Reference Committee C

Report(s) of the Council on Medical Education

01 Council on Medical Education Sunset Review of 2016 House of Delegates' Policies
02 Examining ABMS Processes for New Boards
03 Support for the Establishment of Indigenous-Led Medical Schools in the United States
04 Reflecting the Values and Priorities of Tribal Communities in Indigenous-Led Medical Schools in the United States

Resolutions

301 Expanding Resident and Fellow Exposure to Diverse Healthcare Practice Models to Fulfill ACGME Core Competencies
302 Excessive Cost of Multi-State DEA Licensure
303 Allowing Options for Certification Maintenance
304 Increasing the Use of Retired Physicians in Teaching Students and Residents
305 Leadership by Physicians for Physicians in Graduate Medical Education (GME)
306 Competency-Based Portfolio Assessment of Medical Students, Interns, Residents, and Fellows
307 Recognizing Advocacy as a Component of Faculty Appointment and Promotion in Academic Medicine
308 Impact of Federal and State Restrictive Actions on Gender-Affirming Care on Medical Education and Physician Workforce Development
309 Osteoporosis Education, Awareness, and Musculoskeletal Health Optimization
310 Increasing Capacity and Access to Maternal Health Services in Rural Areas
311 Changing the Paradigm of Medical Student Debt to address the Geriatric Physician Shortfall
312 Advocating for Equitable Application Review in a Single Match System
313 Evaluation of Situational Judgement Tests in Medical School Admissions
314 Promoting Sex- and Gender-Inclusive Diagnostic Practices, Language, and Patient Education
315 Expanding the Native Hawaiian Health Scholarship Program Eligibility
316 Addressing Transitions Within GME Regarding Orientation Standards
317 Support for Intern, Resident, and Fellow Jeopardy Pay and Additional Compensation for Gaps in Trainee Coverage

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 1-A-26

Subject:	Council on Medical Education Sunset Review of 2016 House of Delegates' Policies
Presented by:	Kelly Caverzagie, MD, MPH, Chair
Referred to:	Reference Committee C

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.

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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

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-	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

		effective, and consistent with the requirements for background checks being required of resident physicians and practicing physicians; and (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	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 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.
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.	Retain – still relevant.

		Policy Timeline: Res. 118, I-86; Reaffirmed: Sunset Report, I-96; Reaffirmed: CME Rep. 2, A-06; Reaffirmed: CME Rep. 01, A-16	
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 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	Retain – still relevant.
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	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	Retain – still relevant.

	Violence Screening	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	
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	Retain – still relevant.

		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 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.	Retain – still relevant.

		Policy Timeline: CME Rep. 7, I-96; Reaffirmed: CME Rep. 2, A-06; Reaffirmed: CME Rep. 01, A-16	
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. Policy Timeline: CME Rep. 7, A-96; Reaffirmed: CME Rep. 2, A-06; Reaffirmed: CME Rep. 01, A-16	Retain – still relevant.
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.	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

		Policy Timeline: CME Rep. A, A-86; Reaffirmed: Sunset Report, I-96; Reaffirmed: CME Rep. 2, A-06; Reaffirmed: CME Rep. 01, A-16	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 access care in a timely and affordable manner. Policy Timeline: Res. 904, I-16	Retain – still relevant. Notice provided to HOD after I-16 stated that the AMA Policy Database was updated.
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.

COUNCIL ON MEDICAL EDUCATION REPORT 2-A-26
Examining ABMS Processes for New Boards

EXECUTIVE SUMMARY

At the 2025 Annual Meeting of the American Medical Association (AMA) House of Delegates Policy D-275.943, "Examining ABMS Processed for New Boards," was adopted. The policy asks that the AMA "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 provides a brief history of specialty board formation and American Board of Medical Specialties (ABMS) approval as well as an overview of past and current ABMS requirements and criteria. It discusses input from the HOD and offers principles for board certifying bodies. Finally, the report lays out resources and related AMA policy and concludes with recommendations to the HOD.

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REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 2-A-26

Subject: Examining ABMS Processes for New Boards

Presented by: Kelly Caverzagie, MD, MPH, Chair

Referred to: Reference Committee C

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

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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 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.

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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. 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

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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

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interested parties. Principles are intended to be guiding 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.

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- 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.

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.

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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.~~ (Modify Current HOD Policy)

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.

   (New HOD Policy)

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

Fiscal note: Minimal

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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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COUNCIL ON MEDICAL EDUCATION REPORT 3 – A-26
Support for the Establishment of Indigenous-Led Medical Schools in the United States

EXECUTIVE SUMMARY

Resolves 2 and 4 of Resolution 303-A-25, Support for the Establishment of Indigenous-Led Medical Schools in the United States, were referred for study on the following topics:

> 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)

This report reviews the history and context of physician workforce shortages in Indigenous communities, including the difficulties present early in the educational and other pathways leading up to medical school and the current absence of any Indigenous-led medical school. The report then summarizes the basic process to create a medical school and discusses unique challenges related to implementing this process on tribal land. Finally, the report explores activity in the wider medical education community related to tribally affiliated medical schools, a selection of other relevant Indigenous-focused programs, and AMA's current work related to Indigenous workforce and possible Indigenous medical schools.

The report recommends additional AMA policy in convening, collaboration, feasibility assessment, and advocacy spaces related to Indigenous medical schools as well as pathway and mentorship programs prior to undergraduate medical education.

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REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 3-A-26

Subject:	Support for the Establishment of Indigenous-Led Medical Schools in the United States
Presented by:	Kelly Caverzagie, MD, MPH, Chair
Referred to:	Reference Committee C

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

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as multiracial.)"[4] By contrast, in 2023, there were 3.3 million people in the country 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.

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]

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.

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 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. (New HOD Policy)
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. (New HOD Policy)
3. Our AMA encourages collaboration between our AMA, medical schools, TCUs, and community organizations to increase pathways and funding for Indigenous students in medicine. (New HOD Policy)
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.” (Reaffirm HOD Policy)

Fiscal note: Major

APPENDIX A: RELEVANT AMA POLICY

Disparities in Public Education as a Crisis in Public Health and Civil Rights H-60.917

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.
    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:
    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.
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.
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;
   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.
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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COUNCIL ON MEDICAL EDUCATION REPORT 4 – A-26
Reflecting the Values and Priorities of Tribal Communities in Indigenous-Led Medical Schools in the United States

EXECUTIVE SUMMARY

Resolve 3 of Resolution 303-A-25, Support for the Establishment of Indigenous-Led Medical Schools in the United States, was referred for study on the following topics:

> 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)

This report reviews the history and context of physician workforce shortages in Indigenous communities and explores activity and research in the wider medical education community related to culturally centered medical curricula, Indigenous-focused programs, and faculty and leadership recruitment and development. The report also discusses AMA's current work related to Indigenous workforce needs. Programmatic versus institutional accreditation is also defined and discussed, with resources related to both offered.

The report recommends additional AMA policy supporting the development of leadership training programs for Indigenous physicians, encouraging Indigenous faculty and leadership recruitment/retention, developing and disseminating an Indigenous-centered undergraduate medical education (UME) curricular resource with collaboration and guidance from tribal communities, convening an Indigenous Medical Education Design & Partnership Workshop, and advocating for sustainable funding and workforce policies.

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REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 4-A-26

Subject: Reflecting the Values and Priorities of Tribal Communities in Indigenous-Led Medical Schools in the United States (Res 303-A-25, R3)

Presented by: Kelly Caverzagie, MD, MPH, Chair

Referred to: Reference Committee C

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

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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 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]

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 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.

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. (New HOD policy)
2. Our AMA encourages Indigenous faculty and leadership recruitment/retention through an Indigenous Faculty & Leadership Development Initiative in collaboration with AMA Ed Hub. (New HOD policy)
3. That our AMA develop and disseminate an Indigenous-centered undergraduate medical education curricular resource with collaboration and guidance from tribal communities.(Directive to Take Action)
4. That our AMA convene an Indigenous Medical Education Design & Partnership Workshop to advance Indigenous educational principles and partnerships. (Directive to Take Action)
5. That our AMA advocate for sustainable funding and workforce policies that support Indigenous learners, faculty, and clinical training partnerships. (New HOD policy)
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.” (Reaffirm HOD Policy)

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.

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.
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.
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.

<u>Improving Health Care of American Indians and Alaska Natives H-350.976</u>

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:

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.

<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.

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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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 301
(A-26)

Introduced by: Pennsylvania

Subject: Expanding Resident and Fellow Exposure to Diverse Healthcare Practice Models to Fulfill ACGME Core Competencies

Referred to: Reference Committee C

Whereas, the ACGME requires all accredited residency and fellowship programs to ensure competency in six core areas: Patient Care, Medical Knowledge, Practice-Based Learning and Improvement, Systems-Based Practice, Professionalism, and Interpersonal and Communication Skills; and

Whereas, the core competency of Systems-Based Practice requires residents and fellows to demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal care; and

Whereas, the current healthcare system is increasingly shaped by corporate and employed practice models, which limits trainee exposure to the broader range of healthcare delivery systems, including conventional independent private practice, Direct Primary Care (DPC), Direct Specialty Care (DSC), and other innovative models that emphasize patient access, physician autonomy, and cost transparency; therefore be it

RESOLVED, that our American Medical Association will advocate to the ACGME and other relevant accrediting and educational bodies for the formal inclusion and recognition of diverse practice model exposure as a vital component of Systems-Based Practice training. (Directive to Take Action)

Fiscal Note: Minimal – less than $5,000

Received: 4/9/26

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 302
(A-26)

Introduced by: Michigan

Subject: Excessive Cost of Multi-State DEA Licensure

Referred to: Reference Committee C

Whereas, many physicians seek licensure in multiple states due to locum tenens work, telehealth work, and/or coverage of patients who seek jobs or education in other states; and

Whereas, many physicians seek medical licensure and Drug Enforcement Administration (DEA) licensure in multiple states to legally provide these services across state lines; and

Whereas, a DEA license is a federal license; and

Whereas, DEA licensure requires a separate application and the full DEA licensure fee for each state in which licensure is desired; and

Whereas, obtaining a multi-state DEA licensure application is inconvenient and expensive despite DEA licensure being a federal (national) license; and

Whereas, the DEA has been encouraging improved access to controlled substances utilized as medications for opioid use disorder to reduce opioid-related overdoses as a federal concern; and

Whereas, the DEA has changed the educational requirements for obtaining an initial or a renewed DEA license to reflect this concern with a one-time attestation for this educational requirement at the federal level; and

Whereas, the time and monetary expense of obtaining DEA licensure in multiple states may limit access rather than encourage access to controlled substances utilized as medications for opioid use disorder; therefore be it

RESOLVED, that our American Medical Association continue its support of person-specific rather than site-specific Drug Enforcement Administration (DEA) registration numbers and a one-time DEA registration fee by reaffirming existing AMA policies, “One Fee One Number D-100.975” and “One Fee, One Number D-100.980.” (Reaffirm HOD Policy)

Fiscal Note: Minimal – less than $5,000

Received: 4/10/26

RELEVANT AMA POLICY

One Fee One Number D-100.975
1. Our AMA will work with the Drug Enforcement Administration (DEA) and Congress to move toward a system in which individual physician DEA registration numbers are person-specific rather than site-specific within a state. Additionally, the AMA will work with the DEA to ensure that the full DEA registration fee is paid only once, when the provider initially registers. Following the initial registration, provider should only pay a small re-registration fee every three years to fund the work of the Diversion Control Program.

