REPORTS OF THE COUNCIL ON MEDICAL EDUCATION

The following reports were presented by Kelly Caverzagie, MD, MPH, Chair:

1. COUNCIL ON MEDICAL EDUCATION SUNSET REVIEW OF 2016 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 ten years.

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to the HOD or resolution to sunset a policy earlier than its ten-year horizon if it is no longer relevant, has been superseded by a more current policy, or has been accomplished.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: Minimal

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APPENDIX: RECOMMENDED ACTIONS

Policy Number	Title	Text	Recommendation
D-275.953	Protection of Physicians' Personal Information	Our AMA will work with the Federation of State Medical Boards to standardize the publicly available data on the State Medical Boards' websites to protect the personal data of physicians to decrease the risk of identity theft. Policy Timeline: Res. 602, A-16	Rescind – accomplished. Update provided to HOD after A-16 stated that a letter was sent to the Federation of State Medical Boards (FSMB) to notify them of the House action. In part, the letter addressed the disclosure of multiple data elements about physicians on state medical board websites. The letter asked that state medical boards be encouraged to limit the personal information displayed on their websites to the minimum necessary to reduce the possibility of identity theft among physicians. The House action also was transmitted to medical school deans, residency program directors, directors of medical education at U.S. teaching hospitals, and those leading other interested groups via the AMA MedEd Update newsletter. There is currently no national standard for displaying physician information on websites. While states vary in their approaches given different priorities and state laws, there is convergence on not posting the most sensitive identifiers (e.g., full Social Security number, full date of birth, bank numbers, or tax numbers, etc.). These identifiers may be collected and stored in licensing records. FSMB does not collect comprehensive state-based data on this issue.
D-295.949	Criminal Background Checks for Medical Students	Our AMA will: (1) through relevant Councils and Sections, collaborate with other organizations working to develop policies and procedures for criminal background checks for applicants accepted to medical school and enrolled medical students, including the creation of guidelines for appropriate action related to individuals whose background checks raise concerns; (2) work to ensure that systems for criminal background checks for accepted applicants and medical students are standardized within and across institutions, as well as equitable, cost-effective, and consistent with the requirements for background checks being required of resident physicians and practicing physicians; and	Retain clause 1 and amend by addition and deletion to read: Our AMA ~~will: (1) through relevant Councils and Sections, collaborate with other organizations working to develop policies and procedures for~~ encourages (1) criminal background checks for applicants accepted to medical school and enrolled medical students, ~~including the creation of~~ and (2) dissemination of guidelines for appropriate action related to individuals whose background checks raise concerns. Rescind clauses 2 and 3 – accomplished. Update provided to HOD after A-06 stated that the House action was transmitted to medical school deans, residency program director, and directors of medical education at U.S. teaching hospitals via the AMA Medical Education Bulletin; and that the Council on Medical Education would work

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		(3) continue to monitor the requirement for criminal background checks for accepted applicants and medical students by medical schools, hospitals/health systems, and state laws. Policy Timeline: CME Rep. 9, A-06; Reaffirmed: CME Rep. 01, A-16	with other AMA Councils and Sections as well as the Association of American Medical Colleges (AAMC) to develop guidelines. Related information provided on AAMC and American Association of Colleges of Osteopathic Medicine websites.
D-295.313	Telemedicine in Medical Education	1. Our AMA encourages appropriate stakeholders to study the most effective methods for the instruction of medical students, residents, fellows and practicing physicians in the use of telemedicine and its capabilities and limitations. 2. Our AMA will collaborate with appropriate stakeholders to reduce barriers to the incorporation of telemedicine into the education of physicians and other health care professionals. 3. Our AMA encourages the Liaison Committee on Medical Education and Accreditation Council for Graduate Medical Education to include core competencies in telemedicine in undergraduate medical education and graduate medical education training. Policy Timeline: CME Rep. 06, A-16	Retain – still relevant; amend clauses 1 and 2 by addition and deletion to read: 1. Our AMA encourages appropriate ~~stakeholders~~ interested parties to study the most effective methods for the instruction of medical students, residents, fellows and practicing physicians in the use of telemedicine and its capabilities and limitations. 2. Our AMA will collaborate with appropriate ~~stakeholders~~ interested parties to reduce barriers to the incorporation of telemedicine into the education of physicians and other health care professionals. Update provided to HOD after A-16 stated that the Association of American Medical Colleges, American Osteopathic Association, American Association of Colleges of Osteopathic Medicine, Liaison Committee on Medical Education. and Accreditation Council for Graduate Medical Education were notified of the House action. It was also transmitted to medical school deans, residency program directors, directors of medical education at U.S. teaching hospitals, and leaders of other interested groups via the AMA MedEd Update newsletter.
D-300.977	ACCME Proposed Changes in "Accreditation with Commendation" Continuing Medical Education Criteria Assessment Methodology	Our AMA will continue to monitor the proposed Accreditation Council for Continuing Medical Education (ACCME) "Accreditation with commendation" criteria, provide input to the ACCME Board of Directors, and report to the AMA HOD once the criteria are approved and implemented. Policy Timeline: Res. 313, A-16	Rescind – accomplished. Currently, a member of the AMA Council on Medical Education serves on the ACCME Board of Directors and provides updates to the Council. Update provided to HOD after A-16 stated that the Council on Medical Education prepared informational report CME 8-A-17 on this subject. ACCME's Accreditation with Commendation criteria were updated in 2016 and have been in effect for decisions made after November 2019. New Standards for Integrity and Independence in Accredited Continuing Education went into effect January 2022.

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D-310.951	Mitigating Abusive Pre-Certification / Pre-Authorization Practices	Our AMA will work with the Accreditation Council for Graduate Medical Education to encourage residency programs to offer administrative resources to housestaff for practice-based support, including but not limited to pre-certification and pre-authorization of medications and services. Policy Timeline: Res. 716, A-16	Rescind – accomplished. Update provided to HOD after A-16 stated that the Accreditation Council for Graduate Medical Education was notified of the House action. It was also transmitted to medical school deans, residency program directors, directors of medical education at U.S. teaching hospitals, and leaders of other interested groups via the AMA MedEd Update newsletter.
H-275.936	Mechanisms to Measure Physician Competency	Our AMA: (1) continues to work with the American Board of Medical Specialties and other relevant organizations to explore alternative evidence-based methods of determining ongoing clinical competency; (2) reviews and proposes improvements for assuring continued physician competence, including but not limited to performance indicators, board certification and recertification, professional experience, continuing medical education, and teaching experience; and (3) opposes the development and/or use of "Medical Competency Examination" and establishment of oversight boards for current state medical boards as proposed in the fall 1998 Report on Professional Licensure of the Pew Health Professions Commission, as an additional measure of physician competency. Policy Timeline: Res. 320, I-98; Amended: Res. 817, A-99; Reaffirmed: CME Rep. 7, A-02; Reaffirmed: CME Rep. 7, A-07; Reaffirmed: CME Rep. 16, A-09; Reaffirmed in lieu of Res. 313, A-12; Modified: Res. 309, I-16	Rescind – addressed by H-275.916, H-295.862, H-275.924, D-275.954. Clause 3 is outdated. Update provided to HOD after A-16 stated that the American Board of Medical Specialties (ABMS) was notified of the House action. It was also transmitted to medical school deans, residency program directors, directors of medical education at U.S. teaching hospitals, and leaders of other interested groups via the AMA MedEd Update newsletter. The Council on Medical Education continues to engage with the ABMS on ways in which the continuing board certification (formerly maintenance of certification) process can be made more meaningful, relevant, and reflective of the ways that physicians actually practice.
H-275.979	Medicare Reporting of Adverse Incidents in Hospitals to State Agencies	The AMA opposes the sharing of information generated through the Medicare utilization process or other institutional review with state licensure bodies until hospital quality assurance committees have been notified and given a reasonable time to respond. Policy Timeline: Res. 118, I-86; Reaffirmed: Sunset Report, I-96; Reaffirmed: CME Rep. 2, A-06; Reaffirmed: CME Rep. 01, A-16	Retain – still relevant.
H-275.980	Funding of State Medical Boards	(1) The AMA urges state medical associations to recommend to their respective state legislatures that all fees and charges collected by the state licensing/disciplinary board(s), or on its	Retain – still relevant.

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		behalf, be specifically designated for use of the board(s) in fulfilling its duties under the state's medical practice act. (2) When such funds are inadequate to support such activities, state general funds should be used to support the board's effective fulfillment of its duties mandated by the state's medical practice act. Policy Timeline: Sub. Res. 23, I-86; Reaffirmed: Sunset Report, I-96; Reaffirmed: CME Rep. 2, A-06; Reaffirmed: CME Rep. 01, A-16	
H-275.997	Licensure by Specialty	Experience with licensure by specialty is too limited to determine what the long-range effects will be in the provision of timely, safe and comprehensive medical care. However, the AMA does not consider licensure by specialty to be desirable even in unusual cases. Policy Timeline: CME Rep. F, A-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CME Rep. 2, A-10; Reaffirmed: BOT Rep. 05, I-16	Rescind – addressed by H-275.978 clauses 2 and 16.
H-280.946	Policies on Intimacy and Sexual Behavior in Residential Aged Care Facilities	Our AMA urges long-term care facilities and other appropriate organizations to: (1) adopt policies and procedures on intimacy and sexual behavior that preserve residents' rights to pursue sexual relationships, while protecting them from unsafe, unwanted, or abusive situations; and (2) provide staff with in-service training to develop a framework to address intimacy in their patient population. Policy Timeline: Res. 403, A-16	Retain – still relevant. Notice provided to HOD after A-16 stated that the AMA Policy Database was updated.
H-295.912	Education of Medical Students and Residents about Domestic Violence Screening	Our American Medical Association will continue its support for the education of medical students and residents on domestic violence by advocating that medical schools and graduate medical education programs educate students and resident physicians to sensitively inquire about family abuse with all patients, when appropriate and as part of a comprehensive history and physical examination, and provide information about the available community resources for the management of the patient. Policy Timeline: Res. 303, I-96; Reaffirmed: CME Rep. 2, A-06; Reaffirmed: CME Rep. 01, A-16	Retain – still relevant.

