Our AMA will work with other stakeholders to study the current impact of immigration reform efforts on residency and fellowship programs, physician supply, and timely access of patients to health care throughout the U.S.

(Alt. Res. 308, A-17 Modified: CME Rep. 01, A-18 Reaffirmation: A-19)

**H-200.972, Primary Care Physicians in Underserved Areas**

1. Our AMA should pursue the following plan to improve the recruitment and retention of physicians in underserved areas:

(a) Encourage the creation and pilot-testing of school-based, faith-based, and community-based urban/rural family health clinics, with an emphasis on health education, prevention, primary care, and prenatal care.

(b) Encourage the affiliation of these family health clinics with local medical schools and teaching hospitals.

(c) Advocate for the implementation of AMA policy that supports extension of the rural health clinic concept to urban areas with appropriate federal agencies.

(d) Encourage the AMA Senior Physicians Section to consider the involvement of retired physicians in underserved settings, with appropriate mechanisms to ensure their competence.

(e) Urge hospitals and medical societies to develop opportunities for physicians to work part-time to staff health clinics that help meet the needs of underserved patient populations.

(f) Encourage the AMA and state medical associations to incorporate into state and federal health system reform legislative relief or immunity from professional liability for senior, part-time, or other physicians who help meet the needs of underserved patient populations.

(g) Urge hospitals and medical centers to seek out the use of available military health care resources and personnel, which can be used to help meet the needs of underserved patient populations.

2. Our AMA supports efforts to: (a) expand opportunities to retain international medical graduates after the expiration of allocated periods under current law; and (b) increase the recruitment and retention of physicians practicing in federally designated health professional shortage areas.

(CMS Rep. I-93-2 Reaffirmation A-01 Reaffirmation I-03 Modified: CME Rep. 13, A-06 Reaffirmed: CMS Rep. 01, A-16 Modified: CME Rep. 04, I-18 Appended: Res. 206, I-19)

## REFERENCES

1. The Complexities of Physician Supply and Demand: Projections from 2018 to 2033. April 2019. June 2020. Prepared for the Association of American Medical Colleges. IHS Inc. Available at: <https://www.aamc.org/system/files/2020-06/stratcomm-aamc-physician-workforce-projections-june-2020.pdf>. Accessed 6-26-20.
2. Certification. Educational Commission for Foreign Medical Graduates. Available at: <https://www.ecfmg.org/certification/index.html>. Accessed 6-26-20.
3. Immigration information for international medical graduates. American Medical Association. Available at: <https://www.ama-assn.org/education/international-medical-education/immigration-information-international-medical-graduates>. Accessed 6-25-20.
4. Aronson RD. Immigration Overview for International Medical Graduates. U.S. Medical Licensure Statistics and Current Licensure Requirements. American Medical Association. 2013 Edition.
5. State Specific Requirements for Initial Medical Licensure. Federation of State Medical Boards. Available at: <https://www.fsmb.org/step-3/state-licensure/>. Accessed 6-25-20.
6. New Jersey Division of Consumer Affairs. The State of New Jersey. Office of the Attorney General. Available at: <https://www.njconsumeraffairs.gov/COVID19/Pages/Temporary-Emergency-Foreign-Physician-Licensure-Program.aspx>. Accessed 6-25-20.
7. COVID-19 Pandemic and Professional Practice. Important Information for Licensees Impacted by COVID-19. New York State Education Department. Available at: [http://www.op.nysed.gov/COVID-19\\_EO.html](http://www.op.nysed.gov/COVID-19_EO.html). Accessed 6-25-20.
8. Limited Permits. Office of the Professions. New York State Education Department. Available at: <http://www.op.nysed.gov/prof/med/medlic.htm#limit>. Accessed 6-25-20.
9. Refugee Doctors Programme, Scottish Government. February 9, 2017. <https://www.youtube.com/watch?v=mufT33JdVQQ>. Accessed 4-6-20.
10. Minnesota Legislature Office of the Revisor of Statutes, “2014 Minn. Laws Chap. 228 Art. To d5 Sec. 12,” available at: <https://www.revisor.mn.gov/laws/2014/0/Session+Law/Chapter/228/>. Accessed 6-25-20.
11. Mathema S. Immigrant Doctors Can Help Lower Physician Shortages in Rural America. Center for American Progress. Available at: <https://www.americanprogress.org/issues/immigration/reports/2019/07/29/472619/immigrant-doctors-can-help-lower-physician-shortages-rural-america/>. Accessed 6-25-20.
12. Minnesota Department of Health: International Medical Graduate Assistance (IMG) Program. Available at: <https://www.health.state.mn.us/facilities/ruralhealth/img/index.html>. Accessed 6-25-20.
13. International Medical Graduate Assistance Program Report to the Minnesota Legislature, August 1, 2018. Available at: <https://www.health.state.mn.us/facilities/ruralhealth/img/docs/2018imgleg.pdf>. Accessed June 24, 2020.
14. LegiScan, “Bill VA HJR.682: Health Professions, Department of; utilization of foreign-trained physicians, report,” 2019 sess., January 9, 2019, available at <https://legiscan.com/VA/text/HJR682/id/1840208>. Accessed 6-25-20.
15. Bill H.4639, 190th General Court of Massachusetts, June 19, 2018, available at <https://malegislature.gov/Bills>. Accessed 6-25-20.
16. Lannan K. State urged to 'unlock' pool of foreign care workers. *The Salem News*. Salem, Massachusetts. April 6, 2020. Available at: [https://www.salemnews.com/news/state\\_news/state-urged-to-unlock-pool-of-foreign-care-workers/article\\_b111940f-1859-5fec-bfe2-9680a85dad65.html](https://www.salemnews.com/news/state_news/state-urged-to-unlock-pool-of-foreign-care-workers/article_b111940f-1859-5fec-bfe2-9680a85dad65.html). Accessed 6-25-20.
17. Conrad 30 waivers for physicians on J-1 visas; state policies, practices, and perspectives. WWAMI Rural Health Research Center. Available at:

[https://depts.washington.edu/fammed/rhrc/wp-content/uploads/sites/4/2016/03/RHRC\\_FR157\\_Patterson.pdf](https://depts.washington.edu/fammed/rhrc/wp-content/uploads/sites/4/2016/03/RHRC_FR157_Patterson.pdf). Accessed 6-26-20.

18. New Legislation Offered to Extend and Expand Conrad 30 Waiver Program. JacksonLewis. Available at: <https://www.globalimmigrationblog.com/2019/04/new-legislation-offered-to-extend-and-expand-conrad-30-waiver-program/>. Accessed 6-26-20.
19. Norcini JJ, van Zanten M, Boulet JR. The contribution of international medical graduates to diversity in the U.S. physician workforce: graduate medical education. *Journal of Health Care for the Poor and Underserved*. 2008;19(2):493-499.

REPORT 5 OF THE COUNCIL ON MEDICAL EDUCATION (June 2021)  
Promising Practices Among Pathway Programs to Increase Diversity in Medicine  
(Reference Committee C)

EXECUTIVE SUMMARY

In the early 1960s, cross-sectional efforts began to support increased diversification of the medical workforce through “pipeline programs” in response to a projected nationwide shortage of physicians. The shortage of physicians who are underrepresented in medicine (URM) was a consequence of structural factors that contributed to the marginalization of Black, Hispanic/Latinx, and Indigenous people, including exclusion from participation in medical education and careers in medicine. Legislative efforts such as Title VII programs were a means to improve the maldistribution of physicians and other health professionals and to improve the racial and ethnic diversity of the health care workforce. The two Title VII pipeline programs with the largest impact on enrollment of historically underrepresented groups in medicine are the Health Career Opportunity Program (HCOP) and the Centers of Excellence (COE). Over time, the term pipeline evolved to “pathway” to reflect the multiple paths to a career in medicine and to move away from the negative connotation associated with “pipeline.” These pathway programs have provided opportunities to support the increase of racial, ethnic, gender, and socioeconomic diversity of the medical workforce. In addition to these public programs, there are numerous private pathway programs across the continuum of medical education to support diversity in medicine and access to care for the underserved.

Although there is limited evidence on the effectiveness of pathway programs, high quality studies suggest that interventions such as targeted recruitment and revised admissions policies; curriculum changes; summer enrichment programs; and comprehensive programs that integrate multiple interventions, such as financial, academic, and social support, can exert a meaningful, positive effect on student outcomes and increase diversity across various levels of educational settings.

The success of “pathway programs” has been hindered by anti-affirmative action initiatives; inconsistent funding for Title VII programs; disparities in the development of an adequate applicant pool for medical school admissions; disparities in the admissions, recruitment, and retention rates for historically underrepresented groups in medical education and medicine; and negative social integration into the campus, training, and work environment. Efforts to make the medical workforce more reflective of the nation’s diversity will have to address multiple factors along the continuum of the education system and professional development. Additionally, it should be noted that oppressive structures, policies, and culture are perpetuated in various forms today and new pathway programs have emerged to expand gender equity among specific specialties such as radiology, orthopaedic surgery, and obstetrics/gynecology.

# REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 5-JUN-21

Subject: Promising Practices Among Pathway Programs to Increase Diversity in Medicine

Presented by: Liana Puscas, MD, MHS, Chair

Referred to: Reference Committee C

---

## 1 INTRODUCTION

2  
3 AMA Policy D-200.985 (13), “Strategies for Enhancing Diversity in the Physician Workforce,”  
4 asks that the AMA (a) support the publication of a white paper chronicling health care career  
5 pipeline programs (also known as pathway programs) across the nation aimed at increasing the  
6 number of programs and promoting leadership development of underrepresented minority health  
7 care professionals in medicine and the biomedical sciences, with a focus on assisting such  
8 programs by identifying best practices and tracking participant outcomes; and (b) work with  
9 various stakeholders, including medical and allied health professional societies, established  
10 biomedical science pipeline programs, and other appropriate entities, to establish best practices for  
11 the sustainability and success of health care career pipeline programs.  
12

13 The Council on Medical Education offers this report to provide an overview of interventions used  
14 by “pathway programs” based on targeted milestones along the journey to becoming a physician; to  
15 identify institutional and structural factors that interfere with or create attrition on the journey; and  
16 to discuss recommendations to minimize interference/attrition on the journey to becoming a  
17 physician.  
18

## 19 DEFINITION OF PIPELINE/PATHWAY PROGRAMS IN MEDICINE

20  
21 Historically, the term “pipeline” in medical education has been used as a metaphor to describe the  
22 progression of individuals from one level of medical education to the next.<sup>1</sup> However, it should be  
23 noted that use of this term has been criticized as the model erroneously presents a series of  
24 invariant steps necessary to pursue a career in medicine. This rigid and reductionist approach can  
25 have an especially negative impact on women and underrepresented groups in their pursuit of  
26 medical careers.<sup>2</sup> More recently the adoption of the term “pathway” has gained favor as it  
27 symbolizes a more flexible and less restrictive course that individuals can take on their path to  
28 becoming physicians. For the purposes of this report, the term “pathway programs” will be used to  
29 describe the progression of individuals from one level of medical education to the next. The  
30 pathway therefore begins as early as prekindergarten and extends through college, medical school,  
31 graduate medical education (GME), and up to faculty development. Pathway programs are  
32 designed to assist individuals, particularly those who have been historically underrepresented in  
33 medicine (URM), to envision a career in medicine and successfully transition from any one stage  
34 of education to the next with the goal of bolstering care for historically marginalized and  
35 minoritized patients. Some of the ways that pathway programs support learners include providing  
36 supplemental academic enrichment programs, experiential learning in medical/clinical settings,  
37 research experience, career/college counseling, standardized exam preparation, and mentorship.



Given that health inequities are identified in all areas, URM individuals can be expected to enhance outcomes in any clinical discipline and deserve the opportunity for a rewarding career in medicine. The rationale for encouraging the creation of programs to enhance medical student diversity is that racial and ethnic diversity among health professionals has been shown to promote better access to health care, improve health care quality for underserved populations, and better meet the health care needs of an increasingly diverse population.<sup>3</sup> While it is a duty of all physicians to aid serving the underserved and support primary care, URM physicians have been found to be more likely to work in underserved areas and thereby increase access to health care for historically marginalized and minoritized patients. Additionally, diverse learners add value to medical education and research environments by broadening perspectives represented in discussions, thus influencing peers and improving the cultural competence of the entire physician workforce.<sup>4,5</sup>

## HISTORY OF THE CREATION OF PATHWAY PROGRAMS IN THE UNITED STATES

For the first two-thirds of the twentieth century, U.S. medical schools were de facto segregated, since few medical schools would admit Black students. In 1900, Black students who aspired to have a career in medicine could only choose from 10 schools in the U.S.<sup>6</sup> Following the establishment of the Council on Medical Education in 1904, the Council adopted an “ideal standard” that medical schools ought to require preliminary education sufficient to enable the candidate to enter a recognized university; a five-year medical course; and a sixth year as an intern in the hospital. In 1906, the Council was tasked with rating medical schools and surveyed 160 schools regarding performance of graduates on state licensure examinations. The schools were graded as “acceptable,” “doubtful,” or “nonacceptable” based on a set of 10 defined qualifications. Only 82 schools receive an “acceptable” rating. The Council partnered with the Carnegie Foundation in 1909 to conduct a follow up study, entitled “Medical Education in the United States and Canada, a Report to the Carnegie Foundation for the Advancement of Teaching,” which was known as the Flexner Report of 1910.

The Flexner Report of 1910, which shaped medical education in the subsequent century, alleged support of medical education at the historically Black colleges and universities to provide a physician workforce that would serve Black Americans, yet its recommendations resulted in the closure of 89 medical schools, including five of the remaining seven medical schools that trained Black physicians, due to these schools’ inability to meet the standards set at the time.<sup>7</sup> The report also went beyond describing the substandard conditions at medical schools; it prescribed a limited role for Black physicians in their practices and hinted that Black physicians possessed less potential and ability than their white counterparts. Among his other findings, Flexner concluded that “educating the [Black] race to know and to practice fundamental hygienic principles” fell naturally to the Black doctor. Thus, “a well-taught negro sanitarian will be immensely useful.” Flexner not only limited the role of African American physicians to caring for other African Americans but further restricted Black doctors to matters of public health.<sup>8</sup> While he viewed both Meharry Medical College and Howard University as being suitable for training Black physicians, he recommended divestment from the five underperforming institutions serving Black medical students and reallocation of those resources to Meharry Medical College in Nashville, Tennessee, and Howard University Medical Department in Washington, DC.

As recently as 1964, 93 percent of all medical students in the United States were men and 97 percent of those students were non-Hispanic white. Of the remaining three percent of medical students, all but a few were enrolled in Howard University and Meharry Medical College. At that time, less than 0.2 percent of all medical students were Mexican American, Puerto Rican, American Indian, or Alaska Native. Prevailing societal values and practices within the profession were reflected in restricted opportunities for URM medical school graduates to participate in

1 specialty training, medical society membership, hospital staff membership, and other professional  
2 activities.<sup>7</sup>

3  
4 Beginning in the early 1960s, cross-sectional efforts began to support increased diversification of  
5 the medical workforce. In 1963, Congress passed the Health Professions Educational Assistance  
6 Act (P.L. 88-129, amending the Public Health Service Act or PHSA) in response to a projected  
7 nationwide shortage of physicians. The act was the first comprehensive legislation to address the  
8 supply of health care providers and initially authorized grants for the construction of new teaching  
9 facilities and loans to support students in the study of medicine, dentistry, and osteopathic  
10 medicine. The emphasis of Title VII programs shifted through several reauthorizations in the 1970s  
11 and 1980s. Title VII programs were seen as a means to improve the maldistribution of physicians  
12 and other health professionals. Programs were authorized to increase the numbers of health  
13 professionals in underserved (mostly rural or inner-city) areas and to improve the racial and ethnic  
14 diversity of the health workforce by increasing the numbers of those who had been historically  
15 excluded from careers in medicine. In addition, programs were developed to counter the  
16 nationwide trend of medical specialization. The major objective of these programs was to increase  
17 support for training and curriculum development in primary care.<sup>9</sup> Title VII programs are  
18 administered by the Bureau of Health Professions at the Health Resources and Services  
19 Administration (HRSA) in the Department of Health and Human Services (HHS).

20  
21 The adoption of pathway programs by the Association of American Medical Colleges (AAMC) as  
22 a strategic way to increase the number of URM physicians also emerged from the civil rights  
23 activism of the 1960s. Nickens et al. explain that “actions to promote diversity in medical schools  
24 reflected the heightened sensitivity to racial injustice spurred by the civil rights movement.”<sup>10</sup> In  
25 1964, only 2.2 percent of the total 32,000 medical students enrolled nationwide were Black, and the  
26 two historically Black colleges and universities (HBCUs) enrolled 76 percent of these students. On  
27 average all other medical schools enrolled a single Black student every two years.<sup>8</sup> At the 1968  
28 AAMC annual meeting, medical students, faculty, and administrators asked for the creation of a  
29 task force and strategies to increase enrollment among URM students. The underrepresentation of  
30 these groups was found to be so great that the task force placed highest priority on increasing the  
31 number of URM medical students from 2.8 percent to 12 percent within five years.<sup>9</sup> The other  
32 recommendations centered around retention of students on the medical career pathway, providing  
33 financial assistance, and recruitment of students into the medical pathway.<sup>9</sup> At the same time, there  
34 was widespread implementation of new “academic-enrichment programs” for premedical and post-  
35 baccalaureate students.<sup>8</sup> These enrichment programs as well as a rise in Black college student  
36 enrollment and the use of affirmative action in medical school admission led to a rapid increase in  
37 medical student enrollment among URM students from 3 percent in 1968 to 10 percent by 1974.<sup>11</sup>  
38 Data on the enrollment of non-Black minoritized individuals was not collected until 1971.

39  
40 Although these programs remained in place from 1974-1990, the general population rate of  
41 minoritized communities increased faster than medical school enrollment among those who had  
42 been historically excluded from medicine, so there was greater underrepresentation of these groups  
43 in medical schools in 1990 than in 1975. By 1990, the general minoritized population was 20  
44 percent while URM medical students represented 9 percent of all medical students. In 1990, the  
45 AAMC launched the *3000 by 2000* initiative, which aimed to enroll 3000 URM medical students  
46 annually by the year 2000. As part of this initiative, the AAMC adopted the “pipeline” metaphor  
47 that had been previously used in the science and engineering fields.<sup>10</sup> The first major aspect of this  
48 initiative encouraged medical schools to partner with local magnet high schools to provide  
49 minoritized students early exposure to the health professions and to academically prepare students  
50 to undertake rigorous pre-medical or pre-health professional coursework in college. The second  
51 aspect of the initiative included forming more articulated agreements between undergraduate

institutions and medical schools to encourage the enrollment and advancement of URM students into and through medical school. Last, the initiative encouraged science-education partnerships between academic health education centers (AHECs) and local primary school systems wherein AHEC faculty helped design scientific curricula that encouraged critical thinking and problem solving rather than simple memorization in the public school system. Although the *3000 by 2000* initiative did not achieve its enrollment goal, partially due to national resistance against affirmative action at the time, it paved the way for widespread pathway partnerships between medical schools, undergraduate institutions, and primary schools, many of which remain to this day.<sup>10</sup>

In 2009, the Liaison Committee on Medical Education (LCME), which accredits medical education school programs in the United States and Canada, revised its diversity standards to require that all U.S. allopathic medical schools engage in systemic efforts to attract and retain students from diverse backgrounds. The diversity standards were defined by the medical schools and the standards did not set numerical goals, but sought to ensure that all medical schools had a “mission-appropriate” diversity policy.<sup>12</sup> Evaluation of these medical school programs, some of which are pathway programs, has demonstrated modest enrollment increases in the proportions of URM medical students.<sup>4</sup> According to data collected for the 2019-2020 academic year, 149 (97 percent) of LCME-accredited medical schools have or support at least one pathway program to prepare participants (from the school’s diversity categories) for potential admission to medical school. Table 1 summarizes the types of “pipeline programs” in U.S. MD-granting medical schools.

Table 1 Types of Pipelines Programs in U.S. MD-Granting Medical Schools, 2019-2020

Type of Pipeline Program <sup>a</sup>	No. (%) of Medical Schools <sup>b</sup>
Pre-college-level only	6 (4.0)
College-level only	13 (8.7)
Postbaccalaureate only	1 (0.7)
Pre-college and college-levels	59 (39.6)
Pre-college, college, and postbaccalaureate levels	54 (36.2)
College and postbaccalaureate levels	12 (8.1)
Pre-college and postbaccalaureate levels	4 (2.7)

Source: LCME, 2020

<sup>a</sup>Pre-college level includes programs at the middle school and/or high school levels

College level includes programs at the college/university level and/or BA/MD programs/guaranteed medical school admission programs

Postbaccalaureate programs include programs for college graduates to complete additional course requirements or other pre-medical requirements

<sup>b</sup>149 medical schools reported having one or more pipeline programs: middle school (69 schools), high school (122 schools), college/university (123 schools), BA/MD or guaranteed admission programs (49 schools), postbaccalaureate programs (71 schools)

Table 2 summarizes the number of new medical students matriculating into a U.S. MD- or DO-granting medical school who came from at least one of a school’s supported pathway programs.

Table 2 New Medical Students Who Came from a Pathway Program in 2019-2020

Type of Program	# Matriculating to Respondent's Medical School	# Matriculating to Another U.S. MD/DO Granting Medical School
Middle school program only	7	0
High school program only	158	55
College program only	872	580
BA/MD/guaranteed-admission program only	921	47
Postbaccalaureate program only	907	637
More than one type of the school's pipeline program	210	39

Source: LCME, 2020

1 However, although absolute numbers of Black and Hispanic/Latinx matriculants have increased  
2 since 2009, representation of these groups in medicine as a proportion of the general population has  
3 not increased.<sup>5</sup> Additionally, Lett et al. found “no statistically significant trend towards increased  
4 representation of Black and Hispanic/Latinx male individuals and a modest trend towards increased  
5 representation for Hispanic/Latinx female applicants.” In fact, they found “that Hispanic/Latinx  
6 individuals are underrepresented among medical school applicants and matriculants by nearly 70%  
7 relative to the age-adjusted U.S. population; Black male applicants and matriculants, nearly 60%;  
8 Black female applicants, nearly 30%; and Black female matriculants, nearly 40%.” Additionally,  
9 Lett et al demonstrated that the representation of minoritized faculty relative to the general  
10 population has actually decreased in almost all specialties and across all faculty rankings since  
11 2009.<sup>13</sup>

#### 12 EVOLUTION FROM “PIPELINE” TO “PATHWAY” PROGRAM

15 It is important to consider the implications of using specific terminology about programs focused  
16 on increasing diversity in medicine. The term “pathway program” is gaining favor as it suggests a  
17 more open and flexible path to becoming a physician; the term “pipeline program,” however, is still  
18 prevalent both in the literature and in everyday conversations. Some believe the metaphor of the  
19 “pipeline” is misleading and inaccurate. The pipeline metaphor suggests there is a single path to  
20 becoming a doctor with a single entry and exit point.<sup>14</sup> Many URM medical students follow a non-  
21 traditional path to medical school, such as participating in post-baccalaureate programs to  
22 strengthen their academic profile, so the idea of a rigid pipeline that requires early access and  
23 success in science and medicine may be particularly discouraging to minoritized students.<sup>13</sup>  
24 Giordani et al. demonstrated that non-traditional students with lower Medical College Admission  
25 Test (MCAT) scores and undergraduate GPAs who pursue post-baccalaureate programs are just as  
26 likely as their traditional peers to succeed once they enter medical school.<sup>15</sup> Another reason some  
27 criticize the term “pipeline” is its allusion to the “school-to-prison pipeline,” a phenomenon known  
28 to disproportionately impact minoritized youth.<sup>16</sup> While the criminalization of minoritized children  
29 in schools is a worthwhile concern to address in pathway programs—minoritized students cannot  
30 be guided toward academic success when trapped in a “pipeline” of isolation, punishment,  
31 aggressive school policing, and inadequate academic preparation due to lack of resources—echoing  
32 the same terminology for a program promoting equity is inappropriate. Additionally, the word  
33 “pipeline” has negative connotations in Native American communities that are a prioritized group  
34 for recruitment. “Pipelines” within Indigenous communities are often literal, calling to mind  
35 current struggles with oil industries against environmental degradation, threats to communities’  
36 health and safety, and continued colonization. Alternatively, the term “pathway” implies learners’  
37 agency and offers more than a single path to medicine, which can include non-traditional students,

1 individuals who change careers later in life, and those who did not have early exposure to  
 2 medicine.<sup>13</sup>

### 4 CURRENT FEDERAL PATHWAY PROGRAMS

6 The Title VII health professions and Title VIII nursing workforce development programs, which  
 7 are authorized under the Public Health Service Act and administered by the HRSA, increase the  
 8 supply, distribution, and diversity of the health care workforce, reaching over 400,000  
 9 participants.<sup>17</sup> These programs improve access to, and quality of care for, vulnerable populations,  
 10 including children and families living on low incomes and in rural and underserved communities.  
 11 In addition, as ever-changing public health threats such as the COVID-19 pandemic and substance  
 12 use disorder epidemics, impact patients across the country, continued investment in Title VII  
 13 programs is essential to addressing the health challenges of today and the future.

15 Title VII programs play an essential role in improving the diversity of the health care workforce  
 16 and connecting students to health careers by supporting recruitment, education, training, and  
 17 mentorship opportunities. Inclusive and diverse education and training experiences expose  
 18 physicians and other health care professionals to backgrounds and perspectives other than their  
 19 own and heighten cultural awareness in health care, resulting in benefits for all patients. The Title  
 20 VII programs include:

- 22 • *Centers of Excellence*: Provides grants for mentorship and training programs. In academic  
 23 year 2018-19, this program supported over 1,300 trainees, of whom 99% were  
 24 underrepresented minorities and 64% were from financially or educationally disadvantaged  
 25 backgrounds.
- 27 • *Health Career Opportunity Program*: Invests in K-16 health outreach and education  
 28 programs through partnerships between health professions, schools, and local community-  
 29 based organizations. In academic year 2018-19, over 4,000 students from rural and  
 30 disadvantaged backgrounds were exposed to the health professions pathway.
- 32 • *Primary Care Training and Enhancement (PCTE)*: Supports training programs for  
 33 physicians and physician assistants to encourage practice in primary care, promote  
 34 leadership in health care transformation, and enhance teaching in community-based  
 35 settings. In academic year 2018-19, PCTE grantees trained over 13,000 individuals at  
 36 nearly 1,000 sites, with 61% in medically underserved communities and 30% in rural  
 37 areas.
- 39 • *Medical Student Education*: Supports the primary care workforce by expanding training for  
 40 medical students to become primary care clinicians, targeting institutions of higher  
 41 education in states with the highest primary care workforce shortages. The grants develop  
 42 partnerships between institutions, federally recognized tribes, and community-based  
 43 organizations to train medical students to provide care that improves health outcomes for  
 44 those living on tribal reservations or in rural and underserved communities.
- 46 • *Area Health Education Centers (AHECs)*: Responds to local health needs and serves as a  
 47 crucial link between academic training programs and community-based outreach programs.  
 48 In academic year 2018-19, AHECs supported 192,000 pathway program participants,  
 49 provided over 34,000 clinical training rotations for health professions trainees, and placed  
 50 over 92,000 trainees in rural and underserved training sites.

- *Mental and Behavioral Health:* Funds training programs to expand access to mental and behavioral health services for vulnerable and underserved populations. In academic year 2018-19, the Graduate Psychology Education program partnered with 184 sites to provide clinical training experiences for psychology students. Of these sites, 48% offered substance use disorder treatment services, and 38% offered telehealth services.

HRSA also administers the Minority Faculty Fellowships Program, with the goal of increasing the number of minoritized faculty at awardee institutions. The program awards 50 percent of faculty salary, with the institution matching funds. Fellows are prepared to assume tenured faculty positions at the institution and to provide services in underserved areas.<sup>8</sup>

Additionally, and as previously reported in Council on Medical Education Report 5-A-18, “Study of Declining Native American Medical Student Enrollment,” the Indian Health Service (IHS) supports American Indian/Alaska Native (AI/AN) entry into the health professions and provides opportunities to explore career paths in AI/AN health care. The IHS Scholarship program has awarded more than 7,000 health professions scholarships since 1978. The IHS website provides links to allow potential students to arrange IHS externships (with salary) and to coordinate AI/AN clerkship opportunities for medical students. In addition, post-graduation financial support is available through the IHS, with a loan repayment program of \$20,000 per year of commitment (maximum \$40,000) for health professions education loans, as well as a supplemental loan repayment program. The IHS also participates in the National Health Service Corps loan repayment program, with awards up to \$50,000 for a two-year commitment.<sup>18</sup>

#### CURRENT UNDERGRADUATE PATHWAY PROGRAMS

The CUNY School of Medicine (formerly Sophie Davis Biomedical Education Program), located in Harlem, recruits and educates a diverse, talented pool of students to its MD and physician assistant programs, expanding access to medical education to URM individuals from underserved communities of limited financial resources. The BS/MD degree program admits students directly from high school into an undergraduate biomedical program with a seamless transition into the medical school curriculum based on a seven-year curriculum. The program has graduated over 2,000 alumni who have become physicians, many of whom practice in underserved communities.

The Summer Health Professions Education Program (SHPEP) was initially established following a study by the Robert Wood Johnson Foundation (RWJF) in 1984 to identify strategies to reverse trends dating back to 1977 of declining URM medical school applicants. The program was originally known as the Minority Medical Education Program (MMEP), which was intended to increase the acceptance rates among medical school applicants who were African Americans, Mexican Americans, mainland Puerto Ricans, and AI/AN, as these groups have historically been underrepresented in medicine due to structural racism. Over the years, MMEP’s intensive academic preparation program expanded to 11 medical school campuses and the AAMC assumed the role of National Program Office in 1993. The program changed its name in 2003 to the Summer Medical Education Program (SMEP) to reflect the inclusion of students representing a range of economic, cultural, and geographic diversity. The program continued to evolve in 2006 when it expanded to include dentistry and was renamed the Summer Medical and Dental Education Program (SMDEP). SMDEP focused on students in the first two years of their college education because the experience of previous programs indicated that this is when students derive the most benefit. Most recently, the program expanded again in 2016 to include a range of health professions due to the growing importance of team-based care and interprofessional collaboration, leading to the most recent change in the program name, to SHPEP.<sup>19</sup> As of 2020, the program has served 27,164 participants at 12 universities across the U.S.

Doctors Back to School (DBTS) was launched by the AMA Minority Affairs Consortium (now called the Minority Affairs Section) in 2002. The DBTS program encourages Black, Indigenous, and Hispanic/Latinx students to enter the health care pathway through conversations with these children in a classroom setting. DBTS has developed a Doctors Back to School™ Kit to support physicians and medical students who act as role models by visiting elementary and high schools to talk with marginalized students about careers in medicine. The program demonstrates to marginalized students that a medical career is well within their reach. In 2016, the program declared the second Wednesday in May as National Doctors Back to School™ Day.

The American Academy of Ophthalmology and the Association of University Professors of Ophthalmology partnered to provide first- and second-year URM medical students one-on-one mentorship, valuable guidance in medical career planning, networking opportunities, and access to a variety of educational resources through their Minority Ophthalmology Mentoring (MOM) program. The MOM Class of 2020 provided opportunities for 50 students. Additionally, the National Medical Association developed the Rabb-Venable Excellence in Ophthalmology Research Program to help increase exposure to ophthalmology as a potential specialty choice among URM students and residents/fellows.

In addition to these national programs, there are numerous programs in the U.S. to boost diversity across the medical continuum. Mentoring in Medicine (MIM) prepares marginalized students in 3rd grade to become biomedical professionals by enabling them to interact with, and learn from, experienced health care professionals and scientists from health professional schools around the U.S. MIM offers an array of age-appropriate programs that involve reaching out to students on a regular basis, creating supportive social circles, providing academic enrichment, exposing students to hospital and research environments, coaching them on leadership and life skills, and providing prospective medical students with exposure to a supportive, but rigorous boot camp. Tour for Diversity (T4D) educates, inspires, and cultivates the future generation of URM physicians, dentists, and pharmacists by conducting national tours in February and September to provide comprehensive workshops to high school and college students that focus on motivating them toward a strong career path, building critical skills, optimizing the application process, and developing mentoring relationships. T4D also provides students with virtual opportunities via hosted webinars that are both interactive and recorded. Building the Next Generation of Academic Physicians (BNGAP) was established in 2008 to address the lack of URM individuals serving as faculty at academic health centers and works to promote diversity and inclusion in the academic medicine workforce.

There are also programs that focus on the development of the health care workforce to increase access to care for underserved people such as those in rural communities. Successfully Training and Educating Pre-medical Students (STEPS) aims to increase the number of primary care physicians in northeast Kentucky by providing opportunities such as physician shadowing, mock interviews, and MCAT practice exams for pre-medical students in the Appalachian region. Frontier Area Rural Mental Health Camp and Mentorship Program (FARM CAMP) strives to reduce the shortage of behavioral health professionals in rural Nebraska. FARM CAMP offers a week-long camp to teach high school students in rural and tribal communities about different career options in behavioral health and provides mentorship after the camp ends. Frontier and Rural Workforce Development New Mexico (FORWARD NM) Pathways to Health Careers was established to address the chronic shortages of primary care physicians and other health care professionals in New Mexico's southwestern counties of Hidalgo, Catron, Luna, and Grant; additionally, New Mexico has the oldest physician population in the country. This comprehensive workforce pathway program includes programming for middle and high school students, undergraduate and graduate students, primary care program students, and medical and dental residents.<sup>20</sup>

1 Additionally, in 2010, Columbia University College of Physicians and Surgeons and Bassett  
 2 Medical Center joined forces to launch a new model of medical training to address the severe  
 3 shortage of rural physicians and train a new generation of doctors capable of leading health systems  
 4 that promote both quality of practice and cost-effective delivery of care. Students begin their  
 5 training for 18 months in Manhattan and then head to Cooperstown, N.Y., for two and a half years  
 6 to obtain clinical training. Students experience both an urban health care setting and a rural health  
 7 care environment, while being exposed to features not typically part of the medical school  
 8 curriculum, such as finance, risk management, patient safety, quality improvement, and medical  
 9 informatics. In addition, every Columbia-Bassett student receives grant funding at a minimum of  
 10 \$30,000 per year for all four years.