2. Our AMA will work with the DEA, Congress and state licensing boards to explore changes to the DEA registration system so that a single DEA registration number can be used by physicians who prescribe, dispense, and/or administer controlled substances in multiple states. Our AMA will explore the possible development of a national DEA standard which would be greater than or equal to the most stringent state requirements for controlled substances. Providers could choose whether they would like to apply for the national DEA standard, or, more likely for those practicing in a single state, remain registered with the DEA under their single state requirements.

3. Our AMA continues to monitor implementation of the National Provider Identifier (NPI) system and work with physicians and payers to ensure proper and prompt payment for physician claims. Additionally, the AMA will monitor physician privacy concerns associated with the public consumption of the NPI database.

One Fee, One Number D-100.980
Our AMA will work with the appropriate agencies to require only one federal DEA number that would be physician-specific and not site-specific.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 303
(A-26)

Introduced by: Mississippi

Subject: Allowing Options for Certification Maintenance

Referred to: Reference Committee C

Whereas, it is estimated that 25% of physicians plan to leave medicine within 5 years, not necessarily due to retirement age but the burdens of practice; and

Whereas, the national physician shortage is well-known and growing, predicted to be 124,000 by 2034, and Mississippi is currently facing a physician shortage throughout the state; and

Whereas, problems of the current monopoly of Maintenance of Certification (MOC) are a significant emotional burden for the practicing physician and the problems with MOC are multifaceted and include financial burdens, time constraints, questionable clinical relevance, lack of evidence of improved outcomes, increased potential for burnout, and concerns of fairness and equity; and

Whereas, MOC requirements often overlap with state licensure and hospital Credentialing requirements, creating redundancy and unnecessary administrative burdens; and

Whereas, many argue that local hospital credentialing boards are better equipped to assess physician performance within their systems; and

Whereas, MOC requirements and expenses often chase out experienced and highly trained physicians who allow their certification to lapse, which eliminates quality physicians from clinical and hospital care; and

Whereas, burdensome Maintenance of Certification requirements can drive experienced physicians out of practice or out of hospital participation, only to have those physicians replaced in some settings by nurse practitioners and physician assistants whose training is far less extensive than physician training; and

Whereas, separate accreditation and certification systems for these nonphysician practitioners can create confusion and blur critical distinctions in education, clinical preparation, and qualifications; and

Whereas, the MOC monopoly and its associated burdens may therefore contribute to reduced quality of patient care, physician displacement and premature physician retirement; and

Whereas, there is an alternative MOC pathway for board certified physicians, which is the physician-led nonprofit National Board of Physicians and Surgeons (NBPAS), founded in 2015, which is 1) inexpensive 2) requires previous certification through an ABMS (American Board of Medical Specialties)/AOA (American Osteopathic Association) member board 3) requires an

active, valid, and unrestricted medical license 4) requires submission of substantial CME related to specialty 5) requires Active Hospital Privileges (for most specialties); and

Whereas, NBPAS meets national accreditation standards for hospitals and health plans, verifies physician credentials as required, and is accepted by a growing number of hospitals, health systems, telemedicine companies, and other physicians' employers; and

Whereas, two of the largest accreditors in the United States, The Joint Commission and the NCQA both officially acknowledge NBPAS as a "designated equivalent source agency" and "an acceptable source for board certification," respectively; and

Whereas, NBPAS has grown to over 11,000 physicians in all 50 states and provides physicians both competition and choice in continuing certification; therefore be it

RESOLVED, that our American Medical Association encourage all hospitals and insurance programs in the United States to end the monopoly of MOC and accept NBPAS to accomplish any MOC requirements (New HOD Policy); and be it further

RESOLVED, that our AMA request that the Accreditation Council for Graduate Medical Education (ACGME), the Liaison Committee on Medical Education (LCME), and the Commission on Osteopathic College Accreditation (COCA) accept this alternative route for MOC for all teachers of medical students and physicians in order to maintain quality and experienced instruction in residency programs and medical schools in this era of physician shortages. (Directive to Take Action)

Fiscal Note: Minimal – less than $5,000

Received: 4/13/26

RELEVANT AMA POLICY

H-275.926 Medical Specialty Board Certification Standards

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. [Res. 318, A-07 Reaffirmation A-11 Modified: CME Rep. 2, I-15 Modified: Res. 215, I-19 Modified: Res. 316, I-22 Appended and Reaffirmed: CME Rep. 04, I-23 Reaffirmed in lieu of: Res. 302, A-24]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 304
(A-26)

Introduced by: Mississippi

Subject: Increasing the Use of Retired Physicians in Teaching Students and Residents

Referred to: Reference Committee C

Whereas, in the teaching of medical students and residents, experience plays a significant role in passing on important aspects of patient care and medical treatment; and

Whereas, when physicians retire from active or full practice, they often seek ways to continue to contribute to their communities and profession; and

Whereas, the teaching of medical students and residents is a critical place where retired physicians could continue to contribute their skills and experience to a new generation of physicians and patients; and

Whereas, throughout the country, especially in rural based programs, medical schools and residency programs struggle to find qualified and experienced faculty; and

Whereas, there are often administrative hurdles and roadblocks which prevent retired physicians from fully participating in teaching programs at schools and residencies; therefore be it

RESOLVED, that our American Medical Association explore with the appropriate stakeholders creative and innovative ways to increase opportunities and decrease hurdles for retired physicians to participate fully as medical faculty at medical schools and residency training programs. (Directive to Take Action)

Fiscal Note: Minimal – less than $5,000

Received: 4/13/26

RELEVANT AMA POLICY

H-200.972 Primary Care Physicians in Underserved Areas

1. Our American Medical Association should pursue the following plan to improve the recruitment and retention of physicians in underserved areas:
    a. encourage the creation and pilot-testing of school-based, faith-based, and community-based urban/rural family health clinics, with an emphasis on health education, prevention, primary care, and prenatal care;
    b. encourage the affiliation of these family health clinics with local medical schools and teaching hospitals;
    c. advocate for the implementation of AMA policy that supports extension of the rural health clinic concept to urban areas with appropriate federal agencies;
    d. encourage the AMA Senior Physicians Section to consider the involvement of retired physicians in underserved settings, with appropriate mechanisms to ensure their competence;

e. urge hospitals and medical societies to develop opportunities for physicians to work part-time to staff health clinics that help meet the needs of underserved patient populations;
f. encourage the AMA and state medical associations to incorporate into state and federal health system reform legislative relief or immunity from professional liability for senior, part-time, or other physicians who help meet the needs of underserved patient populations and
g. urge hospitals and medical centers to seek out the use of available military health care resources and personnel, which can be used to help meet the needs of underserved patient populations.

2. Our AMA supports efforts to:
   a. expand opportunities to retain international medical graduates after the expiration of allocated periods under current law; and
   b. increase the recruitment and retention of physicians practicing in federally designated health professional shortage areas. [CMS Rep. I-93-2 Reaffirmation A-01 Reaffirmation I-03 Modified: CME Rep. 13, A-06 Reaffirmed: CMS Rep. 01, A-16 Modified: CME Rep. 04, I-18 Appended: Res. 206, I-19 Reaffirmation: I-22 Reaffirmed: BOT Rep. 11, A-23 Reaffirmed: Res. 724, A-23 Reaffirmed: BOT Rep. 07, I-24]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 305
(A-26)

Introduced by: Mississippi

Subject: Leadership by Physicians for Physicians in Graduate Medical Education (GME)

Referred to: Reference Committee C

Whereas, the Accreditation Council for Graduate Medical Education (ACGME) sets and monitors national standards for residency and fellowship programs, ensuring high-quality graduate medical education (GME) and clinical learning environments across the United States; and

Whereas, GME is a pivotal stage in physician development, shaping lifelong practice patterns, clinical judgment, and professional identity through supervised care, scholarship, and mentorship; and

Whereas, each ACGME-accredited Sponsoring Institution (SI) must designate a Designated Institutional Official (DIO) who serves as the institution's chief GME officer and is responsible for ensuring compliance with ACGME institutional and programmatic requirements; and

Whereas, the role of the DIO has expanded significantly beyond its original scope and now includes oversight of accreditation standards, resident wellness, faculty engagement, NRMP Match strategy, institutional GME policy, and direct interaction with hospital leadership; and

Whereas, unlike ACGME program director standards which require specialty board certification, clinical expertise, and years of documented education experience - the DIO position has no required baseline qualifications, protected time, or minimum FTE support explicitly defined in ACGME Institutional Requirements; and

Whereas, as of 2023, ACGME oversees more than 900 Sponsoring Institutions, and national data shows that approximately 85% of DIOs are physicians, leaving a significant minority filled by non-clinicians with no formal graduate medical education training; and

Whereas, a 2022 survey published in the Journal of Graduate Medical Education found that 92% of program directors and 88% of residents believe the DIO should be a physician with personal experience in graduate medical education, and that physician leadership is essential for institutional credibility, educational alignment, and learner protection; and

Whereas, large academic centers employ physicians as DIOs, but new and rural GME expansion sites, particularly in Mississippi are increasingly placing non-physician administrators into these roles without graduate medical education backgrounds; and

Whereas, national trends show a rising imbalance in healthcare leadership, with approximately 10 administrators per 1 physician in the United States; and

Whereas, physicians who have completed medical education and residency training are best

positioned to understand the complexity, duty, and scope of the training process, and should therefore lead, supervise, and structure medical education programs designed for physicians-in-training; therefore be it