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H-295.915	Residency Program Responsibility for Resident Education	Our American Medical Association affirms that the basic skills and competencies for the practice of medicine and its specialties must be determined solely by the medical profession. Policy Timeline: Res. 313, A-96; Reaffirmed: CME Rep. 2, A-06; Reaffirmed: CME Rep. 01, A-16	Rescind – addressed by policies H-275.916 and Opinion 8.13.
H-295.969	Nondiscrimination Toward Residency Applicants	Our American Medical Association urges the Accreditation Council for Graduate Medical Education to amend its Institutional Requirements to read: "In assessing and selecting applicants for residency/fellowship programs, ACGME-accredited programs must not discriminate on the basis of sex, age, race, creed, national origin, gender identity, or sexual orientation." Policy Timeline: Res. 12, A-89; Reaffirmed: Sunset Report, A-00; Modified: BOT Rep. 11, A-07; Reaffirmed: CCB/CLRPD Rep. 1, A-14; Modified: CME Rep. 01, A-16	Retain; amend by addition and deletion to read: ~~Our American Medical Association urges the Accreditation Council for Graduate Medical Education to amend its Institutional Requirements to read: "In assessing and selecting applicants for residency/fellowship programs, ACGME-accredited programs must not discriminate on the basis of sex, age, race, creed, national origin, gender identity, or sexual orientation."~~ Our American Medical Association encourages that Accreditation Council for Graduate Medical Education-accredited programs should not discriminate on the basis of an individual's sex, age, race, creed, national origin, gender identity, or sexual orientation. Discrimination is addressed by the ACGME in the 2025 Institutional Requirements, specifically: ● (3.2.f.4) addresses all discrimination, while not articulating the types. ● (4.2) addresses recruitment, selection, eligibility, and appointment ● (4.9.e) directs institutional policies prohibiting discrimination in employment and in the learning and working environment.
H-295.981	Geriatric Medicine	1. Our AMA reaffirms its support for: (a) the incorporation of geriatric medicine into the curricula of medical school departments and its encouragement for further education and research on the problems of aging and health care of the aged at the medical school, graduate and continuing medical education levels; and (b) increased training in geriatric pharmacotherapy at the medical student and residency level for all relevant specialties and encourages the Accreditation Council for Graduate Medical Education and the appropriate Residency Review Committees to find ways to incorporate geriatric	Retain – still relevant.

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		pharmacotherapy into their current programs. 2. Our AMA recognizes the critical need to ensure that all physicians who care for older adults, across all specialties, are competent in geriatric care, and encourages all appropriate specialty societies to identify and implement the most expedient and effective means to ensure adequate education in geriatrics at the medical school, graduate, and continuing medical education levels for all relevant specialties. Policy Timeline: Res. 137, A-85; Reaffirmed by CLRPD Rep. 2, I-95; Appended: CSA Rep. 5, A-02; Appended: Res. 301, A-10; Reaffirmed: BOT Rep. 05, I-16	
H-300.951	Credit for Reading Medical Journals	The AMA continues to support appropriate credit for medical journal study and make every effort to simplify the process by which this is accomplished. Policy Timeline: Res. 315, I-96; Reaffirmed: CME Rep. 2, A-06; Reaffirmed: CME Rep. 01, A-16	Rescind – accomplished. AMA Physician's Recognition Award and credit system booklet describes "journal-based CME" on page 4.
H-300.952	Dissemination of Information Regarding CME Activities	The AMA will continue to support the current system of Continuing Medical Education accreditation in which the Accreditation Council for Continuing Medical Education accredits sponsors whose mission and intended audience are on a regional or national level and state medical societies accredit sponsors whose mission and intended audience are physicians within state and contiguous states, following the guidelines enunciated by the ACCME. Policy Timeline: CME Rep. 7, I-96; Reaffirmed: CME Rep. 2, A-06; Reaffirmed: CME Rep. 01, A-16	Retain – still relevant.
H-300.955	Restructuring of Continuing Medical Education Credits	The AMA encourages state licensing boards with CME reporting requirements to allow *AMA PRA Category 1 Credit*" and *AMA PRA Category 2 Credit*" toward reregistration of the license to practice medicine; and all state licensing boards be urged to accept a current and valid AMA Physician's Recognition Award as evidence of completion of these requirements.	Retain – still relevant.

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		Policy Timeline: CME Rep. 7, A-96; Reaffirmed: CME Rep. 2, A-06; Reaffirmed: CME Rep. 01, A-16	
H-310.906	Improving Residency Training in the Treatment of Opioid Dependence	Our AMA: (1) encourages the expansion of residency and fellowship training opportunities to provide clinical experience in the treatment of opioid use disorders, under the supervision of an appropriately trained physician; and (2) supports additional funding to overcome the financial barriers that exist for trainees seeking clinical experience in the treatment of opioid use disorders. Policy Timeline: Res. 301, I-16	Retain – still relevant. Notice provided to HOD after I-16 stated that the AMA Policy Database was updated.
H-310.982	Reevaluation of Residency Selection Process	Our American Medical Association supports continued cooperation with the Association of American Medical Colleges in the evaluation of the residency selection process, with emphasis on the reduction of pressures that induce premature specialty decisions within the undergraduate medical curriculum. Policy Timeline: Sub. Res. 112, I-86; Amended by Sunset Report, I-96; Modified and Reaffirmed: CME Rep. 2, A-06; Reaffirmed: CME Rep. 01, A-16	Retain – still relevant.
H-310.983	Residency Positions for Sale	Our American Medical Association reaffirms its position that selection of residents should be based on the academic and personal qualifications of applicants and that monetary considerations should never compromise the selection process. Policy Timeline: CME Rep. A, A-86; Reaffirmed: Sunset Report, I-96; Reaffirmed: CME Rep. 2, A-06; Reaffirmed: CME Rep. 01, A-16	Retain – still relevant. Append to H-305.925; amend by addition and deletion to read: 27. ~~Our American Medical Association reaffirms its position~~ Upholds that selection of residents should be based on the academic and personal qualifications of applicants and that monetary considerations should never compromise the selection process.”
H-345.970	Improving Mental Health Services for Undergraduate and Graduate Students	Our AMA supports: (1) strategies that emphasize de-stigmatization and enable timely and affordable access to mental health services for undergraduate and graduate students, in order to improve the provision of care and increase its use by those in need; (2) colleges and universities in emphasizing to undergraduate and graduate students and parents the importance, availability, and efficacy of mental health resources; and (3) collaborations of university mental health specialists and local public or private practices and/or health centers in order to provide a larger pool of resources, such that any student is able to	Retain – still relevant. Notice provided to HOD after I-16 stated that the AMA Policy Database was updated.

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		access care in a timely and affordable manner. Policy Timeline: Res. 904, I-16	
H-345.973	Medical and Mental Health Services for Medical Students and Resident and Fellow Physicians	Our AMA promotes the availability of timely, confidential, accessible, and affordable medical and mental health services for medical students and resident and fellow physicians, to include needed diagnostic, preventive, and therapeutic services. Information on where and how to access these services should be readily available at all education/training sites, and these services should be provided at sites in reasonable proximity to the sites where the education/training takes place. Policy Timeline: Res. 915, I-15; Revised: CME Rep. 01, I-16	Retain – still relevant. Notice provided to HOD after I-15 stated that the AMA Policy Database was updated.
H-405.962	The Practice of Public Health by Physicians	Our AMA: (1) recognizes the practice of public health by physicians as the practice of medicine; (2) opposes specialty-specific license restrictions for American Board of Medical Specialties (ABMS)-recognized specialties; and (3) encourages the ABMS and the Federation of State Medical Boards to adopt similar policies recognizing the practice of public health by physicians as a legitimate practice of medicine and opposing specialty-specific license restrictions for ABMS-recognized specialties. Policy Timeline: Res. 815, I-06; Reaffirmed: CME Rep. 01, A-16	Retain clause 1 – still relevant. Rescind clauses 2 and 3 – accomplished. Public health is recognized by the ABMS: Specialties - The American Board of Preventive Medicine. All certifications offered by ABMS Member Boards are endorsed by the ABMS and require approval when they offer a new certification or focused practice designation. No state requires any certification (ABMS or otherwise) to obtain a license to practice medicine. ABMS and FSMB have long held that ABMS certification is voluntary and should not be tied to requirements to obtain a state medical license, which aligns with other AMA policy.
H-405.966	Resident Physician Licenses	Our American Medical Association supports the option of limited educational licenses in all states for resident physicians to provide care within their residency programs; and supports reduced licensure fees for resident physicians for participation solely in graduate medical education training programs when full medical licensure is required by a state. Policy Timeline: Sub. Res. 312, A-96; Reaffirmed: CME Rep. 2, A-06; Reaffirmed: CME Rep. 01, A-16	Retain – still relevant.

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2. EXAMINING ABMS PROCESSES FOR NEW BOARDS

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: REFERRED

At the 2025 Annual Meeting of the American Medical Association (AMA) House of Delegates (HOD), Resolution 301 was co-sponsored by the American College of Cardiology, American Society of Echocardiography, American Society of Nuclear Cardiology, Heart Rhythm Society, Society for Cardiovascular Angiography & Interventions, Society of Cardiovascular Computed Tomography, and Society for Cardiovascular Magnetic Resonance. Their original resolution raised concern for established criteria of oversight bodies and American Board of Medical Specialties (ABMS) processes for new boards. It specifically referenced the application of a new American Board of Cardiovascular Medicine (ABCVM). Testimony addressed support for the belief that board certification is paramount in professional self-governance and that AMA should not interfere with the American Board of Medical Specialties (ABMS) process. Alternate Resolution 301 was adopted as amended in lieu of original Resolution 301 and is now AMA Policy D-275.943, "Examining ABMS Processes for New Boards," which asks the following:

> Our AMA will study and define principles for board certifying bodies including, but not limited to: education and training requirements, initial and ongoing assessment of physician competence in balance with patient safety, and best practices for promoting professional self-regulation, with report back to the HOD at annual 2026.

This report is written in response to its directive.