11  
 12 To help highlight the needs of the Lesbian, Gay, Bisexual, Transgender, and Queer (LGBTQ)  
 13 community, in 2020 the American Medical Association Foundation (AMAF) established its  
 14 LGBTQ Fellowship Program to influence the future of LGBTQ health. The new initiative will  
 15 create a cadre of LGBTQ health specialists through a national fellowship program to promote best  
 16 practices and shared outcomes, while improving the quality of LGBTQ health care across the  
 17 nation. The program was created to address the intersectional issues of discrimination, stigma, and  
 18 limited access to and lower quality of care experienced by lesbian, gay, bisexual, and transgender  
 19 individuals. A primary goal of the program is to create a pathway for LGBTQ health specialists  
 20 who are able to serve the health care needs of the LGBTQ community while growing the pool of  
 21 competent instructors able to “pay it forward” by passing on their knowledge to the next generation  
 22 of LGBTQ physicians.

## 23 24 CURRENT GRADUATE MEDICAL EDUCATION PATHWAY PROGRAMS

25  
 26 There are also initiatives to increase diversity in competitive specialties such as orthopaedic  
 27 surgery and radiology, as well as expand gender equity in the specialties of family medicine and  
 28 obstetrics and gynecology. Nth Dimensions was founded in 2004 by orthopaedic surgeons working  
 29 collaboratively with academic institutions, community surgeons, and industry to address the dearth  
 30 of women and other URM groups in orthopaedic surgery. Nth Dimensions offers an eight-week  
 31 clinical and research internship with a practicing researcher, which also includes a full-day  
 32 orientation and culminates in the student presenting a research poster at the annual National  
 33 Medical Association assembly. Following successful completion of the summer internship  
 34 program, students receive scholarships to participate in a designated Step 1 board review course,  
 35 which is conducted throughout their second year in medical school. Nth Dimension also offers  
 36 clinical correlations lectures and hands-on workshops to increase awareness of the specialty being  
 37 addressed through surgeon-led lectures and hands-on workshops with target groups of URM  
 38 groups and women. The American College of Radiology established the Pipeline Initiative for the  
 39 Enrichment of Radiology (PIER) internship program for first-year medical students at institutions  
 40 across the U.S. in hopes of giving women and other URM groups an opportunity to explore the  
 41 radiology specialty and engage in research. The internship begins in June and culminates with  
 42 presentation of the students’ research to the radiology section of the National Medical Association.  
 43 Additionally, the AMA Reimagining Residency initiative is currently sponsoring two innovative  
 44 pathway programs. California Oregon Medical Partnership to Address Disparities in Rural  
 45 Education and Health (COMPADRE) is a collaboration between Oregon Health & Science  
 46 University and University of California, Davis, 10 health care systems, 10 institutional sponsors,  
 47 and a network of federally qualified health centers that aims to jointly address workforce shortages  
 48 in rural, tribal, urban, and other disadvantaged communities between Sacramento and Portland. The  
 49 University of North Carolina has developed Fully Integrated Readiness for Service Training  
 50 (FIRST): Enhancing the Continuum from Medical School to Residency to Practice, which expands  
 51 the geographic and specialty reach of the University of North Carolina School of Medicine’s



established residency readiness program. Its additional aims include developing and implementing a generalizable health systems science curriculum for GME and competency-based assessment tools that span the educational continuum.

## INSTITUTIONAL AND STRUCTURAL FACTORS THAT INTERFERE WITH PATHWAY PROGRAM SUCCESS

Although many students who indicate an early interest in medicine do not progress from one phase to the next, the attrition rate of URM medical students is even higher than those of their non-minoritized counterparts.<sup>1,21</sup> This disproportionate attrition rate is multifactorial and occurs in all phases of the pathway. Some factors that disproportionately affect URM students include attending lower performing high schools and colleges, financial barriers to higher education, lower levels of academic attainment among parents of minoritized students (which has been found to link to a child's outcomes such as academic achievement), and experiences of racism and implicit bias that deter students from continuing with their trajectory.<sup>4,10</sup> A 2019 study published in *JAMA* found that while the U.S. population of male and female 24- to 30-year-olds, who are Black, Hispanic/Latinx, and Native Hawaiian or Pacific Islander (NHOPI) increased between 2002 and 2017, there were no significant increases in medical school applicants and attendees from these groups over the same period. The study also found that from 2002 to 2012, the proportion of Black, Hispanic/Latinx, NHOPI, and AI/AN medical school matriculants remained relatively unchanged and Black, Hispanic/Latinx, and AI/AN students remain underrepresented among medical school matriculants compared with the U.S. population.<sup>5</sup> Another study the same year found that as medical school enrollment doubled over the past two decades, the percentage of entering underrepresented students actually fell by 16%.<sup>22</sup> There are several possible factors that may explain why these groups are still underrepresented in medicine.

While affirmative action efforts helped initially increase enrollment among URM medical students, these initiatives have been met with resistance. In 1974, a reverse discrimination lawsuit brought by Allan Bakke against the University of California (UC) transformed how colleges think about race and equality in admissions. Bakke was a white man who had twice been denied admission to the medical school at UC Davis during the time when positions in the entering class were “reserved” for qualified minoritized students. The case was ultimately heard by the U.S. Supreme Court. Justice Lewis Powell, in the deciding opinion in the case, wrote “the State has a substantial interest that legitimately may be served by a properly devised admissions program involving the competitive consideration of race and ethnic origin” and concluded that “you could use race as a factor in admissions, but that you could not use quotas” (Powell L. 1978. Bakke, 438 US at 312–13 n.48). The Court's decision in *Regents of the University of California v. Bakke* changed the definition of the Equal Protection Clause and inadvertently changed how colleges approached recruiting and enrolling URM in medicine. According to law professor Kevin Brown at Indiana University, the Equal Protection Clause is a short but critical line in the Fourteenth Amendment that states that Americans in similar circumstances should be treated equally under the law. This clause historically aimed to help “discrete and insular minoritized groups.”<sup>23</sup> The decision upended that view. Bakke was admitted to medical school at UC Davis and the school transitioned to a panel of markers that they term “distance traveled,” which is not race-based but serves to support marginalized people based on non-race indicators of socioeconomic disadvantage. However, the Court's decision affirmed the use of race as one among many factors that could be considered as part of the medical school admissions process.<sup>10</sup> The Court's decision provided the window to weaken the practice of race-based affirmative action and as a result enrollment among minoritized groups stagnated.

1 There were additional anti-affirmative action initiatives to follow that negatively impacted efforts  
 2 to increase diversity in medicine. Most notable was *Hopwood v. University of Texas* in 1996, in  
 3 which the United States Court of Appeals for the Fifth Circuit held that “any consideration of race  
 4 or ethnicity by the law school for the purpose of achieving a diverse student body is not a  
 5 compelling interest under the Fourteenth Amendment.”<sup>24</sup> This decision prohibited public  
 6 universities under its jurisdiction (in Texas, Mississippi, and Louisiana) from taking race into  
 7 account in their admissions policies. The same year, Proposition 209 was passed in California with  
 8 nearly 55 percent of the vote, banning consideration of race and gender in admissions in the state’s  
 9 public universities. In 2008, the University of California (UC) “clarified” their policy in  
 10 recognition that Native Americans enrolled in a federally recognized tribe enjoy a political status  
 11 that enables them to be offered affirmative action, even when the consideration of race or ethnicity  
 12 is banned. This policy shift led to a statistically significant surge in the Native American applicant  
 13 share, acceptance rate, admit share, and enrollment share. Enrollment share increased by 56% from  
 14 2008 to 2010 at the UC.<sup>25</sup> In November 2020, nearly 25 years later, voters in California had the  
 15 opportunity to repeal Proposition 209 through the work of Assemblywoman Shirley Weber (D-San  
 16 Diego), chairwoman of the Legislative Black Caucus and principal author of the proposed  
 17 constitutional amendment.<sup>26</sup> This effort was unsuccessful, and the amendment was not approved by  
 18 voters. Presently, Arizona, Georgia, Michigan, Nebraska, New Hampshire, Oklahoma, and Idaho  
 19 have banned affirmative action. A study of 19 public universities in six of these states (Arizona,  
 20 Georgia, Michigan, Nebraska, New Hampshire, and Oklahoma) found that the elimination of  
 21 affirmative action has led to persistent declines in the share of URM medical students among  
 22 students admitted to and enrolling in flagship public universities in these states.<sup>27</sup>

23  
 24 In June 2003, the US Supreme Court ruled on two separate but parallel admissions cases, *Grutter v.*  
 25 *Bollinger* and *Gratz v. Bollinger*, involving the University of Michigan and the constitutionality of  
 26 using race-conscious decisions as part of its admissions process. Although neither case directly  
 27 involved the medical school or other health profession admissions, the Court’s ruling was widely  
 28 recognized as one that would have profound bearing on the future of affirmative action in public  
 29 higher education nationwide. With these rulings, the Supreme Court recognized the value of  
 30 diversity in higher education and preserved the ability to consider race as a factor in admissions  
 31 decisions.<sup>10</sup>

32  
 33 Aside from the impact of court rulings on affirmative action, support for Title VII programs has  
 34 been inconsistent over the last decade. In 2005, the Office of Management and Budget (OMB)  
 35 published its review of the health professions training programs under Title VII. After years of  
 36 effective ratings for Title VII programs, the OMB concluded that these programs were ineffective.  
 37 As a result, the HRSA administrator, Elizabeth Duke, informed COE and HCOP grantees that the  
 38 administration would no longer support their programs, and in 2006, the federal government cut its  
 39 funding abruptly and drastically reduced the number of Centers of Excellence and Health Careers  
 40 Opportunity Programs. In February 2006, the Government Accountability Office (GAO) issued a  
 41 report entitled *Health Professions Education Programs: Action Still Needed To Measure Impact*,  
 42 which reviewed HRSA’s evaluation of the Title VII and VIII (nursing) programs against its overall  
 43 performance goals and found that these goals did not apply to all of the health professions  
 44 programs and that HRSA’s tracking data was problematic.<sup>28</sup> HRSA was criticized for failing to  
 45 publish national supply, demand, and distribution projections for the physician and dentist  
 46 workforces.

47  
 48 In July 2020, the House Appropriations Committee released their Committee Report accompanying  
 49 the Labor-HHS-Education FY 2021 allocations, which would provide Title VII Health Professions  
 50 and Title VIII Nursing Workforce Development Programs with a total of \$782.5 million, a \$48  
 51 million increase (6.5%) from FY 2020 enacted levels.<sup>29</sup> In December 2020, the Consolidated

1 Appropriations Act of 2021 passed which includes \$50,000,000 for grants to public institutions of  
2 higher education to expand or support graduate education for physicians provided by such  
3 institutions. Priority will be given to public institutions located in states with a projected primary  
4 care physician shortage in 2025 and are limited to public institutions in states in the top quintile of  
5 states with a projected primary care physician shortage in 2025.<sup>30</sup>

6  
7 Historically, disparities in medical school admissions have encompassed more than racial and  
8 ethnic gaps. One root cause for this disparity is a lack of resources to support the development of  
9 education necessary to be an adequate applicant for medical school admission. While overall  
10 educational attainment is increasing, college completion rates and attainment patterns differ  
11 considerably across demographic groups. Household income and education levels are tightly  
12 linked. Consequently, lower levels of education are correlated with lower household income as  
13 well.<sup>31</sup> This has direct implications for the economic diversity of applicants to medical school.  
14 According to a 2018 study conducted by AAMC, roughly three quarters of medical school  
15 matriculants come from the top two household-income quintiles, and this distribution has not  
16 changed in three decades. Black and Hispanic/Latinx medical students are three times as likely as  
17 their white counterparts to come from families with combined parental incomes of less than  
18 \$50,000. Black and Hispanic/Latinx students are also much more likely than white students to have  
19 attended high poverty primary and secondary schools which strongly affects educational  
20 achievement and often leaves these individuals less competitive on traditional academic measures  
21 such as MCAT scores and grade-point averages.

22  
23 The lower admission rate for URM groups is another challenge to diversification of the medical  
24 workforce due to bias. Community college attendance is often viewed negatively by medical  
25 schools in the admissions process, despite being a critical educational pathway for many URM  
26 students.<sup>31</sup> To counter this bias, there is a growing trend of holistic review as an admissions  
27 strategy to assess an applicant's unique experiences alongside traditional measures of academic  
28 achievement such as grades and test scores. It is designed to help admission committees consider a  
29 broad range of factors reflecting the applicant's academic readiness, contribution to the incoming  
30 class, and potential for success, both in school and later as a professional. Holistic review, when  
31 used in combination with a variety of other mission-based practices, constitutes a "holistic  
32 admission" process. A key element is that this review concomitantly reduces historical singular  
33 focus on metrics that are flawed from the perspective of equity for URM medical students,  
34 specifically standardized testing and GPA or the "caliber" of college attended. A holistic admission  
35 process is necessary at the collegiate level to increase the pool for subsequent undergraduate  
36 medical education, GME, and faculty recruitments. In 2003, the U.S. Supreme Court officially  
37 described the strategy as a "highly individualized, holistic review of each applicant's file, giving  
38 serious consideration to all the ways an applicant might contribute to a diverse educational  
39 environment" (*Grutter v. Bollinger*, 539 US 306, 2003). The AAMC has promoted holistic review  
40 in the admissions process to broadly assess how a candidate might contribute value as a medical  
41 student and physician. Although practices vary widely, a national survey of health professional  
42 schools showed that institutions incorporating "many elements of holistic review" reported  
43 increases in class diversity as compared with institutions incorporating few or no elements.<sup>32</sup>

44  
45 Diversity in the ranks of faculty and administration of medical schools is central to creating a  
46 welcoming environment for all students.<sup>31</sup> However, a study to evaluate trends in racial, ethnic, and  
47 gender representation at U.S. medical schools across 16 specialties from 1990–2016 found that the  
48 gap between the URM population in the academic physician workforce widened over time for  
49 nearly all specialties and faculty rankings.<sup>33</sup> This is problematic, as URM faculty often serve as  
50 important role models and mentors for URM medical students and trainees who may struggle with  
51 systemic racism in their schools and training environments.<sup>34</sup> URM faculty can also promote

1 academic excellence and enhance training across all domains to improve outcomes for all students  
 2 related to cultural humility, humanism, empathy, and professionalism. “Most institutions recognize  
 3 the value of multi-cultural outreach and engagement, but often fail in reconciling the associated  
 4 implications for organizational decision-making. In other words, institutional leaders recognize the  
 5 benefits of recruiting URM groups into medicine and gaining ideas from diverse sources but lack  
 6 the understanding or will to ensure that they are integrated into an environment of respect,  
 7 inclusion and meaningful engagement.”<sup>34</sup>

8  
 9 Lastly, negative social integration into the campus environment impacts retention among  
 10 minoritized and marginalized groups. Tinto’s theory of student departure claims that a student’s  
 11 individual characteristics (including personal attributes, family background, and high school  
 12 experiences) directly influence the student’s commitments to an institution, the goal of graduation,  
 13 and, ultimately, the departure decision.<sup>35</sup> Braxton et al. revised the model in 2004 by placing social  
 14 integration as the pivotal factor in retention and claiming that student characteristics (e.g., gender,  
 15 race/ethnicity, socioeconomic status, academic ability, high school preparation, and self-efficacy)  
 16 shape initial commitments to attaining a degree and to the institution.<sup>36</sup> Significant factors for  
 17 minoritized and marginalized student retention include racial climate, presence of an ethnic  
 18 community, community orientation, campus involvement, acclimation to the academic culture,  
 19 social connectedness, and the role of religion.<sup>37</sup> These factors may be interconnected as having the  
 20 presence of a similar ethnic community may increase a student’s feelings of support in the event of  
 21 a racially insensitive incident. Some recent examples of these type of incidents include white  
 22 students posting photographs of themselves in blackface and disseminating the photos via social  
 23 media, along with graffiti with swastikas and other “hateful language” in dormitories and on  
 24 campus buildings; however, incidents do not have to be blatant to be harmful.<sup>38</sup> Microaggressions  
 25 which are brief yet common verbal, behavioral, or environmental indignities, whether intentional or  
 26 unintentional, that communicate hostile, derogatory, or negative racial slights and insults toward  
 27 people of color can also negatively impact one’s experience in the classroom, training environment  
 28 and workplace. URM groups have reported commonly experiencing microaggressions in school  
 29 and in the workplace. These experiences of microaggressions have been associated with harmful  
 30 psychological outcomes including anxiety and depression. Moreover, because microaggressions  
 31 seem benign, they are rarely reported in the workplace.<sup>39</sup> The absence of a supportive affinity  
 32 community may lead a student to experience an estrangement process, which begins with feelings  
 33 of alienation that evolve into disillusionment and emotional rejection, and end with the student  
 34 physically rejecting the campus environment and withdrawing from the institution.<sup>40</sup>

## 35 36 ADDITIONAL CONSIDERATIONS FOR PATHWAY PROGRAMS

37  
 38 As the focus of this report is on existing promising practices to promote a diverse medical  
 39 workforce, the Council would like to address the importance of gender equity across medical  
 40 specialties. Table 3 highlights the gender imbalances among the medical specialties according to  
 41 the 2018 National GME Census, which is compiled by the AMA and the AAMC. It is worth noting  
 42 the lack of data on physicians who identify as non-binary when evaluating the balances in the  
 43 specialties.

Table 3 Top Medical Specialties by Gender, 2018-2019

Female-dominated specialties		Male-dominated specialties	
Obstetrics and gynecology	83.4%	Orthopaedic surgery	84.6%
Allergy and immunology	73.5%	Neurological surgery	82.5%
Pediatrics	72.1%	Interventional radiology (integrated)	80.8%
Medical genetics and genomics	66.7%	Thoracic surgery	78.2%
Hospice and palliative medicine	66.3%	Pain medicine	75.3%
Dermatology	60.8%	Radiology	73.2%

Source: 2018 National GME Census

While efforts are underway to increase diverse representation in orthopaedic surgery and radiology, recent attention has also been given to the dramatic decline of men in obstetrics/gynecology. In an effort to identify how to recruit more male students into the field of obstetrics/gynecology, a study was conducted to identify when students make their decisions on career choice and found that >70% of obstetrics/gynecology residents decided to pursue the specialty during or after their third-year clerkship.<sup>41</sup> Another study found that 78% of male students believed their gender adversely affected their obstetrics/gynecology clerkship experience.<sup>42</sup> The authors recommended the following efforts to increase representation of men in obstetrics/gynecology: improving the quality of the obstetrics/gynecology clerkship experience, engaging students early in their medical school careers, and frankly addressing gender and lifestyle issues that dissuade students from choosing obstetrics/gynecology.

#### RELEVANT AMA POLICY

Our AMA has a number of existing policies and directives that are relevant to the topic of pathway programs; these are shown in the appendix.

#### SUMMARY AND RECOMMENDATIONS

There is limited evidence on the effectiveness of pathway programs and more rigorous evaluation is needed. That said, the following promising practices to increase diversity across the various educational settings are supported in the literature: targeted recruitment; revised admissions policies; summer enrichment programs; and comprehensive programs that integrate multiple interventions such as financial, academic, and social support.<sup>43</sup> Snyder et al. found that “high quality studies suggest that pipeline program interventions can exert a meaningful, positive effect on student outcomes.”<sup>44</sup> The limited evidence available provides reason to be optimistic that these programs are beneficial. For example, a study of three HCOP projects in Kentucky, Tennessee, and Virginia during the years 1990-1999 found that students who participated in HCOP programs were likely to enroll in college (93 percent), major in a health profession program (77 percent), and graduate (58 percent). A total of 87 percent of those who graduated from college were enrolled in a health professions program.<sup>45</sup> Efforts to increase diversity in medicine are needed across multiple levels. Where legally possible, institutions should utilize affirmative action policies to bolster efforts to increase diversity in medicine. University leaders committed to diversity should select deans of their medical programs with a record of active support in this area. Medical programs, through their leaders, at the school and department levels, should support continuing pathway efforts by making statements of support, by cultivating and funding programs that support a culture of diversity on campus, and by recruiting faculty and staff who share this goal. Policymakers at the state level must work to alleviate pre-K-12 educational disparities and improve the college readiness of URM students. Additionally, the efforts to increase gender equity across medical specialties should be encouraged as diverse learners add value to medical education and research

environments by broadening perspectives represented in discussions, thus influencing peers and improving the cultural competence of the entire physician workforce.

The Council on Medical Education therefore recommends the following recommendations be adopted and the remainder of this report be filed:

1. That our AMA recognize some people have been historically underrepresented, excluded from, and marginalized in medical education and medicine because of their race, ethnicity, sexual orientation, and gender identity due to structural racism and other systems of oppression. (New HOD Policy)
2. That our AMA commit to promoting truth and reconciliation in medical education as it relates to improving equity. (New HOD Policy)
3. That our AMA recognize the harm caused by the Flexner Report to historically Black medical schools, the diversity of the physician workforce, and the outcomes of minoritized and marginalized patient populations. (New HOD Policy)
4. That our AMA work with appropriate stakeholders to commission and enact the recommendations of a forward-looking, cross-continuum, external study of 21st century medical education focused on reimagining the future of health equity and racial justice in medical education, improving the diversity of the health workforce, and ameliorating inequitable outcomes among minoritized and marginalized patient populations. (New HOD Policy)
5. That our AMA amend Policy H-200.951, Strategies for Enhancing Diversity in the Physician Workforce by addition and deletion to read as follows: (4) encourages medical schools, health care institutions, managed care and other appropriate groups to adopt and utilize activities that bolster efforts to include and support historically underrepresented groups in medicine, by developing policies that articulate the value and importance of diversity as a goal that benefits all participants, cultivating and funding programs that nurture a culture of diversity on campus, and recruiting faculty and staff who share this and strategies to accomplish that goal. (5) continue to study and provide recommendations to improve the future of health equity and racial justice in medical education, the diversity of the health workforce, and the outcomes of minoritized and marginalized patient populations. (Modify Current HOD Policy)
6. That our AMA amend Policy H-60.917, Disparities in Public Education as a Crisis in Public Health and Civil Rights (3) by addition to read as follows: Our AMA will support and encourage the U.S. Department of Education to develop policies and initiatives to 1) increase the high school graduation rate among historically underrepresented students 2) increase the number of historically underrepresented students participating in high school Advanced Placement courses and 3) decrease the educational opportunity gap. (Modify Current HOD Policy)
7. That our AMA amend Policy D-200.985 (13), “Strategies for Enhancing Diversity in the Physician Workforce,” by deletion to read as follows: ~~(a) supports the publication of a white paper chronicling health care career pipeline programs (also known as pathway programs) across the nation aimed at increasing the number of programs and promoting leadership development of underrepresented minority health care professionals in medicine~~

- 1 ~~and the biomedical sciences, with a focus on assisting such programs by identifying best~~  
2 ~~practices and tracking participant outcomes; and. (Modify Current HOD Policy)~~  
3  
4 8. That our AMA reaffirm Policy D-200.982, “Diversity in the Physician Workforce and  
5 Access to Care.”

Fiscal note: \$5,000.

## APPENDIX: RELEVANT AMA POLICY

### *D-200.982, Diversity in the Physician Workforce and Access to Care*

Our AMA will: (1) continue to advocate for programs that promote diversity in the US medical workforce, such as pipeline programs to medical schools; (2) continue to advocate for adequate funding for federal and state programs that promote interest in practice in underserved areas, such as those under Title VII of the Public Health Service Act, scholarship and loan repayment programs under the National Health Services Corps and state programs, state Area Health Education Centers, and Conrad 30, and also encourage the development of a centralized database of scholarship and loan repayment programs; and (3) continue to study the factors that support and those that act against the choice to practice in an underserved area, and report the findings and solutions at the 2008 Interim Meeting.

### *D-200.985, Strategies for Enhancing Diversity in the Physician Workforce*

1. Our AMA, independently and in collaboration with other groups such as the Association of American Medical Colleges (AAMC), will actively work and advocate for funding at the federal and state levels and in the private sector to support the following: (a) Pipeline programs to prepare and motivate members of underrepresented groups to enter medical school; (b) Diversity or minority affairs offices at medical schools; (c) Financial aid programs for students from groups that are underrepresented in medicine; and (d) Financial support programs to recruit and develop faculty members from underrepresented groups.
2. Our AMA will work to obtain full restoration and protection of federal Title VII funding, and similar state funding programs, for the Centers of Excellence Program, Health Careers Opportunity Program, Area Health Education Centers, and other programs that support physician training, recruitment, and retention in geographically-underserved areas.
3. Our AMA will take a leadership role in efforts to enhance diversity in the physician workforce, including engaging in broad-based efforts that involve partners within and beyond the medical profession and medical education community.
4. Our AMA will encourage the Liaison Committee on Medical Education to assure that medical schools demonstrate compliance with its requirements for a diverse student body and faculty.
5. Our AMA will develop an internal education program for its members on the issues and possibilities involved in creating a diverse physician population.
6. Our AMA will provide on-line educational materials for its membership that address diversity issues in patient care including, but not limited to, culture, religion, race and ethnicity.
7. Our AMA will create and support programs that introduce elementary through high school students, especially those from groups that are underrepresented in medicine (URM), to healthcare careers.
8. Our AMA will create and support pipeline programs and encourage support services for URM college students that will support them as they move through college, medical school and residency programs.
9. Our AMA will recommend that medical school admissions committees use holistic assessments of admission applicants that take into account the diversity of preparation and the variety of talents that applicants bring to their education.
10. Our AMA will advocate for the tracking and reporting to interested stakeholders of demographic information pertaining to URM status collected from Electronic Residency Application Service (ERAS) applications through the National Resident Matching Program (NRMP).



11. Our AMA will continue the research, advocacy, collaborative partnerships and other work that was initiated by the Commission to End Health Care Disparities.

12. Our AMA opposes legislation that would undermine institutions' ability to properly employ affirmative action to promote a diverse student population.

13. Our AMA: (a) supports the publication of a white paper chronicling health care career pipeline programs (also known as pathway programs) across the nation aimed at increasing the number of programs and promoting leadership development of underrepresented minority health care professionals in medicine and the biomedical sciences, with a focus on assisting such programs by identifying best practices and tracking participant outcomes; and (b) will work with various stakeholders, including medical and allied health professional societies, established biomedical science pipeline programs and other appropriate entities, to establish best practices for the sustainability and success of health care career pipeline programs.

14. Our AMA will work with the AAMC and other stakeholders to create a question for the AAMC electronic medical school application to identify previous pipeline program (also known as pathway program) participation and create a plan to analyze the data in order to determine the effectiveness of pipeline programs.

#### *D-305.972, Title VII Funding*

Our AMA will (1) partner with all relevant stakeholders to petition Congress to reinstate funding for Title VII to at least fiscal year 2005 levels of \$300 million and (2) endeavor to educate legislators in Congress about how Title VII-supported programs address health professional shortages, increase the diversity of the workforce, equip health professions students to work in health centers and underserved communities, and ensure that health professionals are ready to address health-related emerging issues.

#### *H-180.944, Plan for Continued Progress Toward Health Equity*

Health equity, defined as optimal health for all, is a goal toward which our AMA will work by advocating for health care access, research, and data collection; promoting equity in care; increasing health workforce diversity; influencing determinants of health; and voicing and modeling commitment to health equity.

#### *H-200.951, Strategies for Enhancing Diversity in the Physician Workforce*

Our AMA (1) supports increased diversity across all specialties in the physician workforce in the categories of race, ethnicity, gender, sexual orientation/gender identity, socioeconomic origin and persons with disabilities; (2) commends the Institute of Medicine for its report, "In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce," and supports the concept that a racially and ethnically diverse educational experience results in better educational outcomes; and (3) encourages medical schools, health care institutions, managed care and other appropriate groups to develop policies articulating the value and importance of diversity as a goal that benefits all participants, and strategies to accomplish that goal.

#### *H-350.960, Underrepresented Student Access to US Medical Schools*

Our AMA: (1) recommends that medical schools should consider in their planning: elements of diversity including but not limited to gender, racial, cultural and economic, reflective of the diversity of their patient population; and (2) supports the development of new and the enhancement of existing programs that will identify and prepare underrepresented students from the high-school level onward and to enroll, retain and graduate increased numbers of underrepresented students.

*H-350.970, Diversity in Medical Education*

Our AMA will: (1) request that the AMA Foundation seek ways of supporting innovative programs that strengthen pre-medical and pre-college preparation for minority students; (2) support and work in partnership with local state and specialty medical societies and other relevant groups to provide education on and promote programs aimed at increasing the number of minority medical school admissions; applicants who are admitted; and (3) encourage medical schools to consider the likelihood of service to underserved populations as a medical school admissions criterion.

*H-350.979, Increase the Representation of Minority and Economically Disadvantaged Populations in the Medical Profession*

Our AMA supports increasing the representation of minorities in the physician population by: (1) Supporting efforts to increase the applicant pool of qualified minority students by: (a) Encouraging state and local governments to make quality elementary and secondary education opportunities available to all; (b) Urging medical schools to strengthen or initiate programs that offer special premedical and precollegiate experiences to underrepresented minority students; (c) urging medical schools and other health training institutions to develop new and innovative measures to recruit underrepresented minority students, and (d) Supporting legislation that provides targeted financial aid to financially disadvantaged students at both the collegiate and medical school levels. (2) Encouraging all medical schools to reaffirm the goal of increasing representation of underrepresented minorities in their student bodies and faculties. (3) Urging medical school admission committees to consider minority representation as one factor in reaching their decisions. (4) Increasing the supply of minority health professionals. (5) Continuing its efforts to increase the proportion of minorities in medical schools and medical school faculty. (6) Facilitating communication between medical school admission committees and premedical counselors concerning the relative importance of requirements, including grade point average and Medical College Aptitude Test scores. (7) Continuing to urge for state legislation that will provide funds for medical education both directly to medical schools and indirectly through financial support to students. (8) Continuing to provide strong support for federal legislation that provides financial assistance for able students whose financial need is such that otherwise they would be unable to attend medical school.

*Code of Ethics 8.5, Disparities in Health Care*

Stereotypes, prejudice, or bias based on gender expectations and other arbitrary evaluations of any individual can manifest in a variety of subtle ways. Differences in treatment that are not directly related to differences in individual patients' clinical needs or preferences constitute inappropriate variations in health care. Such variations may contribute to health outcomes that are considerably worse in members of some populations than those of members of majority populations. This represents a significant challenge for physicians, who ethically are called on to provide the same quality of care to all patients without regard to medically irrelevant personal characteristics. To fulfill this professional obligation in their individual practices physicians should:

- (a) Provide care that meets patient needs and respects patient preferences.
- (b) Avoid stereotyping patients.
- (c) Examine their own practices to ensure that inappropriate considerations about race, gender identify, sexual orientation, sociodemographic factors, or other nonclinical factors, do not affect clinical judgment.

(d) Work to eliminate biased behavior toward patients by other health care professionals and staff who come into contact with patients.

(e) Encourage shared decision making.

(f) Cultivate effective communication and trust by seeking to better understand factors that can influence patients' health care decisions, such as cultural traditions, health beliefs and health literacy, language or other barriers to communication and fears or misperceptions about the health care system.

The medical profession has an ethical responsibility to:

(g) Help increase awareness of health care disparities.

(h) Strive to increase the diversity of the physician workforce as a step toward reducing health care disparities.

(i) Support research that examines health care disparities, including research on the unique health needs of all genders, ethnic groups, and medically disadvantaged populations, and the development of quality measures and resources to help reduce disparities.

## REFERENCES

- <sup>1</sup> Morrison, E., & Cort, D. (2014, March). An Analysis of the Medical School Pipeline: A High School Aspirant to Applicant and Enrollment View. <https://www.aamc.org/data-reports/analysis-brief/report/analysis-medical-school-pipeline-high-school-aspirant-applicant-and-enrollment-view>.
- <sup>2</sup> Hill, W.L. (2019, October 2). *The Myth of the STEM Pipeline*. Inside Higher Ed. <https://www.insidehighered.com/views/2019/10/02/negative-consequences-pipeline-metaphor-stem-fields-opinion>.
- <sup>3</sup> Snyder, C. R., Stover, B., Skillman, S., & Frogner, B. (2016). Supporting Diversity in the Health Professions. <https://www.hrsa.gov/sites/default/files/hrsa/advisory-committees/graduate-medical-edu/resource-papers/May2016.pdf>.
- <sup>4</sup> Diaz, T., Navarro, J. R., & Chen, E. H. (2019). An Institutional Approach to Fostering Inclusion and Addressing Racial Bias: Implications for Diversity in Academic Medicine. *Teaching and Learning in Medicine*, 32(1), 110–116. <https://doi.org/10.1080/10401334.2019.1670665>.
- <sup>5</sup> Lett, L. A., Murdock, H. M., Orji, W. U., Aysola, J., & Sebro, R. (2019). Trends in Racial/Ethnic Representation Among US Medical Students. *JAMA Network Open*, 2(9). <https://doi.org/10.1001/jamanetworkopen.2019.10490>.
- <sup>6</sup> Harley, E. H. (2006). The forgotten history of defunct black medical schools in the 19th and 20th centuries and the impact of the Flexner Report. *Journal of the National Medical Association*, 98(9), 1425.
- <sup>7</sup> Shea, S., & Fullilove, M. T. (1985). Entry of Black and Other Minority Students into U.S. Medical Schools. *New England Journal of Medicine*, 313(15), 933–940. <https://doi.org/10.1056/nejm198510103131506>.
- <sup>8</sup> Savitt, T.L. (1992). Abraham Flexner and the black medical schools. *Flexner and the 1990s: Medical Education in the 20th Century*. New York, NY: Greenwood, 1, 65-81.
- <sup>9</sup> Reyes-Akinbileje, B., Title VII Health Professions Education and Training: Issues in Reauthorization (2008). Library of Congress, Congressional Research Service.
- <sup>10</sup> Nickens, H. W., Ready, T. P., & Petersdorf, R. G. (1994). Project 3000 by 2000 -- Racial and Ethnic Diversity in U.S. Medical Schools. *New England Journal of Medicine*, 331(7), 472–476. <https://doi.org/10.1056/nejm199408183310712>.
- <sup>11</sup> Smedley, B. D., Butler, A. S., & Bristow, L. R. (2004). *In the Nation's Compelling Interest: Ensuring Diversity in the Healthcare Workforce*. National Academies Press.
- <sup>12</sup> Nelson, B. W., Bird, R. A., & Rogers, G. M. (1970). Expanding educational opportunities in medicine for blacks and other minority students. *Academic Medicine*, 45(10), 731–6. <https://doi.org/10.1097/00001888-197010000-00002>.
- <sup>13</sup> Lett, L. A., Orji, W. U., & Sebro, R. (2018). Declining racial and ethnic representation in clinical academic medicine: A longitudinal study of 16 US medical specialties. *Plos One*, 13(11). <https://doi.org/10.1371/journal.pone.0207274>.
- <sup>14</sup> Hill, W. L. (2019, October 2). Inside Higher Ed. The negative consequences of the pipeline metaphor for STEM fields (opinion). <https://www.insidehighered.com/views/2019/10/02/negative-consequences-pipeline-metaphor-stem-fields-opinion>.

