## REPORTS OF THE COUNCIL ON MEDICAL EDUCATION

The following reports were presented by Krystal Tomei, MD, MPH, Chair:

### 1. COUNCIL ON MEDICAL EDUCATION SUNSET REVIEW OF 2015 HOUSE OF DELEGATES' POLICIES

*Reference committee hearing: see report of Reference Committee C.*

**HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS**
**REMAINDER OF REPORT FILED**

Policy G-600.110, "Sunset Mechanism for AMA Policy," calls for the decennial review of American Medical Association (AMA) policies to ensure that our AMA's policy database is current, coherent, and relevant:

1. As the House of Delegates adopts policies, a maximum ten-year time horizon shall exist. A policy will typically sunset after ten years unless action is taken by the House of Delegates to retain it. Any action of our AMA House that reaffirms or amends an existing policy position shall reset the sunset "clock," making the reaffirmed or amended policy viable for another 10years.

2. In the implementation and ongoing operation of our AMA policy sunset mechanism, the following procedures shall be followed: (a) Each year, the Speakers shall provide a list of policies that are subject to review under the policy sunset mechanism; (b) Such policies shall be assigned to the appropriate AMA councils for review; (c) Each AMA council that has been asked to review policies shall develop and submit a report to the House of Delegates identifying policies that are scheduled to sunset; (d) For each policy under review, the reviewing council can recommend one of the following actions: (i) retain the policy; (ii) sunset the policy; (iii) retain part of the policy; or (iv) reconcile the policy with more recent and like policy; (e) For each recommendation that it makes to retain a policy in any fashion, the reviewing council shall provide a succinct, but cogent justification; and (f) The Speakers shall determine the best way for the House of Delegates to handle the sunset reports.

3. Nothing in this policy shall prohibit a report to the HOD or resolution to sunset a policy earlier than its ten-year horizon if it is no longer relevant, has been superseded by a more current policy, or has been accomplished.

4. The AMA councils and the House of Delegates should conform to the following guidelines for sunset: (a) when a policy is no longer relevant or necessary; (b) when a policy or directive has been accomplished; or (c) when the policy or directive is part of an established AMA practice that is transparent to the House and codified elsewhere such as the AMA Bylaws or the AMA House of Delegates Reference Manual: Procedures, Policies and Practices.

5. The most recent policy shall be deemed to supersede contradictory past AMA policies.

6. Sunset policies will be retained in the AMA historical archives.

RECOMMENDATION

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.

Fiscal Note: $1,000.

APPENDIX: RECOMMENDED ACTIONS

| | Policy Number | Title | Text | Recommendation |
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| 1 | D-275.957 | An Update on Maintenance of Licensure | Our American Medical Association will:<br>1. Continue to monitor the evolution of Maintenance of Licensure (MOL), continue its active engagement in discussions regarding MOL implementation, and report back to the House of Delegates on this issue.<br>2. Continue to review, through its Council on Medical Education, published literature and emerging data as part of the Council's ongoing efforts to critically review MOL issues.<br>3. Work with the Federation of State Medical Boards (FSMB) to study whether the principles of MOL are important factors in a physician's decision to retire or have a direct impact on the U.S. physician workforce.<br>4. Work with interested state medical societies and support collaboration with state specialty medical societies and state medical boards on establishing criteria and regulations for the implementation of MOL that reflect AMA guidelines for implementation of state MOL programs and the FSMB's Guiding Principles for MOL.<br>5. Explore the feasibility of developing, in collaboration with other stakeholders, AMA products and services that may help shape and support MOL for physicians.<br>6. Encourage the FSMB to continue to work with state medical boards to accept physician participation in the American Board of Medical Specialties maintenance of certification (MOC) and the American Osteopathic Association Bureau of Osteopathic Specialists (AOA-BOS) osteopathic continuous certification (OCC) as meeting the requirements for MOL and to develop alternatives for physicians who are not certified/recertified, and advocate that MOC or OCC not be the only pathway to MOL for physicians.<br>7. Continue to work with the FSMB to establish and assess MOL principles, with the AMA to assess the impact of MOL on the practicing physician and the FSMB to study its impact on state medical boards.<br>8. Encourage rigorous evaluation of the impact on physicians of any future proposed changes to MOL processes, including cost, staffing, and time. | **Rescind – no longer relevant.**<br><br>Federation of State Medical Boards (FSMB) is not advancing Maintenance of Licensure (MOL) and has archived their MOL policies. |

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| 2 | D-275.973 | Essentials for Approval of Examining Boards in Medical Specialties | Our AMA approves the twelfth revision of the Essentials for the Approval of Examining Boards in Medical Specialties. | **Rescind – no longer relevant.**<br><br>AMA is no longer part of the American Board of Medical Specialties (ABMS) approval process. "Essentials" policy is now called "Admission of new medical specialty boards to membership in the ABMS" (policy 1.8, adopted Oct 2023). |
| 3 | D-275.975 | Sharing of Medical Disciplinary Data Among Nations | Our AMA will, in conjunction with the Federation of State Medical Boards, support the efforts of the International Association of Medical Regulatory Authorities in its current efforts toward the exchange of information among medical regulatory authorities worldwide. | **Retain – still relevant.**<br><br>FSMB was a founder of the International Association of Medical Regulatory Authorities (IAMRA) and its Secretariat continues to be supported by FSMB. |
| 4 | D-295.315 | Enhancing the AMA's Role in Premedical Education | Our AMA will: (1) update its "Becoming a Physician" website with most relevant information to enhance usage and usability, and support the concept and explore the feasibility of enhancing current AMA online resources for premedical students; (2) explore the feasibility of developing innovative online "premedical" engagement activities that are affordable to students and cost-effective for our AMA and have value to medical school admissions personnel; and (3) explore the feasibility of developing resources to enhance premedical student advising and mentoring by physicians and others. | **Rescind – accomplished.**<br><br>Program/website is now defunct. |
| 5 | D-305.965 | Alternative Funding for Continuing Medical Education | 1. Our AMA will seek funding for quality, unbiased continuing medical education for all physicians.<br><br>2. Our AMA supports physician autonomy by partnering with relevant organizations to encourage medical organizations or institutions that employ physicians and offer financial support towards continuing medical education (CME) to avoid prioritizing institutional goals over individual physician educational needs in the choice of CME coursework. | **Rescind clause (1) – accomplished.**<br>**Retain clause (2) – still relevant.**<br><br>(1) The House action was communicated to the Association of American Medical Colleges (AAMC), American Hospital Association, Medical Group Management Association, and Veterans Affairs as well as medical schools, residency program directors, directors of medical education at U.S. teaching hospitals, and other interested groups via the Med Ed Update newsletter. |
| 6 | D-310.952 | Mitigation of Physician Performance Metrics on Trainee Education | Our American Medical Association will ask the Accreditation Council for Graduate Medical Education and other organizations to use data to evaluate the impact of supervising physicians? performance metrics on trainees? learning experience. | **Rescind – accomplished.**<br><br>Accreditation Council for Graduate Medical Education and AAMC were notified of the House action. It was also shared with medical schools, residency program directors, directors of medical education at U.S. teaching hospitals, and other interested groups via AMA Med Ed Update newsletter. |

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| 7 | D-405.984 | Confidentiality of Enrollment in Physicians (Professional) Health Programs | 1. Our American Medical Association will work with other medical professional organizations, the Federation of State Medical Boards, the American Board of Medical Specialties, and the Federation of State Physician Health Programs, to seek and/or support rules and regulations or legislation to provide for confidentiality of fully compliant participants in physician (and similar) health programs or their recovery programs in responding to questions on medical practice or licensure applications.<br>2. Our AMA will work with The Joint Commission, national hospital associations, national health insurer organizations, and the Centers for Medicare and Medicaid Services to avoid questions on their applications that would jeopardize the confidentiality of applicants who are compliant with treatment within professional health programs and who do not constitute a current threat to the care of themselves or their patients. | **Retain – still relevant.** |
| 8 | H-225.960 | Voluntary Use of Hospitalists and Required Consent | It is the policy of our AMA that the use of a hospitalist physician as the physician of record during a hospitalization must be voluntary and the assignment of responsibility to the hospitalist physician must be based on the consent of the patient's personal physician and the patient. | **Retain – still relevant.** |
| 9 | H-255.983 | Graduates of Non-United States Medical Schools | The AMA continues to support the policy that all physicians and medical students should be evaluated for purposes of entry into graduate medical education programs, licensure, and hospital medical staff privileges on the basis of their individual qualifications, skills, and character. | **Rescind – duplicative.**<br><br>Addressed by more recent policies that provide greater clarity on the assessment of students and physicians entering GME.<br>• H-275.934<br>• D-310.945<br>• H-295.895<br>Also, title is inaccurate since it is about “non-U.S.” graduates while policy is much broader. |
| 10 | H-255.989 | A Program for Exchange Visitor Physicians | (1) It is the AMA's policy to separate the issues involved in the support of alien physicians participating in exchange visitor physician programs for purposes of education, training and/or research followed by return to their native lands from the issues involving U.S. citizens who are graduates of foreign medical schools and alien physician graduates of foreign medical schools who seek permanent residence in the United States. | **Retain – still relevant. Amend title and clause (1) to update language as follows:**<br><br>~~A PROGRAM FOR~~ EXCHANGE PROGRAMS FOR VISITOR PHYSICIANS<br><br>(1) ~~It is the~~ AMA~~'s policy to separate the issues involved in the~~ supports ~~of alien~~ non-citizen physicians participating in exchange visitor |

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| | | | (2) The AMA urges government and private funding of the physician exchange visitor program under the auspices of an appropriate organization that will: consider the range and type of medical education and health care needs of those foreign nations sending exchange visitor physicians; the means to evaluate the level of knowledge and needs of prospective participants in graduate medical education programs; and identify truly outstanding public health, geographic medicine, basic medical science, and clinical training programs to answer the needs of the visitor's native land. | physician programs for purposes of education, training and/or research followed by return to their ~~native~~ home ~~lands~~ country. This is separate from the issues involving U.S. citizens who are graduates of foreign medical schools and ~~alien~~ non-citizen physician graduates of foreign medical schools who seek permanent residence in the U.S. ~~United States~~. |
| 11 | H-255.994 | Physician Exemption from Medical School Standards and Performance Evaluation Requirements | Our AMA recommends to medical licensing boards that those physicians who are international medical graduates currently duly licensed by any licensing jurisdiction in the U.S. should not be denied endorsement of their licenses, or denied admission to reexamination when this is required by law, solely because they are unable to provide documentation of graduation from a school meeting "equivalent standards and performance evaluation requirements" to those of programs accredited by the Liaison Committee on Medical Education. | **Retain – still relevant.** |
| 12 | H-275.917 | An Update on Maintenance of Licensure | AMA Principles on Maintenance of Licensure (MOL):<br>1. Our American Medical Association (AMA) established the following guidelines for implementation of state MOL programs:<br>A. Any MOL activity should be able to be integrated into the existing infrastructure of the health care environment.<br>B. Any MOL educational activity under consideration should be developed in collaboration with physicians, should be evidence-based and should be practice-specific. Accountability for physicians should be led by physicians.<br>C. Any proposed MOL activity should undergo an in-depth analysis of the direct and indirect costs, including physicians' time and the impact on patient access to care, as well as a risk/benefit analysis, with particular attention to unintended consequences.<br>D. Any MOL activity should be flexible and offer a variety of compliance options for all physicians, practicing or non-practicing, which may vary depending on their roles (e.g., clinical care, research, administration, education).<br>E. Any MOL activity should be designed for quality improvement and lifelong | **Rescind clauses (1), (2), (3B-D) – no longer relevant.**<br><br>FSMB is not advancing MOL and has archived their MOL policies.<br><br>**Retain clause (3A) – still relevant. Amend title and clause to update language as follows:**<br><br>~~AN UPDATE ON MAINTENANCE OF LICENSURE~~<br>ACCEPTANCE OF AMA PRA CREDIT AS EVIDENCE OF CONTINUING MEDICAL EDUCATION<br>~~3.~~ Our AMA will:<br>~~A. C~~ continue to support and promote the AMA Physician's Recognition Award (PRA) Credit system as one of the three major continuing medical education (CME) credit systems that comprise the foundation for continuing medical education in the U.S., including the Performance Improvement CME (PICME) format, and continue to develop relationships and agreements that may lead to standards accepted by all U.S. |

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| | | | learning.<br>F. Participation in quality improvement activities, such as chart review, should be an option as an MOL activity.<br><br>2. Our AMA supports the Federation of State Medical Boards Guiding Principles for MOL (current as of June 2015), which state that:<br>A. Maintenance of licensure should support physicians' commitment to lifelong learning and facilitate improvement in physician practice.<br>B. Maintenance of licensure systems should be administratively feasible and should be developed in collaboration with other stakeholders. The authority for establishing MOL requirements should remain within the purview of state medical boards.<br>C. Maintenance of licensure should not compromise patient care or create barriers to physician practice.<br>D. The infrastructure to support physician compliance with MOL requirements must be flexible and offer a choice of options for meeting requirements.<br>E. Maintenance of licensure processes should balance transparency with privacy protections (e.g., should capture what most physicians are already doing, not be onerous, etc.).<br><br>3. Our AMA will:<br>A. Continue to support and promote the AMA Physician's Recognition Award (PRA) Credit system as one of the three major CME credit systems that comprise the foundation for continuing medical education in the U.S., including the Performance Improvement CME (PICME) format, and continue to develop relationships and agreements that may lead to standards accepted by all U.S. licensing boards, specialty boards, hospital credentialing bodies, and other entities requiring evidence of physician CME as part of the process for MOL.<br>B. Advocate that if state medical boards move forward with a more intense or rigorous MOL program, each state medical board be required to accept evidence of successful ongoing participation in the ABMS MOC and AOA-Bureau of Osteopathic Specialists Osteopathic Continuous Certification to have fulfilled all three components of the MOL, if performed, | licensing boards, specialty boards, hospital credentialing bodies, and other entities requiring evidence of physician CME ~~as part of the process for MOL~~. |

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| | | | C. Advocate that state medical boards accept programs created by specialty societies as evidence that the physician is participating in continuous lifelong learning and allow physicians to choose which programs they participate in to fulfill their MOL criteria.<br>D. Oppose any MOL initiative that creates barriers to practice, is administratively unfeasible, is inflexible with regard to how physicians practice (clinically or not), does not protect physician privacy, or is used to promote policy initiatives about physician competence. | |
| 13 | H-295.859 | Guidelines for Students Shadowing Physicians | Our American Medical Association: (1) encourages physicians in both private practice and academic settings to provide shadowing opportunities to students interested in a career in medicine--particularly those from underrepresented populations--as part of the physician's commitment to the future of the profession; (2) encourages physicians to adopt the most appropriate shadowing model to the needs of the practice/institution and the student(s); and (3) endorses the clinical shadowing guidelines for students from the Association of American Medical Colleges as one model for such students and will help disseminate this document to K-12 students, premedical students, health professions advisors, hospitals, and physicians. | **Retain clauses (1), (2) - still relevant.**<br><br>**Rescind clause (3) – accomplished.**<br><br>House action was communicated to medical students, medical schools, residency program directors, directors of medical education at U.S. teaching hospitals, health professions advisors, and other interested groups via the MedEd Update newsletter, Medical Student Section (MSS) listserv, and National Association of Advisors for the Health Professions listserv. AMA policy avoids language to "endorse."<br><br>AAMC's guidance document has not been updated since 2013. They conducted a clinical shadowing survey in 2016 and shared the results, which was meant to serve as updated guidance. |
| 14 | H-295.860 | Promoting Transparency in Medical Education and Access to Training | Our American Medical Association: (1) strongly encourages medical schools and graduate medical education training programs to communicate with current and prospective medical students, residents and fellows how affiliations and mergers among health care organizations may impact health care delivery, medical education and training opportunities at their respective institutions; and (2) will work with the Accreditation Council for Graduate Medical Education and other appropriate stakeholders to support transparency within medical education, recommending that medical schools and graduate medical education training programs communicate with current and prospective medical students, residents and fellows how affiliations and mergers among health care organizations may impact health care | **Retain – still relevant.** |

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| | | | delivery, medical education and training opportunities. | |
| 15 | H-295.862 | Alignment of Accreditation Across the Medical Education Continuum | 1. Our AMA supports the concept that accreditation standards for undergraduate and graduate medical education should adopt a common competency framework that is based in the Accreditation Council for Graduate Medical Education (ACGME) competency domains.<br><br>2. Our AMA recommends that the relevant associations, including the AMA, Association of American Medical Colleges (AAMC), American Osteopathic Association (AOA), and American Association of Colleges of Osteopathic Medicine (AACOM), along with the relevant accreditation bodies for undergraduate medical education (Liaison Committee on Medical Education, Commission on Osteopathic College Accreditation) and graduate medical education (ACGME, AOA) develop strategies to:<br>a. Identify guidelines for the expected general levels of learners' competencies as they leave medical school and enter residency training.<br>b. Create a standardized method for feedback from medical school to premedical institutions and from the residency training system to medical schools about their graduates' preparedness for entry.<br>c. Identify areas where accreditation standards overlap between undergraduate and graduate medical education (e.g., standards related to the clinical learning environment) so as to facilitate coordination of data gathering and decision-making related to compliance.<br>All of these activities should be codified in the standards or processes of accrediting bodies.<br><br>3. Our AMA encourages development and implementation of accreditation standards or processes that support utilization of tools (e.g., longitudinal learner portfolios) to track learners' progress in achieving the defined competencies across the continuum.<br><br>4. Our AMA supports the concept that evaluation of physicians as they progress along the medical education continuum should include the following: (a) assessments of each of the six competency | **Rescind clause (1)- accomplished.**<br><br>Liaison Committee on Medical Education (LCME) standards do require that schools include a competency framework as the basis for their educational program objectives.<br><br>**Rescind clause (2) – accomplished.**<br><br>The AMA has been an active member of the Foundational Competencies for Undergraduate Medical Education initiative. Regarding (2b). AAMC developed such a tool.<br><br>**Retain clause (3) – still relevant. Amend to update language as follows:**<br>3. Our AMA ~~encourages~~ supports the development and implementation of ~~accreditation standards or processes that support utilization of~~ tools (e.g., longitudinal learner portfolios) to track learners' progress in achieving the defined competencies across the continuum.<br><br>**Rescind clause (4) – no longer relevant.**<br><br>Addressed by newer policy H-275.916.<br><br>**Rescind clause (5a) – accomplished.**<br><br>Addressed by AMA ChangeMedEd initiative (formerly called Accelerating Change in Medical Education).<br><br>**Rescind Clause (5b) – accomplished.**<br><br>Addressed by AMA's longstanding collaboration with ACGME.<br>**Rescind clauses (6), (7) – accomplished.**<br><br>HOD actions were communicated to the Accreditation Council for Graduate Medical Education, American Osteopathic Association, Association of American Medical |

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| | | | domains of patient care, medical knowledge, interpersonal and communication skills, professionalism, practice-based learning and improvement, and systems-based practice; and (b) use of assessment instruments and tools that are valid and reliable and appropriate for each competency domain and stage of the medical education continuum.<br><br>5. Our AMA encourages study of competency-based progression within and between medical school and residency.<br>a. Through its Accelerating Change in Medical Education initiative, our AMA should study models of competency-based progression within the medical school.<br>b. Our AMA should work with the Accreditation Council for Graduate Medical Education (ACGME) to study how the Milestones of the Next Accreditation System support competency-based progression in residency.<br><br>6. Our AMA encourages research on innovative methods of assessment related to the six competency domains of the ACGME/American Board of Medical Specialties that would allow monitoring of performance across the stages of the educational continuum.<br><br>7. Our AMA encourages ongoing research to identify best practices for workplace-based assessment that allow performance data related to each of the six competency domains to be aggregated and to serve as feedback to physicians in training and in practice. | Colleges, American Association of Colleges of Osteopathic Medicine, American Board of Medical Specialties, Commission on Osteopathic College Accreditation and Liaison Committee on Medical Education. Also, they were shared with medical schools, residency program directors, directors of medical education at U.S. teaching hospitals, and other interested groups via MedEd Update.<br><br>**Amend title as follows:**<br><br>~~ALIGNMENT OF ACCREDITATION ACROSS THE MEDICAL EDUCATION CONTINUUM~~<br><br>TOOLS TO SUPPORT ACHIEVEMENT OF COMPETENCIES ACROSS LEARNING CONTINUUM |
| 16 | H-295.907 | The Impact of the Changing Health Care Environment on Graduate Medical Education | Our American Medical Association will encourage the Accreditation Council for Graduate Medical Education to review the impact of the changing health care environment on the feasibility of meeting accreditation standards related to patient volume, number of procedures to be performed, residency program size, and the requirement for the presence of residency programs in other disciplines. | **Rescind – accomplished.** |
| 17 | H-295.926 | Support for Development of Continuing Education Programs for Primary Care Physicians in | The AMA: (1) supports development, where appropriate, of programs of education for medical students and faculty in non-academic settings, making use of telecommunications as needed; (2) encourages that medical schools provide faculty development programs that are designated for *AMA PRA Category 1* | **Retain – still relevant.** |

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| | | Non-Academic Settings | *Credit*"; and (3) encourages that teaching continue to be accepted for *AMA PRA Category 2 Credit*" when not designated for *AMA PRA Category 1 Credit*" . | |
| 18 | H-295.953 | Medical Student, Resident and Fellow Legislative Awareness | 1. The AMA strongly encourages the state medical associations to work in conjunction with medical schools to implement programs to educate medical students concerning legislative issues facing physicians and medical students.<br><br>2. Our AMA will advocate that political science classes which facilitate understanding of the legislative process be offered as an elective option in the medical school curriculum.<br><br>3. Our AMA will establish health policy and advocacy elective rotations based in Washington, DC for medical students, residents, and fellows.<br><br>4. Our AMA will support and encourage institutional, state, and specialty organizations to offer health policy and advocacy opportunities for medical students, residents, and fellows. | **Retain – still relevant**. |
| 19 | H-295.980 | Clinical Training in STD for Medical Students/ Physicians in Training | The AMA urges medical schools to provide supervised training in sexually transmitted diseases for all medical students and physicians in training. | **Retain – still relevant. Amend title to update language as follows:**<br><br>CLINICAL TRAINING IN ~~STD~~SEXUALLY TRANSMITTED INFECTIONS ~~FOR MEDICAL STUDENTS/ PHYSICIANS IN TRAINING~~<br><br>The AMA urges medical schools to provide supervised training in sexually transmitted ~~diseases~~ infections for all medical students and physicians in training. |
| 20 | H-300.959 | Physician Participation in the AMA Physician's Recognition Award | It is policy that: (1) the AMA, state medical societies, and specialty societies in the AMA House of Delegates publicize and promote physician participation in the AMA Physician's Recognition Award; and (2) that all physicians participate in the AMA Physician's Recognition Award as a visible demonstration of their commitment to continuing medical education. | **Retain – still relevant. Amend to update language as follows:**<br><br>~~It is policy that:~~ AMA encourages (1) ~~the AMA,~~ state medical societies~~,~~ and specialty societies in the AMA House of Delegates to publicize and promote physician participation in the AMA Physician's Recognition Award (PRA); and (2) ~~that~~ all physicians to participate in the AMA Physician's Recognition Award (PRA) as a visible demonstration of their commitment to continuing medical education. |

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| 21 | H-300.969 | Uniform Standards for Continuing Medical Education | The AMA (1) will continue its efforts to develop uniform standards for continuing medical education; and (2) will solicit input from all state medical associations, medical licensure boards, and national specialty organizations concerning the development of the most appropriate uniform standards for continuing medical education. | **Rescind – duplicative.**<br><br>Clause (1) is addressed by newer policies H-300.976 "Unification of Education Credits" and 9.2.6 "Continuing Medical Education."<br><br>Clause (2) was accomplished during simplification and alignment process in 2017. |
| 22 | H-305.942 | The Ecology of Medical Education: The Infrastructure for Clinical Education | The AMA recommends the following to ensure that access to appropriate clinical facilities and faculty to carry out clinical education is maintained: (1) That each medical school and residency program identify the specific resources needed to support the clinical education of trainees, and should develop an explicit plan to obtain and maintain these resources. This planning should include identification of the types of clinical facilities and the number and specialty distribution of full-time and volunteer clinical faculty members needed. (2) That affiliated health care institutions and volunteer faculty members be included in medical school and residency program resource planning for clinical education when appropriate. (3) That medical school planning for clinical network development include consideration of the impact on the education program for medical students and resident physicians. (4) That accrediting bodies for undergraduate and graduate medical education be encouraged to adopt accreditation standards that require notification of changes in clinical affiliations, in order to ensure that changes in the affiliation status of hospitals or other clinical sites do not adversely affect the education of medical students and resident physicians. | **Retain – still relevant.** |
| 23 | H-305.971 | Discrimination Against Resident Candidates Based on Graduate Medical Education Medicare Funding | Our American Medical Association urges residency programs to use the qualifications of residency applicants as a basis for filling available positions, and not the eligibility or level of future Medicare graduate medical education funding. | **Retain – still relevant.** |
| 24 | H-310.917 | Securing Funding for Graduate Medical Education | Our American Medical Association: (1) continues to be vigilant while monitoring pending legislation that may change the financing of medical services (health system reform) and advocate for expanded and broad-based funding for graduate medical education (from federal, state, and | **Retain – still relevant.** |

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| | | | commercial entities); (2) continues to advocate for graduate medical education funding that reflects the physician workforce needs of the nation; (3) encourages all funders of GME to adhere to the Accreditation Council for Graduate Medical Education's requirements on restrictive covenants and its principles guiding the relationship between GME, industry and other funding sources, as well as the AMA's Opinion 8.061, and other AMA policy that protects residents and fellows from exploitation, including physicians training in non-ACGME-accredited programs; and (4) encourages entities planning to expand or start GME programs to develop a clear statement of the benefits of their GME activities to facilitate potential funding from appropriate sources given the goals of their programs. | |
| 25 | H-310.966 | Residency Interview Costs | 1. It is the policy of the AMA to pursue changes to federal legislation or regulation, specifically to the Higher Education Act, to include an allowance for residency interview costs for fourth-year medical students in the cost of attendance definition for medical education.<br><br>2. Our AMA will work with appropriate stakeholders, such as the Association of American Medical Colleges and the Accreditation Council for Graduate Medical Education, in consideration of the following strategies to address the high cost of interviewing for residency/fellowship: a) establish a method of collecting data on interviewing costs for medical students and resident physicians of all specialties for study, and b) support further study of residency/fellowship interview strategies aimed at mitigating costs associated with such interviews. | **Retain – still relevant.** |
| 26 | H-310.993 | Resident Participation on Hospital Committees | The AMA encourages hospitals with graduate medical education programs to include residents on hospital executive, fiscal and other committees. | **Retain – still relevant.** |
| 27 | H-310.994 | Curriculum Orientation of Medical Staff Membership in Teaching Programs | Our American Medical Association believes that teaching programs in hospitals with residencies throughout the US should incorporate information on the privileges and responsibilities of medical staff membership into their education program's orientation materials. | **Retain – still relevant.** |
| 28 | H-310.995 | Anonymity for Resident Inquiries to | Our American Medical Association supports a detailed procedure to guarantee anonymity of a resident physician who | **Retain – still relevant.** |

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| | | Residency Review Committees | initiates an inquiry by a residency review committee into the conduct of a residency program, to protect residents from reprisals and program directors from unfounded complaints. The procedure includes a mechanism for the resident who elects to forward a complaint to the residency review committee (RRC), outlines options for RRC action; and identifies possible final actions open to the RRC. | |
| 29 | H-350.969 | Medical Education for Members in Underserved Minority Populations | Our AMA: (1) actively opposes the reduction of resources and opportunities used to increase the number of minority medical and premedical students in training; (2) uses its influence in states and local communities to increase the representation of minority group members in medical education, as long as domestic health care disparities exist between minority populations and the greater population at-large; and (3) supports the need for an increase in the participation of under-represented minorities as investigators, trainees, reviewers, and subjects in peer review biomedical research at all levels. | **Retain – still relevant.** |
| 30 | H-350.970 | Diversity in Medical Education | Our AMA will: (1) request that the AMA Foundation seek ways of supporting innovative programs that strengthen pre-medical and pre-college preparation for minority students; (2) support and work in partnership with local state and specialty medical societies and other relevant groups to provide education on and promote programs aimed at increasing the number of minority medical school admissions; applicants who are admitted; and (3) encourage medical schools to consider the likelihood of service to underserved populations as a medical school admissions criterion. | **Retain – still relevant.** |
| 31 | H-435.954 | Impact of US Medical Liability Premiums on Clinical Medical Education | Our AMA opposes increases in medical liability insurance premiums based solely on preceptor or volunteer faculty status. | **Retain – still relevant. Amend title to update language as follows:**<br><br>~~IMPACT OF~~ US MEDICAL LIABILITY PREMIUMS ~~ON CLINICAL MEDICAL EDUCATION~~ AND FACULTY STATUS |
| 32 | H-475.985 | Protecting the Integrity of General Surgery as a Specialty | Our American Medical Association policy is that general surgery is a single specialty, distinct from other surgical specialties and that general surgery should be recognized as such by state regulatory agencies. | **Retain – still relevant.** |

## 2. INTERNATIONAL APPLICANTS TO U.S. MEDICAL SCHOOLS

*Reference committee hearing: see report of Reference Committee C.*

**HOUSE ACTION: RECOMMENDATIONS ADOPTED**
**REMAINDER OF REPORT FILED**
*See Policy H-295.842*

INTRODUCTION

Resolution 301 entitled "Fairness for International Medical Students" was referred at the 2024 Annual Meeting of the American Medical Association (AMA) House of Delegates (HOD) and asked that our AMA:

- Encourage additional medical schools to consider applications from and to admit international students to their programs alongside domestic students (New HOD Policy); and be it further
- Amend policy H-255.968 "Advance Tuition Payment Requirements for International Students Enrolled in U.S. Medical Schools" by addition and deletion to read as follows:
  Advance Tuition Payment Requirements for International Students Enrolled in U.S. Medical Schools H-255.968
  Our AMA:
  - supports the autonomy of medical schools to determine optimal tuition requirements for international students;
  - encourages medical schools and undergraduate institutions to fully inform international students interested in medical education in the U.S. of the limited options available to them for tuition assistance;
  - supports the Association of American Medical Colleges (AAMC) in its efforts to increase transparency in the medical school application process for international students by including school policy on tuition requirements in the Medical School Admission Requirements (MSAR); and
  - supports efforts to re-evaluate and minimize the use of pre-payment requirements specific to international medical students; and
  - encourages medical schools to explore alternative means of prepayment, such as a letter of credit, ~~for four years~~ for covering the costs of medical school. (Modify Current HOD Policy); and be it further
- Advocate for increased scholarship and funding opportunities for international students accepted to or currently attending United States medical schools.