BACKGROUND

At the 2023 Interim Meeting, the AMA HOD adopted CME Report 4, "Recognizing Specialty Certifications for Physicians." It provided a detailed history of standardized certification, ABMS, Accreditation Council for Graduate Medical Education (ACGME) core competencies, governance of ABMS member boards, and ABMS board eligibility. The report also explained board eligibility for the American Osteopathic Association Bureau of Osteopathic Specialists (AOA-BOS), and other entities such as the American Association of Neuromuscular & Electrodiagnostic Medicine, American Board of Cosmetic Surgery, American Board of Facial Plastic and Reconstructive Surgery, American Board of Oral & Maxillofacial Surgery, American Board of Physician Specialties, National Board of Physicians and Surgeons, and United Council for Neurologic Subspecialties. Further, it addressed the AMA's Truth in Advertising Campaign. A review of CME 4-I-23 provides historical information and useful context for this report.

History of specialty board formation and ABMS approval

The need for board certification can be traced back to the late 19th century when it was recognized that medical education and training varied widely. Given the lack of universal curricula and evaluation methods, there were no standardized requirements or guidelines for physicians to demonstrate their specialty qualifications. The American Board of Ophthalmology was established in 1917 as the first board allowing ophthalmologists to distinguish themselves from other physicians. As other boards began to form, the AMA established the Advisory Board for Medical Specialties in 1933 to bring order to this growing arena and address conflicts.[1] This board established the first *Essentials for Approval of Examining Boards in Medical Specialties*, which was approved by the HOD in June 1934. The Essentials described "the standards and procedures by which applications for approval of new medical specialty boards are evaluated."[2] In 1942, the AMA Council on Medical Education and Advisory Board established the Liaison Committee for Specialty Boards (LCSB) to receive applications for approval as a medical specialty certifying board and evaluate applications. The Advisory Board was renamed the American Board of Medical Specialties (ABMS) in 1970.[3] As of June 2025, ABMS represents 24 certifying boards and just over one million active board-certified physicians.[4] Over time, other entities were established to provide board certification. For example, the AOA formed the Advisory Board for Osteopathic Specialists in 1939 to oversee the certification of osteopathic physicians; it eventually became the AOA Bureau of Osteopathic Specialists (AOA-BOS).[5]

The HOD approved the twelfth and final revision to the *Essentials*, and they became effective in November 2005. These *Essentials* were implemented until 2023 when ABMS updated their policy to change the process for approval of medical specialty boards. Effective October 27, 2023, the ABMS Board of Directors adopted new Policy 1.8 on Admission of New Medical Specialty Boards to Membership in ABMS[6], thereby establishing a new process for board

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approval and ending the LCSB. Similar to the *Essentials,* ABMS Policy 1.8 lays out eight sections that describe the plans and steps necessary for the creation of a new specialty board.

DISCUSSION

Current requirements and criteria per ABMS Policy 1.8

The current necessary requirements to be recognized as an independent board are described in "Section III. Required Content for Applications." This section states, "In order to be recommended for approval by the ABMS Advisory Body on Specialty Board Development ('Advisory Body' [see Section IV]), a new applicant specialty board must demonstrate that all of the following requirements have been satisfied.

1. The applicant board must demonstrate that it is primarily composed of Diplomates who hold a Doctor of Medicine (MD), Doctor of Osteopathic Medicine (DO), or foreign equivalent (e.g., Bachelor of Medicine, Bachelor of Surgery [MBBS]) degrees. The ABMS Board of Directors will determine whether this criterion has been satisfied in its sole and absolute discretion based on the unique circumstances of each applicant board.
2. The applicant board must define its objectives and function, including a scientific rationale demonstrating a substantial advancement in medicine or technology, evidence of a distinct and well-defined field of medical practice, and/or confirmation of an interdisciplinary practice field sufficiently distinct from existing fields of practice. The applicant board must present data on the field's core content/competencies and scope of practice based on a validated blueprint of the professional area, including present and projected future public needs and expected growth.
3. The applicant board must present a rationale for how this field of practice serves the patient/public interest, as well as supports candidates'/Diplomates' needs.
4. The applicant board must demonstrate how its training and evaluation methods satisfy ABMS' standards.
5. The applicant board must describe the training needed to meet requirements for certification and delineate how this training is sufficiently distinct from the training required for certification by existing ABMS medical specialty boards.
6. The applicant board must define standards for the requisite knowledge and skills in the field of practice. They must demonstrate that candidates for initial certification acquire and maintain these standards. A specific plan for development and validation of the requirements for initial and continuing certification must be presented, along with an outline of and rationale for the qualifications to be required of candidates for certification. The applicant board also must provide a detailed explanation of how the program will adhere to ABMS' initial, continuing, and organizational standards and provide a detailed plan for program review and evaluation.
7. Except as provided in this section, the applicant board must require all new Diplomates to successfully complete an ACGME-accredited residency or training program prior to becoming certified. If the applicant board is in the process of obtaining ACGME accreditation for the GME training program(s) for the field of practice at the time of application for admission to the ABMS (and if all other conditions are satisfied), the ABMS Board of Directors may conditionally approve the applicant board contingent upon ACGME accreditation of the program(s). Applicant boards may not issue new certificates under the ABMS imprimatur or use the ABMS seal until final approval as a medical specialty board has been granted by the ABMS.
8. A plan must be presented to accommodate the certification of individuals who complete their GME prior to the establishment of ACGME-accredited or other accredited programs in the specialty. A description of the practice requirements for Diplomates practicing in the field of practice without ACGME-accredited training must be provided. The description should include a summary of the qualifications, the examination(s) required, and the number of physicians or medical specialists to be certified in this manner. Applicant boards with existing certified diplomates at the time of application to membership in the ABMS must present a plan to accommodate the ABMS certification of individuals if such ABMS certification for existing diplomates is desired by the applicant board.
9. The applicant board must demonstrate broad support from the relevant field of medical practice and broad professional support. The applicant board must provide the communications used to notify the field of medical practice of the proposed application.
10. The applicant board must provide the total number, along with the complete list of institutions providing residency or other acceptable training programs in the field of practice; the total number of residency positions available; and the number of residency programs planned for creation within the next five years.

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This data should demonstrate the growth and sustainability of these training programs. The applicant board further must provide the following:

11. The official name of the proposed board, including the names and professional qualifications of its officials and the organization that each official represents (if applicable).
12. An operational plan, including sufficient detail for evaluation of the following areas:
    - MISSION AND OPERATIONS: The applicant board must have a mission that aligns with the mission of ABMS and articulates the purpose of board certification in the proposed field of medical practice. The applicant board will provide copies of existing policies and procedures that promote professionalism and excellence in operations and that strive to meet the needs of the public and the profession. The applicant board is expected to conduct periodic reviews of its operations as supported by principles of good governance.
    - GOVERNANCE STRUCTURE: The applicant board must demonstrate that its Board of Trustees/Directors follows best practices for governance and is able to address the needs and concerns of its stakeholders. Board members should have sufficient professional expertise for effective board operation and management. The applicant board must specifically articulate how the perspectives of active clinician Diplomates, stakeholders in the field of medical practice, patients, and the public inform board governance, and must explain the presence or absence of any structural or process components related to equity.
    - BUSINESS PLAN: The financial support for a valid, objective program of candidate and Diplomate assessment must be presented, and the applicant board must attest that adequate resources and revenue are available to support and sustain the applicant board. The data should include the approximate number of physicians or medical specialists currently engaged in the practice of the field of medical practice, as well as projected numbers of examinees for initial and continuing certification and projected certification fees. The applicant board must reflect appropriate, transparent financial stewardship in a manner befitting its non-profit status,
13. A copy of the Constitution (if applicable) and Bylaws;
14. A copy of the Articles of Incorporation;
15. A copy of the application form for candidates for initial and continuing certification; and
16. A non-refundable application fee."[6]

Notable differences between the former *Essentials* and new Policy 1.8 include: removal of language regarding the LCSB, reframing oversight and procedure for the recommendation of approval of new specialty boards as solely under ABMS purview, updating of terms (e.g., MOC now referred to as continuing board certification), change from "appeal" to "reapplication," and new reference to "conjoint" boards. Regarding the role of the AMA in this new process, Section IV of Policy 1.8 explains that the sitting Chair of the AMA Council on Medical Education or their designee is a participant in the Advisory Body without vote. Further, ABMS will inform the AMA of the general activities of the Advisory Body once convened, including notification of scheduled meetings, notices of public comment periods, and general timelines related to the work of the Advisory Body.

Input from the HOD

Comments are regularly submitted to the HOD via the "Forthcoming and Pending Reports for the House of Delegates" document to inform the drafting of forthcoming and pending reports. Three comments were submitted regarding Resolution 301/Policy D-275.943. They were reviewed and considered during the development of this report. One comment suggested that the AMA more formally acknowledge the optional drafting note stated in the AMA Truth in Advertising (TIA) campaign, as seen on page twelve of the TIA Campaign booklet. However, there remains an issue of consensus regarding the definition of board certification that will need to be addressed by the HOD.

Principles for board certifying bodies

Policy D-275.943 asks the AMA to develop principles for board certifying bodies with the goal of providing a clear foundation that guides optimal performance of such bodies and further strengthens a commitment to evidence-based lifelong learning. Principles for board certifying bodies should be broad and comprehensive assumptions in alignment with AMA policy. In the development of such principles, careful consideration was given to the policies and protocols of the ABMS and AOA-BOS, the interest expressed in the underlying resolution (to include addressing education and training requirements, initial and ongoing assessment of physician competence, patient safety, and professional self-regulation), testimony from the HOD, and other input from interested parties. Principles are intended to be guiding

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concepts and not replace or supersede established policies and protocols. The Council on Medical Education offers the following principles.

Physician board certifying bodies should:

1. Serve the public interest by supporting high-quality evidence-based care, patient safety, professionalism, and ethical conduct of individual physicians.

2. Maintain independent governance, ensure equitable and transparent processes, engage relevant parties, and uphold fair pathways for transition or reapplication when establishing criteria for certification.

3. Align certification with recognized education and training, clearly define competencies, and use objective, standards-based assessments that reflect clinical practice.

4. Incorporate ongoing evaluation and improvement, supported by effective use of technology to enhance accessibility and efficiency.

5. Ensure representative physician leadership informed by diverse practice settings and provide opportunities for diplomates to participate in governance. *

* Principles created with author oversight by Microsoft Copilot, March 4, 2026.

