

DISCLAIMER

The following is a preliminary report of actions taken by the House of Delegates at its 2023 Annual Meeting and should not be considered final. Only the Official Proceedings of the House of Delegates reflect official policy of the Association.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (A-23)

Report of Reference Committee C

David T. Walsworth, MD, Chair

Your Reference Committee recommends the following consent calendar for acceptance:

1. **RECOMMENDED FOR ADOPTION**

1. Council on Medical Education Report 1 – Council on Medical Education Sunset Review of 2013 House of Delegates’ Policies
2. Council on Medical Education Report 3 – Financial Burdens and Exam Fees for International Medical Graduates (Resolution 305-A-22)
3. Council on Medical Education Report 4 – Decreasing Bias in Assessments of Medical Student Clinical Clerkship Performance (Resolution 309-A-22, Resolve 2)
4. Council on Medical Education Report 5 – Support for Institutional Policies for Personal Days for Undergraduate Medical Students (Resolution 314-A-22)
5. Council on Medical Education Report 6 – Modifying Financial Assistance Eligibility Criteria for Medical School Applicants
6. Council on Medical Education Report 8 – Challenges to Primary Source Verification of International Medical Graduates Resulting from International Conflict
7. Council on Medical Education Report 9 – The Impact of Midlevel Providers on Medical Education (Resolution 201-A-22)
8. Resolution 320 – Banning Affirmative Action is a Critical Threat to Health Equity and to the Medical Profession

RECOMMENDED FOR ADOPTION WITH A TITLE CHANGE

9. Resolution 302 – Antitrust Legislation Regarding the AAMC, ACGME, NRMP, and Other Relevant Associations or Organizations

RECOMMENDED FOR ADOPTION AS AMENDED

10. Council on Medical Education Report 2 – Financing Medical Education
(Resolution 306-A-22)
11. Resolution 304 – Increasing Access to Gender-Affirming Procedures Through
Expanded Training and Equitable Reimbursement
12. Resolution 305 – Indian Health Service Graduate Medical Education
13. Resolution 306 – Increased Education and Access to Fertility Resources for U.S.
Medical Students
14. Resolution 307 – Amending AMA Policy H-295.858, “Access to Confidential
Health Services for Medical Students and Physicians” to Include Annual Opt-Out
Mental Health Screening for Suicide Prevention for Residents
15. Resolution 311 – Residency Application Support for Students of Low-Income
Backgrounds
16. Resolution 314 – Support for International Medical Graduates from Turkey
17. Resolution 316 – Physician Medical Conditions and Questions on Applications
for Medical Licensure, Specialty Boards, and Institutional Privileges
18. Resolution 319 – Supporting Diversity, Equity, & Inclusion Offices and Initiatives
at United States Medical Schools to Enhance Longitudinal Community
Engagement
19. Resolution 321 – Corporate Compliance Consolidation
20. Resolution 322 – Disclosure of Compliance issues and Creating a National
Database of Joint Leadership
21. Resolution 323 – Amend Policy D-275.948, “Education, Training and
Credentialing of Non-Physician Health Care Professionals and Their Impact on
Physician Education and Training”

RECOMMENDED FOR ADOPTION IN LIEU OF

22. Council on Medical Education Report 7 – Management and Leadership Training
in Medical Education
- Resolution 318 – Fostering Pathways for Resident Physicians to Pursue MBA
Programs in Order to Increase the Number of Qualified Physicians for Healthcare
Leadership Positions

- 1 23. Resolution 301 – Increasing Musculoskeletal Education in Primary Care
2 Specialties and Medical School Education through Inclusion of Osteopathic
3 Manual Therapy Education
4
5 Resolution 310 – Teaching and Assessing Osteopathic Manipulative Treatment
6 and Osteopathic Principles and Practice to Resident Physicians in the Context of
7 ACGME Single System of Accreditation
8
9 24. Resolution 308 – Increased Inclusivity and Admission Policies Clarification for
10 DACA Medical School and Residency Applicants
11
12 25. Resolution 309 – Against Legacy Preferences as a Factor in Medical School
13 Admissions
14
15 26. Resolution 312 – Indian Health Service Licensing Exemptions
16
17 27. Resolution 313 – Filtering International Medical Graduates During Residency or
18 Fellowship Applications
19
20 Resolution 315 – Prohibit Discriminatory ERAS® Filters In NRMP Match
21

22 **RECOMMENDED FOR REFERRAL FOR DECISION**

- 23
24 28. Resolution 303 – Medical School Management of Unmatched Medical Students
25

26 **Amendments: If you wish to propose an amendment to an item of business, click**
27 **here: [Submit New Amendment](#)**

RECOMMENDED FOR ADOPTION

- (1) COUNCIL ON MEDICAL EDUCATION REPORT 1 –
COUNCIL ON MEDICAL EDUCATION SUNSET REVIEW
OF 2013 HOUSE OF DELEGATES' POLICIES

RECOMMENDATION:

**Recommendations in Council on Medical Education
Report 1 be adopted and the remainder of the report be
filed.**

**HOD ACTION: Recommendations in Council on Medical
Education Report 1 adopted and the remainder of the
report filed.**

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

No testimony was received for this report. Your Reference Committee appreciates the Council's efforts to identify policies for sunset and recommends that Council Report 1 be adopted.

- (2) COUNCIL ON MEDICAL EDUCATION REPORT 3 –
FINANCIAL BURDENS AND EXAM FEES FOR
INTERNATIONAL MEDICAL GRADUATES
(RESOLUTION 305-A-22)

RECOMMENDATION:

**Recommendations in Council on Medical Education
Report 3 be adopted and the remainder of the report be
filed.**

**HOD ACTION: Recommendations in Council on Medical
Education Report 3 adopted and the remainder of the
report filed.**

1. That our American Medical Association (AMA) encourage key stakeholders, such as the National Board of Medical Examiners, Federation of State Medical Boards, Educational Commission for Foreign Medical Graduates (a member of Intealth), Cambridge Assessment English and Box Hill Institute, and others to (a) study the most equitable approach for achieving parity across U.S. MD and DO trainees and international medical graduates with regard to application, exam, and licensing fees and related financial burdens; and (b) share this information with the medical education and IMG communities. (Directive to Take Action)

2. That our AMA encourage relevant stakeholders to work together to achieve cost equivalency for exams required of all medical students and trainees, including IMGs. (Directive to Take Action)

3. That AMA policy H-255.988, "AMA Principles on International Medical Graduates," be reaffirmed. (Reaffirm HOD Policy)

CME 3-A-23 received online and live testimony in support of this report. The Federation of State Medical Boards (FSMB) testified that the National Board of Medical Examiners makes no distinction between U.S. MD and DO medical school graduates and international medical graduates, and that the core fees and cost for the United States Medical Licensure Exam (USMLE) transcript are the same for both. The FSMB did acknowledge there were additional costs for processing USMLE transcripts for those who took the exam outside of the United States. The Educational Commission for Foreign Medical Graduates (ECFMG) testified that, despite inflation, fees were held flat for services, and they will propose to not increase fees in 2024. Your Reference Committee recommends that Council Report 3 be adopted.

(3) COUNCIL ON MEDICAL EDUCATION REPORT 4 –
DECREASING BIAS IN ASSESSMENTS OF MEDICAL
STUDENT CLINICAL CLERKSHIP
PERFORMANCE (RESOLUTION 309-A-22, RESOLVE 2)

RECOMMENDATION:

Recommendations in Council on Medical Education Report 4 be adopted and the remainder of the report be filed.

HOD ACTION: Recommendations in Council on Medical Education Report 4 adopted and the remainder of the report filed.

That our American Medical Association (AMA):

1. Continue to encourage work in support of the Coalition for Physician Accountability's Undergraduate Medical Education-Graduate Medical Education Review Committee "Recommendations for Comprehensive Improvement of the UME-GME Transition." (Directive to Take Action)

2. Encourage and support UME institutions' investment in a) developing more valid, reliable, and unbiased summative assessments for clinical clerkships, including development of assessors' awareness regarding structural inequities in education and wider society, and b) providing standardized and meaningful competency data to program directors. (New HOD Policy)

3. Encourage institutions to publish information related to clinical clerkship grading systems and residency match rates, with subset data for learners from varied groups, including those that have been historically underrepresented in medicine or may be affected by bias. (New HOD Policy)

4. Encourage UME institutions to include grading system methodology with grades shared with residency programs. (New HOD Policy)

5. Reaffirm the following policies:

- [D-295.307](#), “Decreasing Bias in Evaluations of Medical Student Performance”
- [H-295.866](#), “Supporting Two-Interval Grading Systems for Medical Education”
- D-295.317, “Competency Based Medical Education Across the Continuum of Education and Practice”
- D-295.318, “Competency-Based Portfolio Assessment of Medical Students”

CME 4-A-23 received online and live testimony in support of this report. Your Reference Committee recommends that Council Report 4 be adopted.

- (4) COUNCIL ON MEDICAL EDUCATION REPORT 5 –
SUPPORT FOR INSTITUTIONAL POLICIES FOR
PERSONAL DAYS FOR UNDERGRADUATE MEDICAL
STUDENTS (RESOLUTION 314-A-22)

RECOMMENDATION:

Recommendations in Council on Medical Education Report 5 be adopted and the remainder of the report be filed.

HOD ACTION: Recommendations in Council on Medical Education Report 5 adopted and the remainder of the report filed.

1. That our AMA support a requirement that each medical school have policy defining 1) the number of days a medical student may be excused from each curricular component; 2) the processes for using excused absences, providing alternative, timely means of achieving curricular goals when absent from a curricular component; and 3) effective mechanisms to communicate these policies at appropriate times throughout the curriculum; and that schools be encouraged to create a mechanism by which at least some portion of such days can be used without requiring explanation. (New HOD Policy)

CME 5-A-23 received online and live testimony in support of this report. Your Reference Committee recommends that Council Report 5 be adopted.

