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REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 4-A-17

Subject: Evaluation of DACA-Eligible Medical Students, Residents, and Physicians in Addressing Physician Shortages

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1 Policy D-350.986, “Evaluation of DACA-Eligible Medical Students, Residents and Physicians in
2 Addressing Physician Shortages,” directs our American Medical Association (AMA) to “study the
3 issue of Deferred Action for Childhood Arrivals-eligible medical students, residents, and
4 physicians and consider the opportunities for their participation in the physician profession and
5 report its findings to the House of Delegates.” This report is in response to that directive.
6
7 This policy was adopted at the 2015 Annual Meeting of the AMA House of Delegates. Unanimous
8 supportive testimony at A-15 before Reference Committee C asserted that many Deferred Action
9 for Childhood Arrivals (DACA)-eligible medical students want to meet the health care needs of
10 their communities and have the potential to increase the physician workforce, particularly for
11 underserved populations and in underserved areas. DACA allows individuals who came to the U.S.
12 illegally as minor children, and who meet several guidelines, to apply for deferred deportation and
13 be eligible for a renewable work authorization and Social Security number. While the ethnicity of
14 eligible individuals varies by region, 77 percent of all DACA applicants by 2014 were of Mexican
15 origin; individuals of Mexican, El Salvadoran, Guatemalan, Korean, and Honduran origin
16 accounted for 87 percent of all applicants.¹
17
18 This report offers background information regarding the DACA program; provides estimates of the
19 number of medical students and resident trainees eligible for these opportunities; discusses their
20 potential impact on the physician workforce; and reviews how the current political climate and the
21 results of the 2016 presidential election may affect or eliminate this initiative. All information is
22 current as of March 17, 2017.
23
24 **DEFERRED ACTION FOR CHILDHOOD ARRIVALS**
25
26 In June 2012, then-Secretary of Homeland Security Janet Napolitano issued a memorandum to U.S.
27 Customs and Border Protection, U.S. Citizenship and Immigration Services, and U.S. Immigration
28 and Customs Enforcement to set forth “how, in the exercise of our prosecutorial discretion, the
29 Department of Homeland Security (DHS) should enforce the Nation’s immigration laws against
30 certain young people who were brought to this country as children and know only this country as
31 home.”² The memorandum explains the criteria these federal agencies should use when considering
32 whether or not to remove non-citizens from the country. Later that day, then-President Barack
33 Obama addressed this new inter-agency policy, remarking that “it makes no sense to expel talented
34 young people, who, for all intents and purposes, are Americans—they’ve been raised as
35 Americans; understand themselves to be part of this country—to expel these young people who
36 want to staff our labs, or start new businesses, or defend our country simply because of the actions
37 of their parents—or because of the inaction of politicians.”³ This policy action, which has become
38 known as DACA, had been approved for almost 730,000 qualifying individuals by March 2016.⁴
39 Despite the protections the memorandum appears to offer, however, it ends with a warning that

1 “[t]his memorandum confers no substantive right, immigration status or pathway to citizenship.
2 Only the Congress, acting through its legislative authority, can confer these rights. It remains for
3 the executive branch, however, to set forth policy for the exercise of discretion within the
4 framework of the existing law.”

5
6 In November 2014, President Obama issued an executive action titled Immigration Accountability,
7 which would have expanded the original DACA policy action and introduced a new initiative—
8 Deferred Action for Parents of Americans and Lawful Permanent Residents (DAPA). These two
9 actions were intended to keep families united and simultaneously increase tax revenue. In February
10 2015, the actions were blocked by a federal judge in Texas, effectively preventing the programs
11 from being implemented. That decision was reaffirmed by the 5th Circuit Court of Appeals in New
12 Orleans. The case ultimately was heard by the U.S. Supreme Court, which handed down a split
13 decision in June 2016, preventing these programs from being implemented during the remainder of
14 President Obama’s term. The injunction did not affect the original DACA initiative, and
15 beneficiaries of that program remained—as of June 2016—“low priorities for enforcement.”⁵