The reference committee received mixed testimony on this item. Concerns were raised regarding the Student and Exchange Visitor Program (SEVP), federal regulations regarding international students, limited funding opportunities for international students, the criteria of the F visa program to enter the U.S, the Form I-20 "Certificate of Eligibility for Nonimmigrant Student Status," Title IV federal financial aid funding, and the relationships between medical schools and their parent institutions. Also, testimony recommended that the American Association of Colleges of Osteopathic Medicine (AACOM) be included along with AAMC. Given the complexities raised, the Reference Committee recommended that this item be referred. The HOD also moved to refer. This report was written in response to that directive.

BACKGROUND

To better understand policy proposed in this resolution, several of the foundational topics raised by the author are described.

*International student application and visa processes*

Applicants to U.S. medical schools

For the purpose of this report, "international" medical school applicants are commonly understood to be individuals who are neither U.S. citizens nor hold permanent resident status in the U.S.[1] According to the AAMC, some U.S. MD-

granting medical schools do accept a small number of international applicants. In 2019, 48 schools (out of 155) indicated that they accept applications from international applicants per the AAMC Medical School Admission Requirements™ (MSAR™) guide.[2,3] The 2019 cycle for MD-granting programs in the U.S saw 53,371 total applicants[4] with 21,969 (41%) matriculated into medical school; 325 out of 1,890 foreign applicants who applied to such programs were accepted.[2] Among the 325 students accepted, 272 matriculated into medical school, including those who applied via the American Medical College Application Service® (AMCAS®) and Texas Medical & Dental Schools Application Services (TMDSAS).[2] Related policies vary across schools and can be researched on an allopathic school's website or within the MSAR's section on "Application Deadlines and Requirements." Additional data can be found on the AAMC website. Similar data from AACOM and osteopathic medical schools were not available.

The National Center for Education Statistics offers the College Navigator search engine to identify educational institutions. The first step to studying in the U.S. is to apply to a school approved by the U.S. Immigration and Customs Enforcement (ICE) Student and Exchange Visitor Program (SEVP). This program ensures the government has necessary data related to nonimmigrant students and exchange visitors, provides approval and oversight to authorized schools, and issues guidance to both students and schools regarding the requirements for maintaining their status. If a student is accepted, they are registered in the SEVP platform called Student and Exchange Visitor Information System (SEVIS).[5] For a school to be accepted into SEVP, it must complete the online "Petition for Approval of School for Attendance by Nonimmigrant Student," (Form I-17) in SEVIS and pay all required fees.[6]

Most U.S. medical schools use AMCAS to facilitate and streamline the student application process. Since AMCAS does not accept foreign transcripts or verify foreign coursework (unless the coursework was accepted by an accredited U.S., U.S. Territorial, or Canadian postsecondary institution), individual medical schools may ask an applicant for their transcript with the understanding that some courses may not be accepted.[2] For DO-granting medical schools, the AACOM oversees the American Association of Colleges of Osteopathic Medicine Application Service (AACOMAS).[1] Likewise, admission policies for international students vary across DO schools. Once admission to a SEVP-approved school is secured, an international student can apply for their student visa.

Although not legally U.S. citizens or permanent residents, the admission process and barriers for Deferred Action for Childhood Arrivals (DACA) applicants were determined not to be the intent of the referral and beyond the purview of this report.

Applicant race/ethnicity data

AAMC provides data on the number of applicants to U.S. MD-granting medical schools, to include a breakdown by race/ethnicity and state of legal residence (if known). Such data provides insight into the diversity, or lack thereof, of the incoming students and includes non-citizen and non-permanent residents. AAMC data for the academic year 2024-2025 totals 51,946 applicants and includes 1,852 non-U.S. citizen and non-permanent residents.[7] More detailed R/E data on U.S. citizens is available. 2024 AACOM data totals 22,107 applicants and includes 470 non-U.S. citizens and non-permanent residents.[8] Likewise, more detailed R/E data on U.S. citizens is also available. While much is known about the countries of origin of international medical graduates (IMGs),[9] race/ethnicity data on international student applicants is not as readily available. AAMC indicated that recent international applicants were from 112 countries; among them, matriculants were from 67 countries.[10] Similar data from AACOM or ECFMG were not available.

Visa entry to U.S.

The Immigration and Nationality Act allows the admission of different classes of foreign national nonimmigrants who seek temporary admission to the U.S.[11] The Department of State's Bureau of Consular Affairs oversees the student visa process. Non-citizen students must have a student visa to travel to the U.S. to study. The course of study and the type of school determines which type of visa is needed. For the F visa, the student must be entering the U.S. to attend university or college, high school, private elementary school, seminary, conservatory, or another academic institution, including a language training program. For the M visa, the student must be entering the U.S. to attend a vocational or other recognized nonacademic institution, other than a language training program.[5] J visas are non-immigrant visas for individuals approved to participate in exchange visitor programs in the U.S.[12]

The student must submit the Online Visa Application (Form DS-160), along with a photo and fee, and must schedule an interview at the U.S. Embassy or Consulate in the country where they live. Wait times for interviews at the consulate vary by location, time of year, and visa type and range from the same day to over a year (e.g., Kolkata, India).

Additional documentation may be required at the interview including intent to depart the United States upon completion of the course of study and how the applicant will pay for all educational, living, and travel costs.[5] A visa does not guarantee entry into the United States; rather, the Department of Homeland Security's U.S. Customs and Border Protection officials at the port-of-entry have authority to permit or deny entry. Students in the U.S. with F visas must depart within 60 days after the program end date listed on the Form I-20, including any authorized practical training.[5] The same process described above can be used to apply to renew a visa. More detailed information is provided on the student visa website.

The visa system allowing international students to enter the U.S. is governed by federal immigration policy and law. For example, the current federal administration starting in 2025 has ordered the Departments of State, Justice, and Homeland Security to ensure visa applicants "do not bear hostile attitudes" toward U.S. "citizens, culture, government, institutions, or founding principles" and "are vetted and screened to the maximum degree possible."[13] How this executive order will be implemented may impact the opportunities of international students to enter and stay in the U.S. for study.

*Student payment and financial aid receipt*

According to the AAMC, the majority of medical students pay for their education through student loans. Further, the mean education debt for indebted medical school graduates in 2023 was $206,924, with 70 percent of all students having education debt.[14] MD school-specific information is provided in the AAMC Tuition and Student Fees workbooks, which contain tuition, fees, and health insurance costs reported by accredited medical education programs from academic year 1995 to present.[15]For DO students, the average graduate indebtedness in 2023-2024 was $259,196.[16]

While domestic students may have government financial assistance options, most international medical students need to secure private loans or institutional loans (if available from the enrolled medical school) and, if available for foreign study, financial aid from the student's country of citizenship. The application process for private loans varies from lender to lender. Some medical schools may require international applicants to show proof of financial means to pay for all four years of medical school or may require such applicants to have the full amount in an escrow account as some international medical schools require of U.S. applicants.[2]

The U.S. Department of Education (DOE) oversees federal student aid and determines eligibility for "non-citizens." This designation includes U.S. nationals (including natives of American Samoa or Swains Island), U.S. permanent residents, or individuals with an Arrival-Departure Record (I-94) from U.S. Citizenship and Immigration Services. The latter includes those designated as "Refugee," "Asylum Granted," "Cuban-Haitian Entrant (Status Pending)," "Conditional Entrant" (if issued before April 1, 1980), T-visa holders (victims of human trafficking; T-2, T-3, or T-4), or "Parolee." For the parolee designation, an individual must be paroled into the U.S. for at least one year and must be able to provide evidence from the United States Citizenship and Immigration Services of intention to become a U.S. citizen or permanent resident. If applicable, federal student aid such as Direct Unsubsidized Loans and Direct PLUS Loans may be available if eligibility requirements are met.[17]

According to Harvard Medical School, "Since federal financial aid programs require that the recipient be a citizen or permanent resident of the United States, the programs used to fund international or Deferred Action for Childhood Arrivals (DACA)-eligible MD student financial aid awards come from private and institutional sources. International and DACA-eligible MD students fill out the standard financial aid application materials and receive financial aid award determinations in a similar manner as U.S. citizens and permanent residents. International and DACA-eligible MD students who qualify for need-based institutional funding are first offered a standard loan package which consists of a combination of loans from institutional and/or private sources. A variety of private loan options are available to MD students regardless of financial need with options to borrow with or without a U.S. co-signer."[18]

The Council on Medical Education studied "Medical Student Debt and Career Choice" (CME 4-N-21) and "Financing Medical Education" (CME 2-A-23), both of which provide greater detail into cost, debt, and financial resources.

*Funding medical schools*

While considering how an international student will pay for school, it is also important to understand the mechanisms in which schools are funded and how they use their funding to aid students. A medical school is part of a larger

academic institution that may be public or private. Funding may come from several sources, including but not limited to student tuition fees, federal and/or state monies, philanthropy, clinical revenue, faculty practice plans, industry, grants, and private payers. There may be stipulations on each of these forms of funding and how it is to be spent. Such stipulations may or may not address international student fees. For example, governmental funding for medical schools is partially based on a desire to train more students in or from a certain jurisdiction. A state government may demand that state universities and their medical schools give priority to residents of their state when it comes to admission as well as tuition subsidies. This may also pertain to private universities in their state, especially when they receive government support. Thus, funding for international students will be secondary to supporting additional students from the state that is providing taxpayer funds to universities and their medical schools.

Governmental funding is also driven by law. The Higher Education Act (HEA) of 1965 regulates the relationship between the federal government, colleges and universities, and students. Title IV of the HEA authorizes a variety of programs and provisions to assist students in accessing financial aid in a postsecondary education. These programs are often the primary sources of federal aid to support such education.[19] The regulated entity could be the university, including their medical school or the medical school as a stand-alone entity. "Under the HEA 90/10 rule, proprietary institutions of higher education (IHEs) must derive at least 10 percent of their total tuition and fees revenue from non-Title IV sources (or, conversely, no more than 90 percent of their tuition and fees revenue from Title IV funds) during a fiscal year."[21] Further, the DOE issued rule changes which took effect starting in 2023.[20] "The HEA and accompanying regulatory provisions specify how revenues are to be calculated. If an IHE fails to meet the rule's requirement in a single year, its certification to participate in the Title IV aid programs becomes provisional for two institutional fiscal years. If an IHE fails to meet the rule's requirements in two consecutive years, it loses its eligibility to participate in the Title IV programs for at least two institutional fiscal years. The rationale behind the 90/10 rule is twofold: (1) reducing fraud, waste, and abuse at proprietary IHEs and (2) if a proprietary IHE is of sufficient quality, it should be able to attract a specific percentage of revenues from non-Title IV sources."[21] The impact on school funding could also affect accreditation. This rule may explain why some medical schools require international students to pay up front or show proof of ability to pay, as default of payment can threaten a school's Title IV funding, thereby impacting the availability of financial aid for all students attending their school. Of note, the current federal administration is considering changes to the DOE; the impact of such changes remains to be seen.[22]

The Council on Medical Education has studied medical education, as mentioned above, as well as medical schools in its report "For-Profit Medical Schools or Colleges" (CME 1-I-19).

DISCUSSION

Each of these topics illuminate the complexity of this issue. They also raise further concerns related to heterogeneity, fairness, and involvement of international students as well as the challenges and resources available to them.

*Building a representative workforce*

According to the AAMC, their 10-point strategic plan called "A Healthier Future for All" is focused on supporting the capacity building of pathway programs to expand the U.S. medical school applicant pool in order to diversify the physician workforce.[23] Likewise, AACOM addresses similar points in their strategic plan.[24]

The Council on Medical Education has addressed issues of equity in some recent reports. For example, two reports of relevance are "Ensuring Equity in Interview Processes for Entry to Undergraduate and Graduate Medical Education" (CME 3-I-23) and "Promising Practices Among Pathway Programs to Increase Diversity in Medicine" (CME 5-J-21).

Focus on pathway programs, while important, centers on underrepresented U.S. students who face systemic barriers to medical school admission. Consideration can also be given to the potential contribution of international students in advancing related efforts in U.S. medical schools.

*Impediments for international students*

As described above, international students face significant challenges, including but not limited to the following:

- Medical school application forms, processes, interviews, and deadlines: Cost, language barriers, detailed forms, and deadlines may inhibit international students in their ability to successfully apply and be accepted to a U.S. medical school.

- Visa application forms, processes, interviews, and deadlines: the cost, detailed forms and documentation, deadlines, and immigration policies may prevent some international students from entry into the U.S. for study. Further, wait times for interviews at some consulates can be prolonged, resulting in a significant lag between admission and receipt of an F-visa.
- Pre-payment or proof of ability to pay: Financial capacity is challenging for most medical students, let alone international students who face non-citizenship required fees and may also have financial hardships. In addition, applicants for a student visa may be required by the consular officer to provide documentation of how they will pay for all educational, living, and travel costs. "This evidence of financial ability includes but is not limited to family bank statements, documentation from a sponsor, financial aid letters, scholarship letters, or letter from an employer showing annual salary."[25] Data on how many medical schools also require this proof was not readily available.
- Limited financial aid options: Given their non-citizen status, international students often struggle with knowing where/how to identify possible resources, let alone how to apply for them. Countries often do not provide financial aid to their citizens studying in the U.S.
- Public interest: Voters often demand that their tax dollars should go primarily toward educating their own citizens who reside in their state and that state universities and their medical schools prioritize their own citizens in admissions and financial aid. This may apply as well to private medical schools receiving state support. With competition for medical school admission already high in the U.S., including for U.S. applicants identifying as historically minoritized, increasing admissions to international students may decrease government and public support for medical schools including funding for all medical students.
- Federal immigration policy: The President and current federal administration is prioritizing an "America First" agenda that purports security and safety concerns related to immigrants, migrants, and asylum seekers, which may adversely impact the entry of international persons for study in the U.S.[26] The AMA is monitoring changes in federal immigration law and regulations and its potential impact on the physician workforce.

*Resources for international students*

Despite the challenges, a number of resources are available to aid such students in their ability to study medicine in the U.S. This is in addition to the financial aid office at each medical school. These resources include, but are not limited to:

- AAMC offers information on "Applying to Medical School as an International Applicant" as well as the Financial Information, Resources, Services, and Tools (FIRST) program. FIRST provides free resources to students, including publications, videos, webinars, infographics, and charts to help students and residents make informed financial decisions related to their education.
- Federal Student Aid website provides detailed information on eligibility and options.
- Sallie Mae provides guidance on financial aid and how to control costs associated with medical school.
- F-1 Doctors is a peer-led mentorship platform for international applicants to U.S. medical (and dental) schools and U.S. residency programs. The platform currently hosts over 140 mentors from over 30 countries, providing free guidance on applying to such U.S. schools and programs.[27]

In the AMA, the IMG Section is a member group that convenes on and advocates for relevant issues affecting international medical graduates. The section also provides students with information on how to become certified by the Educational Commission for Foreign Medical Graduates (ECFMG)/Intealth and how to navigate practicing medicine in the U. S. as well as access to mentoring consults. The AMA Medical Education unit produced a 2022 issue brief on Support for IMGs practicing in the U.S. In the last five years, the Council on Medical Education published the following reports related to IMGs:

- Challenges to Primary Source Verification of International Medical Graduates Resulting from International Conflict (CME 8-A-23)
- Financial Burdens and Exam Fees for International Medical Graduates (CME 3-A-23)
- Expediting Entry of Qualified IMG Physicians to U.S. Medical Practice (CME 4-JUN-21)
- Licensure for International Medical Graduates Practicing in U.S. Institutions with Restricted Medical Licenses (CME 2-JUN-21)

Also, the AMA Medical Student Section is a member group that convenes on and advocates for relevant issues impacting medical students in the U.S. The AMA and AMA Foundation (AMAF) can consider additional ways they

can support international applications and students within their own programs and initiatives, such as the AMAF medical student scholarships.

RELEVANT AMA POLICIES

The AMA has many policies in support of medical students, medical education, and medical schools. Such policies are accessible in the AMA Policy Finder. Regarding international medical students, related policies include:

- Advance Tuition Payment Requirements for International Students Enrolled in U.S. Medical Schools H-255.968
- Clinical Skills Assessment During Medical School D-295.988

SUMMARY

The topic of international students applying to and entering U.S. medical schools is complex. While many governmental policies discussed include much broader issues and concerns than the admission of international students into medical school (e.g., visa processes, financial aid, funding, administrative changes, voter/public interest), some of the barriers can be addressed with the above resources.

RECOMMENDATIONS

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

That our AMA:

1. Supports all U.S. medical schools in (a) considering international applicants; (b) investigating additional financial aid opportunities, including scholarships, for international medical school applicants; and (c) re-evaluating their pre-payment requirements specific to international applicants.
2. Recognizes the federal government's current programs that allow for the entry of qualified international medical students into the U.S. and encourages the maintenance and/or improvement of such programs.
3. Supports relevant parties to include international medical students and applicants in data collection, philanthropy, and financial assistance programs.

(New HOD Policy)

Fiscal note: $1,000

APPENDIX: RELEVANT AMA POLICIES

Advance Tuition Payment Requirements for International Students Enrolled in U.S. Medical Schools H-255.968

1. Our American Medical Association supports the autonomy of medical schools to determine optimal tuition requirements for international students.
2. Our AMA encourages medical schools and undergraduate institutions to fully inform international students interested in medical education in the US of the limited options available to them for tuition assistance.
3. Our AMA supports the Association of American Medical Colleges (AAMC) in its efforts to increase transparency in the medical school application process for international students by including school policy on tuition requirements in the Medical School Admission Requirements (MSAR).
4. Our American Medical Association encourages medical schools to explore alternative means of prepayment, such as a letter of credit, for four years of medical school.

Clinical Skills Assessment During Medical School D-295.988

1. Our American Medical Association will encourage its representatives to the Liaison Committee on Medical Education (LCME) to ask the LCME to determine and disseminate to medical schools a description of what constitutes appropriate compliance with the accreditation standard that schools should "develop a system of assessment" to assure that students have acquired and can demonstrate core clinical skills.
2. Our AMA will work with the Federation of State Medical Boards, National Board of Medical Examiners, state medical societies, state medical boards, and other key stakeholders to pursue the transition from and replacement for the current United States Medical Licensing Examination (USMLE) Step 2 Clinical Skills (CS) examination and the Comprehensive Osteopathic Medical Licensing Examination (COMLEX) Level 2-Performance

Examination (PE) with a requirement to pass a Liaison Committee on Medical Education-accredited or Commission on Osteopathic College Accreditation-accredited medical school-administered, clinical skills examination.

3. Our AMA will work to:
   a. ensure rapid yet carefully considered changes to the current examination process to reduce costs, including travel expenses, as well as time away from educational pursuits, through immediate steps by the Federation of State Medical Boards and National Board of Medical Examiners.
   b. encourage a significant and expeditious increase in the number of available testing sites.
   c. allow international students and graduates to take the same examination at any available testing site.
   d. engage in a transparent evaluation of basing this examination within our nation's medical schools, rather than administered by an external organization.
   e. include active participation by faculty leaders and assessment experts from U.S. medical schools, as they work to develop new and improved methods of assessing medical student competence for advancement into residency.
4. Our AMA is committed to assuring that all medical school graduates entering graduate medical education programs have demonstrated competence in clinical skills.
5. Our AMA will continue to work with appropriate stakeholders to assure the processes for assessing clinical skills are evidence-based and most efficiently use the time and financial resources of those being assessed.
6. Our AMA encourages development of a post-examination feedback system for all USMLE test-takers that would:
   a. Identify areas of satisfactory or better performance.
   b. Identify areas of suboptimal performance.
   c. Give students who fail the exam insight into the areas of unsatisfactory performance on the examination.
7. Our AMA, through the Council on Medical Education, will continue to monitor relevant data and engage with stakeholders as necessary should updates to this policy become necessary.

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## 3. UNMATCHED GRADUATING PHYSICIANS

*Reference committee hearing: see report of Reference Committee C.*

**HOUSE ACTION: RECOMMENDATIONS ADOPTED**
**REMAINDER OF REPORT FILED**
*See Policies D-310.977, H-200.954 and H-310.899*

INTRODUCTION

At the 2024 Annual Meeting of the American Medical Association (AMA) House of Delegates (HOD), Resolution 306 was referred and asked that our "Board of Trustees study the role these unmatched physicians can play in providing care to our patients, their impact of lessening the impact of physician shortages, and provide recommendations on how to enroll these graduating physicians with a uniform title, privileges, geographic restrictions, and collaboration choices, and report to the HOD at the next Interim meeting."

The author purported many concerns in Resolution 306, demonstrating the complexities of the problem. These concerns include:

- Graduate medical education (GME) shortage (e.g., lack of funding; lack of residency slots)
- Unmatched physicians (e.g., a Missouri state law allowing physicians without residency training to practice and other similar state laws; lack of support/experiences for unmatched medical students so they can go on to match)
- Workforce (e.g., physician shortage in primary and specialty care; a decrease in practicing physicians; not enough medical students, residents, and fellows to meet the needs of patients)
- Scope of practice (e.g., physician assistants [PAs], advanced practice providers [AAPs], and nurse practitioners [NPs] have replaced physicians in shortage areas; state allowances for non-physician extenders to practice)

The reference committee received mixed testimony on this item. Testimony in opposition raised concerns about the multifactorial and nuanced problem of the physician shortage, variances in state laws related to non-physician providers, patient safety, physician education, lack of physician mentors, and circumvention of Accreditation Council for Graduate Medical Education (ACGME) standards by not participating in an accredited GME program. For these reasons, the reference committee recommended that resolution 306 be not adopted; however, the HOD final action moved for referral. This report is written in response to that directive.

BACKGROUND

To examine if unmatched physicians without residency education would contribute meaningfully to addressing a physician workforce shortage and increase access to care, the following issues and facts need to be considered.

*Physician workforce shortage*

The physician workforce shortage and maldistribution by geography and specialty is impacting access to care. In 2023, the Association of American Medical Colleges (AAMC) conducted a study entitled "The Complexities of Physician Supply and Demand: Projections From 2021 to 2036." The resulting report predicts that by the year 2036, the U.S. will face a physician shortage of up to 86,000 physicians.[1] While the physician shortage is a multifactorial and nuanced problem, the report asserts that the main drivers of the physician shortage are population demographics, retiring physicians, and the needs of groups that have been historically and intentionally excluded.

- Demographics: The study projects the U.S. population will grow by 8.4 percent overall, along with a growth in the aged 65 and older subpopulation by 34.1 percent leading to a significant increase in demand for primary care and for the specialists they most often need.
- Retirement: Currently, 42 percent of the clinical physician workforce is over age 55 (20 percent are aged 65 or older and 22 percent are between age 55 and 64). Thus, a substantial number of physicians will reach retirement age within the next decade.
- Underserved: The U.S. would have already needed 202,800 more physicians (as of 2021) to care for underserved communities in order to provide care at the same rate as other populations.[1]

These forecasts suggest worsening health inequities, particularly for the aging and underserved populations. AAMC offers projected data on physician demand through 2036 by patient race and ethnicity as well as urban-rural location. Of note, the AMA recently issued a brief on "Defining "rural" for the physician workforce."

*Physician education standards and graduate medical education*

For almost a century, successful completion of GME in the United States has been the established standard for physician education in the United States for independent practice and now for many countries around the world. Beginning in 1914, the AMA published the first list of hospitals approved for GME, and in 1927, the AMA Council on Medical Education and Hospitals began publishing the names of all the approved hospitals with GME programs in various specialties in the "Essentials of Approved Residencies and Fellowships." In the mid-20th century, the AMA played a key role with specialty boards in establishing residency review committees (RRCs), beginning with the RRCs for internal medicine and surgery in 1953. In 1956, the Federation of State Medical Boards recommended GME as a requirement for a full, unrestricted license to practice medicine. In 1972, the AMA helped found the Liaison Committee on Graduate Medical Education to accredit residency programs and, in 1981, was one of the five parent

organizations establishing the ACGME.[2] In 2020, osteopathic and allopathic GME were unified into a single accreditation system to standardize GME for all physicians in the United States.[3]

GME is not only a critical part of the education of physicians in preparation for independent practice in a clinical specialty, GME is also a period of assessment for each trainee to ensure they are competent to practice. At completion of a GME program in the U.S., the residency director attests (per the 2024 ACGME Guide to the Common Program Requirements) that the resident has "demonstrated the knowledge, skills, and behaviors necessary to enter autonomous practice."[4] Allowing unmatched physicians to practice without GME would be a significant change in professional standards for patient care.