Update on American Board of Cardiovascular Medicine (ABCVM)

On January 23, 2026, ABCVM issued an update on their status, noting that their "Board of Directors continues to evaluate partnerships with organizations, such as the National Board of Physician and Surgeons (NBPAS), the American Board of Physician Specialties (ABPS), and the American Osteopathic Association (AOA), to accelerate innovation. However, differences in scale, resources, recognition and philosophy limited these options."[7] NBPAS published commentary on this decision, stating that "differences in philosophy ultimately precluded a partnership at this time.[8] In addition, it noted, "From its founding, NBPAS has maintained a clear and consistent mission: to provide a credible, rigorous pathway and platform for lifelong learning without imposing unproven requirements such as point-in-time examinations or longitudinal testing models." ABPS and AOA had not published commentary at the time of the preparation of this report.

Resources

The ABMS website provides general information as well as the following resources:

- Standards for Initial Certification – Presents the standards and annotations for Initial Certification, requirements for each ABMS Member Board's program, and potential pathways to meet the requirements. Of note, ABMS announced on February 27, 2026, a call for comment on Draft Revised Standards for Initial Certification, due April 27. The Council on Medical Education intends to provide comments which will be after the deadline for submitting this report.
- The Recommendations of the Vision Initiative Commission – 2019 report by an independent commission containing fourteen recommendations that address current concerns and outline a path forward for ABMS' continuing certification programs.
- Standards for Continuing Certification – Effective January 2024, provides a comprehensive framework for Member Boards to design certification programs that meaningfully engage diplomates in activities relevant to their practice.
- ABMS Guide to Medical Specialties – Provides descriptions and contact information for the ABMS member board specialties and subspecialties.
- ABMS Board Certification Report – Released annually, it contains data on the specialty and subspecialty certificates approved by ABMS, the number of new specialty and subspecialty certificates issued in the last 10 years, and the distribution of board-certified diplomates by ABMS Member Board, specialty, and state.

Other board certification entities provide their own information. For example, the AOA website offers the "Handbook of the Bureau of Osteopathic Specialist," which includes AOA-BOS policies and new board processes.

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RELEVANT AMA POLICY

AMA Policy H-275.926 "Medical Specialty Board Certification Standards" addresses board certified physicians, ABMS member boards, and ABMS/AOA-BOS board certification processes. Of note, the third clause states, "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."

Given the *Essentials* are defunct, this reference should be removed from clause (3b) of the policy.

AMA Policy D-275.943 "Examining ABMS Processes for New Boards," is the policy resulting from adoption of Resolution 301 that calls for this report. This report fulfills that directive.

CONCLUSION

Board certification provides an ongoing independent evaluation of individual physicians to assure that the specialty physician workforce is clinically competent, skilled, participates in lifelong learning, and meets the standards of practice established by their peers. Further, there is public interest in seeking out board-certified physicians and specialists. The public seeks to trust their physicians with the significant responsibility of care and decision making when it comes to both personal and population health. Such trust exemplifies great public value. Contributing factors to the building of such trust include demonstrated quality care and patient safety as well as expertise and ongoing professional development – all of which are represented through board certification.

Board certification also provides a process to ensure new boards meet the same foundational principles that guide certification itself including competency standards, training requirements, public accountability, and the ability to perform valid, independent assessments. Thorough, high-quality requirements and protocols for new boards are imperative. AMA's continued collaboration with its HOD, ABMS and its member boards, AOA-BOS, and other board certifying entities will ensure ongoing prioritization and review of board approval processes.

RECOMMENDATIONS

The Council on Medical Education recommends that the following be adopted in lieu of Resolution 301-A-25, and the remainder of the report be filed:

1. Policy H-275.926,"Medical Specialty Board Certification Standards," item 3b, be amended by deletion to read as follows:

   3b. 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.~~

2. Our AMA supports the following principles to inform the development of new board certifying bodies:

   Principles for New Board Certifying Bodies
   1. Serve the public interest by supporting high-quality evidence-based care, patient safety, professionalism, and ethical conduct of individual physicians.
   2. Maintain independent governance, ensure impartial and transparent processes, engage relevant parties, and uphold fair pathways for transition or reapplication when establishing criteria for certification.
   3. Align certification with recognized education and training, clearly define competencies, and use objective, standards-based assessments that reflect clinical practice.
   4. Incorporate ongoing evaluation and improvement, supported by effective use of technology to enhance accessibility and efficiency.
   5. Ensure representative physician leadership informed by diverse practice settings and provide opportunities for diplomates to participate in governance.

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3. Policy D-275.943, "Examining ABMS Processes for New Boards," be rescinded as having been accomplished by this report.

Fiscal note: Minimal

RELEVANT AMA POLICY

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.

Examining ABMS Processes for New Boards D-275.943

Our AMA will study and define principles for board certifying bodies including, but not limited to: education and training requirements, initial and ongoing assessment of physician competence in balance with patient safety, and best practices for promoting professional self-regulation, with report back to the HOD at annual 2026.

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3. SUPPORT FOR THE ESTABLISHMENT OF INDIGENOUS-LED MEDICAL SCHOOLS IN THE UNITED STATES

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: RECOMMENDATIONS ADOPTED
REMAINDER OF REPORT FILED
See Policies H-60.917, H-295.840 and H-350.960

Resolution 303-A-25, "Support for the Establishment of Indigenous-Led Medical Schools in the United States," was introduced by the Underrepresented in Medicine Advocacy Section (formerly the Minority Affairs Section), with resolves 2, 3, and 4 being referred. Resolve 3 will be studied in a separate report while the study of resolves 2 and 4 are the focus of this report. These resolves asked the following:

> RESOLVED (2), that our AMA work collaboratively with Tribal Nations, Indigenous-led organizations, academic institutions, and relevant governing bodies to explore the feasibility, infrastructure, and resource needs for such an institution (Directive to Take Action); and be it further
>
> RESOLVED (4), that our AMA advocate for funding and resource development, including through partnerships with academic, philanthropic, health system, and governmental stakeholders, to support sustainable development and operation of an Indigenous-led medical school. (Directive to Take Action)

"Such an institution" in resolve 2 refers to the original resolve 1 in the resolution, which became AMA Policy H-295.840, "Support for the Establishment of Indigenous-Led Medical Schools in the United States," and reads: "Our AMA supports efforts to establish Indigenous-governed medical schools in the United States, with governance and leadership structures grounded in tribal sovereignty and cultural integrity, and guided by principles of accountability to Indigenous Nations, inclusion of Indigenous leadership, and alignment with community-defined values and priorities."

BACKGROUND

Workforce Shortages

Tribal health care is in crisis, with disproportionately poor health outcomes for Indigenous people in the United States. One major basis of this crisis is a severe workforce shortage of Indigenous physicians who are more likely than their peers to serve Indigenous populations.[1,2] However, as discussed in Council on Medical Education Report 8-A-25, Disaggregation of Demographic Data for Indigenous Individuals: "AI/AN people experience significant challenges based on wider systemic oppression and difficulty in accessing education in general and, therefore, also are underrepresented in the number achieving high school and college degrees as well as in medical degrees.[3] 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.)"[4] By contrast, in 2023, there were 3.3 million people in the country

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who identified solely as American Indian/Alaska Native (AI/AN), with 581,100 more identifying as Native Hawaiian/Pacific Islander.[5] This is about 1.5 percent of the U.S. population, but AI/AN individuals account for only 0.28 percent of medical school applicants, with even fewer being accepted and graduating.[6] Among active physicians, in 2018 there were 3,511 total physicians identifying as American Indian, Alaska Native, Native Hawaiian, or other Pacific Islander, in contrast to Indigenous patient populations in the multiple millions.[7]

Challenges related to AI/AN health outcomes, such as those connected to the Indian Health Service, also include inadequate funding, challenges associated with transitioning services from federal to Tribal control through contracting and compacting, evolving federal and state programs, the need for culturally sensitive services, and the promise and challenges of health technology. However, limited human resources are considered one of the top challenges.[8]

Given significant underrepresentation of AI/AN learners and physicians, it is critical to work directly with tribes on the creation of scholarships and programs to support the preparation of AI/AN individuals for medical school.[3] To support AI/AN access to medicine as a career, there are also significant needs that start as early as birth, pre-K, and K-16.[9,10,11] AMA currently has policy related to the importance of early childhood resources (Disparities in Public Education as a Crisis in Public Health and Civil Rights H-60.917), as well as pre-K-16 pathway pilot programs (AMA Support of U.S. Pathway Programs D-200.970), and is engaged in grant work in this area, which includes but is not specifically for Indigenous populations.

Tribal and Indigenous Sovereignty

The multiplicity of Indigenous communities have varying priorities, including 574 American Indian and Alaska Native tribes and villages formally recognized by the U.S. federal government. Each of these entities has "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."[12] Solutions to severe Indigenous health disparities, such as an Indigenous medical school, may potentially involve direct ties to one or more tribal nations and must be driven by and for the unique needs and goals of those nations or communities.

Medical School Creation

A scoping review by Kirubakaran et al., published in 2024 in *Advances in Health Science Education*, reviewed the existing literature on the process for establishing new medical schools, noting that doing so is "a complex undertaking with high financial and political stakes." Though "the literature on new medical school establishment is empirically and theoretically under-developed, it is still useful and reveals a number of important considerations that could assist founding leaders and teams to maximize the outcomes and impact of their establishment efforts."[13] Generally speaking, plans for a new medical school must be both descriptive and substantive—a vision for what the values and purpose of a new medical school will be, in addition to specific plans related to both the creation and sustainability of the school.

The Liaison Committee on Medical Education (LCME) accredits allopathic medical schools in the United States. The LCME accreditation standards are included in the document "Functions and Structure of a Medical School: Standards for Accreditation of Medical Education Programs Leading to the MD Degree," available on the LCME website.[14] A developing medical school must demonstrate its potential to meet the requirements in accreditation standards by providing specific information in the Data Collection Instrument for Preliminary Accreditation Surveys.[14] The American Osteopathic Association, specifically the Commission on Osteopathic College Accreditation (COCA), accredits osteopathic medical schools in the United States and provides accreditation guidelines and policies on their website.[15]

While the administrative processes, resources, and other requirements may be similar to any other medical school in regard to creating a school and seeking allopathic or osteopathic accreditation, a tribal medical school may potentially have differences due to a tribe's status as a sovereign nation. No literature currently exists in this area, given that no tribal medical schools currently exist.