- <sup>15</sup> Giordani, B., Edwards, A. S., Segal, S. S., Gillum, L. H., Lindsay, A., & Johnson, N. (2001). Effectiveness of a Formal Post-baccalaureate Pre-medicine Program for Underrepresented Minority Students. *Academic Medicine*, 76(8), 844–848. <https://doi.org/10.1097/00001888-200108000-00020>.
- <sup>16</sup> Collier, C. N. (2019). In the Pipeline vs On the Pathway. *Journal of Best Practices in Health Professions Diversity*, 12(1).
- <sup>17</sup> HRSA. (2012). *Health Professions Training Program*. Retrieved from <https://data.hrsa.gov/topics/health-workforce/training-programs>.
- <sup>18</sup> Reynolds, P. P. (2008). A Legislative History of Federal Assistance for Health Professions Training in Primary Care Medicine and Dentistry in the United States, 1963–2008. *Academic Medicine*, 83(11), 1004–1014. <https://doi.org/10.1097/acm.0b013e318189278c>.
- <sup>19</sup> SHPEP. (2020). History of the Summer Health Professions Education Program. <http://www.shpep.org/about/history/>
- <sup>20</sup> Rural Health Information Hub. Rural Project Examples Addressing Health workforce pipeline. <https://www.ruralhealthinfo.org/project-examples/topics/health-workforce-pipeline>.
- <sup>21</sup> Freeman, B. K., Landry, A., Trevino, R., Grande, D., & Shea, J. A. (2016). Understanding the Leaky Pipeline. *Academic Medicine*, 91(7), 987–993. <https://doi.org/10.1097/acm.0000000000001020>.
- <sup>22</sup> Talamantes, E., Henderson, M. C., Fancher, T. L., & Mullan, F. (2019). Closing the Gap — Making Medical School Admissions More Equitable. *New England Journal of Medicine*, 380(9), 803–805. <https://doi.org/10.1056/nejmp1808582>.
- <sup>23</sup> Harris, A. (2018, October 30). The Supreme Court Justice Who Forever Changed Affirmative Action. *The Atlantic*. <https://www.theatlantic.com/education/archive/2018/10/how-lewis-powell-changed-affirmative-action/572938/>.
- <sup>24</sup> Scanlan, L. C. (1996). Hopwood v. Texas: A Backward View at Affirmative Action in Education. *New York University Law Review*, 71. <https://www.nyulawreview.org/wp-content/uploads/2018/08/NYULawReview-71-6-Scanlan.pdf>.
- <sup>25</sup> Herman, C.R., "The Clarification of Proposition 209: Gauging the Impact on Native Americans at the University of California" (2014). *Pomona Senior Theses*. 123. [https://scholarship.claremont.edu/pomona\\_theses/123](https://scholarship.claremont.edu/pomona_theses/123)
- <sup>26</sup> Koseff, A. (2020, June 11). California bill asking voters whether to repeal anti-affirmative action Prop. 209 advances. *SFChronicle.com*. <https://www.sfchronicle.com/politics/article/California-bill-asking-voters-whether-to-repeal-15331604.php>.
- <sup>27</sup> Long, M. C., & Bateman, N. A. (2020). Long-Run Changes in Underrepresentation After Affirmative Action Bans in Public Universities. *Educational Evaluation and Policy Analysis*, 42(2), 188–207. <https://doi.org/10.3102/0162373720904433>.
- <sup>28</sup> United States Government Accountability Office. (2006, March 30). *Health Professions Education Programs: Action Still Needed to Measure Impact*. Retrieved from <https://www.gao.gov/assets/250/249121.html>.
- <sup>29</sup> U.S. House of Representative Committee on Appropriations. (2020). Report. Retrieved from <https://appropriations.house.gov/sites/democrats.appropriations.house.gov/files/LHHS%20Report%20-%20GPO%20-%207.8.20.pdf>.

- <sup>30</sup> Consolidated Appropriations Act of 2021, H.R. 133, 116th Cong. (2020) (enacted). <https://rules.house.gov/sites/democrats.rules.house.gov/files/BILLS-116HR133SA-RCP-116-68.pdf>. Accessed February 5, 2021.
- <sup>31</sup> Youngclaus, J., & Roskovensky, L. (2018). *An updated look at the economic diversity of US medical students*. AAMC Anal Brief, 18(5), 1-3.
- <sup>32</sup> Glazer, G., Danek, J., Michaels, J., Bankston, K., Fair, M., Johnson, S. & Nivet, M. (2014). Holistic admissions in the health professions: findings from a national survey. Urban Universities for HEALTH. Washington, DC.
- <sup>33</sup> Lett, L. A., Orji, W. U., & Sebro, R. (2018). Declining racial and ethnic representation in clinical academic medicine: A longitudinal study of 16 US medical specialties. Plos One, 13(11). <https://doi.org/10.1371/journal.pone.0207274>.
- <sup>34</sup> Price, E. G., Gozu, A., Kern, D. E., Powe, N. R., Wand, G. S., Golden, S., & Cooper, L. A. (2005). The role of cultural diversity climate in recruitment, promotion, and retention of faculty in academic medicine. Journal of General Internal Medicine, 20(7), 565–571. <https://doi.org/10.1111/j.1525-1497.2005.0127.x>
- <sup>35</sup> Tinto, V. (1975). Dropout from Higher Education: A Theoretical Synthesis of Recent Research. Review of Educational Research, 45(1), 89–125. <https://doi.org/10.3102/00346543045001089>.
- <sup>36</sup> Braxton, J. M., Hirschy, A. S., & McClendon, S. A. (2004). Understanding and reducing college student departure. Jossey-Bass.
- <sup>37</sup> Creighton, L. M. (2007). Factors Affecting the Graduation Rates of University Students from Underrepresented Populations. International Electronic Journal for Leadership in Learning. <https://eric.ed.gov/?id=EJ987305>.
- <sup>38</sup> Jaschik, S. (2016, September 26). Campuses see flurry of racist incidents and protests against racism. <https://www.insidehighered.com/news/2016/09/26/campuses-see-flurry-racist-incidents-and-protests-against-racism>.
- <sup>39</sup> Boatright, D., Branzetti, J., Duong, D., Hicks, M., Moll, J., Perry, M., ... & Heron, S. (2018). Racial and ethnic diversity in academic emergency medicine: how far have we come? Next steps for the future. *AEM education and training*, 2, S31-S39.
- <sup>40</sup> Huffman, T. (2001). Resistance Theory and the Transculturation Hypothesis as Explanations of College Attrition and Persistence Among Culturally Traditional American Indian Students. Journal of American Indian Education, 40(3), 1-23. Retrieved July 14, 2020, from [www.jstor.org/stable/24398349](http://www.jstor.org/stable/24398349).
- <sup>41</sup> Blanchard, M.H., Autry, A.M., Brown, H.L., Musich, J.R., Kaufman, L., Wells, D.R., Stager, R.D., Swanson, J.L., Lund, K.J., Wiper III, D.W. and Bailit, J.L. (2005). *A multicenter study to determine motivating factors for residents pursuing obstetrics and gynecology*. American journal of obstetrics and gynecology, 193(5), 1835-1841.
- <sup>42</sup> Emmons SL, Adams KE, Nichols M, Cain J. (2004). *The impact of perceived gender bias on obstetrics and gynecology skills acquisition by third-year medical students*. Acad Med;79:326e32.
- <sup>43</sup> U.S. Department of Health and Human Services. (2009). (rep.). Pipeline Programs to Improve Racial and Ethnic Diversity in the Health Professions. Retrieved from <https://www.aapcho.org/wp/wp-content/uploads/2012/11/PipelineToImproveDiversityInHealthProfessions.pdf>.
- <sup>44</sup> Snyder, C. R., Stover, B., Skillman, S. M., & Frogner, B. K. (2015). (rep.). Facilitating Racial and Ethnic Diversity in the Health Workforce. Retrieved from

[http://depts.washington.edu/uwrhrc/uploads/FINALREPORT\\_Facilitating%20Diversity%20in%20the%20Health%20Workforce\\_7.8.2015.pdf](http://depts.washington.edu/uwrhrc/uploads/FINALREPORT_Facilitating%20Diversity%20in%20the%20Health%20Workforce_7.8.2015.pdf).

<sup>45</sup> Lewin, V. E. (2002). Effectiveness of pre-baccalaureate Health Careers Opportunity Programs (HCOP) for disadvantaged students in three Southern states (dissertation).

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 301  
(JUN-21)

Introduced by: New York

Subject: Medical Education Debt Cancellation in the Face of a Physician Shortage  
During the COVID-19 Pandemic

Referred to: Reference Committee C

---

1 Whereas, There is a physician shortage facing our nation; and<sup>i</sup>

2  
3 Whereas, The shortage is going to worsen since 2 of 5 current physicians will be 65 years or  
4 older and in retirement age this year; and<sup>i</sup>

5  
6 Whereas, The shortage is amplified now during the COVID-19 pandemic, demonstrating now  
7 more than ever the need for a sufficient and robust physician workforce; and<sup>i</sup>

8  
9 Whereas, An unprecedented number of physicians now plan to retire in the next year and many  
10 of whom are under 45 years old and therefore would be retiring earlier than expected by  
11 workforce shortage predictors due to COVID-19; and<sup>ii</sup>

12  
13 Whereas, 8% of physicians surveyed across the United States have closed their practices  
14 during the pandemic, amounting to approximately 16,000 closed practices further exacerbating  
15 the shortage of healthcare providers; and<sup>iii</sup>

16  
17 Whereas, The COVID-19 pandemic has placed immense financial strain on physicians across  
18 specialties who have reported loss of staff, lack of reimbursement, and closure of independent  
19 physician practices during the COVID-19 pandemic; and<sup>iii,iv</sup>

20  
21 Whereas, Young physicians are expected to be part of the workforce for many years to come,  
22 yet the majority of healthcare workers (HCW) who died during the COVID-19 pandemic were  
23 under 60 years old with primary care physicians (PCPs) accounting for a disproportionate  
24 number of these HCW deaths; and<sup>v,vi</sup>

25  
26 Whereas, Before the pandemic, the physician shortage in New York State (NYS) was already  
27 predicted to be between 2,500 and 17,000 by 2030; and<sup>vii</sup>

28  
29 Whereas, During the pandemic, the shortage has been amplified in that New York City has had  
30 the highest COVID-19 death rate in the country with NYS accounting for the greatest number of  
31 HCW deaths in the USA; and<sup>v,viii</sup>

32  
33 Whereas, 73% of medical students graduated with debt in 2020; and<sup>ix</sup>

34  
35 Whereas, The cost of medical school has increased 129% in the past 20 years after adjusting  
36 for inflation, affecting newer generations of students and physicians substantially more than past  
37 ones; and<sup>x</sup>



1 Whereas, The average medical student debt is \$207,003--an approximately 28% increase in the  
2 past 10 years--however, the average physician ultimately pays \$365,000-\$440,000 for an  
3 educational loan with interest; and<sup>ix,x,xi</sup>

4  
5 Whereas, In the United States, 50% of low-income medical school graduates have educational  
6 debt that exceeds \$100,000; and<sup>x</sup>

7  
8 Whereas, The financial barrier to entry into medical school is significant in that over half of  
9 medical students belong to the top quintile of US household income, with 20-30% of students  
10 belonging to the top 5% of income; however, only less than 5% of students come from the  
11 lowest quintile of US household income; and<sup>x</sup>

12  
13 Whereas, A recent study found that higher debt levels among medical students is more likely to  
14 motivate them to choose higher paying specialties than primary care specialties; and<sup>xii</sup>

15  
16 Whereas, Higher burdens of educational debt has been demonstrated to cause residents to  
17 place greater emphasis on financial considerations when choosing a specialty; and<sup>xiii</sup>

18  
19 Whereas, The COVID-19 pandemic is producing a secondary surge in primary care need that  
20 has been studied previously in natural disasters and has been shown to persist for years;  
21 and<sup>xiv,xv</sup>

22  
23 Whereas, It is well-established that health inequities existed before the pandemic in that  
24 individuals with low socioeconomic status are more likely to also be from minority populations,  
25 and are more likely to have worse health outcomes; and<sup>xvi</sup>

26  
27 Whereas, These inequities have now been exacerbated by the pandemic, with the heaviest  
28 burden of COVID-19 disease falling upon Black, Latinx, and immigrant communities; and<sup>xvii</sup>

29  
30 Whereas, Over 27 million Americans have lost their employer-sponsored health insurance  
31 during the pandemic; thus, we will need more physicians now than ever before to address these  
32 disparities and rising needs in health care; and<sup>xviii</sup>

33  
34 Whereas, 72% of physicians surveyed across specialties reported loss of income during the  
35 pandemic, with over half of these respondents reporting losses of 26% or more; and<sup>iii</sup>

36  
37 Whereas, Policies modeled to include provisions for debt relief or increase in incomes were  
38 found by one study to be more likely to incentivize students to choose primary care physician  
39 specialties; and<sup>xix</sup>

40  
41 Whereas, Current AMA policies support methods to alleviate debt burden but do not address  
42 debt cancellation specifically; and

43  
44 Whereas, \$50 billion of the initial CARES Act Provider Relief Fund were allocated to support the  
45 current healthcare system by giving hospitals and providers funding "to support health care-  
46 related expenses or lost revenue attributable to COVID-19..."; however, funding formulas based  
47 on market shares of Medicare costs and total patient revenue are most likely to bankrupt  
48 independent physicians, specifically primary care providers; and<sup>xx,xxi</sup>

49  
50 Whereas, One study found that primary care internists whose medical education were funded  
51 through Public Service Loan Forgiveness and Federally Granted Loans were predicted to have

1 significantly less net present value than primary care internists who received military or private  
2 funding; and<sup>xxii</sup>

3  
4 Whereas, Medical education debt has been shown to be a significant barrier for  
5 underrepresented minorities and low/middle income strata students to choose medicine for a  
6 career; and<sup>xxii</sup>

7  
8 Whereas, A key strategy to address health needs of underserved communities involves  
9 recruiting students from these communities as they may be more likely to return to address local  
10 health needs; and<sup>xxiii</sup>

11  
12 Whereas, One medical school has created a debt-free program for matriculated students and  
13 saw (1) an increase in applicants to supply the future physician workforce and (2) an increase in  
14 applicants from groups underrepresented in medicine to help address socioeconomic and  
15 racial/ethnic disparities in the medical workforce and in healthcare; and<sup>xxiv</sup>

16  
17 Whereas, There is currently a student debt forgiveness resolution in the United States Senate to  
18 cancel \$50,000 of student debt which will also apply to all medical students, training physicians,  
19 and early career physicians; and<sup>xxv</sup>

20  
21 Whereas, Data suggests women and people of color will benefit most from such debt  
22 cancellation because they are most in need; therefore be it<sup>xxv</sup>

23  
24 RESOLVED, That our American Medical Association study the issue of medical education debt  
25 cancellation and consider the opportunities for integration of this into a broader solution  
26 addressing debt for all medical students, physicians in training, and early career physicians.  
27 (Directive to Take Action)

Fiscal Note: Modest - between \$1,000 - \$5,000

Received: 04/23/21

The topic of this resolution is currently under study by the Council on Medical Education.

#### AUTHOR'S STATEMENT OF PRIORITY

Students, training and attending docs are facing increasing amounts of administrative, regulatory and financial pressures that take a toll and cause increased rates of physician stress, demoralization, burnout and depression.

Data and experience show that physician stress and burnout result in reduced quality of care and reduced quality of patient-doc relationships and reduced patient satisfaction.

This loan forgiveness if achieved would reduce burdens on students and physicians and would contribute to reduced burnout and depression and mitigate reductions in quality of care that result from high levels of burnout.

Students and physicians need help now - this can't wait until the November AMA meetings. Physician needs will be forgotten by the end of summer when we are projected to be near herd immunity.

**RELEVANT AMA POLICY****Cares Act Equity and Loan Forgiveness in the Medicare Accelerated Payment Program D-305.953**

In the setting of the COVID-19 pandemic, our AMA will advocate for additional financial relief for physicians to reduce medical school educational debt.

Citation: Res. 202, I-20

**Principles of and Actions to Address Medical Education Costs and Student Debt H-305.925**

The costs of medical education should never be a barrier to the pursuit of a career in medicine nor to the decision to practice in a given specialty. To help address this issue, our American Medical Association (AMA) will:

1. Collaborate with members of the Federation and the medical education community, and with other interested organizations, to address the cost of medical education and medical student debt through public- and private-sector advocacy.
2. Vigorously advocate for and support expansion of and adequate funding for federal scholarship and loan repayment programs--such as those from the National Health Service Corps, Indian Health Service, Armed Forces, and Department of Veterans Affairs, and for comparable programs from states and the private sector--to promote practice in underserved areas, the military, and academic medicine or clinical research.
3. Encourage the expansion of National Institutes of Health programs that provide loan repayment in exchange for a commitment to conduct targeted research.
4. Advocate for increased funding for the National Health Service Corps Loan Repayment Program to assure adequate funding of primary care within the National Health Service Corps, as well as to permit: (a) inclusion of all medical specialties in need, and (b) service in clinical settings that care for the underserved but are not necessarily located in health professions shortage areas.
5. Encourage the National Health Service Corps to have repayment policies that are consistent with other federal loan forgiveness programs, thereby decreasing the amount of loans in default and increasing the number of physicians practicing in underserved areas.
6. Work to reinstate the economic hardship deferment qualification criterion known as the "20/220 pathway," and support alternate mechanisms that better address the financial needs of trainees with educational debt.
7. Advocate for federal legislation to support the creation of student loan savings accounts that allow for pre-tax dollars to be used to pay for student loans.
8. Work with other concerned organizations to advocate for legislation and regulation that would result in favorable terms and conditions for borrowing and for loan repayment, and would permit 100% tax deductibility of interest on student loans and elimination of taxes on aid from service-based programs.
9. Encourage the creation of private-sector financial aid programs with favorable interest rates or service obligations (such as community- or institution-based loan repayment programs or state medical society loan programs).
10. Support stable funding for medical education programs to limit excessive tuition increases, and collect and disseminate information on medical school programs that cap medical education debt, including the types of debt management education that are provided.
11. Work with state medical societies to advocate for the creation of either tuition caps or, if caps are not feasible, pre-defined tuition increases, so that medical students will be aware of their tuition and fee costs for the total period of their enrollment.
12. Encourage medical schools to (a) Study the costs and benefits associated with non-traditional instructional formats (such as online and distance learning, and combined baccalaureate/MD or DO programs) to determine if cost savings to medical schools and to medical students could be realized without jeopardizing the quality of medical education; (b) Engage in fundraising activities to increase the availability of scholarship support, with the support of the Federation, medical schools, and state and specialty medical societies, and develop or enhance financial aid opportunities for medical students, such as self-managed, low-interest loan programs; (c) Cooperate with postsecondary institutions to establish collaborative debt counseling for entering first-year medical students; (d) Allow for flexible scheduling for medical students who encounter financial difficulties that can be remedied only by employment, and consider creating opportunities for paid employment for medical students; (e) Counsel individual medical student borrowers on the status of their indebtedness and payment schedules prior to their graduation; (f) Inform students of all government loan opportunities and disclose the reasons that preferred lenders were chosen; (g) Ensure that all medical student fees are earmarked for specific and well-defined purposes,

and avoid charging any overly broad and ill-defined fees, such as but not limited to professional fees; (h) Use their collective purchasing power to obtain discounts for their students on necessary medical equipment, textbooks, and other educational supplies; (i) Work to ensure stable funding, to eliminate the need for increases in tuition and fees to compensate for unanticipated decreases in other sources of revenue; mid-year and retroactive tuition increases should be opposed.

13. Support and encourage state medical societies to support further expansion of state loan repayment programs, particularly those that encompass physicians in non-primary care specialties.

14. Take an active advocacy role during reauthorization of the Higher Education Act and similar legislation, to achieve the following goals: (a) Eliminating the single holder rule; (b) Making the availability of loan deferment more flexible, including broadening the definition of economic hardship and expanding the period for loan deferment to include the entire length of residency and fellowship training; (c) Retaining the option of loan forbearance for residents ineligible for loan deferment; (d) Including, explicitly, dependent care expenses in the definition of the “cost of attendance”; (e) Including room and board expenses in the definition of tax-exempt scholarship income; (f) Continuing the federal Direct Loan Consolidation program, including the ability to “lock in” a fixed interest rate, and giving consideration to grace periods in renewals of federal loan programs; (g) Adding the ability to refinance Federal Consolidation Loans; (h) Eliminating the cap on the student loan interest deduction; (i) Increasing the income limits for taking the interest deduction; (j) Making permanent the education tax incentives that our AMA successfully lobbied for as part of Economic Growth and Tax Relief Reconciliation Act of 2001; (k) Ensuring that loan repayment programs do not place greater burdens upon married couples than for similarly situated couples who are cohabitating; (l) Increasing efforts to collect overdue debts from the present medical student loan programs in a manner that would not interfere with the provision of future loan funds to medical students.

15. Continue to work with state and county medical societies to advocate for adequate levels of medical school funding and to oppose legislative or regulatory provisions that would result in significant or unplanned tuition increases.

16. Continue to study medical education financing, so as to identify long-term strategies to mitigate the debt burden of medical students, and monitor the short-and long-term impact of the economic environment on the availability of institutional and external sources of financial aid for medical students, as well as on choice of specialty and practice location.

17. Collect and disseminate information on successful strategies used by medical schools to cap or reduce tuition.

18. Continue to monitor the availability of and encourage medical schools and residency/fellowship programs to (a) provide financial aid opportunities and financial planning/debt management counseling to medical students and resident/fellow physicians; (b) work with key stakeholders to develop and disseminate standardized information on these topics for use by medical students, resident/fellow physicians, and young physicians; and (c) share innovative approaches with the medical education community.

19. Seek federal legislation or rule changes that would stop Medicare and Medicaid decertification of physicians due to unpaid student loan debt. The AMA believes that it is improper for physicians not to repay their educational loans, but assistance should be available to those physicians who are experiencing hardship in meeting their obligations.

20. Related to the Public Service Loan Forgiveness (PSLF) Program, our AMA supports increased medical student and physician benefits the program, and will: (a) Advocate that all resident/fellow physicians have access to PSLF during their training years; (b) Advocate against a monetary cap on PSLF and other federal loan forgiveness programs; (c) Work with the United States Department of Education to ensure that any cap on loan forgiveness under PSLF be at least equal to the principal amount borrowed; (d) Ask the United States Department of Education to include all terms of PSLF in the contractual obligations of the Master Promissory Note; (e) Encourage the Accreditation Council for Graduate Medical Education (ACGME) to require residency/fellowship programs to include within the terms, conditions, and benefits of program appointment information on the PSLF program qualifying status of the employer; (f) Advocate that the profit status of a physicians training institution not be a factor for PSLF eligibility; (g) Encourage medical school financial advisors to counsel wise borrowing by medical students, in the event that the PSLF program is eliminated or severely curtailed; (h) Encourage medical school financial advisors to increase medical student engagement in service-based loan repayment options, and other federal and military programs, as an attractive alternative to the PSLF in terms of financial prospects as well as providing the opportunity to provide care in medically underserved areas; (i)

Strongly advocate that the terms of the PSLF that existed at the time of the agreement remain unchanged for any program participant in the event of any future restrictive changes.

21. Advocate for continued funding of programs including Income-Driven Repayment plans for the benefit of reducing medical student load burden.

22. Formulate a task force to look at undergraduate medical education training as it relates to career choice, and develop new policies and novel approaches to prevent debt from influencing specialty and subspecialty choice.

Citation: CME Report 05, I-18; Appended: Res. 953, I-18; Reaffirmation: A-19; Appended: Res. 316, A-19

- 
- <sup>i</sup> "The Complexities of Physician Supply and Demand: Projections From 2018 to 2033." American Association of Medical Colleges. June 2020. Retrieved from <<https://www.aamc.org/media/45976/download>>
- <sup>ii</sup> The Physicians Foundation 2020 Physician Survey: Part 2. The Physicians Foundation. <https://physiciansfoundation.org/research-insights/the-physicians-foundation-2020-physician-survey-part-2/>. Published September 17, 2020. Accessed March 10, 2021.
- <sup>iii</sup> The Physicians Foundation 2020 Physician Survey: Part 1. The Physicians Foundation. <https://physiciansfoundation.org/research-insights/2020physiciansurvey/>. Published August 18, 2020. Accessed March 10, 2021.
- <sup>iv</sup> Primary Care & COVID-19: Week 9 Survey. Primary Care Collaborative. <https://www.pcpcc.org/2020/05/13/primary-care-covid-19-week-9-survey>. Published May 13, 2020. Accessed March 10, 2021.
- <sup>v</sup> Our key findings about US healthcare worker deaths to date. The Guardian. <https://www.theguardian.com/us-news/ng-interactive/2020/dec/22/lost-on-the-frontline-our-findings-to-date>. Published February 10, 2021. Accessed March 10, 2021.
- <sup>vi</sup> Gouda D, Singh PM, Gouda P, Goudra B. An Overview of Health Care Worker Reported Deaths During the COVID-19 Pandemic. *The Journal of the American Board of Family Medicine*. 2021;34(Supplement):S244-S246. doi:10.3122/jabfm.2021.s1.200248
- <sup>vii</sup> New York Physician Supply and Demand Through 2030. The Center for Health Workforce Studies. <https://www.albany.edu/news/images/PhysicianShortagereport.pdf>. Published March 2009. Accessed March 10, 2021.
- <sup>viii</sup> CDC COVID Data Tracker. Centers for Disease Control and Prevention. [https://covid.cdc.gov/covid-data-tracker/?CDC\\_AA\\_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fcases-updates%2Fcases-in-us.html#compare-trends\\_newcases](https://covid.cdc.gov/covid-data-tracker/?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fcases-updates%2Fcases-in-us.html#compare-trends_newcases). Published 2021. Accessed March 10, 2021.
- <sup>ix</sup> "Medical Student Education: Debt Costs, and Loan Repayment Fact Card for the Class of 2020". American Association of Medical Colleges. October 2020. Retrieved from <<https://store.aamc.org/medical-student-education-debt-costs-and-loan-repayment-fact-card-for-the-class-of-2020.html>>
- <sup>x</sup> Average Medical School Debt [2021]: Student Loan Statistics. EducationData. <https://educationdata.org/average-medical-school-debt>.
- <sup>xi</sup> "Trends in Cost and Debt at U.S. Medical Schools Using a New Measure of Medical School Cost of Attendance". *Analysis in Brief*. American Association of Medical Colleges. Vol 12. No 2. July 2012. Retrieved from <<https://www.aamc.org/media/5951/download#:~:text=In%201978%20indebted%20graduates%20across,average%2C%207.8%20percent%20per%20year>>
- <sup>xii</sup> Pisaniello MS, Asahina AT, Bacchi S, et al. Effect of medical student debt on mental health, academic performance and specialty choice: a systematic review. *BMJ Open*. 2019;9(7):e029980. Published 2019 Jul 2. doi:10.1136/bmjopen-2019-029980
- <sup>xiii</sup> West CP, Drefahl MM, Popkave C, Kolars JC. Internal medicine resident self-report of factors associated with career decisions. *J Gen Intern Med*. 2009 Aug;24(8):946-9. doi: 10.1007/s11606-009-1039-0. Epub 2009 Jun 24. PMID: 19551448; PMCID: PMC2710478.
- <sup>xiv</sup> Weinstein E, Ragazzoni L, Burkle F, Allen M, Hogan D, Della Corte F. Delayed Primary and Specialty Care: The Coronavirus Disease-2019 Pandemic Second Wave. *Disaster Medicine and Public Health Preparedness*. 2020;14(3):e19-e21. doi:10.1017/dmp.2020.148
- <sup>xv</sup> Runkle JD, Brock-Martin A, Karmaus W, Svendsen ER. Secondary Surge Capacity: A Framework for Understanding Long-Term Access to Primary Care for Medically Vulnerable Populations in Disaster Recovery. *American Journal of Public Health*. 2012;102(12):e24-e32. doi:10.2105/ajph.2012.301027
- <sup>xvi</sup> Chowkwanyun M, Reed AL Jr. Racial Health Disparities and Covid-19 - Caution and Context. *N Engl J Med*. 2020 Jul 16;383(3):201-203. doi: 10.1056/NEJMp2012910. Epub 2020 May 6. PMID: 32374952.
- <sup>xvii</sup> Krouse HJ. COVID-19 and the Widening Gap in Health Inequity. *Otolaryngol Head Neck Surg*. 2020 Jul;163(1):65-66. doi: 10.1177/0194599820926463. Epub 2020 May 5. PMID: 32366172.
- <sup>xviii</sup> Geyman JP. Beyond the COVID-19 Pandemic: The Urgent Need to Expand Primary Care and Family Medicine. *Fam Med*. 2021 Jan;53(1):48-53. doi: 10.22454/FamMed.2021.709555. PMID: 33471922.
- <sup>xix</sup> Vaughn BT, DeVrieze SR, Reed SD, Schulman KA. Can we close the income and wealth gap between specialists and primary care physicians? *Health Aff (Millwood)*. 2010 May;29(5):933-40. doi: 10.1377/hlthaff.2009.0675. PMID: 20439883.
- <sup>xx</sup> Mulvany C. CARES Act payback problem for some healthcare providers. Healthcare Financial Management Association (HFMA). <https://www.hfma.org/topics/coronavirus/cares-act-payback-problem-for-some-healthcare-providers-.html>. Published May 20, 2020. Accessed March 15, 2021.
- <sup>xxi</sup> Chin MH. Cherry Blossoms, COVID-19, and the Opportunity for a Healthy Life. *The Annals of Family Medicine*. 2021;19(1):63-65. doi:10.1370/afm.2630
- <sup>xxii</sup> Marcu MI, Kellermann AL, Hunter C, Curtis J, Rice C, Wilensky GR. Borrow or Serve? An Economic Analysis of Options for Financing a Medical School Education. *Academic Medicine*. 2017;92(7):966-975. doi:10.1097/acm.0000000000001572
- <sup>xxiii</sup> Larkins S, Michielsen K, Iputo J, Elsanousi S, Mammen M, Graves L, Willems S, Cristobal FL, Samson R, Ellaway R, Ross S, Johnston K, Derese A, Neusy AJ. Impact of selection strategies on representation of underserved populations and intention to practise: international findings. *Med Educ*. 2015 Jan;49(1):60-72. doi: 10.1111/medu.12518. PMID: 25545574.
- <sup>xxiv</sup> Kang, Y, et al. "Debt-Free Medical Education - A Tool for Health Care Workforce Diversity." *JAMA*. December 2020. Retrieved from <<https://jamanetwork.com/channels/health-forum/fullarticle/2774066>>
- <sup>xxv</sup> Warren, E et al. US Senate Resolution. 116th Congress, 2d Session. Retrieved from <<https://www.warren.senate.gov/imo/media/doc/Schumer%20Warren%20resolution.pdf>>

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 302  
(JUN-21)

Introduced by: New York

Subject: Non-Physician Post-Graduate Medical Training

Referred to: Reference Committee C

---

1 Whereas, Data collected by AMA's Truth in Advertising campaign suggest nearly 90% of  
2 patients believe "only a medical doctor or doctor of osteopathic medicine should be able to use  
3 the title "physician"; and  
4

5 Whereas, In the same campaign, nearly 80% of patients "support legislation to require all health  
6 care advertising materials to clarify designate the level of education, skills, and training of all  
7 health care professionals promising their services"; and  
8

9 Whereas, The Centers for Medicare and Medicaid Services defines a resident as "an intern,  
10 resident, or fellow who is formally accepted, enrolled, and participating in an approved medical  
11 residency program including programs in osteopathy, dentistry, and podiatry as required to  
12 become certified by the appropriate specialty board"; and  
13

14 Whereas, There has been an increase in the number of physician assistant (PA) and nurse  
15 practitioner (NP) postgraduate programs, many of which are inappropriately referred to as  
16 "residencies" or "fellowships"; and  
17

18 Whereas, On September 3rd, 2020, every major academic emergency medicine association  
19 issued a joint statement affirming that "the terms 'resident,' 'residency,' 'fellow,' and 'fellowship'  
20 in a medical setting must be limited to postgraduate clinical training of medical school physician  
21 graduates within graduate medical education (GME) training programs"; and  
22

23 Whereas, Several of these training programs pay their first-year trainees more than the  
24 first-year residents in physician residencies; therefore be it  
25

26 RESOLVED, That our American Medical Association recognize that the terms "medical  
27 student," "resident," "residency," "fellow," "fellowship," "doctor," and "attending," when used in  
28 the healthcare setting, all connote completing structured, rigorous, medical education  
29 undertaken by physicians; thus these terms should be reserved to describe physician roles  
30 (New HOD Policy); and be it further  
31

32 RESOLVED, That our AMA work with relevant stakeholders to define appropriate labels for  
33 postgraduate clinical and diagnostic training programs for non-physicians that recognizes the  
34 rigor of these programs but prevents role confusion associated with the terms "resident,"  
35 "residency," "fellow," or "fellowship" (Directive to Take Action); and be it further

1 RESOLVED, That our AMA object to the American Board of Medical Specialists, the American  
 2 Osteopathic Association Bureau of Osteopathic Specialists, and their member boards having  
 3 designated seats for Nurse Practitioners, Physician Assistants, Certified Registered Nurse  
 4 Anesthetists, Anesthesia Assistants, or any other healthcare professional that are independent  
 5 from the public member seats (Directive to Take Action); and be it further  
 6

7 RESOLVED, That our AMA work with relevant stakeholders to assure that funds to support the  
 8 expansion of postgraduate clinical training for non-physicians does not divert funding from  
 9 physician graduate medical education. (Directive to Take Action)

Fiscal Note: Modest - between \$1,000 - \$5,000

Received: 04/26/21

#### AUTHOR'S STATEMENT OF PRIORITY

This resolution aims to recognize the unique skill set held by physicians and the important educational opportunities afforded to them. Words matter and it is important to provide clarity and transparency when describing the roles of physicians and allied healthcare professionals, especially for patients. It is important to act now given the increasing proliferation of post-graduate specialty training programs for physician assistants and nurse practitioners in the context of the simultaneous push to expand these non-physician practitioners' scope of practice using the ongoing COVID19 pandemic as an excuse.