*How many unmatched U.S. medical graduates are there?*

Physicians applying for residency or fellowship enter a match to determine in which program they will train. The Council on Medical Education provides greater detail on the match processes and alternatives in their 2024 report, The Current Match Process and Alternatives (CME 2-A-24).

The National Residency Matching Program (NRMP) publishes annual results and reports on various data topics. According to the NRMP's report, "2024 Main Residency Match® By the Numbers," there were 41,503 total positions, and 38,941 of them were filled (93.8 percent), leaving 2,562 unfilled.[5] For PGY-1 positions, there were 38,494 total positions, and 35,984 of them were filled (93.5 percent), leaving 2,510 unfilled. In both instances (total positions and PGY-1 only), the percentages of filled spots went up 0.5 percent from the previous year.[5] See Appendix A for more report highlights or visit the NRMP® website for the complete data. Further Match data shows a match rate of 93.5 percent for U.S. MD seniors (an all-time high), 92.3 percent for U.S. DO seniors, 67 percent match rate for U.S. citizen international medical graduates (IMGs), and 58.5 percent match rate for non-U.S. citizen IMGs.[6]

Regarding IMGs in 2024, "19,050 U.S. citizen and non-U.S. citizen students and graduates of international medical schools (IMGs) registered for the Match, 1,668 more than 2023. Of the 4,751 U.S. IMGs who submitted rank order lists of programs, 3,181 matched to a PGY-1 position for a match rate of 67.0 percent. Of the 10,021 non-U.S. citizen IMGs who submitted rank order lists of programs, 5,864 matched to a PGY-1 position for a match rate of 58.5 percent. In 2024, the overall number of registered applicants was 50,413, the highest in the history of the Match. The number of registered non-U.S. citizen IMGs was 12,787, 1,986 more than last year."[7]

A total of 2,655 positions went unfilled in the 2024 NRMP Match, which included the 2,562 mentioned above as well as 93 additional positions in programs that did not submit a rank order list. Also, some unfilled programs had submitted a rank order list but chose not to participate in the Supplemental Offer and Acceptance Program® (SOAP®)to fill their unfilled positions. Among the 2,655 mentioned above, 97 percent (2,575) were placed in the SOAP offered by the NRMP during Match Week.[7] The SOAP is a process whereby eligible unmatched or partially matched applicants in The Match can apply for and be offered positions that went unfilled after the matching algorithm was processed. At the conclusion of SOAP, 176 positions still remained unfilled from 109 SOAP-participating programs. The matching and SOAP processes combined filled 99.6 percent of positions available through the Match, resulting in 0.4 percent unfilled positions."[7] This data does not include other match processes outside the NRMP. See Appendix A for a graph of NRMP Match data.

*Reasons U.S. medical graduates are unmatched*

Data provided by medical schools to the Liaison Committee on Medical Education (LCME) in the LCME Part II Annual Medical School Questionnaire offers insight into reasons medical school graduates did not match into a residency program. In 2023, 20,484 graduates accepted a residency position, and the total number of potential graduates who reported not entering residency training in 2023-2024 was 309 and their reasons given were:

- Research/pursuing additional degree or training: 113
- Did not find a residency position: 80
- Changing careers: 56
- Other: 56
- Family responsibilities/childcare: 4[8]

The LCME does not have additional details about the reasons. It is possible that those who "did not find a residency position" may not have found one in their desired specialty or geography even if other positions were available. Data on osteopathic medical school graduates not entering residency training were not available.

Notably, 80 U.S. LCME medical graduates reported being unable to find a residency position, while the NRMP reported 176 unfilled residency positions after the SOAP. It is likely that the unmatched physicians had preferences for residency positions that were not met by the available vacant positions.

Regarding osteopathic medical schools, American Association of Colleges of Osteopathic Medicine's (AACOM) UME-GME Task Force Residency Match Working Group sent a survey to medical school advisers and deans in 2018-2019 to assess reasons why students did not match. The results indicated low board scores and lack of parallel plans were the main reasons students did not match.[9]

*ACGME statement on those who are unmatched*

The ACGME issued a statement of note in 2020 regarding "Unmatched US (Domestic, non-IMG) Allopathic and Osteopathic Medical Graduates, and International Medical Graduates with valid Educational Commission for Foreign Medical Graduates (ECFMG) certification Scenarios." It reads, "ACGME-accredited Sponsoring Institutions that permit programs to appoint unmatched/ uncommitted graduates, consistent with their programs'/ Sponsoring Institutions' match participation agreements, must offer at least 1 year of appointment in an ACGME-accredited program (if eligible per ACGME requirements). Any such appointments must be reviewed and approved in advance by the Sponsoring Institution's Graduate Medical Education Committee (GMEC). Enrollment in preliminary year positions, categorical positions, and positions in Transitional Year programs may be appropriate in this circumstance.

1. If the program would be within its approved complement, appointment in an ACGME-accredited program may proceed.
2. If the program would not be within its approved complement, Review Committee approval of a temporary complement increase must be obtained prior to appointment in an ACGME-accredited program. Approval of temporary complement increases, when required, must be obtained by programs of Sponsoring Institutions that have declared pandemic emergency status (Stage 3)."[10]

DISCUSSION

*Concerns and considerations*

Ultimately, Resolution 306 seeks to determine if unmatched physicians can have a significant impact on the physician shortage by creating opportunities for these physicians to practice.

There is a common misperception that there are not enough GME positions for graduates of U.S. medical schools. However, the data provided in this report proves otherwise, with the number of U.S. medical graduates who are unable to obtain a residency each year being very small (under 100) compared to the overall number of physicians entering GME (almost 40,000) and would have a very small potential impact on the physician workforce. For U.S. medical school graduates who are seeking a residency position but who remain without a residency position, there is likely a mismatch between their preferences and the residency positions available to them. Similarly, unmatched physicians may have preferences that may result in a lack of interest in some practice opportunities.

Residency is mandatory for medical licensure in the U.S. Thus, guidance for unmatched physicians is usually focused on getting them into a residency, which means applying for SOAP to attempt to match into unfilled positions or taking a year to prepare to reapply for The Match. Given AAMC predictions, it would be most advantageous to the health of the public if trainees choose to pursue the specialties of most need and seek employment in areas of most need. Should unmatched physicians decide not to reapply, they can pursue other careers in health care that contribute to the health of patients. Depending on their skills and interests, such employment paths include medical writing, consulting, administration, research, education, entrepreneurship, technology, or government agencies.

For DO students looking to strengthen their application, the National Board of Osteopathic Medical Examiners (NBOME) suggests that unmatched graduates also "consider applying to take COMLEX-USA Level 3 under the alternate pathway attestation, which permits candidates to obtain eligibility with endorsement by their COM dean."[11]

Completion of Level 3 may be a way for DO applicants to strength their application while reapplying. Equivalent information for MD students was not available on the National Board of Medical Examiners website, although it is widely accepted that passing Step 3 can strength an application while reapplying.

There is little evidence to suggest that U.S. unmatched physicians can address the physician shortage. Without completing a residency, it is unlikely that they could provide the quality of care of a physician who completed an ACGME-accredited residency program. Residents cannot bill for their services and must be under supervision of fully licensed physicians, including in-person supervision during the first 6 months of residency. Thus, it would seem unmatched physicians should need at least this level of supervision, if not more. Further, hospital medical staff, medical groups, and/or payors should not grant privileges to unmatched physicians without residency training. For privileges, these entities often require completion of ACGME residency training.[12]

While ACGME accreditation standards call for structured supervision and longitudinal assessment in GME, an alternate pathway for unmatched physicians to enter practice lacks detailed guidelines for and enforcement of appropriate clinical supervision to assure patient safety and assess competence. In addition, a shortage of physicians in underserved areas able to supervise may lead to subquality oversight of unmatched physicians in these communities. Related, the AMA recently issued a brief on "The role of supervision in assessment of physician competency."

Also, the resolution implies that unmatched physicians should be granted practice privileges that are potentially greater than those who did match and entered GME. This issue could create distrust between physicians in residency programs and unmatched physicians.

In recent years, there has been movement toward creating positions for these individuals where they may function similarly to a non-physician provider. At least ten states have passed laws to provide this opportunity. For example, the Medical Association of the State of Alabama introduced a bill that was signed into state law in 2023 entitled the "Physician Workforce Act."[13] It creates a Bridge Year Graduate Physician Program. This program allows unmatched physicians to gain experience and skills under the supervision of licensed physicians. These individuals will receive a one-year renewable permit to practice medicine under an Alabama-licensed physician.[14] Since it is a new program, data is limited. While it seems that Alabama seeks to eventually get these individuals into residency positions, some states do not offer an end goal whereby these individuals may remain under supervision much like a non-physician provider. It calls into question the consequences for unmatched physicians who are unable to secure a desired GME position for years. It is unclear if this role is truly transitional, how long they will be allowed to continue in such a role, and how the medical community can prevent exploitation of unmatched physicians. For example, a St. Louis physician was recently sentenced to prison for employing physician assistants and unmatched physicians to see patients but billing health plans as if he was the one providing direct care. The Department of Justice concluded that "under Missouri law, this is expressly illegal, especially since many of the assistants were not qualified to provide unsupervised care. While they had completed medical school, they did not finish a required residency. …Further, when hiring the assistants, the physician would market the roles as 'residency prep' and a 'stepping stone' toward full qualification."[15]

In 2023, the urology program at Case Western Reserve University School of Medicine in Ohio introduced a pilot program designed to afford an unmatched student a mentored and supervised year as a "Resident Team Assistant (RTA)," with support for research projects, attendance of educational didactic conferences, and experience within their subspecialty that reflects an experience similar to a one-year acting internship. Their responsibilities were limited by the lack of a training permit, but their duties were aligned to the needs of an ACGME-accredited residency program with educational exposure and resources afforded by such a position. This individual successfully matched the next year.[16]

An example of support for DO students who did not initially match into a residency program is a program at the Rocky Vista University (RVU) College of Osteopathic Medicine. In 2021, this institution launched the Predoctoral Internship (PDI) and Master's Predoctoral Internship (MPDI), both designed to aid students who did not match into a residency program to reenter the match process and successfully match. According to RVU, "The PDI and MPDI are rigorous, milestone-based programs designed to develop personalized experiences to meet the individual needs of an unplaced student to prepare them to reenter the match process and successfully match to a residency program. The key difference between the PDI and MPDI, outside of the curriculum structure, is that a student in the MPDI program will also be concurrently enrolled in an accredited master's program of their choice at a different institution. … The successes of these programs have spurred conversations about ways the university can incorporate components of the PDI and

MPDI programs into the core curriculum of the COM to mitigate the need for such programs to exist."[17] The programs included 11 participants and achieved a 100 percent success rate for those re-entering the Match, while also helping to reduce anxiety and increase support throughout the process.[17] Additional information about the RVU innovation is available on the school's website and here. AACOM offers a toolkit to aid such students reentering the residency application and match process.[9]

A great concern about creating a pathway for unmatched physicians to enter practice absent completion of an ACGME accredited residency in order to ameliorate the physician shortage would essentially create a two-tiered health care system, further clouding the distinction in training and ability between physicians and non-physician providers. However, examples of successful programs to provide unmatched graduates with structured educational clinical experiences have shown greater success in truly assisting these graduates with a later successful match. Key parties are encouraged to consider the need and utility of programs to support unmatched physicians.

Another potential etiology of unmatched students underlies the decision of some residency programs to choose not to participate in the SOAP. These programs will only accept applicants who matched during the main residency Match. Understanding the decision of these residency programs to keep their positions unfilled rather than considering unmatched applicants for those positions may elucidate opportunities to increase the slots available for unmatched students. Programs need to actively indicate their participation in the SOAP each year; if overlooked it may result in programs with unfilled positions inadvertently not being available in the SOAP. Key parties are encouraged to investigate processes to enable all unfilled residency positions to be available in the SOAP.

*IMGs*

Resolution 306 did not specify "U.S." unmatched physicians. Thus, it can be interpreted to include IMGs and open the door to broader implications. Regarding IMGs, the AMA is an active member of the newly formed Advisory Commission on Additional Licensing Models, co-chaired by the Federation of State Medical Boards (FSMB), Intealth™, and the ACGME. This Commission, established in March 2024, released draft preliminary recommendations on eligibility requirements for public comment through December 6, 2024. Notably, requiring GME training is recommended for the IMGs in any additional licensing pathway. More information is expected in 2025.

*AMA efforts and resources*

GME, matching, and the physician shortage are areas of significant concern of the AMA and often addressed in its Advocacy efforts. See Appendix B for a list of relevant accomplishments in the last two years alone.

In addition to the report cited earlier, the Council on Medical Education has actively addressed concerns related to GME and the physician workforce in reports such as:

- Guiding Principles and Appropriate Criteria for Assessing the Competency of Physicians Across the Professional Continuum, CME 1-I-21
- Optimizing Match Outcomes, CME 3-A-21
- Expanding UME Without Concurrent GME Expansion, CME 3-A-18
- Options for Unmatched Medical Students, CME 5-A-17
- Standardizing the Allopathic Residency Match System and Timeline, CME 6-A-17
- Addressing the Increasing Number of Unmatched Medical Students, CME 3-A-16

FREIDA™ is the AMA's Residency & Fellowship Database® that enables unmatched students to research residencies from more than 13,000 programs both during and following SOAP.

AMA media coverage and educational resources in the last two years include:

- Powerful Senate committee takes up physician shortage (Aug 2024)
- AMA president sounds alarm on national physician shortage (Oct 2023)
- Match: Which specialties place most residents through SOAP (Feb 2024)
- What if you don't match? 4 things you should do (March 2024)
- What's exacerbating the physician shortage crisis—and what's needed to fix it (May 2024).

REVANT AMA POLICIES

The AMA has strong policy in support of GME, medical licensure, board certification, and competent patient care – all of which illuminate the importance of completion of a residency. See Appendix C for full policies. To support an alternative to residency training that allows for insufficiently supervised patient care would go against longstanding AMA policy.

AMA policy D-310.977 entitled "National Resident Matching Program Reform" addresses the unmatched in clauses 11-15 and 17 to read as follows:

11. Our AMA will work with the Association of American Medical Colleges (AAMC), American Osteopathic Association (AOA), American Association of Colleges of Osteopathic Medicine (AACOM), and National Resident Matching Program (NRMP) to evaluate the current available data or propose new studies that would help us learn how many students graduating from US medical schools each year do not enter into a US residency program; how many never enter into a US residency program; whether there is disproportionate impact on individuals of minority racial and ethnic groups; and what careers are pursued by those with an MD or DO degree who do not enter residency programs.
12. Our AMA will work with the AAMC, AOA, AACOM and appropriate licensing boards to study whether US medical school graduates and international medical graduates who do not enter residency programs may be able to serve unmet national health care needs;
13. Our AMA will work with the AAMC, AOA, AACOM and the NRMP to evaluate the feasibility of a national tracking system for US medical students who do not initially match into a categorical residency program.
14. Our AMA will discuss with the National Resident Matching Program, Association of American Medical Colleges, American Osteopathic Association, Liaison Committee on Medical Education, Accreditation Council for Graduate Medical Education, and other interested bodies potential pathways for reengagement in medicine following an unsuccessful match and report back on the results of those discussions.
15. Our AMA encourages the Association of American Medical Colleges to work with U.S. medical schools to identify best practices, including career counseling, used by medical schools to facilitate successful matches for medical school seniors, and reduce the number who do not match.
17. Our AMA encourages the Educational Commission for Foreign Medical Graduates (ECFMG) and other interested stakeholders to study the personal and financial consequences of ECFMG-certified U.S. IMGs who do not match in the National Resident Matching Program and are therefore unable to get a residency or practice medicine.

Also, AMA Policy H-200.954 entitled "US Physician Shortage" addresses the underlying issue of this resolution — the physician shortage. Additional related policies are located in the AMA Policy Finder and include:

- Educational Strategies for Meeting Rural Health Physician Shortage H-465.988
- Proposed Revisions to AMA Policy on the Financing of Medical Education Programs H-305.929
- Evaluation of DACA-Eligible Medical Students, Residents and Physicians in Addressing Physician Shortages D-350.986
- Financing of Medical Education Programs D-305.973
- Fixing the VA Physician Shortage with Physicians D-510.990
- The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education D-305.967
- Residents and Fellows' Bill of Rights H-310.912

SUMMARY

This report examined issues surrounding physicians who do not secure entry into an accredited residency program by graduation. It addressed concerns related to competency to perform patient care as well as the growing physician shortage, both of which were raised by the resolution author. Based on the data and analysis in this report, changing professional standards to permit the small number of unmatched physicians without GME training to practice is a problematic and negligible response to physician workforce shortages and lack of access to care. Successful completion of a residency is a key tenant of medical education and licensure and is highly supported by AMA policy. However, there may be more that key parties can do to support and prepare applicants to succeed is securing a GME position in their residency applications and The Match (or other match processes). Such parties should evaluate their roles and efforts.

RECOMMENDATIONS

The Council on Medical Education recommends that the following be adopted in lieu of Resolution 306-A-24, and the remainder of the report be filed:

1. Encourage relevant parties to examine the root causes for physicians who do not secure entry into an accredited residency program by graduation and evaluate each of their efforts to address them including informing medical students and their advisers how to obtain GME training opportunities. Such parties include but are not limited to medical schools, residency programs, Association of American Medical Colleges, American Association of Colleges of Osteopathic Medicine, National Resident Matching Program , Intealth, and Accreditation Council for Graduate Medical Education . (New HOD Policy)

2. Encourage relevant parties to evaluate opportunities that have successfully matched previously unmatched physicians into residency positions, so students can be better counselled on opportunities that improve their chances of matching into a residency program. (New HOD Policy)

3. Reaffirm AMA policies D-310.977 "National Resident Matching Program Reform" and H-200.954 "U.S. Physician Shortage." (Reaffirm HOD Policy)

Fiscal note: $1,000

APPENDIX A:

PGY-1 Match and Placement Rates by Applicant Type, 2024

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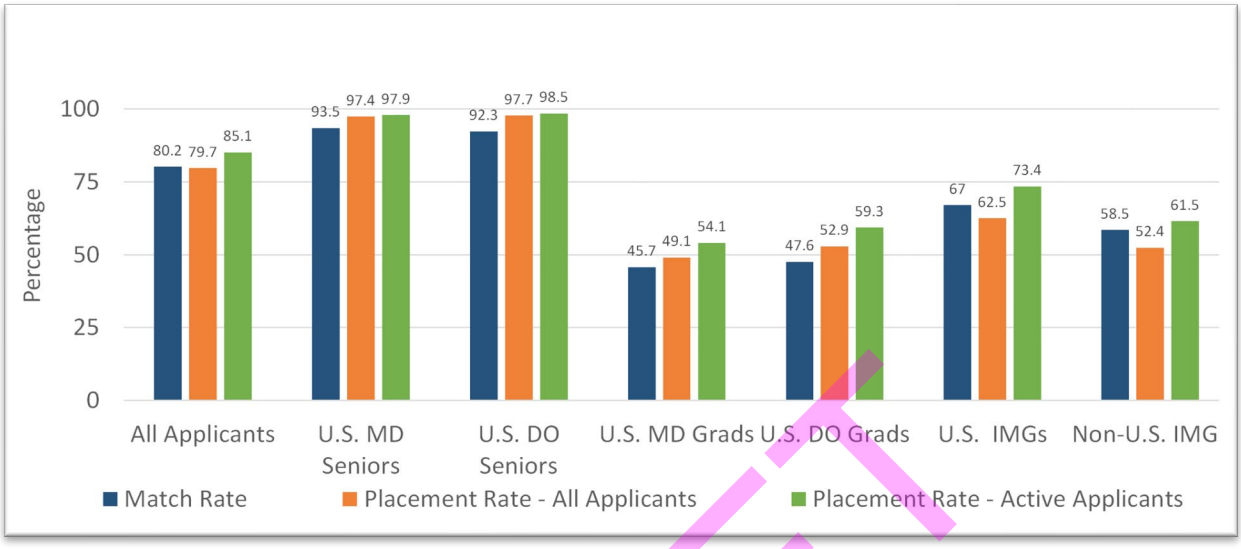


*National Resident Matching Program, Results and Data: 2024 Main Residency Match. Reprinted with permission from NRMP, 2025.*

APPENDIX B: AMA ADVOCACY EFFORTS IN LAST TWO YEARS

- June 24, 2024: comments were submitted on the Senate Finance Committee's draft policy proposal and specific questions for consideration on policies related to the Medicare Graduate Medical Education (GME) program. If workforce barriers for physicians are reduced and additional investments in GME are made, it will help to increase the number of physicians in the U.S., which will lead to healthier communities and ultimately a healthier country as access to much-needed medical care increases.
- June 10, 2024: comments were submitted to the Centers for Medicare & Medicaid Services (CMS) on the Fiscal Year 2025 Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals (IPPS) and the Long-Term Care Hospital Prospective Payment System (LTCH PPS), supporting the expansion of resources and the removal of barriers to the training and retention of obstetric care physicians, especially in rural and underserved areas. We also recommended that CMS consider increasing support for programs that integrate comprehensive approaches to maternity care and highlight the importance of social determinants of health (SODH) in maternal and infant outcomes. The AMA also supported the allocation of Graduate Medical Education (GME) slots to strategically address the most pressing needs within the health care system, including the shortage of mental health professionals. We urged CMS to adopt a distribution framework that considers the specific needs of communities and the capacity of institutions to provide high quality education and training to residents.
- May 16, 2024: Statement for the Record was submitted to the U.S. Senate Committee on Finance as part of the hearing entitled, "Rural Health Care: Supporting Lives and Improving Communities." The statement covered a number of issues, including recommendations on ways to increase and retain the physician workforce, especially in rural communities.
- October 19, 2023: Statement for the Record was submitted to the U.S. House of Representatives Committee on Energy and Commerce Subcommittee on Health as part of the hearing entitled "What's the Prognosis? Examining Medicare Proposals to Improve Patient Access to Care & Minimize Red Tape for Doctors." This statement covers a number of issues including GME and workforce issues that the AMA would like addressed to strengthen the physician workforce.
- October 5, 2023: letter was sent by request from the House Committee on Ways and Means' for information (RFI) commenting on ways to improve health care in rural and underserved areas. A number of subject areas were covered including needed improvements for workforce issues and scope of practice considerations.

- March 20, 2023: comments were submitted to the Senate Committee on Health, Education, Labor and Pensions responding to their request for comment concerning health care workforce shortages. We discussed rural hospitals, physician burnout, prior authorization, loan repayment and scholarship programs, support for physician led teams, and physician payment.
- On July 29, 2022: information was provided regarding the Department of Health and Human Services' (HHS) Initiative To Strengthen Primary Health Care.
- May 22, 2023: letter was signed in support of the Resident Physician Shortage Reduction Act of 2023 (S. 1302). This bipartisan legislation is crucial to expanding the physician workforce and to ensuring that patients across the country are able to access quality care from physicians.
- On May 9, 2023: letter was sent in strong support of H.R. 2389, the "Resident Physician Shortage Reduction Act of 2023." This bipartisan legislation would gradually raise the number of Medicare-supported graduate medical education (GME) positions by 2,000 per year for seven years, for a total of 14,000 new slots. A share of these positions would be targeted to hospitals with diverse needs including hospitals in rural areas, hospitals serving patients from health professional shortage areas (HPSAs), hospitals affiliated with historically Black medical schools, hospitals in states with new medical schools or branch campuses, and hospitals already training over their caps.

APPENDIX C: RELEVANT AMA POLICIES

National Resident Matching Program Reform D.310.977

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

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

12. Our AMA will work with the AAMC, AOA, AACOM and appropriate licensing boards to study whether US medical school graduates and international medical graduates who do not enter residency programs may be able to serve unmet national health care needs;
13. Our AMA will work with the AAMC, AOA, AACOM and the NRMP to evaluate the feasibility of a national tracking system for US medical students who do not initially match into a categorical residency program.
14. Our AMA will discuss with the National Resident Matching Program, Association of American Medical Colleges, American Osteopathic Association, Liaison Committee on Medical Education, Accreditation Council for Graduate Medical Education, and other interested bodies potential pathways for reengagement in medicine following an unsuccessful match and report back on the results of those discussions.
15. Our AMA encourages the Association of American Medical Colleges to work with U.S. medical schools to identify best practices, including career counseling, used by medical schools to facilitate successful matches for medical school seniors, and reduce the number who do not match.
16. Our AMA supports the movement toward a unified and standardized residency application and match system for all non-military residencies.
17. Our AMA encourages the Educational Commission for Foreign Medical Graduates (ECFMG) and other interested stakeholders to study the personal and financial consequences of ECFMG-certified U.S. IMGs who do not match in the National Resident Matching Program and are therefore unable to get a residency or practice medicine.
18. Our AMA encourages the AAMC, AACOM, NRMP, and other key stakeholders to jointly create a no-fee, easily accessible clearinghouse of reliable and valid advice and tools for residency program applicants seeking cost-effective methods for applying to and successfully matching into residency.
19. Our AMA will work with appropriate stakeholders to study options for improving transparency in the resident application process.
20. Our AMA encourages the piloting of innovations to the residency application process with aims to reduce application numbers per applicant, focus applicants on programs with reciprocal interest, and maximize residency placement. With support from the medical education community, successful pilots should be expanded to enhance the standardized process.
21. Our AMA will continue to engage the National Resident Matching Program® (NRMP®) and other matching organizations on behalf of residents and medical students to further develop ongoing relationships, improve communications, and seek additional opportunities to collaborate including the submission of suitable nominees for their governing bodies as appropriate.

US Physician Shortage H-200.954

1. Our American Medical Association explicitly recognizes the existing shortage of physicians in many specialties and areas of the US.
2. Our AMA supports efforts to quantify the geographic maldistribution and physician shortage in many specialties.
3. Our AMA supports current programs to alleviate the shortages in many specialties and the maldistribution of physicians in the US.
4. Our AMA encourages medical schools and residency programs to consider developing admissions policies and practices and targeted educational efforts aimed at attracting physicians to practice in underserved areas and to provide care to underserved populations.
5. Our AMA encourages medical schools and residency programs to continue to provide courses, clerkships, and longitudinal experiences in rural and other underserved areas as a means to support educational program objectives and to influence choice of graduates' practice locations.
6. Our AMA encourages medical schools to include criteria and processes in admission of medical students that are predictive of graduates' eventual practice in underserved areas and with underserved populations.
7. Our AMA will continue to advocate for funding from public and private payers for educational programs that provide experiences for medical students in rural and other underserved areas.
8. Our AMA will continue to advocate for funding from all payers (public and private sector) to increase the number of graduate medical education positions in specialties leading to first certification.
9. Our AMA will work with other groups to explore additional innovative strategies for funding graduate medical education positions, including positions tied to geographic or specialty need.
10. Our AMA continues to work with the Association of American Medical Colleges (AAMC) and other relevant groups to monitor the outcomes of the National Resident Matching Program; and

11. Our AMA continues to work with the AAMC and other relevant groups to develop strategies to address the current and potential shortages in clinical training sites for medical students.
12. Our AMA will:
    a. promote greater awareness and implementation of the Project ECHO (Extension for Community Healthcare Outcomes) and Child Psychiatry Access Project models among academic health centers and community-based primary care physicians;
    b. work with stakeholders to identify and mitigate barriers to broader implementation of these models in the United States; and
    c. monitor whether health care payers offer additional payment or incentive payments for physicians who engage in clinical practice improvement activities as a result of their participation in programs such as Project ECHO and the Child Psychiatry Access Project; and if confirmed, promote awareness of these benefits among physicians.
13. Our AMA will work to augment the impact of initiatives to address rural physician workforce shortages.
14. Our AMA supports opportunities to incentivize physicians to select specialties and practice settings which involve delivery of health services to populations experiencing a shortage of providers, such as women, LGBTQ+ patients, children, elder adults, and patients with disabilities, including populations of such patients who do not live in underserved geographic areas.