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The LCME accredits educational programs that lead to the MD degree; it does not accredit institutions. A medical school or its sponsoring institution, such as a university, must hold institutional accreditation from an accrediting body recognized by the U.S. Department of Education for Title IV purposes.[16] This institutional accreditation is what allows students to access federal financial aid, such as low-interest student loans under Title IV of the Higher Education Act. In contrast, the COCA accredits DO-granting colleges of osteopathic medicine and is recognized by the U.S. Department of Education as an institutional accreditor, meaning COCA accreditation can satisfy Title IV institutional eligibility requirements for osteopathic medical schools.

Resource Development to Open and Sustain a Medical School

According to LCME staff, funding for a prospective medical school may come from a variety of sources and specifically requires a feasible plan and evidence for financial sustainability. The resources a school has access to prior to opening may differ from those in place later but must be sustainable for a period of time: often a clear, specific, and realistic budget for the next six years. A new school needs to consider the revenue sources available at the beginning and how these will change but remain sufficient over time.

Characteristics of Tribally-Owned Higher Education Institutions

According to the American Indian Higher Education Consortium (AIHEC), "Tribal Colleges and Universities (TCUs) are chartered by their respective Tribal governments, including the ten Tribes within the largest reservations in the United States. The 35 accredited TCUs operate more than 90 campuses and sites in 15 states—covering most of Indian Country—and serve students from more than 250 federally recognized Indian Tribes. TCUs vary in enrollment (size), focus (liberal arts, sciences, workforce development/training), location (woodlands, desert, frozen tundra, rural reservation, urban), and student population (predominantly American Indian). However, Tribal identity is the core of every TCU, and they all share the mission of Tribal self-determination and service to their respective nations."[17] Though most students attending TCUs identify as Indigenous, all students are welcome, including international students.[18] Two additional institutions are not Title IV-eligible nor accredited by mainstream organizations[19] but are considered "developing" members of AIHEC.[20] It is possible that tribes, as sovereign nations, could have different educational priorities or hypothetically wish to develop differing accreditation standards. However, all current TCUs appear to be either accredited or in the process of obtaining accreditation, which ensures transferability of credits and access to federal financial aid for learners. An Indigenous medical school would need accreditation from a recognized institutional accreditor for it to be eligible for LCME programmatic accreditation. LCME or COCA accreditation currently is required for the students/graduates to access medical licensing examinations and accredited graduate medical education.

Unique Resource Challenges for Tribal Land

Environmental injustice can result in infrastructure and transportation challenges on tribal lands. The same factors that create difficulties accessing basic needs such as food and health care also create difficult conditions for the development of schools. "For tribes, multiple and cumulative risks and impacts cannot be separated from the historical legacy of land loss. Indigenous nations in the United States have lost 98.9 percent of their historical land base since European settlers began colonizing the continent."[21] The General Allotment Act of 1887 often resulted in reservations placed on more difficult land, with more productive or "high-quality" land taken for non-Indigenous settlement.[22] In some cases, there are also significant location-based health risks from pollution on or near tribal lands, such as uranium exposure from toxic waste either improperly managed or dumped.[23,24]

However, Indigenous communities also have many stories of transcending the harms experienced: "… life on Native American reservations cannot be defined by hardship alone. It is complex, layered, and often misunderstood. While the challenges are real, ranging from poverty and health disparities to underfunded infrastructure, so too are the stories of cultural preservation, grassroots leadership, and community-driven progress."[25]

Creating Pathways to Support Sustainable Development and Operation of an Indigenous-Led Medical School

Below is a brief review of some of the active collaborations that exist between medical schools and tribal nations that could inform the sustainable development and operation of an Indigenous-led medical school. At the time of this writing in January 2026, there are no tribal medical schools (in contrast to tribally affiliated).[26]

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Oklahoma State University College of Osteopathic Medicine at the Cherokee Nation. At the time of this writing (January 2026), Oklahoma State University College of Osteopathic Medicine at the Cherokee Nation (OSU-COM CN) is the only tribally affiliated medical campus in the nation.

The OSU-COM's relationship with the Cherokee Nation deepened over 12 years, eventually leading to the creation of a new college of medicine campus: "In 2006, our medical students started completing clinical rotations at W.W. Hastings Hospital. In 2009, we established a family medicine residency program in Tahlequah. We now have the opportunity to take this partnership to the next level..."[27] Since 2021, the Cherokee Nation has invested more than $440 million to improve and grow the tribe's health care infrastructure in Oklahoma: "Most of the tribal nations have robust health centers… But they are in rural areas, so recruiting physicians can be difficult."[28] This is a persistent problem, and students from underrepresented populations are those most likely to work in those communities.[29],[30] OSU-COM has as high as 16 percent Native American medical school students, compared to the national average of 0.2 percent.[31]

Oregon Health & Science University Northwest Native American Center of Excellence. The Northwest Native American Center of Excellence (NNACoE) was founded in 2017 with an initial five-year grant from the Health Resources and Services Administration (HRSA). The center "works to sustainably address the health care needs of all people by increasing AI/AN representation in the health professions workforce via culturally informed, evidence-based health education programming and research interventions designed for Indigenous health care learners and professionals. NNACoE sits within the Department of Family Medicine and is an institution-wide resource for AI/AN students and faculty. NNACoE's 12 study initiatives span five critical points along the education continuum, beginning in high school and continuing through early faculty development."[32] Initiatives for high school students were also created via funding from the Indian Health Service Indians into Medicine Program, foundation grants, and state-legislated funds for expanded partnerships with the University of California, Davis and Washington State University.[33]

AMA Collaborations and Wider Medical Education Work. What follows is a brief overview of current work related to the support for Indigenous medical schools, including but not limited to AMA dialogues with existing groups, such as Indigenous School of Medicine (ISOM, isomhealth.com) and the American Indian Higher Education Consortium's Indigenous Health, Education, and Resources Taskforce (IHEART).

Since the initiation of this report at the A-25 meeting, AMA adopted new policies or amended existing policies relevant to the important work of improving pathways for Indigenous physicians and communities and developing the physician workforce based on societal needs. This includes updates to Policy H-350.960, "Underrepresented Student Access to US Medical Schools" at the I-25 meeting, stating that "Our AMA will partner with relevant public and private sector organizations and relevant parties to advance restorative efforts that address the impact of the 1910 report Medical Education in the United States and Canada ("Flexner Report") and the resulting actions by state medical licensing boards and other groups including the AMA, by promoting and supporting the development, opening, and/or reopening of medical schools in historically marginalized and underserved communities, including those affiliated with Historically Black Colleges & Universities (HBCUs), Tribal Colleges & Universities (TCUs), and Minority-Serving Institutions (MSIs) through collaborative feasibility assessments, resource development partnerships, and community-guided planning processes, among others." This now guides further work by the AMA and will be reported on in future documents.

Some of AMA's work in this space also centers around the AMA's Truth, Reconciliation, and Healing Task Force (TRHT),[34] which advised the AMA Board of Trustees related to amelioration of past harms. AMA also has an Advisory Committee on American Indian and Alaska Native (AI/AN) Affairs which "provides guidance to the AMA Board of Trustees and AMA management on policy and advocacy initiatives impacting AI/AN medical students, physicians, and patients, while also contributing to broader AMA efforts aimed at improving health outcomes for this population."[35] This was created via Advisory Committee on Tribal Affairs D-615.976 and a report is expected at a future HOD meeting.

AMA Board of Trustees Report 31-A-24, The Morrill Act and Its Impact on the Diversity of the Physician Workforce, discussed the history of Indigenous lands appropriated for higher education institutions, called for additional AMA work in collaboration with other relevant organizations related to Indigenous health, and described recent AMA activity, including federal advocacy efforts.

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The California Oregon Medical Partnership to Address Disparities in Rural Education and Health (COMPADRE) received a $1.8 million AMA grant through the Reimagining Residency initiative that started in 2019. This network of residency programs serving rural and underserved communities offers elective opportunities to existing medical students, including in tribal health.[36]

More recently, the AMA awarded an Innovation Grant to the University of Hawaii John A. Burns School of Medicine for "Evaluation of an Indigenous Approach to Professional Identity Formation through Coaching."[37] AMA staff and the AMA's TRHT task force also led the project planning and implementation for convenings for Equity and Justice in Medical Education (EJME), with participants from nine organizations, including but not limited to the Association of American Indian Physicians (AAIP) and Association of Native American Medical Students (ANAMS). EJME's goals centered participatory trust building between organizations engaged in equitable workforce development strategies responsive to the June 2023 Supreme Court of the United States (SCOTUS) ruling against race as a consideration in holistic review of medical school applications. These convenings led to explorations of best practices for power sharing within collaborative work and a commitment to future collaboration.[38] AMA staff are also working to develop trainings related to population health as well as genocide remembrance and prevention, broad topics that in some areas include information related to Indigenous health for the AMA EdHub. AMA Excellence in Medical Education grants also aim to improve the pathway toward becoming a physician, including for underrepresented groups such as Indigenous learners.

The Robert Wood Johnson Foundation awarded a grant of $999,994 on September 12, 2025, to Indigenous School of Medicine for a timeframe of 8/31/2025 - 8/30/2027, titled "Redefining medical education by centering and incorporating Indigenous voices."[39] One of ISOM's leaders, Dr. Donald Warne, also a leader on the AMA's TRHT task force, emphasizes that current modern medicine is also Indigenous medicine, though often uncredited—citing examples of traditional Indigenous science and medicine like cranial surgery, aspirin, and the field of osteopathic medicine. Stated goals for ISOM include traditional Indigenous medicine men/women/elders on faculty, not just as advisers; incorporating traditional medicines, beliefs, and practices; and for the culture of medical education to be overhauled to be healing rather than traumatizing to the learner.[26] AMA has engaged in dialogues with ISOM leaders at several meetings and conferences, including the most recent Association of American Indian Physicians conference.