RESOLVED, that our American Medical Association work with the ACGME to examine and strengthen minimum qualifications for Designated Institutional Officials to ensure physician leadership in the oversight of graduate medical education programs. (Directive to Take Action)

Fiscal Note: Minimal – less than $5,000

Received: 4/13/26

RELEVANT AMA POLICY

H-310.912 Residents and Fellows' Bill of Rights

1. Our American Medical Association continues to advocate for improvements in the ACGME Institutional and Common Program Requirements that support AMA policies as follows:
    a. Adequate financial support for and guaranteed leave to attend professional meetings.
    b. Submission of training verification information to requesting agencies within 30 days of the request.
    c. Adequate compensation with consideration to local cost-of-living factors and years of training, and to include the orientation period.
    d. Health insurance benefits to include dental and vision services.
    e. Paid leave for all purposes (family, educational, vacation, sick) to be no less than six weeks per year.
    f. Stronger due process guidelines.
2. Our AMA encourages the ACGME to ensure access to educational programs and curricula as necessary to facilitate a deeper understanding by resident physicians of the US health care system and to increase their communication skills.
3. Our AMA regularly communicates to residency and fellowship programs and other GME stakeholders this Resident/Fellows Physicians' Bill of Rights.
4. Our AMA:
    a. will promote residency and fellowship training programs to evaluate their own institution's process for repayment and develop a leaner approach. This includes disbursement of funds by direct deposit as opposed to a paper check and an online system of applying for funds.
    b. encourages a system of expedited repayment for purchases of $200 or less (or an equivalent institutional threshold), for example through payment directly from their residency and fellowship programs (in contrast to following traditional workflow for reimbursement).
    c. encourages training programs to develop a budget and strategy for planned expenses versus unplanned expenses, where planned expenses should be estimated using historical data, and should include trainee reimbursements for items such as educational materials, attendance at conferences, and entertaining applicants. Payment in advance or within one month of document submission is strongly recommended.
5. Our AMA will partner with ACGME and other relevant stakeholders to encourage training programs to reduce financial burdens on residents and fellows by providing employee benefits including, but not limited to, on-call meal allowances, transportation support, relocation stipends, and childcare services.
6. Our AMA will work with the Accreditation Council for Graduate Medical Education (ACGME) and other relevant stakeholders to amend the ACGME Common Program Requirements to allow flexibility in the specialty-specific ACGME program requirements enabling specialties to require salary reimbursement or "protected time" for resident and fellow education by "core faculty," program directors, and assistant/associate program directors.

7. Our AMA encourages teaching institutions to offer retirement plan options, retirement plan matching, financial advising and personal finance education.
8. Our AMA adopts the following "Residents and Fellows' Bill of Rights" as applicable to all resident and fellow physicians in ACGME-accredited training programs:

RESIDENT/FELLOW PHYSICIANS' BILL OF RIGHTS
Residents and fellows have a right t

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

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

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

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

E. **Adequate compensation and benefits that provide for resident well-being and health.**

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

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

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

H. **Access to and protection by institutional and accreditation authorities when reporting violations**
With regard to reporting violations to the ACGME, residents and fellows should:
    1. Be informed by their program at the beginning of their training and again at each semi-annual review of the resources and processes available within the residency program for addressing resident concerns or complaints, including the program director, Residency Training Committee, and the designated institutional official.
    2. Be able to file a formal complaint with the ACGME to address program violations of residency training requirements without fear of recrimination and with the guarantee of due process.
    3. Have the opportunity to address their concerns about the training program through confidential channels, including the ACGME concern process and/or the annual ACGME Resident Survey.

9. Our AMA will work with the ACGME and other relevant stakeholders to advocate for ways to defray additional costs related to residency and fellowship training, including essential amenities and/or high cost specialty-specific equipment required to perform clinical duties.
10. Our AMA believes that healthcare trainee salary, benefits, and overall compensation should, at minimum, reflect length of pre-training education, hours worked, and level of independence and complexity of care allowed by an individual's training program (for example when comparing physicians in training and midlevel providers at equal postgraduate training levels).
11. The Residents and Fellows' Bill of Rights will be prominently published online on the AMA website and disseminated to residency and fellowship programs.
12. Our AMA will distribute and promote the Residents and Fellows' Bill of Rights online and individually to residency and fellowship training programs and encourage changes to institutional processes that embody these principles, including resident/fellow empowerment and peer-selected representation in institutional leadership.
13. Our AMA encourages development of accreditation standards and institutional policies designed to facilitate and protect residents/fellows who seek to exercise their rights.
14. Our AMA encourages the formation of peer-led resident/fellow organizations that can advocate for trainees' interests, as outlined by the AMA's Residents and Fellows' Bill of Rights, at sponsoring institutions. [CME Rep. 8, A-11 Appended: Res. 303, A-14 Reaffirmed: Res. 915, I-15 Appended: CME Rep. 04, A-16 Modified: CME Rep. 06, I-18 Appended: Res. 324, A-19 Modified: Res. 304, A-21 Modified: Res. 305, A-21 Modified: BOT Rep. 18, I-21 Reaffirmation: A-22 Reaffirmed in lieu of: Res. 307, I-22 Modified: CME Rep. 05, I-23 Reaffirmed: CME Rep. 02, A-24 Modified: Res. 304, I-24]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 306
(A-26)

Introduced by: Women Physicians Section

Subject: Competency-Based Portfolio Assessment of Medical Students, Interns, Residents, and Fellows

Referred to: Reference Committee C

Whereas, standardized evaluations in undergraduate and graduate medical education play a central role in determining learner advancement, residency and fellowship selection, remediation, and access to professional opportunities; and

Whereas, studies have demonstrated that narrative language and rating patterns in trainee evaluations may vary systematically by gender, race, ethnicity, socioeconomic status, and personal background, independent of measured clinical competence; and

Whereas, a systematic review of nine studies found that more than half of studies reported differences in evaluation outcomes attributed to gender, including gender-based differences in assessed traits, with female residents receiving more discordant feedback than male residents, particularly regarding assertiveness and receptivity to guidance;[1] and

Whereas, a qualitative analysis of 1,317 emergency medicine PGY-3 resident evaluations demonstrated significant gender-based differences in feedback, with female residents more frequently receiving inconsistent or discordant assessments in which behaviors related to assertiveness and autonomy were more likely to be characterized as aggression or resistance to feedback;[2] and

Whereas, a large retrospective study of approximately 90,000 third-year medical students identified 37 descriptive terms applied differently by gender and 53 terms applied differently by underrepresented-in-medicine (URM) status, with women and URM students more frequently described using personality-based descriptors such as “pleasant,” “nice,” and “lovely”;[3] and

Whereas, bias affecting URM physicians in evaluations was also identified among resident physicians in a large cohort study of 9,026 residents across 305 internal medicine residency programs;[4] and

Whereas, such variation in evaluations can undermine the validity, reliability, and fairness of assessment systems and may contribute to inequities in training outcomes, leadership selection, and workforce retention; and

Whereas, bias in high-stakes evaluations disproportionately affects groups underrepresented in medicine, with negative downstream consequences for the physician workforce pipeline; and

Whereas, the AMA has long supported evidence-based medical education, equitable training environments, and assessment systems that accurately reflect physician competence in order to

promote patient safety and high-quality care, yet a policy gap remains regarding competency-based evaluation practices for interns, residents, and fellows; therefore be it

RESOLVED, that our American Medical Association amend D-295.318 "Competency-Based Portfolio Assessment of Medical Students" by addition and deletion to read as follows:

1. Our American Medical Association will work with the Association of American Medical Colleges, the American Osteopathic Association, the American Association of Colleges of Osteopathic Medicine, and the Accreditation Council for Graduate Medical Education, and other organizations to examine new and emerging approaches to medical student and trainee evaluations, including competency-based portfolio assessment; and be it further

2. Our AMA will work with the NRMP, ACGME and ~~the 11 schools in the AMA's Accelerating Change in Medical Education consortium~~ medical schools to develop pilot projects to study the impact of competency-based frameworks on student graduation, the residency and fellowship match process ~~and off-cycle entry into residency programs,~~ and transitions across the UME-GME practice continuum; including off-cycle entry pathways.

(Modify Current HOD Policy); and be it further

RESOLVED, that our AMA amend H-65.951 "Healthcare and Organizational Policies and Cultural Changes to Prevent and Address Racism, Discrimination, Bias and Microaggressions" by addition to read as follows:

Our American Medical Association recognizes that implicit biases in evaluations, including those related to gender, race, ethnicity, socioeconomic status, and/or personal background, may influence learner assessment, advancement, and professional opportunities across the medical education continuum;

Our American Medical Association adopted the following guidelines for healthcare organizations and systems, including academic medical centers, to establish policies and an organizational culture to prevent and address systemic racism, explicit and implicit bias and microaggressions in the practice of medicine:

GUIDELINES TO PREVENT AND ADDRESS SYSTEMIC RACISM, EXPLICIT BIAS AND MICROAGGRESSIONS IN THE PRACTICE OF MEDICINE

Health care organizations and systems, including academic medical centers, should establish policies to prevent and address discrimination including systemic racism, explicit and **implicit bias** and microaggressions in their workplaces.

An effective healthcare anti-discrimination policy should:

- Clearly define discrimination, systemic racism, explicit and **implicit bias** and microaggressions in the healthcare setting.
- Ensure the policy is prominently displayed and easily accessible.
- Describe the management's commitment to providing a safe and healthy environment that actively seeks to prevent and address systemic racism, explicit and **implicit bias** and microaggressions.
- Establish training requirements for systemic racism, explicit and **implicit bias**, and microaggressions for all members of the healthcare system.

- Prioritize safety in both reporting and corrective actions as they relate to discrimination, systemic racism, explicit and **implicit bias** and microaggressions.
- Create anti-discrimination policies that:
- Specify to whom the policy applies (i.e., medical staff, students, trainees, administration, patients, employees, contractors, vendors, etc.).
- Define expected and prohibited behavior.
- Outline steps for individuals to take when they feel they have experienced discrimination, including racism, explicit and **implicit bias** and microaggressions.
- Ensure privacy and confidentiality to the reporter.
- Provide a confidential method for documenting and reporting incidents.
- Outline policies and procedures for investigating and addressing complaints and determining necessary interventions or action.