16
17 **DACA-ELIGIBLE TRAINEES IN UNDERGRADUATE MEDICAL EDUCATION**

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19 Medical schools traditionally may have been unwilling to offer admission to individuals who might
20 not have been able to complete their training due to the uncertainty of their immigration status.
21 DACA status is therefore key to opening doors to medical school for qualified non-citizen
22 applicants, as achieving such status also secures work authorization—necessary for any individual
23 who wants to eventually enter residency/fellowship training. According to the Association of
24 American Medical Colleges (AAMC), 61 U.S. allopathic medical schools reported that they
25 considered applications from students with DACA status for the 2016/2017 academic year.⁶ In
26 2016, 108 students with DACA status applied to U.S. allopathic medical schools, and 34 of those
27 individuals matriculated, bringing total allopathic medical school enrollment of DACA-eligible
28 individuals to approximately 70 students.⁷

29
30 While DACA status might provide opportunities for entry into higher education, it does not confer
31 eligibility for federal financial aid. This financial barrier has implications for students and schools.
32 Like others, undocumented medical students may find the average cost of a medical school
33 education out of reach: the AAMC estimates the median cost of attending four years of medical
34 school for the class of 2017 at \$240,351 for public school and \$314,202 for private school.⁸

35
36 Loyola University Chicago Stritch School of Medicine—the first U.S. medical school to accept
37 DACA-eligible applicants—has taken steps to address financial barriers by working with local
38 partners to create a program similar to public health service loans. No taxpayer funds are used, and
39 recipients are required to dedicate one year of service to underserved populations/areas in the state
40 of Illinois for each year of training during which the loans are used.⁹

41
42 California has pursued another pathway that seeks to assist undocumented individuals as they
43 pursue training in health care (not limited to physician training). A 2016 bill signed into law
44 permits individuals to apply for multiple sources of state training funding regardless of citizenship
45 status, and further prohibits medical school and residency training programs from denying
46 admission to individuals solely based on this status.¹⁰

1 **DACA-ELIGIBLE TRAINEES IN GRADUATE MEDICAL EDUCATION**

2
3 While the Accreditation Council for Graduate Medical Education (ACGME) does not currently
4 track numbers of medical school graduates with DACA status who have entered ACGME-
5 accredited residency training programs, the AAMC is currently aware of four DACA resident
6 trainees at four different institutions.¹¹ Overall numbers of current DACA-eligible resident
7 trainees/fellows therefore appear quite small; however, several impediments that might previously
8 have prevented medical school graduates from entering residency training programs recently have
9 been addressed. One barrier was removed in 2014, and strengthened in 2016, when the Veterans
10 Health Administration (VA) agreed to allow DACA-eligible trainees to rotate through VA
11 facilities, a required rotation for many residency training programs.¹² Also, the Electronic
12 Residency Application System (ERAS)—the online application tool medical school graduates use
13 to apply to most ACGME-accredited residency training programs—recently added a DACA
14 category, thereby allowing DACA-eligible residency applicants to participate in this process.¹³ The
15 renewable work authorization granted under DACA allows recipients to be hired using customary
16 I-9 verification.¹⁴ Therefore, payment barriers are alleviated, and DACA recipients with work
17 authorization are protected from employment discrimination as well.¹⁵

18
19 **STATE LICENSURE**

20
21 Eligibility for medical licensure of undocumented, U.S.-educated physicians who have completed
22 residency training varies by state, and the Federation of State Medical Boards (FSMB) does not
23 maintain a centralized repository of this information. While some states specifically allow medical
24 licensure for qualified DACA-eligible individuals, others are silent on this issue.¹⁶

25
26 **POTENTIAL PHYSICIAN WORKFORCE IMPLICATIONS**

27
28 Because of a lack of data, due in large part to the relative youth of the DACA program, little is
29 known about the potential impact of DACA-eligible medical students and trainees on the U.S.
30 physician workforce. The Migration Policy Institute projected that of the 1.2 million immediately
31 DACA-eligible youth in 2014, four percent had completed a bachelor's (three percent) or advanced
32 degree (one percent).¹⁷ This would imply that only a small number of individuals would be
33 prepared to even consider application to medical school. Another model, however, predicts that the
34 DACA initiative could introduce 5,400 previously ineligible physicians into the U.S. health care
35 system in the coming decades (although “coming decades” is not defined).¹⁸ Nevertheless, even if
36 this projection is accurate, speculation regarding both specialty choice and practice location, and
37 extrapolation regarding patient populations served, would be rash at this time.