DISCUSSION

Although AMA has not historically founded medical schools directly, AMA does serve in a role developing the physician workforce. For instance, alongside the Association of American Medical Colleges (AAMC), AMA jointly sponsors the Liaison Committee for Medical Education (LCME), which accredits allopathic medical schools in the United States. When the resolution that initiated this report was discussed within the HOD, one area of conversation surrounded potential concerns regarding conflicts of interest if the AMA were to have a hand in any particular medical school or schools. Discussions with LCME staff emphasized the firewall between AMA and the LCME regarding accreditation: decisions about accreditation rest solely with the LCME, and no school is given special treatment, regardless of a connection or lack thereof to AMA, just as allopathic medical schools are members of AAMC, the other co-sponsor of the LCME, but AAMC also cannot and does not influence accreditation decisions. AMA is free to pursue any projects it feels would further its mission to promote the art and science of medicine and the betterment of public health and need not avoid collaborative work in this space. Anyone can apply for LCME accreditation, and the same standards are applied to all applicants.

As discussed in several examples above, AMA is engaged in work on Indigenous health and the possibility of Indigenous medical schools. Although the AMA is not an Indigenous-led organization and therefore cannot determine the best path forward for Indigenous-led work, work is in progress to partner with several organizations on "collaborative feasibility assessments, resource development partnerships, and community-guided planning processes" per Policy H-350.960, "Underrepresented Student Access to US Medical Schools." According to AMA Medical Education staff focused on workforce challenges and attending relevant discussions: Indigenous-governed higher education already in existence (i.e., TCUs, Tribal Colleges and Universities) may either be worthwhile models for new medical schools, or, with sufficient resources and if a priority for respective tribes, may even be places where medical school(s) may form. Indigenous-led discussions center around where there may be greater potential for rotations as well as pathways into graduate medical education for students, an important component of undergraduate medical education. Three specific locations were discussed as possible areas where Indigenous schools of medicine may form, though these details are under development and currently not publicly available. AMA has also been in

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touch with Canadian Medical Association leadership on the topic of reconciliation and advancing Indigenous health, including discussions of schools.[40]

Beyond any hypothetical schools themselves, as noted above, significant challenges for Indigenous learners begin far before reaching medical school. Therefore, work must also focus earlier, even into early childhood.

RELEVANT AMA POLICY

AMA has several policies related to Indigenous communities and medical education. These are listed in Appendix A.

CONCLUSION

AMA is engaged with and will continue to engage with ways to support its mission to promote the art and science of medicine and the betterment of public health, including Indigenous health and medical education workforce. Though tribally-led medical education institutions must by definition be initiated by Indigenous communities according to their own priorities and needs, AMA continues to engage directly with those leading this work to provide guidance and support where appropriate.

RECOMMENDATIONS

The Council on Medical Education recommends that the following be adopted in lieu of Resolution 303-A-25, resolves 2 and 4, and the remainder of the report be filed:

1. Our AMA convenes a collaborative with Tribal Nations, Tribal Colleges and Universities (TCUs), Indigenous-led medical education organizations, and academic partners to conduct structured feasibility assessments that lead to the development of Indigenous-led medical schools, including infrastructure needs, accreditation pathways, financing models, and governance structures grounded in tribal sovereignty.
2. Our AMA advocates for the development and funding of comprehensive mentorship and pathway programs connecting Indigenous pre-medical students with physician and other mentors, guiding academic preparation, MCAT preparation, the medical school application process, and career development.
3. Our AMA encourages collaboration between our AMA, medical schools, TCUs, and community organizations to increase pathways and funding for Indigenous students in medicine.
4. Reaffirm AMA policies H-60.917 "Disparities in Public Education as a Crisis in Public Health and Civil Rights," H-295.840 "Support for the Establishment of Indigenous-Led Medical Schools in the United States," and H-350.960 "Underrepresented Student Access to US Medical Schools."

Fiscal note: Major

APPENDIX A: RELEVANT AMA POLICY

<u>Disparities in Public Education as a Crisis in Public Health and Civil Rights H-60.917</u>

1. Our American Medical Association:
    a. considers continued educational disparities based on ethnicity, race and economic status a detriment to the health of the nation.
    b. will issue a call to action to all educational private and public stakeholders to come together to organize and examine, and using any and all available scientific evidence, to propose strategies, regulation and/or legislation to further the access of all children to a quality public education, including early childhood education, as one of the great unmet health and civil rights challenges of the 21st century.
    c. acknowledges the role of early childhood brain development in persistent educational and health disparities and encourage public and private stakeholders to work to strengthen and expand programs to support optimal early childhood brain development and school readiness.
2. Our AMA will work with:
    a. the Health and Human Services Department (HHS) and Department of Education (DOE) to raise awareness about the health benefits of education.

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   b. the Centers for Disease Control and Prevention and other stakeholders to promote a meaningful health curriculum (including nutrition) for grades kindergarten through 12.
3. Our AMA will encourage the U.S. Department of Education and Department of Labor to develop policies and initiatives in support of students from marginalized backgrounds that:
   a. Decrease the educational opportunity gap.
   b. Increase participation in high school Advanced Placement courses.
   c. Increase the high school graduation rate.
4. Our AMA will advocate for universal access to high-quality and affordable childcare and preschool.

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.

US Physician Shortage H-200.954

1. Our AMA 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:

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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.

AMA Support of U.S. Pathway Programs D-200.970

Our American Medical Association supports development of pilot grant programs advised by a diverse body of AMA member physicians, trainees, staff, and allied organization representatives in medicine and public health (i.e., administration; grantee criteria and selection; periodic reporting) that will:

1. Support existing and new pre-K-16 pathway, Science, Technology, Engineering, Math, and Medicine (STEMM), and pre-med programs;
2. Include program goals of scaling organizational grantees' ability to expand their reach among youth, increasing diversity in medicine, achieving health equity, and improving medical education; and
3. Convene a summit among pathway and STEMM programs regarding best practices, collaboration, and strategic planning.

Support for the Establishment of Indigenous-Led Medical Schools in the United States H-295.840

Our AMA supports efforts to establish Indigenous-governed medical schools in the United States, with governance and leadership structures grounded in tribal sovereignty and cultural integrity, and guided by principles of accountability to Indigenous Nations, inclusion of Indigenous leadership, and alignment with community-defined values and priorities.

Enhancing the Cultural Competence of Physicians H-295.897

1. Our American Medical Association continues to inform medical schools and residency program directors about activities and resources related to assisting physicians in providing culturally competent care to patients throughout their life span and encourage them to include the topic of culturally effective health care in their curricula.
2. Our AMA continues to support research into the need for and effectiveness of training in cultural competence and cultural humility, using existing mechanisms such as the annual medical education surveys.
3. Our AMA will assist physicians in obtaining information about and/or training in culturally effective health care through dissemination of currently available resources from the AMA and other relevant organizations.
4. Our AMA encourages training opportunities for students and residents, as members of the physician-led team, to learn cultural competency from community health workers, when this exposure can be integrated into existing rotation and service assignments.
5. Our AMA supports initiatives for medical schools to incorporate diversity in their Standardized Patient programs as a means of combining knowledge of health disparities and practice of cultural competence with clinical skills.
6. Our AMA will encourage the inclusion of peer-facilitated intergroup dialogue in medical education programs nationwide.
7. Our AMA supports the development of national standards for cultural humility training in the medical school curricula.

Support Permanent Funding and Expansion of Native Hawaiian Healthcare H-350.933

1. Our American Medical Association supports federal policies that uphold the federal trust obligations to improve the health of Native Hawaiian communities by strengthening access to comprehensive, culturally informed, and physician-led health care.

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2. Our AMA supports stable, long-term federal funding and infrastructure for Native Hawaiian health care programs to ensure continuity of care, workforce development, and equitable access to services across all islands.
3. Our AMA supports the expansion of Native Hawaiian Health Care Systems, including additional sites, mobile clinics, transportation support, workforce development, and culturally grounded health services that integrate traditional Indigenous healing alongside physician-led care.
4. Our AMA encourages collaboration with Native Hawaiian organizations, leaders, and communities to ensure that federally supported health care initiatives are responsive to local needs, culturally respectful, and community-driven.

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.
11. Our AMA will partner with relevant public and private sector organizations and relevant parties to advance restorative efforts that address the harms of the 1910 Flexner Report by promoting and supporting the development, opening, and/or reopening of medical schools in historically marginalized and underserved communities, including those affiliated with Historically Black Colleges & Universities (HBCUs), Tribal Colleges & Universities (TCUs), and Minority-Serving Institutions (MSIs) through collaborative feasibility assessments, resource development partnerships, and community-guided planning processes, among others.

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.

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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 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;

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   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.

<u>AMA Support of American Indian Health Career Opportunities H-350.981</u>
Our American Medical Association policy on American Indian health career opportunities is as follows:
1. Our AMA, 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.

<u>Advisory Committee on Tribal Affairs D-615.976</u>
1. Our AMA will establish and report back at the 2025 Interim Meeting on the formation of a Task Force on Tribal Affairs composed of AMA members who themselves identify as American Indian and Alaska Native (AI/AN), close professional relationships with AI/AN communities (e.g., members of Association of Native American Medical Students and Association of American Indian Physicians), or have direct experience

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working with AI/AN communities at Indian Health Service federal direct-care, Tribally-operated and/or Urban Indian Health Programs (I/T/U) to advise the Board of Trustees on how to implement policy specific to AI/AN communities and that the Task Force report back at the 2026 Annual Meeting with recommendations for the establishment of an Advisory Committee to ensure sustained attention to tribal health equity and Indigenous physician representation.

Our AMA will promote and foster educational opportunities for AMA members and the medical community to better understand the contributions of AI/AN communities to medicine and public health, including cultivating a rich understanding and appreciation of AI/AN perspectives on health and wellness.