Educational Strategies for Meeting Rural Health Physician Shortage H-465.988

1. In light of the data available from the current literature as well as ongoing studies being conducted by staff, our American Medical Association recommends that:
    a. Our AMA encourage medical schools and residency programs to develop educationally sound rural clinical preceptorships and rotations consistent with educational and training requirements, and to provide early and continuing exposure to those programs for medical students and residents.
    b. Our AMA encourage medical schools to develop educationally sound primary care residencies in smaller communities with the goal of educating and recruiting more rural physicians.
    c. Our AMA encourage state and county medical societies to support state legislative efforts toward developing scholarship and loan programs for future rural physicians.
    d. Our AMA encourage state and county medical societies and local medical schools to develop outreach and recruitment programs in rural counties to attract promising high school and college students to medicine and the other health professions.
    e. Our AMA urge continued federal and state legislative support for funding of Area Health Education Centers (AHECs) for rural and other underserved areas.
    f. Our AMA continue to support full appropriation for the National Health Service Corps Scholarship Program, with the proviso that medical schools serving states with large rural underserved populations have a priority and significant voice in the selection of recipients for those scholarships.
    g. Our AMA support full funding of the new federal National Health Service Corps loan repayment program.
    h. Our AMA encourage continued legislative support of the research studies being conducted by the Rural Health Research Centers funded by the National Office of Rural Health in the Department of Health and Human Services.
    i. Our AMA continue its research investigation into the impact of educational programs on the supply of rural physicians.
    j. Our AMA continue to conduct research and monitor other progress in development of educational strategies for alleviating rural physician shortages.
    k. Our AMA reaffirm its support for legislation making interest payments on student debt tax deductible.
    l. Our AMA encourage state and county medical societies to develop programs to enhance work opportunities and social support systems for spouses of rural practitioners.
2. Our AMA will work with state and specialty societies, medical schools, teaching hospitals, the Accreditation Council for Graduate Medical Education (ACGME), the Centers for Medicare and Medicaid Services (CMS) and other interested stakeholders to identify, encourage and incentivize qualified rural physicians to serve as preceptors and volunteer faculty for rural rotations in residency.
3. Our AMA will:
    a. work with interested stakeholders to identify strategies to increase residency training opportunities in rural areas with a report back to the House of Delegates; and
    b. work with interested stakeholders to formulate an actionable plan of advocacy with the goal of increasing residency training in rural areas.

4. Our AMA will encourage ACGME review committees to consider adding exposure to rural medicine as appropriate, to encourage the development of rural program tracks in training programs and increase physician awareness of the conditions that pose challenges and lack of resources in rural areas.
5. Our AMA will encourage adding educational webinars, workshops and other didactics via remote learning formats to enhance the educational needs of smaller training programs.

Proposed Revisions to AMA Policy on the Financing of Medical Education Programs H-305.929

1. It is AMA policy that:

   A. Since quality medical education directly benefits the American people, there should be public support for medical schools and graduate medical education programs and for the teaching institutions in which medical education occurs. Such support is required to ensure that there is a continuing supply of well-educated, competent physicians to care for the American public.

   B. Planning to modify health system organization or financing should include consideration of the effects on medical education, with the goal of preserving and enhancing the quality of medical education and the quality of and access to care in teaching institutions are preserved.

   C. Adequate and stable funding should be available to support quality undergraduate and graduate medical education programs. Our AMA and the federation should advocate for medical education funding.

   D. Diversified sources of funding should be available to support medical schools' multiple missions, including education, research, and clinical service. Reliance on any particular revenue source should not jeopardize the balance among a medical school's missions.

   E. All payers for health care, including the federal government, the states, and private payers, benefit from graduate medical education and should directly contribute to its funding.

   F. Full Medicare direct medical education funding should be available for the number of years required for initial board certification. For combined residency programs, funding should be available for the longest of the individual programs plus one additional year. There should be opportunities to extend the period of full funding for specialties or subspecialties where there is a documented need, including a physician shortage.

   G. Medical schools should develop systems to explicitly document and reimburse faculty teaching activity, so as to facilitate faculty participation in medical student and resident physician education and training.

   H. Funding for graduate medical education should support the training of resident physicians in both hospital and non-hospital (ambulatory) settings. Federal and state funding formulas must take into account the resources, including volunteer faculty time and practice expenses, needed for training residents in all specialties in non-hospital, ambulatory settings. Funding for GME should be allocated to the sites where teaching occurs.

   I. New funding should be available to support increases in the number of medical school and residency training positions, preferably in or adjacent to physician shortage/underserved areas and in undersupplied specialties.
2. Our AMA endorses the following principles of social accountability and promotes their application to GME funding: (a) Adequate and diverse workforce development; (b) Primary care and specialty practice workforce distribution; (c) Geographic workforce distribution; and (d) Service to the local community and the public at large.
3. Our AMA encourages transparency of GME funding through models that are both feasible and fair for training sites, affiliated medical schools and trainees.
4. Our AMA believes that financial transparency is essential to the sustainable future of GME funding and therefore, regardless of the method or source of payment for GME or the number of funding streams, institutions should publicly report the aggregate value of GME payments received as well as what these payments are used for, including: (a) Resident salary and benefits; (b) Administrative support for graduate medical education; (c) Salary reimbursement for teaching staff; (d) Direct educational costs for residents and fellows; and (e) Institutional overhead.
5. Our AMA supports specialty-specific enhancements to GME funding that neither directly nor indirectly reduce funding levels for any other specialty.

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

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

Financing of Medical Education Programs D-305.973

1. Our American Medical Association will work with the federal government, including the Centers for Medicare and Medicaid Services, and the states, along with other interested parties, to bring about the following outcomes:
   a. Ensure adequate Medicaid and Medicare funding for graduate medical education.
   b. Ensure adequate Disproportionate Share Hospital funding.
   c. Make the Medicare direct medical education per-resident cost figure more equitable across teaching hospitals while assuring adequate funding of all residency positions.
   d. Revise the Medicare and Medicaid funding formulas for graduate medical education to recognize the resources utilized for training in non-hospital settings.
   e. Stabilize funding for pediatric residency training in children's hospitals.
   f. Explore the possibility of extending full direct medical education per-resident payment beyond the time of first board eligibility for specialties/subspecialties in shortage/defined need.
   g. Identify funding sources to increase the number of graduate medical education positions, especially in or adjacent to physician shortage/underserved areas and in undersupplied specialties.
   h. Act on existing policy by seeking federal legislation requiring all health insurers to support graduate medical education through an all-payer trust fund created for this purpose.
2. Our AMA will work with other interested parties to ensure adequate funding to support medical school educational programs, including creating mechanisms to fund additional medical school positions.

Fixing the VA Physician Shortage with Physicians D-510.990

1. Our AMA will work with the VA to enhance its loan forgiveness efforts to further incentivize physician recruiting and retention and improve patient access in the Veterans Administration facilities.
2. Our AMA will call for an immediate change in the Public Service Loan Forgiveness Program to allow physicians to receive immediate loan forgiveness when they practice in a Veterans Administration facility.
3. Our AMA will work with the Veterans Administration to minimize the administrative burdens that discourage or prevent non-VA physicians without compensation (WOCs) from volunteering their time to care for veterans.
4. Our AMA will: (a) continue to support the mission of the Department of Veterans Affairs Office of Academic Affiliations for expansion of graduate medical education (GME) residency positions; and (b) collaborate with appropriate stakeholder organizations to advocate for preservation of Veterans Health Administration funding for GME and support its efforts to expand GME residency positions in the federal budget and appropriations process.
5. Our AMA supports postgraduate medical education service obligations through programs where the expectation for service, such as military service, is reasonable and explicitly delineated in the contract with the trainee.
6. Our AMA opposes the blanket imposition of service obligations through any program where physician trainees rotate through the facility as one of many sites for their training.

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

1. Our American Medical Association will actively collaborate with appropriate stakeholder organizations, (including Association of American Medical Colleges, American Hospital Association, state medical societies, medical specialty societies/associations) to advocate for the preservation, stability and expansion of full funding for the direct and indirect costs of graduate medical education (GME) positions from all existing sources (e.g. Medicare, Medicaid, Veterans Administration, CDC and others).
2. Our AMA will actively advocate for the stable provision of matching federal funds for state Medicaid programs that fund GME positions.
3. Our AMA will actively seek congressional action to remove the caps on Medicare funding of GME positions for resident physicians that were imposed by the Balanced Budget Amendment of 1997 (BBA-1997).
4. Our AMA will strenuously advocate for increasing the number of GME positions to address the future physician workforce needs of the nation.
5. Our AMA will oppose efforts to move federal funding of GME positions to the annual appropriations process that is subject to instability and uncertainty.
6. Our AMA will oppose regulatory and legislative efforts that reduce funding for GME from the full scope of resident educational activities that are designated by residency programs for accreditation and the board certification of their graduates (e.g. didactic teaching, community service, off-site ambulatory rotations, etc.).
7. Our AMA will actively explore additional sources of GME funding and their potential impact on the quality of residency training and on patient care.
8. Our AMA will vigorously advocate for the continued and expanded contribution by all payers for health care (including the federal government, the states, and local and private sources) to fund both the direct and indirect costs of GME.

9. Our AMA will work, in collaboration with other stakeholders, to improve the awareness of the general public that GME is a public good that provides essential services as part of the training process and serves as a necessary component of physician preparation to provide patient care that is safe, effective and of high quality.
10. Our AMA staff and governance will continuously monitor federal, state and private proposals for health care reform for their potential impact on the preservation, stability and expansion of full funding for the direct and indirect costs of GME.
11. Our AMA:
    a. recognizes that funding for and distribution of positions for GME are in crisis in the United States and that meaningful and comprehensive reform is urgently needed.
    b. will immediately work with Congress to expand medical residencies in a balanced fashion based on expected specialty needs throughout our nation to produce a geographically distributed and appropriately sized physician workforce; and to make increasing support and funding for GME programs and residencies a top priority of the AMA in its national political agenda.
    c. will continue to work closely with the Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, American Osteopathic Association, and other key stakeholders to raise awareness among policymakers and the public about the importance of expanded GME funding to meet the nation's current and anticipated medical workforce needs.
12. Our AMA will collaborate with other organizations to explore evidence-based approaches to quality and accountability in residency education to support enhanced funding of GME.
13. Our AMA will continue to strongly advocate that Congress fund additional graduate medical education (GME) positions for the most critical workforce needs, especially considering the current and worsening maldistribution of physicians.
14. Our AMA will advocate that the Centers for Medicare and Medicaid Services allow for rural and other underserved rotations in Accreditation Council for Graduate Medical Education (ACGME)-accredited residency programs, in disciplines of particular local/regional need, to occur in the offices of physicians who meet the qualifications for adjunct faculty of the residency program's sponsoring institution.
15. Our AMA encourages the ACGME to reduce barriers to rural and other underserved community experiences for graduate medical education programs that choose to provide such training, by adjusting as needed its program requirements, such as continuity requirements or limitations on time spent away from the primary residency site.
16. Our AMA encourages the ACGME and the American Osteopathic Association (AOA) to continue to develop and disseminate innovative methods of training physicians efficiently that foster the skills and inclinations to practice in a health care system that rewards team-based care and social accountability.
17. Our AMA will work with interested state and national medical specialty societies and other appropriate stakeholders to share and support legislation to increase GME funding, enabling a state to accomplish one or more of the following: (a) train more physicians to meet state and regional workforce needs; (b) train physicians who will practice in physician shortage/underserved areas; or (c) train physicians in undersupplied specialties and subspecialties in the state/region.
18. Our AMA supports the ongoing efforts by states to identify and address changing physician workforce needs within the GME landscape and continue to broadly advocate for innovative pilot programs that will increase the number of positions and create enhanced accountability of GME programs for quality outcomes.
19. Our AMA will continue to work with stakeholders such as Association of American Medical Colleges (AAMC), ACGME, AOA, American Academy of Family Physicians, American College of Physicians, and other specialty organizations to analyze the changing landscape of future physician workforce needs as well as the number and variety of GME positions necessary to provide that workforce.
20. Our AMA will explore innovative funding models for incremental increases in funded residency positions related to quality of resident education and provision of patient care as evaluated by appropriate medical education organizations such as the Accreditation Council for Graduate Medical Education.
21. Our AMA will utilize its resources to share its content expertise with policymakers and the public to ensure greater awareness of the significant societal value of graduate medical education (GME) in terms of patient care, particularly for underserved and at-risk populations, as well as global health, research and education.
22. Our AMA will advocate for the appropriation of Congressional funding in support of the National Healthcare Workforce Commission, established under section 5101 of the Affordable Care Act, to provide data and healthcare workforce policy and advice to the nation and provide data that support the value of GME to the nation.
23. Our AMA supports recommendations to increase the accountability for and transparency of GME funding and continue to monitor data and peer-reviewed studies that contribute to further assess the value of GME.

24. Our AMA will explore various models of all-payer funding for GME, especially as the Institute of Medicine (now a program unit of the National Academy of Medicine) did not examine those options in its 2014 report on GME governance and financing.
25. Our AMA encourages organizations with successful existing models to publicize and share strategies, outcomes and costs.
26. Our AMA encourages insurance payers and foundations to enter into partnerships with state and local agencies as well as academic medical centers and community hospitals seeking to expand GME.
27. Our AMA will develop, along with other interested stakeholders, a national campaign to educate the public on the definition and importance of graduate medical education, student debt and the state of the medical profession today and in the future.
28. Our AMA will collaborate with other stakeholder organizations to evaluate and work to establish consensus regarding the appropriate economic value of resident and fellow services.
29. Our AMA will monitor ongoing pilots and demonstration projects, and explore the feasibility of broader implementation of proposals that show promise as alternative means for funding physician education and training while providing appropriate compensation for residents and fellows.
30. Our AMA will monitor the status of the House Energy and Commerce Committee's response to public comments solicited regarding the 2014 IOM report, Graduate Medical Education That Meets the Nation's Health Needs, as well as results of ongoing studies, including that requested of the GAO, in order to formulate new advocacy strategy for GME funding, and will report back to the House of Delegates regularly on important changes in the landscape of GME funding.
31. Our AMA will advocate to the Centers for Medicare & Medicaid Services to adopt the concept of "Cap-Flexibility" and allow new and current Graduate Medical Education teaching institutions to extend their cap-building window for up to an additional five years beyond the current window (for a total of up to ten years), giving priority to new residency programs in underserved areas and/or economically depressed areas.
32. Our AMA will:
    a. encourage all existing and planned allopathic and osteopathic medical schools to thoroughly research match statistics and other career placement metrics when developing career guidance plans.
    b. strongly advocate for and work with legislators, private sector partnerships, and existing and planned osteopathic and allopathic medical schools to create and fund graduate medical education (GME) programs that can accommodate the equivalent number of additional medical school graduates consistent with the workforce needs of our nation.
    c. encourage the Liaison Committee on Medical Education (LCME), the Commission on Osteopathic College Accreditation (COCA), and other accrediting bodies, as part of accreditation of allopathic and osteopathic medical schools, to prospectively and retrospectively monitor medical school graduates' rates of placement into GME as well as GME completion.
33. Our AMA encourages the Secretary of the U.S. Department of Health and Human Services to coordinate with federal agencies that fund GME training to identify and collect information needed to effectively evaluate how hospitals, health systems, and health centers with residency programs are utilizing these financial resources to meet the nation's health care workforce needs. This includes information on payment amounts by the type of training programs supported, resident training costs and revenue generation, output or outcomes related to health workforce planning (i.e., percentage of primary care residents that went on to practice in rural or medically underserved areas), and measures related to resident competency and educational quality offered by GME training programs.
34. Our AMA will publicize best practice examples of state-funded Graduate Medical Education positions and develop model state legislation where appropriate.
35. Our American Medical Association will ask federal agencies that fund graduate medical education (including but not limited to the Centers for Medicare and Medicaid Services, the Department of Veterans Affairs, the Department of Defense, the Health Resources and Services Administration, and others) to issue an annual report detailing the quantity of total GME funding for each year including how Direct GME funds are allocated on a per resident or fellow basis, for the previous year.

Residents and Fellows' Bill of Rights H-310.912

1. Our American Medical Association continues to advocate for improvements in the ACGME Institutional and Common Program Requirements that support AMA policies as follows:
    a. Adequate financial support for and guaranteed leave to attend professional meetings.
    b. Submission of training verification information to requesting agencies within 30 days of the request.

c. Adequate compensation with consideration to local cost-of-living factors and years of training, and to include the orientation period.
d. Health insurance benefits to include dental and vision services.
e. Paid leave for all purposes (family, educational, vacation, sick) to be no less than six weeks per year.
f. Stronger due process guidelines.

2. Our AMA encourages the ACGME to ensure access to educational programs and curricula as necessary to facilitate a deeper understanding by resident physicians of the US health care system and to increase their communication skills.
3. Our AMA regularly communicates to residency and fellowship programs and other GME stakeholders this Resident/Fellows Physicians' Bill of Rights.
4. Our AMA:
   a. will promote residency and fellowship training programs to evaluate their own institution's process for repayment and develop a leaner approach. This includes disbursement of funds by direct deposit as opposed to a paper check and an online system of applying for funds.
   b. encourages a system of expedited repayment for purchases of $200 or less (or an equivalent institutional threshold), for example through payment directly from their residency and fellowship programs (in contrast to following traditional workflow for reimbursement).
   c. encourages training programs to develop a budget and strategy for planned expenses versus unplanned expenses, where planned expenses should be estimated using historical data, and should include trainee reimbursements for items such as educational materials, attendance at conferences, and entertaining applicants. Payment in advance or within one month of document submission is strongly recommended.
5. Our AMA will partner with ACGME and other relevant stakeholders to encourage training programs to reduce financial burdens on residents and fellows by providing employee benefits including, but not limited to, on-call meal allowances, transportation support, relocation stipends, and childcare services.
6. Our AMA will work with the Accreditation Council for Graduate Medical Education (ACGME) and other relevant stakeholders to amend the ACGME Common Program Requirements to allow flexibility in the specialty-specific ACGME program requirements enabling specialties to require salary reimbursement or "protected time" for resident and fellow education by "core faculty," program directors, and assistant/associate program directors.
7. Our AMA encourages teaching institutions to offer retirement plan options, retirement plan matching, financial advising and personal finance education.
8. Our AMA adopts the following "Residents and Fellows' Bill of Rights" as applicable to all resident and fellow physicians in ACGME-accredited training programs:

RESIDENT/FELLOW PHYSICIANS' BILL OF RIGHTS

Residents and fellows have a right to

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

With regard to education, residents and fellows should expect:

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

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

With regard to supervision, residents and fellows must be ultimately supervised by physicians who are adequately qualified and allow them to assume progressive responsibility appropriate to their level of education, competence, and experience. In instances where clinical education is provided by non-physicians, there must be an identified physician supervisor providing indirect supervision, along with mechanisms for reporting inappropriate, non-physician supervision to the training program, sponsoring institution or ACGME as appropriate.

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

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

E. Adequate compensation and benefits that provide for resident well-being and health.
   1. With regard to contracts, residents and fellows should receive:
      a. Information about the interviewing residency or fellowship program including a copy of the currently used contract clearly outlining the conditions for (re)appointment, details of remuneration, specific responsibilities including call obligations, and a detailed protocol for handling any grievance.
      b. At least four months advance notice of contract non-renewal and the reason for non-renewal.
   2. With regard to compensation, residents and fellows should receive:
      a. Compensation for time at orientation.
      b. Compensation, including salary and benefits, commensurate with their level of training and experience. Compensation should reflect cost of living differences based on local economic factors, such as housing, transportation, and energy costs (which affect the purchasing power of wages), and include appropriate adjustments for changes in the cost of living.
   3. With regard to benefits, residents and fellows must be fully informed of and should receive:
      a. Quality and affordable comprehensive medical, mental health, dental, and vision care for residents and their families, as well as retirement plan options, professional liability insurance and disability insurance to all residents for disabilities resulting from activities that are part of the educational program.
      b. An institutional written policy on and education in the signs of excessive fatigue, clinical depression, substance abuse and dependence, and other physician impairment issues.
      c. Confidential access to mental health and substance abuse services.
      d. A guaranteed, predetermined amount of paid vacation leave, sick leave, family and medical leave and educational/professional leave during each year in their training program, the total amount of which should not be less than six weeks.
      e. Leave in compliance with the Family and Medical Leave Act.
      f. The conditions under which sleeping quarters, meals and laundry or their equivalent are to be provided.

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

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

H. Access to and protection by institutional and accreditation authorities when reporting violations With regard to reporting violations to the ACGME, residents and fellows should:

   1. Be informed by their program at the beginning of their training and again at each semi-annual review of the resources and processes available within the residency program for addressing resident concerns or complaints, including the program director, Residency Training Committee, and the designated institutional official.
   2. Be able to file a formal complaint with the ACGME to address program violations of residency training requirements without fear of recrimination and with the guarantee of due process.
   3. Have the opportunity to address their concerns about the training program through confidential channels, including the ACGME concern process and/or the annual ACGME Resident Survey.
9. Our AMA will work with the ACGME and other relevant stakeholders to advocate for ways to defray additional costs related to residency and fellowship training, including essential amenities and/or high cost specialty-specific equipment required to perform clinical duties.
10. Our AMA believes that healthcare trainee salary, benefits, and overall compensation should, at minimum, reflect length of pre-training education, hours worked, and level of independence and complexity of care allowed by an individual's training program (for example when comparing physicians in training and midlevel providers at equal postgraduate training levels).
11. The Residents and Fellows' Bill of Rights will be prominently published online on the AMA website and disseminated to residency and fellowship programs.
12. Our AMA will distribute and promote the Residents and Fellows' Bill of Rights online and individually to residency and fellowship training programs and encourage changes to institutional processes that embody these principles, including resident/fellow empowerment and peer-selected representation in institutional leadership.
13. Our AMA encourages development of accreditation standards and institutional policies designed to facilitate and protect residents/fellows who seek to exercise their rights.
14. Our AMA encourages the formation of peer-led resident/fellow organizations that can advocate for trainees' interests, as outlined by the AMA's Residents and Fellows' Bill of Rights, at sponsoring institutions.



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## 4. ACCESS TO RESTRICTED HEALTH SERVICES WHEN COMPLETING PHYSICIAN CERTIFICATION EXAMS

*Reference committee hearing: see report of Reference Committee C.*

**HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS**
**REMAINDER OF REPORT FILED**
*See Policy D-275.944*

Resolution 307-A-24, "Access to Reproductive Health Services When Completing Physician Certification Exams," was introduced by the California delegation at the 2024 Annual Meeting of the American Medical Association (AMA). Alternate language was proposed in Reference Committee C to reduce the risk of unintended consequences from implementation, while supporting the original resolution's intentions as an urgent issue regarding the potential for personal health and/or legal risk in states with laws restricting health services, particularly reproductive and gender-affirming care.

Alternate Resolution 307 was adopted by the House of Delegates, becoming AMA Policy D-275.944, Access to Reproductive Health Services When Completing Physician Certification Exams. The first resolve was already implemented, and states: "Our American Medical Association will encourage national specialty boards who hold in-person centralized mandatory exams for board certification to provide alternate options when those exams take place in states with laws banning or restricting abortion, gender-affirming care, or reproductive healthcare services such that travel to those states would present either a limitation in access to necessary medical care, or threat of civil or criminal penalty against the examinees and examiners."

The second resolve states that the AMA will "study the impact of laws restricting reproductive healthcare and gender-affirming care on examinees and examiners of national specialty board exams and existing alternatives to in-person board examinations." This report is that study. The title has been modified to "Access to Restricted Health Services When Completing Physician Certification Exams" to reflect the report's wider scope for potentially restricted health services.

BACKGROUND

National specialty board examinations are one mechanism by which specialty boards determine whether a physician has the knowledge and skills to practice safely and effectively in their area of specialization, both initially and on a continuing basis. As discussed in Council on Medical Education Report 4-I-23, "Recognizing Specialty Certifications for Physicians," the history of specialty board examinations is as follows:

"In 1933, the [AMA] established the American Board of Medical Specialties (ABMS) to bring order to the proliferation of specialty boards and address conflicts arising between specialty boards. Other entities later emerged as certification boards and have varying standards for obtaining initial board certification and maintaining continuing certification over time. AMA support of these entities is contingent with the certification program meeting accepted standards that include offering an independent, external assessment of knowledge and skills for both initial certification and recertification or continuous certification in the medical specialty."[1]

Historically, there has been discrimination against osteopathic board certification,[2] which is changing over time,[3] and some osteopathic boards, such as Obstetrics & Gynecology and Emergency Medicine, are open to MDs as well as DOs.[4] AMA policy Medical Specialty Board Certification Standards H-275.926 opposes discrimination against physicians based solely on lack of ABMS or equivalent American Osteopathic Association Bureau of Osteopathic Specialists (AOA-BOS) board certification. However, in the current health care system, board certification is "no longer as discretionary as it once was."[5]

*Current Examination Locations*

Each entity engaged in specialty board examination has different procedures for examination, and this varies between specialties. As a non-comprehensive example of differences—not representing the hundreds of possibilities for board certification—the following table compares a few different entities and specialty board examinations within these entities' standards, based on data publicly available in December 2024:

| **Umbrella Entity** | **Specialty** | **Types of exams for board certification** | **Location of in-person exams** |
|---|---|---|---|
| American Board of Medical Specialties (ABMS) | American Board of Obstetrics & Gynecology (ABOG) | In-person certifying exam | Dallas, TX |
| American Osteopathic Association Bureau of Osteopathic Specialists (AOA-BOS) | American Osteopathic Board of Obstetrics & Gynecology (AOBOG) | Written AOBOG exam (or ABOG qualifying exam) and in-person oral exam | Chicago, IL |
| American Board of Physician Specialties (ABPS) | Obstetrics & Gynecology | Initial certification not offered,[6] recertification requires ABOG or AOBOG initial certification | N/A |
| ABMS | American Board of Pediatrics (ABP) | In-person computer-based exam | Prometric testing centers (multiple locations) |
| AOA-BOS | American Osteopathic Board of Pediatrics (AOBP) | Written exam | N/A (remotely proctored) |
| ABMS | American Board of Emergency Medicine (ABEM) | Written qualifying exam and in-person certifying exam[7] | Written exam at Pearson-Vue testing centers; Raleigh, NC certifying exam in 2026[8] |
| AOA-BOS | American Osteopathic Board of Emergency Medicine (AOBEM) | Written and oral exam | N/A (remotely proctored) |

*Examiners and Examinees*

When safety concerns arise, attention to concerns from both board examiners and examinees is important. However, differences exist between examinees and examiners. If they wish to be board certified, examinees must take mandatory examinations to achieve board certification for their career within a specific time frame. Examiners are also examinees (board certified, with varying requirements for continuing certification) but in the role of examiner are typically optional volunteers who choose to participate for a variety of reasons, such as leadership and professional development, deeper involvement in the specialty, and credit toward continuing certification. This report will focus primarily on initial board certification and examinees due to the disproportionate impact, though the needs of both groups are important, deserve attention, and often overlap.