38
39 **IMPACTS OF THE 2016 PRESIDENTIAL ELECTION**

40
41 All of the foregoing information is, of course, subject to any policy action taken by President
42 Donald Trump and the 115th Congress. In the lead-up to the election, Mr. Trump referred to the
43 DACA initiative as “one of the most unconstitutional actions ever undertaken by a president,” and
44 spoke of immediately expelling all undocumented immigrants.¹⁹ As of the writing of this report,
45 however, no official actions have been taken by the new administration to abolish DACA or
46 punitively identify and deport individuals covered by the initiative, and comments offered during
47 the administration’s first official White House Press Briefing suggest that there will be no
48 immediate effort to terminate DACA.^{20, 21} While the President generally has been expanding
49 immigration enforcement efforts, he still has not taken any action to rescind or roll back the DACA
50 program. Furthermore, the recently issued executive orders and guidance memoranda do not
51 address the DACA program.

1 A number of different groups have expressed concern for the status of DACA-eligible medical
2 students and resident trainees. At the 2016 Interim Meeting, the House adopted a resolution in
3 support of current U.S. health care professionals, including medical students and resident/fellow
4 trainees, who are DACA recipients. In December 2016, the AAMC sent a letter to then President-
5 Elect Trump “strongly” encouraging him not to eliminate the protections conferred by the DACA
6 initiative.²² The AMA expressed its concerns about the future of the DACA initiative in a letter to
7 Department of Homeland Security Secretary John F. Kelly in February 2017, which urged the
8 administration to carefully consider any future action related to individuals with DACA status. The
9 AMA stated its strong support for medical students and physicians with DACA status and
10 advocated that the administration retain the current DACA initiative until a permanent solution on
11 lawful immigration status for DACA participants could be implemented.
12

13 Legislators also are addressing this concern. In January 2017, a bipartisan group of six senators—
14 Lindsey Graham (R-SC), Richard Durbin (D-IL), Lisa Murkowski (R-AK), Dianne Feinstein (D-
15 CA), Jeff Flake (R-AZ), and Charles Schumer (D-NY)—reintroduced the BRIDGE Act (Bar
16 Removal of Individuals who Dream and Grow our Economy), S. 128. Provisions of this
17 legislation—at the time of this report’s writing—would amend Chapter 4 of Title II of the
18 Immigration and Nationality Act to offer DACA-eligible individuals “provisional protected
19 presence,” which also includes employment authorization.^{23, 24} The AMA subsequently sent a letter
20 of support to Senators Graham and Durbin in February, which noted that DACA-eligible medical
21 students “help contribute to a diverse and culturally responsive physician workforce, which in turn
22 helps benefit not only traditionally underserved patients, but all patients as well.”²⁵ This bill also
23 was introduced in the House of Representatives as H.R. 496 by Representatives Mike Coffman (R-
24 CO), Luis Gutiérrez (D-IL), and 18 cosponsors from both sides of the aisle. The AMA sent an
25 additional letter of support to Representatives Coffman and Gutiérrez.
26

27 If DACA status were to be eliminated, previously DACA-eligible medical students might not be
28 able to continue in their programs, and DACA-eligible medical school graduates would not be
29 eligible to enter residency training in the United States. These individuals’ status also would
30 preclude them from entering residency training as international medical graduates (IMGs), a
31 category officially recognized by U.S residency and fellowship training programs. In order to
32 qualify as an IMG, an applicant is required to have a certificate from the Educational Commission
33 for Foreign Medical Graduates (ECFMG). An individual who has graduated from a Liaison
34 Committee on Medical Education (LCME)- or Commission on Osteopathic College Accreditation
35 (COCA)-accredited medical school is not eligible to receive an ECFMG certificate. While the
36 ECFMG does sponsor J-1 visas for non-IMGs (often graduates of Canadian medical schools),
37 individuals pursuing this route would need to leave the country and reenter with a valid visa; this
38 seems an unlikely path for individuals with current DACA status.
39

40 SUMMARY AND AREAS FOR FURTHER STUDY

41 Extensive AMA policy and previous Council on Medical Education reports support a diverse, well
42 distributed physician workforce and promote access to care for underserved populations; for these
43 reasons, our AMA should promote policies that enable individuals from diverse backgrounds to
44 complete medical school and residency training and enter into U.S. practice. At this time, DACA-
45 eligible individuals are not likely to have a significant impact on physician workforce shortages,
46 and the effects of their entry into the workforce on physician maldistribution are unknown.
47 Regardless, the practice patterns of DACA-eligible medical school graduates and trainees in
48 residency training programs should be studied to better understand their future potential
49 relationship to medically underserved areas and populations. The Council on Medical Education
50 will continue to monitor this issue and its implications and report back as needed.
51

APPENDIX: RELEVANT AMA POLICIES

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.