These policies should include:

- Taking every complaint seriously.
- Acting upon every complaint immediately.
- Developing appropriate resources to resolve complaints.
- Creating a procedure to ensure a healthy work environment is maintained for complainants and prohibit and penalize retaliation for reporting.
- Communicating decisions and actions taken by the organization following a complaint to all affected parties.
- Document training requirements to all the members of the healthcare system and establish clear expectations about the training objectives.

In addition to formal policies, organizations should promote a culture in which discrimination, including systemic racism, explicit and **implicit bias** and microaggressions are mitigated and prevented. Organized medical staff leaders should work with all stakeholders to ensure safe, discrimination-free work environments within their institutions.

Tactics to help create this type of organizational culture include:

- Surveying staff, trainees and medical students, anonymously and confidentially to assess:
- Perceptions of the workplace culture and prevalence of discrimination, systemic racism, explicit and **implicit bias** and microaggressions.
- Ideas about the impact of this behavior on themselves and patients.
- Integrating lessons learned from surveys into programs and policies.
- Encouraging safe, open discussions for staff and students to talk freely about problems and/or encounters with behavior that may constitute discrimination, including racism, **bias** or microaggressions.
- Establishing programs for staff, faculty, trainees and students, such as Employee Assistance Programs, Faculty Assistance Programs, and Student Assistance Programs, that provide a place to confidentially address personal experiences of discrimination, systemic racism, explicit or **implicit bias** or microaggressions.
- Providing designated support person to confidentially accompany the person reporting an event through the process.

(Modify Current HOD Policy)

Fiscal Note: Minimal – less than $5,000

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RELEVANT AMA POLICY

D-295.318 Competency-Based Portfolio Assessment of Medical Students

1. Our American Medical Association will work with the Association of American Medical Colleges, the American Osteopathic Association and the Accreditation Council for Graduate Medical Education, and other organizations to examine new and emerging approaches to medical student evaluation, including competency-based portfolio assessment.
2. Our AMA will work with the NRMP, ACGME and the 11 schools in the AMA's Accelerating Change in Medical Education consortium to develop pilot projects to study the impact of competency-based frameworks on student graduation, the residency match process and off-cycle entry into residency programs.
   [Res. 314, A-10; Appended: Res. 311, A-14; Reaffirmed: CME Rep. 04, A-23]

H-65.961 Principles for Advancing Gender Equity in Medicine

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

Our AMA encourages: (1) state and specialty societies, academic medical centers, medical schools, hospitals, group practices and other physician employers to adopt the AMA Principles for Advancing Gender Equity in Medicine; and (2) academic medical centers, medical schools, hospitals, group practices and other physician employers to: (a) adopt policies that prohibit harassment, discrimination and retaliation; (b) provide anti-harassment training; and (c) prescribe disciplinary and/or corrective action should violation of such policies occur.
[BOT Rep. 27, A-19; Reaffirmed: Res. 604, I-24; Reaffirmed: Res. 606, I-24]

AMERICAN MEDICAL ASSOCIATION ACADEMIC PHYSICIANS SECTION

Resolution: 307
(A-26)

Introduced by: Academic Physicians Section

Subject: Recognizing Advocacy as a Component of Faculty Appointment and Promotion in Academic Medicine

Referred to: Reference Committee C

Whereas, academic medicine has traditionally evaluated faculty for appointment, promotion, and tenure based on clinical excellence, teaching, scholarly activity, and service to institutions and professional organizations; and

Whereas, physician advocacy—including engagement in health policy, community partnerships, public health initiatives, and systems-level improvement—is increasingly recognized as essential to advancing patient care, health equity, and population health; and

Whereas, many medical school promotion and tenure guidelines do not explicitly recognize advocacy activities as a distinct and valued form of academic service, resulting in such efforts being pursued primarily through individual motivation rather than institutional support; and

Whereas, the absence of formal recognition for advocacy work may discourage faculty engagement, contribute to professional dissatisfaction, and undermine the broader mission of academic medicine; and

Whereas, emerging literature supports the importance of building faculty capacity for advocacy and aligning institutional structures to recognize and support these efforts as legitimate academic contributions; therefore be it

RESOLVED, that our American Medical Association reaffirm AMA Policy G-615.103, Improving Medical Student, Resident/Fellow and Academic Physician Engagement in Organized Medicine and Legislative Advocacy (Reaffirm HOD Policy); and be it further

RESOLVED, that our AMA encourage medical education institutions and academic medical centers to recognize physician advocacy activities as a component of faculty appointment, promotion, and tenure criteria (New HOD Policy); and be it further

RESOLVED, that our AMA collaborate with relevant organizations representing medical school leadership, to promote best practices for incorporating advocacy efforts into protected non-clinical faculty effort and academic productivity models. (Directive to Take Action)

Fiscal Note: Minimal – less than $5,000

Received: 4/15/26

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RELEVANT AMA POLICY

Increasing Education on Physician-Led Care and Advocacy in Residency Training H-310.898

1. Our AMA will develop, provide, expand upon, and promote the educational resources in the AMA GME Competency Education Program, as well as toolkits and workshops that residency programs can implement to teach residents about physician-led care, advocacy strategies, and how to effectively engage with health care policymakers and organizations.
2. Our AMA encourages residency programs to promote opportunities for residents and trainees to engage in real-world advocacy efforts at the local, state, and national levels, in collaboration with state societies and other medical organizations. [Res. 309, A-25]

Improving Medical Student, Resident/Fellow and Academic Physician Engagement in Organized Medicine and Legislative Advocacy G-615.103

1. Our American Medical Association will study the participation of academic and teaching physicians, residents, fellows, and medical students in organized medicine and legislative advocacy.
2. Our AMA will study the participation of community-based faculty members of medical schools and graduate medical education programs in organized medicine and legislative advocacy.
3. Our AMA will identify successful, innovative and best practices to engage academic physicians (including community-based physicians), residents/fellows, and medical students in organized medicine and legislative advocacy.
4. Our AMA will study mechanisms to mitigate costs incurred by medical students, residents and fellows who participate at national, in person AMA conferences. [Res. 608, A-17; Appended: Res. 617, A-22]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 308
(A-26)

Introduced by: LGBTQ+ Section

Subject: Impact of Federal and State Restrictive Actions on Gender-Affirming Care on Medical Education and Physician Workforce Development

Referred to: Reference Committee C

Whereas, gender-affirming care (GAC) is recognized as evidence-based medical care by major professional medical organizations, including the American Medical Association[1–11]; and

Whereas, A growing number of states have enacted or proposed legislation restricting or prohibiting the provision of gender-affirming care to minors, and in some cases limiting training in or exposure to such care[12–16]; and

Whereas, recent federal actions, including executive orders, agency directives, regulatory proposals, or funding conditions, have sought to restrict access to or federal support for gender-affirming care, potentially affecting academic medical centers, federally funded training programs, and research institutions[17–20]; and

Whereas, medical education programs, including undergraduate medical education (UME), graduate medical education (GME), and continuing medical education (CME), are expected to provide comprehensive, evidence-based training across the spectrum of patient populations; and

Whereas, restrictions on the provision of gender-affirming care may limit clinical training opportunities for learners in affected states, potentially resulting in variability in competency, preparedness, and accreditation compliance[21–26]; and

Whereas, limitations on clinical exposure may affect recruitment and retention of medical students, residents, fellows, and faculty in states with restrictions on gender-affirming care[27–30]; and

Whereas, disruptions to training in gender-affirming care may have downstream effects on the physician workforce's ability to provide comprehensive care to transgender and gender-diverse patients nationally, which aligns with AMA priorities regarding physician workforce development and preservation; therefore be it

RESOLVED, that our American Medical Association study the impact of federal and state restrictive actions on gender-affirming care on undergraduate medical education (UME), graduate medical education (GME), and continuing medical education (CME), including effects on: (1) clinical training opportunities, (2) accreditation standards and compliance, (3) federal funding streams for medical education and research, (4) faculty recruitment and retention, (5) trainee recruitment, retention, and geographic distribution, (6) academic freedom and curricular integrity, and (7) physician workforce preparedness to provide comprehensive, evidence-based care (Directive to Take Action); and be it further

RESOLVED, that our AMA assess the implications of federal executive actions, agency guidance, regulatory changes, and funding conditions on academic medical centers and training programs that provide or teach gender-affirming care. (Directive to Take Action)

Fiscal Note: Minimal – less than $5,000

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RELEVANT AMA POLICY

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

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

Medical Spectrum of Gender D-295.312

Given the medical spectrum of gender identity and sex, our AMA: (1) will work with appropriate medical organizations and community based organizations to inform and educate the medical community and the public on the medical spectrum of gender identity; (2) will educate state and federal policymakers and legislators on and advocate for policies addressing the medical spectrum of gender identity to ensure access to quality health care; and (3) affirms that an individual's genotypic sex, phenotypic sex, sexual orientation, gender and gender identity are not always aligned or indicative of the other, and that gender for many individuals may differ from the sex assigned at birth.

Eliminating Health Disparities - Promoting Awareness and Education of Sexual Orientation and Gender Identity Health Issues in Medical Education H-295.878

Our AMA: (1) supports the right of medical students and residents to form groups and meet on-site to further their medical education or enhance patient care without regard to their gender, gender identity, sexual orientation, race, religion, disability, ethnic origin, national origin or age; (2) supports students and residents who wish to conduct on-site educational seminars and workshops on health issues related to sexual orientation and gender identity; and (3) encourages medical education accreditation bodies to both continue to encourage and periodically reassess education on health issues related to sexual orientation and gender identity in the basic science, clinical care, and cultural competency curricula in undergraduate and graduate medical education.

Increasing Access to Gender-Affirming Care Through Expanded Training and Equitable Coverage H-295.847
Our American Medical Association will advocate for expanded structured training for gender-affirming procedures by working with relevant stakeholders including but not limited to the Accreditation Council for Graduate Medical Education.