*Pre-Existing General Accommodations*

For all specialty boards in the United States, reasonable accommodations must be provided in alignment with the Americans with Disabilities Act, a federal civil rights law prohibiting discrimination against people with disabilities in everyday activities.[9] A 2024 article on structural bias in board examinations points out, however, that "society often overlooks individuals who do not qualify for federally protected disability benefits but are nevertheless unable to overcome hurdles equitably."[10] In practice, accommodations—disability-related and otherwise—vary between specialties.[11] A non-comprehensive sample of current accommodation policies (as of December 2024) is below:

According to ABMS Standards for Initial Certification, "Test accommodations must be offered to candidates with documented disabilities (e.g., learning and reading disabilities; physical disabilities; visual impairments) to comply with the Americans with Disabilities Act; Member Boards may also offer accommodations in other situations (e.g., extra break time for nursing mothers). Applicants should be provided with information describing the documentation to be submitted with the request for accommodations and the timeframe within which an accommodation decision will be made. Procedures for responding to these requests should be equitable and consistent and should include a mechanism for handling candidate appeals of these decisions."[12]

According to AOA Testing Accommodation Policies & Procedures, "Reasonable and appropriate accommodations are provided in accordance with the Americans with Disabilities Act (ADA) for individuals with documented disabilities, as well as to those requiring accommodations for use/availability of specific personal items, nursing/breastfeeding and/or related to religious observation. All requests for accommodation must be submitted at least 90 days before the applicable examination."[13] Materials also note a procedure for late requests.

*Pre-Existing Security Policies*

Some boards offer additional information about security for test-takers, such as ABOG, which noted on their website in February 2025, for instance: "ABOG always has security measures in place both during examination weeks as well as during off-examination timeframes. While we do not want to publicize every security measure taken, below are some of the security features you can expect during the Certifying Examination:

- No ABOG site (hotel meeting room for registration, building where the examinations are held, exam floors, etc.) is designated to the public as ABOG spaces by signage.
- ABOG staff is trained in security/emergency protocols including but not limited to fire evacuation, CPR and first aid, and active shooter response.
- The elevators in the ABOG building are badge access only. Only ABOG staff members can move freely about the building.
- The stairwells in the ABOG building are locked and can only be accessed with a code which is changed frequently.
- Additional security personnel are on-site during exam weeks in a number of high-traffic locations.
- Security cameras are live throughout the ABOG building."[14]

*Alternatives to In-Person Board Examinations*

Each specialty board decides on the best format and location for its respective examinations. During the height of the COVID-19 pandemic, several ABMS member boards pivoted from postponing their oral exams to converting to a virtual format.[15] Later research in 2023 found that the American Board of Emergency Medicine (ABEM)'s virtual

oral exam had "substantial validity evidence and reliability to support ongoing use… to make confident and defensible certification decisions,"[16] and good satisfaction with comparable passing rates for the virtual general surgery certifying exam through the American Board of Surgery.[17] Research on the American Board of Anesthesiology's virtual exam, however, demonstrated both pros and cons of the virtual format and prompted a return to an in-person exam due to standardization and security concerns, as well as imperfect technology.[18]

Decisions about relocation, meanwhile, also vary between specialties. Some specialty boards partner with nationwide companies that already offer multiple testing locations, depending on the exam type, while others contract with one specific physical location only. Rapidly changing laws and political climates also offer difficulties as state policies on important issues may shift more rapidly in the future than in-person contracts and logistical planning reasonably allows for.

ABMS offered the following information highlighting some of the considerations Member Board Executives are taking into account when looking at existing and alternative test sites:

- Not all assessments measure the same things: "When ABMS Member Boards were required to move from in-person exams to virtual during COVID, data collected demonstrated that not all content or constructs could be tested equally in a virtual environment as in-person."
- "High variability in the content and components of assessments across specialties. Each Member Board designs assessments critical to the skills, knowledge, and behaviors that are specific to each specialty and sub-specialty."
- "Inability to include low fidelity simulations in remote exams."
- "Consistency to ensure, within each Member Board, every candidate is tested in the same way."
- "Ensuring exam security."
- "Increased exam costs to create and support alternate in-person testing facilities that are equal to existing assessment sites in equipment, staffing, timing and security. Projections by some Member Boards who have explored these options would result in a 4-fold increase in costs for all candidates."
- "How specific laws could impact individuals traveling from out-of-state during participation in certifying exams."

"All Member Boards," ABMS stated, "are committed to providing testing environments that minimize the stress to candidates and are exploring options for alternative test sites with respect to the above."[19]

*Restricted Health Care and Safety Concerns*

As described later in this report, some states in the U.S. currently have laws restricting reproductive and/or gender-affirming health care. National specialty board examination testing location concerns, for the purposes of this report, center multiple arenas, including but not limited to potential risks (physical and legal) to:

- pregnant examiners and examinees
- examiners and examinees who provide reproductive care
- transgender or gender non-conforming examiners and examinees
- examiners and examinees who are primary caregivers of and travel with transgender or gender non-conforming children
- examiners and examinees who provide gender-affirming care

These concerns regarding potential risks are also diverse in terms of levels of legal authorization and overt versus covert threat, including but not limited to:

- states with proposed bills that have not been implemented into law, but wherein overall societal hostility and violence toward people seeking and/or providing reproductive and/or gender-affirming care may be heightened;
- states with implemented laws against reproductive and/or gender-affirming care, but with no known examples of criminal or civil penalties enacted;
- states with implemented laws against reproductive and/or gender-affirming care, with known examples of actual criminal or civil penalties;

- states with implemented laws against reproductive and/or gender-affirming care, with known examples of physical harm to patients due to inadequate care;
- states with officials in authority who seek notoriety from threatening or harming individuals engaged in providing and/or receiving reproductive and/or gender affirming care.

Proposed bills fluctuate quickly and will not be tracked in this report. However, several of the below sections describe current state laws at the time of this writing, as well as known examples of additional tangible actions that have been taken, with acknowledgment that a social climate of hatred and fear has significant negative impacts on people, whether or not overt legal actions occurred against them.[20] As one of the goals of specialty board examination, as stated by ABMS, is consistency within each Member Board, ensuring every candidate is tested in the same way, such health and safety considerations are also relevant to the disproportionate impact some test-takers may experience in states with restrictions on health care.

*Legal Restrictions to Reproductive Health Care*

According to the New York Times abortion ban tracker, sourced from the Center for Reproductive Rights, the Guttmacher Institute, and KFF (formerly known as the Kaiser Family Foundation), as of December 3, 2024, the 13 states with the most restrictive laws for reproductive health care are: Idaho, South Dakota, Oklahoma, Texas, Arkansas, Louisiana, Indiana, Kentucky, Tennessee, Mississippi, Alabama, West Virginia, and Missouri.[21] Though Missouri voted to enshrine abortion rights in the constitution at the end of 2024, ongoing regulatory complexities mean this medical procedure remains unavailable in that state.[22] However, according to Guttmacher, 27 states are predominantly restrictive toward reproductive health care.[23] The remaining 23 states have some protections, either paired simultaneously with restrictions, or primarily protective. Within restrictive states, many also have laws deemed "targeted regulation of abortion providers (TRAP)" laws, imposing standards beyond what the medical profession has deemed necessary for patient safety in order to make providing reproductive care more difficult.[24] Private litigation against physicians and health care workers is currently possible under Texas' SB8.[25] Although some states have proposed prison sentences for physicians who perform abortions past gestational limits,[26] to date no physician has been criminally prosecuted for this reason.[27]

Though no specific board exam related examples are publicly known, potential risks to pregnant examinees or examiners in emergency situations in states with abortion bans may include life-threatening delays in and/or inadequate care.[28,29] In response to this concern, ABOG's website states: "ABOG has a partnership with UT Southwestern to provide medical care in unanticipated, urgent, or emergency situations for examination candidates, examiners, or staff. [University of Texas Southwestern] is in close proximity to the ABOG offices and offers high standards of obstetrical care in medical emergencies." In July 2024, the Texas Medical Board clarified that "imminence of death or impairment of a major bodily function is not required" for legal emergency reproductive care.[30] However, nationwide more generally, laws tend to create situations of "hesitant medicine" that negatively impact the patient-physician relationship and destabilize decision-making within health care,[31] and many broader anecdotes exist about the dangers.[32]

At least one Texas woman was also arrested and indicted on murder charges following a self-managed abortion in 2022, though charges were later dropped and current Texas law exempts patients seeking abortions from criminal charges.[33]

Potential legal risks to examinees or examiners who provide reproductive health care may not currently be problematic for out-of-state test takers within Texas. ABOG, in regards to the Texas location of their specialty board exam, notes: "Any candidate taking a Certifying Exam, whether it be virtual or physically in Texas, should not be at legal risk. SB8 only applies to abortions performed in Texas. More importantly, SB8 text specifically references and pertains to the performance or induction of an abortion: '… a physician may not knowingly perform or induce an abortion on a pregnant woman' beyond the point in time when a fetal heartbeat is detected. Additionally, civil liability for aiding and abetting applies only to abortions performed in Texas. This should mean that the action for which a plaintiff is filing a lawsuit must be proven to be tied to a specific abortion performed. Care of patients on a case list and ensuing discussion with examiners during the Certifying Exam are not subject to SB8."[34] The only current, known instance of a suit against a physician related to SB8 was dismissed after a ruling that a bystander not directly impacted by an abortion service provided cannot sue the abortion provider.[35] Dallas and several other cities chose in 2022 to deprioritize using city resources to investigate abortions,[36] and several elected city prosecutors vowed in 2023 not to prosecute individuals who seek or provide abortion care.[37]

Fears remain, however. Unrelated to board examinations, in December 2024, the Texas Attorney General sued a New York physician for allegedly providing telemedicine and mailing abortion pills to a patient who lived in Texas—however, enforcement, even in the event the plaintiff wins, is ambiguous due to New York's shield laws.[38] In Indiana, a physician was publicly targeted by the state's Attorney General and reprimanded and fined by the Indiana Medical Licensing Board after publicly recounting a case where an abortion was provided to a young patient who was a victim of rape.[39] While there is reason for physicians to be concerned about legal repercussions in many states, no known successful prosecutions of physicians resulting in criminal or civil penalties have thus far taken place. AMA advocates for legal protections for medical students and physicians who cross state lines to receive education in or deliver reproductive health services, including contraception and abortion (Preserving Access to Reproductive Health Services D-5.999).

In November 2023, the Attorneys General of New York, Arizona, California, Colorado, Connecticut, Delaware, the District of Columbia, Hawaii, Illinois, Maine, Maryland, Massachusetts, Michigan, Minnesota, Nevada, New Jersey, New Mexico, North Carolina, Oregon, Pennsylvania, Rhode Island, Vermont, Washington, and Wisconsin collectively began correspondence with ABOG regarding concerns around OB/GYN specialty exam required travel to Texas and has engaged with ABOG on the possibility of establishing testing exemptions related to restrictive laws under certain circumstances. At the time of this writing, this is under consideration by ABOG.[40]

*Legal Restrictions to Gender-Affirming Care and Facilities*

According to the American Civil Liberties Union (ACLU) "Mapping Attacks on LGBTQ Rights in U.S. State Legislatures in 2024," seven states have official, active laws restricting LGBTQ+ rights within health care specifically as of December 2024. These states are: Idaho, New Hampshire, Ohio, South Carolina, Tennessee, Utah, and Wyoming.[41] The Human Rights Campaign"Attacks on Gender Affirming Care by State" notes 26 states with law or policy banning gender affirming care when states with litigation proceedings challenging the bans are included.[42] Related to other health impacts, according to the Movement Advancement Project's "Equality Maps: Bans on Transgender People's Use of Public Bathrooms & Facilities According to Their Gender Identity,"[43] both Florida and Utah currently make it a criminal offense in certain circumstances for transgender people to use bathrooms or facilities consistent with their gender identity, and these two states, as well as North Dakota, Louisiana, Mississippi, Alabama, and Ohio ban transgender people from using bathrooms consistent with their gender identity in some or all government-owned buildings and locations, including some colleges. K-12 school bathroom bans are even more extensive, though outside the direct scope of this report regarding physicians and travel. Restrictions such as these can lead to significant physical health impacts,[44] and bathroom discrimination is associated with poorer mental health outcomes.[45]

No specific board exam related examples are publicly known regarding enforcement of the above policies. Several non-comprehensive general examples of enforcement thus far include the following: in 2022, Texas Attorney General office and governor encouraged the Texas Department of Family and Protective Services to consider gender-affirming care to constitute child abuse,[46] and some investigations have taken place for this reason,[47] prompting fear for parents or caregivers of transgender children. Physicians who provide transgender care have in some cases been threatened with violence.[48] There are no known arrests of physicians providing gender-affirming care, but Texas Attorney General Ken Paxton has, at the time of this writing, sued three Texas physicians for providing gender-affirming care to minors.[49]

DISCUSSION

Little data currently exists on the impact of these issues on board examiners and examinees directly, and state laws restricting reproductive and gender affirming care have been only recently enforced against patients and physicians. The most obvious impact is a threat to physical safety due to inappropriate or reduced access to care and facilities, which has been demonstrated more broadly in research discussed above, though no public anecdotes exist related to taking board exams. In terms of criminal or civil liability, many laws have not currently been officially enforced at all, serving instead to perpetuate bias and fear without direct legal action. While there is genuine reason for physicians to be concerned about legal repercussions in many states, few actual successful prosecutions of physicians resulting in criminal or civil penalties have taken place.

In some cases, legal restrictions may be intended primarily to have an overall "chilling effect,"[50] which has unfortunately been "successful" to some degree. For instance, research has found that there is a lower OB/GYN supply

in abortion-ban states, despite minimal tangible state-level changes in the 2 years post-*Dobbs*.[51] The difficult balance becomes balancing legitimate psychological and physical safety concerns with strategies to counter the chilling effect of a fear-driven political climate, particularly encouragement for providers of gender-affirming care and providers of reproductive care to continue delivering high-quality, legal patient care in defiance of disinformation and social pressure, when feasible and appropriate. This is a challenging balance, and policy around the concept tends to focus around high-risk public health crises and emphasizes institutional responsibility as well, such as AMA's Pandemic Ethics and the Duty of Care H-140.821, which includes statements such as: "The duty to treat is foundational to the profession of medicine but is not absolute. The health care work force is not an unlimited resource and must be preserved to ensure that care is available in the future. For their part, physicians have a responsibility to protect themselves, as well as a duty of solidarity to colleagues to share risks and burdens in a public health crisis. So too, health care institutions have responsibilities to support and protect health care professionals and to apportion the risks and benefits of providing care as equitably as possible."

Hypothetical risk during direct patient care is also different than hypothetical risk during certification exams, when educational environments should ideally remain as physically and psychologically safe as possible for appropriate learning.[52,53]

*Numbers of Impacted Examiners or Examinees*

The numbers of those who could be directly impacted by physical safety concerns (i.e., pregnant examiners and examinees, transgender examiners and examinees) are not readily available for a variety of reasons within most medical education demographic information. These reasons include privacy and discrimination concerns, particularly in a political climate when this information may be misused against individuals, as well as the tendency for gender-related data collection to focus on a male/female binary based on birth sex, despite the problematic nature of this framing.[54] Some respondents within binary male/female gender demographic questions are likely transgender but this disaggregation is not available.

ABMS board certification data does list those who chose not to report their gender, which may partially include but is not limited to non-binary or gender non-conforming people. As of June 2024 data, the number of ABMS active diplomates in the United States who did not report gender was 59,498 individuals, or about six percent of the 957,915 active U.S. diplomates, though this does not accurately reflect actual transgender information. Not specific to physicians, approximately 1.1 percent of the U.S. population openly identifies as transgender, with an additional 1.5 percent neither trans, cis male, nor cis female, for a total of 2.6 percent, according to a Jan-Apr census pulse 2024.[55] This nationwide data is likely underreported, although within medicine, transgender and gender non-conforming physicians are likely to be underrepresented compared to general proportions within the overall U.S. population.[56] In general, transgender medical students and physicians already experience significant barriers,[57] signaling a need for systemic and individual responses to improve gender equity within medical education.[58]

Approximations of pregnancy or potential for pregnancy are also highly problematic to calculate, especially because gender is not inherently tied to pregnancy and health information is unknown. Regarding pregnancy, in 2020, research focusing on "reproductive age women" approximated that 3.9% of this population subset was pregnant at any given time.[59] Compared loosely to ABMS diplomate data for "female" diplomates under age 45 (131,331 individuals), this may be approximately 5,121 people pregnant at any given time, though this data describes those who hold board certification status through ABMS, not those taking exams.

Within the field of OB/GYN specifically, according to 2024 National Resident Matching Program (NRMP) data,[60] applicants who obtained a position and ranked their preferred specialty as OB/GYN were approximately 90 percent "female" in 2024.[61] There were 1,533 matches into OB/GYN, 1,103 of which were MD seniors.[62] An additional six positions were filled with SOAP, for a total of 1,539 filled residency positions. Thus, approximately 1,385 individuals (who may be more likely to be capable of pregnancy) matched into residency in 2024 alone. Approximately 54 of these individuals may be pregnant at any given time based on above pregnancy likelihood calculations. These individuals may sit for board exams in the near future in one state with restrictive laws (Texas), if specialty certified by ABOG (not if certified by AOBOG). Note, however, that laws restricting reproductive care may also feel or be threatening to anyone capable of pregnancy, regardless of actual pregnancy status.

Anyone practicing gender-affirming care or reproductive care may also have legal or safety concerns, particularly when treating patients who travel from out of state or via telemedicine or simply for being a known practitioner in

general, regardless of their own personal experiences. Regardless of identity, the majority of providers of adolescent gender-affirming care in one study, for instance, reported receiving harassment and targeted threats.[63] Fear and harassment have increased even for those not directly impacted,[64] and some research suggests worsened negative impacts in states with restrictive laws.[65]

*Social Injustice, Safety, and Educational Equity*

One limitation regarding navigating safety, risk, and equity during certification exams is the difficulty of navigating safety threats for examinees and examiners across the many domains where genuine safety concerns arise in the face of systemic oppression. This is true for rapidly shifting legal landscapes, where bills are introduced but may not be implemented into law or laws may be enacted, challenged in courts, modified, and so on. Threats are particularly difficult to react to when significant but generally extrajudicial. For example, police murder of unarmed Black Americans has significant spillover effects on the sense of safety and mental health of Black Americans in the U.S. in general.[66] Experiences of racism and oppression negatively impact cognitive function due to trauma[67] already setting up inequity within education and testing compared to those with more social privilege, i.e., anyone less likely to be targeted by oppression, who need not use as many resources preparing oneself for the possibility of experiencing life-ending systemic violence. Certain areas of the U.S. may also informally be more dangerous for visibly Black examinees and other learners of color, depending on a variety of factors, even without overtly discriminatory laws in place.

For gender and LGBTQ+ rights specifically, it is also difficult to tackle a much wider problem with individualized testing location changes alone, as it is a systemic problem that continues to proliferate. Transgender people, for instance, particularly transgender women of color, have long been subject to violence, discrimination, and arrest for existing,[68] and genuine safety concerns or health inequities (such as inappropriately gendered restroom facilities) may exist in any public location in the U.S., even in locations without overtly hostile laws—though those locations are on the face of it the most apparently dangerous.

Exemptions and other strategies for examiner and examinee safety, therefore, may be best understood as broadly as feasible within a social justice lens through a variety of thoughtful strategies as requested by those most impacted by injustice, rather than solely focused on the direct enforcement of specific hostile laws or an individual burden of proof at any given time.

RELEVANT AMA POLICY

AMA has robust policy in support of both gender-affirming and reproductive care, and already encourages "national specialty boards who hold in-person centralized mandatory exams for board certification to provide alternate options when those exams take place in states with laws banning or restricting abortion, gender-affirming care, or reproductive healthcare services such that travel to those states would present either a limitation in access to necessary medical care, or threat of civil or criminal penalty against the examinees and examiners" (Access to Reproductive Health Services When Completing Physician Certification Exams, D-275.944). AMA continues to advocate for the physician-patient relationship, as well as the improvement of medical education in other ways. Additional examples are listed in Appendix A.

SUMMARY

Concerns related to potential risk, both physical and legal, for those who provide and/or receive evidence-based reproductive and/or gender-affirming health care are genuine and can be particularly challenging to alleviate when comprised of a rapidly shifting blend of formal legal restrictions, ambiguity in enforcement, fear-provoking social contexts, and informal, extrajudicial threat. The AMA, through its Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care is Banned or Restricted, as well as several other avenues, remains committed to engaging with issues related to federal and state policies on reproductive and gender-affirming care that may impact both physicians and patients, including but not limited to national specialty board examiners and examinees. AMA policy also encourages national specialty boards who hold in-person centralized mandatory exams for board certification to provide alternate options when those exams take place in states with laws banning or restricting abortion, gender-affirming care, or reproductive health care services. Although research is not yet available on the specific impacts of reproductive and gender-affirming care restrictions on board examiners and examinees, the

Council on Medical Education supports the work of AMA's task force and continues to closely monitor these rapidly evolving issues.

RECOMMENDATION

The Council on Medical Education recommends that the following be adopted, and the remainder of the report be filed:

1. That our AMA amend D-275.944 "Access to Reproductive Health Services When Completing Physician Certification Exams," by deletion and addition as follows:

   2. ~~Our AMA will study the impact of laws restricting reproductive healthcare and gender-affirming care on examinees and examiners of national specialty board exams and existing alternatives to in-person board examinations.~~

   Our AMA advocates to relevant parties for the physical and psychological safety of board examination candidates when taking certification examinations through mechanisms such as exam relocation to nonrestrictive states, remote examination, and/or exemption processes to ensure the protection of all physicans.

Fiscal note: $1,000

APPENDIX A: RELEVANT AMA POLICY

Access to Reproductive Health Services When Completing Physician Certification Exams D-275.944

1. Our American Medical Association will encourage national specialty boards who hold in-person centralized mandatory exams for board certification to provide alternate options when those exams take place in states with laws banning or restricting abortion, gender-affirming care, or reproductive healthcare services such that travel to those states would present either a limitation in access to necessary medical care, or threat of civil or criminal penalty against the examinees and examiners.
2. Our AMA will study the impact of laws restricting reproductive healthcare and gender-affirming care on examinees and examiners of national specialty board exams and existing alternatives to in-person board examinations.

Establishing A Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care Is Banned or Restricted G-605.009

1. Our American Medical Association will convene a task force of appropriate AMA councils and interested state and medical specialty societies, in conjunction with the AMA Center for Health Equity, and in consultation with relevant organizations, practices, government bodies, and impacted communities for the purpose of preserving the patient-physician relationship.
2. This task force, which will serve at the direction of our AMA Board of Trustees, will inform the Board to help guide organized medicine's response to bans and restrictions on abortion, prepare for widespread criminalization of other evidence-based care, implement relevant AMA policies, and identify and create implementation-focused practice and advocacy resources on issues including but not limited to:
   a. Health equity impact, including monitoring and evaluating the consequences of abortion bans and restrictions for public health and the physician workforce and including making actionable recommendations to mitigate harm, with a focus on the disproportionate impact on under-resourced, marginalized, and minoritized communities.
   b. Practice management, including developing recommendations and educational materials for addressing reimbursement, uncompensated care, interstate licensure, and provision of care, including telehealth and care provided across state lines.
   c. Training, including collaborating with interested medical schools, residency and fellowship programs, academic centers, and clinicians to mitigate radically diminished training opportunities.
   d. Privacy protections, including best practice support for maintaining medical records privacy and confidentiality, including under HIPAA, for strengthening physician, patient, and clinic security measures, and countering law enforcement reporting requirements.
   e. Patient triage and care coordination, including identifying and publicizing resources for physicians and patients to connect with referrals, practical support, and legal assistance.

f. Coordinating implementation of pertinent AMA policies, including any actions to protect against civil, criminal, and professional liability and retaliation, including criminalizing and penalizing physicians for referring patients to the care they need.
g. Anticipation and preparation, including assessing information and resource gaps and creating a blueprint for preventing or mitigating bans on other appropriate health care, such as gender affirming care, contraceptive care, sterilization, infertility care, and management of ectopic pregnancy and spontaneous pregnancy loss and pregnancy complications.
h. Work with interested parties to encourage the development of institution-level guidance and protection for physicians practicing in states with restrictions potentially interfering with the patient-physician relationship.

3. Our American Medical Association will appoint an ad hoc committee or task force, composed of physicians from specialties who routinely provide gender-affirming care, payers, community advocates, and state Medicaid directors and/or insurance commissioners, to identify issues with physician payment and reimbursement for gender-affirming care and recommend solutions to address these barriers to care.

Medical Specialty Board Certification Standards H-275.926

1. Our American Medical Association opposes any action, regardless of intent, that appears likely to confuse the public about the unique credentials of American Board of Medical Specialties (ABMS) or American Osteopathic Association Bureau of Osteopathic Specialists (AOA-BOS) board certified physicians in any medical specialty, or take advantage of the prestige of any medical specialty for purposes contrary to the public good and safety.
2. Our AMA opposes any action, regardless of intent, by organizations providing board certification for non-physicians that appears likely to confuse the public about the unique credentials of medical specialty board certification or take advantage of the prestige of medical specialty board certification for purposes contrary to the public good and safety.
3. Our AMA continues to work with other medical organizations to educate the profession and the public about the ABMS and AOA-BOS board certification process. It is AMA policy that when the equivalency of board certification must be determined, the certification program must first meet accepted standards for certification that include both
    a. a process for defining specialty-specific standards for knowledge and skills and
    b. offer an independent, external assessment of knowledge and skills for both initial certification and recertification or continuous certification in the medical specialty. In addition, accepted standards, such as those adopted by state medical boards or the Essentials for Approval of Examining Boards in Medical Specialties, will be utilized for that determination.
4. Our AMA opposes discrimination against physicians based solely on lack of ABMS or equivalent AOA-BOS board certification, or where board certification is one of the criteria considered for purposes of measuring quality of care, determining eligibility to contract with managed care entities, eligibility to receive hospital staff or other clinical privileges, ascertaining competence to practice medicine, or for other purposes. Our AMA also opposes discrimination that may occur against physicians involved in the board certification process, including those who are in a clinical practice period for the specified minimum period of time that must be completed prior to taking the board certifying examination.
5. Our AMA advocates for nomenclature to better distinguish those physicians who are in the board certification pathway from those who are not.
6. Our AMA encourages member boards of the ABMS to adopt measures aimed at mitigating the financial burden on residents related to specialty board fees and fee procedures, including shorter preregistration periods, lower fees and easier payment terms.
7. Our AMA encourages continued advocacy to federal and state legislatures, federal and state regulators, physician credentialing organizations, hospitals, and other interested parties to define physician board certification as the medical profession establishing specialty-specific standards for knowledge and skills, using an independent assessment process to determine the acquisition of knowledge and skills for initial certification and recertification.

Accommodating Lactating Individuals Taking Medical Examinations H-295.861

1. Our American Medical Association urges all medical licensing, certification and board examination agencies, and all board proctoring centers, to grant special requests to give breastfeeding individuals additional break time and a suitable environment during examinations to express milk.
2. Our AMA encourages that such accommodations to breastfeeding individuals include necessary time per exam day, in addition to the standard pool of scheduled break time found in the specific exam, as well as access to a private, non-bathroom location on the testing center site with an electrical outlet for individuals to breast pump.

Clarification of Evidence-Based Gender-Affirming Care H-185.927

1. Our American Medical Association recognizes that medical and surgical treatments for gender dysphoria and gender incongruence, as determined by shared decision making between the patient and physician, are medically necessary as outlined by generally-accepted standards of medical and surgical practice.
2. Our AMA will work with state and specialty societies and other interested stakeholders to:
    a. advocate for federal, state, and local laws and policies to protect access to evidence-based care for gender dysphoria and gender incongruence;
    b. oppose laws and policies that criminalize, prohibit or otherwise impede the provision of evidence-based, gender-affirming care, including laws and policies that penalize parents and guardians who support minors seeking and/or receiving gender-affirming care;
    c. support protections against violence and criminal, civil, and professional liability for physicians and institutions that provide evidence-based, genderaffirming care and patients who seek and/or receive such care, as well as their parents and guardians; and
    d. communicate with stakeholders and regulatory bodies about the importance of gender-affirming care for patients with gender dysphoria and gender incongruence.
3. Our AMA will advocate for equitable, evidence-based coverage of gender-affirming care by health insurance providers, including public and private insurers.