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4. REFLECTING THE VALUES AND PRIORITIES OF TRIBAL COMMUNITIES IN INDIGENOUS-LED MEDICAL SCHOOLS IN THE UNITED STATES

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: RECOMMENDATIONS ADOPTED
REMAINDER OF REPORT FILED
See Policies H-295.840 and H-350.960

Resolution 303-A-25, "Support for the Establishment of Indigenous-Led Medical Schools in the United States," was introduced by the Underrepresented in Medicine Advocacy Section (formerly the Minority Affairs Section). The original resolve 1 was amended and adopted becoming Policy H-295.840, "Support for the Establishment of Indigenous-Led Medical Schools in the United States." Resolves 2, 3, and 4 were referred. Resolves 2 and 4 will be addressed in CME 3-A-26, with the study of resolve 3 as the focus of this report. This resolve asked the following:

> RESOLVED (3), that our AMA support initiatives to develop culturally centered medical curricula, recruit Indigenous faculty and leadership, and facilitate pathways to institutional accreditation that reflect the values and priorities of Tribal communities. (Directive to Take Action)

BACKGROUND

The contextual factors informing this report's analysis, namely, persistent physician workforce shortages affecting Indigenous communities and the foundational principles of tribal and Indigenous sovereignty as they relate to health professions education are addressed in detail in CME 3-A-26, Support for the Establishment of Indigenous-Led Medical Schools in the United States. That report provides a comprehensive review of historical, policy, and workforce dynamics that shape the need for Indigenous-led medical education pathways. To avoid duplicating that discussion, this report builds on the established background and focuses specifically on considerations unique to development of culturally centered medical curricula, recruitment of Indigenous faculty and leadership, and facilitation of pathways to institutional accreditation that reflect the values and priorities of Tribal communities.

Existing Activities

Below is a brief review of some of the active collaborations that exist between medical schools and tribal nations regarding culturally centered curricula and/or faculty and leadership development for Indigenous physicians.

Oklahoma State University College of Osteopathic Medicine at the Cherokee Nation. The Oklahoma State University College of Osteopathic Medicine at the Cherokee Nation (OSU-COM CN) is the only tribally affiliated medical school campus in the nation. This program offers the following: "The Tribal Medical Track prepares medical students for a primary care residency at tribal facilities and a successful practice in tribal, rural and underserved Oklahoma… [with] unique learning opportunities for motivated students to fully develop their skills, knowledge and abilities to succeed in a challenging practice environment while learning about the rich cultures of American Indians."[1]

UC Davis PRIME Tribal Health Pathway. The UC Davis Programs in Medical Education (PRIME) Tribal Health Pathway focuses on recruiting new physicians to serve California's tribal, urban, and rural communities and reduce health inequities, as well as building partnerships with tribal communities, improving training in relevant determinants of health, and building a deeper understanding of self-determination and health advocacy.[2] Indigenous physicians are co-founders of the Huwighurruk post-baccalaureate pathway program, as well as co-directors of the PRIME Tribal Health Pathway,[3] which accepts up to 6 students per academic year.[4]

Oregon Health & Science University Northwest Native American Center of Excellence. The Northwest Native American Center of Excellence (NNACoE) was founded in 2017 with an initial five-year grant from the Health Resources and Services Administration (HRSA). The center "works to sustainably address the health care needs of all people by increasing AI/AN representation in the health professions workforce via culturally informed, evidence-based health education programming and research interventions designed for Indigenous healthcare learners and professionals. NNACoE sits within the Department of Family Medicine and is an institution-wide resource for AI/AN students and faculty. NNACoE's 12 study initiatives span five critical points along the education continuum, beginning in high school and continuing through early faculty development."[5] Initiatives for high school students were

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also created via funding from the Indian Health Service Indians Into Medicine Program, foundation grants, and state-legislated funds for expanded partnerships with University of California, Davis and Washington State University.[6]

AMA Efforts to Support the Development of an Indigenous Physician Workforce

What follows is a brief overview of current AMA work related to Indigenous health curricula and faculty development. AMA, though it does not play a role in creating specific medical school curricula, does have extensive policy in support of culturally appropriate and evidence-based curricula.

Since the initiation of this report at the A-25 meeting, AMA adopted new policies or amended existing policies relevant to the important work of improving pathways for Indigenous physicians and communities and developing the physician workforce based on societal needs. This includes updates to Underrepresented Student Access to US Medical Schools H-350.960 at the I-25 meeting, stating that "Our AMA will partner with relevant public and private sector organizations and relevant parties to advance restorative efforts that address the impact of the 1910 report Medical Education in the United States and Canada ("Flexner Report") and the resulting actions by state medical licensing boards and other groups including the AMA, by promoting and supporting the development, opening, and/or reopening of medical schools in historically marginalized and underserved communities, including those affiliated with Historically Black Colleges & Universities (HBCUs), Tribal Colleges & Universities (TCUs), and Minority-Serving Institutions (MSIs) through collaborative feasibility assessments, resource development partnerships, and community-guided planning processes, among others." This now guides further work by the AMA and will be reported on in future documents.

Some of AMA's work in this space also centers around the AMA's Truth, Reconciliation, and Healing Task Force (TRHT),[7] which advised the AMA Board of Trustees related to amelioration of past harms. AMA also has an Advisory Committee on American Indian and Alaska Native (AI/AN) Affairs which "provides guidance to the AMA Board of Trustees and AMA management on policy and advocacy initiatives impacting AI/AN medical students, physicians, and patients, while also contributing to broader AMA efforts aimed at improving health outcomes for this population."[8] This was created via Advisory Committee on Tribal Affairs D-615.976 and will receive a report in a future HOD meeting.

The California Oregon Medical Partnership to Address Disparities in Rural Education and Health (COMPADRE) received a $1.8 million AMA grant through the Reimagining Residency Initiative that started in 2019. The program trained medical students and resident physicians in seven medical specialties, including internal medicine, family medicine, emergency medicine, general surgery, ob-gyn, pediatrics, and psychiatry at 10 health care systems, 16 hospitals, and a network of Federally Qualified Health Center partners throughout Northern California and Oregon. The goal of COMPADRE was to address health care workforce shortages in rural, tribal, urban, and other communities that lack resources; increase access to health care professionals; and improve the health of patients who are disproportionately affected by certain conditions.

More recently, the AMA awarded an Innovation Grant to the University of Hawaii John A. Burns School of Medicine for "Evaluation of an Indigenous Approach to Professional Identity Formation through Coaching."[9] AMA staff and the AMA's TRHT task force also led the project planning and implementation for convenings for Equity and Justice in Medical Education (EJME), with participants from nine organizations, including but not limited to the Association of American Indian Physicians (AAIP) and Association of Native American Medical Students (ANAMS). EJME's goals centered participatory trust building between organizations engaged in equitable workforce development strategies responsive to the June 2023 Supreme Court of the United States (SCOTUS) ruling against race as a consideration in holistic review of medical school applications. These convenings led to explorations of best practices for power sharing within collaborative work and a commitment to future collaboration.[10] AMA staff are also working to develop trainings related to population health as well as genocide remembrance and prevention, broad topics that in some areas include information related to Indigenous health for the AMA EdHub. AMA Excellence in Medical Education grants also hope to improve the pathway toward becoming a physician, including for underrepresented groups such as Indigenous learners. The AMA EdHub has other resources available to help faculty develop deeper cultural sensitivity when practicing with Indigenous populations on topics such as: Ethics Talk: Representation, Sovereignty, and Caring for Native American Patients[11] and Disparities in Telehealth Use for Mental Health Care Among American Indian/Alaska Native Veterans.[12] Similarly, JAMA Network hosts relevant resources to increase physician faculty understanding of Indigenous health issues, such as Feasibility of an Indigenous Food Is Medicine Program for Patients With Heart Failure in Rural Navajo Nation.[13]

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The Robert Wood Johnson Foundation awarded a grant of $999,994 on September 12, 2025, to Indigenous School of Medicine (ISOM) for a timeframe of 8/31/2025 - 8/30/2027, titled "Redefining medical education by centering and incorporating Indigenous voices."[14] One of ISOM's leaders, Dr. Donald Warne, also a leader on the AMA's TRHT task force, emphasizes that current modern medicine is also Indigenous medicine, though often uncredited—citing examples of traditional Indigenous science and medicine like cranial surgery, aspirin, and the field of osteopathic medicine. Stated goals for ISOM include traditional Indigenous medicine men/women/elders on faculty, not just as advisers; incorporating traditional medicines, beliefs, and practices; and for the culture of medical education to be overhauled to be healing rather than traumatizing to the learner.[15] AMA has engaged in dialogues with ISOM leaders at several meetings and conferences, including the most recent Association of American Indian Physicians conference.

The American Indian Higher Education Consortium's Indigenous Health, Education, and Resources Taskforce (IHEART) is "a national collaborative, formed in 2021 to address the scarcity of American Indian and Alaska Native (AI/AN) communities in the health professions…led by the Association of American Indian Physicians, American Indian Higher Education Consortium, Association of Native American Medical Students, Association of American Medical Colleges, and the Indian Health Service."[16] One IHEART objective is "Develop regional infrastructure to identify educational pathways programs to support and encourage American Indian/Alaska Native students to enter into the health professions workforce." AMA has also been invited to attend and engage in these discussions.

AMA staff was also engaged with some work in this space with Johns Hopkins Center for Indigenous Health,[17] although as of January 14, 2026, five Indigenous health programs at this institution were ended due to federal budget cuts.[18]

Culturally Centered Indigenous Medical Curricula

The Association of American Medical Colleges (AAMC) offers a blueprint for overall cultural competence within medical school curricula, including a tool for assessing its effectiveness.[19] More specific to Indigenous health, AAMC also convenes the Indigenous Health Educators Alliance (IHEAL), a "national collective of scholars and leaders committed to advancing the contribution of Indigenous principles and practices in health professions education and training."[20] This includes publications and resources on how to develop and implement curricula, and is also related to the recruitment and development of Indigenous faculty. Other work has been done in this space, including guiding principles in the development of Indigenous health curricula[21] and research demonstrating the potentially harmful assumptions that must be understood prior to succeeding at truly incorporating Indigenous knowledge into curricula.[22] One study showed that first-year medical students of all identities had improved Indigenous health knowledge, cultural intelligence, ethnocultural empathy, and social justice beliefs immediately after a lecture series and six months later.[23]

In Canada, the National Consortium for Indigenous Medical Education published "Guidelines for the Development of Indigenous Studies, Cultural Safety & Antiracism Assessment in Medical Education" in 2024, and this may be useful within the context of the United States as well.[24]

