AMERICAN MEDICAL ASSOCIATION YOUNG PHYSICIANS SECTION

Resolution: 1
(A-25)

Introduced by: Anna Yap, MD; Daniel Udrea, MD; James Docherty DO, MS, MS; Amar Kelkar, MD, MPH, FACP; Scott H Pasichow, MD, MPH

Subject: Addressing Professionalism Standards in Medical Training

Referred to: YPS Reference Committee

Whereas, professionalism is often ambiguously defined—either as a set of beliefs about appropriate workplace behavior or as “the state or practice of doing one’s job with skill, competence, ethics, and courtesy”—and its largely subjective nature can create opportunities for bias, harm, and discrimination[1-3]; and

Whereas, medical education places heavy emphasis on professionalism through course syllabi, clinical evaluations, and residency recommendation letters—meaning that subjective assessments of professionalism can have direct and lasting impacts on a medical student’s future career[4-6]; and

Whereas, the AMA Code of Medical Ethics centers professionalism around maintaining the patient-physician relationship, public trust, ethical behavior, privacy and confidentiality, with no consistent incorporation of cultural diversity[27-31]; and

Whereas, varying interpretations of professionalism can contribute to inconsistent and potentially biased evaluations, particularly affecting students from diverse or underrepresented backgrounds, underscoring the need for a more consistent and equitable definition that supports fair and inclusive assessment[7-9]; and

Whereas, professionalism standards frequently reference "appropriateness" in areas such as speech and dress without clearly defining what is considered appropriate, leaving subjective interpretation to administrations whose judgments can vary significantly, resulting in inconsistent and potentially biased enforcement[2,3]; and

Whereas, expectations around professionalism and cultural norms within medical institutions may unintentionally place greater burdens on students from diverse and underrepresented backgrounds, contributing to disparities in well-being and increasing the risk of physical and mental health challenges[10-17]; and

Whereas, previous encounters of professionalism violations have not explicitly addressed the concerns for which an individual was unprofessional, but rather the concept itself was cited as the reason, which allows a method of weaponization as institutions do not have to acknowledge their rationale[2]; and

Whereas, physicians and trainees are in unique positions as community leaders to advocate for our patients and for humanity[19-21]; and

Whereas, even today, individuals who engage in advocacy have been penalized or labeled as exhibiting “unprofessional behavior,” despite the fact that the First Amendment was held to

protect college campus advocacy activities under the Supreme Court ruling Healy v. James (1972) [22-24]; and

Whereas, an overemphasis on professionalism can discourage open communication between doctors and patients by causing trainees to focus more on projecting a specific image than on engaging in genuine, human-centered interactions—ultimately limiting the diversity and inclusion of perspectives that medical practice seeks to promote[13,25-27]; and

Whereas, although our AMA supports due process protections for medical students and residents, the lack of clear, objective, and equitable professionalism standards may enable discriminatory practices to influence evaluations and disciplinary actions—undermining the intent of due process and disproportionately harming trainees from marginalized backgrounds[32, 33]; therefore be it

RESOLVED, that our American Medical Association supports regular institutional review, including review by DEI offices or other appropriate entities, of professionalism policies in medical school and residency programs, ensuring that they do not lead to discriminatory practices; and be it further

RESOLVED, that our AMA supports the ACGME, the AAMC, and AACOM to establish guidelines for residency programs and medical school professionalism policies that encourage institutions to outline actions that constitute a violation; and be it further

RESOLVED, that our AMA advocates for AAMC, ACGME, and AACOM to support measures that prevent medical schools and residency programs from using professionalism violations as a means to stop trainee advocacy measures.

Fiscal Note: Moderate

Received:

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RELEVANT AMA POLICY

Decreasing Bias in Assessments of Medical Student Clinical Clerkship Performance H-295.851
Our AMA will encourage and support UME institutions' investment in

- 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
- providing standardized and meaningful competency data to program directors.