#### **RELEVANT AMA POLICY**

##### **Clarification of the Title "Doctor" in the Hospital Environment D-405.991**

1. Our AMA Commissioners will, for the purpose of patient safety, request that The Joint Commission develop and implement standards for an identification system for all hospital facility staff who have direct contact with patients which would require that an identification badge be worn which indicates the individual's name and credentials as appropriate (i.e., MD, DO, RN, LPN, DC, DPM, DDS, etc), to differentiate between those who have achieved a Doctorate, and those with other types of credentials.
2. Our AMA Commissioners will, for the purpose of patient safety, request that The Joint Commission develop and implement new standards that require anyone in a hospital environment who has direct contact with a patient who presents himself or herself to the patient as a "doctor," and who is not a "physician" according to the AMA definition (H-405.969, ?that a physician is an individual who has received a "Doctor of Medicine" or a "Doctor of Osteopathic Medicine" degree or an equivalent degree following successful completion of a prescribed course of study from a school of medicine or osteopathic medicine?) must specifically and simultaneously declare themselves a "non-physician" and define the nature of their doctorate degree.
3. Our AMA will request the American Osteopathic Association (AOA) to (1) expand their standards to include proper identification of all medical staff and hospital personnel with their applicable credential (i.e., MD, DO, RN, LPN, DC, DPM, DDS, etc), and (2) Require anyone in a hospital environment who has direct contact with a patient presenting himself or herself to the patient as a "doctor", who is not a "Physician" according to the AMA definition (AMA Policy H-405.969 .. that a physician is an individual who has received a "Doctor of Medicine" or a "Doctor of Osteopathic Medicine" degree or an equivalent degree following successful completion of a prescribed course of study from a school of medicine or osteopathic medicine) must specifically and simultaneously declare themselves a "non-physician" and define the nature of their doctorate degree.

Citation: (Res. 846, I-08; Modified: BOT Rep. 9, I-09; Reaffirmed: Res. 218, A-12)

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

1. Our AMA will actively collaborate with appropriate stakeholder organizations, (including Association of American Medical Colleges, American Hospital Association, state medical societies, medical specialty societies/associations) to advocate for the preservation, stability and expansion of full funding for the direct and indirect costs of graduate medical education (GME) positions from all existing sources (e.g. Medicare, Medicaid, Veterans Administration, CDC and others).
2. Our AMA will actively advocate for the stable provision of matching federal funds for state Medicaid programs that fund GME positions.
3. Our AMA will actively seek congressional action to remove the caps on Medicare funding of GME positions for resident physicians that were imposed by the Balanced Budget Amendment of 1997 (BBA-1997).
4. Our AMA will strenuously advocate for increasing the number of GME positions to address the future physician workforce needs of the nation.
5. Our AMA will oppose efforts to move federal funding of GME positions to the annual appropriations process that is subject to instability and uncertainty.
6. Our AMA will oppose regulatory and legislative efforts that reduce funding for GME from the full scope of resident educational activities that are designated by residency programs for accreditation and the board certification of their graduates (e.g. didactic teaching, community service, off-site ambulatory rotations, etc.).
7. Our AMA will actively explore additional sources of GME funding and their potential impact on the quality of residency training and on patient care.
8. Our AMA will vigorously advocate for the continued and expanded contribution by all payers for health care (including the federal government, the states, and local and private sources) to fund both the direct and indirect costs of GME.
9. Our AMA will work, in collaboration with other stakeholders, to improve the awareness of the general public that GME is a public good that provides essential services as part of the training process and serves as a necessary component of physician preparation to provide patient care that is safe, effective and of high quality.
10. Our AMA staff and governance will continuously monitor federal, state and private proposals for health care reform for their potential impact on the preservation, stability and expansion of full funding for the direct and indirect costs of GME.
11. Our AMA: (a) recognizes that funding for and distribution of positions for GME are in crisis in the United States and that meaningful and comprehensive reform is urgently needed; (b) will immediately work with Congress to expand medical residencies in a balanced fashion based on expected specialty needs throughout our nation to produce a geographically distributed and appropriately sized physician workforce; and to make increasing support and funding for GME programs and residencies a top priority of the AMA in its national political agenda; and (c) will continue to work closely with the Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, American Osteopathic Association, and other key stakeholders to raise awareness among policymakers and the public about the importance of expanded GME funding to meet the nation's current and anticipated medical workforce needs.
12. Our AMA will collaborate with other organizations to explore evidence-based approaches to quality and accountability in residency education to support enhanced funding of GME.
13. Our AMA will continue to strongly advocate that Congress fund additional graduate medical education (GME) positions for the most critical workforce needs, especially considering the current and worsening maldistribution of physicians.
14. Our AMA will advocate that the Centers for Medicare and Medicaid Services allow for rural and other underserved rotations in Accreditation Council for Graduate Medical Education (ACGME)-accredited residency programs, in disciplines of particular local/regional need, to occur in the offices of physicians who meet the qualifications for adjunct faculty of the residency program's sponsoring institution.
15. Our AMA encourages the ACGME to reduce barriers to rural and other underserved community experiences for graduate medical education programs that choose to provide such training, by adjusting as needed its program requirements, such as continuity requirements or limitations on time spent away from the primary residency site.
16. Our AMA encourages the ACGME and the American Osteopathic Association (AOA) to continue to develop and disseminate innovative methods of training physicians efficiently that foster the skills and inclinations to practice in a health care system that rewards team-based care and social accountability.



17. Our AMA will work with interested state and national medical specialty societies and other appropriate stakeholders to share and support legislation to increase GME funding, enabling a state to accomplish one or more of the following: (a) train more physicians to meet state and regional workforce needs; (b) train physicians who will practice in physician shortage/underserved areas; or (c) train physicians in undersupplied specialties and subspecialties in the state/region.

18. Our AMA supports the ongoing efforts by states to identify and address changing physician workforce needs within the GME landscape and continue to broadly advocate for innovative pilot programs that will increase the number of positions and create enhanced accountability of GME programs for quality outcomes.

19. Our AMA will continue to work with stakeholders such as Association of American Medical Colleges (AAMC), ACGME, AOA, American Academy of Family Physicians, American College of Physicians, and other specialty organizations to analyze the changing landscape of future physician workforce needs as well as the number and variety of GME positions necessary to provide that workforce.

20. Our AMA will explore innovative funding models for incremental increases in funded residency positions related to quality of resident education and provision of patient care as evaluated by appropriate medical education organizations such as the Accreditation Council for Graduate Medical Education.

21. Our AMA will utilize its resources to share its content expertise with policymakers and the public to ensure greater awareness of the significant societal value of graduate medical education (GME) in terms of patient care, particularly for underserved and at-risk populations, as well as global health, research and education.

22. Our AMA will advocate for the appropriation of Congressional funding in support of the National Healthcare Workforce Commission, established under section 5101 of the Affordable Care Act, to provide data and healthcare workforce policy and advice to the nation and provide data that support the value of GME to the nation.

23. Our AMA supports recommendations to increase the accountability for and transparency of GME funding and continue to monitor data and peer-reviewed studies that contribute to further assess the value of GME.

24. Our AMA will explore various models of all-payer funding for GME, especially as the Institute of Medicine (now a program unit of the National Academy of Medicine) did not examine those options in its 2014 report on GME governance and financing.

25. Our AMA encourages organizations with successful existing models to publicize and share strategies, outcomes and costs.

26. Our AMA encourages insurance payers and foundations to enter into partnerships with state and local agencies as well as academic medical centers and community hospitals seeking to expand GME.

27. Our AMA will develop, along with other interested stakeholders, a national campaign to educate the public on the definition and importance of graduate medical education, student debt and the state of the medical profession today and in the future.

28. Our AMA will collaborate with other stakeholder organizations to evaluate and work to establish consensus regarding the appropriate economic value of resident and fellow services.

29. Our AMA will monitor ongoing pilots and demonstration projects, and explore the feasibility of broader implementation of proposals that show promise as alternative means for funding physician education and training while providing appropriate compensation for residents and fellows.

30. Our AMA will monitor the status of the House Energy and Commerce Committee's response to public comments solicited regarding the 2014 IOM report, Graduate Medical Education That Meets the Nation's Health Needs, as well as results of ongoing studies, including that requested of the GAO, in order to formulate new advocacy strategy for GME funding, and will report back to the House of Delegates regularly on important changes in the landscape of GME funding.

31. Our AMA will advocate to the Centers for Medicare & Medicaid Services to adopt the concept of "Cap-Flexibility" and allow new and current Graduate Medical Education teaching institutions to extend their cap-building window for up to an additional five years beyond the current window (for a total of up to ten years), giving priority to new residency programs in underserved areas and/or economically depressed areas.

32. Our AMA will: (a) encourage all existing and planned allopathic and osteopathic medical schools to thoroughly research match statistics and other career placement metrics when developing career guidance plans; (b) strongly advocate for and work with legislators, private sector partnerships, and existing and planned osteopathic and allopathic medical schools to create and fund graduate medical education (GME) programs that can accommodate the equivalent number of additional medical school graduates consistent with the workforce needs of our nation; and (c) encourage the Liaison Committee on

Medical Education (LCME), the Commission on Osteopathic College Accreditation (COCA), and other accrediting bodies, as part of accreditation of allopathic and osteopathic medical schools, to prospectively and retrospectively monitor medical school graduates' rates of placement into GME as well as GME completion.

33. Our AMA encourages the Secretary of the U.S. Department of Health and Human Services to coordinate with federal agencies that fund GME training to identify and collect information needed to effectively evaluate how hospitals, health systems, and health centers with residency programs are utilizing these financial resources to meet the nation's health care workforce needs. This includes information on payment amounts by the type of training programs supported, resident training costs and revenue generation, output or outcomes related to health workforce planning (i.e., percentage of primary care residents that went on to practice in rural or medically underserved areas), and measures related to resident competency and educational quality offered by GME training programs.

Citation: 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; Reaffirmation A-11; Appended: Res. 910, I-11; Reaffirmed in lieu of Res. 303, A-12; Reaffirmed in lieu of Res. 324, A-12; Reaffirmation: I-12; Reaffirmation A-13; Appended: Res. 320, A-13; Appended: CME Rep. 5, A-13; Appended: CME Rep. 7, A-14; Appended: Res. 304, A-14; Modified: CME Rep. 9, A-15; Appended: CME Rep. 1, I-15; Appended: Res. 902, I-15; Reaffirmed: CME Rep. 3, A-16; Appended: Res. 320, A-16; Appended: CME Rep. 04, A-16; Appended: CME Rep. 05, A-16; Reaffirmation A-16; Appended: Res. 323, A-17; Appended: CME Rep. 03, A-18; Appended: Res. 319, A-18; Reaffirmed in lieu of: Res. 960, I-18; Modified: Res. 233, A-19; Modified: BOT Rep. 25, A-19

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 303  
(JUN-21)

Introduced by: American Orthopaedic Foot & Ankle Society  
American Academy of Orthopaedic Surgeons

Subject: Improving the Standardization Process for Assessment of Podiatric Medical Students and Residents by Initiating a Process Enabling Them to Take the USMLE

Referred to: Reference Committee C

---

Whereas, According to the National Board of Medical Examiners (NBME), “All medical boards in the United States accept a passing score on the United States Medical Licensure Examination (USMLE) as evidence that an applicant demonstrates the core competencies to practice medicine. As a result, healthcare consumers throughout the nation enjoy a high degree of confidence that their doctors have met a common standard;” and

Whereas, Medical associations have long supported a uniform standard for licensing, including a public position saying that changes in licensure by non-MD/DO practitioners must be based on education, training, and experience, to ensure patient safety. This is the same position held by the American Podiatric Medical Association (APMA) and the American College of Foot and Ankle Surgeons (ACFAS); and

Whereas, Patients, as well as referring physicians should be able to have the same high degree of confidence that Doctors of Podiatric Medicine (DPMs) have also met this common standard as they provide medical and surgical care to patients within their scope of practice; and

Whereas, To accomplish this goal, and be considered physicians, DPMs should be required to receive sufficient education and training to take and pass all three parts of the USMLE; and

Whereas, AAOS, AOFAS, APMA, and ACFAS have collaborated and agreed upon the pathway for qualified DPM graduates to take all three parts of the USMLE; and

Whereas, The decision as to whether DPM students and graduates would be permitted to take the USMLE rests with the NBME and would be based in part on whether Council on Podiatric Medical Education (CPME) accreditation standards are comparable to Liaison Committee on Medical Education (LCME) standards and sufficient to meet NBME requirements; and

Whereas, Our AMA has the resources to objectively study these standards and if earned, its support would be beneficial to this process; therefore be it

RESOLVED, That our American Medical Association study, with report back at the 2021 Interim House of Delegates Meeting, whether Council on Podiatric Medical Education (CPME) accreditation standards are comparable to Liaison Committee on Medical Education (LCME) standards and sufficient to meet requirements which would allow Doctors of Podiatric Medicine (DPMs) to take all parts of the USMLE. (Directive to Take Action)

Fiscal Note: Modest - between \$1,000 - \$5,000

Received: 05/05/21

#### AUTHORS STATEMENT OF PRIORITY

The preservation of physician-led, team-based care impacts all physicians and patients, and fits squarely within the AMA's mission and strategic plan. Restricting the title "physician" to individuals with M.D. and D.O. degrees is also important to the AMA's membership. Non-physicians have successfully prioritized increasing their scope of practice (SOP) and being given the title of physician through legislative and regulatory means, as opposed to meeting M.D./ D.O. standards of education and training. The pandemic has accelerated this activity with states creating 'temporary' waivers involving SOP, licensure and supervision. Once adopted, these changes are rarely reversed, with permanent seriously deleterious impact.

The AOFAS and AAOS have agreed with two national podiatric organizations on a process by which only podiatrists who meet M.D./D.O. standards for undergraduate and residency accreditation, board certification, and examination requirements would be considered physicians within their scope of practice. However, only the AMA, an organization representing all physicians, has the expertise and resources to evaluate and initiate this new process. Near-term action supporting this important policy of non-physicians being considered physicians by meeting physician standards, instead of lobbying legislators and regulators, will have a positive impact and improve patient care.

This resolution, originally intended to be introduced last year, only asks for a study. The more extensive discussion about what to do with the study results would be a future topic.

#### **RELEVANT AMA POLICY**

##### **Definition of a Physician H-405.969**

1. The AMA affirms that a physician is an individual who has received a "Doctor of Medicine" or a "Doctor of Osteopathic Medicine" degree or an equivalent degree following successful completion of a prescribed course of study from a school of medicine or osteopathic medicine.
2. AMA policy requires anyone in a hospital environment who has direct contact with a patient who presents himself or herself to the patient as a "doctor," and who is not a "physician" according to the AMA definition above, must specifically and simultaneously declare themselves a "non-physician" and define the nature of their doctorate degree.
3. Our AMA actively supports the Scope of Practice Partnership in the Truth in Advertising campaign.

Citation: (CME Rep. 4-A-94 Reaffirmed by Sub. Res. 712, I-94 Reaffirmed and Modified: CME Rep. 2, A-04 Res. 846, I-08 Reaffirmed in lieu of Res. 235, A-09 Reaffirmed: Res. 821, I-09 Appended: BOT Rep. 9, I-09 Reaffirmed: BOT Rep. 9, I-11 Reaffirmation A-13 Reaffirmation A-15 Reaffirmed in lieu of: Res. 225, A-17 Reaffirmed: Res. 228, A-19)

##### **Physician and Nonphysician Licensure and Scope of Practice D-160.995**

1. Our AMA will: (a) continue to support the activities of the Advocacy Resource Center in providing advice and assistance to specialty and state medical societies concerning scope of practice issues to include the collection, summarization and wide dissemination of data on the training and the scope of practice of physicians (MDs and DOs) and nonphysician groups and that our AMA make these issues a legislative/advocacy priority; (b) endorse current and future funding of research to identify the most cost effective, high-quality methods to deliver care to

patients, including methods of multidisciplinary care; and (c) review and report to the House of Delegates on a periodic basis on such data that may become available in the future on the quality of care provided by physician and nonphysician groups.

2. Our AMA will: (a) continue to work with relevant stakeholders to recognize physician training and education and patient safety concerns, and produce advocacy tools and materials for state level advocates to use in scope of practice discussions with legislatures, including but not limited to infographics, interactive maps, scientific overviews, geographic comparisons, and educational experience; (b) advocate for the inclusion of non-physician scope of practice characteristics in various analyses of practice location attributes and desirability; (c) advocate for the inclusion of scope of practice expansion into measurements of physician well-being; and (d) study the impact of scope of practice expansion on medical student choice of specialty.

3. Our AMA will consider all available legal, regulatory, and legislative options to oppose state board decisions that increase non-physician health care provider scope of practice beyond legislative statute or regulation.

Citation: (CME Rep. 1, I-00 Reaffirmed: CME Rep. 2, A-10 Modified: CCB/CLRPD Rep. 2, A-14 Appended: Res. 251, A-18 Appended: Res. 222, I-19)

### **Non-Physician "Fellowship" Programs D-275.979**

Our AMA will (1) in collaboration with state and specialty societies, develop and disseminate informational materials directed at the public, state licensing boards, policymakers at the state and national levels, and payers about the educational preparation of physicians, including the meaning of fellowship training, as compared with the preparation of other health professionals; and (2) continue to work collaboratively with the Federation to ensure that decisions made at the state and national levels on scope of practice issues are informed by accurate information and reflect the best interests of patients.

Citation: (CME Rep. 4, I-04 Reaffirmed: CME Rep. 2, A-14)

### **Practicing Medicine by Non-Physicians H-160.949**

Our AMA: (1) urges all people, including physicians and patients, to consider the consequences of any health care plan that places any patient care at risk by substitution of a non-physician in the diagnosis, treatment, education, direction and medical procedures where clear-cut documentation of assured quality has not been carried out, and where such alters the traditional pattern of practice in which the physician directs and supervises the care given;

(2) continues to work with constituent societies to educate the public regarding the differences in the scopes of practice and education of physicians and non-physician health care workers;

(3) continues to actively oppose legislation allowing non-physician groups to engage in the practice of medicine without physician (MD, DO) training or appropriate physician (MD, DO) supervision;

(4) continues to encourage state medical societies to oppose state legislation allowing non-physician groups to engage in the practice of medicine without physician (MD, DO) training or appropriate physician (MD, DO) supervision;

(5) through legislative and regulatory efforts, vigorously support and advocate for the requirement of appropriate physician supervision of non-physician clinical staff in all areas of medicine; and

(6) opposes special licensing pathways for physicians who are not currently enrolled in an Accreditation Council for Graduate Medical Education of American Osteopathic Association training program, or have not completed at least one year of accredited post-graduate US medical education.

Citation: (Res. 317, I-94 Modified by Res. 501, A-97 Appended: Res. 321, I-98 Reaffirmation A-99 Appended: Res. 240, Reaffirmed: Res. 708 and Reaffirmation A-00 Reaffirmed: CME Rep. 1, I-00 Reaffirmed: CMS Rep. 6, A-10 Reaffirmed: Res. 208, I-10 Reaffirmed: Res. 224, A-11 Reaffirmed: BOT Rep. 9, I-11 Reaffirmed: Res. 107, A-14 Appended: Res. 324, A-14)

**Clarification of the Title "Doctor" in the Hospital Environment D-405.991**

1. Our AMA Commissioners will, for the purpose of patient safety, request that The Joint Commission develop and implement standards for an identification system for all hospital facility staff who have direct contact with patients which would require that an identification badge be worn which indicates the individual's name and credentials as appropriate (i.e., MD, DO, RN, LPN, DC, DPM, DDS, etc), to differentiate between those who have achieved a Doctorate, and those with other types of credentials.

2. Our AMA Commissioners will, for the purpose of patient safety, request that The Joint Commission develop and implement new standards that require anyone in a hospital environment who has direct contact with a patient who presents himself or herself to the patient as a "doctor," and who is not a "physician" according to the AMA definition (H-405.969, ?that a physician is an individual who has received a "Doctor of Medicine" or a "Doctor of Osteopathic Medicine" degree or an equivalent degree following successful completion of a prescribed course of study from a school of medicine or osteopathic medicine?) must specifically and simultaneously declare themselves a "non-physician" and define the nature of their doctorate degree.

3. Our AMA will request the American Osteopathic Association (AOA) to (1) expand their standards to include proper identification of all medical staff and hospital personnel with their applicable credential (i.e., MD, DO, RN, LPN, DC, DPM, DDS, etc), and (2) Require anyone in a hospital environment who has direct contact with a patient presenting himself or herself to the patient as a "doctor", who is not a "Physician" according to the AMA definition (AMA Policy H-405.969 .. that a physician is an individual who has received a "Doctor of Medicine" or a "Doctor of Osteopathic Medicine" degree or an equivalent degree following successful completion of a prescribed course of study from a school of medicine or osteopathic medicine) must specifically and simultaneously declare themselves a "non-physician" and define the nature of their doctorate degree.

Citation: (Res. 846, I-08; Modified: BOT Rep. 9, I-09; Reaffirmed: Res. 218, A-12)

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 304  
(JUN-21)

Introduced by: Resident and Fellow Section

Subject: Decreasing Financial Burdens on Residents and Fellows

Referred to: Reference Committee C

---

1 Whereas, Upon completion of medical school, trainees are often faced with significant financial  
2 burdens. According to the annual AAMC Graduation Questionnaire, 52.6% of medical students  
3 who graduated in 2019 had a combined premedical and medical school debt of \$150,000 or  
4 more, with 26.2% reporting \$200,000-299,000.<sup>1</sup>; and

5  
6 Whereas, Between these financial restraints and 80-hour work weeks, trainees often struggle  
7 with having the time and budget for necessities, such as childcare, meals, and transportation to  
8 and from the hospital. When residency and fellowship programs provide benefits to assist with  
9 these needs, it can significantly improve trainee wellbeing; and

10  
11 Whereas, For trainees looking at residency and fellowship programs, information on benefits  
12 offered by individual programs are essential to informed residency ranking. The recent 2019  
13 expansion of the FREIDA database now includes the information requested in the RFS I-19  
14 Report F recommendation.<sup>2</sup> Programs may report their employment policies and benefits, such  
15 as on-site child care, on-call meal allowance, free parking, and housing stipend. This data is  
16 collected through an AAMC survey of residency and fellowship programs, which has  
17 approximately a 95% response rate; and

18  
19 Whereas, Of the total 11,949 active residency and fellowship programs, 11,296 responded to  
20 the survey. Of these, 7,566 (67%) indicated that they provide a meal allowance, 6,932 (61%)  
21 provided free parking, 798 (7%) subsidized child-care, and 3,330 (29%) on-site childcare. The  
22 number of programs offering each benefit varies widely between specialties, as can be seen in  
23 the below graph. Summary reports with this data are published by the AAMC every year.<sup>3</sup>; and

24  
25 Whereas, While strides have been made in providing more resources to trainees and increasing  
26 transparency, there is clearly still much room for improvement in decreasing the financial burden  
27 on residents and fellows; and

28  
29 Whereas, Though the ACGME has extensive institutional requirements regarding work hours,  
30 educational standards, and the provision of mental health resources, there are no standardized  
31 guidelines for GME programs on policies like childcare or transportation assistance. It is up to  
32 individual programs to decide what services to provide, leading to significant variance between  
33 specialties, institutions, and programs; therefore be it

34  
35 RESOLVED, That our American Medical Association work with the Accreditation Council for  
36 Graduate Medical Education (ACGME), the Association of American Medical Colleges (AAMC),  
37 and other relevant stakeholders to advocate that medical trainees not be required to pay for  
38 essential amenities and/or high cost or safety-related, specialty-specific equipment required to  
39 perform clinical duties (Directive to Take Action); and be it further

1 RESOLVED, That our AMA work with relevant stakeholders including the AAMC to define  
2 "access to food" for medical trainees to include 24-hour access to fresh food and healthy meal  
3 options within all training hospitals (Directive to Take Action); and be it further  
4

5 RESOLVED, That our AMA work with relevant stakeholders to ensure that medical trainees  
6 have access to on-site and subsidized childcare (Directive to Take Action); and be it further  
7

8 RESOLVED, That the Residents and Fellows' Bill of Rights be prominently published online on  
9 the AMA website and be disseminated to residency and fellowship programs (Directive to Take  
10 Action); and be it further  
11

12 RESOLVED, That the AMA Policy H-310.912, "Residents and Fellows' Bill of Rights," be  
13 amended by addition and deletion to read as follows:  
14

15 5. Our AMA partner with ACGME and other relevant stakeholders to encourages  
16 training programs to reduce financial burdens on residents and fellows by providing  
17 employee benefits including, but not limited to, on-call meal allowances, transportation  
18 support, relocation stipends, and childcare services. ~~teaching institutions to explore~~  
19 ~~benefits to residents and fellows that will reduce personal cost of living expenditures,~~  
20 ~~such as allowances for housing, childcare, and transportation.~~ (Modify Current HOD  
21 Policy)

Fiscal Note: Minimal - less than \$1,000

Received: 05/10/21

#### AUTHOR'S STATEMENT OR PRIORITY

The AMA has an extensive catalogue of policy on GME trainee protections. However, there have been some gaps in trainee protections that have become more salient as the average trainee is getting older and in areas where enforcement of ACGME requirements has been lacking. This collection of asks will help strengthen the protections for vulnerable populations, ask for child care coverage which is in line with current AMA actions, and ensure that as the costs of medical education increase, it does not do so at the expense of the trainee.

#### REFERENCES

1. <https://www.aamc.org/system/files/2019-08/2019-gq-all-schools-summary-report.pdf>
2. <https://freida.ama-assn.org/Freida/#/>
3. <https://www.aamc.org/system/files/reports/1/2018stipendsurveyreportfinal.pdf>  
<https://www.acgme.org/Portals/0/PFAssets/InstitutionalRequirements/000InstitutionalRequirements2018.pdf?ver=2018-02-19-132236-600>

#### RELEVANT AMA POLICY

##### **Residents and Fellows' Bill of Rights H-310.912**

1. Our AMA continues to advocate for improvements in the ACGME Institutional and Common Program Requirements that support AMA policies as follows: a) adequate financial support for and guaranteed leave to attend professional meetings; b) submission of training verification information to requesting agencies within 30 days of the request; c) adequate compensation with consideration to local cost-of-living factors and years of training, and to include the orientation period; d) health insurance benefits to include dental and vision services; e) paid leave for all purposes (family, educational, vacation, sick) to be no less than six weeks per year; and f) stronger due process guidelines.
2. Our AMA encourages the ACGME to ensure access to educational programs and curricula as necessary to facilitate a deeper understanding by resident physicians of the US health care system and to increase their communication skills.



3. Our AMA regularly communicates to residency and fellowship programs and other GME stakeholders this Resident/Fellows Physicians' Bill of Rights.
4. Our AMA: a) will promote residency and fellowship training programs to evaluate their own institution's process for repayment and develop a leaner approach. This includes disbursement of funds by direct deposit as opposed to a paper check and an online system of applying for funds; b) encourages a system of expedited repayment for purchases of \$200 or less (or an equivalent institutional threshold), for example through payment directly from their residency and fellowship programs (in contrast to following traditional workflow for reimbursement); and c) encourages training programs to develop a budget and strategy for planned expenses versus unplanned expenses, where planned expenses should be estimated using historical data, and should include trainee reimbursements for items such as educational materials, attendance at conferences, and entertaining applicants. Payment in advance or within one month of document submission is strongly recommended.
5. Our AMA encourages teaching institutions to explore benefits to residents and fellows that will reduce personal cost of living expenditures, such as allowances for housing, childcare, and transportation.
6. Our AMA will work with the Accreditation Council for Graduate Medical Education (ACGME) and other relevant stakeholders to amend the ACGME Common Program Requirements to allow flexibility in the specialty-specific ACGME program requirements enabling specialties to require salary reimbursement or "protected time" for resident and fellow education by "core faculty," program directors, and assistant/associate program directors.
7. Our AMA adopts the following 'Residents and Fellows' Bill of Rights' as applicable to all resident and fellow physicians in ACGME-accredited training programs:

#### RESIDENT/FELLOW PHYSICIANS' BILL OF RIGHTS

Residents and fellows have a right to:

A. An education that fosters professional development, takes priority over service, and leads to independent practice.

With regard to education, residents and fellows should expect: (1) A graduate medical education experience that facilitates their professional and ethical development, to include regularly scheduled didactics for which they are released from clinical duties. Service obligations should not interfere with educational opportunities and clinical education should be given priority over service obligations; (2) Faculty who devote sufficient time to the educational program to fulfill their teaching and supervisory responsibilities; (3) Adequate clerical and clinical support services that minimize the extraneous, time-consuming work that draws attention from patient care issues and offers no educational value; (4) 24-hour per day access to information resources to educate themselves further about appropriate patient care; and (5) Resources that will allow them to pursue scholarly activities to include financial support and education leave to attend professional meetings.

B. Appropriate supervision by qualified faculty with progressive resident responsibility toward independent practice.

With regard to supervision, residents and fellows should expect supervision by physicians and non-physicians who are adequately qualified and which allows them to assume progressive responsibility appropriate to their level of education, competence, and experience. It is neither feasible nor desirable to develop universally applicable and precise requirements for supervision of residents.

C. Regular and timely feedback and evaluation based on valid assessments of resident performance.

With regard to evaluation and assessment processes, residents and fellows should expect: (1) Timely and substantive evaluations during each rotation in which their competence is objectively assessed by faculty who have directly supervised their work; (2) To evaluate the faculty and the program confidentially and in writing at least once annually and expect that the training program will address deficiencies revealed by these evaluations in a timely fashion; (3) Access to their training file and to be made aware of the contents of their file on an annual basis; and (4) Training programs to complete primary verification/credentialing forms and recredentialing forms, apply all required signatures to the forms, and then have the forms permanently secured in their educational files at the completion of training or a period of training and, when requested by any organization involved in credentialing process, ensure the submission of those documents to the requesting organization within thirty days of the request.

D. A safe and supportive workplace with appropriate facilities.

With regard to the workplace, residents and fellows should have access to: (1) A safe workplace that enables them to fulfill their clinical duties and educational obligations; (2) Secure, clean, and comfortable

on-call rooms and parking facilities which are secure and well-lit; (3) Opportunities to participate on committees whose actions may affect their education, patient care, workplace, or contract.

E. Adequate compensation and benefits that provide for resident well-being and health.

(1) With regard to contracts, residents and fellows should receive: a. Information about the interviewing residency or fellowship program including a copy of the currently used contract clearly outlining the conditions for (re)appointment, details of remuneration, specific responsibilities including call obligations, and a detailed protocol for handling any grievance; and b. At least four months advance notice of contract non-renewal and the reason for non-renewal.

(2) With regard to compensation, residents and fellows should receive: a. Compensation for time at orientation; and b. Salaries commensurate with their level of training and experience. Compensation should reflect cost of living differences based on local economic factors, such as housing, transportation, and energy costs (which affect the purchasing power of wages), and include appropriate adjustments for changes in the cost of living.

(3) With Regard to Benefits, Residents and Fellows Must Be Fully Informed of and Should Receive: a. Quality and affordable comprehensive medical, mental health, dental, and vision care for residents and their families, as well as professional liability insurance and disability insurance to all residents for disabilities resulting from activities that are part of the educational program; b. An institutional written policy on and education in the signs of excessive fatigue, clinical depression, substance abuse and dependence, and other physician impairment issues; c. Confidential access to mental health and substance abuse services; d. A guaranteed, predetermined amount of paid vacation leave, sick leave, family and medical leave and educational/professional leave during each year in their training program, the total amount of which should not be less than six weeks; e. Leave in compliance with the Family and Medical Leave Act; and f. The conditions under which sleeping quarters, meals and laundry or their equivalent are to be provided.

F. Clinical and educational work hours that protect patient safety and facilitate resident well-being and education.

With regard to clinical and educational work hours, residents and fellows should experience: (1) A reasonable work schedule that is in compliance with clinical and educational work hour requirements set forth by the ACGME; and (2) At-home call that is not so frequent or demanding such that rest periods are significantly diminished or that clinical and educational work hour requirements are effectively circumvented. Refer to AMA Policy H-310.907, "Resident/Fellow Clinical and Educational Work Hours," for more information.

G. Due process in cases of allegations of misconduct or poor performance.

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

H. Access to and protection by institutional and accreditation authorities when reporting violations.

With regard to reporting violations to the ACGME, residents and fellows should: (1) Be informed by their program at the beginning of their training and again at each semi-annual review of the resources and processes available within the residency program for addressing resident concerns or complaints, including the program director, Residency Training Committee, and the designated institutional official; (2) Be able to file a formal complaint with the ACGME to address program violations of residency training requirements without fear of recrimination and with the guarantee of due process; and (3) Have the opportunity to address their concerns about the training program through confidential channels, including the ACGME concern process and/or the annual ACGME Resident Survey.

Citation: CME Rep. 8, A-11Appended: Res. 303, A-14Reaffirmed: Res. 915, I-15Appended: CME Rep. 04, A-16Modified: CME Rep. 06, I-18Appended: Res. 324, A-19

### **Preserving Childcare at AMA Meetings G-600.115**

Our AMA will arrange onsite supervised childcare at no cost to members attending AMA Annual and Interim meetings.