Health Care Needs of Lesbian, Gay, Bisexual, Transgender and Queer Populations H-160.991

1. Our AMA: (a) believes that the physician's nonjudgmental recognition of patients' sexual orientations, sexual behaviors, and gender identities enhances the ability to render optimal patient care in health as well as in illness. In the case of lesbian, gay, bisexual, transgender, queer/questioning, and other (LGBTQ) patients, this recognition is especially important to address the specific health care needs of people who are or may be LGBTQ; (b) is committed to taking a leadership role in: (i) educating physicians on the current state of research in and knowledge of LGBTQ Health and the need to elicit relevant gender and sexuality information from our patients; these efforts should start in medical school, but must also be a part of continuing medical education; (ii) educating physicians to recognize the physical and psychological needs of LGBTQ patients; (iii) encouraging the development of educational programs in LGBTQ Health; (iv) encouraging physicians to seek out local or national experts in the health care needs of LGBTQ people so that all physicians will achieve a better understanding of the medical needs of these populations; and (v) working with LGBTQ communities to offer physicians the opportunity to better understand the medical needs of LGBTQ patients; and (c) opposes, the use of "reparative" or "conversion" therapy for sexual orientation or gender identity.
2. Our AMA will collaborate with our partner organizations to educate physicians regarding: (i) the need for sexual and gender minority individuals to undergo regular cancer and sexually transmitted infection screenings based on anatomy due to their comparable or elevated risk for these conditions; and (ii) the need for comprehensive screening for sexually transmitted diseases in men who have sex with men; (iii) appropriate safe sex techniques to avoid the risk for sexually transmitted diseases; and (iv) that individuals who identify as a sexual and/or gender minority (lesbian, gay, bisexual, transgender, queer/questioning individuals) experience intimate partner violence, and how sexual and gender minorities present with intimate partner violence differs from their cisgender, heterosexual peers and may have unique complicating factors.
3. Our AMA will continue to work alongside our partner organizations, including GLMA, to increase physician competency on LGBTQ health issues.
4. Our AMA will continue to explore opportunities to collaborate with other organizations, focusing on issues of mutual concern in order to provide the most comprehensive and up-to-date education and information to enable the provision of high quality and culturally competent care to LGBTQ people.
5. Our AMA supports preservation and maintenance of federal and state public funding for physicians and institutions engaged in clinical care, research, and medical education regarding LGBTQ+ populations.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 309
(A-26)

Introduced by: American Association of Neurological Surgeons, Congress of Neurological Surgeons

Subject: Osteoporosis Education, Awareness, and Musculoskeletal Health Optimization

Referred to: Reference Committee C

Whereas, osteoporosis affects approximately 10 million Americans and contributes to over 2 million fragility fractures annually, resulting in substantial morbidity, mortality, disability, and health care expenditures; and

Whereas, osteoporosis and low bone mineral density are increasingly recognized as important contributors to frailty, impaired mobility, and surgical risk, particularly in spine surgery and other musculoskeletal procedures; and

Whereas, emerging evidence suggests bone health optimization may influence surgical outcomes, hardware stability, fracture risk, rehabilitation potential, and long-term functional outcomes; and

Whereas, current osteoporosis screening recommendations are primarily population-based and may not fully address the needs of patients at elevated risk for musculoskeletal deterioration, spinal deformity progression, or those being considered for complex spine surgery; and

Whereas**,** osteoporosis frequently coexists with sarcopenia and other age-related conditions that collectively contribute to frailty and loss of independence; and

Whereas**,** the American Medical Association House of Delegates has previously recognized the importance of musculoskeletal health through educational and awareness efforts related to sarcopenia and healthy aging; and

Whereas**,** opportunities may exist to further enhance physician and patient awareness regarding osteoporosis prevention, identification, and optimization strategies across specialties including primary care, endocrinology, geriatrics, orthopedics, neurosurgery, and rehabilitation medicine; and

Whereas, the AMA is well positioned to support physician education, interdisciplinary collaboration, and public health awareness efforts even though it does not establish clinical practice guidelines; and

Whereas, increasing awareness of bone health optimization strategies including nutrition, resistance exercise, fall prevention, and appropriate medical management may improve patient outcomes and reduce long-term health care costs; therefore be it

RESOLVED, that our American Medical Association study opportunities to enhance physician education regarding osteoporosis as a component of musculoskeletal health, frailty prevention, and surgical risk optimization (Directive to Take Action); and be it further

RESOLVED, that our AMA encourage development or promotion of continuing medical education (CME), educational resources, or multidisciplinary programming highlighting the relevance of bone health to mobility preservation, healthy aging, and surgical outcomes (New HOD Policy); and be it further

RESOLVED, that our AMA support efforts to increase patient and physician awareness of evidence-based preventive strategies for osteoporosis including physical activity, nutrition, fall prevention, and appropriate screening consistent with existing recommendations (New HOD Policy); and be it further

RESOLVED, that our AMA encourage research examining the relationship between bone health and outcomes such as frailty, disability, surgical recovery, and health care utilization (New HOD Policy); and be it further

RESOLVED, that our AMA encourage physician education regarding the role of bone health optimization as part of comprehensive strategies to preserve mobility, reduce disability, and improve functional outcomes in aging populations (New HOD Policy); and be it further

RESOLVED, that our AMA advocate for insurance coverage of evidence-based osteoporosis screening tests and osteoporosis therapies (Directive to Take Action); and be it further

RESOLVED, that our AMA encourage physician awareness that clinical decision-making regarding osteoporosis screening and treatment may appropriately incorporate individualized risk assessment, including consideration of patients at elevated risk for musculoskeletal deterioration or those being considered for complex spine surgery, consistent with clinical judgment and existing evidence. (New HOD Policy)

Fiscal Note: Modest – between $5,000 - $10,000

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RELEVANT AMA POLICY

H-25.988 Community-Based Falls Prevention Programs
Our American Medical Association will work with relevant organizations to support community-based falls prevention programs [Res. 408, A-15Reaffirmed: CSAPH Rep. 01, A-25]

H-425.997 Preventive Services
1. Our AMA encourages the development of policies and mechanisms to assure the continuity, coordination and continuous availability of patient care, including professional preventive care and early-detection screening services, provided the services are cost effective.
2. It is the policy of the AMA that any preventive service that is being considered for inclusion in public or private sector insurance products have evidence-based data to demonstrate improved outcomes or quality of life and the cost effectiveness of the service.
3. Our AMA believes that preventive care should ideally be coordinated by a patient's physician [OT Rep. A, NCCMC Rec. 31, A-78Reaffirmed: CLRPD Rep. C, A-89Reaffirmed: Sunset Report and Reaffirmed and Appended: CMS Rep. 7, A-00, Reaffirmed in lieu of Res. 104, A-06Reaffirmation A-07Modified and Reaffirmed: Sub. Res. 101, A-08Reaffirmed: CMS Rep. 03, I-16Reaffirmed: CMS Rep. 03, I-17]

H-425.994 Medical Evaluations of Healthy Persons
The AMA supports the following principles of healthful living and proper medical care: (1) The periodic evaluation of healthy individuals is important for the early detection of disease and for the recognition and correction of certain risk factors that may presage disease. (2) The optimal frequency of the periodic evaluation and the procedures to be performed vary with the patient's age, socioeconomic status, heredity, and other individual factors. Nevertheless, the evaluation of a healthy person by a physician can serve as a convenient reference point for preventive services and for counseling about healthful living and known risk factors. (3) These recommendations should be modified as appropriate in terms of each person's age, sex, occupation and other characteristics. All recommendations are subject to modification, depending upon factors such as the sensitivity and specificity of available tests and the prevalence of the diseases being sought in the particular population group from which the person comes. (4) The testing of individuals and of population groups should be pursued only when adequate treatment and follow-up can be arranged for the abnormal conditions and risk factors that are identified. (5) Physicians need to improve their skills in fostering patients' good health, and in dealing with long recognized problems such as hypertension, obesity, anxiety and depression, to which could be added the excessive use of alcohol, tobacco and drugs. (6) Continued investigation is required to determine the usefulness of test procedures that may be of value in detecting disease among asymptomatic populations. [CSA Rep. D, A-82Reaffirmed: CLRPD Rep. A, I-92Reaffirmed: CSA Rep. 8, A-03Reaffirmed: CSAPH Rep. 1, A-13Reaffirmed: CMS Rep. 03, I-17]

D-25.997 Addressing Sarcopenia and its Impact on Quality of Life
1. Our American Medical Association supports educational awareness targeting healthcare professionals, caregivers, and at-risk populations to increase knowledge about sarcopenia, its risk factors and consequences, in order to facilitate prevention, early recognition and evidence-based management as a routine part of clinical practice.
2. Our AMA supports nutritional interventions aimed at optimizing protein intake, essential amino acids, and micronutrients.
3. Our AMA promotes regular physical activity, including resistance training, aerobic exercise, and balance exercises, tailored to individual capabilities and preferences.
4. Our AMA supports allocation of resources for research initiatives aimed at advancing our understanding of sarcopenia, its pathophysiology, risk factors, and treatment modalities.
5. Our AMA advocates for policy changes to support reimbursement for sarcopenia screening, diagnosis, and interventions.
6. Our AMA will collaborate with all stakeholders to integrate sarcopenia prevention and management into public health agendas and aging-related initiatives. [Res. 509, A-24]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 310
(A-26)

Introduced by: California, ACOG, Hawaii, Idaho, Oregon, Washington

Subject: Increasing Capacity and Access to Maternal Health Services in Rural Areas

Referred to: Reference Committee C

Whereas, rural communities already suffering from physician shortages, hospitals closures, less health insurance coverage, and thus, higher rates of chronic disease and age-adjusted mortality are at even greater risk with the significant $1 trillion in Medicaid and Affordable Care Act (ACA) funding cuts (CBO) recently imposed by Congress through the passage of HR 1; and

Whereas, to mitigate some of these cuts, Congress enacted the Rural Health Transformation Program that provides $50 billion to states to address rural health care challenges; and

Whereas, given that more than half of rural adults and children are either on Medicaid, the ACA or uninsured, and up to 14 million Medicaid and ACA enrollees could lose coverage nationwide under HR 1 (CBO), the need for AMA to provide leadership and assistance to rural physicians and communities is even greater; and

Whereas, while the AMA has extensive policy on improving rural health provider shortages, infrastructure, health care disparities, and access to care, this resolution includes additional specific policies that are warranted to augment AMA's rural health advocacy; and

Whereas, counties that lack maternity care resources, have no hospitals or birth centers offering obstetric care, or have no obstetric providers, are called maternity care deserts, or "OB deserts"; more than half of current rural hospitals in the United States lack a maternity ward and according to the Center for Healthcare Quality and Payment Reform (CHQPR), more than 700 rural hospitals in 2025 were at risk of closure due to financial problems; and

Whereas, hospital administrators cite a number of reasons for the closures, including high costs, labor shortages, low public and private reimbursement, and declining birth rates. Labor and delivery units are one of the most expensive departments for hospitals to maintain, second only to emergency departments; and