Principles for Advancing Gender Equity in Medicine H-65.961

Our AMA:

1. declares it is opposed to any exploitation and discrimination in the workplace based on personal characteristics (i.e., gender);
2. affirms the concept of equal rights for all physicians and that the concept of equality of rights under the law shall not be denied or abridged by the U.S. Government or by any state on account of gender;
3. endorses the principle of equal opportunity of employment and practice in the medical field;
4. affirms its commitment to the full involvement of women in leadership roles throughout the federation, and encourages all components of the federation to vigorously continue their efforts to recruit women members into organized medicine;
5. acknowledges that mentorship and sponsorship are integral components of one's career advancement, and encourages physicians to engage in such activities;
6. declares that compensation should be equitable and based on demonstrated competencies/expertise and not based on personal characteristics;
7. recognizes the importance of part-time work options, job sharing, flexible scheduling, re-entry, and contract negotiations as options for physicians to support work-life balance;
8. affirms that transparency in pay scale and promotion criteria is necessary to promote gender equity, and as such academic medical centers, medical schools, hospitals, group practices and other physician employers should conduct periodic reviews of compensation and promotion rates by gender and evaluate protocols for advancement to determine whether the criteria are discriminatory; and
9. affirms that medical schools, institutions and professional associations should provide training on leadership development, contract and salary negotiations and career advancement strategies that include an analysis of the influence of gender in these skill areas.

Our AMA encourages: (1) state and specialty societies, academic medical centers, medical schools, hospitals, group practices and other physician employers to adopt the AMA Principles for Advancing Gender Equity in Medicine; and (2) academic medical centers, medical schools, hospitals, group practices and other physician employers to: (a) adopt policies that prohibit harassment, discrimination and retaliation; (b) provide anti-harassment training; and (c) prescribe disciplinary and/or corrective action should violation of such policies occur.

Effects of Work on Pregnancy H-420.960

1. Our American Medical Association supports the right of employees to work in safe workplaces that do not endanger their reproductive health or that of their unborn children.
2. Our AMA supports workplace policies that minimize the risk of excessive exposure to toxins with known reproductive hazards irrespective of gender or age.
3. Our AMA encourages physicians to consider the potential benefits and risks of occupational activities and exposures on an individual basis and work with patients and employers to define a healthy working environment for pregnant people.

4. Our AMA encourages employers to accommodate increased physical requirements of pregnant people; recommended accommodations include varied work positions, adequate rest and meal breaks, access to regular hydration, and minimizing heavy lifting.
5. Our AMA acknowledges that future research done by interdisciplinary study groups composed of obstetricians/gynecologists, occupational medicine specialists, pediatricians, and representatives from industry can best identify adverse reproductive exposures and appropriate accommodations.

Strategies for Enhancing Diversity in the Physician Workforce H-200.951
1. Our American Medical Association 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. Our AMA 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. Our AMA 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. Our AMA encourages physicians to engage in their communities to guide, support, and mentor high school and undergraduate students with a calling to medicine.
5. Our AMA 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.
6. Our AMA continues 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.

Encouraging LGBTQ+ Representation in Medicine D-200.972
1. Our American Medical Association will advocate for the creation of targeted efforts to recruit sexual and gender minority students in efforts to increase medical student, resident, and provider diversity.
2. Our AMA encourages the inclusion of sexual orientation and gender identity data in all surveys as part of standard demographic variables, including but not limited to governmental, AMA, and the Association of American Medical Colleges surveys, given respondent confidentiality and response security can be ensured.
3. Our AMA will work with the Association of American Medical Colleges to disaggregate data of LGBTQ+ individuals in medicine to better understand the representation of the unique experiences within the LGBTQ+ communities and their overlap with other identities.

Access to Basic Human Services for Transgender Individuals H-65.964
Our AMA: (1) opposes policies preventing transgender individuals from accessing basic human services and public facilities in line with one’s gender identity, including, but not limited to, the use of restrooms; and (2) will advocate for the creation of policies that promote social equality and safe access to basic human services and public facilities for transgender individuals according to one’s gender identity.

Support for Access to Preventive and Reproductive Health Services H-425.969
Our American Medical Association supports access to preventive and reproductive health services for all patients and opposes legislative and regulatory actions that utilize federal or state health care funding mechanisms to deny established and accepted medical care to any segment of the population.

Support for Access to Preventive and Reproductive Health Services H-425.969
Our American Medical Association supports access to preventive and reproductive health services for all patients and opposes legislative and regulatory actions that utilize federal or state health care funding mechanisms to deny established and accepted medical care to any segment of the population.

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## 5. DISAFFILIATION FROM HONOR MEDICAL SOCIETIES DUE TO PERPETUATION OF RACIAL INEQUITIES IN MEDICINE

*Reference committee hearing: see report of Reference Committee C.*

**HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS**
**REMAINDER OF REPORT FILED**
*See Policies D-295.297, D-295.317, and D-310.945*

Resolution 309-A-24, "Disaffiliation from the Alpha Omega Alpha Honor Medical Society due to Perpetuation of Racial Inequities in Medicine," was introduced by the Resident and Fellow Section at the 2024 Annual Meeting of the American Medical Association (AMA) House of Delegates and was referred for study.

This resolution originally stated the following:

> RESOLVED, that our American Medical Association recognizes that the Alpha Omega Alpha Honor Medical Society disproportionately benefits privileged trainees (New HOD Policy); and be it further
>
> RESOLVED, that our AMA supports institutional disaffiliation from the Alpha Omega Alpha Honor Medical Society due to its perpetuation of racial inequities in medicine (New HOD Policy); and be it further
>
> RESOLVED, that our AMA recognizes that the Alpha Omega Alpha Honor Medical Society perpetuates and accentuates discrimination against trainees of color that is inherent in medical training. (New HOD Policy)

Reference Committee C heard testimony about historical inequities exhibited by Alpha Omega Alpha (AΩA) Honor Medical Society, and an amendment was offered in the online testimony to add an osteopathic medical honor society to this resolution. Testimony also noted that such inequities may be a chapter level problem. The Council on Medical Education noted that the broader issue has been studied and addressed in its report CME 2-I-22, which considered the potential of bias fostered by several honor societies including AΩA, resulting in policy D-310.945, "Mitigating Demographic and Socioeconomic Inequities in the Residency and Fellowship Selection Process." Among other clauses, in this policy, AMA advocates "to remove membership in medical honor societies as a mandated field of entry on the Electronic Residency Application Service (ERAS)—thereby limiting its use as an automated screening mechanism…"

Testimony also discussed AMA's own history of discrimination, with only recent efforts to rectify this, and suggested a restorative justice informed approach to address past and current harms. In addition, testimony noted that AΩA recently secured new leadership six months prior and requested time for that leader to demonstrate AΩA's commitment to diversity, equity, and belonging. Reference Committee C recommended that D-310.945 be reaffirmed in lieu of Resolution 309 and noted that calling for disaffiliation from AΩA could induce reputational risk to the AMA when amicable relationships are needed to encourage and assist such groups to collaborate with us to build a diverse physician workforce. In the full House of Delegates meeting, the complexities of Resolution 309 were emphasized, and the resolution was referred for study.

The Medical Student Section submitted comments to the Council on Medical Education suggesting disaffiliation from both AΩA and the osteopathic equivalent, Sigma Sigma Phi (SSP) would give further emphasis on holistic review of medical students in residency applications, allowing for a more level application field for underrepresented medical students.

The Council on Medical Education acknowledges the potential conflict of interest that, at the time of this writing, some Council members are members of AΩA and/or SSP.

BACKGROUND

CME Report 2-I-22, "Mitigating Demographic and Socioeconomic Inequities in the Residency and Fellowship Selection Process," previously provided an extensive review of multiple medical honor societies, including AΩA and SSP. Within this report, we presented the background of these honor societies and discussed the ongoing efforts to reduce bias and mitigate inequities that may result from these honor society memberships. The report resulted in AMA Policy D-310.945, which includes but is not limited to language that encourages "medical schools, medical honor societies, and residency/fellowship programs to work toward ethical, equitable, and transparent recruiting processes, which are made available to all applicants," advocates "for residency and fellowship programs to avoid using objective criteria available in the Electronic Residency Application Service (ERAS) application process as the sole determinant for deciding which applicants to offer interviews," and advocates "to remove membership in medical honor societies as a mandated field of entry on the Electronic Residency Application Service (ERAS)—thereby limiting its use as an automated screening mechanism…" This policy also emphasizes AMA's support of innovation work to improve medical education transitions.

It is also noteworthy that while SSP was hypothetically suggested for inclusion in the resolution's call for disaffiliation, SSP has significantly different in criteria than AΩA, as referenced in that report, and known studies about specific honor society inequities did not investigate SSP. There are also several other honor society organizations, and each has different, varied, and unknown impacts. AΩA also committed to tackling bias within the organization after concerns were raised.

*Updated Information Since 2022*

Since the House of Delegates adopted the previous Council report in November 2022, the following new information has been made available.

One November-December 2022 perspectives piece was published in the *Journal of Surgical Education* that proposed that AΩA leadership overhaul national criteria in the following ways: "(1) convene a national task force to review current selection criteria and make actionable recommendations, (2) incorporate standardized diversity goals into selection criteria to hold chapters accountable and limit internal bias, and 3) report diversity and inclusivity statistics annually to the public to promote organizational accountability."[1]

One institution's November 2023 study described holistic review of applicants within one neurosurgery program with the intention of reducing bias and shifting the focus away from traditional metrics such as USMLE scores and AΩA status, which no longer predict rank lists in this program.[2] Actual diversity impacts, if any, were not directly studied due to a lack of retrospective data. Another study published in November 2023 explored natural language processing in an effort to reduce bias in medical student clerkship assessments, researching the use of a statement provided to clinical performance assessors that included the following language: "As medical educators, we value diversity and inclusion and strive to treat our students fairly and equitably. Data show that, despite our intentions, bias continues to impact student assessment. This leads to persistent inequities in grades, residency attainment, and Alpha Omega Alpha Honors Society achievement."[3] Results on the impact on narrative language use at two institutions were inconsistent, which the authors suggested may be related to the optionality of the module.

In December 2023, AΩA elected Dr. Bradley E. Barth as nationwide Executive Director, noting in Dr. Barth's biography the priority of increasing diversity within the organization: "While a Councilor at KUSM [the University of Kansas School of Medicine], Dr. Barth increased the number of newly elected AΩA students traditionally underrepresented in medicine from 6% to 24%, a trend that has continued since he stepped down as Councilor in 2022. His work on diversity, equity, and inclusion at KUSM has been used as an example of a best practice for numerous other AΩA Chapters across the country."[4]

The original Council report noted that according to the 2021 National Resident Matching Program (NRMP) data set, "student membership in AΩA was 13th on the list of important factors of an applicant, cited by 50.6 percent of program directors. Comparable data showed GHHS [Gold Humanism Honor Society] membership at 14th (50.5 percent) and SSP membership at 22nd (21 percent)."[5] Updated data from the 2024 NRMP program director survey indicated AΩA status became less important when determining which applicants to interview: 43 percent of program directors considered it important. Reported GHHS importance also declined (48 percent), while SSP stayed the same at 21 percent.[6]

DISCUSSION

Beyond the specifics of any individual organization, honors societies conceptually are part of a hierarchy-based framework of medical education, and one piece of a larger system. As also discussed in the Council's report, CME Report 04-A-23, "Decreasing Bias in Assessments of Medical Student Clinical Clerkship Performance," attempting to eliminate hierarchy in only one facet of an inequitable system is a challenge that may result in a cascade where inequities are shifted to another domain rather than alleviated.

The inherent concept of competition between learners, and exclusivity in honors (rather than a focus on every learner eventually meeting high standards of competency for workforce needs) would need to be overhauled within a competency-based medical education model. However, this is not specific to any single honor society, nor would reform or even elimination of honor societies necessarily tackle wider issues related to the current system, such as competition between learners to secure a limited number of highly desired residency positions due to specialty, geography, perceived prestige, and/or other factors, despite discordance between medical student choices and public demand for certain specialties and geographies. Within the current system, all measures of student performance and achievement during medical school play a role in competition and can be potentially subject to bias.

AΩA's new efforts in addressing immediate bias concerns specific to AΩA, as discussed above, have not yet been studied and should be reviewed once enough time has passed for impact data to be gathered and analyzed. AΩA also functions as individual chapters within medical schools, so successful program-specific efforts toward equity would be eliminated with a broad disaffiliation. AMA policy should also, generally, put forth wider values to inform AMA's mission, rather than targeting specific organizations whose impacts are unknown as in the case of SSP and whose practices may shift over time after a recent commitment to change as in the case of AΩA.

Many of these values are already expressed within D-310.945, "Mitigating Demographic and Socioeconomic Inequities in the Residency and Fellowship Selection Process."

RELEVANT AMA POLICY

AMA has several policies related to honor societies, fairness in residency and fellowship selection processes, decreasing bias, and supporting diversity within medical education. These are listed in Appendix A.

SUMMARY

Valid concerns exist regarding bias within medical education. This includes AMA's own history of harms within structural and institutional racism and research on bias within honor society selection processes, including AΩA's past practices. At a structural level, many concerns exist centered around the negative impacts of hierarchy-based educational systems, of which honor societies are one small, downstream component. There is a significant need to tackle wider challenges related to the inherent issues with competitive and time-based medical education systems. In the context of AΩA's recent commitment to changed processes and equity, unknown equity data on selection processes for the other organization in question (SSP), and potential unintended negative consequences to minoritized groups by broadly rejecting ranking learners in one context alone, regardless of the heterogeneity of individual honor society chapters, official AMA disaffiliation from AΩA and/or SSP is not appropriate. Consideration of these issues does, however, further emphasize the need for equity work and competency-based medical education more broadly. Educational institutions are encouraged to discern in their own contexts what practices and affiliations are most beneficial for equity among their learners. AMA has existing policies in place promoting ethical, equitable, and transparent processes within the current system, as well as policies supporting innovation toward necessary structural changes.

RECOMMENDATION

The Council on Medical Education recommends that AMA Policy D-310.945, "Mitigating Demographic and Socioeconomic Inequities in the Residency and Fellowship Selection Process," and AMA Policy D-295.317, "Competency Based Medical Education Across the Continuum of Education and Practice," be reaffirmed in lieu of Resolution 309-A-24, and the remainder of the report be filed.

That our AMA study and report back at the 2030 Annual Meeting on the impact of efforts to increase representation of individuals historically underrepresented in medicine within Alpha Omega Alpha and Sigma Sigma Phi and assess whether institutional disaffiliation from these organizations should be considered based on the progress made.

Fiscal note: $1,000

APPENDIX A: RELEVANT AMA POLICY

Mitigating Demographic and Socioeconomic Inequities in the Residency and Fellowship Selection Process D-310.945

1. Our American Medical Association will encourage medical schools, medical honor societies, and residency/fellowship programs to work toward ethical, equitable, and transparent recruiting processes, which are made available to all applicants.
2. Our AMA will advocate for residency and fellowship programs to avoid using objective criteria available in the Electronic Residency Application Service (ERAS) application process as the sole determinant for deciding which applicants to offer interviews.
3. Our AMA will advocate to remove membership in medical honor societies as a mandated field of entry on the Electronic Residency Application Service (ERAS)—thereby limiting its use as an automated screening mechanism—and encourage applicants to share this information within other aspects of the ERAS application.
4. Our AMA will advocate for and support innovation in the undergraduate medical education to graduate medical education transition, especially focusing on the efforts of the Accelerating Change in Medical Education initiative, to include pilot efforts to optimize the residency/fellowship application and matching process and encourage the study of the impact of using filters in the Electronic Residency Application Service (ERAS) by program directors on the diversity of entrants into residency.
5. Our AMA will encourage caution among medical schools and residency/fellowship programs when utilizing novel online assessments for sampling personal characteristics for the purpose of admissions or selection and monitor use and validity of these tools.

Decreasing Bias in Assessments of Medical Student Clinical Clerkship Performance H-295.851

1. Our American Medical Association will 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."
2. Our AMA will 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.
3. Our AMA will 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.
4. Our AMA will encourage UME institutions to include grading system methodology with grades shared with residency programs.

Supporting Two-Interval Grading Systems for Medical Education H-295.866

Our American Medical Association will work with stakeholders to encourage the establishment of a two-interval grading system in medical colleges and universities in the United States for the non-clinical curriculum.

Competency Based Medical Education Across the Continuum of Education and Practice D-295.317

1. Our American Medical Association Council on Medical Education will continue to study and identify challenges and opportunities and critical stakeholders in achieving a competency-based curriculum across the medical education continuum and other health professions that provides significant value to those participating in these curricula and their patients.

2. Our AMA Council on Medical Education will work to establish a framework of consistent vocabulary and definitions across the continuum of health sciences education that will facilitate competency-based curriculum, andragogy and assessment implementation.
3. Our AMA will continue to explore, with the Accelerating Change in Medical Education initiative and with other stakeholder organizations, the implications of shifting from time-based to competency-based medical education on residents' compensation and lifetime earnings.

Competency-Based Portfolio Assessment of Medical Students D-295.318

1. Our American Medical Association will work with the Association of American Medical Colleges, the American Osteopathic Association and the Accreditation Council for Graduate Medical Education, and other organizations to examine new and emerging approaches to medical student evaluation, including competency-based portfolio assessment.
2. Our AMA will work with the NRMP, ACGME and the 11 schools in the AMA's Accelerating Change in Medical Education consortium to develop pilot projects to study the impact of competency-based frameworks on student graduation, the residency match process and off-cycle entry into residency programs.

Filtering International Medical Graduates During Residency or Fellowship Applications H-255.963

1. Our American Medical Association recognizes the exclusion of certain residency applicants from consideration, such as international medical graduates.
2. Our AMA opposes discriminatory use of filters designed to inequitably screen applicants, including international medical graduates, using the Electronic Residency Application Service® (ERAS®) system.

Continued Support for Diversity in Medical Education D-295.963

1. Our American Medical Association will publicly state and reaffirm its support for diversity in medical education and acknowledge the incorporation of DEI efforts as a vital aspect of medical training.
2. Our AMA will request that the Liaison Committee on Medical Education regularly share statistics related to compliance with accreditation standards IS-16 and MS-8 with medical schools and with other stakeholder groups.
3. Our AMA will 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.
4. Our AMA will 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. Our AMA will directly oppose any local, state, or federal actions that aim to limit diversity, equity, and inclusion initiatives, curriculum requirements, or funding in medical education.
6. Our AMA will 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.
7. Our AMA will investigate the impacts of state legislation regarding DEI-related efforts on the education and careers of students, trainees, and faculty.
8. Our AMA will recognize the disproportionate efforts by and additional responsibilities placed on minoritized individuals to engage in diversity, equity, and inclusion efforts.
9. Our AMA will 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.

Strategies for Enhancing Diversity in the Physician Workforce H-200.951

1. Our American Medical Association 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. Our AMA 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. Our AMA 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. Our AMA encourages physicians to engage in their communities to guide, support, and mentor high school and undergraduate students with a calling to medicine.
5. Our AMA 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.
6. Our AMA continues 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.

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## 6. REPORTING OF TOTAL ATTEMPTS OF USMLE STEP 1 AND COMLEX-USA LEVEL 1 EXAMINATIONS

*Reference committee hearing: see report of Reference Committee C.*

**HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS**
**REMAINDER OF REPORT FILED**
*See Policies D-200.985, H-295.841 and H-275.953*

INTRODUCTION

At the 2024 Annual Meeting of the American Medical Association (AMA) House of Delegates (HOD), Resolution 315 entitled "Cease Reporting of Total Attempts of USMLE Step 1 and COMLEX-USA Level 1 Examinations," was referred. The resolution asked our AMA to "advocate that NBME and NBOME cease reporting the total number of attempts of the Step 1 and COMLEX-USA Level 1 examinations to residency and fellowship programs and licensure."

Resolution 315 received mixed testimony as well as commentary from the National Board of Osteopathic Medical Examiners (NBOME). Testimony against reporting addressed personal stories related to failing the United States Medical Licensing Examination (USMLE®) Step 1, stressing perceived possible impact on career advancement. On the other hand, testimony in favor of reporting addressed the value of transparency to inform holistic review, enhance precision education, and determine residency program resource needs to support learners in their programs. Also, concerns were raised regarding public safety perceptions and scope of practice when advocating for increased numbers of exam attempts. Further, testimony noted current state laws requiring the reporting of exam attempts for licensure. Given the concerns, the reference committee recommended that Resolution 315 not be adopted; however, the HOD moved to refer the item for study. This report was written in response to that directive.

It should be noted that while the Resolved statement in Resolution 315 addressed both allopathic (USMLE) and osteopathic (COMLEX-USA) medical school exams, the Whereas statements only addressed Step 1.

BACKGROUND

*USMLE® Step 1*

The USMLE is a joint program of the Federation of State Medical Boards (FSMB) and National Board of Medical Examiners (NBME) and pertains to students enrolled in MD schools. It is comprised of three exams — Step 1, Step 2 Clinical Knowledge (CK), and Step 3. Step 1 is usually taken at the end of the second year of medical school. It assesses whether the examinee "understands and can apply important concepts of the sciences basic to the practice of medicine, with special emphasis on principles and mechanisms underlying health, disease, and modes of therapy. It ensures mastery of not only the sciences that provide a foundation for the safe and competent practice of medicine in the present, but also the scientific principles required for maintenance of competence through lifelong learning."[1] The exam is administered by Prometric at its various locations. Beginning in 2022, the results of Step 1 are reported as pass/fail only. Examinees receive a Step 1 Score Report. It does not provide performance feedback; however, examinees who fail will receive information to help assess how close they scored in relation to the passing standard. This report is provided to the examinee; in some circumstances, medical schools may receive scores and pass/fail outcomes for their students. The total number of attempts allowed per Step exam is four.[2]

If an examinee needs to reschedule their exam due to an unforeseen circumstance, they do so through the Prometric website which states, "The fee to reschedule an exam varies by testing organization, as does the amount of time you have to do so without penalty. Please check the procedures specific to the organization whose exam you are taking for rescheduling timeliness and penalties."[3]

It is policy of the USMLE program that a student's complete examination history of all Steps and its components be reported on the USMLE transcript. This includes all passes, failures, and incomplete attempts for each Step and its components.[4] Communication with NBME staff indicated that no exceptions are made to this policy.

USMLE Step 1 examinee performance data since the implementation of pass/fail scoring is provided in the table below:[5]

| **US/Canadian Schools** | **2022 Number Tested** | **2022 Percent Passing** | **2023* Number Tested** | **2023* Percent Passing** |
|---|---|---|---|---|
| **MD Degree** | 24,317 | 91% | 25,146 | 90% |
| **1st Takers** | 22,828 | 93% | 23,100 | 92% |
| **Repeaters**** | 1,489 | 71% | 2,046 | 70% |
| **DO Degree** | 4,722 | 89% | 4,913 | 86% |
| **1st Takers** | 4,659 | 89% | 4,798 | 87% |
| **Repeaters**** | 63 | 67% | 115 | 60% |
| **Total** | 29,039 | 91% | 30,059 | 90% |
| **Non-US/Canadian Schools** | **2022 Number Tested** | **2022 Percent Passing** | **2023* Number Tested** | **2023* Percent Passing** |
| **1st Takers** | 22,030 | 74% | 22,611 | 72% |
| **Repeaters**** | 2,926 | 45% | 3,530 | 47% |
| **Total** | 24,956 | 71% | 26,141 | 68% |

*Table reprinted with permission from NBME, 2025.*

* Represents data for examinees tested in 2023 and reported through March 13, 2024.
** "Repeaters" represents examinations given, not number of examinees.

*COMLEX-USA® Level 1*

The Comprehensive Osteopathic Medical Licensure Exam (COMLEX-USA®) is offered by the National Board of Osteopathic Medical Examiners (NBOME) and pertains to students enrolled in DO schools. It is also comprised of three exams — Level 1, Level 2 Cognitive Evaluation (CE), and Level 3. Level 1 is taken after the end of the second year of medical school prior to the clerkship training. The exam assesses "competency in the areas of knowledge related to practicing medicine. It tests the medical knowledge and clinical skills that are considered essential for an osteopathic physician to practice medicine without supervision."[6] Starting in May 2023, the exam is offered by Pearson VUE. Level 1 is reported as pass/fail. In addition, examinees receive a "formative performance profile that compares both total examination performance and performance in individual content areas to the performance of other first-time test-takers who passed the examination."[7] It is only provided to the examinee and their school; the NBOME cautions against using the profile for any other purpose and discourages residency programs from requesting it. Like USMLE, the switch to pass/fail was instituted in 2022, and examinees are allowed a total of four attempts per Level exam.

If an examinee needs to reschedule their exam due to an unforeseen circumstance, it is done through their NBOME account. The NBOME website states the examinee has "up to 24 hours before your scheduled exam date to reschedule or cancel your appointment. You may reschedule or cancel your appointment more than 30 days before your scheduled date at no charge. Failure to reschedule or cancel within 24 hours and failure to appear at the testing center will cause your exam to be deemed a 'No Show,' and a fee will be assessed."[8]

The certified COMLEX-USA transcript contains scores and/or pass/fail status for all COMLEX-USA examinations taken and score interpretation annotations/notes and is sent directly to either participating state medical boards or the Federation Credentials Verification Service (FCVS).[9]

COMLEX-USA Level 1 examinee performance data since the implementation of pass/fail scoring is provided in the table below:[10]

| Years | First Time Takers | First Time Pass Rate | Repeat Test Takers | Repeat Pass Rate |
|---|---|---|---|---|
| 2023-2024 | 9,222 | 93.0% | 822 | 80.8% |
| 2022-2023 | 8,798 | 90.6% | 861 | 75.6% |

*Table reprinted with permission from NBOME, 2025. Data accessed 12/06/24. NBOME website indicates data is updated automatically every 5 minutes.*

DISCUSSION

*Author's concerns*

The resolution raised concerns about Step 1 overall as well as concerns related specifically to the pass/fail scoring system. In general, the author conveyed that Step 1 is an inadequate indicator of future professional competence as a physician. Also, they noted issues regarding stress (i.e., burnout, social isolation, suicidal ideation, substance use) and inequities (i.e., performance disparities related to gender and age).

In addition to the concern about reporting of total number of attempts, on which the Resolved statement is based, the author also noted other concerns about pass/fail. The author cited declining pass rates since the introduction of the new scoring system. The author surmised that examinees experience heightened pressure to pass on the first attempt, and that pass/fail scoring has placed an increased emphasis on Step 2 exam results and extracurricular activities.

*Other concerns and considerations*

Process assistance: The process of preparing for and taking (and rescheduling/retaking) the Step 1 or Level 1 exam can be daunting. While NBME, NBOME, Prometric, and Pearson VUE all offer a bounty of information on their websites, some students may benefit from more direct assistance. MD and DO schools may consider if they can better advise and assist student examinees with arranging their Step 1 or Level 1 exam.