Citation: Res. 602, I-19

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 305  
(JUN-21)

Introduced by: Resident and Fellow Section

Subject: Non-Physician Post-Graduate Medical Training

Referred to: Reference Committee C

---

1 Whereas, Data collected by AMA's Truth in Advertising campaign suggest nearly 90% of  
2 patients believe "only a medical doctor or doctor of osteopathic medicine should be able to use  
3 the title "physician.""; and  
4

5 Whereas, In the same campaign, nearly 80% of patients "support legislation to require all health  
6 care advertising materials to clarify designate the level of education, skills and training of all  
7 health care professionals promising their services" <sup>ii</sup>; and  
8

9 Whereas, The Center for Medicare and Medicaid Services defines resident as "an intern,  
10 resident, or fellow who is formally accepted, enrolled, and participating in an approved medical  
11 residency program including programs in osteopathy, dentistry, and podiatry as required to  
12 become certified by the appropriate specialty board"<sup>iii</sup>; and  
13

14 Whereas, There has been an increase in the number of physician assistant (PA) and nurse  
15 practitioner (NP) postgraduate programs, many of which are inappropriately referred to as  
16 "residencies" or "fellowships"<sup>ivvvi</sup>; and  
17

18 Whereas, On September 3, 2020 every major academic emergency medicine association  
19 issued a joint statement affirming that "the terms 'resident,' 'residency,' 'fellow,' and 'fellowship'  
20 in a medical setting must be limited to postgraduate clinical training of medical school physician  
21 graduates within GME training programs"<sup>vii</sup>; and  
22

23 Whereas, Several of these training programs pay their first-year trainees more than the first-  
24 year residents in physician residencies<sup>viii</sup>; therefore be it  
25

26 RESOLVED, That our American Medical Association believe that healthcare trainee salary,  
27 benefits, and overall compensation should, at minimum, reflect length of pre-training education,  
28 hours worked, and level of independence and complexity of care allowed by an individual's  
29 training program (for example when comparing physicians in training and midlevel providers at  
30 equal postgraduate training levels) (New HOD Policy); and be it further

1 RESOLVED, That our AMA amend policy H-275.925 "Protection of the Titles "Doctor,"  
2 "Resident" and "Residency," by addition and deletion to read as follows:  
3

4 Our AMA:

5 (1) recognize that the terms "medical student," "resident," "residency," "fellow,"  
6 "fellowship," "physician," and "attending," when used in the healthcare setting, all  
7 connote completing structured, rigorous, medical education undertaken by physicians,  
8 as defined by the Centers for Medicare and Medicaid Services, and thus these terms  
9 must be reserved only to describe physician roles; (2) advocate that professionals in a  
10 clinical health care setting clearly and accurately identify to patients their qualifications  
11 and degree(s) attained and develop model state legislation for implementation; (3)  
12 supports and develop model state legislation that would penalize misrepresentation of  
13 one's role in the physician-led healthcare team, up to and including to make it a felony  
14 to misrepresent oneself as a physician (MD/DO); and (4) support and develop model  
15 state legislation that calls for statutory restrictions for non-physician post-graduate  
16 diagnostic and clinical training programs using the terms "medical student," "resident,"  
17 "residency," "fellow," "fellowship," "physician," or "attending" in a healthcare setting  
18 except by physicians. (Modify Current HOD Policy); and be it further  
19

20 RESOLVED, That our AMA study and report back, by the 2022 Annual Meeting, on curriculum,  
21 accreditation requirements, accrediting bodies, and supervising boards for graduate and  
22 postgraduate clinical training programs for non-physicians and the impact of non-physician  
23 graduate clinical education on physician graduate medical education (Directive to Take Action);  
24 and be it further  
25

26 RESOLVED, That our AMA work with relevant stakeholders to assure that funds to support the  
27 expansion of post-graduate clinical training for non-physicians do not divert funding from  
28 physician GME (Directive to Take Action); and be it further  
29

30 RESOLVED, That our AMA partner with the Accreditation Council for Graduate Medical  
31 Education (ACGME) to create standards requiring Designated Institutional Officials to notify the  
32 ACGME of proposed training programs for physicians or non-physicians that may impact the  
33 educational experience of trainees in currently approved residencies and fellowships (Directive  
34 to Take Action); and be it further  
35

36 RESOLVED, That policy H-310.912 "Resident and Fellow Bill of Rights," be amended by  
37 addition and deletion to read as follows:  
38

39 B. Appropriate supervision by qualified physician faculty with progressive resident  
40 responsibility toward independent practice. With regard to supervision, residents  
41 and fellows ~~should expect supervision by physicians and non-physicians~~ must be  
42 ultimately supervised by physicians who are adequately qualified and ~~which~~ allows  
43 them to assume progressive responsibility appropriate to their level of education,  
44 competence, and experience. ~~It is neither feasible nor desirable to develop~~  
45 ~~universally applicable and precise requirements for supervision of residents.~~ In  
46 instances where clinical education is provided by non-physicians, there must be an  
47 identified physician supervisor providing indirect supervision, along with  
48 mechanisms for reporting inappropriate, non-physician supervision to the training  
49 program, sponsoring institution or ACGME as appropriate. (Modify Current HOD  
50 Policy); and be it further  
51

1 RESOLVED, That our AMA distribute and promote the Residents and Fellows' Bill of Rights  
2 online and individually to residency and fellowship training programs and encourage changes to  
3 institutional processes that embody these principles (Directive to Take Action); and be it further  
4

5 RESOLVED, That our AMA oppose non-physician healthcare providers from holding a seat on  
6 the board of an organization that regulates and/or provides oversight of physician  
7 undergraduate and graduate medical education, accreditation, certification, and credentialing  
8 when these types of non-physician healthcare providers either possess or seek to possess the  
9 ability to practice without physician supervision as it represents a conflict of interest.  
(Directive to Take Action)

Fiscal Note: Modest - between \$1,000 - \$5,000

Received: 05/10/21

#### AUTHOR'S STATEMENT OR PRIORITY

We present this Scope of Practice concern from the RFS for consideration by the HOD in lieu of others as this policy will have the greatest impact. The resolved clauses encourage a higher standard for our allied health colleagues in specialty fields, equal pay for trainees for equal work compared to the PA and NP colleagues we work side-by-side with, and a biennial study to track non-physician provider training standards and oversight. This is a worthwhile discussion that affects all areas of medicine. Given the recent ACEP report on the EM workforce and the influence of non-physicians on the workforce without specialty training, this issue is timely not only to those currently in training, but to the future of the profession. We cannot wait to be reactive when our patients and our profession are at stake.

<sup>i</sup> <https://www.ama-assn.org/system/files/2018-10/truth-in-advertising-campaign-booklet.pdf>

<sup>ii</sup> <https://www.ama-assn.org/system/files/2018-10/truth-in-advertising-campaign-booklet.pdf>

<sup>iii</sup> <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Teaching-Physicians-Fact-Sheet-ICN006437.pdf>

<sup>iv</sup> <https://www.aaem.org/resources/statements/position/em-training-programs-for--pas-and-nps>

<sup>v</sup> <https://appap.org/wp-content/uploads/2020/03/APPAP-Postgraduate-Program-Membership-Roster-by-Specialty-March-2020.pdf>

<sup>vi</sup> 12. Association of Postgraduate Physician Assistant Programs. APPAP programs by specialty. Accessed at <http://appap.org/Programs/tabid/58/Default.aspx> on January 30, 2010.

<sup>7</sup> <https://architectinperson.wordpress.com/2011/11/16/stop-calling-me-the-intern/>

<sup>vii</sup> <https://www.emra.org/be-involved/be-an-advocate/working-for-you/post-grad-statement-pa-np/>, accessed 9/12/2020

<sup>viii</sup> <https://med.dartmouth-hitchcock.org/pa-residency/ccappresidency.html>

#### **RELEVANT AMA POLICY**

##### **Residents and Fellows' Bill of Rights H-310.912**

1. Our AMA continues to advocate for improvements in the ACGME Institutional and Common Program Requirements that support AMA policies as follows: a) adequate financial support for and guaranteed leave to attend professional meetings; b) submission of training verification information to requesting agencies within 30 days of the request; c) adequate compensation with consideration to local cost-of-living factors and years of training, and to include the orientation period; d) health insurance benefits to include dental and vision services; e) paid leave for all purposes (family, educational, vacation, sick) to be no less than six weeks per year; and f) stronger due process guidelines.
2. Our AMA encourages the ACGME to ensure access to educational programs and curricula as necessary to facilitate a deeper understanding by resident physicians of the US health care system and to increase their communication skills.
3. Our AMA regularly communicates to residency and fellowship programs and other GME stakeholders this Resident/Fellows Physicians' Bill of Rights.
4. Our AMA: a) will promote residency and fellowship training programs to evaluate their own institution's process for repayment and develop a leaner approach. This includes disbursement of funds by direct deposit as opposed to a paper check and an online system of applying for funds; b) encourages a system

of expedited repayment for purchases of \$200 or less (or an equivalent institutional threshold), for example through payment directly from their residency and fellowship programs (in contrast to following traditional workflow for reimbursement); and c) encourages training programs to develop a budget and strategy for planned expenses versus unplanned expenses, where planned expenses should be estimated using historical data, and should include trainee reimbursements for items such as educational materials, attendance at conferences, and entertaining applicants. Payment in advance or within one month of document submission is strongly recommended.

5. Our AMA encourages teaching institutions to explore benefits to residents and fellows that will reduce personal cost of living expenditures, such as allowances for housing, childcare, and transportation.

6. Our AMA will work with the Accreditation Council for Graduate Medical Education (ACGME) and other relevant stakeholders to amend the ACGME Common Program Requirements to allow flexibility in the specialty-specific ACGME program requirements enabling specialties to require salary reimbursement or "protected time" for resident and fellow education by "core faculty," program directors, and assistant/associate program directors.

7. Our AMA adopts the following 'Residents and Fellows' Bill of Rights' as applicable to all resident and fellow physicians in ACGME-accredited training programs:

#### RESIDENT/FELLOW PHYSICIANS' BILL OF RIGHTS

Residents and fellows have a right to:

A. An education that fosters professional development, takes priority over service, and leads to independent practice.

With regard to education, residents and fellows should expect: (1) A graduate medical education experience that facilitates their professional and ethical development, to include regularly scheduled didactics for which they are released from clinical duties. Service obligations should not interfere with educational opportunities and clinical education should be given priority over service obligations; (2) Faculty who devote sufficient time to the educational program to fulfill their teaching and supervisory responsibilities; (3) Adequate clerical and clinical support services that minimize the extraneous, time-consuming work that draws attention from patient care issues and offers no educational value; (4) 24-hour per day access to information resources to educate themselves further about appropriate patient care; and (5) Resources that will allow them to pursue scholarly activities to include financial support and education leave to attend professional meetings.

B. Appropriate supervision by qualified faculty with progressive resident responsibility toward independent practice.

With regard to supervision, residents and fellows should expect supervision by physicians and non-physicians who are adequately qualified and which allows them to assume progressive responsibility appropriate to their level of education, competence, and experience. It is neither feasible nor desirable to develop universally applicable and precise requirements for supervision of residents.

C. Regular and timely feedback and evaluation based on valid assessments of resident performance.

With regard to evaluation and assessment processes, residents and fellows should expect: (1) Timely and substantive evaluations during each rotation in which their competence is objectively assessed by faculty who have directly supervised their work; (2) To evaluate the faculty and the program confidentially and in writing at least once annually and expect that the training program will address deficiencies revealed by these evaluations in a timely fashion; (3) Access to their training file and to be made aware of the contents of their file on an annual basis; and (4) Training programs to complete primary verification/credentialing forms and recredentialing forms, apply all required signatures to the forms, and then have the forms permanently secured in their educational files at the completion of training or a period of training and, when requested by any organization involved in credentialing process, ensure the submission of those documents to the requesting organization within thirty days of the request.

D. A safe and supportive workplace with appropriate facilities.

With regard to the workplace, residents and fellows should have access to: (1) A safe workplace that enables them to fulfill their clinical duties and educational obligations; (2) Secure, clean, and comfortable on-call rooms and parking facilities which are secure and well-lit; (3) Opportunities to participate on committees whose actions may affect their education, patient care, workplace, or contract.

E. Adequate compensation and benefits that provide for resident well-being and health.

(1) With regard to contracts, residents and fellows should receive: a. Information about the interviewing residency or fellowship program including a copy of the currently used contract clearly outlining the conditions for (re)appointment, details of remuneration, specific responsibilities including call obligations,

---

and a detailed protocol for handling any grievance; and b. At least four months advance notice of contract non-renewal and the reason for non-renewal.

(2) With regard to compensation, residents and fellows should receive: a. Compensation for time at orientation; and b. Salaries commensurate with their level of training and experience. Compensation should reflect cost of living differences based on local economic factors, such as housing, transportation, and energy costs (which affect the purchasing power of wages), and include appropriate adjustments for changes in the cost of living.

(3) With Regard to Benefits, Residents and Fellows Must Be Fully Informed of and Should Receive: a. Quality and affordable comprehensive medical, mental health, dental, and vision care for residents and their families, as well as professional liability insurance and disability insurance to all residents for disabilities resulting from activities that are part of the educational program; b. An institutional written policy on and education in the signs of excessive fatigue, clinical depression, substance abuse and dependence, and other physician impairment issues; c. Confidential access to mental health and substance abuse services; d. A guaranteed, predetermined amount of paid vacation leave, sick leave, family and medical leave and educational/professional leave during each year in their training program, the total amount of which should not be less than six weeks; e. Leave in compliance with the Family and Medical Leave Act; and f. The conditions under which sleeping quarters, meals and laundry or their equivalent are to be provided.

F. Clinical and educational work hours that protect patient safety and facilitate resident well-being and education.

With regard to clinical and educational work hours, residents and fellows should experience: (1) A reasonable work schedule that is in compliance with clinical and educational work hour requirements set forth by the ACGME; and (2) At-home call that is not so frequent or demanding such that rest periods are significantly diminished or that clinical and educational work hour requirements are effectively circumvented. Refer to AMA Policy H-310.907, "Resident/Fellow Clinical and Educational Work Hours," for more information.

G. Due process in cases of allegations of misconduct or poor performance.

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

H. Access to and protection by institutional and accreditation authorities when reporting violations.

With regard to reporting violations to the ACGME, residents and fellows should: (1) Be informed by their program at the beginning of their training and again at each semi-annual review of the resources and processes available within the residency program for addressing resident concerns or complaints, including the program director, Residency Training Committee, and the designated institutional official; (2) Be able to file a formal complaint with the ACGME to address program violations of residency training requirements without fear of recrimination and with the guarantee of due process; and (3) Have the opportunity to address their concerns about the training program through confidential channels, including the ACGME concern process and/or the annual ACGME Resident Survey.

Citation: CME Rep. 8, A-11; Appended: Res. 303, A-14; Reaffirmed: Res. 915, I-15; Appended: CME Rep. 04, A-16; Modified: CME Rep. 06, I-18; Appended: Res. 324, A-19

#### **H-275.925 Protection of the Titles "Doctor," "Resident" and "Residency"**

Our AMA: (1) will advocate that professionals in a clinical health care setting clearly and accurately identify to patients their qualifications and degree(s) attained and develop model state legislation for implementation; and (2) supports state legislation that would make it a felony to misrepresent oneself as a physician (MD/DO).

*Sub. Res. 232, A-08; Reaffirmation I-09; Reaffirmed: BOT Rep. 9, I-09; Reaffirmed: BOT Rep. 09, A-19*

#### **D-160.995 Physician and Nonphysician Licensure and Scope of Practice**

1. Our AMA will: (a) continue to support the activities of the Advocacy Resource Center in providing advice and assistance to specialty and state medical societies concerning scope of practice issues to include the collection, summarization and wide dissemination of data on the training and the scope of practice of physicians (MDs and DOs) and nonphysician groups and that our AMA make these issues a legislative/advocacy priority; (b) endorse current and future funding of research to identify the most cost effective, high-quality methods to deliver care to patients, including methods of multidisciplinary care; and

(c) review and report to the House of Delegates on a periodic basis on such data that may become available in the future on the quality of care provided by physician and nonphysician groups.

2. Our AMA will: (a) continue to work with relevant stakeholders to recognize physician training and education and patient safety concerns, and produce advocacy tools and materials for state level advocates to use in scope of practice discussions with legislatures, including but not limited to infographics, interactive maps, scientific overviews, geographic comparisons, and educational experience; (b) advocate for the inclusion of non-physician scope of practice characteristics in various analyses of practice location attributes and desirability; (c) advocate for the inclusion of scope of practice expansion into measurements of physician well-being; and (d) study the impact of scope of practice expansion on medical student choice of specialty.

3. Our AMA will consider all available legal, regulatory, and legislative options to oppose state board decisions that increase non-physician health care provider scope of practice beyond legislative statute or regulation.

*CME Rep. 1, I-00; Reaffirmed: CME Rep. 2, A-10; Modified: CCB/CLRPD Rep. 2, A-14; Appended: Res. 251, A-18; Appended: Res. 222, I-19*

#### **H-270.958 Need for Active Medical Board Oversight of Medical Scope-of-Practice Activities by Mid Level Practitioners**

1. It is AMA policy that state medical boards shall have authority to regulate the practice of medicine by all persons within a state notwithstanding claims to the contrary by nonphysician practitioner state regulatory boards or other such entities.

2. Our AMA will work with interested Federation partners: (a) in pursuing legislation that requires all health care practitioners to disclose the license under which they are practicing and, therefore, prevent deceptive practices such as nonphysician healthcare practitioners presenting themselves as physicians or "doctors"; (b) on a campaign to identify and have elected or appointed to state medical boards physicians (MDs or DOs) who are committed to asserting and exercising the state medical board's full authority to regulate the practice of medicine by all persons within a state notwithstanding efforts by nonphysician practitioner state regulatory boards or other such entities that seek to unilaterally redefine their scope of practice into areas that are true medical practice.

*BOT Action in response to referred for decision Res. 902, I-06; Reaffirmed: BOT Rep. 06, A-16*

#### **D-35.996 Scope of Practice Model Legislation**

Our AMA Advocacy Resource Center will continue to work with state and specialty societies to draft model legislation that deals with non-physician independent practitioners, reflecting the goal of ensuring that non-physician scope of practice is determined by training, experience, and demonstrated competence; and our AMA will distribute to state medical and specialty societies the model legislation as a framework to deal with questions regarding non-physician independent practitioners.

*Res. 923, I-03 Reaffirmed: BOT Rep. 28, A-13*

#### **H-160.950 Guidelines for Integrated Practice of Physician and Nurse Practitioner**

Our AMA endorses the following guidelines and recommends that these guidelines be considered and quoted only in their entirety when referenced in any discussion of the roles and responsibilities of nurse practitioners: (1) The physician is responsible for the supervision of nurse practitioners and other advanced practice nurses in all settings.

(2) The physician is responsible for managing the health care of patients in all practice settings.

(3) Health care services delivered in an integrated practice must be within the scope of each practitioner's professional license, as defined by state law.

(4) In an integrated practice with a nurse practitioner, the physician is responsible for supervising and coordinating care and, with the appropriate input of the nurse practitioner, ensuring the quality of health care provided to patients.

(5) The extent of involvement by the nurse practitioner in initial assessment, and implementation of treatment will depend on the complexity and acuity of the patients' condition, as determined by the supervising/collaborating physician.

(6) The role of the nurse practitioner in the delivery of care in an integrated practice should be defined through mutually agreed upon written practice protocols, job descriptions, and written contracts.

(7) These practice protocols should delineate the appropriate involvement of the two professionals in the care of patients, based on the complexity and acuity of the patients' condition.



- 
- (8) At least one physician in the integrated practice must be immediately available at all times for supervision and consultation when needed by the nurse practitioner.
- (9) Patients are to be made clearly aware at all times whether they are being cared for by a physician or a nurse practitioner.
- (10) In an integrated practice, there should be a professional and courteous relationship between physician and nurse practitioner, with mutual acknowledgment of, and respect for each other's contributions to patient care.
- (11) Physicians and nurse practitioners should review and document, on a regular basis, the care of all patients with whom the nurse practitioner is involved. Physicians and nurse practitioners must work closely enough together to become fully conversant with each other's practice patterns.
- CMS Rep. 15 - I-94; BOT Rep. 6, A-95; Reaffirmed: Res. 240, A-00; Reaffirmation A-00; Reaffirmed: BOT Rep. 28, A-09; Reaffirmed: BOT Rep. 9, I-11; Reaffirmed: Joint CME-CMS Rep., I-12; Reaffirmed: BOT Rep. 16, A-13*

**Code of Medical Ethics: 10.5 Allied Health Professionals**

Physicians often practice in concert with optometrists, nurse anesthetists, nurse midwives, and other allied health professionals. Although physicians have overall responsibility for the quality of care that patients receive, allied health professionals have training and expertise that complements physicians'. With physicians, allied health professionals share a common commitment to patient well-being. In light of this shared commitment, physicians' relationships with allied health professionals should be based on mutual respect and trust. It is ethically appropriate for physicians to:

- (a) Help support high quality education that is complementary to medical training, including by teaching in recognized schools for allied health professionals.
- (b) Work in consultation with or employ appropriately trained and credentialed allied health professionals.
- (c) Delegate provision of medical services to an appropriately trained and credentialed allied health professional within the individual's scope of practice.

*AMA Principles of Medical Ethics: I, V, VII*

**D-160.993 Limitation of Scope of Practice of Certified Registered Nurse Anesthetists**

Our AMA, in conjunction with the state medical societies, will vigorously inform all state Governors and appropriate state regulatory agencies of AMA's policy position which requires physician supervision for certified registered nurse anesthetists for anesthesia services in Medicare participating hospitals, ambulatory surgery centers, and critical access hospitals.

*Res. 220, I-01; Reaffirmed: CMS Rep. 7, A-11*

**D-275.979 Non-Physician "Fellowship" Programs**

Our AMA will (1) in collaboration with state and specialty societies, develop and disseminate informational materials directed at the public, state licensing boards, policymakers at the state and national levels, and payers about the educational preparation of physicians, including the meaning of fellowship training, as compared with the preparation of other health professionals; and (2) continue to work collaboratively with the Federation to ensure that decisions made at the state and national levels on scope of practice issues are informed by accurate information and reflect the best interests of patients.

*CME Rep. 4, I-04; Reaffirmed: CME Rep. 2, A-14*

**D-160.993 Limitation of Scope of Practice of Certified Registered Nurse Anesthetists**

Our AMA, in conjunction with the state medical societies, will vigorously inform all state Governors and appropriate state regulatory agencies of AMA's policy position which requires physician supervision for certified registered nurse anesthetists for anesthesia services in Medicare participating hospitals, ambulatory surgery centers, and critical access hospitals.

*Res. 220, I-01; Reaffirmed: CMS Rep. 7, A-11*

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 306  
(JUN-21)

Introduced by: Resident and Fellow Section

Subject: Establishing Minimum Standards for Parental Leave during Graduate Medical Education Training

Referred to: Reference Committee C

---

1 Whereas, A substantial number of trainees become parents during their training as a resident or  
2 fellow; and  
3

4 Whereas, PGY-1 trainees will not meet eligibility for the Family Medical Leave Act, which has a  
5 12-month employment eligibility threshold; and  
6

7 Whereas, Unlike other industries, such as technology and law, “there is no standardized  
8 approach to parental leave across GME programs”<sup>1</sup>; and  
9

10 Whereas, The Accreditation Council for Graduate Medical Education (ACGME) does not  
11 establish minimum standards for duration of parental leave for trainees; and  
12

13 Whereas, A lack of minimum national standards may result in some trainees receiving  
14 substandard resources and benefits<sup>2</sup>; and  
15

16 Whereas, Current AMA policy (H-405.960) encourages residency programs, among other  
17 stakeholders, to incorporate a “six-week minimum leave allowance;” therefore be it  
18

19 RESOLVED, That our American Medical Association support current efforts by the Accreditation  
20 Council for Graduate Medical Education (ACGME), the American Board of Medical Specialties  
21 (ABMS), and other relevant stakeholders to develop and align minimum requirements for  
22 parental leave during residency and fellowship training and urge these bodies to adopt minimum  
23 requirements in accordance with policy H-405.960 (Directive to Take Action); and be it further  
24

25 RESOLVED, That our AMA petition the ACGME to recommend strategies to prevent undue  
26 burden on trainees related to parental leave (Directive to Take Action); and be it further  
27

28 RESOLVED, That our AMA petition the ACGME, ABMS, and other relevant stakeholders to  
29 develop specialty specific pathways for residents and fellows in good standing, who take  
30 maximum allowable parental leave, to complete their training within the original time frame.  
31 (Directive to Take Action)

Fiscal Note: Minimal - less than \$1,000

Received: 05/10/21

#### AUTHOR'S STATEMENT OR PRIORITY

As conversations are actively occurring around the country regarding trainee compensation, bills of rights, and benefits, discussion of this resolution by the HOD would be timely and guide the AMA with policy it does not currently have. Specifically, the ACGME is actively working on this and not having AMA policy on an issue that affects a significant number of trainees while discussions are actively being had by decision makers makes this policy particularly relevant and timely. This policy applies to current and all future physician trainees.

#### **References:**

1. Vassallo P, Jeremiah J, Forman L, et al. Parental Leave in Graduate Medical Education: Recommendations for Reform. *Am J Med.* 2019;132(3):385-389. doi:10.1016/j.amjmed.2018.11.006
2. Baril N. Parenting during Graduate Medical Training — Practical Policy. 2019:995-997. doi:10.1056/NEJMp1902966

#### **RELEVANT AMA POLICY**

##### **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 housestaff 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.

Citation: CME Rep. 9, A-99; Reaffirmed: CME Rep. 2, A-09; Reaffirmed: CME Rep. 14, A-09; Modified: CME Rep. 06, I-18

### **Policies for Parental, Family and Medical Necessity Leave H-405.960**

AMA adopts as policy the following guidelines for, and encourages the implementation of, Parental, Family and Medical Necessity Leave for Medical Students and Physicians:

1. Our AMA urges medical schools, residency training programs, medical specialty boards, the Accreditation Council for Graduate Medical Education, and medical group practices to incorporate and/or encourage development of leave policies, including parental, family, and medical leave policies, as part of the physician's standard benefit agreement.
2. Recommended components of parental leave policies for medical students and physicians include: (a) duration of leave allowed before and after delivery; (b) category of leave credited; (c) whether leave is paid or unpaid; (d) whether provision is made for continuation of insurance benefits during leave, and who pays the premium; (e) whether sick leave and vacation time may be accrued from year to year or used in advance; (f) how much time must be made up in order to be considered board eligible; (g) whether make-up time will be paid; (h) whether schedule accommodations are allowed; and (i) leave policy for adoption.
3. AMA policy is expanded to include physicians in practice, reading as follows: (a) residency program directors and group practice administrators should review federal law concerning

maternity leave for guidance in developing policies to assure that pregnant physicians are allowed the same sick leave or disability benefits as those physicians who are ill or disabled; (b) staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in other physicians' workloads, particularly in residency programs; and (c) physicians should be able to return to their practices or training programs after taking parental leave without the loss of status.

4. Our AMA encourages residency programs, specialty boards, and medical group practices to incorporate into their parental leave policies a six-week minimum leave allowance, with the understanding that no parent should be required to take a minimum leave.

5. Residency program directors should review federal and state law for guidance in developing policies for parental, family, and medical leave.

6. Medical students and physicians who are unable to work because of pregnancy, childbirth, and other related medical conditions should be entitled to such leave and other benefits on the same basis as other physicians who are temporarily unable to work for other medical reasons.

7. Residency programs should develop written policies on parental leave, family leave, and medical leave for physicians. Such written policies should include the following elements: (a) leave policy for birth or adoption; (b) duration of leave allowed before and after delivery; (c) category of leave credited (e.g., sick, vacation, parental, unpaid leave, short term disability); (d) whether leave is paid or unpaid; (e) whether provision is made for continuation of insurance benefits during leave and who pays for premiums; (f) whether sick leave and vacation time may be accrued from year to year or used in advance; (g) extended leave for resident physicians with extraordinary and long-term personal or family medical tragedies for periods of up to one year, without loss of previously accepted residency positions, for devastating conditions such as terminal illness, permanent disability, or complications of pregnancy that threaten maternal or fetal life; (h) how time can be made up in order for a resident physician to be considered board eligible; (i) what period of leave would result in a resident physician being required to complete an extra or delayed year of training; (j) whether time spent in making up a leave will be paid; and (k) whether schedule accommodations are allowed, such as reduced hours, no night call, modified rotation schedules, and permanent part-time scheduling.

8. Our AMA endorses the concept of equal parental leave for birth and adoption as a benefit for resident physicians, medical students, and physicians in practice regardless of gender or gender identity.

9. Staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in the workloads of other physicians, particularly those in residency programs.

10. Physicians should be able to return to their practices or training programs after taking parental leave, family leave, or medical leave without the loss of status.

11. Residency program directors must assist residents in identifying their specific requirements (for example, the number of months to be made up) because of leave for eligibility for board certification and must notify residents on leave if they are in danger of falling below minimal requirements for board eligibility. Program directors must give these residents a complete list of requirements to be completed in order to retain board eligibility.

12. Our AMA encourages flexibility in residency training programs, incorporating parental leave and alternative schedules for pregnant house staff.

13. In order to accommodate leave protected by the federal Family and Medical Leave Act, our AMA encourages all specialties within the American Board of Medical Specialties to allow graduating residents to extend training up to 12 weeks after the traditional residency completion date while still maintaining board eligibility in that year.

14. These policies as above should be freely available online and in writing to all applicants to medical school, residency or fellowship. Citation: CCB/CLRPD Rep. 4, A-13; Modified: Res. 305, A-14; Modified: Res. 904, I-14

**Parental Leave H-405.954**

1. Our AMA encourages the study of the health implications among patients if the United States were to modify one or more of the following aspects of the Family and Medical Leave Act (FMLA): a reduction in the number of employees from 50 employees; an increase in the number of covered weeks from 12 weeks; and creating a new benefit of paid parental leave.
2. Our AMA will study the effects of FMLA expansion on physicians in varied practice environments.
3. Our AMA: (a) encourages employers to offer and/or expand paid parental leave policies; (b) encourages state medical associations to work with their state legislatures to establish and promote paid parental leave policies; (c) advocates for improved social and economic support for paid family leave to care for newborns, infants and young children; and (d) advocates for federal tax incentives to support early child care and unpaid child care by extended family members. Citation: Res. 215, I-16; Appended: BOT Rep. 11, A-19;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 307  
(JUN-21)

Introduced by: Resident and Fellow Section

Subject: Updating Current Wellness Policies and Improving Implementation

Referred to: Reference Committee C

Whereas, Previous AMA-RFS policy asked our AMA to study resident burnout prevention and wellness strategies (291.015R); and

Whereas, This same policy was reaffirmed at I-18 (291.036R); and

Whereas, Current Accreditation Council for Graduate Medical Education (ACGME) policy does include program requirements for specific aspects, but is unclear about what satisfies those requirements<sup>1</sup>; and

Whereas, New data exists regarding the efficacy of various specific burnout prevention strategies<sup>2-7</sup>; and

Whereas, Some organizations such as Stanford Medicine have been leaders in the field of physician wellness and burnout prevention through research, novel approaches and curriculum and support such as House Staff Wellbeing Panel and it may be prudent to apply these strategies into ACGME common requirements of residency programs<sup>8</sup>; and

Whereas, These specific strategies may be a more effective way to mitigate burnout than the current ACGME policy as listed; therefore be it

RESOLVED, That our American Medical Association work with the Accreditation Council on Graduate Medical Education and other appropriate stakeholders in the creation of an evidence-based best practices reference to address trainee burnout prevention and mitigation. (Directive to Take Action)

Fiscal Note: Minimal - less than \$1,000

Received: 05/10/21

AUTHOR'S STATEMENT OR PRIORITY

Although there is much focus on wellness in the era of COVID-19, this has been a long-standing concern for which too little has been done to affect change, and it is now taking its toll. Although this is less urgent due to the declining pandemic, medicine has struggled with how to address burnout and sustain wellness for years and there is no better place to begin to address this than at the GME level.



## References:

1. "Common Program Requirements." ACGME, Accreditation Council for Graduate Medical Education, <https://www.acgme.org/What-We-Do/Accreditation/Common-Program-Requirements>.
2. [Mindfulness therapies on health professionals](#). Ruiz-Fernández MD, Ortíz-Amo R, Ortega-Galán ÁM, Ibáñez-Masero O, Rodríguez-Salvador MDM, Ramos-Pichardo JD. Int J Ment Health Nurs. 2019 Sep 9. doi: 10.1111/inm.12652. [Epub ahead of print] Review. PMID: 31498549
3. Gazelle G, Liebschutz JM, Riess H. Physician burnout: coaching a way out. J Gen Intern Med. 2015;30(4):508–513. doi:10.1007/s11606-014-3144-y
4. [Doctor, how can we help you? Qualitative interview study to identify key interventions to target burnout in hospital doctors](#). Walsh G, Hayes B, Freeney Y, McArdle S. BMJ Open. 2019 Sep 5;9(9):e030209. doi: 10.1136/bmjopen-2019-030209. PMID: 31492785
5. [Interventions to increase resilience in physicians: A structured literature review](#). Moorfield C, Cope V. Explore (NY). 2019 Aug 12. pii: S1550-8307(19)30448-3. doi: 10.1016/j.explore.2019.08.005. [Epub ahead of print] Review. PMID: 31492550
6. [What Is Underlying Resident Burnout in Urology and What Can Be Done to Address this?](#) Fainberg J, Lee RK. Curr Urol Rep. 2019 Sep 2;20(10):62. doi: 10.1007/s11934-019-0925-1. Review. PMID: 31478112
7. [The effects of playing music on mental health outcomes](#). Wesseldijk LW, Ullén F, Mosing MA. Sci Rep. 2019 Aug 30;9(1):12606. doi: 10.1038/s41598-019-49099-9. PMID: 31471550
8. <https://wellmd.stanford.edu/>

**RELEVANT AMA POLICY****Code of Medical Ethics****9.3.1 Physician Health & Wellness**

When physician health or wellness is compromised, so may the safety and effectiveness of the medical care provided. To preserve the quality of their performance, physicians have a responsibility to maintain their health and wellness, broadly construed as preventing or treating acute or chronic diseases, including mental illness, disabilities, and occupational stress.

To fulfill this responsibility individually, physicians should:

(a) Maintain their own health and wellness by:

(i) following healthy lifestyle habits;

(ii) ensuring that they have a personal physician whose objectivity is not compromised.

(b) Take appropriate action when their health or wellness is compromised, including:

(i) engaging in honest assessment of their ability to continue practicing safely;

(ii) taking measures to mitigate the problem;

(iii) taking appropriate measures to protect patients, including measures to minimize the risk of transmitting infectious disease commensurate with the seriousness of the disease;

(iv) seeking appropriate help as needed, including help in addressing substance abuse.

Physicians should not practice if their ability to do so safely is impaired by use of a controlled substance, alcohol, other chemical agent or a health condition.

Collectively, physicians have an obligation to ensure that colleagues are able to provide safe and effective care, which includes promoting health and wellness among physicians.

Citation: Issued: 2016

**Physician and Medical Student Burnout D-310.968**

1. Our AMA recognizes that burnout, defined as emotional exhaustion, depersonalization, and a reduced sense of personal accomplishment or effectiveness, is a problem among residents, fellows, and medical students.

2. Our AMA will work with other interested groups to regularly inform the appropriate designated institutional officials, program directors, resident physicians, and attending faculty about resident, fellow, and medical student burnout (including recognition, treatment, and prevention of burnout) through appropriate media outlets

3. Our AMA will encourage partnerships and collaborations with accrediting bodies (e.g., the Accreditation Council for Graduate Medical Education and the Liaison Committee on Medical Education) and other major medical organizations to address the recognition, treatment, and prevention of burnout among residents, fellows, and medical students and faculty.

4. Our AMA will encourage further studies and disseminate the results of studies on physician and medical student burnout to the medical education and physician community.

5. Our AMA will continue to monitor this issue and track its progress, including publication of peer-reviewed research and changes in accreditation requirements.
6. Our AMA encourages the utilization of mindfulness education as an effective intervention to address the problem of medical student and physician burnout.
7. Our AMA will encourage medical staffs and/or organizational leadership to anonymously survey physicians to identify local factors that may lead to physician demoralization.
8. Our AMA will continue to offer burnout assessment resources and develop guidance to help organizations and medical staffs implement organizational strategies that will help reduce the sources of physician demoralization and promote overall medical staff well-being.
9. Our AMA will continue to: (a) address the institutional causes of physician demoralization and burnout, such as the burden of documentation requirements, inefficient work flows and regulatory oversight; and (b) develop and promote mechanisms by which physicians in all practices settings can reduce the risk and effects of demoralization and burnout, including implementing targeted practice transformation interventions, validated assessment tools and promoting a culture of well-being.