- (5) COUNCIL ON MEDICAL EDUCATION REPORT 6 –
MODIFYING FINANCIAL ASSISTANCE ELIGIBILITY
CRITERIA FOR MEDICAL SCHOOL APPLICANTS

RECOMMENDATION:

Recommendations in Council on Medical Education Report 6 be adopted and the remainder of the report be filed.

HOD ACTION: Recommendations in Council on Medical Education Report 6 adopted and the remainder of the report filed.

1. That AMA policy [D-305.950](#), Modifying Financial Assistance Eligibility Criteria for Medical School Applicants, be amended by addition and deletion to read as follows:

1. Our AMA will ~~work with~~ encourage the Association of American Medical Colleges, ~~and American Association of Colleges of Osteopathic Medicine, and other appropriate stakeholders~~ to study process reforms ~~that could help to~~ mitigate the high cost of applying to medical school ~~for low-income applicants, including better targeting application fee waivers through broadened eligibility criteria,~~ and ensure cost parity among applicants to DO and MD granting institutions.

2. Our AMA will encourage the Association of American Medical Colleges, American Association of Colleges of Osteopathic Medicine, and U.S. Department of Education to reevaluate application forms to financial aid programs such as the Fee Assistance Program (FAP), Fee Waiver Program (FWP), and Free Application for Federal Aid (FASFA) to broaden eligibility criteria for low-income students.

3. Our AMA will commend the U.S. Department of Education for removing references to parental/guardian income for all medical students in the Free Application for Federal Aid (FASFA).

4. Our AMA will encourage the Association of American Medical Colleges and American Association of Colleges of Osteopathic Medicine as well as medical school and state-based financial aid programs to remove references to parental/guardian income for all medical students and follow the U.S. Department of Education's definition of "independent student" as described in the Free Application for Federal Aid (FASFA). (Modify Current HOD Policy)

CME 6-A-23 received online and live testimony in support of this report. Your Reference Committee recommends that Council Report 6 be adopted.

- (6) COUNCIL ON MEDICAL EDUCATION REPORT 8 –
CHALLENGES TO PRIMARY SOURCE VERIFICATION
OF INTERNATIONAL MEDICAL GRADUATES
RESULTING FROM INTERNATIONAL CONFLICT

RECOMMENDATION:

Recommendations in Council on Medical Education Report 8 be adopted and the remainder of the report be filed.

HOD ACTION: Recommendations in Council on Medical Education Report 8 adopted and the remainder of the report filed.

1. That American Medical Association (AMA) Policy D-275.989, "Credentialing Issues," be amended as follows:

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 by the Educational Commission for Foreign Medical Graduates (a member of Intealth) as proof of primary source verification of an IMG's international medical education credentials. (Modify Current HOD Policy)

2. That AMA Policy D-255.975, "Hardship for International Medical Graduates from Russia and Belarus," be rescinded, as having been fulfilled by this report:

~~"Our AMA will study the impact of the current political crisis on international medical graduates with medical degrees from Russia and Belarus who are already in the U.S. either in training or practicing in regards to their ability to obtain primary source verification and report back during the 2022 Interim House of Delegates meeting."~~
(Rescind HOD Policy)

CME 8-A-23 received online and live testimony in support of this report. Your Reference Committee recommends that Council Report 8 be adopted.

- (7) COUNCIL ON MEDICAL EDUCATION REPORT 9 – THE IMPACT OF MIDLEVEL PROVIDERS ON MEDICAL EDUCATION (RESOLUTION 201-A-22)

RECOMMENDATION:

Recommendations in Council on Medical Education Report 9 be adopted and the remainder of the report be filed.

HOD ACTION: Recommendations in Council on Medical Education Report 9 adopted and the remainder of the report filed.

1. That the American Medical Association (AMA) encourage appropriate medical education accreditation organizations in allopathic and osteopathic medicine including the Liaison Committee on Medical Education, Commission on Osteopathic College Accreditation, American Osteopathic Association, and Accreditation Council for Graduate Medical Education to:

A) Incorporate the phrase "physician-led" as a modifier for "interprofessional education" into their relevant medical education accreditation standards, where appropriate;

B) Require education in and evaluation of competency in physician-led interprofessional health care team leadership as part of the systems-based practice competency in medical education accreditation standards. (New HOD Policy)

2. That the AMA encourage medical educators to study how interprofessional learning and teamwork promote the development of physician leadership in team-based care. (New HOD Policy)
3. Amend D-295.934 (2) by addition as follows: "Our AMA supports the concept that medical education should prepare students for practice in, and leadership of, physician-led interprofessional health care teams." (New HOD Policy)
4. That the AMA encourage medical standards-setting organizations, including the American Board of Medical Specialties and its member boards, to inform policymakers of the standards physicians are held to for independent practice in order to protect patients and that these standards make physicians the appropriate leaders of the interprofessional health care team. (Modify Current HOD Policy)

CME 9-A-23 received online and live testimony in support of this report. Your Reference Committee recommends that Council Report 9 be adopted.

(8) RESOLUTION 320 – BANNING AFFIRMATIVE ACTION
IS A CRITICAL THREAT TO HEALTH EQUITY AND TO
THE MEDICAL PROFESSION

RECOMMENDATION:

Resolution 320 be adopted.

HOD ACTION: Resolution 320 adopted.

RESOLVED, That our American Medical Association amend H-350.979, Increase the Representation of Minority and Economically Disadvantaged Populations in the Medical Profession, by deletion and addition to read as follows:

(3) urging medical school and undergraduate admissions committees to ~~consider minority representation as one factor in reaching their decisions~~ proactively implement policies and procedures that operationalize race-conscious admission practices in admissions decisions, among other factors (Modify Current HOD Policy); and be it further

RESOLVED, That our AMA amend D-200.985, Strategies for Enhancing Diversity in the Physician Workforce, by deletion and addition to read as follows:

(12) unequivocally opposes legislation that would ~~undermine institutions' ability to properly employ~~ dissolve affirmative action or punish institutions for properly employing race-conscious admissions as a measure of affirmative action in order to promote a diverse student population (Modify Current HOD Policy); and be it further

RESOLVED, That our AMA recognize the consideration of race in admissions is a necessary safeguard in creating a pipeline to an environment within medical education that will propagate the advancement of health equity through diversification of the physician workforce. (New HOD Policy)

Resolution 320 received testimony in support of the proposed amendments to Policies [H-350.979](#) and [D-200.985](#) as well as one new resolve. Your Reference Committee recommends that Resolution 320 be adopted.

RECOMMENDED FOR ADOPTION WITH A TITLE CHANGE

- (9) RESOLUTION 302 – ANTITRUST LEGISLATION
REGARDING THE AAMC, ACGME, NRMP, AND OTHER
RELEVANT ASSOCIATIONS OR ORGANIZATIONS

RECOMMENDATION A:

Resolution 302 be adopted.

RECOMMENDATION B:

The title of Resolution 302 be changed, to read as follows:

STUDY OF THE CURRENT MATCH PROCESS AND ALTERNATIVES

HOD ACTION: Resolution 302 adopted with a change in title to read as follows:

STUDY OF THE CURRENT MATCH PROCESS AND ALTERNATIVES

RESOLVED, That our American Medical Association study alternatives to the current residency and fellowship Match process which would be less restrictive on free market competition for applicants. (Directive to Take Action)

Resolution 302 received mixed online and live testimony on this item. Testimony by the National Resident Matching Program (NRMP) noted concerns about the perception of its role, the accuracy and implications of the statements of the resolution, and possible conflict with AMA policy. The authors of this resolution acknowledged the testimony of the NRMP but maintained support of the resolution as written. The Council on Medical Education offered testimony in support of a study to look more closely at this issue and address concerns. Further, your Reference Committee felt it was appropriate to change the title to better reflect the resolve. Your Reference Committee appreciates the Council's willingness to study the topic and recommends that Resolution 302 be adopted.

RECOMMENDED FOR ADOPTION AS AMENDED

- (10) COUNCIL ON MEDICAL EDUCATION REPORT 2 –
FINANCING MEDICAL EDUCATION (RESOLUTION 306-
A-22)

RECOMMENDATION A:

Council on Medical Education Report 2 be amended by the addition of a fifth Recommendation, to read as follows:

5. That our AMA support federal efforts to forgive debt incurred during medical school and other higher education by physicians and medical students, including educational and cost of attendance debt. (New HOD Policy)

RECOMMENDATION B:

Recommendations in Council on Medical Education Report 2 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Recommendations in Council on Medical Education Report 2 adopted as amended and the remainder of the report filed.

1. That Policy D-305.952, "Medical Student Debt and Career Choice," be reaffirmed. (Reaffirm HOD Policy)
2. That Policy H-305.925, "Principles of and Actions to Address Medical Education Costs and Student Debt," be amended by addition of a new point (23), to read "(23) continue to monitor opportunities to reduce additional expense burden upon medical students including reduced-cost or free programs for residency applications, virtual or hybrid interviews, and other cost-reduction initiatives aimed at reducing non-educational debt." (Amend HOD Policy)
3. That our AMA encourage medical students, residents, fellows and physicians in practice to take advantage of available loan forgiveness programs and grants and scholarships that have been historically underutilized, as well as financial information and resources available through the Association of American Medical Colleges and American Association of Colleges of Osteopathic Medicine, as required by the Liaison Committee on Medical Education and Commission on Osteopathic College Accreditation, and resources available at the federal, state and local levels. (New HOD Policy)
4. That Policy D-305.984 (5), "Reduction in Student Loan Interest Rates," be rescinded, as having been fulfilled by this report:

~~"Work with appropriate organizations, such as the Accreditation Council for Graduate Medical Education and the Association of American Medical Colleges, to collect data and report on student indebtedness that includes total loan costs at completion of graduate medical education training." (Rescind HOD Policy)~~

Your Reference Committee received online and live testimony largely in favor of this report. Regarding the Medical Student Section's proposed amendment, the Council on Medical Education noted that "non-educational debt" could be interpreted very broadly (e.g., mortgage, car loan, etc.) and go beyond the purview of the AMA. Other testimony supported ongoing efforts to reduce non-educational debt but did not support efforts to seek forgiveness of non-educational debt.