Whereas, a study by the American Journal of Public Health that looked at adverse maternal outcomes in rural and urban areas across the country found that pregnant individuals residing in rural areas experienced slightly increased rates of Intensive Care Unit admissions and maternal mortality rates almost twice the rate of individuals in urban areas; and

Whereas, even states with high numbers of OB-GYNs have a geographic maldistribution within states. One opportunity to expand the number of physicians providing maternity care in rural areas is to increase the number of family physicians who provide obstetric care as part of their family practice. Family physicians may complete a Family Practice Obstetrics fellowship and other requirements to become board certified in Family Medicine Obstetrics; and

Whereas, there is a need to creatively engage in efforts to ensure that pregnant patients in rural regions have access to the care necessary to ensure healthy outcomes for both baby and mother; therefore be it

RESOLVED, that our American Medical Association continue to address the nation's obstetrics and gynecology training and workforce needs, by evaluating additional ways to increase physicians providing OB-GYN services in shortage areas, including but not limited to increasing postgraduate positions in OB-GYN and family medicine OB fellowships, and increasing ACGME funding, (Directive to Take Action); and be it further

RESOLVED, that our AMA support board certification programs that offer family medicine physician training in obstetric care to expand access to maternal health care services in rural areas (New HOD Policy); and be it further

RESOLVED, that our AMA support expansion of Family Medicine obstetrical care provided by family physicians who are trained and privileged to deliver such services (New HOD Policy); and be it further

RESOLVED, that our AMA support increased funding and prioritization within the National Health Service Corps Rural Community Loan Repayment Program for OB-GYN and family medicine physicians providing obstetric care working in Maternity Care Target Areas (MCTAs). (New HOD Policy)

Fiscal Note: Minimal – less than $5,000

Received: 4/15/26

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RELEVANT AMA POLICY

H-420.946 Advancing Evidence-Based Strategies to Improve Rural Obstetrical Health Care and Access
8. Our American Medical Association strongly supports federal legislation that provides funding for the creation and implementation of a national obstetric emergency training program for rural health care facilities with and without a dedicated labor and delivery unit.
9. Our AMA supports the expansion and implementation of innovative obstetric telementoring/teleconsultation models to address perinatal health disparities and improve access to evidence-informed perinatal care in rural communities.
10. Our AMA encourages academic medical centers and health systems to actively participate in obstetric telementoring/teleconsultation models to support rural physicians and nonphysician practitioners who provide obstetric care as part of a physician-led team and improve perinatal health outcomes in rural communities.
11. Our AMA supports ongoing research to evaluate the effectiveness of national implementation of obstetric telementoring/teleconsultation models to improve rural perinatal health outcomes and reduce rural-urban health disparities.

H-200.954 U.S. Physician Shortages
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.
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.

H-465.988 Educational Strategies for Meetings Rural Health Physician Shortages
1. In light of the data available from the current literature as well as ongoing studies being conducted by staff, our American Medical Association recommends that:
a. Our AMA encourage medical schools and residency programs to develop educationally sound rural clinical preceptorships and rotations consistent with educational and training requirements, and to provide early and continuing exposure to those programs for medical students and residents.
b. Our AMA encourage medical schools to develop educationally sound primary care residencies in smaller communities with the goal of educating and recruiting more rural physicians.
c. Our AMA encourage state and county medical societies to support state legislative efforts toward developing scholarship and loan programs for future rural physicians.
d. Our AMA encourage state and county medical societies and local medical schools to develop outreach and recruitment programs in rural counties to attract promising high school and college students to medicine and the other health professions.
e. Our AMA urge continued federal and state legislative support for funding of Area Health Education Centers (AHECs) for rural and other underserved areas.
f. Our AMA continue to support full appropriation for the National Health Service Corps Scholarship Program, with the proviso that medical schools serving states with large rural underserved populations have a priority and significant voice in the selection of recipients for those scholarships.
g. Our AMA support full funding of the new federal National Health Service Corps loan repayment program.
h. Our AMA encourage continued legislative support of the research studies being conducted by the Rural Health Research Centers funded by the National Office of Rural Health in the Department of Health and Human Services.
i. Our AMA continue its research investigation into the impact of educational programs on the supply of rural physicians.
j. Our AMA continue to conduct research and monitor other progress in development of educational strategies for alleviating rural physician shortages.
k. Our AMA reaffirm its support for legislation making interest payments on student debt tax deductible.
l. Our AMA encourage state and county medical societies to develop programs to enhance work opportunities and social support systems for spouses of rural practitioners.
2. Our AMA will work with state and specialty societies, medical schools, teaching hospitals, the Accreditation Council for Graduate Medical Education (ACGME), the Centers for Medicare and Medicaid Services (CMS) and other interested stakeholders to identify, encourage and incentivize qualified rural physicians to serve as preceptors and volunteer faculty for rural rotations in residency.
3. Our AMA will:
m. work with interested stakeholders to identify strategies to increase residency training opportunities in rural areas with a report back to the House of Delegates; and
n. work with interested stakeholders to formulate an actionable plan of advocacy with the goal of increasing residency training in rural areas.

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

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 311
(A-26)

Introduced by: Senior Physicians Section

Subject: Changing the Paradigm of Medical Student Debt to address the Geriatric Physician Shortfall

Referred to: Reference Committee C

Whereas, rising medical student debt, averaging $212,000 and often over $300,000, places an undue burden financially disproportionately limiting access for medical students unable to assume this debt and thereby which influences specialty choice away from critical fields like geriatrics, pediatrics, internal medicine, and family medicine[1,2]; and

Whereas, a diverse physician workforce representative of society is essential, yet current debt burden hinders young physicians from considering and pursuing lower paying specialties because they are required to pay back large amounts of debt upon graduation; and

Whereas, the U.S. must begin looking at having an essential number of doctors to care for aging patients; and

Whereas, as the U.S. population of older adults rapidly increases with the aging of the baby boomer generation, it is crucial for the nation to swiftly tackle the shortage of physicians needed to provide care for this group; and

Whereas, recent studies show that three-year medical school programs immediately reduce student debt by 25% without compromising resident quality[3,4,5,6,7]; and

Whereas, only a few medical schools currently offer three-year programs, limiting the number of lower income students who can reasonably be expected to apply; and

Whereas, the One Big Beautiful Bill Act (OBBBA), will begin capping federal student loans for medical and professional students at $50,000 per year beginning in July 2026, with a maximum lifetime aggregate limit of $200,000; therefore be it

RESOLVED, that our American Medical Association (AMA) develop a platform supporting a 3-year medical school curriculum in order to help reduce medical student debt and reduce the coming physician shortage (Directive to Take Action); and be it further

RESOLVED, that our AMA, in order to advance equity in the medical profession, work to ensure all specialties—especially primary care—can compete fairly, reduce the looming physician shortage especially those providing care to older patients (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate that the AAMC and Liaison Committee on Medical Education (LCME) begin steps to ensure that all medical schools offer a 3-year program by 2030 to help reduce student debt. (Directive to Take Action)

Fiscal Note: Minimal – less than $5,000

Received: 4/16/26

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RELEVANT AMA POLICY

H-200.949 Principles of and Actions to Address Primary Care Workforce
1. Our patients require a sufficient, well-trained supply of primary care physicians--family physicians, general internists, general pediatricians, and obstetricians/gynecologists--to meet the nation's current and projected demand for health care services.
2. To help accomplish this critical goal, our American Medical Association (AMA) will work with a variety of key stakeholders, to include federal and state legislators and regulatory bodies; national and state specialty societies and medical associations, including those representing primary care fields; and accreditation, certification, licensing, and regulatory bodies from across the continuum of medical education (undergraduate, graduate, and continuing medical education).
3. Through its work with these stakeholders, our AMA will encourage development and dissemination of innovative models to recruit medical students interested in primary care, train primary care physicians, and enhance both the perception and the reality of primary care practice, to encompass the following components: a) Changes to medical school admissions and recruitment of medical students to primary care specialties, including counseling of medical students as they develop their career plans; b) Curriculum changes throughout the medical education continuum; c) Expanded financial aid and debt relief options; d) Financial and logistical support for primary care practice, including adequate reimbursement, and enhancements to the practice environment to ensure professional satisfaction and practice sustainability; and e) Support for research and advocacy related to primary care.
4. Admissions and recruitment: The medical school admissions process should reflect the specific institution's mission. Those schools with missions that include primary care should consider those predictor variables among applicants that are associated with choice of these specialties.
5. Medical schools, through continued and expanded recruitment and outreach activities into secondary schools, colleges, and universities, should develop and increase the pool of applicants likely to practice primary care by seeking out those students whose profiles indicate a likelihood of practicing in primary care and underserved areas, while establishing strict guidelines to preclude discrimination.
6. Career counseling and exposure to primary care: Medical schools should provide to students career counseling related to the choice of a primary care specialty, and ensure that primary care physicians are well-represented as teachers, mentors, and role models to future physicians.
7. Financial assistance programs should be created to provide students with primary care experiences in ambulatory settings, especially in underserved areas. These could include funded preceptorships or summer work/study opportunities.