Citation: CME Rep. 8, A-07; Modified: Res. 919, I-11; Modified: BOT Rep. 15, A-19

#### **Programs on Managing Physician Stress and Burnout H-405.957**

1. Our American Medical Association supports existing programs to assist physicians in early identification and management of stress and the programs supported by the AMA to assist physicians in early identification and management of stress will concentrate on the physical, emotional and psychological aspects of responding to and handling stress in physicians' professional and personal lives, and when to seek professional assistance for stress-related difficulties.
2. Our AMA will review relevant modules of the STEPs Forward Program and also identify validated student-focused, high quality resources for professional well-being, and will encourage the Medical Student Section and Academic Physicians Section to promote these resources to medical students.

Citation: Res. 15, A-15; Appended: Res. 608, A-16; Reaffirmed: BOT Rep. 15, A-19;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 308  
(JUN-21)

Introduced by: Pennsylvania

Subject: Rescind USMLE Step 2 CS and COMLEX Level 2 PE Examination  
Requirement for Medical Licensure

Referred to: Reference Committee C

---

1 Whereas, The 2020 registration fee for the United States Medical Licensing Exam (USMLE)  
2 Step 2 Clinical Skills (CS) exam is \$1,300 (1); and  
3

4 Whereas, The 2020 registration fee for the Comprehensive Osteopathic Medical Licensing  
5 Examination (COMLEX) Level 2 Performance Evaluation (PE) exam is \$1,295 (9); and  
6

7 Whereas, Students incur additional travel and lodging expenses to take the Step 2 Clinical  
8 Exam in one of five locations across the country or to take the COMPLEX Level 2 PE exam in  
9 one of two locations (2,10); and  
10

11 Whereas, The average medical school debt for class of 2019 graduates in the United States  
12 (U.S.) was \$201,490 (8); and  
13

14 Whereas, The Liaison Committee on Medical Education and Commission on Osteopathic  
15 College Accreditation ensure standards of clinical proficiency by students attending U.S.-  
16 accredited MD and DO programs, respectively (3,4); and  
17

18 Whereas, Scores on USMLE Step 2 CS exams are not predictive of intern clinical skills  
19 performance (6); and  
20

21 Whereas, There is a lack of data on usefulness USMLE Step 2 CS exam results provide (6);  
22 and  
23

24 Whereas, USMLE Step 2 CS is a costly method of evaluating clinical skills and adds little value  
25 to the U.S. healthcare system (7); and  
26

27 Whereas, Existing American Medical Association (AMA) policy, last affirmed in 2019, commits  
28 to working with appropriate stakeholders, including state medical boards, to replace USMLE  
29 Step 2 CS and COMLEX Level 2 PE exams (5); and  
30

31 Whereas, Existing AMA policy commits to timely changes in the clinical skills examination  
32 process to reduce cost to medical students (5); and  
33

34 Whereas, Existing PAMED policy supports the elimination of the USMLE Step 2 CS and  
35 COMLEX Level 2 PE exams, with the creation of standards for a clinical schools exam to be  
36 held at accredited medical or osteopathic schools (13); and  
37

38 Whereas, These two examinations have been administratively suspended during the pandemic:  
39 USMLE Step 2 CS till June 2021 and COMLEX Level 2 PE till November 2020 (11,12); and

Whereas, Existing approaches for addressing this have focused on the Federation of State Medical Board (FSMB); and

Whereas, Advocacy targeting FSMB on this issue has not yielded resolution of this matter; and

Whereas, While the Covid pandemic has resulted in the cessation of both exams, at the present there is concern that as the pandemic eases one or both of these exams may be resurrected either in their previous form or in some new modified version in the near future; therefore be it

RESOLVED, That our American Medical Association work to rescind USMLE Step 2 CS and COMLEX Level 2 PE examination requirements and encourage a “fifty-state approach” by all individual state medical societies to engage with their respective state medical boards on this issue. (Directive to Take Action)

Fiscal Note: Minimal - less than \$1,000

Received: 05/11/21

#### AUTHOR'S STATEMENT OF PRIORITY

This resolution is listed as only a high priority and not a top priority since it's impact is not on all physicians. Yet it is of top importance to those individuals for which these exams apply. The reason that this resolution is not reaffirmation is that this resolution seeks the AMA to approach this problem in a new direction. Working with individual state societies can help withdraw the sense that these exams are an appropriate evaluation criteria. Even if only 1/4 of the individual states withdraw this requirement from their individual state boards there will be increased pressure on other state boards to fall in line.

The question as to whether it is better to continue to have the AMA to continue to work from a top down approach on this and other issues will be determined by how easy and or successful we are with a decentralized “fifty state” approach that is coordinated and lead by the AMA

#### References:

1. <https://www.nbme.org/taking-assessment/united-states-medical-licensing-examr-usmler>
2. <https://www.csecassessments.org/test-centers/>
3. <https://lcme.org/about/>
4. <https://osteopathic.org/accreditation/accreditation-guidelines/>
5. AMA policy as below, D-295.988
6. Flier LA, Henderson CR, Treasure CL. Time to Eliminate the Step 2 Clinical Skills Examination for US Medical Graduates. JAMA Intern Med. 2016;176(9):1245–1246. doi:10.1001/jamainternmed.2016.3753
7. Lehman EP IV, Guercio JR. The step 2 clinical skills exam: a poor value proposition. N Engl J Med. 2013;368(10):889-891.
8. Medical Student Education: Debt, Costs, and Loan Repayment Fact Card 2019. AAMC. <https://store.aamc.org/medical-student-education-debt-costs-and-loan-repayment-fact-card2019-pdf.html>
9. <https://www.nbome.org/exams-assessments/comlex-usa/comlex-usa-level-2-pe/registration-scheduling/>
10. <https://www.nbome.org/exams-assessments/comlex-usa/comlex-usa-level-2-pe/locations-travel/>
11. <https://www.usmle.org/announcements/?ContentId=266>
12. <https://www.nbome.org/uncategorized/important-notice-regarding-covid-19-coronavirus/>
13. <https://www.pamedsoc.org/docs/librariesprovider2/pamed-documents/pamed-downloads/HODAEC/> 16-205.pdf

**RELEVANT AMA POLICY****Clinical Skills Assessment During Medical School D-295.988**

1. Our AMA will encourage its representatives to the Liaison Committee on Medical Education (LCME) to ask the LCME to determine and disseminate to medical schools a description of what constitutes appropriate compliance with the accreditation standard that schools should "develop a system of assessment" to assure that students have acquired and can demonstrate core clinical skills.
  2. Our AMA will work with the Federation of State Medical Boards, National Board of Medical Examiners, state medical societies, state medical boards, and other key stakeholders to pursue the transition from and replacement for the current United States Medical Licensing Examination (USMLE) Step 2 Clinical Skills (CS) examination and the Comprehensive Osteopathic Medical Licensing Examination (COMLEX) Level 2-Performance Examination (PE) with a requirement to pass a Liaison Committee on Medical Education-accredited or Commission on Osteopathic College Accreditation-accredited medical school-administered, clinical skills examination.
  3. Our AMA will work to: (a) ensure rapid yet carefully considered changes to the current examination process to reduce costs, including travel expenses, as well as time away from educational pursuits, through immediate steps by the Federation of State Medical Boards and National Board of Medical Examiners; (b) encourage a significant and expeditious increase in the number of available testing sites; (c) allow international students and graduates to take the same examination at any available testing site; (d) engage in a transparent evaluation of basing this examination within our nation's medical schools, rather than administered by an external organization; and (e) include active participation by faculty leaders and assessment experts from U.S. medical schools, as they work to develop new and improved methods of assessing medical student competence for advancement into residency.
  4. Our AMA is committed to assuring that all medical school graduates entering graduate medical education programs have demonstrated competence in clinical skills.
  5. Our AMA will continue to work with appropriate stakeholders to assure the processes for assessing clinical skills are evidence-based and most efficiently use the time and financial resources of those being assessed.
  6. Our AMA encourages development of a post-examination feedback system for all USMLE test-takers that would: (a) identify areas of satisfactory or better performance; (b) identify areas of suboptimal performance; and (c) give students who fail the exam insight into the areas of unsatisfactory performance on the examination.
  7. Our AMA, through the Council on Medical Education, will continue to monitor relevant data and engage with stakeholders as necessary should updates to this policy become necessary.
- Citation: CME Rep. 7, I-99; Reaffirmed: CME Rep. 2, A-09; Appended: Alt. Res. 311, A-16; Appended: CME Rep. 9, A-17; Reaffirmation: I-19; Reaffirmed: Res. 306, I-20;

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 309  
(JUN-21)

Introduced by: Pennsylvania

Subject: Supporting GME Program Child Care Consideration During Residency Training

Referred to: Reference Committee C

---

1 Whereas, Residency training often occurs during one's childbearing and child-rearing years  
2 while residents concurrently work long hours with unpredictable, demanding schedules,  
3 necessitating childcare for those residents who are parents, especially women (1); and  
4

5 Whereas, On-site, extended-hour, and/or drop-in child care is desired by both male and female  
6 residents because it allows residents (a) more frequent contact with their children, (b) reduced  
7 stress and anxiety with scheduling of work and children's needs, and (c) decreased utilization of  
8 parental and/or FMLA leave policies, providing net financial benefit to the healthcare provider  
9 facility through tax benefits and increased resident productivity (2, 3, 4, 5, 6, 7); and  
10

11 Whereas, Childcare costs are financially burdensome. In the northeast, the overall annual  
12 household cost of childcare was \$24,815 in 2017 for a family with two children. In  
13 Pennsylvania, the cost of individual part-time center-based child care was \$7,148 which is  
14 ranked as the highest in the nation and itself exceeds the 7% household child care expense  
15 share of income for residents and fellows – as recommended by the United States Department  
16 of Health and Human Services; this cost comes at a time when most residents also begin  
17 repayment of their cumulative higher education student loan debt which compounds the  
18 financial burdens faced by residents (8, 9, 10); and  
19

20 Whereas, Childcare resources available to residents are inconsistent between graduate  
21 medical education residency program host institutions. A national survey of graduating  
22 pediatric residents found that only 24% reported access to on-site childcare at their training  
23 institution, 19% reported access to sick-child care, and 9% received subsidies for childcare  
24 expenses (11). In a survey of pediatrics department chairs, 59% indicated that on-site childcare  
25 or assistance with finding childcare was available at their institution for residents, but 50%  
26 responded that demand for childcare always or almost always exceeded availability (12). In a  
27 survey of general surgery program directors, 40% indicated on-site childcare at their facility  
28 with residents facing enrollment waiting lists and challenges scheduling for pick-up and drop-off  
29 (13). Similar findings have been recently described in a survey among obstetrics and  
30 gynecology residency program directors (14); and  
31

32 Whereas, Childbearing and child-rearing responsibilities are disproportionately burdensome  
33 upon women in the United States, regardless of occupation (15); and  
34

35 Whereas, Surgery residents who report perceiving stigma during pregnancy practiced at  
36 institutions that did not have a formal institutional maternal leave policy or were required to alter  
37 training plans (16); and

Whereas, Supportive childcare policies may enable more equity for female physician career advancement and contribute to a wider variety of specialty choices. In a study conducted at Stanford University School of Medicine, female physicians ranked flexible working environments – with particular regard to childcare, including emergency childcare on-site or nearby – as the highest priority and most important need to improve their career success and well-being (17). Likewise, in a survey of general surgery residency program directors, 61% of directors indicated that having children negatively affects female trainees' work and places an increased burden on colleagues (18); therefore be it

RESOLVED, That our American Medical Association convene a group of interested stakeholders to examine the need for innovative childcare policies and flexible working environments for all residents in order to promote equity in all training settings. (Directive to Take Action)

Fiscal Note: Modest - between \$1,000 - \$5,000

Received: 05/11/21

#### AUTHOR'S STATEMENT OF PRIORITY

The Pennsylvania Delegation would appreciate the committee considering its Resolution A-20, "Supporting GME Program Child Care Consideration During Residency Training," to be "Medium Priority" for the upcoming June HOD. There is a marked overlap between the usual residency training period and the optimal years for childbearing and rearing. Residents are often faced with not only long and demanding work schedules but childcare costs that are financially burdensome and often occur simultaneous with the repayment of student loans. Further, these responsibilities often fall disproportionately on female residents and resources available to residents are inconsistent and often inadequate. Supportive policies for childcare will promote greater equity, inclusion and career advancement for females in all GME programs as reflected in a study from Stanford. As an example of educational needs for training programs, a recent survey of program directors in general surgery residencies noted that, "having children negatively affects female trainees' work and places and increased burden on colleagues". This stigmatizing of female trainees is not only traumatizing to the trainees but also sets a terrible example for others. We believe that it is in the best interest of the AMA as well as US medicine to address this important topic now and work diligently to remove this unnecessary burden on our junior colleagues.

#### REFERENCES:

1. Snyder RA, Tarpley MJ, Phillips SE, Terhune KP. The case for on-site childcare in residency training and afterward. J Grad Med Educ. 2013 Sep;5(3):365-7.
2. Ibid.
3. Herman RE, Koppa D, Sullivan P. Sick-child daycare promotes healing and staffing. Nurs Manage. 1999;30(4):46– 47.
4. Beck J. How Some Companies Are Making Child Care Less Stressful for Their Employees. Harvard Business Review. April 2017.
5. Moran G. What will it take for employers to offer on-site day care? Fast Company. February 2016.
6. Marcario R. Patagonia's CEO Explains How To Make On-Site Child Care Pay For Itself. Fast Company. August 2016.
7. Schulte B. The Corporate Case for Child Care. Slate. February 2018.
8. Childcare Aware of America. The US and the High Cost of Child Care: 2018 Report.
9. AAMC 2013-2014 Survey of Resident/Fellow Stipends and Benefits Report. American Association of Medical Colleges. 2013.
10. Gould E., Austin JEL, and Whitebook M. What does good childcare reform look like? Economic Policy Institute. March 2017. <https://epi.org/123954>
11. Berkowitz CD, Frintner MP, Cull WL. Pediatric resident perceptions of family-friendly benefits. Acad Pediatr. 2010;10(5):360–366.
12. McPhillips HA, Burke AE, Sheppard K, Pallant A, Stapleton FB, Stanton B. Toward creating family friendly work environments in pediatrics: baseline data from pediatric department chairs and pediatric program directors. Pediatrics. 2007;119(3):e596–e602.
13. Henry TA. Making a medical resident's life more family friendly. AMA Resident & Student Health. 2016. <https://www.ama-assn.org/residents-students/resident-student-health/making-medical-residents-life-more-family-friendly> Accessed June 1, 2018.

14. Hariton, E, MD, MBA, et al; Pregnancy and parental leave among obstetrics and gynecology residents: results of a nationwide survey of program directors; AJOG, Aug. 2018, Volume 219, Issue 2, Pages 199.e1–199.e8
15. Suzanne M. Bianchi, Liana C. Sayer, Melissa A. Milkie, John P. Robinson, Housework: Who Did, Does or Will Do It, and How Much Does It Matter?, Social Forces, Volume 91, Issue 1, September 2012, 55–63.
16. Rangel, E., Liu, H, et al: Factors Associated with Residency and Career dissatisfaction in Childbearing Surgical Residents: JAMA Surg. August 1, 2018.
17. McGuire LK, Bergen MR, Polan ML. Career advancement for women faculty in a U.S. school of medicine: perceived needs. Acad Med. 2004;79(4):319–325.
18. Sandler, Britt J., et al. "Pregnancy and Parenthood among Surgery Residents: Results of the First Nationwide Survey of General Surgery Residency Program Directors." Journal of the American College of Surgeons, vol. 222, no. 6, 2016, 1090–1096.



## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 310  
(JUN-21)

Introduced by: Pennsylvania

Subject: Unreasonable Fees Charged and Inaccuracies by the American Board of Internal Medicine (ABIM)

Referred to: Reference Committee C

1 Whereas, Our American Medical Association has noted the heavy financial and emotional toll  
2 that the Maintenance of Certification (MOC) programs of some of the American Board of  
3 Medical Specialties Boards (ABMS) have had on physicians; and  
4

5 Whereas, Many physicians are certified by more than one ABMS Board but participate in MoC  
6 with only one of those boards, and  
7

8 Whereas, The ABIM, while recognizing that some ABIM certified physicians hold and maintain  
9 board certification by a board other than the ABIM, and  
10

11 Whereas, The ABIM charges such physicians a fee which is nearly as high as that charged  
12 physicians maintaining certification with the ABIM, and  
13

14 Whereas, The ABIM refuses to accurately reflect such physicians' status as "Participating in  
15 MOC" in the ABIM Directory unless they pay that fee, therefore be it  
16

17 RESOLVED, That our American Medical Association work with the American Board of Medical  
18 Specialties Boards (ABMS), in general, and American Board of Internal Medicine (ABIM),  
19 specifically, to require the ABIM stop charging physicians with two or more board certifications,  
20 who participate in Maintenance of Certification (MOC) with a board other than the ABIM, a fee to  
21 accurately list their current board status in the ABIM Directory. (Directive to Take Action)

Fiscal Note: Minimal - less than \$1,000

Received: 05/11/21

### AUTHOR'S STATEMENT OF PRIORITY

Over the last several sessions our AMA has been presented issues of MOC and recertification. This resolution focuses on issues of multiple board certifications, expenses of certification and discrepancies with accurately listing of physician status by the ABMS and the ABIM specifically.

The resolution asks that the AMA stop the ABMS and the ABIM from multiple charges for physicians with more than one board certification and to have the ABIM accurately list a physician participating in MOC with other boards and list their board status as such without paying full fee to the ABIM.

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 311  
(JUN-21)

Introduced by: Illinois

Subject: Student Loan Forgiveness

Referred to: Reference Committee C

1 Whereas, The cost of medical education, all facets included, is a significant burden for resident  
2 physicians as well as for young physicians beginning practice; and  
3

4 Whereas, Such costs and burdens significantly influence medical specialty and location of  
5 practice selection and it is widely thought that this limits the numbers of students selecting  
6 primary care specialties; and  
7

8 Whereas, The Public Service Loan Forgiveness Program, a federal program, allows payment  
9 for 10 years against the loan balance then the application for loan forgiveness of the remaining  
10 loan amounts at that point; and  
11

12 Whereas, 98% of applications for loan forgiveness under the Public Service Loan Forgiveness  
13 Program are denied; therefore be it  
14

15 RESOLVED, That our American Medical Association study the cause for the unacceptably high  
16 denial rate of applications made to the Public Health Services Student Loan Forgiveness  
17 Program, and advocate for improvements in the administration and oversight of the Program,  
18 including but not limited to increasing transparency of and streamlining program requirements;  
19 ensuring consistent and accurate communication between loan services and borrowers; and  
20 establishing clear expectations regarding oversight and accountability of the loan servicers  
21 responsible for the program. (Directive to Take Action)

Fiscal Note: Modest - between \$1,000 - \$5,000

Received: 05/11/21

The topic of this resolution is currently under study by the Council on Medical Education.

### AUTHOR'S STATEMENT OF PRIORITY

This resolution reflects an issue that is both urgent and high priority. Medical school debt loads are reaching crisis levels, and the high cost of medical education is significantly impacting the size and distribution of the physician work force. The Public Health Services Student Loan Forgiveness program was supposed to be a lifeline for medical students, but the denial rates under the program have been astronomical, clearly an indication of poor communication and implementation of program requirements. It is critical that this issue be addressed as soon as possible so that students who adhere to the service requirements of program are able to access the loan terms they were promised.

**References:**

<https://students-residents.aamc.org/financial-aid/article/public-service-loan-forgiveness-pslf/>  
<https://www.nytimes.com/2019/11/28/us/politics/student-loan-forgiveness.html>

**RELEVANT AMA POLICY****H-305.925 - Principles of and Actions to Address Medical Education Costs and Student Debt**

The costs of medical education should never be a barrier to the pursuit of a career in medicine nor to the decision to practice in a given specialty. To help address this issue, our American Medical Association (AMA) will:

1. Collaborate with members of the Federation and the medical education community, and with other interested organizations, to address the cost of medical education and medical student debt through public- and private-sector advocacy.
2. Vigorously advocate for and support expansion of and adequate funding for federal scholarship and loan repayment programs--such as those from the National Health Service Corps, Indian Health Service, Armed Forces, and Department of Veterans Affairs, and for comparable programs from states and the private sector--to promote practice in underserved areas, the military, and academic medicine or clinical research.
3. Encourage the expansion of National Institutes of Health programs that provide loan repayment in exchange for a commitment to conduct targeted research.
4. Advocate for increased funding for the National Health Service Corps Loan Repayment Program to assure adequate funding of primary care within the National Health Service Corps, as well as to permit: (a) inclusion of all medical specialties in need, and (b) service in clinical settings that care for the underserved but are not necessarily located in health professions shortage areas.
5. Encourage the National Health Service Corps to have repayment policies that are consistent with other federal loan forgiveness programs, thereby decreasing the amount of loans in default and increasing the number of physicians practicing in underserved areas.
6. Work to reinstate the economic hardship deferment qualification criterion known as the "20/220 pathway," and support alternate mechanisms that better address the financial needs of trainees with educational debt.
7. Advocate for federal legislation to support the creation of student loan savings accounts that allow for pre-tax dollars to be used to pay for student loans.
8. Work with other concerned organizations to advocate for legislation and regulation that would result in favorable terms and conditions for borrowing and for loan repayment, and would permit 100% tax deductibility of interest on student loans and elimination of taxes on aid from service-based programs.
9. Encourage the creation of private-sector financial aid programs with favorable interest rates or service obligations (such as community- or institution-based loan repayment programs or state medical society loan programs).
- ...
14. Take an active advocacy role during reauthorization of the Higher Education Act and similar legislation, to achieve the following goals: (a) Eliminating the single holder rule; (b) Making the availability of loan deferment more flexible, including broadening the definition of economic hardship and expanding the period for loan deferment to include the entire length of residency and fellowship training; (c) Retaining the option of loan forbearance for residents ineligible for loan deferment; (d) Including, explicitly, dependent care expenses in the definition of the "cost of attendance"; (e) Including room and board expenses in the definition of tax-exempt scholarship income; (f) Continuing the federal Direct Loan Consolidation program, including the ability to "lock in" a fixed interest rate, and giving consideration to grace periods in renewals of federal loan programs; (g) Adding the ability to refinance Federal Consolidation Loans; (h) Eliminating the cap on the student loan interest deduction; (i) Increasing the income limits for taking the

interest deduction; (j) Making permanent the education tax incentives that our AMA successfully lobbied for as part of Economic Growth and Tax Relief Reconciliation Act of 2001; (k) Ensuring that loan repayment programs do not place greater burdens upon married couples than for similarly situated couples who are cohabitating; (l) Increasing efforts to collect overdue debts from the present medical student loan programs in a manner that would not interfere with the provision of future loan funds to medical students.

...

20. Related to the Public Service Loan Forgiveness (PSLF) Program, our AMA supports increased medical student and physician benefits the program, and will: (a) Advocate that all resident/fellow physicians have access to PSLF during their training years; (b) Advocate against a monetary cap on PSLF and other federal loan forgiveness programs; (c) Work with the United States Department of Education to ensure that any cap on loan forgiveness under PSLF be at least equal to the principal amount borrowed; (d) Ask the United States Department of Education to include all terms of PSLF in the contractual obligations of the Master Promissory Note; (e) Encourage the Accreditation Council for Graduate Medical Education (ACGME) to require residency/fellowship programs to include within the terms, conditions, and benefits of program appointment information on the PSLF program qualifying status of the employer; (f) Advocate that the profit status of a physicians training institution not be a factor for PSLF eligibility; (g) Encourage medical school financial advisors to counsel wise borrowing by medical students, in the event that the PSLF program is eliminated or severely curtailed; (h) Encourage medical school financial advisors to increase medical student engagement in service-based loan repayment options, and other federal and military programs, as an attractive alternative to the PSLF in terms of financial prospects as well as providing the opportunity to provide care in medically underserved areas; (i) Strongly advocate that the terms of the PSLF that existed at the time of the agreement remain unchanged for any program participant in the event of any future restrictive changes.

21. Advocate for continued funding of programs including Income-Driven Repayment plans for the benefit of reducing medical student load burden.

22. Formulate a task force to look at undergraduate medical education training as it relates to career choice, and develop new policies and novel approaches to prevent debt from influencing specialty and subspecialty choice.

CME Report 05, I-18 Appended: Res. 953, I-18 Reaffirmation: A-19 Appended: Res. 316, A-19

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 312  
(JUN-21)

Introduced by: American College of Preventive Medicine  
American College of Occupational and Environmental Medicine  
American Association of Public Health Physicians

Subject: AMA Support for Increased Funding for the American Board of Preventive  
Medicine (ABPM) Residency Programs

Referred to: Reference Committee C

---

1 Whereas, The AMA mission statement supports the betterment of public health; and

2  
3 Whereas, The American Board of Preventive Medicine is the Board responsible for certification  
4 of the skills, knowledge and professional acumen of physicians in specialties of Aerospace  
5 Medicine, Occupational and Environmental Medicine, and Public Health & General Preventive  
6 Medicine, and subspecialties including Undersea & Hyperbaric Medicine, Medical Toxicology,  
7 Clinical Informatics and Addiction Medicine; and

8  
9 Whereas, These specialties and subspecialties are the core residencies of training for future  
10 public health physicians and leaders in this country; and

11  
12 Whereas, The COVID-19 pandemic has clearly emphasized the imperative for trained public  
13 health leadership to ensure proper preparedness and response in the US; and

14  
15 Whereas, The COVID-19 pandemic has raised the awareness of a shortage of physician trained  
16 to address prevention, preparedness, response, recovery, and resiliency in rural communities  
17 across America; and

18  
19 Whereas, Funding support for preventive medicine specialties is not generally understood nor  
20 offered through traditional sources from the Centers for Medicare and Medicaid Services (CMS);  
21 and

22  
23 Whereas, Variable funding comes from Health Resources and Services Administration (HRSA),  
24 Centers for Disease Control and Prevention (CDC), National Institutes of Occupational Safety  
25 and Health (NIOSH) and the Defense Act; and

26  
27 Whereas, These residency programs continually lack sufficient funding to fill the slots available  
28 and financially support the training for this important aspect of the health care workforce;  
29 therefore be it

1 RESOLVED, That our American Medical Association support and advocate for increased  
2 funding through the Health Resources and Services Administration (HRSA), National Institute  
3 for Occupational Safety and Health (NIOSH), Centers for Disease Control and Prevention  
4 (CDC), and other mechanisms for all residencies training physicians in the Preventive Medicine  
5 specialties of Aerospace Medicine, Occupational and Environmental Medicine and Public Health  
6 & General Preventive Medicine, and subspecialties including Undersea & Hyperbaric Medicine,  
7 Medical Toxicology, Clinical Informatics and Addiction Medicine (Directive to Take Action); and  
8 be it further

9  
10 RESOLVED, That our AMA actively increase further awareness of the importance of public  
11 health training, leadership, and principles among all medical students and physicians in training  
12 and in practice. (Directive to Take Action)

Fiscal Note: Minimal - less than \$1,000

Received: 05/12/21

AUTHOR'S STATEMENT OF PRIORITY

We are public health. We are the Section Council on Preventive Medicine (SCPM), the conscience of public health in the American Medical Association (AMA) House of Delegates. The mission of AMA includes the betterment of public health in this country and we need to do a better job emulating, supporting and advancing this important work.

The severity of the covid-19 pandemic clearly uncovered the deficits and deficiencies of the public health system in response to this crisis. The threat continues even as we meet for the AMA annual meeting. One of the important and pressing deficits in the US system is the lack of a strong cadre of medical leaders in the public health system. Preventive medicine specialties are the areas in medicine where physicians receive appropriate training in public health matters. Good medical leadership is critical for the foundation of the public health infrastructure. Residencies in preventive medicine specialties are disappearing due to necessary funding sources. The AMA as the voice of medicine in this country can sound the alarms now about this pressing need. In doing so, the AMA would be meeting its mission of the betterment of public health.

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 313  
(JUN-21)

Introduced by: Women Physicians Section

Subject: Fatigue Mitigation Respite for Faculty and Residents

Referred to: Reference Committee C

---

1 Whereas, During the COVID-19 pandemic, physicians have been on the front lines, and have  
2 experienced increased duress and extreme fatigue during the case surges as hospitals are  
3 overrun with patients; and  
4

5 Whereas, Longer shifts, disruptions to sleep and to work-life balance, and occupational hazards  
6 associated with exposure to COVID-19 have contributed to physical and mental fatigue; and  
7

8 Whereas, About 20-30 percent of shift workers experience prominent insomnia symptoms and  
9 excessive daytime sleepiness consistent with circadian rhythm sleep disorder, also known as  
10 shift work disorder;<sup>5</sup> and  
11

12 Whereas, Drowsy driving causes almost 1,000 estimated fatal motor vehicle crashes in the  
13 United States (2.5 percent of all fatal crashes), 37,000 injury crashes, and 45,000 property  
14 damage-only crashes;<sup>2</sup> and  
15

16 Whereas, Physicians have a higher likelihood of dying from accidents than from other causes  
17 relative to the general populations;<sup>4</sup> and  
18

19 Whereas, Physicians' risk of crashing while driving after working extended shifts ( $\geq 24$  hours)  
20 was 2.3 times greater and the risk for a "near miss" crash was 5.9 times greater, compared to a  
21 non-extended shift. The estimated risk of a crash rose by 9.1 percent for every additional  
22 extended work shift hour;<sup>3</sup> and  
23

24 Whereas, Forty-one percent (41%) of physicians report falling asleep at the wheel after a night  
25 shift;<sup>6</sup> and  
26

27 Whereas, A simulation study demonstrated that being awake for 18 hours, which is common for  
28 physicians working a swing shift (i.e., from 6 p.m. to 2 a.m.), produced an impairment equal to a  
29 blood alcohol concentration (BAC) of 0.05 and rose to equal 0.10 after 24 hours without sleep;<sup>7</sup>  
30 and  
31

32 Whereas, Driving simulator studies show driving home from the night shift is associated with two  
33 to eight times the incidents of off track veering, decreased time to first accident, increased eye  
34 closure duration, and increased subjective sleepiness. Night-shift work increases driver  
35 drowsiness, degrading driving performance and increasing the risk of near-crash drive events;<sup>8</sup>  
36 and

Whereas, Actual driving studies post-night shift versus post-sleep night showed eleven near-crashes occurred in 6 of 16 post night-shift drives (37.5 percent), and 7 of 16 post night-shift drives (43.8 percent) were terminated early for safety reasons, compared with zero near-crashes or early drive terminations during 16 post-sleep drives;<sup>9</sup> and

Whereas, AMA Policy H-15.958, "Fatigue, Sleep Disorders, and Motor Vehicle Crashes," notes the risks associated with sleep deprivation and actions physicians can take to help protect patients; therefore be it

RESOLVED, That our American Medical Association make available resources to institutions and physicians that support self-care and fatigue mitigation, help protect physician health and well-being, and model appropriate health promoting behaviors (Directive to Take Action); and be it further

RESOLVED, That the AMA advocate for policies that support fatigue mitigation programs, which include, but are not limited to, quiet places to rest and funding for alternative transport including return to work for vehicle recovery at a later time for all medical staff who feel unsafe driving due to fatigue after working. (Directive to Take Action)

Fiscal Note: Minimal - less than \$1,000

Received: 05/12/21

#### AUTHOR'S STATEMENT OF PRIORITY

COVID fatigue has been used to describe the intense and overwhelming fatigue, irritability and disorientation experienced by physicians and healthcare workers during the pandemic. The high patient volumes and extra shifts during surges place additional physiologic strain on physicians. It is important for that the AMA advocate for policies that support fatigue mitigation programs and make available resources to institutions and physicians that support self-care and fatigue mitigation, help protect physician health and well-being.

#### References:

1. Fatigue Mitigation Transportation Reimbursement for Trainees. Available at <https://medschool.ucla.edu/gme/transportation-reimbursement-for-fatigued-trainees>.
2. Research on Drowsy Drive. Available at <https://one.nhtsa.gov/Driving-Safety/Drowsy-Driving/scope%E2%80%93of%E2%80%93the%E2%80%93problem>.
3. Barger LK, Cade BE, Ayas NT, Cronin JW, Rosner B, Speizer FE, et al. Extended work shifts and the risk of motor vehicle crashes among interns. *N Engl J Med*. 2005;352(2):125–34.
4. Frank, E, Biola, H, Burnett, CA. Mortality rates and causes among U.S. physicians. *Am J Prev Med* 2000; 19: 155–9.
5. Booker LA, Magee M, Rajaratnam SMW, Sletten TL, Howard ME. Individual vulnerability to insomnia, excessive sleepiness and shift work disorder amongst healthcare shift workers. A systematic review. *Sleep Med Rev*. 2018;41:220–33.
6. <https://www.bbc.com/news/uk-england-suffolk-36767868>
7. Williamson AM, Feyer AM. Moderate sleep deprivation produces impairments in cognitive and motor performance equivalent to legally prescribed levels of alcohol intoxication. *Occup Environ Med*. 2000;57(10):649–655. doi:10.1136/oem.57.10.649.
8. Akerstedt T<sup>1</sup>, Peters B, Anund A, Kecklund G. Impaired alertness and performance driving home from the night shift: a driving simulator study. *J Sleep Res*. 2005 Mar;14(1):17-20.
9. Lee MI1, Howard Me2, Horrey Wj3, Liang Y3, Anderson C4, Shreeve Ms5, O'brien Cs5, Czeisler Ca6. High Risk Of Near-Crash Driving Events Following Night-Shift Work. *Proc Natl Acad Sci U S A*. 2016 Jan 5;113(1):176-81. doi: 10.1073/pnas.1510383112.