Testimony by the New York Delegation proffered a new fourth recommendation to "support federal efforts to forgive debt incurred during medical school and college by physicians and medical students, including educational and cost of attendance debt." Additional testimony reflected a desire for the report to go further with regards to action toward advocating for debt cancellation and federal loan forgiveness. Your Reference Committee concurs and recommends that Council Report 2 be adopted as amended.

- (11) RESOLUTION 304 – INCREASING ACCESS TO
GENDER-AFFIRMING PROCEDURES THROUGH
EXPANDED TRAINING AND EQUITABLE
REIMBURSEMENT

RECOMMENDATION A:

The first Resolve of Resolution 304 be amended by addition and deletion, to read as follows:

RESOLVED, That our AMA ~~advocate for~~ encourage interested parties, including medical schools, relevant specialty residency/fellowship programs, professional associations, and regulatory bodies to increase opportunities for expanded structured training for education in gender-affirming care for both practicing physicians and students/trainees by working with relevant stakeholders including but not limited to the Accreditation Council for Graduate Medical Education; (Directive to Take Action) and be it further

RECOMMENDATION B:

The second Resolve of Resolution 304 be amended by addition and deletion, to read as follows:

RESOLVED, That our AMA advocate for equitable, evidence-based coverage reimbursement of gender-affirming care procedures by health insurance providers, including public and private insurers. (Directive to Take Action)

RECOMMENDATION C:

Resolution 304 be adopted as amended.

RECOMMENDATION D:

The title of Resolution 304 be changed, to read as follows:

**INCREASING ACCESS TO GENDER-AFFIRMING CARE
THROUGH EXPANDED TRAINING AND EQUITABLE
COVERAGE**

HOD ACTION: Resolution 304 adopted as amended with a change in title, to read as follows:

The second Resolve of Resolution 304 amended by addition and deletion, to read as follows:

RESOLVED, That our AMA advocate for equitable coverage reimbursement of evidence-based gender-affirming care procedures by health insurance providers, including public and private insurers. (Directive to Take Action)

**INCREASING ACCESS TO GENDER-AFFIRMING CARE
THROUGH EXPANDED TRAINING AND EQUITABLE
COVERAGE**

RESOLVED, That our American Medical Association advocate for expanded structured training for gender-affirming procedures by working with relevant stakeholders including but not limited to the Accreditation Council for Graduate Medical Education (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate for equitable reimbursement of gender-affirming procedures by health insurance providers, including public and private insurers. (Directive to Take Action)

1 Resolution 304 received predominantly supportive online and live testimony, including
2 amendments to the resolves and title to address the full spectrum of medical,
3 psychosocial, and procedural care that encompasses gender-affirming care. The author
4 supported these amendments. Further, the Council on Medical Education offered
5 amendments to clarify the first resolve. The Council on Medical Service also testified in
6 support of the spirit of the resolution and offered an amendment to the second resolve to
7 “support evidence-based coverage of gender-affirming health care, including procedures,
8 by public and private health insurance.” Your Reference Committee agrees and
9 recommends that Resolution 304 be adopted as amended.

(12) RESOLUTION 305 – INDIAN HEALTH SERVICE
GRADUATE MEDICAL EDUCATION

RECOMMENDATION A:

The first Resolve of Resolution 305 be amended by addition and deletion, to read as follows:

RESOLVED, That our American Medical Association advocate that the Indian Health Service (IHS) for the establishment of an Office of Academic Affiliations with the Indian Health Service (IHS) responsible for coordinating partnerships with LCME- and COCA-accredited medical schools and ACGME-accredited residency programs (Directive to Take Action); and be it further

RECOMMENDATION B:

The second Resolve of Resolution 305 be amended by addition and deletion, to read as follows:

RESOLVED, That our AMA ~~support~~ encourage the development of ~~novel graduate medical education (GME)~~ novel graduate medical education (GME) funding streams to promote rotations and learning opportunities for full-time positions at Indian Health Service, Tribal, and Urban Indian Health Programs. (New HOD Policy)

RECOMMENDATION C:

Resolution 305 be adopted as amended.

HOD ACTION: Resolution 305 adopted as amended

RESOLVED, That our American Medical Association advocate for the establishment of an Office of Academic Affiliations with the Indian Health Service (IHS) responsible for coordinating partnerships with LCME- and COCA-accredited medical schools and ACGME-accredited residency programs (Directive to Take Action); and be it further

RESOLVED, That our AMA support the development of novel graduate medical education (GME) funding streams for full-time positions at Indian Health Service, Tribal, and Urban Indian Health Programs. (New HOD Policy)

Resolution 305 received supportive online and live testimony. The Council on Medical Education offered amendments to both resolves to clarify intent. Testimony also suggested that Section 403 of the Mission Act, which explores funding GME training off the traditional Veterans Affairs campus at Indian Health Service and other tribal health care facilities, addresses the second resolve. Reference Committee review of Section 403 showed that it is a pilot program that only partially addresses the ask in the second resolve.

1 Other testimony supported funding streams for additional educational opportunities.
2 Therefore, your Reference Committee recommends that Resolution 305 be adopted as
3 amended.

4
5 (13) RESOLUTION 306 – INCREASED EDUCATION AND
6 ACCESS TO FERTILITY RESOURCES FOR U.S.
7 MEDICAL STUDENTS
8

9 **RECOMMENDATION A:**

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11 **The first Resolve of Resolution 306 be amended by**
12 **addition and deletion, to read as follows:**

13
14 **RESOLVED, That our American Medical Association**
15 **~~work with the Association of American Medical~~**
16 **~~Colleges and other appropriate organizations~~**
17 **encourage interested parties to develop gender- and**
18 **sexual minority-inclusive initiatives in medical**
19 **education that raise awareness about (1) how peak**
20 **child-bearing years correspond to the peak career-**
21 **building years for many medical students and trainees;**
22 **(2) the significant decline in oocyte quality and quantity**
23 **and increase in miscarriage and infertility rates, with**
24 **increasing age in medical students and trainees; (3) the**
25 **high rate of infertility among medical students, trainees,**
26 **and physicians; and (4) various fertility preservation**
27 **options and including cryopreservation of oocytes and**
28 **sperm and associated costs (Directive to Take Action);**
29 **and be it further**
30

31 **RECOMMENDATION B:**

32
33 **The second Resolve of Resolution 306 be amended by**
34 **addition and deletion, to read as follows:**

35
36 **RESOLVED, That our AMA ~~work with relevant~~**
37 **~~organizations~~ encourage interested parties to increase**
38 **access to strategies by which medical students can**
39 **preserve fertility (such as cryopreservation of oocytes,**
40 **sperm, and embryos), with associated mechanisms for**
41 **insurance coverage. (Directive to Take Action)**
42

43 **RECOMMENDATION C:**

44
45 **Resolution 306 be adopted as amended.**

46
47 **HOD ACTION: Resolution 306 adopted as amended.**

1 RESOLVED, That our American Medical Association work with the Association of
 2 American Medical Colleges and other appropriate organizations to develop gender- and
 3 sexual minority-inclusive initiatives in medical education that raise awareness about (1)
 4 how peak child-bearing years correspond to the peak career-building years for many
 5 medical students and trainees; (2) the significant decline in oocyte quality and quantity
 6 and increase in miscarriage and infertility rates, with increasing age in medical students
 7 and trainees; (3) the high rate of infertility among medical students, trainees, and
 8 physicians; and (4) various fertility preservation options and including cryopreservation of
 9 oocytes and sperm and associated costs (Directive to Take Action); and be it further

10
 11 RESOLVED, That our AMA work with relevant organizations to increase access to
 12 strategies by which medical students can preserve fertility (such as cryopreservation of
 13 oocytes, sperm, and embryos), with associated mechanisms for insurance coverage.
 14 (Directive to Take Action)

15
 16 Resolution 306 received online and live testimony in support of this item. The Council on
 17 Medical Education was concerned that the first resolve might imply a medical education
 18 mandate; however, the Council expressed support for the second resolve. Your Reference
 19 Committee appreciates the Council's concerns and therefore has proposed amendments
 20 to the first resolve to remove the perceived mandate. In addition, your Reference
 21 Committee recommends inclusion of all interested parties in this work and that Resolution
 22 306 be adopted as amended.