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.

H-295.874, Educating Medical Students in the Social Determinants of Health and Cultural Competence

Our AMA: (1) Supports efforts designed to integrate training in social determinants of health and cultural competence across the undergraduate medical school curriculum to assure that graduating medical students in the social determinants of health and cultural competence.

H-310.919, Eliminating Questions Regarding Marital Status, Dependents, Plans for Marriage or Children, Sexual Orientation, Gender Identity, Age, Race, National Origin and Religion During the Residency and Fellowship Application Process

Our AMA: 1. Opposes questioning residency or fellowship applicants regarding marital status, dependents, plans for marriage or children, sexual orientation, gender identity, age, race, national origin, and religion; 2. Will work with the Accreditation Council for Graduate Medical Education, the National Residency Matching Program, and other interested parties to eliminate questioning about or discrimination based on marital and dependent status, future plans for marriage or children, sexual orientation, age, race, national origin, and religion during the residency and fellowship application process; and 3. Will continue to support efforts to enhance racial and ethnic diversity in medicine. Information regarding race and ethnicity may be voluntarily provided by residency and fellowship applicants.

H-295.897, Enhancing the Cultural Competence of Physicians

1. Our AMA continues to inform medical schools and residency program directors about activities and resources related to assisting physicians in providing culturally competent care to patients throughout their life span and encourage them to include the topic of culturally effective health care in their curricula; 2. Our AMA continues research into the need for and effectiveness of training in cultural competence, using existing mechanisms such as the annual medical education surveys and focus groups at regularly scheduled meetings; 3. Our AMA will form an expert national advisory panel (including representation from the AMA Minority Affairs Consortium and International Medical Graduate Section) to consult on all areas related to enhancing the cultural competence of physicians, including developing a list of resources on cultural competencies for physicians and maintaining it and related resources in an electronic database; 4. Our AMA will assist physicians in

obtaining information about and/or training in culturally effective health care through development of an annotated resource database on the AMA home page, with information also available through postal distribution on diskette and/or CD-ROM; 5. Our AMA will seek external funding to develop a five-year program for promoting cultural competence in and through the education of physicians, including a critical review and comprehensive plan for action, in collaboration with the AMA Consortium on Minority Affairs and the medical associations that participate in the consortium (National Medical Association, National Hispanic Medical Association, and Association of American Indian Physicians,) the American Medical Women's Association, the American Public Health Association, the American Academy of Pediatrics, and other appropriate groups. The goal of the program would be to restructure the continuum of medical education and staff and faculty development programs to deliberately emphasize cultural competence as part of professional practice; and 6. Our AMA encourages training opportunities for students and residents, as members of the physician-led team, to learn cultural competency from community health workers, when this exposure can be integrated into existing rotation and service assignments.

D-350.986, Evaluation of DACA-Eligible Medical Students, Residents and Physicians in Addressing Physician Shortages

1. Our American Medical Association will study the issue of Deferred Action for Childhood Arrivals-eligible medical students, residents, and physicians and consider the opportunities for their participation in the physician profession and report its findings to the House of Delegates; and 2. Our AMA will issue a statement in support of current US healthcare professionals, including those currently training as medical students or residents and fellows, who are Deferred Action for Childhood Arrivals recipients.

D-350.995, Reducing Racial and Ethnic Disparities in Health Care

Our AMA's initiative on reducing racial and ethnic disparities in health care will include the following recommendations: 1. Studying health system opportunities and barriers to eliminating racial and ethnic disparities in health care; 2. Working with public health and other appropriate agencies to increase medical student, resident physician, and practicing physician awareness of racial and ethnic disparities in health care and the role of professionalism and professional obligations in efforts to reduce health care disparities; and 3. Promoting diversity within the profession by encouraging publication of successful outreach programs that increase minority applicants to medical schools, and take appropriate action to support such programs, for example, by expanding the "Doctors Back to School" program into secondary schools in minority communities.

H-200.950, Retraining Refugee Physicians

Our AMA supports federal programs, and funding for such programs, that assist refugee physicians who wish to enter the US physician workforce, especially in specialties experiencing shortages and in underserved geographical areas in the US and its territories.

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; and 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.

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-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.

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