## RELEVANT AMA POLICY

### Resident/Fellow Clinical and Educational Work Hours H-310.907

Our AMA adopts the following Principles of Resident/Fellow Clinical and Educational Work Hours, Patient Safety, and Quality of Physician Training:

1. Our AMA supports the 2017 Accreditation Council for Graduate Medical Education (ACGME) standards for clinical and educational work hours (previously referred to as “duty hours”).
2. Our AMA will continue to monitor the enforcement and impact of clinical and educational work hour standards, in the context of the larger issues of patient safety and the optimal learning environment for residents.
3. Our AMA encourages publication and supports dissemination of studies in peer-reviewed publications and educational sessions about all aspects of clinical and educational work hours, to include such topics as extended work shifts, handoffs, in-house call and at-home call, level of supervision by attending physicians, workload and growing service demands, moonlighting, protected sleep periods, sleep deprivation and fatigue, patient safety, medical error, continuity of care, resident well-being and burnout, development of professionalism, resident learning outcomes, and preparation for independent practice.
4. Our AMA endorses the study of innovative models of clinical and educational work hour requirements and, pending the outcomes of ongoing and future research, should consider the evolution of specialty- and rotation-specific requirements that are evidence-based and will optimize patient safety and competency-based learning opportunities.
5. Our AMA encourages the ACGME to:
  - a) Decrease the barriers to reporting of both clinical and educational work hour violations and resident intimidation.
  - b) Ensure that readily accessible, timely and accurate information about clinical and educational work hours is not constrained by the cycle of ACGME survey visits.
  - c) Use, where possible, recommendations from respective specialty societies and evidence-based approaches to any future revision or introduction of clinical and educational work hour rules.
  - d) Broadly disseminate aggregate data from the annual ACGME survey on the educational environment of resident physicians, encompassing all aspects of clinical and educational work hours.
6. Our AMA recognizes the ACGME for its work in ensuring an appropriate balance between resident education and patient safety, and encourages the ACGME to continue to:
  - a) Offer incentives to programs/institutions to ensure compliance with clinical and educational work hour standards.
  - b) Ensure that site visits include meetings with peer-selected or randomly selected residents and that residents who are not interviewed during site visits have the opportunity to provide information directly to the site visitor.
  - c) Collect data on at-home call from both program directors and resident/fellow physicians; release these aggregate data annually; and develop standards to ensure that appropriate education and supervision are maintained, whether the setting is in-house or at-home.
  - d) Ensure that resident/fellow physicians receive education on sleep deprivation and fatigue.
7. Our AMA supports the following statements related to clinical and educational work hours:
  - a) Total clinical and educational work hours must not exceed 80 hours per week, averaged over a four-week period (Note: “Total clinical and educational work hours” includes providing direct patient care or supervised patient care that contributes to meeting educational goals; participating in formal educational activities; providing administrative and patient care services of limited or no educational value; and time needed to transfer the care of patients).
  - b) Scheduled on-call assignments should not exceed 24 hours. Residents may remain on-duty for an additional 4 hours to complete the transfer of care, patient follow-up, and education; however, residents may not be assigned new patients, cross-coverage of other providers’ patients, or continuity clinic during that time.
  - c) Time spent in the hospital by residents on at-home call must count towards the 80-hour maximum weekly hour limit, and on-call frequency must not exceed every third night averaged over four weeks. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one-day-in-seven free of duty, when averaged over four weeks.
  - d) At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident.
  - e) Residents are permitted to return to the hospital while on at-home call to care for new or established patients. Each episode of this type of care, while it must be included in the 80-hour weekly maximum, will not initiate a new “off-duty period.”
  - f) Given the different education and patient care needs of the various specialties and changes in resident responsibility as training progresses, clinical and educational work hour requirements should allow for flexibility for different disciplines and different training levels to ensure appropriate resident education and patient safety; for example, allowing exceptions for certain disciplines, as appropriate, or allowing a limited increase to the total number of clinical and educational work hours when need is demonstrated.
  - g) Resident physicians should be ensured a sufficient duty-free interval prior to returning to duty.
  - h) Clinical and educational work hour limits must not adversely impact resident physician participation in organized educational activities. Formal educational activities must be scheduled and available within total clinical and educational work hour limits for all resident physicians.
  - i) Scheduled time providing patient care services of limited or no educational value should be minimized.
  - j) Accurate, honest, and complete reporting of clinical and educational work hours is an essential element of medical professionalism and ethics.
  - k) The medical profession maintains the right and responsibility for self-regulation (one of the key tenets of

professionalism) through the ACGME and its purview over graduate medical education, and categorically rejects involvement by the Centers for Medicare & Medicaid Services, The Joint Commission, Occupational Safety and Health Administration, and any other federal or state government bodies in the monitoring and enforcement of clinical and educational work hour regulations, and opposes any regulatory or legislative proposals to limit the work hours of practicing physicians.

l) Increased financial assistance for residents/fellows, such as subsidized child care, loan deferment, debt forgiveness, and tax credits, may help mitigate the need for moonlighting. At the same time, resident/fellow physicians in good standing with their programs should be afforded the opportunity for internal and external moonlighting that complies with ACGME policy.

m) Program directors should establish guidelines for scheduled work outside of the residency program, such as moonlighting, and must approve and monitor that work such that it does not interfere with the ability of the resident to achieve the goals and objectives of the educational program.

n) The costs of clinical and educational work hour limits should be borne by all health care payers. Individual resident compensation and benefits must not be compromised or decreased as a result of changes in the graduate medical education system.

o) The general public should be made aware of the many contributions of resident/fellow physicians to high-quality patient care and the importance of trainees' realizing their limits (under proper supervision) so that they will be able to competently and independently practice under real-world medical situations.

8. Our AMA is in full support of the collaborative partnership between allopathic and osteopathic professional and accrediting bodies in developing a unified system of residency/fellowship accreditation for all residents and fellows, with the overall goal of ensuring patient safety.

9. Our AMA will actively participate in ongoing efforts to monitor the impact of clinical and educational work hour limitations to ensure that patient safety and physician well-being are not jeopardized by excessive demands on post-residency physicians, including program directors and attending physicians.

Citation: CME Rep. 5, A-14; Modified: CME Rep. 06, I-18

#### **Fatigue, Sleep Disorders, and Motor Vehicle Crashes H-15.958**

Our AMA: (1) recognizes sleepiness behind the wheel as a major public health issue and continues to encourage a national public education campaign by appropriate federal agencies and relevant advocacy groups

(2) recommends that the National Institutes of Health and other appropriate organizations support research projects to provide more accurate data on the prevalence of sleep-related disorders in the general population and in motor vehicle drivers, and provide information on the consequences and natural history of such conditions.

(3) recommends that the U.S. Department of Transportation (DOT) and other responsible agencies continue studies on the occurrence of highway crashes and other adverse occurrences in transportation that involve reduced operator alertness and sleep.

(4) encourages continued collaboration between the DOT and the transportation industry to support research projects for the devising and effectiveness- testing of appropriate countermeasures against driver fatigue, including technologies for motor vehicles and the highway environment.

(5) urges responsible federal agencies to improve enforcement of existing regulations for truck driver work periods and consecutive working hours and increase awareness of the hazards of driving while fatigued. If changes to these regulations are proposed on a medical basis, they should be justified by the findings of rigorous studies and the judgments of persons who are knowledgeable in ergonomics, occupational medicine, and industrial psychology.

(6) recommends that physicians: (a) become knowledgeable about the diagnosis and management of sleep-related disorders; (b) investigate patient symptoms of drowsiness, wakefulness, and fatigue by inquiring about sleep and work habits and other predisposing factors when compiling patient histories; (c) inform patients about the personal and societal hazards of driving or working while fatigued and advise patients about measures they can take to prevent fatigue-related and other unintended injuries; (d) advise patients about possible medication-related effects that may impair their ability to safely operate a motor vehicle or other machinery; (e) inquire whether sleepiness and fatigue could be contributing factors in motor vehicle-related and other unintended injuries; and (f) become familiar with the laws and regulations concerning drivers and highway safety in the state(s) where they practice.

(7) encourages all state medical associations to promote the incorporation of an educational component on the dangers of driving while sleepy in all drivers education classes (for all age groups) in each state.

(8) recommends that states adopt regulations for the licensing of commercial and private drivers with sleep-related and other medical disorders according to the extent to which persons afflicted with such disorders experience crashes and injuries.

(9) reiterates its support for physicians' use of E-codes in completing emergency department and hospital records, and urges collaboration among appropriate government agencies and medical and public health organizations to improve state and national injury surveillance systems and more accurately determine the relationship of fatigue and sleep disorders to motor vehicle crashes and other unintended injuries.

Citation: CSA Rep. 1, A-96; Appended: Res. 418, I-99; Reaffirmed: CSAPH Rep. 1, A-09; Modified: CSAPH Rep. 01, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 314  
(JUN-21)

Introduced by: Medical Student Section

Subject: Standard Procedure for Accommodations in USMLE and NBME Exams

Referred to: Reference Committee C

---

1 Whereas, The Americans with Disabilities Act (ADA) section 36.309 requires that any  
2 documentation requested by a testing entity in order to evaluate a request for testing  
3 accommodations be both reasonable and limited to only the information needed to determine  
4 the nature of a candidate's disability and their need for the requested testing accommodations<sup>1</sup>;  
5 and  
6

7 Whereas, Under ADA section 36.309, examples of legally-appropriate accommodation request  
8 documents include: (1) recommendations by qualified healthcare professionals, (2) proof of past  
9 testing accommodations, (3) observations by educators, (4) results of psycho-educational or  
10 other professional evaluations, (5) an applicant's history of diagnosis, and (6) an applicant's  
11 statement of his or her history regarding testing accommodations<sup>1</sup>; and  
12

13 Whereas, Under ADA section 36.309, depending on the nature of either the disability, or the  
14 form of requested accommodation, a testing entity might only need one or two forms of  
15 documentation to verify the nature of the candidate's disability and his or her need for the  
16 requested accommodation<sup>1</sup>; and  
17

18 Whereas, Under ADA section 36.309, proof of past testing accommodations in similar test  
19 settings is generally sufficient to support a request for the same testing accommodations for a  
20 subsequent standardized exam or other high stakes test<sup>1</sup>; and  
21

22 Whereas, Under ADA section 36.309, if a candidate previously received testing  
23 accommodations under an Individualized Education Program (IEP) or Section 504 Plan, they  
24 should generally receive the same testing accommodations for a subsequent standardized  
25 exam, with examples including extra time, additional or extended breaks, testing in a private  
26 room, or other sight- or hearing-based accommodation<sup>1,2</sup>; and  
27

28 Whereas, Under ADA section 36.309, recognizing the importance of face-to-face evaluation for  
29 a correct diagnosis, directs testing entities to give precedence to reports from qualified  
30 professionals who have personally evaluated the candidate over reports from testing entity  
31 reviewers who did not conduct an assessment of the candidate for diagnosis and treatment<sup>1</sup>;  
32 and  
33

34 Whereas, The National Board of Medical Examiners (NBME) has a practice of reviewing and  
35 sometimes denying accommodations requests without a face-to-face evaluation<sup>1,3</sup>; and  
36

37 Whereas, In *Berger v. the National Board of Medical Examiners*, the NBME denied an  
38 accommodation request based on the testimony of NBME-paid outside experts who provided  
39 their opinions without having evaluated the candidate<sup>1,3</sup>; and

Whereas, This practice violates the ADA's requirement of deference to the opinions based on in-person evaluations<sup>1,3</sup>; and

Whereas, ADA section 36.309, states a qualified professional's decision not to provide results from a specific test or evaluation instrument should not preclude approval of a request for testing accommodations where the documentation provided by the candidate, in its entirety, demonstrates that the candidate has a disability and needs a requested testing accommodation<sup>1</sup>; and

Whereas, According to ADA section 36.309, a testing entity must respond in a timely manner to requests for testing accommodations, including when that entity requests additional information, to ensure equal opportunity for applicants with disabilities to register and take the test in the same testing cycle as their classmates as to not delay their medical education<sup>1</sup>; and

Whereas, According to ADA section 36.309, failure by a testing entity to act in a timely manner, coupled with requests for duplicative, unnecessary, or extraneous documentation, could result in an extended delay such that it denies persons with disabilities equal opportunity or equal treatment as their peers without disabilities<sup>1</sup>; and

Whereas, American College Testing (ACT), which administered the ACT to approximately 1.91 million students in 2018, states that requests are normally processed in 10-14 business days<sup>4,5</sup>; and

Whereas, The Law School Admission Council (LSAC), which administered the Law School Admission Test (LSAT) to 138,597 students between June of 2018 and March of 2019, states that students who request the same accommodations that they have received previously will receive those accommodations without further documentation, as long as they provide verification of that previous accommodation for a standardized test and the accommodation does not require administration over multiple days<sup>6,7</sup>; and

Whereas, The United States Medical Licensing Examination (USMLE) website states that the applicant should wait 60 days for processing and requires a personal statement, complete and comprehensive evaluation from a qualified professional done in the past three years, and supporting documentation potentially including academic records, score transcripts for previous standardized exams, verification of prior academic/test accommodations, relevant medical records, previous psychoeducational evaluations, faculty or supervisor feedback, job performance evaluations, and course evaluations<sup>2,8,9</sup>; and

Whereas, The Guide to Assisting Students with Disabilities: Equal Access in Health Science and Professional Education, a book which is written for health science administrators and disability service providers, recommends beginning the accommodation request process 10 months before the planned exam date due to the rigor of completing the appropriate documentation coupled with the time needed for processing and approval<sup>2</sup>; and

Whereas, The Guide to Assisting Students with Disabilities: Equal Access in Health Science and Professional Education states that the assessments students often need to qualify for accommodations cost between \$1,200 to more than \$5,000 dollars depending on health insurance and geographic location<sup>2</sup>; and

Whereas, A study by the Association of American Medical Colleges and the Human Resources Research Organization found that medical students who received extended time on the Medical College Admission Test (MCAT) had no difference in either MCAT scores or in rates of

admission to medical school, and even after they controlled for undergraduate GPA, the students who had received MCAT accommodations had between 8.1% to 18.9% lower graduation rates based on the number of years it took to graduate and an 11%, 9%, and 5% lower pass rate on Steps 1, 2 CK, and 2 CS respectively<sup>10</sup>; therefore be it

RESOLVED, That our American Medical Association collaborate with medical licensing organizations to facilitate a timely accommodations application process (Directive to Take Action); and be it further

RESOLVED, That our AMA, in conjunction with the National Board of Medical Examiners, develop a plan to reduce the amount of proof required for approving accommodations to lower the burden of cost and time to medical students with disabilities. (Directive to Take Action)

Fiscal Note: Modest - between \$1,000 - \$5,000

Date Received: 05/12/21

#### AUTHORS STATEMENT OF PRIORITY

The issue of equitable access and disabilities is a priority for our delegation. This resolution touches on the heart of an issue not often considered for physicians: representation of all abilities. Both schools' technical requirements and the strict processes of NBME deter students with disabilities from becoming physicians. NBME requirements are even more stringent and difficult for students with temporary disabilities or new-onset disability, as it is difficult to prove "previous accommodations" on short notice given the timeline of requesting accommodations.

We believe that the asks of this resolution to standardize and improve the accommodations of medical students with disabilities to be salient. Although not officially recognized by the AAMC as underrepresented in medicine, persons with disabilities represent 0.3-2.7% of medical students and practicing physicians compared to 19.4% of US citizens. Medical students and physicians with disabilities provide high quality and culturally competent care to a diverse patient population, but are met by many barriers to practicing medicine. A standardized process to accommodations for licensing exams would be an appropriate step to addressing these barriers to practice.

#### **References:**

1. U.S. Department of Justice. Americans with Disabilities Act. 1990. [www.ada.gov/regs2010/titleIII\\_2010/titleIII\\_2010\\_regulations.htm#a2010guidance](http://www.ada.gov/regs2010/titleIII_2010/titleIII_2010_regulations.htm#a2010guidance). Accessed August 24, 2019.
2. Meeks, L. and Jain, N. *The Guide to Assisting Students with Disabilities: Equal Access in Health Science and Professional Education*. New York: Springer Publishing Company; 2016:99.
3. *Berger v. Nat'l Bd. of Med. Exam'rs*. No. 1:19-cv-99, S.D. Ohio (August 27, 2019). <https://casetext.com/case/berger-v-natl-bd-of-med-examiners>. Accessed September 20, 2019.
4. Anderson, N. SAT Reclaims Title of Most Widely Used College Admissions Test. *The Washington Post*. Published October 23, 2018. <https://www.washingtonpost.com/education/2018/10/23/sat-reclaims-title-most-widely-used-college-admission-test/>. Accessed September 19, 2019.
5. Accommodations and English Language Supports for Educators. ACT website. <https://www.act.org/content/act/en/products-and-services/the-act-educator/accommodations.html>. Accessed August 24, 2019.
6. LSAT Trends: Total LSATs Administered by Admin & Year. LSAC website. <https://www.lsac.org/data-research/data/lsat-trends-total-lsats-administered-admin-year>. Accessed September 19, 2019.
7. LSAC Policy Accommodations for Test Takers with Disabilities. LSAC website. <https://www.lsac.org/lsat/lsac-policy-accommodations-test-takers-disabilities>. Accessed August 24, 2019.
8. Request for Test Accommodations. USMLE website. <https://www.usmle.org/pdfs/test-accommodations/accom-request-form.pdf>. Accessed August 24, 2019.
9. General Guidelines for Test Accommodations. USMLE website. <https://www.usmle.org/test-accommodations/guidelines.html>. Accessed August 24, 2019.
10. Searcy CA, Dowd KW, Hughes, MG, Baldwin S, Pigg T. Association of MCAT Scores Obtained With Standard vs Extra Administration Time With Medical School Admission, Medical Student Performance, and Time to Graduation. *JAMA*. 2015;313(22):2253-2262.

## **RELEVANT AMA POLICY**

### **Accommodating Lactating Mothers Taking Medical Examinations H-295.861**

Our AMA: (1) urges all medical licensing, certification and board examination agencies, and all board proctoring centers, to grant special requests to give breastfeeding individuals additional break time and a suitable environment during examinations to express milk; and (2) encourages that such accommodations to breastfeeding individuals include necessary time per exam day, in addition to the standard pool of scheduled break time found in the specific exam, as well as access to a private, non-bathroom location on the testing center site with an electrical outlet for individuals to breast pump. (Sub Res. 903, I-14; Modified Res. 310, A-17)

### **Strategies for Enhancing Diversity in the Physician Workforce H-200.951**

Our AMA (1) supports increased diversity across all specialties in the physician workforce in the categories of race, ethnicity, gender, sexual orientation/gender identity, socioeconomic origin and persons with disabilities; (2) commends the Institute of Medicine for its report, "In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce," and supports the concept that a racially and ethnically diverse educational experience results in better educational outcomes; and (3) encourages medical schools, health care institutions, managed care and other appropriate groups to develop policies articulating the value and importance of diversity as a goal that benefits all participants, and strategies to accomplish that goal. (CME Rep. 1, I-06, Reaffirmed: CME Rep. 7, A-08, Reaffirmed: CCB/CLRPD Rep. 4, A-13, Modified: CME Rep. 01, A-16, Reaffirmation: A-16)

### **Advocacy for Physicians with Disabilities D-90.991**

1. Our AMA will study and report back on eliminating stigmatization and enhancing inclusion of physicians with disabilities including but not limited to: (a) enhancing representation of physicians with disabilities within the AMA, and (b) examining support groups, education, legal resources and any other means to increase the inclusion of physicians with disabilities in the AMA.
2. Our AMA will identify medical, professional and social rehabilitation, education, vocational training and rehabilitation, aid, counseling, placement services and other services which will enable physicians with disabilities to develop their capabilities and skills to the maximum and will hasten the processes of their social and professional integration or reintegration.
3. Our AMA supports physicians and physicians-in-training education programs about legal rights related to accommodation and freedom from discrimination for physicians, patients, and employees with disabilities. (Res. 617, A-19)

### **Preserving Protections of the Americans with Disabilities Act of 1990 D-90.992**

1. Our AMA supports legislative changes to the Americans with Disabilities Act of 1990, to educate state and local government officials and property owners on strategies for promoting access to persons with a disability.
2. Our AMA opposes legislation amending the Americans with Disabilities Act of 1990, that would increase barriers for disabled persons attempting to file suit to challenge a violation of their civil rights.
3. Our AMA will develop educational tools and strategies to help physicians make their offices more accessible to persons with disabilities, consistent with the Americans With Disabilities Act as well as any applicable state laws. (Res. 220, I-17)

### **Enhancing Accommodations for People with Disabilities H-90.971**

Our AMA encourages physicians to make their offices accessible to patients with disabilities, consistent with the Americans with Disabilities Act (ADA) guidelines. (Res. 705, A-13)

### **A Study to Evaluate Barriers to Medical Education for Trainees with Disabilities D-295.929**

Our AMA will work with relevant stakeholders to study available data on: (1) medical trainees with disabilities and consider revision of technical standards for medical education programs; and (2) medical graduates with disabilities and challenges to employment after training. (Res. 317, A-19)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 315  
(JUN-21)

Introduced by: Medical Student Section

Subject: Representation of Dermatological Pathologies in Varying Skin Tones

Referred to: Reference Committee C

---

1 Whereas, Worse healthcare outcomes result from the under recognition of dermatologic  
2 pathologies, such as erythema migrans and the late detection of melanoma in individuals with  
3 darker skin tones – also known as Fitzpatrick skin types III-VI<sup>1-4</sup>; and  
4

5 Whereas, There is a higher probability that individuals with darker skin tones have late detection of  
6 disease when compared to lighter skin tones (Fitzpatrick skin types I-II)<sup>5-8</sup>; and  
7

8 Whereas, There is a lack of targeted skin cancer awareness and prevention efforts for patients with  
9 darker skin tones<sup>9</sup> resulting in lower rates of skin cancer screening; and  
10

11 Whereas, Research has demonstrated that patients with darker skin tones feel frustrated when  
12 dermatologists do not demonstrate competency recognizing and treating pathologies on darker  
13 skin<sup>10</sup>; and  
14

15 Whereas, It has been shown that overrepresentation of minority group skin tones relative to their  
16 proportion in the population is required to achieve equitable diagnostic outcomes<sup>11-13</sup>; and  
17

18 Whereas, About 75 percent of dermatological imagery in medical textbooks represent individuals  
19 with lighter skin tones while core dermatology textbooks used to educate trainees, dermatologists,  
20 and generalists have limited representations of skin of color<sup>14</sup>; and  
21

22 Whereas, Terms such as “Classic Presentation” are usually examples of lighter skin tones<sup>15</sup>; and  
23

24 Whereas, Although our AMA recognizes the importance of racial and ethnic disparities in  
25 healthcare (H-350.974), the terms “race” and “ethnicity” are not equivalent nor interchangeable  
26 with the genotypic and phenotypic characteristics of “skin tone”<sup>16-18</sup>; and  
27

28 Whereas, Existing AMA policy “promote[s] education on the importance of skin cancer screening  
29 and skin cancer screening in patients of color” (H-55.972) but lacks policy to ensure medical  
30 students are adequately primed to recognize such pathologies in a variety of skin colors; and  
31

32 Whereas, While current AMA policy supports ensuring diversity in United States Medical Licensing  
33 Examination exam test/oversight committees representative of the test takers (D-275.963), this  
34 policy does not cover diversity in test questions themselves, nor the importance of skin tone as a  
35 relevant pathological factor missing in dermatological exam questions; therefore be it  
36

37 RESOLVED, That our American Medical Association encourage the inclusion of a diverse range of  
38 skin tones in preclinical and clinical dermatologic medical education materials and evaluation (New  
39 HOD Policy); and be it further

1 RESOLVED, That our AMA encourage the development of educational materials for medical  
2 students and physicians that contribute to the equitable representation of diverse skin tones (New  
3 HOD Policy); and be it further

4  
5 RESOLVED, That our AMA support the overrepresentation of darker skin tones in dermatologic  
6 medical education materials. (New HOD Policy)

Fiscal Note: Minimal - less than \$1,000

Date Received: 05/12/21

#### AUTHOR'S STATEMENT OF PRIORITY

Our delegation believes that this expands upon existing AMA priorities on race in medicine and medical education. Our colleagues have shared anecdotes on the paucity of pathologies presented on various skin tones, making the recognition of even "simple" skin diagnoses or clinical findings more challenging. That lack of exposure to presentations of various skin tones or awareness of their preconceived biases in this realm can further misdiagnoses or missed diagnoses. Dearth in knowledge of this increases risk for misdiagnosis in patients and shows another example of how disparities in healthcare occur.

#### **References:**

1. Lester JC, Jia JL, Zhang L, Okoye GA, Linos E. Absence of images of skin of colour in publications of COVID-19 skin manifestations. *Br J Dermatol*. 2020. <https://doi.org/10.1111/bjd.19258>
2. Chansky PB, Mittal L, Werth VP. Dermatological evaluation in patients with skin of colour: The effect of erythema on outcome measures in atopic dermatitis. *Br J Dermatol*. 2017;176(4):853-854. <https://doi.org/10.1111/bjd.15433>
3. Huang AH, Kwatra SG, Khanna R, Semenov YR, Okoye GA, Sweren RJ. Racial disparities in the clinical presentation and prognosis of patients with mycosis fungoides. *J Natl Med Assoc*. 2019;111(6):633-639. <https://doi.org/10.1016/j.jnma.2019.08.006>
4. Nelson B. How dermatology is failing melanoma patients with skin of color. *Cancer Cytopathol*. 2020;128(1):7-8. <https://doi.org/10.1002/cncy.22229>
5. Jia JL, Wang JY, Mills DE, Shen A, Sarin KY. Fitzpatrick phototype disparities in identification of cutaneous malignancies by Google reverse image. *J Am Acad Dermatol*. 2020. <https://doi.org/10.1016/j.jaad.2020.05.005>
6. Cobbinah SS, Lewis J. Racism & health: A public health perspective on racial discrimination. *J Eval Clin Pract*. 2018;24(5):995-998. <https://www.doi.org/10.1111/jep.12894>
7. Bailey ZD, Krieger N, Ag  nor M, Graves J, Linos N, Bassett MT. Structural racism and health inequities in the USA: Evidence and interventions. *The Lancet*. 2017;389(10077):1453-1463. [https://doi.org/10.1016/S0140-6736\(17\)30569-X](https://doi.org/10.1016/S0140-6736(17)30569-X)
8. Sommers MS, Fargo JD, Regueira Y, et al. Are the Fitzpatrick skin phototypes valid for cancer risk assessment in a racially and ethnically diverse sample of women? *Ethn Dis*. 2019;29(3):505-512. <https://doi.org/10.18865/ed.29.3.505>
9. Buchanan Lunsford N, Berkold J, Holman DM, Stein K, Prempeh A, Yerkes A. Skin cancer knowledge, awareness, beliefs and preventive behaviors among Black and Hispanic men and women. *Preventive Medicine Reports*. 2018;12:203-209. <https://doi.org/10.1016/j.pmedr.2018.09.017>
10. Gorbatenko-Roth K, Prose N, Kundu RV, Patterson S. Assessment of Black patients' perception of their dermatology care. *JAMA Dermatol*. 2019;155(10):1129-1134. <https://doi.org/doi:10.1001/jamadermatol.2019.2063>
11. Vaughan R. Oversampling in health surveys: Why, when, and how? *Am J Public Health*. 2017;107(8):1214-1215. <https://doi.org/10.2105/AJPH.2017.303895>
12. Mercer A. Oversampling is used to study small groups, not bias poll results. Pew Reserach. Fact Tank: News in the Numbers. <https://www.pewresearch.org/fact-tank/2016/10/25/oversampling-is-used-to-study-small-groups-not-bias-poll-results/>. Published 2016. Accessed August 26, 2020.
13. Lazar J, Feng JH, Hochheiser H. *Research Methods in Human-Computer Interaction*. 2nd ed. Cambridge, MA: Elsevier; 2017. <https://www.sciencedirect.com/book/9780128053904/research-methods-in-human-computer-interaction>
14. Adelekun A, Onyekaba G, Lipoff JB. Skin color in dermatology textbooks: An updated evaluation and analysis. *J Am Acad Dermatol*. 2020. <https://doi.org/10.1016/j.jaad.2020.04.084>
15. Centers for Disease Control and Prevention. Lyme disease rashes and look-alikes. Centers for Disease Control and Prevention. Lyme Disease. [https://www.cdc.gov/lyme/signs\\_symptoms/rashes.html](https://www.cdc.gov/lyme/signs_symptoms/rashes.html). Updated July 20, 2020. Accessed August 26, 2020.
16. Louie P, Wilkes R. Representations of race and skin tone in medical textbook imagery. *Soc Sci Med*. 2018;202:38-42. <https://doi.org/10.1016/j.socscimed.2018.02.023>
17. Stewart QT, Cobb RJ, Keith VM. The color of death: Race, observed skin tone, and all-cause mortality in the United States. *Ethn Health*. 2018;1-23. <https://doi.org/10.1080/13557858.2018.1469735>
18. Ferreira KM, Wassink J, Harris KM. Beyond race/ethnicity: Skin color, gender, and the health of young adults in the United States. *Population Research and Policy Review*. 2019;38(2):271-299. <https://doi.org/10.1007/s11113-018-9503-3>



## **RELEVANT AMA POLICY**

### **Early Detection and Prevention of Skin Cancer H-55.972**

Our AMA: (1) encourages all physicians to (a) perform skin self-examinations and to examine themselves and their families on the first Monday of the month of May, which is designated by the American Academy of Dermatology as Melanoma Monday; (b) examine their patients' skins for the early detection of melanoma and nonmelanoma skin cancer; (c) urge their patients to perform regular self-examinations of their skin and assist their family members in examining areas that may be difficult to examine; and (d) educate their patients concerning the correct way to perform skin self-examination; (2) supports mechanisms for the education of lay professionals, such as hairdressers and barbers, on skin self-examination to encourage early skin cancer referrals to qualified health care professionals; and (3) supports and encourages prevention efforts to increase awareness of skin cancer risks and sun-protective behavior in communities of color. Our AMA will continue to work with the American Academy of Dermatology, National Medical Association and National Hispanic Medical Association and public health organizations to promote education on the importance of skin cancer screening and skin cancer screening in patients of color.

CCB/CLRPD Rep. 3, A-14

### **Educating Medical Students in the Social Determinants of Health and Cultural Competence H-295.874**

Our AMA: (1) Supports efforts designed to integrate training in social determinants of health, cultural competence, and meeting the needs of underserved populations across the undergraduate medical school curriculum to assure that graduating medical students are well prepared to provide their patients safe, high quality and patient-centered care. (2) Supports faculty development, particularly clinical faculty development, by medical schools to assure that faculty provide medical students' appropriate learning experiences to assure their cultural competence and knowledge of social determinants of health. (3) Supports medical schools in their efforts to evaluate the effectiveness of their social determinants of health and cultural competence teaching of medical students, for example by the AMA serving as a convener of a consortium of interested medical schools to develop Objective Standardized Clinical Exams for use in evaluating medical students' cultural competence. (4) Will conduct ongoing data gathering, including interviews with medical students, to gain their perspective on the integration of social determinants of health and cultural competence in the undergraduate medical school curriculum. (5) Recommends studying the integration of social determinants of health and cultural competence training in graduate and continuing medical education and publicizing successful models.

CME Rep. 11, A-06, Reaffirmation A-11, Modified in lieu of Res. 908, I-14, Reaffirmed in lieu of Res. 306, A-15, Reaffirmed: BOT Rep. 39, A-18, Modified: CME Rep. 01, A-20

### **Racial and Ethnic Disparities in Health Care H-350.974**

1. Our AMA recognizes racial and ethnic health disparities as a major public health problem in the United States and as a barrier to effective medical diagnosis and treatment. The AMA maintains a position of zero tolerance toward racially or culturally based disparities in care; encourages individuals to report physicians to local medical societies where racial or ethnic discrimination is suspected; and will continue to support physician cultural awareness initiatives and related consumer education activities. The elimination of racial and ethnic disparities in health care an issue of highest priority for the American Medical Association.

2. The AMA emphasizes three approaches that it believes should be given high priority:

A. Greater access - the need for ensuring that black Americans without adequate health care insurance are given the means for access to necessary health care. In particular, it is urgent that Congress address the need for Medicaid reform.

B. Greater awareness - racial disparities may be occurring despite the lack of any intent or purposeful efforts to treat patients differently on the basis of race. The AMA encourages physicians

to examine their own practices to ensure that inappropriate considerations do not affect their clinical judgment. In addition, the profession should help increase the awareness of its members of racial disparities in medical treatment decisions by engaging in open and broad discussions about the issue. Such discussions should take place in medical school curriculum, in medical journals, at professional conferences, and as part of professional peer review activities.

C. Practice parameters - the racial disparities in access to treatment indicate that inappropriate considerations may enter the decision making process. The efforts of the specialty societies, with the coordination and assistance of our AMA, to develop practice parameters, should include criteria that would preclude or diminish racial disparities

3. Our AMA encourages the development of evidence-based performance measures that adequately identify socioeconomic and racial/ethnic disparities in quality. Furthermore, our AMA supports the use of evidence-based guidelines to promote the consistency and equity of care for all persons.

4. Our AMA: (a) actively supports the development and implementation of training regarding implicit bias, diversity and inclusion in all medical schools and residency programs; (b) will identify and publicize effective strategies for educating residents in all specialties about disparities in their fields related to race, ethnicity, and all populations at increased risk, with particular regard to access to care and health outcomes, as well as effective strategies for educating residents about managing the implicit biases of patients and their caregivers; and (c) supports research to identify the most effective strategies for educating physicians on how to eliminate disparities in health outcomes in all at-risk populations.

CLRPD Rep. 3, I-98, Appended and Reaffirmed: CSA Rep.1, I-02, Reaffirmed: BOT Rep. 4, A-03, Reaffirmed in lieu of Res. 106, A-12, Appended: Res. 952, I-17, Reaffirmed: CMS Rep. 10, A-19

### **Ensuring Diversity in United States Medical Licensing Examination Exams D-275.963**

Our AMA will pursue diversity on all United States Medical Licensing Examination test/oversight committees in order to include the perspectives from others, including international medical graduates, to better reflect the diversity of the test takers.

Sub. Res. 306, A-09, Reaffirmed: CME Rep. 01, A-19

### **Continued Support for Diversity in Medical Education D-295.963**

1. Our American Medical Association will publicly state and reaffirm its stance on diversity in medical education.

2. Our AMA will request that the Liaison Committee on Medical Education regularly share statistics related to compliance with accreditation standards IS-16 and MS-8 with medical schools and with other stakeholder groups.