23
 24 (14) RESOLUTION 307 – AMENDING AMA POLICY H-
 25 295.858, “ACCESS TO CONFIDENTIAL HEALTH
 26 SERVICES FOR MEDICAL STUDENTS AND
 27 PHYSICIANS” TO INCLUDE ANNUAL OPT-OUT MENTAL
 28 HEALTH SCREENING FOR SUICIDE PREVENTION FOR
 29 RESIDENTS

30 31 **RECOMMENDATION A:**

32
 33 **The first Resolve of Resolution 307 be amended by**
 34 **addition and deletion, to read as follows:**

- 35
 36 **3. Our AMA encourages medical schools undergraduate**
 37 **and graduate medical education programs to create**
 38 **mental health, and substance abuse awareness, and**
 39 **suicide prevention screening programs that would:**
 40 **A. be available to all medical students, residents, and**
 41 **fellows on an opt-out basis**
 42 **B. ensure anonymity, confidentiality, and protection**
 43 **from administrative action;**
 44 **C. provide proactive intervention for identified at-risk**
 45 **students by mental health and addiction**
 46 **professionals; and**
 47 **D. inform students and faculty about personal mental**
 48 **health, substance use and addiction, and other risk**
 49 **factors that may contribute to suicidal ideation.**

RECOMMENDATION B:**Resolution 307 be adopted as amended.****HOD ACTION: Resolution 307 adopted as amended.**

RESOLVED, That our American Medical Association policy [H-295.858](#), "Access to Confidential Health Services for Medical Students and Physicians," be amended by addition and deletion to read as follows:

Access to Confidential Health Services for Medical Students and Physicians H-295.858

1. Our AMA will ask the Liaison Committee on Medical Education, Commission on Osteopathic College Accreditation, American Osteopathic Association, and Accreditation Council for Graduate Medical Education to encourage medical schools and residency/fellowship programs, respectively, to:
 - A. Provide or facilitate the immediate availability of urgent and emergent access to low-cost, confidential health care, including mental health and substance use disorder counseling services, that:
 - (1) include appropriate follow-up; (2) are outside the trainees' grading and evaluation pathways; and (3) are available (based on patient preference and need for assurance of confidentiality) in reasonable proximity to the education/training site, at an external site, or through telemedicine or other virtual, online means;
 - B. Ensure that residency/fellowship programs are abiding by all duty hour restrictions, as these regulations exist in part to ensure the mental and physical health of trainees;
 - C. Encourage and promote routine health screening among medical students and resident/fellow physicians, and consider designating some segment of already-allocated personal time off (if necessary, during scheduled work hours) specifically for routine health screening and preventive services, including physical, mental, and dental care; and
 - D. Remind trainees and practicing physicians to avail themselves of any needed resources, both within and external to their institution, to provide for their mental and physical health and well-being, as a component of their professional obligation to ensure their own fitness for duty and the need to prioritize patient safety and quality of care by ensuring appropriate self-care, not working when sick, and following generally accepted guidelines for a healthy lifestyle.
2. Our AMA will urge state medical boards to refrain from asking applicants about past history of mental health or substance use disorder diagnosis or treatment, and only focus on current impairment by mental illness or addiction, and to accept "safe haven" non-reporting for physicians seeking licensure or relicensure who are undergoing treatment for mental health or addiction issues, to help ensure confidentiality of such treatment for the individual physician while providing assurance of patient safety.
3. Our AMA encourages ~~medical schools~~ undergraduate and graduate medical programs to create mental health and substance abuse awareness and suicide prevention screening programs that would:

- A. be available to all medical students, residents, and fellows on an opt-out basis
 - B. ensure anonymity, confidentiality, and protection from administrative action;
 - C. provide proactive intervention for identified at-risk students by mental health and addiction professionals; and
 - D. inform students and faculty about personal mental health, substance use and addiction, and other risk factors that may contribute to suicidal ideation.
4. Our AMA: (a) encourages state medical boards to consider physical and mental conditions similarly; (b) encourages state medical boards to recognize that the presence of a mental health condition does not necessarily equate with an impaired ability to practice medicine; and (c) encourages state medical societies to advocate that state medical boards not sanction physicians based solely on the presence of a psychiatric disease, irrespective of treatment or behavior.
 5. Our AMA: (a) encourages study of medical student mental health, including but not limited to rates and risk factors of depression and suicide; (b) encourages medical schools to confidentially gather and release information regarding reporting rates of depression/suicide on an opt-out basis from its students; and (c) will work with other interested parties to encourage research into identifying and addressing modifiable risk factors for burnout, depression and suicide across the continuum of medical education
 6. Our AMA encourages the development of alternative methods for dealing with the problems of student-physician mental health among medical schools, such as: (a) introduction to the concepts of physician impairment at orientation; (b) ongoing support groups, consisting of students and house staff in various stages of their education; (c) journal clubs; (d) fraternities; (e) support of the concepts of physical and mental well-being by heads of departments, as well as other faculty members; and/or (f) the opportunity for interested students and house staff to work with students who are having difficulty. Our AMA supports making these alternatives available to students at the earliest possible point in their medical education.
 7. Our AMA will engage with the appropriate organizations to facilitate the development of educational resources and training related to suicide risk of patients, medical students, residents/fellows, practicing physicians, and other health care professionals, using an evidence-based multidisciplinary approach. (Modify Current HOD Policy)

Resolution 307 seeks to amend the third clause of AMA Policy [H-295.858](#). This item received supportive online and live testimony. Testimony also referenced the timeliness of this resolution in light of a recent resident suicide and noted institutional success in offering support services through dedicated counseling and psychological services (e.g., CAPS) instead of traditional student health services. The Council on Medical Education offered an amendment to the third clause of Policy H-295.858 to explicitly include undergraduate and graduate medical education. Additional testimony also offered amendments to amend “substance abuse” to the more appropriate term “substance use.” Your Reference Committee agrees and recommends that Resolution 307 be adopted as amended.

(15) RESOLUTION 311 – RESIDENCY APPLICATION
SUPPORT FOR STUDENTS OF LOW-INCOME
BACKGROUNDS

RECOMMENDATION A:

The first Resolve of Resolution 311 be amended by deletion, to read as follows:

~~RESOLVED, That our American Medical Association advocate for residency application platforms that are no-cost to all residency applicants (Directive to Take Action); and be it further~~

RECOMMENDATION B:

The second Resolve of Resolution 311 be amended by addition, to read as follows:

RESOLVED, That our AMA support that residency and fellowship application services grant fee assistance to applicants who previously received fee assistance from medical school application services or are determined to have financial need through another formal mechanism. (New HOD Policy)

RECOMMENDATION C:

Resolution 311 be adopted as amended.

HOD ACTION: Resolution 311 adopted as amended.

RESOLVED, That our American Medical Association advocate for residency application platforms that are no-cost to all residency applicants (Directive to Take Action); and be it further

RESOLVED, That our AMA support that residency and fellowship application services grant fee assistance to applicants who previously received fee assistance from medical school application services. (New HOD Policy)

Resolution 311 received mixed testimony. While some testimony supported the entire item, others opposed the first resolve, noting possible unintended consequences of a no-cost application process. The Council on Medical Education suggested that the two resolves were not in alignment; hence, they recommended that the first resolve not be adopted and the second be amended to clarify the determination of financial need. The Council also referenced its new report, CME 2-A-23, as providing a comprehensive review of the current status of medical education financing. Your Reference Committee is sensitive to the concerns of the author and also appreciates the Council's guidance. Your Reference Committee therefore recommends that Resolution 311 be adopted as amended.

(16) RESOLUTION 314 - SUPPORT FOR INTERNATIONAL
MEDICAL GRADUATES FROM TURKEY

RECOMMENDATION A:

The first Resolve of Resolution 314 be amended by deletion, to read as follows:

~~RESOLVED, That our American Medical Association publicly recognize and express its support to immigrant physicians and trainees from Turkey (New HOD Policy); and be it further~~

RECOMMENDATION B:

The second Resolve of Resolution 314 be amended by deletion, to read as follows:

~~RESOLVED, That our AMA acknowledge and address interpersonal and acute systemic factors that negatively affect Turkish IMGs and their families (New HOD Policy); and be it further~~

RECOMMENDATION C:

Resolution 314 be adopted as amended.

RECOMMENDATION D:

The title of Resolution 314 be changed, to read as follows:

**SUPPORT FOR INTERNATIONAL MEDICAL
GRADUATES FROM COUNTRIES FACING MAJOR
HUMANITARIAN CRISES**

HOD ACTION: Resolution 314 adopted as amended with a change in title, to read as follows.

The third Resolve of Resolution 314 amended by addition, to read as follows:

RESOLVED, That our AMA affirm its support and advocate for immigrant physicians and trainees working in the United States when their country of origin faces major humanitarian crises, regardless of their country's political alignment, to promote an understanding of the challenges specific to immigrant physicians (Directive to Take Action); and be it further

**SUPPORT FOR INTERNATIONAL MEDICAL
GRADUATES FROM COUNTRIES FACING MAJOR
HUMANITARIAN CRISES**

RESOLVED, That our American Medical Association publicly recognize and express its support to immigrant physicians and trainees from Turkey (New HOD Policy); and be it further

RESOLVED, That our AMA acknowledge and address interpersonal and acute systemic factors that negatively affect Turkish IMGs and their families (New HOD Policy); and be it further

RESOLVED, That our AMA affirm its support and advocate for immigrant physicians and trainees working in the United States when their country of origin faces major humanitarian crises, to promote an understanding of the challenges specific to immigrant physicians (Directive to Take Action); and be it further

RESOLVED, That our AMA support the development and implementation of channels of communication for immigrant physicians to share their personal and professional journey when facing severe destruction, humanitarian crises, or personal losses in their country of origin, contributing therefore to improving the understanding of the difficulties faced by immigrant physicians. (New HOD Policy)

Resolution 314 received testimony acknowledging the impact on IMGs of humanitarian crises that may occur in their country of origin, and thus were in support of the third and fourth resolves, but in opposition to the first and second resolves. Testimony expressed concern that the first resolve is too narrowly focused on only the terrible events in Turkey, and the second resolve presents unclear fiscal implications. Your Reference Committee agrees with the testimony and recommends that Resolution 314 be adopted as amended, with deletion of the first and second resolves.