8. Curriculum: Voluntary efforts to develop and expand both undergraduate and graduate medical education programs to educate primary care physicians in increasing numbers should be continued. The establishment of appropriate administrative units for all primary care specialties should be encouraged.
9. Medical schools with an explicit commitment to primary care should structure the curriculum to support this objective. At the same time, all medical schools should be encouraged to continue to change their curriculum to put more emphasis on primary care.
10. All four years of the curriculum in every medical school should provide primary care experiences for all students, to feature increasing levels of student responsibility and use of ambulatory and community-based settings.
11. Federal funding, without coercive terms, should be available to institutions needing financial support to expand resources for both undergraduate and graduate medical education programs designed to increase the number of primary care physicians. Our AMA will advocate for public (federal and state) and private payers to a) develop enhanced funding and related incentives from all sources to provide education for medical students and resident/fellow physicians, respectively, in progressive, community-based models of integrated care focused on quality and outcomes (such as the patient-centered medical home and the chronic care model) to enhance primary care as a career choice; b) fund and foster innovative pilot programs that change the current approaches to primary care in undergraduate and graduate medical education, especially in urban and rural underserved areas; and c) evaluate these efforts for their effectiveness in increasing the number of students choosing primary care careers and helping facilitate the elimination of geographic, racial, and other health care disparities.
12. Medical schools and teaching hospitals in underserved areas should promote medical student and resident/fellow physician rotations through local family health clinics for the underserved, with financial assistance to the clinics to compensate their teaching efforts.
13. The curriculum in primary care residency programs and training sites should be consistent with the objective of training generalist physicians. Our AMA will encourage the Accreditation Council for Graduate Medical Education to (a) support primary care residency programs, including community hospital-based programs, and (b) develop an accreditation environment and novel pathways that promote innovations in graduate medical education, using progressive, community-based models of integrated care focused on quality and outcomes (such as the patient-centered medical home and the chronic care model).
14. The visibility of primary care faculty members should be enhanced within the medical school, and positive attitudes toward primary care among all faculty members should be encouraged.
15. Support for practicing primary care physicians: Administrative support mechanisms should be developed to assist primary care physicians in the logistics of their practices, along with enhanced efforts to reduce administrative activities unrelated to patient care, to help ensure professional satisfaction and practice sustainability.
16. There should be increased financial incentives for physicians practicing primary care, especially those in rural and urban underserved areas, to include scholarship or loan repayment programs, relief of professional liability burdens, and Medicaid case management programs, among others. Our AMA will advocate to state and federal legislative and regulatory bodies, among others, for development of public and/or private incentive programs, and expansion and increased funding for existing programs, to further encourage practice in underserved areas and decrease the debt load of primary care physicians. The imposition of specific outcome targets should be resisted, especially in the absence of additional support to the schools.
17. Our AMA will continue to advocate, in collaboration with relevant specialty societies, for the recommendations from the AMA/Specialty Society RVS Update Committee (RUC) related to reimbursement for E&M services and coverage of services related to care coordination, including patient education, counseling, team meetings and other functions; and work to ensure that private payers fully recognize the value of E&M services, incorporating the RUC-recommended increases adopted for the most current Medicare RBRVS.
18. Our AMA will advocate for public (federal and state) and private payers to develop physician reimbursement systems to promote primary care and specialty practices in progressive, community-based models of integrated care focused on quality and outcomes such as the patient-centered medical home and the chronic care model consistent with current AMA Policies H-160.918 and H-160.919.

19. There should be educational support systems for primary care physicians, especially those practicing in underserved areas.
20. Our AMA will urge urban hospitals, medical centers, state medical associations, and specialty societies to consider the expanded use of mobile health care capabilities.
21. Our AMA will encourage the Centers for Medicare & Medicaid Services to explore the use of telemedicine to improve access to and support for urban primary care practices in underserved settings.
22. Accredited continuing medical education providers should promote and establish continuing medical education courses in performing, prescribing, interpreting and reinforcing primary care services.
23. Practicing physicians in other specialties--particularly those practicing in underserved urban or rural areas--should be provided the opportunity to gain specific primary care competencies through short-term preceptorships or postgraduate fellowships offered by departments of family medicine, internal medicine, pediatrics, etc., at medical schools or teaching hospitals. In addition, part-time training should be encouraged, to allow physicians in these programs to practice concurrently, and further research into these concepts should be encouraged.
24. Our AMA supports continued funding of Public Health Service Act, Title VII, Section 747, and encourages advocacy in this regard by AMA members and the public.
25. Research: Analysis of state and federal financial assistance programs should be undertaken, to determine if these programs are having the desired workforce effects, particularly for students from disadvantaged groups and those that are underrepresented in medicine, and to gauge the impact of these programs on elimination of geographic, racial, and other health care disparities. Additional research should identify the factors that deter students and physicians from choosing and remaining in primary care disciplines. Further, our AMA should continue to monitor trends in the choice of a primary care specialty and the availability of primary care graduate medical education positions. The results of these and related research endeavors should support and further refine AMA policy to enhance primary care as a career choice.
[CME Rep.04, I-18; Reaffirmed: CMS Rep. 08, A-24; Reaffirmed: Res. 237, I-25]

H-305.925 Principles of and Actions to Address Medical Education Costs and Student Debt
The costs of medical education should never be a barrier to the pursuit of a career in medicine nor to the decision to practice in a given specialty. To help address this issue, our American Medical Association (AMA) will:

1. Collaborate with members of the Federation and the medical education community, and with other interested organizations, to address the cost of medical education and medical student debt through public- and private-sector advocacy.
2. Vigorously advocate for and support expansion of and adequate funding for federal scholarship and loan repayment programs--such as those from the National Health Service Corps, Indian Health Service, Armed Forces, and Department of Veterans Affairs, and for comparable programs from states and the private sector--to promote practice in underserved areas, the military, and academic medicine or clinical research.
3. Encourage the expansion of National Institutes of Health programs that provide loan repayment in exchange for a commitment to conduct targeted research.
4. Advocate for increased funding for the National Health Service Corps Loan Repayment Program to assure adequate funding of primary care within the National Health Service Corps, as well as to permit:
    a. inclusion of all medical specialties in need, and
    b. service in clinical settings that care for the underserved but are not necessarily located in health professions shortage areas.
5. Encourage the National Health Service Corps to have repayment policies that are consistent with other federal loan forgiveness programs, thereby decreasing the amount of loans in default and increasing the number of physicians practicing in underserved areas.
6. Work to reinstate the economic hardship deferment qualification criterion known as the “20/220 pathway,” and support alternate mechanisms that better address the financial needs of trainees with educational debt.
7. Advocate for federal legislation to support the creation of student loan savings accounts that allow for pre-tax dollars to be used to pay for student loans.

8. Work with other concerned organizations to advocate for legislation and regulation that would result in favorable terms and conditions for borrowing and for loan repayment, and would permit 100% tax deductibility of interest on student loans and elimination of taxes on aid from service-based programs.
9. Encourage the creation of private-sector financial aid programs with favorable interest rates or service obligations (such as community- or institution-based loan repayment programs or state medical society loan programs).
10. Support stable funding for medical education programs to limit excessive tuition increases, and collect and disseminate information on medical school programs that cap medical education debt, including the types of debt management education that are provided.
11. Work with state medical societies to advocate for the creation of either tuition caps or, if caps are not feasible, pre-defined tuition increases, so that medical students will be aware of their tuition and fee costs for the total period of their enrollment.
12. Encourage medical schools to:
    a. study the costs and benefits associated with non-traditional instructional formats (such as online and distance learning, and combined baccalaureate/MD or DO programs) to determine if cost savings to medical schools and to medical students could be realized without jeopardizing the quality of medical education;
    b. engage in fundraising activities to increase the availability of scholarship support, with the support of the Federation, medical schools, and state and specialty medical societies, and develop or enhance financial aid opportunities for medical students, such as self-managed, low-interest loan programs;
    c. cooperate with postsecondary institutions to establish collaborative debt counseling for entering first-year medical students;
    d. allow for flexible scheduling for medical students who encounter financial difficulties that can be remedied only by employment, and consider creating opportunities for paid employment for medical students;
    e. counsel individual medical student borrowers on the status of their indebtedness and payment schedules prior to their graduation;
    f. inform students of all government loan opportunities and disclose the reasons that preferred lenders were chosen;
    g. ensure that all medical student fees are earmarked for specific and well-defined purposes, and avoid charging any overly broad and ill-defined fees, such as but not limited to professional fees;
    h. use their collective purchasing power to obtain discounts for their students on necessary medical equipment, textbooks, and other educational supplies;
    i. work to ensure stable funding, to eliminate the need for increases in tuition and fees to compensate for unanticipated decreases in other sources of revenue; mid-year and retroactive tuition increases should be opposed.
13. Support and encourage state medical societies to support further expansion of state loan repayment programs, particularly those that encompass physicians in non-primary care specialties.
14. Take an active advocacy role during reauthorization of the Higher Education Act and similar legislation, to achieve the following goals:
    a. Eliminating the single holder rule.
    b. Making the availability of loan deferment more flexible, including broadening the definition of economic hardship and expanding the period for loan deferment to include the entire length of residency and fellowship training.
    c. Retaining the option of loan forbearance for residents ineligible for loan deferment.
    d. Including, explicitly, dependent care expenses in the definition of the “cost of attendance”.
    e. Including room and board expenses in the definition of tax-exempt scholarship income.
    f. Continuing the federal Direct Loan Consolidation program, including the ability to “lock in” a fixed interest rate, and giving consideration to grace periods in renewals of federal loan programs.

g. Adding the ability to refinance Federal Consolidation Loans.
h. Eliminating the cap on the student loan interest deduction.
i. Increasing the income limits for taking the interest deduction.
j. Making permanent the education tax incentives that our AMA successfully lobbied for as part of Economic Growth and Tax Relief Reconciliation Act of 2001.
k. Ensuring that loan repayment programs do not place greater burdens upon married couples than for similarly situated couples who are cohabitating.
l. Increasing efforts to collect overdue debts from the present medical student loan programs in a manner that would not interfere with the provision of future loan funds to medical students.

15. Continue to work with state and county medical societies to advocate for adequate levels of medical school funding and to oppose legislative or regulatory provisions that would result in significant or unplanned tuition increases.
16. Continue to study medical education financing, so as to identify long-term strategies to mitigate the debt burden of medical students, and monitor the short-and long-term impact of the economic environment on the availability of institutional and external sources of financial aid for medical students, as well as on choice of specialty and practice location.
17. Collect and disseminate information on successful strategies used by medical schools to cap or reduce tuition.
18. Continue to monitor the availability of and encourage medical schools and residency/fellowship programs to:
    a. provide financial aid opportunities and financial planning/debt management counseling to medical students and resident/fellow physicians;
    b. work with key stakeholders to develop and disseminate standardized information on these topics for use by medical students, resident/fellow physicians, and young physicians; and
    c. share innovative approaches with the medical education community.
19. Seek federal legislation or rule changes that would stop Medicare and Medicaid decertification of physicians due to unpaid student loan debt. Our AMA believes that it is improper for physicians not to repay their educational loans, but assistance should be available to those physicians who are experiencing hardship in meeting their obligations.
20. Related to the Public Service Loan Forgiveness (PSLF) Program, our AMA supports increased medical student and physician participation in the program, and will:
    a. Advocate that all resident/fellow physicians have access to PSLF during their training years.
    b. Advocate against a monetary cap on PSLF and other federal loan forgiveness programs.
    c. Work with the United States Department of Education to ensure that any cap on loan forgiveness under PSLF be at least equal to the principal amount borrowed.
    d. Ask the United States Department of Education to include all terms of PSLF in the contractual obligations of the Master Promissory Note.
    e. Encourage the Accreditation Council for Graduate Medical Education (ACGME) to require residency/fellowship programs to include within the terms, conditions, and benefits of program appointment information on the employer's PSLF program qualifying status.
    f. Advocate that the profit status of a physician's training institution not be a factor for PSLF eligibility,
    g. Encourage medical school financial advisors to counsel wise borrowing by medical students, in the event that the PSLF program is eliminated or severely curtailed.
    h. Encourage medical school financial advisors to increase medical student engagement in service-based loan repayment options, and other federal and military programs, as an attractive alternative to the PSLF in terms of financial prospects as well as providing the opportunity to provide care in medically underserved areas.

i. Strongly advocate that the terms of the PSLF that existed at the time of the agreement remain unchanged for any program participant in the event of any future restrictive changes.
j. Monitor the denial rates for physician applicants to the PSLF.
k. Undertake expanded federal advocacy, in the event denial rates for physician applicants are unexpectedly high, to encourage release of information on the basis for the high denial rates, increased transparency and streamlining of program requirements, consistent and accurate communication between loan servicers and borrowers, and clear expectations regarding oversight and accountability of the loan servicers responsible for the program.
l. Work with the United States Department of Education to ensure that applicants to the PSLF and its supplemental extensions, such as Temporary Expanded Public Service Loan Forgiveness (TEPSLF), are provided with the necessary information to successfully complete the program(s) in a timely manner.
m. Work with the United States Department of Education to ensure that individuals who would otherwise qualify for PSLF and its supplemental extensions, such as TEPSLF, are not disqualified from the program(s).