Res. 325, A-03, Appended: CME Rep. 6, A-11, Modified: CME Rep. 3, A-13

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 316  
(JUN-21)

Introduced by: Medical Student Section

Subject: Improving Support and Access for Medical Students with Disabilities

Referred to: Reference Committee C

---

1 Whereas, The Americans with Disabilities Act (ADA) defines a disability as “a physical or mental  
2 impairment that substantially limits one or more major life activities of an individual; a record of  
3 such an impairment; or being regarded as having such an impairment”<sup>1,2</sup>; and  
4

5 Whereas, In enacting the Americans with Disabilities Act, “Congress recognized that physical  
6 and mental disabilities in no way diminish a person’s right to fully participate in all aspects of  
7 society, but that people with physical or mental disabilities are frequently precluded from doing  
8 so because of prejudice, antiquated attitudes, or the failure to remove societal and institutional  
9 barriers”<sup>1</sup>; and  
10

11 Whereas, Research has found that concordances between patient and physician’s race and  
12 ethnicity significantly enhanced the patient’s healthcare experience, compliance and outcomes,  
13 yet little has been done to ensure the same for patients with disabilities<sup>3,4</sup>; and  
14

15 Whereas, Patients with disabilities feel their doctors who don’t have disabilities do not  
16 understand the realities of their struggles, yet barriers persist in preventing people with  
17 disabilities from entering the medical profession<sup>5,6</sup>; and  
18

19 Whereas, People with disabilities comprise about a quarter of the US adult population, but only  
20 5 percent of medical students and 2 to 10 percent of practicing physicians<sup>6-10</sup>; and  
21

22 Whereas, Medical school applicants and students may not be aware that they qualify for  
23 protection based on the broader definition of disability in the ADA or may be discouraged from  
24 disclosing an existing or newly arising disability due to fear of discrimination in admissions or  
25 licensure<sup>11-13</sup>; and  
26

27 Whereas, Section 504 of the Rehabilitation Act states that, at the postsecondary level,  
28 institutions are “required to provide students with appropriate academic adjustments and  
29 auxiliary aids and services that are necessary to afford an individual with a disability an equal  
30 opportunity to participate in a school’s program”<sup>14</sup>; and  
31

32 Whereas, Accrediting bodies, including but not limited to the Liaison Committee on Medical  
33 Education (LCME) and the Commission on Osteopathic College Accreditation (COCA), have not  
34 established a uniform list of essential abilities and technical standards or requirements for  
35 reasonable accommodations in medical school or residency<sup>15-17</sup>; and  
36

37 Whereas, This lack of standardized guidelines directly impacts a medical school’s  
38 understanding of accommodations, assistive technology, acceptable use of intermediaries,  
39 alternative learning experiences, and individualized assessment of disability under current law<sup>15-  
40 17</sup>; and

1 Whereas, Studies have shown that as many as 49 percent of the medical schools did not clearly  
2 state accommodation policies, many accommodation policies were difficult to locate, and some  
3 schools provided no information whatsoever, making them non-compliant with Section 504 of  
4 the Rehabilitation Act<sup>17-19</sup>; and

5  
6 Whereas, A recent study showed that most medical school technical standards do not support  
7 the provision of reasonable accommodations for students with disabilities as intended by the  
8 ADA (e.g., proscribing intermediaries and auxiliary aids for hearing, vision, and mobility  
9 disabilities)<sup>19</sup>; and

10  
11 Whereas, Hearing loss is the most common physical and sensory disability encountered in  
12 medical schools, with accommodations ranging from sign language interpreters to stethoscopes  
13 that amplify heart and lung sounds, but closed captions, which provide full and equitable access  
14 to video content to individuals with hearing loss, are not a standard option<sup>20,21</sup>; and

15  
16 Whereas, Closed captions translate spoken language into written language and provide helpful  
17 clues to the person reading them by also identifying the person speaking, describing sound  
18 effects, and giving other relevant information<sup>22</sup>; and

19  
20 Whereas, Closed captioning services are simple and inexpensive to implement through software  
21 that supports real time voice-to-text transcription to automatically caption videos<sup>23</sup>; and

22  
23 Whereas, Although closed captions were originally designed to aid individuals who were deaf or  
24 hard-of-hearing, a meta-analysis of over 100 studies has shown that captions benefit student  
25 learners regardless of disability status by improving retention and comprehension (including  
26 those who are watching videos in a non-native language)<sup>22-25</sup>; and

27  
28 Whereas, Existing AMA policies support improving access and support for clinicians, learners,  
29 and patients with disabilities (e.g., H-350.978, H-200.951, H-90.987, H-90.971, D-295.963); and

30  
31 Whereas, Our AMA plays an existing role in developing policy and initiatives related to  
32 improving undergraduate medical education, including but not limited to the Accelerating  
33 Change in Medical Education Initiative, which has already begun to investigate meeting  
34 disability-related needs<sup>26</sup>; and

35  
36 Whereas, Improving support and access for medical students and physicians with disabilities  
37 can improve patient care, impact research agendas and workplace attitudes toward disability,  
38 and reduce the significant barriers to health care, discrimination, and ableism experienced by  
39 people with disabilities<sup>3,27-32</sup>; therefore be it

1 RESOLVED, That our American Medical Association amend policy D-295.929 by addition to  
2 read as follows:

3  
4 D-295.929 – A STUDY TO EVALUATE BARRIERS TO MEDICAL EDUCATION FOR  
5 TRAINEES WITH DISABILITIES

6 Our AMA will work with relevant stakeholders to study available data on: (1) medical  
7 trainees and students with disabilities and consider revision of technical standards for  
8 medical education programs; and (2) medical graduates and students with disabilities  
9 and challenges to employment after training and medical education; and 3) work with  
10 relative stakeholders to encourage medical education institutions to make their policies  
11 for inquiring about and obtaining accommodations related to disability transparent and  
12 easily accessible through multiple avenues including, but not limited to, online platforms.  
13 (Modify Current HOD Policy); and be it further  
14

15 RESOLVED, That our AMA amend policy D-90.991 by addition and deletion to read as follows:

16  
17 D-90.991 – ADVOCACY FOR PHYSICIANS WITH DISABILITIES

18 1. Our AMA will study and report back on eliminating stigmatization and enhancing  
19 inclusion of physicians and medical students with disabilities including but not limited  
20 to: (a) enhancing representation of physicians and medical students with disabilities  
21 within the AMA, and (b) examining support groups, education, legal resources and any  
22 other means to increase the inclusion of physicians and medical students with  
23 disabilities in the AMA.

24 2. Our AMA will identify medical, professional and social rehabilitation, education,  
25 vocational training and rehabilitation, aid, counseling, placement services and other  
26 services which will enable physicians and medical students with disabilities to develop  
27 their capabilities and skills to the maximum and will hasten the processes of their  
28 social and professional integration or reintegration.

29 3. Our AMA supports physicians, and physicians-in-training, and medical  
30 student education programs about legal rights related to accommodation and freedom  
31 from discrimination for physicians, patients, and employees with disabilities. (Modify  
32 Current HOD Policy); and be it further  
33

34 RESOLVED, That our AMA collaborate with the Association of American Medical Colleges  
35 (AAMC), American Association of Colleges of Osteopathic Medicine (AACOM), and other  
36 relevant stakeholders to encourage the incorporation of closed captioning to all relevant medical  
37 school communications, including but not limited to lecture recordings, videos, webinars, and  
38 audio recordings, that may prohibit any students from accessing information. (Directive to Take  
39 Action)

Fiscal Note: Modest - between \$1,000 - \$5,000

Date Received: 05/12/21

**AUTHOR'S STATEMENT OF PRIORITY**

Medical trainees with disability graduate medical school at a significantly lower rate than trainees without disability, despite meeting the medical school physical/intellectual requirements for admission. These trainees experience significant barriers to receiving accommodations, including lack of access to proper care and evaluation, lack of approval of accommodations, stigma of accommodations, and a need to spend precious study time self-advocating and learning the legal framework. Medical trainees with disability spend many hours a week managing disability and advocating from it, which detracts from their ability to spend time on medical school. In order to minimize the amount of time spent on advocating for accommodations and pushing for administration to respond, systemic access should be promoted to accommodate all individuals pursuing medical studies.

Medicine is not a field that is accommodative of individuals not in perfect health, despite being a field that tries to serve such populations. This has been shown time and time again when NBME has received litigation for violating Americans with Disabilities Act. In 2020, NBME had 2 lawsuits brought forth against it for ADA violations. In the light of the COVID pandemic, disability rights in education have been further infringed upon, making this resolution timely and in line with AMA priorities to promote health equity for all individuals, including medical trainees pursuing their careers as physicians.

**References:**

1. United States Congress. ADA Amendments Act of 2008 (P.L. 110-325). Available at: <https://www.gpo.gov/fdsys/pkg/PLAW-110publ325/pdf/PLAW-110publ325.pdf>. Accessed March 27, 2021.
2. U.S. Department of Justice. A guide to Disability Rights Laws. Available at: <https://www.ada.gov/cguide.htm>. Accessed April 20, 2021.
3. Iezzoni LI. Why increasing numbers of physicians with disability could improve care for patients with disability. *AMA J Ethics*. 2016;18(10):1041-1049.
4. Iezzoni LI. Make no assumptions: communication between persons with disabilities and clinicians. *Assist Technol*. 2006;18(2):212-219.
5. DeLisa JA, Lindenthal JJ. Learning from physicians with disabilities and their patients. *AMA J Ethics*. 2016;18(10):1003-1009.
6. Meeks, L. et al. Change in Prevalence of Disabilities and Accommodation Practices Among U.S. Medical Schools, 2016 vs 2019. *JAMA*. 2019;322(20):2022-2024.
7. Courtney-Long EA, Carroll DD, Zhang QC, et al. Prevalence of Disability and Disability Type Among Adults--United States, 2013. *MMWR Morb Mortal Wkly Rep* 2015;64(29):777-783.
8. Meeks LM, Herzer KR. Prevalence of Self-disclosed Disability Among Medical Students in US Allopathic Medical Schools. *JAMA* 2016;316(21):2271-2272. doi:10.1001/jama.2016.10544.
9. DeLisa JA, Lindenthal JJ. Commentary: reflections on diversity and inclusion in medical education. *Acad. Med*. 2012;87(11):1461-1463. doi:10.1097/ACM.0b013e31826b048c.
10. Meeks LM, Jain NR. Accessibility, Inclusion, and Action in Medical Education: Lived Experiences of Learners and Physicians With Disabilities. Washington, DC: American Association of Medical Colleges; 2018.
11. Miller S, Ross S, Cleland J. Medical students' attitudes towards disability and support for disability in medicine. *Med. Teach*. 2009;31(6):e272-7. doi:10.1080/01421590802516814.
12. Polfliet SJ. A national analysis of medical licensure applications. *J. Am. Acad. Psychiatry Law* 2008;36(3):369-374.
13. Snashall D. Doctors with disabilities: licensed to practise? *Clin. Med*. 2009;9(4):315-319. doi:10.7861/clinmedicine.9-4-315.
14. Office for Civil Rights. Protecting Students With Disabilities. U.S. Department of Education; January 10, 2020.
15. Meeks LM, Herzer K, Jain NR. Removing barriers and facilitating access. *Acad. Med*. 2018;93(4):540-543. doi:10.1097/ACM.0000000000002112.
16. Meeks L, Jain NR. The Guide to Assisting Students with Disabilities: Equal Access in Health Science and Professional Education. New York: Springer Publishing Company; 2015.
17. McKee M, Case B, Fausone M, Zazove P, Ouellette A, Feters MD. Medical Schools' Willingness to Accommodate Medical Students with Sensory and Physical Disabilities: Ethical Foundations of a Functional Challenge to "Organic" Technical Standards. *AMA J. Ethics* 2016;18(10):993-1002. doi:10.1001/journalofethics.2016.18.10.medu1-1610.
18. Weiner S. Paving the way for physicians with disabilities | AAMC. *AAMC Divers Incl*. November 2019.
19. Zazove P. et al. U.S. medical schools' Compliance with the Americans with disabilities act: Findings from a national study. *Acad Med*. 2016;91(7):979-986.
20. Argenyi M. Technical standards and deaf and hard-of-hearing medical school applicants and students: Interrogating sensory capacity and practice capacity. *AMA J Ethics*. 2016;18(10):1050-1059.
21. National Deaf Center on Postsecondary Outcomes. Why Captions Provide Equal Access. National Deaf Center. 2019.
22. Gernsbacher, M. Video Captions Benefit Everyone. *Policy Insights from the Behavioral and Brain Sciences*. 2015;2(1):195-202.
23. Kmetz Morris K. et al. D. Closed Captioning Matters: Examining the Value of Closed Captions for All Students. *J Postsecond Educ Disabil*. 2016;29(3):238.

24. Bergey, R. et al. Serving English Language Learners in Higher Education: Unlocking the Potential. American Institutes for Research. 2018 February. 1-21.
25. Stritto, M. et al. A Rising Tide: How Closed Captions Can Benefit All Students. Educause Review. Published August 28, 2017. Accessed March 10, 2020.
26. American Medical Association. Academic Physicians Section. Available at: <https://www.ama-assn.org/about/academic-physicians-section-aps>
27. Lagu T, Hannon NS, Rothberg MB, et al. Access to subspecialty care for patients with mobility impairment: a survey. Ann. Intern. Med. 2013;158(6):441-446. doi:10.7326/0003-4819-158-6-201303190-00003.
28. U.S. Department of Health and Human Services. Healthy People 2020 Topics and Objectives: Disability and Health. 2018. Available at: <https://www.healthypeople.gov/2020/topics-objectives/topic/disability-and-health>. Accessed March 27, 2018.
29. Moreland CJ, Latimore D, Sen A, Arato N, Zazove P. Deafness among physicians and trainees: a national survey. Acad. Med. 2013;88(2):224-232. doi:10.1097/ACM.0b013e31827c0d60.
30. Smeltzer SC, Avery C, Haynor P. Interactions of people with disabilities and nursing staff during hospitalization. Am. J. Nurs. 2012;112(4):30-7; quiz 38, 52. doi:10.1097/01.NAJ.0000413454.07369.e3.
31. Disability Rights Education & Defense Fund. Welcome to healthcare stories. Available at: <https://dredf.org/healthcare-stories>. Accessed March 27, 2018.
32. Khullar D. Doctors With Disabilities: Why They're Important. The New York Times. July 11, 2017. Available at: <https://www.nytimes.com/2017/07/11/upshot/doctors-with-disabilities-why-theyre-important.html> Accessed March 27, 2018.

## RELEVANT AMA POLICY

### Discrimination B-14

Membership in the AMA or in any constituent association, national medical specialty society or professional interest medical association represented in the House of Delegates, shall not be denied or abridged because of sex, color, creed, race, religion, disability, ethnic origin, national origin, sexual orientation, gender identity, age, or for any other reason unrelated to character, competence, ethics, professional status or professional activities.

### Civil Rights & Medical Professionals 9.5.4

Opportunities in medical society activities or membership, medical education and training, employment and remuneration, academic medicine and all other aspects of professional endeavors must not be denied to any physician or medical trainee because of race, color, religion, creed, ethnic affiliation, national origin, gender or gender identity, sexual orientation, age, family status, or disability or for any other reason unrelated to character, competence, ethics, professional status, or professional activities.

Issued: 2016

### Minorities in the Health Professions H-350.978

The policy of our AMA is that (1) Each educational institution should accept responsibility for increasing its enrollment of members of underrepresented groups.

(2) Programs of education for health professions should devise means of improving retention rates for students from underrepresented groups.

(3) Health profession organizations should support the entry of disabled persons to programs of education for the health professions, and programs of health profession education should have established standards concerning the entry of disabled persons.

(4) Financial support and advisory services and other support services should be provided to disabled persons in health profession education programs. Assistance to the disabled during the educational process should be provided through special programs funded from public and private sources.

(5) Programs of health profession education should join in outreach programs directed at providing information to prospective students and enriching educational programs in secondary and undergraduate schools.

(6) Health profession organizations, especially the organizations of professional schools, should establish regular communication with counselors at both the high school and college level as a means of providing accurate and timely information to students about health profession education.

(7) The AMA reaffirms its support of: (a) efforts to increase the number of black Americans and other minority Americans entering and graduating from U.S. medical schools; and (b) increased financial aid from public and private sources for students from low income, minority and socioeconomically disadvantaged backgrounds.

(8) The AMA supports counseling and intervention designed to increase enrollment, retention, and graduation of minority medical students, and supports legislation for increased funding for the HHS Health Careers Opportunities Program.

CLRPD Rep. 3, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmed: CEJA Rep. 06, A-18

**Strategies for Enhancing Diversity in the Physician Workforce H-200.951**

Our AMA (1) supports increased diversity across all specialties in the physician workforce in the categories of race, ethnicity, gender, sexual orientation/gender identity, socioeconomic origin and persons with disabilities; (2) commends the Institute of Medicine for its report, "In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce," and supports the concept that a racially and ethnically diverse educational experience results in better educational outcomes; and (3) encourages medical schools, health care institutions, managed care and other appropriate groups to develop policies articulating the value and importance of diversity as a goal that benefits all participants, and strategies to accomplish that goal. CME Rep. 1, I-06; Reaffirmed: CME Rep. 7, A-08; Reaffirmed: CCB/CLRPD Rep. 4, A-13; Modified: CME Rep. 01, A\_16; Reaffirmation: A-16

**Strategies for Enhancing Diversity in the Physician Workforce D-200.985**

1. Our AMA, independently and in collaboration with other groups such as the Association of American Medical Colleges (AAMC), will actively work and advocate for funding at the federal and state levels and in the private sector to support the following: a. Pipeline programs to prepare and motivate members of underrepresented groups to enter medical school; b. Diversity or minority affairs offices at medical schools; c. Financial aid programs for students from groups that are underrepresented in medicine; and d. Financial support programs to recruit and develop faculty members from underrepresented groups.
  2. Our AMA will work to obtain full restoration and protection of federal Title VII funding, and similar state funding programs, for the Centers of Excellence Program, Health Careers Opportunity Program, Area Health Education Centers, and other programs that support physician training, recruitment, and retention in geographically-underserved areas.
  3. Our AMA will take a leadership role in efforts to enhance diversity in the physician workforce, including engaging in broad-based efforts that involve partners within and beyond the medical profession and medical education community.
  4. Our AMA will encourage the Liaison Committee on Medical Education to assure that medical schools demonstrate compliance with its requirements for a diverse student body and faculty.
  5. Our AMA will partner with key stakeholders (including but not limited to the Association of American Medical Colleges, Association of American Indian Physicians, Association of Native American Medical Students, We Are Healers, and the Indian Health Service) to study and report back by July 2018 on why enrollment in medical school for Native Americans is declining in spite of an overall substantial increase in medical school enrollment, and lastly to propose remedies to solve the problems identified in the AMA study.
  6. Our AMA will develop an internal education program for its members on the issues and possibilities involved in creating a diverse physician population.
  7. Our AMA will provide on-line educational materials for its membership that address diversity issues in patient care including, but not limited to, culture, religion, race and ethnicity.
  8. Our AMA will create and support programs that introduce elementary through high school students, especially those from groups that are underrepresented in medicine (URM), to healthcare careers.
  9. Our AMA will create and support pipeline programs and encourage support services for URM college students that will support them as they move through college, medical school and residency programs.
  10. Our AMA will recommend that medical school admissions committees use holistic assessments of admission applicants that take into account the diversity of preparation and the variety of talents that applicants bring to their education.
  11. Our AMA will advocate for the tracking and reporting to interested stakeholders of demographic information pertaining to URM status collected from Electronic Residency Application Service (ERAS) applications through the National Resident Matching Program (NRMP).
  12. Our AMA will continue the research, advocacy, collaborative partnerships and other work that was initiated by the Commission to End Health Care Disparities.
- CME Rep. 1, I-06; Reaffirmation: I-10; Reaffirmation: A-13; Modified: CCB/CLRPD Rep. 2, A-14; Reaffirmation: A-16; Appended: Res. 313, A-17; Appended: Res. 314, A-17; Modified: CME Rep. 01, A-18; Appended: Res. 207, I-18; Reaffirmation: A-19; Appended: Res. 304, A-19; Appended: Res. 319, A-19

**Equal Access for Physically Challenged Physicians H-90.987**

Our AMA supports equal access to all hospital facilities for physically challenged physicians as part of the Americans with Disabilities Act.

Res. 816, I-91; Reaffirmed: Sunset Report, I-01; Modified: CSAPH Rep. 1, A-11



**Preserving Protections of the Americans with Disabilities Act of 1990 D-90.992**

1. Our AMA supports legislative changes to the Americans with Disabilities Act of 1990, to educate state and local government officials and property owners on strategies for promoting access to persons with a disability.
2. Our AMA opposes legislation amending the Americans with Disabilities Act of 1990, that would increase barriers for disabled persons attempting to file suit to challenge a violation of their civil rights.
3. Our AMA will develop educational tools and strategies to help physicians make their offices more accessible to persons with disabilities, consistent with the Americans With Disabilities Act as well as any applicable state laws.

Res. 220, I-17

**Diversity in the Physician Workforce and Access to Care D-200.982**

Our AMA will: (1) continue to advocate for programs that promote diversity in the US medical workforce, such as pipeline programs to medical schools; (2) continue to advocate for adequate funding for federal and state programs that promote interest in practice in underserved areas, such as those under Title VII of the Public Health Service Act, scholarship and loan repayment programs under the National Health Services Corps and state programs, state Area Health Education Centers, and Conrad 30, and also encourage the development of a centralized database of scholarship and loan repayment programs; and (3) continue to study the factors that support and those that act against the choice to practice in an underserved area, and report the findings and solutions at the 2008 Interim Meeting.

CME Rep. 7, A\_08; Reaffirmation: A-13; Reaffirmation: A-16

**Creating an Effective Environment for Medical Student Education H-295.900**

1. The AMA encourages the development of a model student orientation program that includes workshops that address health awareness for students and standards of behavior for teachers and learners.
2. Our AMA will: (A) ask the Liaison Committee on Medical Education to ensure that medical schools have policies to protect medical students from retaliation based on reporting incidents of mistreatment; and (B) through the Learning Environment Study, conduct research and disseminate findings on the medical education learning environment including the positive and negative elements of that environment that impact the teacher-learner relationship; and (C) encourage the Association of American Medical Colleges and the American Association of Colleges of Osteopathic Medicine to identify best practices and strategies to assure an appropriate learning environment for medical students.

CME Rep. 9, A-98; Reaffirmed: CME Rep. 2, A-08; Appended: CME Rep. 9, A-13

**Teacher-Learner Relationship In Medical Education H-295.955**

The AMA recommends that each medical education institution have a widely disseminated policy that: (1) sets forth the expected standards of behavior of the teacher and the learner; (2) delineates procedures for dealing with breaches of that standard, including: (a) avenues for complaints, (b) procedures for investigation, (c) protection and confidentiality, (d) sanctions; and (3) outlines a mechanism for prevention and education. The AMA urges all medical education programs to regard the following Code of Behavior as a guide in developing standards of behavior for both teachers and learners in their own institutions, with appropriate provisions for grievance procedures, investigative methods, and maintenance of confidentiality.

**CODE OF BEHAVIOR**

The teacher-learner relationship should be based on mutual trust, respect, and responsibility. This relationship should be carried out in a professional manner, in a learning environment that places strong focus on education, high quality patient care, and ethical conduct.

A number of factors place demand on medical school faculty to devote a greater proportion of their time to revenue-generating activity. Greater severity of illness among inpatients also places heavy demands on residents and fellows. In the face of sometimes conflicting demands on their time, educators must work to preserve the priority of education and place appropriate emphasis on the critical role of teacher.

In the teacher-learner relationship, each party has certain legitimate expectations of the other. For example, the learner can expect that the teacher will provide instruction, guidance, inspiration, and leadership in learning.

The teacher expects the learner to make an appropriate professional investment of energy and intellect to acquire the knowledge and skills necessary to become an effective physician. Both parties can expect the other to prepare appropriately for the educational interaction and to discharge their responsibilities in the educational relationship with unfailing honesty.

Certain behaviors are inherently destructive to the teacher-learner relationship. Behaviors such as violence, sexual harassment, inappropriate discrimination based on personal characteristics must never be tolerated.

Other behavior can also be inappropriate if the effect interferes with professional development. Behavior patterns such as making habitual demeaning or derogatory remarks, belittling comments or destructive criticism fall into this category. On the behavioral level, abuse may be operationally defined as behavior by medical school faculty, residents, or students which is consensually disapproved by society and by the academic

community as either exploitive or punishing. Examples of inappropriate behavior are: physical punishment or physical threats; sexual harassment; discrimination based on race, religion, ethnicity, sex, age, sexual orientation, gender identity, and physical disabilities; repeated episodes of psychological punishment of a student by a particular superior (e.g., public humiliation, threats and intimidation, removal of privileges); grading used to punish a student rather than to evaluate objective performance; assigning tasks for punishment rather than educational purposes; requiring the performance of personal services; taking credit for another individual's work; intentional neglect or intentional lack of communication.

On the institutional level, abuse may be defined as policies, regulations, or procedures that are socially disapproved as a violation of individuals' rights. Examples of institutional abuse are: policies, regulations, or procedures that are discriminatory based on race, religion, ethnicity, sex, age, sexual orientation, gender identity, and physical disabilities; and requiring individuals to perform unpleasant tasks that are entirely irrelevant to their education as physicians.

While criticism is part of the learning process, in order to be effective and constructive, it should be handled in a way to promote learning. Negative feedback is generally more useful when delivered in a private setting that fosters discussion and behavior modification. Feedback should focus on behavior rather than personal characteristics and should avoid pejorative labeling.

Because people's opinions will differ on whether specific behavior is acceptable, teaching programs should encourage discussion and exchange among teacher and learner to promote effective educational strategies. People in the teaching role (including faculty, residents, and students) need guidance to carry out their educational responsibilities effectively.

Medical schools are urged to develop innovative ways of preparing students for their roles as educators of other students as well as patients.

BOT Rep. ZZ, I-90; Reaffirmed by CME Rep. 9, A-98; Reaffirmed: CME Rep. 2, I-99; Modified: BOT Rep. 11, A-07; Reaffirmed: CME Rep. 9, A-13; Reaffirmed: BOT Rep. 9, I-20

#### **Insurance Coverage for Medical Students and Resident Physicians H-295.942**

The AMA urges (1) all medical schools to pay for or offer affordable policy options and, assuming the rates are appropriate, require enrollment in disability insurance plans by all medical students; (2) all residency programs to pay for or offer affordable policy options for disability insurance, and strongly encourage the enrollment of all residents in such plans; (3) medical schools and residency training programs to pay for or offer comprehensive and affordable health insurance coverage, including but not limited to medical, dental, and vision care, to medical students and residents which provides no less than the minimum benefits currently recommended by the AMA for employer-provided health insurance and to require enrollment in such insurance; (4) carriers offering disability insurance to: (a) offer a range of disability policies for medical students and residents that provide sufficient monthly disability benefits to defray any educational loan repayments, other living expenses, and an amount sufficient to continue payment for health insurance providing the minimum benefits recommended by the AMA for employer-provided health insurance; and (b) include in all such policies a rollover provision allowing continuation of student disability coverage into the residency period without medical underwriting. (5) Our AMA: (a) actively encourages medical schools, residency programs, and fellowship programs to provide access to portable group health and disability insurance, including human immunodeficiency virus positive indemnity insurance, for all medical students and resident and fellow physicians; (b) will work with the ACGME and the LCME, and other interested state medical societies or specialty organizations, to develop strategies and policies to ensure access to the provision of portable health and disability insurance coverage, including human immunodeficiency virus positive indemnity insurance, for all medical students, resident and fellow physicians; and (c) will prepare informational material designed to inform medical students and residents concerning the need for both disability and health insurance and describing the available coverage and characteristics of such insurance.

BOT Rep. W, I-91; Reaffirmed: BOT Rep. 14, I-93; Appended: Res. 311, I-98; Modified: Res. 306, A-04; Modified: CME Rep. 2, A-14

#### **Due Process H-295.998**

(1) Our AMA reaffirms its 1974 approval of the policy adopted by the Liaison Committee on Medical Education, which states: "A medical school should develop and publicize to its faculty and students a clear definition of its procedures for the evaluation, advancement, and graduation of students. Principles of fairness and 'due process' must apply when considering actions of the faculty or administration which will adversely affect the student to deprive him of his valuable rights."

(2) In addition, to clarify and protect the rights of medical students, the AMA recommends that: (a) Each school develop and publish in its catalog, student handbook or similar publication the institutional policies and procedures both for evaluation of academic performance (promotion, graduation, dismissal, probation, remedial work, and the like) and for nonacademic disciplinary decisions. (b) These policies and procedures should define the responsible bodies and their function and membership, provide for timely progressive verbal and

written notification to the student that his/her academic/nonacademic performance is in question, and provide an opportunity for the student to learn why it has been questioned. (c) These policies and procedures should also ensure that when a student has been notified of recommendations by the responsible committee for nonadvancement or dismissal, he/she has adequate notice and the opportunity to appear before the decision-making body to respond to the data submitted and introduce his/her own data. (d) The student should be allowed to be accompanied by a student or faculty advisor. (e) The policies and procedures should include an appeal mechanism within the medical school. (f) The student should be allowed to continue in the academic program during the proceedings unless extraordinary circumstances exist, such as physical threat to others. CME Rep. D, A-79; Reaffirmed: CLRPD Rep. B, I-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CME Rep. 2, A-10; Modified: CEJA Rep. 01, A-20

#### **Self-Incriminating Questions on Applications for Licensure and Specialty Boards H-275.945**

The AMA will: (1) encourage the Federation of State Medical Boards and its constituent members to develop uniform definitions and nomenclature for use in licensing and disciplinary proceedings to better facilitate the sharing of information; (2) seek clarification of the application of the Americans with Disabilities Act to the actions of medical licensing and medical specialty boards; and (3) until the applicability and scope of the Americans with Disabilities Act are clarified, will encourage the American Board of Medical Specialties and the Federation of State Medical Boards and their constituent members to advise physicians of the rationale behind inquiries on mental illness, substance abuse or physical disabilities in materials used in the licensure, reregistration, and certification processes when such questions are asked.

BOT Rep. 1, I-93; CME Rep. 10, I-94; Reaffirmed: CME Rep. 2, A\_04; Reaffirmed: CME Rep. 2, A-14

#### **Continued Support for Diversity in Medical Education D-295.963**

1. Our American Medical Association will publicly state and reaffirm its stance on diversity in medical education.
2. Our AMA will request that the Liaison Committee on Medical Education regularly share statistics related to compliance with accreditation standards IS-16 and MS-8 with medical schools and with other stakeholder groups.

Res. 325, A-03; Appended: CME Rep. 6, A-11; Modified: CME Rep. 3, A-13

#### **Physician and Medical Student Burnout D-310.968**

1. Our AMA recognizes that burnout, defined as emotional exhaustion, depersonalization, and a reduced sense of personal accomplishment or effectiveness, is a problem among residents, and fellows, and medical students.
2. Our AMA will work with other interested groups to regularly inform the appropriate designated institutional officials, program directors, resident physicians, and attending faculty about resident, fellow, and medical student burnout (including recognition, treatment, and prevention of burnout) through appropriate media outlets.
3. Our AMA will encourage the Accreditation Council for Graduate Medical Education and the Association of American Medical Colleges to address the recognition, treatment, and prevention of burnout among residents, fellows, and medical students.
4. Our AMA will encourage further studies and disseminate the results of studies on physician and medical student burnout to the medical education and physician community.
5. Our AMA will continue to monitor this issue and track its progress, including publication of peer-reviewed research and changes in accreditation requirements.
6. Our AMA encourages the utilization of mindfulness education as an effective intervention to address the problem of medical student and physician burnout.

CME Rep. 8, A-07; Modified: Res. 919, I-11; Modified: BOT Rep. 15, A-19

#### **Enhancing Accommodations for People with Disabilities H-90.971**

Our AMA encourages physicians to make their offices accessible to patients with disabilities, consistent with the Americans with Disabilities Act (ADA) guidelines.

Res. 705, A-13

#### **Remediation Programs for Physicians D-295.325**

1. Our AMA supports the efforts of the Federation of State Medical Boards (FSMB) to maintain an accessible national repository on remediation programs that provides information to interested stakeholders and allows the medical profession to study the issue on a national level.
2. Our AMA will collaborate with other appropriate organizations, such as the FSMB and the Association of American Medical Colleges, to study and develop effective methods and tools to assess the effectiveness of physician remediation programs, especially the relationship between program outcomes and the quality of patient care.
3. Our AMA supports efforts to remove barriers to assessment programs including cost and accessibility to physicians.

4. Our AMA will partner with the FSMB and state medical licensing boards, hospitals, professional societies and other stakeholders in efforts to support the development of consistent standards and programs for remediating deficits in physician knowledge and skills.

5. Our AMA will ask the Liaison Committee on Medical Education and the Accreditation Council for Graduate Medical Education to develop standards that would encourage medical education programs to engage in early identification and remediation of conditions, such as learning disabilities, that could lead to later knowledge and skill deficits in practicing physicians.

CME Rep. 3, A-09; Reaffirmed: CME Rep. 01, A-19

#### **Medical Staff Development Plans H-225.961**

1. All hospitals/health systems incorporate the following principles for the development of medical staff development plans: (a) The medical staff and hospital/health system leaders have a mutual responsibility to: cooperate and work together to meet the overall health and medical needs of the community and preserve quality patient care; acknowledge the constraints imposed on the two by limited financial resources; recognize the need to preserve the hospital/health system's economic viability; and respect the autonomy, practice prerogatives, and professional responsibilities of physicians. (b) The medical staff and its elected leaders must be involved in the hospital/health system's leadership function, including: the process to develop a mission that is reflected in the long-range, strategic, and operational plans; service design; resource allocation; and organizational policies. (c) Medical staffs must ensure that quality patient care is not harmed by economic motivations. (d) The medical staff should review and approve and make recommendations to the governing body prior to any decision being made to close the medical staff and/or a clinical department. (e) The best interests of patients should be the predominant consideration in granting staff membership and clinical privileges. (f) The medical staff must be responsible for professional/quality criteria related to appointment/reappointment to the medical staff and granting/renewing clinical privileges. The professional/quality criteria should be based on objective standards and the standards should be disclosed. (g) The medical staff should be consulted in establishing and implementing institutional/community criteria. Institutional/community criteria should not be used inappropriately to prevent a particular practitioner or group of practitioners from gaining access to staff membership. (h) Staff privileges for physicians should be based on training, experience, demonstrated competence, and adherence to medical staff bylaws. No aspect of medical staff membership or particular clinical privileges shall be denied on the basis of sex, race, age, creed, color, national origin, religion, disability, ethnic origin sexual orientation, gender identity or physical or mental impairment that does not pose a threat to the quality of patient care. (i) Physician profiling must be adjusted to recognize case mix, severity of illness, age of patients and other aspects of the physician's practice that may account for higher or lower than expected costs. Profiles of physicians must be made available to the physicians at regular intervals.

2. The AMA communicates the medical staff development plan principles to the President and Chair of the Board of the American Hospital Association and recommend that state and local medical associations establish a dialogue regarding medical staff development plans with their state hospital association.

BOT Rep. 14, A-98; Modified: BOT Rep. 11, A-07; Reaffirmation: A-10; Modified: CMS Rep. 01, A-20