(17) **RESOLUTION 316 – PHYSICIAN MEDICAL
CONDITIONS AND QUESTIONS ON APPLICATIONS
FOR MEDICAL LICENSURE, SPECIALTY BOARDS, AND
INSTITUTIONAL PRIVILEGES**

RECOMMENDATION A:

Resolution 316 be amended by addition and deletion, to read as follows:

RESOLVED, That our American Medical Association amend Policy H-275.970, Licensure Confidentiality, by addition to read as follows:

1. The AMA (a) encourages specialty boards, hospitals, and other organizations involved in credentialing and/or privileging, as well as state licensing boards, to take all necessary steps to assure the confidentiality of information contained on application forms for credentials; (b) encourages boards these entities to

1 include in application forms only requests for
2 information that can reasonably be related to medical
3 practice; (c) encourages state licensing boards,
4 specialty boards, hospitals and other organizations
5 involved in credentialing and/or privileging to exclude
6 from license application forms and associated
7 application forms including credentialing/privileging
8 application forms information that refers to
9 psychoanalysis, counseling, or psychotherapy
10 required or undertaken as part of medical training; (d)
11 encourages state medical societies and specialty
12 societies to join with the AMA in efforts to change
13 statutes and regulations to provide needed
14 confidentiality for information collected by licensing
15 boards and related organizations; and (e) encourages
16 state licensing boards, specialty boards, hospitals and
17 other organizations involved in credentialing and/or
18 privileging to require disclosure of physical or mental
19 health conditions only when a physician is suffering
20 from any condition that currently impairs their his/her
21 judgment or that would otherwise adversely affect their
22 his/her ability to practice medicine in a competent,
23 ethical, and professional manner, or when the
24 physician presents a public health danger.

25 2. Our AMA will encourage will verify that, by 2024,
26 those state medical boards, specialty boards, hospitals,
27 and other organizations involved in
28 credentialing/privileging that wish to retain questions
29 about the health of applicants on medical licensing
30 applications use language consistent with that
31 recommended by the Federation of State Medical
32 Boards, which reads, "Are you currently suffering from
33 any condition for which you are not being appropriately
34 treated that impairs your judgment or that would
35 otherwise adversely affect your ability to practice
36 medicine in a competent, ethical and professional
37 manner? (Yes/No)."

38
39 3. Our AMA will work with the Federation of State
40 Medical Boards, the American Hospital Association, the
41 American Board of Medical Specialties, and state
42 medical societies to develop policies and strategies to
43 ensure that by 2024 all new and renewal medical
44 licensure and associated applications and application
45 reference forms, privileging, credentialing and related
46 applications and documentation will request or
47 disclose only information that is reasonably needed to
48 address the applicant's current fitness to practice
49 medicine and respect the privacy of physician's

1 protected health information. (Modify Current HOD
2 Policy)

3
4 **RECOMMENDATION B:**

5
6 **Resolution 316 be adopted as amended.**

7
8 **HOD ACTION: Resolution 316 adopted as amended**

9
10 RESOLVED, That our American Medical Association amend Policy H-275.970, Licensure
11 Confidentiality, by addition to read as follows:

12
13 1. The AMA (a) encourages specialty boards, hospitals, and other organizations involved
14 in credentialing and/or privileging, as well as state licensing boards, to take all necessary
15 steps to assure the confidentiality of information contained on application forms for
16 credentials; (b) encourages boards these entities to include in application forms only
17 requests for information that can reasonably be related to medical practice; (c) encourages
18 state licensing boards, specialty boards, hospitals and other organizations involved in
19 credentialing and/or privileging to exclude from license application forms and associated
20 application forms including credentialing/privileging application forms information that
21 refers to psychoanalysis, counseling, or psychotherapy required or undertaken as part of
22 medical training; (d) encourages state medical societies and specialty societies to join with
23 the AMA in efforts to change statutes and regulations to provide needed confidentiality for
24 information collected by licensing boards and related organizations; and (e) encourages
25 state licensing boards, specialty boards, hospitals and other organizations involved in
26 credentialing and/or privileging to require disclosure of physical or mental health
27 conditions only when a physician is suffering from any condition that currently impairs
28 his/her judgment or that would otherwise adversely affect his/her ability to practice
29 medicine in a competent, ethical, and professional manner, or when the physician
30 presents a public health danger.

31
32 2. Our AMA will encourage will verify that, by 2024, those state medical boards, specialty
33 boards, hospitals, and other organizations involved in credentialing/privileging that wish to
34 retain questions about the health of applicants on medical licensing applications use
35 language consistent with that recommended by the Federation of State Medical Boards,
36 which reads, "Are you currently suffering from any condition for which you are not being
37 appropriately treated that impairs your judgment or that would otherwise adversely affect
38 your ability to practice medicine in a competent, ethical and professional manner?
39 (Yes/No)."

3. Our AMA will work with the Federation of State Medical Boards, the American Hospital Association, the American Board of Medical Specialties, and state medical societies to develop policies and strategies to ensure that by 2024 all new and renewal medical licensure and associated applications and application reference forms, privileging, credentialing and related applications and documentation will request or disclose only information that is reasonably needed to address the applicant's current fitness to practice medicine and respect the privacy of physician's protected health information. (Modify Current HOD Policy)

Resolution 316 seeks to amend AMA Policy [H-275.970](#). This item received supportive testimony. The Council on Medical Education offered testimony that concurred with the author's amendments to the first clause but recommended changing the author's amendment in the second clause from "will verify that" to "encourage" given the AMA's lack of authority or ability to verify. The Council also recommended removal of "by 2024" in the second and third resolves because the AMA lacks the authority to impose such a deadline. In addition, your Reference Committee recommended the use of gender-neutral language. Further testimony supported the Council's testimony, including that of the Council on Legislation. Your Reference Committee appreciates the input of these Councils and recommends that Resolution 316 be adopted as amended.

(18) RESOLUTION 319 – SUPPORTING DIVERSITY, EQUITY, & INCLUSION OFFICES AND INITIATIVES AT UNITED STATES MEDICAL SCHOOLS TO ENHANCE LONGITUDINAL COMMUNITY ENGAGEMENT

RECOMMENDATION A:

The third Resolve of Resolution 319 be amended by addition and deletion, to read as follows:

RESOLVED, That our AMA amend D-295.963, Continued Support for Diversity in Medical Education, by addition and deletion to read as follows:

Our AMA will: (1) publicly state and reaffirm its stance on support for diversity in medical education and acknowledge the incorporation of DEI efforts as a vital aspect of medical training; (2) 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; (3) 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; and (4) advocate

for funding to support the creation and sustainability of Historically Black College and University (HBCU), Hispanic-Serving Institution (HSI), and Tribal College and University (TCU) affiliated medical schools and residency programs, with the goal of achieving a physician workforce that is proportional to the racial, ethnic, and gender composition of the United States population; (5) directly oppose any local, state, or federal actions that aim to limit diversity, equity, and inclusion initiatives, curriculum requirements, or funding in medical education; and (6) advocate for resources to establish and maintain DEI offices at medical schools that are staff-managed and student- and physician-guided as well as committed to longitudinal community engagement; and (7) investigate the impacts of state legislation regarding DEI-related efforts on the education and careers of students, trainees, and faculty.

RECOMMENDATION B:

Resolution 319 be adopted as amended.

HOD ACTION: Resolution 319 adopted as amended

RESOLVED, That our American Medical Association recognize the disproportionate efforts by and additional responsibilities placed on minoritized individuals to engage in diversity, equity, and inclusion efforts (New HOD Policy); and be it further

RESOLVED, That our AMA collaborate with the Association of American Medical Colleges, the Liaison Committee on Medical Education, and relevant stakeholders to encourage academic institutions to utilize Diversity, Equity, and Inclusion activities and community engagement as criteria for faculty and staff promotion and tenure (Directive to Take Action); and be it further

RESOLVED, That our AMA amend D-295.963, Continued Support for Diversity in Medical Education, by addition and deletion to read as follows:

Our AMA will: (1) publicly state and reaffirm its stance on support for diversity in medical education and acknowledge the incorporation of DEI efforts as a vital aspect of medical training; (2) 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; (3) 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; and (4) advocate for funding to support the creation and sustainability of Historically Black College and University (HBCU), Hispanic-Serving Institution (HSI), and Tribal College and University (TCU) affiliated medical

schools and residency programs, with the goal of achieving a physician workforce that is proportional to the racial, ethnic, and gender composition of the United States population; (5) directly oppose any local, state, or federal actions that aim to limit diversity, equity, and inclusion initiatives, curriculum requirements, or funding in medical education; and (6) advocate for resources to establish and maintain DEI offices at medical schools that are staff-managed and student- and physician-guided as well as committed to longitudinal community engagement.

Resolution 319 offered two new resolves as well as amendments to AMA Policy [D-295.963](#). While the abundance of testimony supported this resolution, concern was raised as to its potential impact on some states where funding may be affected. An amendment of an additional clause was offered to investigate the impacts of state legislation regarding DEI-related efforts on the education and careers of students, trainees, and faculty. The author of the resolution accepted this amendment. Therefore, your Reference Committee recommends that Resolution 319 be adopted as amended.

(19) RESOLUTION 321 – CORPORATE COMPLIANCE
CONSOLIDATION

RECOMMENDATION A:

The first Resolve of Resolution 321 be amended by deletion, to read as follows:

~~RESOLVED, That our American Medical Association work to create a minimum, standard curriculum for corporate compliance education requirements, the completion of which is acceptable to all stakeholders (Directive to Take Action); and be it further~~

RECOMMENDATION B:

The second Resolve of Resolution 321 be amended by addition and deletion, to read as follows:

~~RESOLVED, That our AMA advocate for satisfactory completion of the new approved standard~~ encourage reciprocity for corporate compliance curriculum between institutions to minimize duplicate training and assessment of physicians at one setting to fulfill the requirements of all settings that require such a mandate, to eliminate wasting of valuable physician time and effort. (Directive to Take Action)

RECOMMENDATION C:

Resolution 321 be adopted as amended.

