AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 323
(A-22)

Introduced by: Medical Student Section

Subject: Cultural Leave for American Indian Trainees

Referred to: Reference Committee C

Whereas, American Indian and Alaska Native students have disparately lower four-year medical school graduation rates compared to their non-Hispanic white peers (71% vs. 87%)[1]; and

Whereas, The Association of American Medical Colleges and Association of American Indian Physicians recognize that perception of one's school/workplace environment influences medical student retention and success and that a positive psychological climate can be fostered when student programming and student affairs offices are responsive to American Indian and Alaska Native culture and history[1]; and

Whereas, A 2021 survey conducted by the Association of Native American Medical Students found that 20% of respondents cited loss of culture and distance from family as significant challenges to their progression in medical training;[2] and

Whereas, The American Indian Religious Freedom Act of 1978 requires protection and preservation of American Indians' inherent right of freedom to believe, express, and exercise the traditional religions of the American Indian, Eskimo, Aleut, and Native Hawaiians, including but not limited to access to sites, use and possession of sacred objects, and the freedom to worship through ceremonial and traditional rites[3]; and

Whereas, Despite this law, American Indian and Alaska Native K-12 students are more likely to face disciplinary action in education systems, including suspension and expulsion, than their peers due to a lack of cultural responsiveness[4]; and

Whereas, Cultural responsiveness enables individuals and organizations to respond respectfully and effectively to people of all cultures, languages, classes, races, ethnic backgrounds, disabilities, religions, genders, sexual orientations, and other diversity factors in a manner that recognizes, affirms, and values their worth[5]; and

Whereas, Culturally-responsive practices involve recognizing and incorporating the assets and strengths all students bring into the classroom, and ensuring that learning experiences, from curriculum through assessment, are relevant to all students, and are grounded in evidence-based community practice[6]; and

Whereas, Existing AMA policy focused on equity, diversity and, inclusion (H-200.951, D-200.985) is not specific to or inclusive of cultural leave practices; and

Whereas, American Indian and Alaska Native cultural responsiveness must be an ongoing and deliberate effort, taking root across the school spectrum—curriculum, pedagogy, engagement with students and their families, and overall policies and practices;[7-8] and

Whereas, There is strong evidence that institutions must accommodate American Indian and Alaska Native cultural practices instead of relying on the student to navigate non-specific policies allowing for leave;[9] therefore be it

RESOLVED, That our AMA amend H-310.923, Eliminating Religious Discrimination from Residency Programs, by addition as follows:

Eliminating Religious and Cultural Discrimination from Residency and Fellowship Programs and Medical Schools H-310.923

Our AMA encourages residency programs, fellowship programs, and medical schools to: (1) ~~make an effort to accommodate~~ Allow ~~residents'~~ trainees to take leave and attend religious and cultural holidays and observances, including those practiced by American Indians and Alaskan Natives, provided that patient care and the rights of other ~~resi~~dents trainees are not compromised; and (2) explicitly inform applicants and entrants about their policies and procedures related to accommodation for religious and cultural holidays and observances; (Modify Current HOD Policy) and be it further

RESOLVED, That our AMA will work with the Association of American Indian Physicians, Association of Native American Medical Students, and other appropriate stakeholders to design model cultural leave policies for undergraduate and graduate medical education programs and healthcare employers. (Directive to Take Action)

Fiscal Note: Not yet determined

Received: 05/11/22

References:

1. Association of American Medical Colleges. Reshaping the Journey: American Indian/Alaska Natives in Medicine. October 2018.
2. Swain, W. Calac, A. Assessing the experience of American Indian and Alaska Native medical students in undergraduate medical education. 2021.Manuscript in preparation.
3. American Indian Religious Freedom Act 42 U.S.C. § (1978, amended 1996).
4. Community College Equity Assessment Lab. New report exposes extreme school suspension rates for Native youth in California schools. Indian Country Today. News Release. 2019.
5. Cultural Responsiveness. U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau: Child Welfare Information. Gateway. https://www.childwelfare.gov/topics/systemwide/cultural/. Accessed August 24, 2021.
6. Culturally-Responsive Practices. Digital Promise. https://challengemap.digitalpromise.org/equity/culturally-responsive-practices/. Accessed August 24, 2021.
7. Broaddus M. Response: Meeting the Needs of Native American Students (Opinion). Education Week. https://www.edweek.org/leadership/opinion-response-meeting-the-needs-of-native-american-students/2019/04. Published 2019. Accessed August 24, 2021.
8. Building Cultural Awareness in Support of American Indian/Alaska Native Students. Colorado Department of Education. https://www.cde.state.co.us/fedprograms/building-cultural-awarenessinsupportofamericanindianandalaskanativestudents. Published 2020. Accessed August 24, 2021.
9. Fish, J., & Syed, M. (2018). Native Americans in higher education: An ecological systems perspective. *Journal of College Student Development, 59*(4), 387–403. https://doi.org/10.1353/csd.2018.0038

RELEVANT AMA POLICY

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.
CCB/CLRPD Rep. 4, A-13; Modified: Res. 305, A-14; Modified: Res. 904, I-14

Eliminating Religious Discrimination from Residency Programs H-310.923
Our AMA encourages residency programs to: (1) make an effort to accommodate residents' religious holidays and observances, provided that patient care and the rights of other residents are not compromised; and (2) explicitly inform applicants and entrants about their policies and procedures related to accommodation for religious holidays and observances. CME Rep. 10, A-06; Reaffirmed: CME Rep. 01, A-16.

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, disability status, sexual orientation, gender identity, socioeconomic origin, and rurality; (2) commends the Institute of Medicine (now known as the National Academies of Sciences, Engineering, and 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; (3) encourages the development of evidence-informed programs to build role models among academic leadership and faculty for the mentorship of students, residents, and fellows underrepresented in medicine and in specific specialties; (4) encourages physicians to engage in their communities to guide, support, and mentor high school and undergraduate students with a calling to medicine; (5) encourages medical schools, health care institutions, managed care and other appropriate groups to adopt and utilize activities that bolster efforts to include and support individuals who are underrepresented 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 goal; and (6) 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 marginalized patient populations.
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; Modified: Res. 009, A-21; Modified: CME Rep. 5, A-21

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 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 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.
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; Modified: CME Rep. 5, A-21