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.
[CME Rep. 04, A-23]

Decreasing Bias in Evaluations of Medical Student Performance D-295.307
Our American Medical Association will work with appropriate stakeholders to promote efforts to evaluate methods for decreasing the impact of bias in medical student performance evaluation as well as reducing the impact of bias in the review of disciplinary actions.
[CME Rep. 04, A-23]

Fostering Professionalism During Medical School and Residency Training D-295.983
Our AMA, in consultation with other relevant medical organizations and associations, will work to develop a framework for fostering professionalism during medical school and residency training. This planning effort should include the following elements:

a. Synthesize existing goals and outcomes for professionalism into a practice-based educational framework, such as provided by the AMA's Principles of Medical Ethics.

b. Examine and suggest revisions to the content of the medical curriculum, based on the desired goals and outcomes for teaching professionalism.

c. Identify methods for teaching professionalism and those changes in the educational environment, including the use of role models and mentoring, which would support trainees' acquisition of professionalism.

d. Create means to incorporate ongoing collection of feedback from trainees about factors that support and inhibit their development of professionalism.

Our AMA, along with other interested groups, will continue to study the clinical training environment to identify the best methods and practices used by medical schools and residency programs to fostering the development of professionalism, to include an evaluation of professional behavior, carried out at regular intervals and employing methods shown to be valuable in adding to the information that can be obtained from observational reports. An ideal system would utilize multiple evaluation formats and would build upon educational experiences that are already in place. The results of such evaluations should be used both for timely feedback and appropriate interventions for medical students and resident physicians aimed at improving their performance and for summative decisions about progression in training.
[CME Rep. 3, A-01; Reaffirmation I-09; Reaffirmed: CME Rep. 01, A-19; Modified: CME Rep. 01, A-20]

Professionalism in the Use of Social Media 2.3.2
Physicians and medical students should be aware that they cannot realistically separate their personal and professional personas entirely online and should curate their social media presence accordingly. Physicians and medical students therefore should:

a. When publishing any content, consider that even personal social media posts have the potential to damage their professional reputation or even impugn the integrity of the profession.

b. Respect professional standards of patient privacy and confidentiality and refrain from publishing patient information online without appropriate consent.
[Issued: 2016]

Due Process H-295.998

1. Our American Medical Association reaffirms its 1974 approval of the policy adopted by the Liaison Committee on Medical Education, which states: "The faculty of a medical school establish criteria for student selection and develop and implement effective policies and procedures regarding, and make decisions about, medical student application, selection, admission, assessment, promotion, graduation, and any disciplinary action. The medical school makes available to all interested parties its criteria, standards, policies, and procedures regarding these matters."

2. In addition, to clarify and protect the rights of medical students, our AMA recommends that:
    a. Each school develop and publish in its catalog, student handbook or similar publication the institutional policies and procedures both for evaluation of academic performance (promotion, graduation, dismissal, probation, remedial work, and the like) and for nonacademic disciplinary decisions.
    b. These policies and procedures should define the responsible bodies and their function and membership, provide for timely progressive verbal and written notification to the student that their academic/nonacademic performance is in question, and provide an opportunity for the student to learn why it has been questioned.
    c. These policies and procedures should also ensure that when a student has been notified of recommendations by the responsible committee for nonadvancement or dismissal, they have adequate notice and the opportunity to appear before the decision-making body to respond to the data submitted and introduce their own data.
    d. The student should be allowed to be accompanied by a student or faculty advisor.
    e. The policies and procedures should include an appeal mechanism within the medical school.
    f. The student should be allowed to continue in the academic program during the proceedings unless extraordinary circumstances exist, such as physical threat to others.

[CME Rep. D, A-79; Reaffirmed: CLRPD Rep. B, I-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CME Rep. 1, A-10; Modified: CEJA Rep. 01, A-20; Modified: Speakers rep. 02, I-24]