HOD ACTION: Resolution 321 adopted as amended.

1 RESOLVED, That our American Medical Association work to create a minimum, standard
2 curriculum for corporate compliance education requirements, the completion of which is
3 acceptable to all stakeholders (Directive to Take Action); and be it further

4
5 RESOLVED, That our AMA advocate for satisfactory completion of the new approved
6 standard corporate compliance curriculum at one setting to fulfill the requirements of all
7 settings that require such a mandate, to eliminate wasting of valuable physician time and
8 effort. (Directive to Take Action)

9
10 Resolution 321 received mixed testimony, noting physicians' frustration of having to
11 complete corporate compliance education requirements from multiple institutions as well
12 as desire for a universal solution to address what is seen as a duplicative unfunded
13 mandate on physicians' time and resources. Testimony expressed the lack of feasibility in
14 being able to implement a standard curriculum that appeases all institutions and
15 employers—each with their own legal requirements. Your Reference Committee noted
16 that the second resolve appears predicated on the success of the first resolve, which
17 testimony noted may not be feasible. Understanding the spirit of this resolution and
18 frustrations expressed, your Reference Committee clarified the language to accomplish
19 the goal of reciprocity to reduce redundancies and preserve physician time and effort.
20 Therefore, your Reference Committee recommends that Resolution 321 be adopted as
21 amended.

22
23 (20) RESOLUTION 322 – DISCLOSURE OF COMPLIANCE
24 ISSUES AND CREATING A NATIONAL DATABASE OF
25 JOINT LEADERSHIP

26
27 **RECOMMENDATION A:**

28
29 **The first Resolve of Resolution 322 be amended by**
30 **addition and deletion, to read as follows:**

31
32 **RESOLVED, That our American Medical Association**
33 **urge encourage the Accreditation Council for**
34 **Continuing Medical Education to ask accredited CME**
35 **providers to include in their CME applications for joint**
36 **providership a question about past denial(s) for**
37 **accreditation ~~require organizations that apply for joint~~**
38 **~~providership for accreditation of Continuing Medical~~**
39 **~~Education activities to disclose on its application if the~~**
40 **~~activity has previously been denied accreditation and~~**
41 **~~the reason for denial~~ (Directive to Take Action); and be**
42 **it further**

RECOMMENDATION B:

The second Resolve of Resolution 322 be amended by deletion, to read as follows:

~~RESOLVED, That our AMA urge the Accreditation Council for Continuing Medical Education to develop a national database for this information (in a manner similar to the Program and Activity Reporting System) which would allow State Medical Societies providers to cross-reference this information. (Directive to Take Action)~~

RECOMMENDATION C:

Resolution 322 be adopted as amended.

RECOMMENDATION D:

The title of Resolution 322 be changed, to read as follows:

DISCLOSURE OF COMPLIANCE ISSUES RELATED TO JOINT PROVIDERSHIP

HOD ACTION: Resolution 322 adopted as amended with a change in title:

DISCLOSURE OF COMPLIANCE ISSUES RELATED TO JOINT PROVIDERSHIP

RESOLVED, That our American Medical Association urge the Accreditation Council for Continuing Medical Education to require organizations that apply for joint providership for accreditation of Continuing Medical Education activities to disclose on its application if the activity has previously been denied accreditation and the reason for denial (Directive to Take Action); and be it further

RESOLVED, That our AMA urge the Accreditation Council for Continuing Medical Education to develop a national database for this information (in a manner similar to the Program and Activity Reporting System) which would allow State Medical Societies providers to cross-reference this information. (Directive to Take Action)

Testimony on Resolution 322 noted that the ACCME does not have any information on organizations that are not ACCME-accredited, so there would be no way to compile the data requested in the second resolve. The Council on Medical Education recommended that the first resolve be amended to encourage the ACCME to ask accredited CME providers about past denial(s) for accreditation in their CME applications for joint providership. The Council suggested the second resolve not be adopted as it is predicated on the first resolve and not something the ACCME can institute since they do not have purview over nonaccredited organizations seeking joint providership. Resolution 322

received testimony from the author suggesting a change in title from “joint leadership” to “joint providership.” Your Reference Committee was informed that “[joint providership](#)” is when an ACCME-accredited CME provider partners with a non-accredited organization on a learning activity. Your Reference Committee concurs with the guidance of the Council and therefore recommends that Resolution 322 be adopted as amended.

- (21) RESOLUTION 323 – AMEND POLICY D-275.948,
“EDUCATION, TRAINING AND CREDENTIALING OF
NON-PHYSICIAN HEALTH CARE PROFESSIONALS
AND THEIR IMPACT ON PHYSICIAN EDUCATION AND
TRAINING”

RECOMMENDATION A:

Resolution 323 be amended by addition and deletion, to read as follows:

RESOLVED, That our AMA amend policy D-275.948 by addition to read as follows:

1.) Our AMA acknowledges that a conflict of interest exists when non-physician health care professionals hold positions on physician regulatory bodies or physician boards when these individuals represent a field that either possesses or seeks to possess the ability to practice without physician supervision; and
2.) Our AMA will work with and advocate to encourage key regulatory bodies involved with physician education, accreditation, certification, licensing, and credentialing to: (1) increase transparency of the process by encouraging them to openly disclose how their board is composed and members are selected; and (2) review and amend their conflict of interest and other policies related to non-physician health care professionals holding formal leadership positions (e.g., board, committee) when that non-physician professional represents a field that either possesses or seeks to possess the ability to practice without physician supervision; and

3.) Our AMA opposes any non-physician having a voting position on a regulatory body or physician board responsible for physician education, accreditation, certification, licensing, or credentialing.

RECOMMENDATION B:

Resolution 323 be adopted as amended.

HOD ACTION: Resolution 323 adopted as amended.

1 RESOLVED, That our AMA amend policy D-275.948 by addition to read as follows:

2
3 1.) Our AMA acknowledges that a conflict of interest exists when non-physician health
4 care professionals hold positions on physician regulatory bodies or physician boards when
5 these individuals represent a field that either possesses or seeks to possess the ability to
6 practice without physician supervision; and

7
8 2). Our AMA will work with and advocate to key regulatory bodies involved with physician
9 education, accreditation, certification, licensing, and credentialing to: (1) increase
10 transparency of the process by encouraging them to openly disclose how their board is
11 composed and members are selected; and (2) review and amend their conflict of interest
12 and other policies related to non-physician health care professionals holding formal
13 leadership positions (e.g., board, committee) when that non-physician professional
14 represents a field that either possesses or seeks to possess the ability to practice without
15 physician supervision; and

16
17 3.) Our AMA opposes any non-physician having a voting position on a regulatory body or
18 physician board responsible for physician education, accreditation, certification, licensing,
19 or credentialing.

20
21 This resolution received testimony expressing concerns about conflict of interest and
22 scope issues, while also expressing the value of the representation of public members on
23 boards. Your Reference Committee noted that a resolution on this issue was brought forth
24 to the 2021 Special June Meeting, including language similar to the third resolve of this
25 resolution, and was referred. The Council on Medical Education studied the issue and
26 submitted CME 5-A-22, which was subsequently adopted by the HOD, resulting in
27 D-275.948—the policy this resolution seeks to amend. The Council on Medical Education
28 offered testimony in support of the new first clause from the author. They offered further
29 amendments to the second clause, suggesting the AMA “encourage” key regulatory
30 bodies. Also, they noted continued concerns about the third resolve, which was not
31 adopted at J-21, given potential negative implications for key interested parties and
32 relationships, and suggested it not be adopted. Your Reference Committee agrees with
33 the Council and recommends that Resolution 323 be adopted as amended.

RECOMMENDED FOR ADOPTION IN LIEU OF

- (22) COUNCIL ON MEDICAL EDUCATION REPORT 7 –
MANAGEMENT AND LEADERSHIP TRAINING IN
MEDICAL EDUCATION

RESOLUTION 318 – FOSTERING PATHWAYS
FOR RESIDENT PHYSICIANS TO PURSUE MBA
PROGRAMS IN ORDER TO INCREASE THE
NUMBER OF QUALIFIED PHYSICIANS FOR
HEALTHCARE LEADERSHIP POSITIONS

RECOMMENDATION:

Recommendations in Council on Medical Education
Report 7 be adopted in lieu of Resolution 318 and the
remainder of the report be filed.

HOD ACTION: Recommendations in Council on
Medical Education Report 7 adopted in lieu of
Resolution 318 and the remainder of the report filed.

1. That clause (1) of AMA policy [D-295.316](#) be rescinded as such directives have been accomplished per the actions, programs, and resources summarized in this report.