Financial assistance: Registering for the exam (and rescheduling, if necessary) can be costly for students. In August 2024, USMLE announced the "NBME is introducing a new fee assistance program for students with demonstrated financial need who meet the required criteria to use towards the registration cost of the USMLE Step exams. This program will provide aid to approximately 1,300 medical students to cover their fees for USMLE Step 1 or Step 2 Clinical Knowledge (CK) examinations."[11] NBOME states, "If for some reason beyond your control you are unable to get to your COMLEX-USA examination or complete it, you may qualify to have all or part of your rescheduling or cancellation fees waived that would otherwise be incurred. Additionally, we may be able to assist you with other fees you have incurred. For example, you may qualify for assistance if your flight is cancelled on your way to take your COMLEX-USA examination, your examination is cancelled though force majeure, you had a family emergency, or (knock on wood) you are ill on the day of your scheduled administration."[12] While the cost burdens on the examinees is clear, there is also a financial cost incurred to the testing center for arranging exam administration and security when an examinee cancels without sufficient notice, which may raise the overall cost of the exam.

Test accommodations: Both NBME and NBOME state on their websites that they provide reasonable and appropriate accommodations in accordance with the Americans with Disabilities Act for examinees who provide the required documentation.[13,14] Thus, it is incumbent on the examinee to read and adhere to the processes and related deadlines. However, further assistance and flexibility may be needed, whether from the organizations themselves or the medical schools, to aid such students and ensure their comprehension and timeliness.

Test offerings: While NBME, NBOME, Prometric, and Pearson VUE all indicate some levels of flexibility in the availability and scheduling of exams, there may be sensitivities around the school curriculum and cycles that can be further considered in order to provide the most optimal scheduling for students. There are anecdotes that students are delaying taking Step 1 or Level 1. Medical schools should advise students and provide them opportunities to take the exam at the most appropriate stage of their medical school curriculum for passing.

*Reporting of total attempts*

While the Resolved statement of Resolution 315 is focused on ceasing reporting of total number of exam attempts, it is important to fully explore this issue. For the residency application process, students may be reticent to disclose why they rescheduled or retook an exam for fear of judgment and exclusion. These concerns need to be addressed by relevant parties (medical schools and residency programs) to communicate to students that disclosure allows faculty the opportunity to provide support and assistance to improve their success on the numerous future exams students will encounter in their medical education.

As discussed in the reference committee hearing, disclosure of the total number of exam attempts may be an important data point for residency program directors. In the spirit of holistic assessment, knowing if and why a student took Step 1or Level 1 more than once can help to determine the support the applicant needs as a resident. The path to licensure and board certification involves several examinations, and if the applicant has difficulty with passing such exams, faculty need to be aware so problems can be quickly identified and mitigated. Conversely, denying applicant performance information to program directors only masks problems that may lead to failure to complete residency.

The primary purpose of the USMLE is for licensure by state medical boards. State medical licensing boards have their own criteria for the number of attempts per Step or Level exam, which may be in state law. This information is provided by the FSMB and can be found at https://www.fsmb.org/step-3/state-licensure/. Applicants should consider in advance which state(s) they wish to practice in and review this information in preparation for their exams.

Another consideration is public transparency. When it comes to government agencies, including state licensing boards, the public demands transparency including disclosure about licensing decisions. While it is unlikely that individual patients may ask if a physician ever failed a Step or Level exam, advocates and journalists often demand that performance information on license holders should be available to foster public accountability.

The significance of Step 1 passage as it relates to Match rates has been studied. The National Resident Matching Program® (NRMP®) provides data on such correlations. They also offer information from program director surveys; 2024 results indicate that "program director key considerations for interviewing included USMLE Step 1 pass."[15] Additional information is provided on their website. While past studies have indicated that a high Step 1 score is a significant predictor of passing a specialty board exam,[16] it may be too soon to show correlation between today's pass/fail scoring and board passage.

RELEVANT AMA POLICIES

AMA policy H-275.953(2)(c) "The Grading Policy for Medical Licensure Examinations" states that "Scores are reported in pass/fail format for each student to the medical school. The school also receives a frequency distribution of numerical scores for the aggregate of their students." Given that it supports the reporting of each attempt, it thereby implies support in knowing the total number of attempts. Therefore, Resolution 315's desire to cease total reporting may conflict with current policy. However, this policy does support holistic review of applicants; such review may include an understanding of not only the total number of attempts but why. H-275.953(1) states that "selection of residents should be based on a broad variety of evaluative criteria, and to propose that the ACGME General Requirements state clearly that residency program directors must not use NBME or USMLE ranked passing scores as a screening criterion for residency selection." It supports that for holistic review to be truly beneficial to students and programs, program directors should want to understand why a student failed or needed to reschedule licensing exams.

Further, policy D-200.985(9) "Strategies for Enhancing Diversity in the Physician Workforce," asserts that "Our AMA will recommend that medical school admissions committees and residency/ fellowship programs use holistic assessments of applicants that take into account the diversity of preparation and the variety of talents that applicants bring to their education with the goal of improving health care for all communities." It infers the notion that holistic review works better with more data. Such holistic assessment also aligns with the AMA's efforts related to precision education and competency-based medical education, both addressed in its ChangeMedEd initiative.

Additional policies of relevance are located in the AMA Policy Finder and include:

- Clinical Skills Assessment During Medical School D-295.988
- Discouraging the Use of Licensing Exams for Internal Promotion in Medical Schools H-275.958
- Alternatives to the Federation of State Medical Boards Recommendations on Licensure H-275.934

SUMMARY

Resolution 315-A-24 raised important considerations related to the implications of total reporting of exam attempts, whether it be USMLE® Step 1 or COMLEX-USA® Level 1. As discussed, the culture shift toward holistic assessment in residency applications should ease some concerns. Regarding licensure, such disclosure is state-mandated in most cases and would need to be considered further by such relevant parties to determine its pertinence. Medical schools and residency programs can consider how they may play a stronger role in assisting examinees and applicants.

RECOMMENDATIONS

The Council on Medical Education recommends that the following be adopted in lieu of Resolution 315-A-24, and the remainder of the report be filed:

1. Encourage the National Board of Medical Examiners (NBME) and National Board of Osteopathic Medical Examiners (NBOME) to continue evaluating barriers for students related to testing centers (e.g., rescheduling, cost, etc.).

2. Encourage medical schools to assist examinees in scheduling of USMLE® and COMLEX-USA® exams and consider opportunities for flexibility.

3. Reaffirm policies H-275.953 "The Grading Policy for Medical Licensure Examinations" and D-200.985 "Strategies for Enhancing Diversity in the Physician Workforce."

Fiscal note: $1,000

APPENDIX: RELEVANT AMA POLICIES

The Grading Policy for Medical Licensure Examinations H-275.953

1. Our American Medical Association's representatives to the ACGME are instructed to promote the principle that selection of residents should be based on a broad variety of evaluative criteria, and to propose that the ACGME General Requirements state clearly that residency program directors must not use NBME or USMLE ranked passing scores as a screening criterion for residency selection.

2. Our AMA adopts the following policy on NBME or USMLE examination scoring:
   a. Students receive "pass/fail" scores as soon as they are available. (If students fail the examinations, they may request their numerical scores immediately.)
   b. Numerical scores are reported to the state licensing authorities upon request by the applicant for licensure. At this time, the applicant may request a copy of their numerical scores.
   c. Scores are reported in pass/fail format for each student to the medical school. The school also receives a frequency distribution of numerical scores for the aggregate of their students.
3. Our AMA will:
   a. promote equal acceptance of the USMLE and COMLEX at all United States residency programs.
   b. work with appropriate stakeholders including but not limited to the National Board of Medical Examiners, Association of American Medical Colleges, National Board of Osteopathic Medical Examiners, Accreditation Council for Graduate Medical Education and American Osteopathic Association to educate Residency Program Directors on how to interpret and use COMLEX scores.
   c. work with Residency Program Directors to promote higher COMLEX utilization with residency program matches in light of the new single accreditation system.
4. Our AMA will work with appropriate stakeholders to release guidance for residency and fellowship program directors on equitably comparing students who received 3-digit United States Medical Licensing Examination Step 1 or Comprehensive Osteopathic Medical Licensing Examination of the United States Level 1 scores and students who received Pass/Fail scores.

Strategies for Enhancing Diversity in the Physician Workforce D-200.985

1. Our American Medical Association, 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.
   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 and residency/fellowship programs use holistic assessments of applicants that take into account the diversity of preparation and the variety of talents that applicants bring to their education with the goal of improving health care for all communities.
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 unequivocally opposes legislation that would 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.

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.

Clinical Skills Assessment During Medical School D-295.988

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

Discouraging the Use of Licensing Exams for Internal Promotion in Medical Schools H-275.958

It is the policy of the AMA to encourage the discontinuation of the use of the USMLE Step 1 Exam as a requirement for the promotion of medical students to the clinical phase.

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

Our American Medical Association adopts the following principles:

1. Ideally, all medical students should successfully complete Steps 1 and 2 of the United States Medical Licensing Examination (USMLE) or Levels 1 and 2 of the Comprehensive Osteopathic Medical Licensing Examination (COMLEX USA) prior to entry into residency training. At a minimum, individuals entering residency training must have successfully completed Step 1 of the USMLE or Level 1 of COMLEX USA. There should be provision made for students who have not completed Step 2 of the USMLE or Level 2 of the COMLEX USA to do so during the first year of residency training.
2. All applicants for full and unrestricted licensure, whether graduates of U.S. medical schools or international medical graduates, must have completed one year of accredited graduate medical education (GME) in the U.S., have passed all state-required licensing examinations (USMLE or COMLEX USA), and must be certified by their residency program director as ready to advance to the next year of GME and to obtain a full and unrestricted license to practice medicine. State medical licensing boards are encouraged to allow an alternate set of criteria for granting licensure in lieu of this requirement for completing one year of accredited GME in the U.S.: (a) completion of

medical school and residency training outside the U.S.; (b) extensive U.S. medical practice; and (c) evidence of good standing within the local medical community.
3. There should be a training permit/educational license for all resident physicians who do not yet have a full and unrestricted license to practice medicine. To be eligible for an initial training permit/educational license, the resident must have completed Step 1 of the USMLE or Level 1 of COMLEX USA.
4. Residency program directors shall report only those actions to state medical licensing boards that are reported for all licensed physicians.
5. Residency program directors should receive training to ensure that they understand the process for taking disciplinary action against resident physicians, and are aware of procedures for dismissal of residents and for due process. This requirement for residency program directors should be enforced through Accreditation Council for Graduate Medical Education accreditation requirements.
6. There should be no reporting of actions against medical students to state medical licensing boards.
7. Medical schools are responsible for identifying and remediating and/or disciplining medical student unprofessional behavior, problems with substance abuse, and other behavioral problems. as well as gaps in student knowledge and skills.
8. The Dean's Letter of Evaluation should be strengthened and standardized, to serve as a better source of information to residency programs about applicants.

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## 7. DESIGNATION OF DESCENDANTS OF ENSLAVED AFRICANS IN AMERICA

*Reference committee hearing: see report of Reference Committee C.*

**HOUSE ACTION: RECOMMENDATIONS ADOPTED**
**REMAINDER OF REPORT FILED**
*See Policy H-350.935*

Resolution 218-A-24, "Designation of Descendants of Enslaved Africans in America," was introduced by the Michigan delegation at the 2024 Annual Meeting of the American Medical Association (AMA) House of Delegates and was referred. The original resolution stated:

RESOLVED, that our American Medical Association work with appropriate organizations including, but not limited to, the Association of American Medical Colleges to adopt and define the term Descendants of Enslaved Africans in America and separate it from the generic terms African American and Black in glossaries and on medical school applications. (Directive to Take Action)

Reference Committee B heard mixed testimony on Resolution 218, indicating that it is important to disaggregate data to make sure everyone is recognized and that the data influencing policies, programs, and solutions are accurate. However, testimony also highlighted that over the last four years, our AMA has been working with the Association of American Medical Colleges and the Accreditation Council for Graduate Medical Education through the Physician Data Initiative (PDI) to establish best practices for data sharing and standards for sociodemographic data, including race, ethnicity, and more. Reference Committee B also heard that the Office of Management and Budget recently concluded an extensive national consultation process concerning updating race and ethnicity standards, which our AMA provided comments on. The process found that further research is needed to fully understand the implications of a designation for "Descendants of Enslaved Africans in America," because individuals and civil rights groups disagreed on whether or how to implement this potential revision. Due to the need for more time to understand the resolution's nuances and implications and to collaborate with partners through the PDI, Resolution 218 was referred for study by the House of Delegates.

BACKGROUND

The AMA recognizes racism as a public health threat.[1] Medical education must strive to alleviate systemic and institutional racism, including but not limited to, anti-Black racism, which has been perpetuated by the AMA itself.[2] For this reason, it is also important for the AMA to act based on priorities established by affected communities and civil rights organizations, particularly when questions of individual and group identity are raised. This is a better approach than the AMA determining itself how subsections of underrepresented groups define and understand themselves. This report reviews some of the basic history and current conversations surrounding the disaggregation of "Descendants of Enslaved Africans in America" and related terms, both outside of and within medical education, with the observation that Black and/or African American viewpoints on these considerations are not monolithic.

*The Context for Defining "Descendants of Enslaved Africans in America"*

Defining and disaggregating subsections of Black and African American people according to whether they had enslaved African ancestors or not is a challenge, particularly when narrowly defined within the continental U.S. The authors of this resolution stated that "Descendants of Enslaved Africans in America are the only people in U.S. history to be classified as nonhuman and property" and "the only people for whom it was illegal to attend school or learn how to read or write in the United States." There have been discussions of reparations for systemic harms to Black Americans. According to the University of California, San Francisco's "Medical Reparations: A Resolution Paper,"[3] there are multiple viewpoints for the appropriate recipients of reparations:

> "Some have argued that reparations in the form of compensation should be exclusively paid to those whose families were wronged by slavery because slavery was the original wrong, inflicting the original harm. Thus those who are descendants of slaves have been living in a position of deficit that needs to be addressed and rectified."
>
> "Others have argued that the legacies of slavery in the US have impacted all Black Americans, thus reparations should be focused on eliminating anti-Black Racism and providing compensation to all Black Americans (including those whose families were never slaves). In other words, reparations should not only compensate descendants of slaves but also funding efforts to root out and eradicate ongoing forms of institutional racism, namely the lack of people of color at every level of the socio-economic hierarchy."

*Differing Viewpoints on Definitions and Categorization*

When emphasis is on defining and disaggregating descendants of enslaved Africans in America (and other related terms) into a separate category from Black and African American demographic questions, stances on this are varied. For example, NAACP's work on reparations describes them as for "every descendant of an enslaved African American and [every] Black person [who is] a descendant of those living in the United States including during American slavery until the Jim Crow era," and acknowledges evidence of systemic racism still present today.[4] The National African American Reparations Commission (NAARC) focuses on "people of African descent" and "the benefit of Black America as a whole."[5] The National Coalition of Blacks for Reparations in America (N'COBRA) is "a mass-based coalition organized for the sole purpose of obtaining reparations for African descendants in the United States," and in terms of definitions, states: "Within the broadest definition, all Black people of African descent in the United States should receive reparations in the form of changes in or elimination of laws and practices that allow them to be treated differently and less well than White people."[6]

While none of these organizations focus on distinct racial identity for descendants of enslaved Africans, other groups do. A well-known variation on this phrasing is "American Descendants of Slavery" (ADOS), which, according to those who claim the term, emerged in 2016 for the purpose of "categorizing Black Americans with generational roots in the United States as American descendants of slavery (ADOS), distinct from African or Caribbean immigrants."[7] The ADOS Foundation "[insists] upon a specific group designation" for "descendants of chattel slavery in the United States of America." Even those who may under certain conditions be considered to "qualify" as ADOS may struggle with the wording or believe that it does not reflect the depth of their own experience.[8] On the other hand, some find value and meaning in the term and suggest genealogical lineage as a possible alternative to the current nationwide ban on race-based admissions in higher education.[9]

The discussion of descendants of enslaved Africans existed well before 2016.[10] People have many reasons for using the term ADOS or variations of this acronym to refer to Black and African American people experiencing the violent, harmful legacy of slavery via direct experiences of their known ancestors in the U.S. Though not reflective of every individual who identifies with ADOS, some have raised concerns about the primary organization associated with the ADOS-specific acronym, the ADOS Advocacy Foundation. For example, a *New York Times* article raised concerns about the movement's anti-migrant rhetoric within some ADOS discussions, public use of and defense of a Nazi slogan, and alleged affiliations with white supremacist groups, as well as reported fears by Black scholars of messaging co-optation by white supremacists, even when individual ADOS supporters are well-intentioned.[11] The ADOS Advocacy Foundation's website itself states: "Although our justice claim for reparations is sacred to ADOS, we are fiercely committed to advocating for policies that eliminate the divides faced by black citizens with immigrant backgrounds. We recognize the lived experience of racism and discrimination among all black people in America, and we invite all people from all backgrounds to join this cause."[12]

Groups like the Institute of the Black World 21st Century (IBW21) recognize the impacts of slavery and support reparations but reject the use of ADOS in the context of the 2016 movement, expressing the opinion that use of the term in this context could "further marginalize and oppress Black communities."[13] Given the variation of views on the purpose of self-identification of Black descendants of slavery within the Black community, it is problematic for organizations outside the community to impose their own definitions of identity.

*Concerns with Medical Education Definition and Enactment of Lineage-Specific Terms*

Systemic oppression and anti-Black racism continue in the U.S. to this day in a variety of forms,[14] and many forms of this violence do not inherently depend upon an awareness of a Black person's specific ancestry.[15] The history of anti-Black racism in the U.S., including within medical education, is complex and systemic, and there are challenges inherent in institutionally establishing categories based on descendancy. As one scholar points out, "for good or for ill, the social and political history of this country has defined the Black race using the rule of hypodescent."[16] This is also known as the one-drop rule, which asserts that even one drop of blood from a Black ancestor makes one Black. This establishes wide-ranging, pervasive anti-Black racism in opposition to supposed white "racial purity." Hickman warns against viewing "racial injustice in the drawing of the boundaries around the Black race rather than in racism itself,"[17] while also acknowledging a diversity of experiences within those racialized as Black within the U.S.

There are problems inherent in the AMA delineating and defining a specific category for Black identity. The AMA as an organization has only recently begun to address its own history of racism, and only 4.3 percent of AMA member physicians and medical students[18] identify as "non-Hispanic Black" compared to 13.6 percent "non-Hispanic" Black people in the U.S.[19] Implementation issues would also arise with doing so. Some people who "qualify" for whatever definition is chosen may choose the label, but the label may not be claimed by all those who "qualify" to claim the terms. Some prefer terms like Descendants of Enslaved Africans in America. Some may actively oppose these terms or prefer others, and some may be uncertain. The term does not necessarily capture clear or objective data if it were to be used. The scope of slavery definitions in the Americas is also ambiguous—for example, a family history of slavery in the continental U.S., versus the wider "Americas," or slavery in places that are now considered U.S. territory, such as Puerto Rico.

Finally, in the background of the original resolution, concerns were raised regarding lying about race on medical education applications. Verification of self-reported demographic information is problematic regardless of which categorization is used. Self-reported descendancy from enslaved Africans is not inherently more objective than any other self-reported experience. It would be inappropriate, resource intensive, and likely intrusive and exclusionary for already underrepresented populations if medical education institutions attempted to collect and verify genealogical records. These records may or may not also be known to individuals or accurately represent someone's direct lived experience within systemic racism.

*Federal Efforts and the Office of Management and Budget (OMB) Revisions*

In March 2024, the Office of Management and Budget (OMB) finalized revisions to Statistical Policy Directive No. 15: Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity (SPD 15).[20] This process included the following:

> "*Summary of Public Input*. The [Federal Register Notice] asked, "How can Federal surveys or forms collect data related to descent from enslaved peoples originally from the African continent? For example, when collecting and coding responses, what term best describes this population group (e.g., is the preferred term 'American Descendants of Slavery,' 'American Freedmen,' or something else)? How should this group be defined? Should it be collected as a detailed group within the 'Black or African American' minimum category, or through a separate question or other approach?"
>
> "The majority of the public input on this subject expressed support for adding a category or question to identify descendants of persons enslaved in the United States. There was support for terms including: Foundational Black American, American Descendant of Slavery, American Freedman or Freedman, Black American, African-American, and Negro or American Negro; however, there was disagreement about which term is preferred. Commenters described the importance of collecting these data and the value for data users and policymakers, pointed to existing research that shows differences in outcome measures, like income and wealth, and stated that descendants of persons who were enslaved in the United States are ethnically distinct from African immigrants."
>
> "Other commenters, including civil rights groups, opposed the collection of these data. Commenters expressed concern about the difficulty of verifying that identification is accurate, the usefulness or necessity of the data, the exclusion of other groups of historically enslaved people, and the creation of confusion that could make the Black or African American community harder to count. Related,

there was also concern about potential harm to the full and accurate count of the Black or African American population, particularly Black or African American immigrants. The comments noted the lack of in-depth research and engagement with the diverse Black or African American community on terminology, definition, and data collection and coding protocol, as well as implications on the counts of other Black or African American diasporic populations."

"*Working Group's Final Recommendation*. The Working Group did not recommend disaggregation of the Black or African American category by descent from persons who were enslaved in the United States. They identified the disaggregation of Black or African American population groups as a priority area for future research and noted that additional stakeholder engagement is also needed."

"*OMB Decision*. OMB concurs with this recommendation and the Working Group's determination that further research is needed."

*Physician Data Initiative Recommended Standards*

In 2024, a partnership between the AMA, the Accreditation Council for Graduate Medical Education (ACGME), and the Association of American Medical Colleges (AAMC) released recommended standards[21] for data collection and reporting in race and ethnicity as well as language proficiency.[22]

The "short version" of the race and ethnicity standards asks "How do you self-identify?" and offers the following options:

"Please check as many categories as may apply:

□ American Indian or Alaska Native
□ Asian
□ Black or African American
□ Hispanic or Latino
□ Middle Eastern or North African
□ Native Hawaiian or Pacific Islander
□ White
□ Some other race or ethnicity: [write-in]"

The "long version" asks "How do you self-identify? Please check as many categories and subcategories as may apply:" and within the Black or African American category, offers the following options:

□ African
□ African American
□ Afro-Caribbean
□ Ethiopian
□ Haitian
□ Jamaican
□ Nigerian
□ Somali
□ Some other Black or African American: [write-in]"

DISCUSSION

People targeted for anti-Black racism have diverse experiences and histories that may be ambiguous to define, including potential histories of dehumanization, state violence, and enslavement within and outside of the continental United States. Narratives of "choice" in immigration are also not always clear cut for many individuals and their past family experiences. When speaking of "chosen" immigration in contrast to those with family history of being enslaved in the continental US, not all those called "immigrants" have an experience based in free will, either: they may also have family contexts of chattel slavery (i.e., enslavement outside continental U.S. before ancestors arrived to the U.S.), traumatic refugee circumstances, imprisonment, forced unpaid labor, and/or human trafficking.

While specifically defining and verifying family history of enslavement in the U.S. for the purposes of one aspect of reparations may be valuable to consider, this would be inappropriate for the AMA, AAMC, or medical schools to determine and define this, and this work should be led and determined by the affected communities and civil rights groups. Some individuals and groups may choose to identify with these family experiences as part of a racial or ethnic identity distinguished from or in addition to an overall identity of being Black or African American. Individuals' feelings on this concept vary.

There may also be value in disaggregating and exploring health inequities for subsets of racial/ethnic groups based on the known traumatic experiences of one's ancestors, such as chattel slavery. However, populations of medical education learners or applicants are not the appropriate group to study to determine this information in a comprehensive way. There are also limitations on self-reporting and verification of any genealogical information in medical education demographics and varying opinions within the affected communities about the benefits or harms of this delineation.

It also remains important to avoid single narratives of divisions between Black, African, and/or African American lineages of "immigrants" or "non-immigrants," as experiences of ancestral and/or current slavery and/or oppression are highly complex issues. Current Physician Data Initiative recommendations include space for people to self-identify as they prefer, without imposing specific definitions.

RELEVANT AMA POLICY

The AMA has several policies related to racial justice and diversity within medical education. A selection of these are listed in Appendix A.

SUMMARY

The AMA and medical education have a responsibility to oppose systemic and institutional racism, including but not limited to anti-Black racism and the legacy of chattel slavery, which have resulted in inequities in health outcomes. Black and/or African American viewpoints on designations like "Descendants of Enslaved Africans in America" are highly complex and non-monolithic. Support should be given to ongoing collective work, led by civil rights groups and by communities most affected by anti-Black racism, to determine the appropriate means of identifying and addressing the harmful ramifications of slavery and racism on these communities. AMA is not an appropriate institution to define and designate how underrepresented individuals should identify themselves, and the current Physician Data Initiative recommendations include write-in space for people to self-identify as they prefer, without imposing specific definitions.

RECOMMENDATIONS

The Council on Medical Education therefore recommends that the following be adopted in lieu of Resolution 218-A-24, and the remainder of the report be filed:

1. Our AMA acknowledges that anti-Black racism, including but not limited to direct experiences and/or family histories of slavery, results in significant and ongoing harm to Black people and communities.
2. Our AMA will raise awareness of the Physician Data Initiative's work to disaggregate racial/ethnic identification categories on demographic forms and offer opportunities for individuals to self-identify.

Fiscal note: $2,000

APPENDIX A: RELEVANT AMA POLICY

<u>Racism as a Public Health Threat H-65.952</u>

1. Our American Medical Association acknowledges that, although the primary drivers of racial health inequity are systemic and structural racism, racism and unconscious bias within medical research and health care delivery have caused and continue to cause harm to marginalized communities and society as a whole.
2. Our AMA recognizes racism, in its systemic, cultural, interpersonal, and other forms, as a serious threat to public health, to the advancement of health equity, and a barrier to appropriate medical care.

3. Our AMA encourages the development, implementation, and evaluation of undergraduate, graduate, and continuing medical education programs and curricula that engender greater understanding of:
    a. The causes, influences, and effects of systemic, cultural, institutional, and interpersonal racism.
    b. How to prevent and ameliorate the health effects of racism.
4. Our AMA:
    a. supports the development of policy to combat racism and its effects.
    b. encourages governmental agencies and nongovernmental organizations to increase funding for research into the epidemiology of risks and damages related to racism and how to prevent or repair them.
5. Our AMA will work to prevent and combat the influences of racism and bias in innovative health technologies.

Immigration Status is a Public Health Issue D-350.975

1. Our American Medical Association declares that immigration status is a public health issue that requires a comprehensive public health response and solution.
2. Our AMA recognizes interpersonal, institutional, structural, and systemic factors that negatively affect immigrants' health.
3. Our AMA will promote the development and implementation of educational resources for healthcare professionals to better understand health and healthcare challenges specific for the immigrant population.
4. Our AMA will support the development and implementation of public health policies and programs that aim to improve access to healthcare and minimize systemic health barriers for immigrant communities.

Elimination of Race as a Proxy for Ancestry, Genetics, and Biology in Medical Education, Research and Clinical Practice H-65.953

1. Our AMA recognizes that race is a social construct and is distinct from ethnicity, genetic ancestry, or biology.
2. Our AMA supports ending the practice of using race as a proxy for biology or genetics in medical education, research, and clinical practice.
3. Our AMA encourages undergraduate medical education, graduate medical education, and continuing medical education programs to recognize the harmful effects of presenting race as biology in medical education and that they work to mitigate these effects through curriculum change that: (a) demonstrates how the category "race" can influence health outcomes; (b) that supports race as a social construct and not a biological determinant and (c) presents race within a socio-ecological model of individual, community and society to explain how racism and systemic oppression result in racial health disparities.
4. Our AMA recommends that clinicians and researchers focus on genetics and biology, the experience of racism, and social determinants of health, and not race, when describing risk factors for disease.