Indigenous Faculty Recruitment, Development, and Retention

In one publication related to faculty recruitment best practices, the author emphasized, "Residency leadership can benefit from maintaining a mindset that they are always recruiting faculty, even when recruiting students, where mentorship and role modeling efforts can help expand students' imagination of what an academic career can look like."[25] To this point, recruitment and retention of Indigenous faculty can be especially challenging when there are already disproportionate challenges to Indigenous learners even before entering medical school: "American Indian and Alaska Native individuals had a 63% lower odds of applying to medical school… and 48% lower odds of holding a full-time faculty position… compared with their White counterparts, yet had 54% higher odds of working in a residency specialty deemed as a priority by the Indian Health Service."[26] Unfortunately this is a circular problem, as the lack of diverse faculty mentorship also serves as an obstacle for medical trainees who may otherwise be interested in pursuing a career in medicine.[26]

As keynote speaker for the 2024 National Diversity in STEM Conference, Dr. Donald Warne's vision for an Indigenous school of medicine included tribal medicine people as faculty—elders and healers who are not necessarily exclusively physicians, though physicians would clearly also be important.[27] This corresponds with other research on the importance of respect for Indigenous elders' teachings within health professions education.[28] This may also increase the pool of appropriate mentors for Indigenous physicians. Pragmatic solutions[29] to existing issues—such as

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funding shortages and threatened layoffs to Indian Health Service physicians[30]—may also be helpful. Organized advocacy also can play a critical supporting role. The AMA conducts advocacy in the areas of GME funding and student loan forgiveness.[31]

Some initial research on best practices in developing existing faculty has been done, noting the importance of Indigenous-specific space, skill building, networking, and ongoing mentorship, "each of which were included to specifically mitigate isolation and tokenism that negatively affects promotion and advancement." Next steps in this research include longitudinal evaluation.[32]

Pathways to Accreditation

One area of the original resolution that was referred for study references facilitating "pathways to institutional accreditation."

AMA policy Preserving Accreditation Standards on Diversity, Equity, and Inclusion H-310.896 does oppose "any federal actions or executive orders that threaten the ability of accreditation bodies, including the Accreditation Council for Graduate Medical Education (ACGME), the Commission on Osteopathic College Accreditation (COCA), and the Liaison Committee on Medical Education (LCME), to enforce appropriate accreditation standards."

For the accreditation of allopathic medical schools in the United States (programmatic accreditation), the Liaison Committee on Medical Education (LCME) publishes a document called "Functions and Structure of a Medical School: Standards for Accreditation of Medical Education Programs Leading to the MD Degree," available on their website, describing what is required of a medical school for accreditation. LCME also publishes a Data Collection Instrument for Preliminary Accreditation Surveys, which details the types of questions a new medical school would need to answer in order to work toward preliminary accreditation.[33]

The American Osteopathic Association, specifically COCA, accredits osteopathic medical schools in the United States and also provides accreditation guidelines and policies on their website.[34]

While the administrative process for accreditation of an Indigenous medical school may be similar to any other medical school in regard to the requirements to create a school and seek allopathic or osteopathic accreditation, a tribal medical school may potentially have differences due to a tribe's status as a sovereign nation (see discussion in CME 3-A-26, Support for the Establishment of Indigenous-Led Medical Schools in the United States). Accreditation of medical education programs by the LCME does not grant access low-interest student loans via Title IV funding. Eligibility for this depends on institutional accreditation, which is via national accreditors and differs from specialized accreditation for a specific profession (such as medicine).[35] Many existing tribal colleges and universities (TCUs) already have institutional accreditation, though they do not currently have medical schools.

In terms of institutional accreditation, as of this writing (February 2026), only freestanding colleges of osteopathic medicine are eligible to seek COCA accreditation as a pathway to participation in Title IV programs[36] through one of the six institutional accreditors recognized by the United States Department of Education that covey Title IV eligibility.[36] COCA also provides guidance and resources for new and developing colleges of osteopathic medicine,[37] and the full 2026 COCA accreditation standards for new and developing colleges of medicine are available on their website.[38]

DISCUSSION

Existing AMA policy and actions do support initiatives to develop culturally centered medical curricula and recruit Indigenous faculty and leadership. However, AMA does not facilitate specific pathways to institutional nor programmatic accreditation, although the AMA can participate in feasibility planning alongside other groups, as discussed above.

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RELEVANT AMA POLICY

AMA has several policies related to Indigenous communities and medical education. These are listed in Appendix A.

CONCLUSION

AMA is engaged with and will continue to engage with ways to support its mission to promote the art and science of medicine and the betterment of public health, including Indigenous health and medical education workforce. AMA continues to engage directly with those leading this work to provide guidance and support where appropriate.

RECOMMENDATIONS

The Council on Medical Education recommends that the following be adopted in lieu of Resolution 303-A-25, resolve 3, and the remainder of the report be filed:

1. Our AMA supports the development of leadership training programs for Indigenous physicians, equipping them with the skills and knowledge to assume leadership roles in academic medicine, health care administration, and public health.
2. Our AMA encourages Indigenous faculty and leadership recruitment/retention through an Indigenous Faculty & Leadership Development Initiative in collaboration with AMA Ed Hub.
3. That our AMA develop and disseminate an Indigenous-centered undergraduate medical education curricular resource with collaboration and guidance from tribal communities.
4. That our AMA convene an Indigenous Medical Education Design & Partnership Workshop to advance Indigenous educational principles and partnerships.
5. That our AMA advocate for sustainable funding and workforce policies that support Indigenous learners, faculty, and clinical training partnerships.
6. Reaffirm AMA policies H-295.840 “Support for the Establishment of Indigenous-Led Medical Schools in the United States” and H-350.960 “Underrepresented Student Access to US Medical Schools.”

Fiscal note: Major

APPENDIX A: RELEVANT AMA POLICY

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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US Physician Shortage H-200.954

1. Our AMA 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.

Providing Transparent and Accurate Data Regarding Students and Faculty at Medical Schools D-295.306

Our American Medical Association will work with the Liaison Committee on Medical Education and Commission on Osteopathic College Accreditation to encourage their respective accredited medical schools to make publicly available without charge transparent and accurately reported race and ethnicity demographic data regarding students and faculty.

Support for the Establishment of Indigenous-Led Medical Schools in the United States H-295.840

Our AMA supports efforts to establish Indigenous-governed medical schools in the United States, with governance and leadership structures grounded in tribal sovereignty and cultural integrity, and guided by principles of accountability to Indigenous Nations, inclusion of Indigenous leadership, and alignment with community-defined values and priorities.

Enhancing the Cultural Competence of Physicians H-295.897

1. Our American Medical Association continues to inform medical schools and residency program directors about activities and resources related to assisting physicians in providing culturally competent care to patients throughout their life span and encourage them to include the topic of culturally effective health care in their curricula.

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2. Our AMA continues to support research into the need for and effectiveness of training in cultural competence and cultural humility, using existing mechanisms such as the annual medical education surveys.
3. Our AMA will assist physicians in obtaining information about and/or training in culturally effective health care through dissemination of currently available resources from the AMA and other relevant organizations.
4. Our AMA encourages training opportunities for students and residents, as members of the physician-led team, to learn cultural competency from community health workers, when this exposure can be integrated into existing rotation and service assignments.
5. Our AMA supports initiatives for medical schools to incorporate diversity in their Standardized Patient programs as a means of combining knowledge of health disparities and practice of cultural competence with clinical skills.
6. Our AMA will encourage the inclusion of peer-facilitated intergroup dialogue in medical education programs nationwide.
7. Our AMA supports the development of national standards for cultural humility training in the medical school curricula.

Preserving Accreditation Standards on Diversity, Equity, and Inclusion H-310.896

1. Our American Medical Association opposes any federal actions or executive orders that threaten the ability of accreditation bodies, including the Accreditation Council for Graduate Medical Education (ACGME), the Commission on Osteopathic College Accreditation (COCA), and the Liaison Committee on Medical Education (LCME), to enforce appropriate accreditation standards.
2. Our AMA supports ACGME, COCA, and LCME in advocating for their accreditation standards focused on diversity, equity, and inclusion for the betterment of patient care and public health.
3. Consistent with applicable laws, our AMA supports allopathic and osteopathic medical education accreditation bodies in strengthening accreditation standards focused on diversity, equity, and inclusion.

Support Permanent Funding and Expansion of Native Hawaiian Healthcare H-350.933

1. Our American Medical Association supports federal policies that uphold the federal trust obligations to improve the health of Native Hawaiian communities by strengthening access to comprehensive, culturally informed, and physician-led health care.
2. Our AMA supports stable, long-term federal funding and infrastructure for Native Hawaiian health care programs to ensure continuity of care, workforce development, and equitable access to services across all islands.
3. Our AMA supports the expansion of Native Hawaiian Health Care Systems, including additional sites, mobile clinics, transportation support, workforce development, and culturally grounded health services that integrate traditional Indigenous healing alongside physician-led care.
4. Our AMA encourages collaboration with Native Hawaiian organizations, leaders, and communities to ensure that federally supported health care initiatives are responsive to local needs, culturally respectful, and community-driven.

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.

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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.
11. Our AMA will partner with relevant public and private sector organizations and relevant parties to advance restorative efforts that address the harms of the 1910 Flexner Report by promoting and supporting the development, opening, and/or reopening of medical schools in historically marginalized and underserved communities, including those affiliated with Historically Black Colleges & Universities (HBCUs), Tribal Colleges & Universities (TCUs), and Minority-Serving Institutions (MSIs) through collaborative feasibility assessments, resource development partnerships, and community-guided planning processes, among others.

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 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:

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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.

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 AMA, 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.

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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.

Advisory Committee on Tribal Affairs D-615.976

1. Our AMA will establish and report back at the 2025 Interim Meeting on the formation of a Task Force on Tribal Affairs composed of AMA members who themselves identify as American Indian and Alaska Native (AI/AN), close professional relationships with AI/AN communities (e.g., members of Association of Native American Medical Students and Association of American Indian Physicians), or have direct experience working with AI/AN communities at Indian Health Service federal direct-care, Tribally-operated and/or Urban Indian Health Programs (I/T/U) to advise the Board of Trustees on how to implement policy specific to AI/AN communities and that the Task Force report back at the 2026 Annual Meeting with recommendations for the establishment of an Advisory Committee to ensure sustained attention to tribal health equity and Indigenous physician representation.
2. Our AMA will promote and foster educational opportunities for AMA members and the medical community to better understand the contributions of AI/AN communities to medicine and public health, including cultivating a rich understanding and appreciation of AI/AN perspectives on health and wellness.

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