~~1. “Our AMA will study advantages and disadvantages of various educational options on management and leadership for physicians with a report back to the House of Delegates; and develop an online report and guide aimed at physicians interested in management and leadership that would include the advantages and disadvantages of various educational options.” (Rescind HOD Policy)~~

2. That clauses (2) and (3) of AMA policy D-295.316 be amended by addition and deletion to read as follows:

~~2. “Our AMA supports will work with key stakeholders to advocate for collaborative programs among medical schools, residency programs, and related schools of business and management to better give physicians the opportunity to assume for administrative, financial, and leadership responsibilities in medical management.”~~

~~3. “Our AMA: (a) will advocate for and supports and participates in the creation and promotion of management and leadership programs and curricula that emphasize experiential and active learning models to include knowledge, skills, and management techniques integral to achieving personal and professional financial literacy and leading interprofessional team health care teams, in the spirit of the AMA's Accelerating Change in Medical Education initiative; and (b) encourages will advocate with the Liaison Committee for Medical Education, Association of American Medical Colleges and other to the organizations governing bodies responsible for the education of future physicians to implement~~

1 ~~programs early in throughout~~ medical training to ~~promote the development of~~
2 ~~management and leadership competencies~~ and ~~personal and professional~~
3 ~~financial literacy capabilities.~~" (Modify Current HOD Policy)

- 4
5 3. That AMA policy D-295.316 be amended by addition of new clause (3c) to read as
6 follows:

7
8 Our AMA: (c) encourages key stakeholders to collect and analyze data on the
9 effectiveness of management and leadership training and share such information
10 with the medical education community. (Directive to Take Action)

- 11
12 4. That clause (4a) of AMA policy D-295.316 be rescinded, as having been accomplished
13 by the writing of this report.

14
15 Our AMA will: ~~(a) study the extent of the impact of AMA Policy D-295.316,~~
16 ~~"Management and Leadership for Physicians," on elective curriculum; and (b)~~
17 ~~expand efforts to promote the tenets of health systems science to prepare trainees~~
18 ~~for leadership roles and address prevalent challenges in the practice of medicine~~
19 ~~and public health.~~ (Rescind HOD Policy)

- 20
21 5. That AMA policy D-295.316 be amended by addition of a new clause (5), to read as
22 follows:

23
24 Our AMA will create a central online directory of its management and leadership
25 resources that is searchable on the AMA website and promote the directory and
26 these resources to AMA members and the medical education community.

27
28 Resolution 318:

29
30 RESOLVED, That our American Medical Association encourage education for medical
31 trainees in healthcare leadership, which may include additional degrees at the master's
32 level and/or certificate programs, in order to increase physician-led healthcare systems.
33 (New HOD Policy)

34
35 CME 7-A-23 received online and live testimony in support of this report. The Council on
36 Medical Education noted that this report is aligned with the spirit of Resolution 318, both
37 of which support leadership education. While Resolution 318 addresses additional
38 training, the Council report is broader and encourages various pathways of learning in
39 leadership and management. Your Reference Committee agrees and recommends that
40 Council Report 7 be adopted in lieu of Resolution 318.

(23) RESOLUTION 301 – INCREASING MUSCULOSKELETAL
EDUCATION IN PRIMARY CARE SPECIALTIES AND
MEDICAL SCHOOL EDUCATION THROUGH INCLUSION
OF OSTEOPATHIC MANUAL THERAPY EDUCATION

RESOLUTION 310 – TEACHING AND ASSESSING
OSTEOPATHIC MANIPULATIVE TREATMENT AND
OSTEOPATHIC PRINCIPLES AND PRACTICE TO
RESIDENT PHYSICIANS IN THE CONTEXT OF ACGME
SINGLE SYSTEM OF ACCREDITATION

RECOMMENDATION A:

**Alternate Resolution 301 be adopted in lieu of
Resolutions 301 and 310, to read as follows:**

**RESOLVED, That our American Medical Association
(AMA) continue to support equal treatment of
osteopathic students, trainees, and physicians in the
residency application cycle and workplace through
continued education on the training of osteopathic
physicians (New HOD Policy); and be it further**

**RESOLVED, That our AMA encourage physician
awareness of the benefits of evidence-based
Osteopathic Manipulative Medicine for musculoskeletal
conditions (New HOD Policy); and be it further**

**RESOLVED, That our AMA collaborate with the
Accreditation Council for Graduate Medical Education
(ACGME), the American Osteopathic Association
(AOA), and any other interested parties to assess the
need for graduate medical education faculty
development in the supervision of Osteopathic
Manipulative Medicine across ACGME-accredited
residency programs. (New HOD Policy)**

RECOMMENDATION B:

**The title of Resolution 301 be changed, to read as
follows:**

**TEACHING AND ASSESSING OSTEOPATHIC
MANIPULATIVE MEDICINE AND OSTEOPATHIC
PRINCIPLES AND PRACTICE**

**HOD ACTION: Alternate Resolution 301 adopted in lieu
of Resolutions 301 and 310, to read as follows with a
change in title:**

RESOLVED, That our American Medical Association (AMA) continue to support equal treatment of osteopathic students, trainees, and physicians in the residency application cycle and workplace through continued education on the training of osteopathic physicians (New HOD Policy); and be it further

RESOLVED, That our AMA encourage physician awareness of the benefits of evidence-based Osteopathic Manipulative Medicine for musculoskeletal conditions (New HOD Policy); and be it further

RESOLVED, That our AMA collaborate with the Accreditation Council for Graduate Medical Education (ACGME), the American Osteopathic Association (AOA), and any other interested parties to assess the need for graduate medical education faculty development in the supervision of Osteopathic Manipulative Medicine across ACGME-accredited residency programs. (New HOD Policy)

**TEACHING AND ASSESSING OSTEOPATHIC
MANIPULATIVE MEDICINE AND OSTEOPATHIC
PRINCIPLES AND PRACTICE**

Resolution 301:

RESOLVED, That our American Medical Association continue to support equal treatment of osteopathic students, trainees and physicians in the residency application cycle and workplace through continued education on the training of Osteopathic physicians (New HOD Policy); and be it further

RESOLVED, That our American Medical Association encourage education on the benefits of evidence-based Osteopathic Manual Therapy for musculoskeletal conditions in medical education of allopathic students and in primary care residencies. (New HOD Policy)

Resolution 310:

RESOLVED, That our American Medical Association collaborate with the Accreditation Council on Graduate Medical Education (ACGME), the American Osteopathic Association (AOA), and any other relevant stakeholders to investigate the need for graduate medical education faculty development in the supervision of Osteopathic Manipulative Treatment across ACGME accredited residency programs. (Directive to Take Action)

Resolution 301 received predominantly supportive online and live testimony. The American Osteopathic Association (AOA) and Student Osteopathic Medical Association offered amendments to correct terminology. The Council on Medical Education offered alternate language to combine Resolutions 301 and 310. Testimony supported the

evidence base for Osteopathic Manipulative Medicine (OMM). The American Osteopathic Association (AOA) testified that OMM is separate and unique from physical and occupational therapy. Testimony was also supportive of all physicians being exposed to osteopathic training so that they might better understand the differences in treatment. Your Reference Committee concurred with combining resolutions since they both address osteopathic medicine, appreciates the clarification of terminology by AOA, and agrees with the alternate language provided by the Council. Therefore, your Reference Committee recommends that alternate Resolution 301 be adopted in lieu of Resolutions 301 and 310.

(24) RESOLUTION 308 – INCREASED INCLUSIVITY AND
ADMISSION POLICIES CLARIFICATION FOR DACA
MEDICAL SCHOOL AND RESIDENCY APPLICANTS

RECOMMENDATION A:

**Alternate Resolution 308 be adopted in lieu of
Resolution 308, to read as follows:**

**RESOLVED, That our AMA (a) commend the
Association of American Medical Colleges (AAMC) for
its collection of data on medical schools that accept
applicants eligible for Deferred Action for Childhood
Arrivals (DACA) and encourage ongoing data
collection; (b) request that the AAMC expand its data
collection to include financial assistance options for
DACA-eligible students; and (c) publicize and
disseminate this information to interested parties.
(Directive to Take Action)**

RECOMMENDATION B:

**The title of Resolution 308 be changed, to read as
follows:**

**INCREASED INCLUSIVITY AND ADMISSION POLICIES
CLARIFICATION FOR DACA-ELIGIBLE MEDICAL
SCHOOL AND RESIDENCY APPLICANTS**

**HOD ACTION: Alternate Resolution 308 be adopted in
lieu of Resolution 308, to read as follows with a change
in title:**

**RESOLVED, That our AMA (a) commend the
Association of American Medical Colleges (AAMC) for
its collection of data on medical schools that accept
applicants eligible for Deferred Action for Childhood
Arrivals (DACA) and encourage ongoing data
collection; (b) request that the AAMC expand its data
collection to include financial assistance options for
DACA-eligible students; and (c) publicize and**

disseminate this information to interested parties.
(Directive to Take Action)

**INCREASED INCLUSIVITY AND ADMISSION POLICIES
CLARIFICATION FOR DACA-ELIGIBLE MEDICAL
SCHOOL AND RESIDENCY APPLICANTS**

RESOLVED, That our American Medical Association encourage transparency from institutions in the medical school application process for DACA recipients, including the following and on a national level when possible: (1) the percentage of Deferred Action for Childhood Arrivals applicants of total applicants, (2) the percentage of accepted Deferred Action for Childhood Arrivals applicants of total accepted applicants, (3) the percentage of matriculated Deferred Action for Childhood Arrivals students of total matriculated applicants, (4) financial aid and scholarship options available for Deferred Action for Childhood Arrivals applicants. (New HOD Policy)

Resolution 308 received mixed online and live testimony on this item. Testimony expressed concern for the potential unintended consequences of collecting data on DACA-eligible applicants, in particular potential discrimination against these applicants and cessation of funds to institutions who educate and train these applicants. Testimony was also given to express support for increased transparency from institutions that are willing to receive DACA-eligible applicants. Your Reference Committee recognizes this is a complex issue and identified existing resources for DACA-eligible applicants, such as the [2024 AAMC Medical School Admission Requirements™ \(MSAR®\) Report for Applicants and Advisors for Deferred Action for Childhood Arrivals \(DACA\)](#). Your Reference Committee appreciates the spirit of the author's intent and proposes an amendment to prioritize the safety of DACA-eligible applicants. Your Reference Committee recommends that Resolution 308 be adopted as amended.