Continued Support for Diversity in Medical Education D-295.963

1. Our American Medical Association will publicly state and reaffirm its support for diversity in medical education and acknowledge the incorporation of DEI efforts as a vital aspect of medical training.
2. Our AMA will request that the Liaison Committee on Medical Education regularly share statistics related to compliance with accreditation standards IS-16 and MS-8 with medical schools and with other stakeholder groups.
3. Our AMA will 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.
4. Our AMA will 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. Our AMA will directly oppose any local, state, or federal actions that aim to limit diversity, equity, and inclusion initiatives, curriculum requirements, or funding in medical education.
6. Our AMA will 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.
7. Our AMA will investigate the impacts of state legislation regarding DEI-related efforts on the education and careers of students, trainees, and faculty.
8. Our AMA will recognize the disproportionate efforts by and additional responsibilities placed on minoritized individuals to engage in diversity, equity, and inclusion efforts.

9. Our AMA will 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.

Strategies for Enhancing Diversity in the Physician Workforce D-200.985

1. Our American Medical Association, 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.
    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 and residency/fellowship programs use holistic assessments of applicants that take into account the diversity of preparation and the variety of talents that applicants bring to their education with the goal of improving health care for all communities.
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 unequivocally opposes legislation that would 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.
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.

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

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

Underrepresented Student Access to US Medical Schools H-350.960

1. Our American Medical Association recommends that medical schools should consider in their planning: elements of diversity including but not limited to gender, racial, cultural and economic, reflective of the diversity of their patient population.
2. Our AMA supports the development of new and the enhancement of existing programs that will identify and prepare underrepresented students from the high-school level onward and to enroll, retain and graduate increased numbers of underrepresented students.
3. Our AMA recognizes some people have been historically underrepresented, excluded from, and marginalized in medical education and medicine because of their race, ethnicity, disability status, sexual orientation, gender identity, socioeconomic origin, and rurality, due to racism and other systems of exclusion and discrimination.
4. Our AMA is committed to promoting truth and reconciliation in medical education as it relates to improving equity.
5. Our AMA recognizes the harm caused by the Flexner Report to historically Black medical schools, the diversity of the physician workforce, and the outcomes of minoritized and marginalized patient populations.
6. Our AMA will urge medical schools to develop or expand the reach of existing pathway programs for underrepresented middle school, high school and college aged students to motivate them to pursue and prepare them for a career in medicine.
7. Our AMA will encourage collegiate programs to establish criteria by which completion of such programs will secure an interview for admission to the sponsoring medical school.
8. Our AMA will recommend that medical school pathway programs for underrepresented students be free-of-charge or provide financial support with need-based scholarships and grants.
9. Our AMA will encourage all physicians to actively participate in programs and mentorship opportunities that help expose underrepresented students to potential careers in medicine.
10. Our AMA will consider quality of K-12 education a social determinant of health and thus advocate for implementation of Policy H-350.979,

encouraging state and local governments to make quality elementary and secondary education available to all.

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## 8. DISAGGREGATION OF DEMOGRAPHIC DATA FOR INDIVIDUALS OF FEDERALLY RECOGNIZED TRIBES

*Reference committee hearing: see report of Reference Committee C.*

**HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS**
**REMAINDER OF REPORT FILED**
*See Policies H-350.934, H-350.981 and H-460.884*

Resolution 243-A-24, "Disaggregation of Demographic Data for Individuals of Federally Recognized Tribes," was introduced by the Minority Affairs Section at the 2024 Annual Meeting of the American Medical Association (AMA) House of Delegates and was referred. The resolution asked the following:

> "RESOLVED, that our American Medical Association add 'Enrolled Member of a Federally Recognized Tribe' on all AMA demographic forms (Directive to Take Action); and be it further
>
> "RESOLVED, that our AMA advocate for the use of 'Enrolled Member of a Federally Recognized Tribe' as an additional category in all uses of demographic data including but not limited to medical records, government data collection and research, and within medical education (Directive to Take Action); and be it further
>
> "RESOLVED, that our AMA support the Association of American Medical Colleges (AAMC) inclusion of 'Enrolled Member of a Federally Recognized Tribe' on all AAMC demographic forms (New HOD Policy); and be it further
>
> "RESOLVED, that our AMA advocate for the Accreditation Council for Graduate Medical Education (ACGME) to include 'Enrolled Member of a Federally Recognized Tribe' on all ACGME demographic forms. (Directive to Take Action)"

Reference Committee B testimony noted AMA's work with the AAMC and the ACGME through the Physician Data Initiative (PDI) to establish best practices for data sharing and standards for sociodemographic data, including race, ethnicity, and more. Testimony also discussed that the Office of Management and Budget (OMB) recently concluded an extensive national consultation process concerning updating race and ethnicity standards, to which AMA provided comments. Testimony highlighted that the OMB ultimately decided to "remove the phrase 'who maintains tribal affiliation or community attachment' in the American Indian/Alaska Native (AI/AN) definition... to improve estimates of the AI/AN population in Federal statistics." However, testimony also indicated the possible value in collecting data about members of federally recognized tribes because it is a legal designation, not a racial category, and therefore not subject to the recent U.S. Supreme Court decisions banning the use of race in holistic college admissions processes. Testimony indicated it would be beneficial to study the implications of this designation to ensure that AMA policy is more comprehensive and does not exclude AI/AN individuals because their tribe is not federally recognized. Testimony also noted that more time is needed to understand the nuances and implications of this resolution and to collaborate with partners through the PDI to fully consider the short and long-term implications of these changes. Resolution 243 was referred for study.

BACKGROUND

According to the U.S. Department of the Interior, Indian Affairs, "A federally recognized tribe is an American Indian or Alaska Native tribal entity that is recognized as having a government-to-government relationship with the United States, with the responsibilities, powers, limitations, and obligations attached to that designation, and is eligible for funding and services from the Bureau of Indian Affairs. Furthermore, federally recognized tribes are recognized as possessing certain inherent rights of self-government (i.e., tribal sovereignty) and are entitled to receive certain federal benefits, services, and protections because of their special relationship with the United States. At present, there are 574 federally recognized American Indian and Alaska Native tribes and villages."[1]

Federally recognized tribal enrollment in the United States is a legal and political category in relation to the U.S. government, rather than a racial or ethnic identity.[2] The U.S. does not grant sovereign status to these tribes but rather chooses whether or not to acknowledge the continued existence of a tribe's inherent sovereignty. Many tribes remain

unacknowledged by the federal government, with some of these recognized only by states,[3] or not at all. Native Hawaiians, for instance, are not federally recognized as a sovereign tribe or tribes.[4] Recognition itself may be linked to the process of colonization. For example, Patty Ferguson-Bohnee, JD, associate dean, clinical professor of law, and faculty director of the Indian Legal Program at Arizona State University, indicated in a 2021 presentation that, "The inclusion of a federal acknowledgement requirement poses a direct threat to the right and sovereignty of all tribes and creates a particular challenge for non-BIA listed tribes by attempting to link tribal sovereignty to federal acknowledgement… The Federal Acknowledgement Process persists in functioning as a barrier to historically well documented tribes seeking to achieve federal recognition."[5] These concerns are a natural consequence of the current social structure: "Because the foundation of colonial governments requires those entities to ignore the inherent rights of Indigenous Peoples, these governments—such as the United States government—have a tendency to ignore some Indigenous Peoples, and recognize others."[6]

Various U.S. government actions over time have also broken treaties with many tribes,[7] including actions to terminate federal recognition of tribal sovereignty.[8] As noted by the U.S. National Archives, "From 1953 until 1970, Congress initiated 60 separate termination proceedings against American Indian tribes, and over three million acres of tribal lands were relinquished as a result. Although the Nixon administration repudiated termination in 1970 and shifted federal Indian policy toward self-determination, the effect of termination was nevertheless devastating for many tribes."[9]

The United Nations Declaration on the Rights of Indigenous Peoples does not directly determine or define tribal status or Indigenous identity, stating in Article 9, "Indigenous peoples and individuals have the right to belong to an indigenous community or nation, in accordance with the traditions and customs of the community or nation concerned," and in Article 33, "Indigenous peoples have the right to determine their own identity or membership in accordance with their customs and traditions."[10]

*Demographic Definitions and the Indian Health Service*

The original resolution's interest in including additional categorization of Indigenous medical education learners and physicians was in part driven by the Indian Health Service's (IHS) role, referred to in the resolution, as "a health care system for federally recognized American Indians and Alaska Natives in the United States," noting significant physician vacancies as well as the IHS Physician Scholarship program's requirement for applicants to be enrolled members of federally recognized tribes.[11] Indeed, while earlier IHS scholarship opportunities (such as for pre-medicine) are also eligible for both descendants and members of either federal or state recognized tribes in the 2025-2026 scholarship cycle, health professions scholarships, including for physicians-in-training, are restricted to enrolled members of federally recognized tribes—no descendants of members, nor members of state recognized tribes.[12]

While tribes and groups eligible for IHS health care are restricted to those federally recognized, individual patient eligibility for IHS is complex. Though it generally defaults to federal recognition, there are several exceptions where patients who are not enrolled members of a federally recognized tribe may receive services at the time of this writing, including but not limited to: non-enrolled membership in an AI/AN federally recognized group evidenced by other "reasonable" factors, children of otherwise eligible patients, spouses if the appropriate tribal organization deems them eligible, people who are pregnant under some circumstances, and others. IHS employees are not required to be AI/AN, although IHS does by law provide preference to AI/AN applicants,[13] and determines this via Bureau of Indian Affairs (BIA) standards.[14]

Physician vacancies in IHS have been attributed to issues such as matching local market salaries and housing scarcity,[15] as well as lack of GME funding[16] and management concerns.[17] AI/AN people experience significant challenges based on wider systemic oppression in education in general and therefore are underrepresented in high school and college degrees as well as in the physician workforce.[18]

*Tribal Enrollment Data and Data Sovereignty*

There are currently 574 AI/AN tribes federally recognized by the U.S. government. While the BIA maintains a list of tribal leaders,[19] AI/AN nations maintain their own enrollment records and processes.[20] Racial or ethnic self-identity, or status as an Indigenous person per one's own community or nation's customs and traditions, would not and likely should not be defined by broad medical education groups like the AMA. Enrollment in a federally recognized tribe is a verifiable legal and political status, and any data collected on this would therefore need to be verified. As discussed

in a presentation by the American Indian Health Commission for Washington State, available on the U.S. Bureau of Justice Assistance website, tribal data sovereignty is of the utmost importance: "Tribal Nations' inherent sovereign authority to administer the collection, ownership, and application of their own data is rooted in a tribal nation's right to govern their people."[21] Collecting and reporting on alleged federally recognized tribal enrollment without each tribal nation's permission or verification would be a direct violation of tribal sovereignty and inappropriate.[22] Hypothetical collection of this data would require meaningful partnerships with the appropriate and specific tribal leaders in each of the potential 574 federally recognized tribes to ascertain if collection and verification of this data within medical education is even a desirable priority for each nation, and if so, the resources and data privacy and dissemination agreements needed.

*Office of Management and Budget Revisions*

In March 2024, OMB finalized revisions to Statistical Policy Directive No. 15: Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity (SPD 15).[23] Previously, the demographic data standards on AI/AN included the phrase "who maintain tribal affiliation or community attachment," and the removal of this phrase was supported by the National Congress of American Indians and several other relevant organizations.[24]

This was removed in the final recommendations, such that, within a combined question for race and ethnicity, AI/AN is defined as follows: "American Indian or Alaska Native. Individuals with origins in any of the original peoples of North, Central, and South America, including, for example, Navajo Nation, Blackfeet Tribe of the Blackfeet Indian Reservation of Montana, Native Village of Barrow Inupiat Traditional Government, Nome Eskimo Community, Aztec, and Maya." The standards allow for minimum category data collection with no write-ins, but they also allow for a write-in field for "additional details." The OMB stated this is "especially critical for the American Indian or Alaska Native category, which does not have required detailed categories under these standards." The revised standards do not collect information on federal recognition.

*Physician Data Initiative Recommended Standards*

In 2024, a partnership between the AMA, ACGME, and AAMC released recommended standards[25] for data collection and reporting in race and ethnicity as well as language proficiency, "driven by the importance of a diverse physician workforce and a more equitable health system."[26]

The "short version" of the race and ethnicity standards asks, "How do you self-identify?" and offers the following options:

"Please check as many categories as may apply:

□ American Indian or Alaska Native
□ Asian
□ Black or African American
□ Hispanic or Latino
□ Middle Eastern or North African
□ Native Hawaiian or Pacific Islander
□ White
□ Some other race or ethnicity: [write-in]"

The "long version" asks "How do you self-identify? Please check as many categories and subcategories as may apply:" and within the AI/AN subsection states:

"□ American Indian or Alaska Native
□ Tribal affiliation: [write-in]"

DISCUSSION

No current standards support broad official medical education collection of federal tribal enrollment recognition status, and significant concerns arise related to accurately collecting this data. It is especially concerning regarding tribal data sovereignty, and the potential consequences to state recognized tribal members and other Indigenous learners who are not federally or state recognized.

There may also be privacy concerns within certain forms of disaggregation in medical education. For instance, according to the AAMC, in 2023, there were only 90 total AI/AN self-reported applicants to U.S. MD-granting medical schools, and 57 Native Hawaiian or Other Pacific Islander (though some Indigenous applicants may have been aggregated under other ethnic categories, such as multiracial.)[27] Based on some AI/AN organizational recommendations, it may be valuable to disaggregate data on those who indicate multiple ethnicities, without disaggregating based on federal recognition of enrollment in specific tribes. For instance, the National Congress of American Indians "has recommended applying the approach used by the U.S. Census Bureau to report data on AI/AN alone… and AI/AN in combination with other races and ethnicities."[28]

Given significant underrepresentation of AI/AN medical education learners and physicians, it is valuable to work directly with tribes on admissions pathways, scholarships, and other programs.[29] AMA policy acknowledges "long-standing federal precedent that membership or lineal descent from an enrolled member in a federally recognized tribe is distinct from racial identification as American Indian or Alaska Native and should be considered in medical school admissions even when restrictions on race-conscious admissions policies are in effect."[30] Rather than broadly attempting to collect and verify federal enrollment data from any applicant, the focused work of engaging directly with tribes to create programs to reduce inequities may be beneficial. Although federally recognized tribes tend to have more legal protections in the U.S., where legal and feasible, this work should ideally also include tribes and communities that are not federally recognized. This is in alignment with AMA's stance that "Our AMA will continue to support the concept of American Indian self-determination as imperative to the success of American Indian programs."[31] AMA policy also supports AI/AN access to health care both within and outside of IHS.[32]

Any collection or reporting on enrollment status, whether federally recognized or not, must be in direct collaboration with tribes as sovereign nations with inherent rights to self-determine priorities and data strategies. This should be undertaken on a case-by-case basis in response to each tribe's communicated needs, as collection of delineated enrollment data within medical education may or may not be relevant to each nation's priorities.

RELEVANT AMA POLICY

The AMA has policy related to Indigenous peoples and medical education. Some examples are as follows:

- H-350.981, "AMA Support of American Indian Health Career Opportunities," continues to support the concept of American Indian self-determination as imperative to the success of American Indian programs and recognize that enduring acceptable solutions to American Indian health problems can only result from program and project beneficiaries having initial and continued contributions in planning and program operations. This includes training a workforce from and for these tribal nations.
- H-350.976, "Improving Health Care of American Indians and Alaska Natives," recommends that the federal government provide sufficient funds to support needed health services for American Indians and Alaska Natives.
- H-270.950, "Indian Health Service Licensing Exemptions," works 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.
- H-350.939, "Health Care Access for American Indians and Alaska Natives," supports the federal government continuing to enhance and develop alternative pathways for American Indian and Alaska Native patients to access the full spectrum of health care, including within and outside of the established Indian Health Service (IHS) system.
- H-350.950, "Tribal Public Health Authority," supports the use of data-sharing agreements between local and state public health departments and American Indian and Alaska Native Tribes and Villages and Tribal Epidemiology Centers.
- H-350.977, "Indian Health Service," supports efforts in Congress to enable the Indian Health Service to meet its obligation to bring American Indian health up to the general population level.

- H-460.884, "Indigenous Data Sovereignty," recognizes that American Indian and Alaska Native (AI/AN) Tribes and Villages are sovereign governments that should be consulted before the conduct of research specific to their members, lands, and properties.

SUMMARY

Attending to the health care workforce needs of AI/AN and Indigenous populations is very important, as is respect for tribal data sovereignty. It would not be appropriate nor feasible for the AMA to collect and verify federal tribal enrollment data as part of medical education demographic information. It would also not be appropriate for the AMA to advocate for other medical education organizations to do so unless in direct collaboration with each of the relevant sovereign nations and led by the communicated priorities and needs of these tribal governments.

RECOMMENDATIONS

The Council on Medical Education recommends that the following be adopted in lieu of Resolution 243-A-24, and that the remainder of this report be filed.

1. That AMA Policy H-460.884, "Indigenous Data Sovereignty," be amended by addition:

   4. Our AMA affirms that any collection or storage of tribal affiliation or Indigenous identity data must respect tribal data sovereignty and be guided by consultation with tribal leadership organizations and Indigenous-led institutions.

2. That our AMA reaffirm Policy H-350.981, "AMA Support of American Indian Health Career Opportunities."

3. That our AMA affirm that tribal affiliation represents a distinct political and cultural status, not a racial category, and that, when shared by validating bodies, such information may carry relevance for understanding representation in medical education, access to federal health programs if part of a federally recognized tribe, and eligibility for specific workforce pathways.

4. That our AMA support the ability of individuals to voluntarily self-identify their tribal affiliation on demographic forms used across the medical education continuum, and continue to work with the Association of American Medical Colleges (AAMC), the Accreditation Council for Graduate Medical Education (ACGME), and other relevant partners to explore the feasibility of accepting, storing, and responsibly stewarding such self-reported information within AMA systems, including Physician Professional Data, consistent with legal guidance and tribal data sovereignty principles, and identify opportunities to transparently share progress, barriers, and timelines related to these efforts, where appropriate.

5. That our AMA engage with tribal leadership organizations, such as the Association of American Indian Physicians (AAIP), Indian Health Service (IHS), National Congress of American Indians (NCAI), and National Indian Health Board (NIHB), alongside American Indian and Alaska Native physicians and data sovereignty experts, to help inform AMA's internal policies, data use practices, and governance models related to tribal affiliation and American Indian and Alaska Native identity data.

Fiscal note: $1,000

APPENDIX A: RELEVANT AMA POLICY

AMA Support of American Indian Health Career Opportunities H-350.981
Our American Medical Association policy on American Indian health career opportunities is as follows:
1. Our American Medical Association, and other national, state, specialty, and county medical societies recommend special programs for the recruitment and training of American Indians in health careers at all levels and urge that these be expanded.
2. Our AMA supports the inclusion of American Indians in established medical training programs in numbers adequate to meet their needs. Such training programs for American Indians should be operated for a sufficient period of time to ensure a continuous supply of physicians and other health professionals, prioritize consideration of applicants who self-identify as American Indian or Alaska Native and can provide some form of affiliation

with an American Indian or Alaska Native tribe in the United States, and support the successful advancement of these trainees.

3. Our AMA will utilize its resources to create a better awareness among physicians and other health providers of the special problems and needs of American Indians and particular emphasis will be placed on the need for stronger clinical exposure and a greater number of health professionals to work among the American Indian population.
4. Our AMA will continue to support the concept of American Indian self-determination as imperative to the success of American Indian programs and recognize that enduring acceptable solutions to American Indian health problems can only result from program and project beneficiaries having initial and continued contributions in planning and program operations to include training a workforce from and for these tribal nations.
5. Our AMA acknowledges long-standing federal precedent that membership or lineal descent from an enrolled member in a federally recognized tribe is distinct from racial identification as American Indian or Alaska Native and should be considered in medical school admissions even when restrictions on race-conscious admissions policies are in effect.
6. Our AMA acknowledges the significance of the Morrill Act of 1862, the resulting land-grant university system, and the federal trust responsibility related to tribal nations.

Improving Health Care of American Indians and Alaska Natives H-350.976

1. Our American Medical Association recommends that all individuals, special interest groups, and levels of government recognize the American Indian and Alaska Native people as full citizens of the US, entitled to the same equal rights and privileges as other US citizens.
2. Our AMA recommends that the federal government provide sufficient funds to support needed health services for American Indians and Alaska Natives.
3. Our AMA recommends that state and local governments give special attention to the health and health-related needs of nonreservation American Indians and Alaska Natives in an effort to improve their quality of life.
4. Our AMA recommends that American Indian and Alaska Native religious and cultural beliefs be recognized and respected by those responsible for planning and providing services in Indian health programs.
5. Our AMA recognizes practitioners of Indigenous medicine as an integral and culturally necessary individual in delivering health care to American Indians and Alaska Natives.
6. Our AMA monitors Medicaid Section 1115 waivers that recognize the value of traditional American Indian and Alaska Native healing services as a mechanism for improving patient-centered care and health equity among American Indian and Alaska Native populations when coordinated with physician-led care.
7. Our AMA supports consultation with Tribes to facilitate the development of best practices, including but not limited to culturally sensitive data collection, safety monitoring, the development of payment methodologies, healer credentialing, and tracking of traditional healing services utilization at Indian Health Service, Tribal, and Urban Indian Health Programs.
8. Our AMA recommends strong emphasis be given to mental health programs for American Indians and Alaska Natives in an effort to reduce the high incidence of alcoholism, homicide, suicide, and accidents.
9. Our AMA recommends a team approach drawing from traditional health providers supplemented by psychiatric social workers, health aides, visiting nurses, and health educators be utilized in solving these problems.
10. Our AMA will continue its liaison with the Indian Health Service and the National Indian Health Board and establish a liaison with the Association of American Indian Physicians.
11. Our AMA recommends that state and county medical associations establish liaisons with intertribal health councils in those states where American Indians and Alaska Natives reside.
12. Our AMA supports and encourages further development and use of innovative delivery systems and staffing configurations to meet American Indian and Alaska Native health needs but opposes overemphasis on research for the sake of research, particularly if needed federal funds are diverted from direct services for American Indians and Alaska Natives.
13. Our AMA strongly supports those bills before Congressional committees that aim to improve the health of and health-related services provided to American Indians and Alaska Natives and further recommends that members of appropriate AMA councils and committees provide testimony in favor of effective legislation and proposed regulations.

Indian Health Service Licensing Exemptions H-270.950

Our American Medical Association will 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.

Health Care Access for American Indians and Alaska Natives H-350.939

1. Our American Medical Association supports the federal government continuing to enhance and develop alternative pathways for American Indian and Alaska Native patients to access the full spectrum of health care, including within and outside of the established Indian Health Service (IHS) system.
2. Our AMA supports collaborative research efforts to better understand the limitations of IHS health care, including barriers to access, disparities in treatment outcomes, and areas for improvement.
3. Our AMA encourages studies between the IHS and the CDC to better evaluate regional health outcomes, and potential treatment deficiencies among American Indian and Alaska Native populations, including with respect to cancer care.
4. Our AMA supports federal and other efforts to increase funding for and provide technical assistance to develop and expand accessible specialty care services at IHS, Tribal, and Urban Indian Health Programs and associated facilities, including by contracting with other physician practices.

Tribal Public Health Authority H-350.950

1. Our American Medical Association will support the Department of Health and Human Services issuing guidance, through the Centers for Disease Control and Prevention and the Indian Health Service, on Public Health and Tribal-affiliated data-sharing with American Indian and Alaska Native Tribes and Villages and Tribal Epidemiology Centers.
2. Our AMA will support the use of data-sharing agreements between local and state public health departments and American Indian and Alaska Native Tribes and Villages and Tribal Epidemiology Centers.

Indian Health Service H-350.977

The policy of the American Medical Association is to support efforts in Congress to enable the Indian Health Service to meet its obligation to bring American Indian health up to the general population level. Our AMA specifically recommends:

1. Indian Population:
    a. In current education programs, and in the expansion of educational activities suggested below, special consideration be given to involving the American Indian and Alaska native population in training for the various health professions, in the expectation that such professionals, if provided with adequate professional resources, facilities, and income, will be more likely to serve the tribal areas permanently;
    b. Exploration with American Indian leaders of the possibility of increased numbers of nonfederal American Indian health centers, under tribal sponsorship, to expand the American Indian role in its own health care;
    c. Increased involvement of private practitioners and facilities in American Indian care, through such mechanisms as agreements with tribal leaders or Indian Health Service contracts, as well as normal private practice relationships; and
    d. Improvement in transportation to make access to existing private care easier for the American Indian population.
2. Federal Facilities: Based on the distribution of the eligible population, transportation facilities and roads, and the availability of alternative nonfederal resources, the AMA recommends that those Indian Health Service facilities currently necessary for American Indian care be identified and that an immediate construction and modernization program be initiated to bring these facilities up to current standards of practice and accreditation.
3. Personnel:
    a. Compensation scales for Indian Health Service physicians be increased to a level competitive with other Federal agencies and nongovernmental service;
    b. Consideration should be given to increased compensation for specialty and primary care service in remote areas;
    c. In conjunction with improvement of Service facilities, efforts should be made to establish closer ties with teaching centers and other federal health agencies, thus increasing both the available staffing and the level of professional expertise available for consultation;
    d. Allied health professional staffing of Service facilities should be maintained at a level appropriate to the special needs of the population served without detracting from physician compensation;
    e. Continuing education opportunities should be provided for those health professionals serving these communities, and especially those in remote areas, and, increased peer contact, both to maintain the quality of care and to avert professional isolation and burnout; and

   f. Consideration should be given to a federal statement of policy supporting continuation of the Public Health Service to reduce the great uncertainty now felt by many career officers of the corps.
4. Medical Societies: In those states where Indian Health Service facilities are located, and in counties containing or adjacent to Service facilities, that the appropriate medical societies should explore the possibility of increased formal liaison with local Indian Health Service physicians. Increased support from organized medicine for improvement of health care provided under their direction, including professional consultation and involvement in society activities should be pursued.
5. Our AMA also supports the removal of any requirement for competitive bidding in the Indian Health Service that compromises proper care for the American Indian population.
6. Our AMA will advocate that the Indian Health Service (IHS) establish an Office of Academic Affiliations responsible for coordinating partnerships with LCME- and COCA-accredited medical schools and ACGME-accredited residency programs.
7. Our AMA will encourage the development of funding streams to promote rotations and learning opportunities at Indian Health Service, Tribal, and Urban Indian Health Programs.
8. Our AMA will call for an immediate change in the Public Service Loan Forgiveness Program to allow physicians to receive immediate, but incremental, loan forgiveness when they practice in an Indian Health Service, Tribal, or Urban Indian Health Program.
9. Our AMA supports reform of the Indian Health Service (IHS) Loan Repayment Program eligibility for repayment with either a part-time or full-time employment commitment to IHS and Tribal Health Programs.

Indigenous Data Sovereignty H-460.884
1. Our American Medical Association recognizes that American Indian and Alaska Native (AI/AN) Tribes and Villages are sovereign governments that should be consulted before the conduct of research specific to their members, lands, and properties.
2. Our AMA supports that AI/AN Tribes and Villages' Institutional Review Boards (IRBs) and research departments retain the right to oversee and regulate the collection, ownership, and management of research data with the consent of their members, and that individual members of AI/AN Tribes and Villages retain their autonomy and privacy regarding research data shared with researchers, AI/AN Tribes and Villages, and governments, consistent with existing protections under 45 CFR 46.
3. Our AMA encourages:
   a. the use and regular review of data-sharing agreements for all studies between academic medical centers and AI/AN Tribes and Villages be mutually agreed upon and aligned with AI/AN Tribes' and Villages' preferences.
   b. the National Institutes of Health and other stakeholders to provide flexible funding to AI/AN Tribes and Villages for research efforts, including the creation and maintenance of IRBs.

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