(25) RESOLUTION 309 – AGAINST LEGACY PREFERENCES
AS A FACTOR IN MEDICAL SCHOOL ADMISSIONS

RECOMMENDATION:

**Alternate Resolution 309 be adopted in lieu of
Resolution 309, to read as follows:**

**RESOLVED, That our AMA recognize that legacy status
may be one of many stated reasons an applicant may
offer for interest in a particular medical school. Medical
schools are encouraged to avoid specific questions
about legacy status in their application process. (New
HOD Policy)**

HOD ACTION: Alternate Resolution 309 adopted in lieu of Resolution 309, to read as follows:

RESOLVED, That our AMA recognize that legacy status may be one of many stated reasons an applicant may offer for interest in a particular medical school, but oppose the use of questions about legacy status in the medical school application process due to their discriminatory impact. (New HOD Policy)

RESOLVED, That our American Medical Association recognize that legacy admissions are rooted in discriminatory practices (New HOD Policy); and be it further

RESOLVED, That our AMA oppose the use of legacy status as a screening tool for medical school admissions (New HOD Policy); and be it further

RESOLVED, That our AMA study the prevalence and impact of legacy status in medical school admissions. (Directive to Take Action)

Your Reference Committee heard testimony in support of this resolution. The authors testified as to the serious threat to medical student diversity posed by legacy admissions to medical school. They stated that the AMA “has championed policies that speak to the eradication of discriminatory practices in medical school admissions” and called for attention to legacy admissions as a critical aspect to further this work. Testimony reflected that legacy applicants benefit from a discriminatory practice, which should be ended to improve access for historically marginalized populations applying to medical school. The Council on Medical Education called for a nuanced view, such that an applicant could volunteer this information, while opposing the school specifically asking about legacy status in the application. Additional testimony also reflected that a study of the issue would not uncover any new or actionable information or data and might delay AMA action on this front. Accordingly, your Reference Committee recommends adoption of the alternate language as proposed.

(26) RESOLUTION 312 – INDIAN HEALTH SERVICE
LICENSING EXEMPTIONS

RECOMMENDATION:

Alternate Resolution 312 be adopted in lieu of Resolution 312, to read as follows:

RESOLVED, That our AMA work with interested parties to evaluate existing regulatory and licensure opportunities and barriers to physician participation in health care services for Native Americans, Alaska Natives, and Native Hawaiians. (Directive to Take Action)

HOD ACTION: Alternate Resolution 312 adopted in lieu of Resolution 312, to read as follows:

RESOLVED, That our AMA work with interested parties to evaluate existing regulatory and licensure opportunities and barriers to physician participation in health care services for Native Americans, Alaska Natives, and Native Hawaiians. (Directive to Take Action)

RESOLVED, That our American Medical Association advocate that physicians at Indian Health Service, Tribal, and Urban Indian Health Programs be exempt from duplicative licensure requirements, such as requirements for state licensure when these physicians are already federally licensed (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate that future health reform proposals include corresponding licensure and eligibility exceptions for Indian Health Service, Tribal, and Urban Indian Health Program facilities and physicians to ensure that these physicians can fully participate. (Directive to Take Action)

Resolution 312 received testimony expressing concern for issues facing physicians at Indian Health Service as well as Tribal and Urban Indian Health Programs. The Council on Medical Education noted that the first resolve references “federally licensed”; however, there is no federal licensure since only states license physicians. Federally employed physicians can use their state license in any federal facility across the country. The Council supported the spirit of the resolution, but noted concern that it may not represent all the affected communities. Therefore, the Council offered alternate language to clarify the issue and demonstrate support. The Board of Trustees offered testimony in strong support of the author’s intentions as well as the Council’s alternate language. Your Reference Committee understands the concerns of the author and appreciates the Council’s alternate language, which provides a more actionable approach to this issue, and therefore recommends adoption of alternate Resolution 312 in lieu of the original item.

(27) RESOLUTION 313 – FILTERING INTERNATIONAL MEDICAL GRADUATES DURING RESIDENCY OR FELLOWSHIP APPLICATIONS

RESOLUTION 315 – PROHIBIT DISCRIMINATORY ERAS® FILTERS IN NRMP MATCH

RECOMMENDATION:

Alternate Resolution 313 be adopted in lieu of Resolutions 313 and 315, to read as follows:

RESOLVED, That our AMA recognize the exclusion of certain residency applicants from consideration, such as international medical graduates (New HOD Policy); and be it further

RESOLVED, That our AMA oppose discriminatory use of filters designed to inequitably screen applicants using the Electronic Residency Application Service® (ERAS®) system. (Directive to Take Action)

HOD ACTION: Alternate Resolution 313 adopted in lieu of Resolutions 313 and 315, to read as follows:

RESOLVED, That our AMA recognize the exclusion of certain residency applicants from consideration, such as international medical graduates (New HOD Policy); and be it further

RESOLVED, That our AMA oppose discriminatory use of filters designed to inequitably screen applicants, including international medical graduates, using the Electronic Residency Application Service® (ERAS®) system. (Directive to Take Action)

Resolution 313:

RESOLVED, That our American Medical Association collaborate with relevant stakeholders to identify alternative methods of reducing the number of applications to review without using a discriminatory filtering system that deprives international medical graduates of equitable training opportunities (Direction to Take Action); and be it further

RESOLVED, That our AMA advocate for removal of the ability to filter out international medical graduates during application to a residency or fellowship. (Directive to Take Action)

Resolution 315:

RESOLVED, That our American Medical Association oppose the use of discriminatory filters for foreign graduates in the Electronic Residency Application Service® (ERAS®) system and aggressively work to eliminate discriminatory filters including, but not limited to, those based on foreign medical school training, that prevent international medical graduates and others from consideration based on merit. (Directive to Take Action)

Resolution 313 received favorable testimony, including testimony from the author that supported combining this item with Resolution 315, given the similarities of the respective items.

Resolution 315 received significant supportive testimony. Like Resolution 313, the author of Resolution 315 also supported combining the two items into one. The Council on Medical Education concurred and offered alternate language to aid in this goal, while strongly opposing the use of filters that discriminate against marginalized medical school graduates, including international medical graduates. Your Reference Committee believes in equity for all medical graduates and therefore recommends that alternate Resolution 313 be adopted in lieu of original Resolutions 313 and 315.

RECOMMENDED FOR REFERRAL FOR DECISION**(28) RESOLUTION 303 – MEDICAL SCHOOL MANAGEMENT
OF UNMATCHED MEDICAL STUDENTS****RECOMMENDATION:****Resolution 303 be referred for decision.****HOD ACTION: Resolution 303 referred for decision.**

RESOLVED, That our American Medical Association convene a task force of appropriate AMA councils, medical education organizations, licensing and credentialing boards, government bodies, impacted communities, and other relevant stakeholders to:

1. Study institutional and systemic factors associated with the unmatched medical graduate status, including, but not limited to:

- a) The GME bottleneck on training positions, including the balance of entry-level position and categorical/advanced positions;
- b) New medical schools and the expansion of medical school class sizes;
- c) Race, geography, income, wealth, primary language, gender, religion, ability, and other structural factors;
- d) Student loan debt;
- e) Predatory business practices by medical schools, loan agencies, private equity, and other groups that prioritize profit over student success rates;
- f) The context, history, and impact of past reports on the state of undergraduate medical education, including the Flexner Report;
- g) The format and variations of institutional and medical organization guidance on best practices to successful matching;

2. Develop best practices for medical schools and medical organizations to support unmatched medical graduates, including, but not limited to:

- a) Tools to identify and remediate students at high risk for not matching into GME programs;
- b) Adequate data on student success rates (e.g., by specialty), and factors associated with success in matching;
- c) Medical school responsibilities to unmatched medical students and graduates;
- d) Outcomes-based tuition relief or reimbursement for unmatched students, wherein, unmatched students are returned some component of their tuition to ease the financial burden of being unable to practice clinical medicine;
- e) Transparent, equity-based solutions to address and ameliorate any inequities identified in the match process;
- f) Alternative, cost-neutral, graduate-level degrees with earlier graduation for students at high risk for not matching;

g) Career opportunities for unmatched U.S. seniors and US-IMGs; and

3. Require transparency from stakeholders, including medical schools, about any actions taken based on the report of this task force, particularly with regard to the remediation of medical students. (Directive to Take Action)

1 Resolution 303 received online and live testimony on this item. While this resolution asks
2 for a task force, the Council on Medical Education shared that such a body exists in the
3 form of the Coalition for Physician Accountability, of which the AMA is an active member.
4 The Coalition's UME-to-GME Review Committee (UGRC) issued [recommendations](#) on
5 this topic. The Council also noted that the AMA has several policies that address the
6 various aspects of this resolution, and that they should be reaffirmed in lieu of this
7 resolution to avoid duplicative policy. The New England Delegation testified that the
8 recommendations of the UGRC focus on the transition from undergraduate medical
9 education to graduate medical education and did not think this reflected the intent of the
10 resolution. Your Reference Committee believes this is a complex issue involving multiple
11 interested parties with diverse viewpoints that need to be considered and recognizes this
12 is an urgent problem that highlights a misattunement of need and resources. Your
13 Reference Committee is also concerned that the right mechanism to address the concerns
14 of the resolution is unknown, and therefore recommends that Resolution 303 be referred
15 for decision.

- 1 This concludes the report of Reference Committee C. I would like to thank committee
- 2 members Shanna Combs, Cheryl Hurd, David Jakubowicz, Shaminy Manoranjithan,
- 3 Celeste Peay, and Christopher Wee; our AMA team Amber Ryan, Tanya Lopez, Fred
- 4 Lenhoff, and Richard Pan; and all those who testified before the committee.

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