21. Advocate for continued funding of programs including Income-Driven Repayment plans for the benefit of reducing medical student load burden.
22. Strongly advocate for the passage of legislation to allow medical students, residents and fellows who have education loans to qualify for interest-free deferment on their student loans while serving in a medical internship, residency, or fellowship program, as well as permitting the conversion of currently unsubsidized Stafford and Graduate Plus loans to interest free status for the duration of undergraduate and graduate medical education.
23. Continue to monitor opportunities to reduce additional expense burden upon medical students including reduced-cost or free programs for residency applications, virtual or hybrid interviews, and other cost-reduction initiatives aimed at reducing non-educational debt.
24. Encourage medical students, residents, fellows and physicians in practice to take advantage of available loan forgiveness programs and grants and scholarships that have been historically underutilized, as well as financial information and resources available through the Association of American Medical Colleges and American Association of Colleges of Osteopathic Medicine, as required by the Liaison Committee on Medical Education and Commission on Osteopathic College Accreditation, and resources available at the federal, state and local levels.
25. Support federal efforts to forgive debt incurred during medical school and other higher education by physicians and medical students, including educational and cost of attendance debt.
26. Support that residency and fellowship application services grant fee assistance to applicants who previously received fee assistance from medical school application services or are determined to have financial need through another formal mechanism.

[CME Rep. 05, I-18; Appended: Res. 953, I-18; Reaffirmation: A-19; Appended: Res. 316, A-19; Appended: Res. 226, A-21; Reaffirmed in lieu of : Res. 311, A-21; Modified: CME Rep. 4, I-21; Reaffirmation A-22; Appended: CME Rep. 02, A-23; Appended: Res. 311, A-23; Reaffirmed: Res. 314, A-24; Reaffirmed: Res. 215, I-24; Reaffirmed: BOT Rep. 07, I-24: Reaffirmed in lieu of Res. 224, A-25; Reaffirmed: Res. 308, I-25]

D-305.952 Medical Student Debt and Career Choice

1. Our American Medical Association encourages key stakeholders to collect and disseminate data on the impacts of medical education debt on career choice, especially with regard to the potentially intersecting impacts of race/ethnicity, socioeconomic status, and other key sociodemographic factors.
2. Our AMA will monitor new policies and novel approaches to influence career choice based on the key factors that affect the decision to enter a given specialty and subspecialty.

[CME Rep. 4, I-21; Reaffirmed: CME Rep. 02, A-23]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 312
(A-26)

Introduced by: American College of Legal Medicine

Subject: Advocating for Equitable Application Review in a Single Match System

Referred to: Reference Committee C

Whereas, both Doctors of Osteopathic Medicine (D.O.) and Doctors of Medicine (M.D.) are fully licensed physicians in the United States, completing rigorous, and necessary education and clinical training to practice medicine; and

Whereas, our American Medical Association (AMA) discourages discrimination against medical students, trainees and physicians based on their osteopathic or allopathic training; and

Whereas, our AMA supports equitable access to and fees associated with clinical electives for both osteopathic and allopathic medical students; and

Whereas, the Association of American Medical Colleges (AAMC) Visiting Student Learning Opportunities (VSLO) program provides tools that enable host institutions offering elective rotations to use applicant filters as a management tool that can discriminate by training institution; and

Whereas, in addition to the AAMC application service fees, host institutions can charge enormous fees for clinical rotations, with documented reports of great disparity in host institution fees for D.O. versus M.D. applicants; and

Whereas, a single, unified accreditation system for graduate medical education has been supported by our AMA and fully implemented, signifying that D.O. and M.D. graduates meet the same professional standards and compete for the same residency and fellowship positions; and

Whereas, the professional competence of a student, trainee or physician is determined by a wide array of factors, including academic performance, clinical skills, research, and interpersonal attributes; and

Whereas, the distinction between D.O. and M.D. is irrelevant to the vast majority of graduate medical education curricula and should therefore only be considered in the evaluation of an applicant if a program requires specific training in the osteopathic component (e.g., Osteopathic Manipulative Treatment or Osteopathic Neuromusculoskeletal Medicine); and

Whereas, application platforms, such as the Electronic Residency Application Service (ERAS), provide program directors with built-in software tools to apply filters that automatically screen, sort, or hide applications based on specific criteria, including the applicant's medical degree type; and

Whereas, this mechanism for easy differentiation with the filter allows for simplistic, initial screening and filtering of applicants that may inadvertently exclude highly qualified candidates by prematurely ending the review process based on a single data point; and

Whereas, reliance on the degree designation prevents institutions from conducting a comprehensive review of a candidate's full profile, thereby limiting their access to a diverse and highly qualified pool of physicians and inappropriately affects the osteopathic profession; and

Whereas, adopting equitable, competency-based selection criteria that value clinical excellence and broad professional experience over a single data point is in the best interest of all medical institutions and the patients they serve; therefore be it

RESOLVED, that our American Medical Association collaborate with its partners to advocate for and ensure the removal of filters within clinical elective application systems which differentiate between applicants' allopathic or osteopathic degree status (Directive to Take Action); and be it further

RESOLVED, that our AMA collaborate with its partners to advocate for and ensure the removal of all filters within the residency and fellowship application systems which differentiate between allopathic and osteopathic degree status (Directive to Take Action); and be it further

RESOLVED, that our AMA provide a report at A-28 on the status of filtering by degree status within clinical elective application, residency and fellowship application systems (Directive to Take Action); and be it further

RESOLVED, that our AMA reaffirm H-295.876: Equal Fees for Osteopathic and Allopathic Medical Students and H-295.848: Teaching and Assessing Osteopathic Manipulative Medicine and Osteopathic Principles and Practice. (Reaffirm HOD Policy)

Fiscal Note: Modest – between $5,000 - $10,000

Received: 4/19/26

RELEVANT AMA POLICY

H-295.876: Equal Fees for Osteopathic and Allopathic Medical Students
H-295.848: Teaching and Assessing Osteopathic Manipulative Medicine and Osteopathic Principles and Practice
D-310.977: National Resident Matching Program Reform

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 313
(A-26)

Introduced by: Medical Student Section

Subject: Evaluation of Situational Judgement Tests in Medical School Admissions

Referred to: Reference Committee C

Whereas, medical school applicants face substantial barriers, and the application process itself is becoming increasingly inaccessible to students, being both monetarily and mentally taxing[1-2, 18-19]; and

Whereas, situational judgment tests (SJT) are video- and text-based examinations that evaluate an applicant's judgment and decision-making skills, interpersonal competencies, professionalism, ethics, and empathy[3]; and

Whereas, 64 medical schools require or recommend, two common SJTs in medical school admissions[4-5]; and

Whereas, despite medical students and applicants overwhelmingly calling for greater transparency in admissions processes, medical schools rarely elaborate on how these examinations are used in admissions[6]; and

Whereas, while SJTs may play a role in a holistic admissions process, they do not replace existing, more personal methods of interpersonal evaluations, such as multiple mini-interviews[7]; and

Whereas, holistic evaluation of a candidate is impossible to successfully conduct in a timed SJT[8]; and

Whereas, there is little to no correlation between performance on SJTs and both academic success and likelihood of disciplinary action[9,10]; and

Whereas, SJT scores show significant group differences by race, ethnicity, and gender, and provide only modest predictive value beyond traditional metrics such as MCAT and GPA, raising equity concerns[11-16]; and

Whereas, the AMA itself has encouraged caution when utilizing novel online personality assessments for admission and/or selection for residency and fellowship programs[17]; therefore be it

RESOLVED, that our American Medical Association work with the Association of American Medical Colleges, the American Association of Colleges of Osteopathic Medicine, and other relevant stakeholders to evaluate the utilization of situational judgment tests, and other similar online decision-making assessments in the medical school admissions process and determine whether or not this style of examination meets the AMA's stated goal of holistic applicant review, unbiased by non-modifiable factors. (Directive to Take Action)

Fiscal Note: Modest – between $5,000 - $10,000

Received: 4/20/2026

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RELEVANT AMA POLICY

Medical Student Involvement and Validation of the Standardized Video Interview Implementation D-310.949

Our AMA: (1) will work with the Association of American Medical Colleges and its partners to advocate for medical students and residents to be recognized as equal stakeholders in any changes to the residency application process, including any future working groups related to the residency application process; (2) will advocate for delaying expansion of the Standardized Video Interview until data demonstrates the Association of American Medical Colleges' stated goal of predicting resident performance, and make timely recommendations regarding the efficacy and implications of the Standardized Video Interview as a mandatory residency application requirement; and (3) will, in collaboration with the Association of American Medical Colleges, study the potential implications and repercussions of expanding the Standardized Video Interview to all residency applicants.
Res. 960, I-17

Increasing Medical School Class Sizes D-295.938

Our AMA supports increasing the number of medical students, provided that such expansion would not jeopardize the quality of medical education.

Res. 309, A-08 Reaffirmed: CME Rep. 01, A-18

Strategies for Enhancing Diversity in the Physician Workforce D-200.985

Our American Medical Association, independently and in collaboration with other groups such as the Association of American Medical Colleges (AAMC), will actively work and advocate for funding at the federal and state levels and in the private sector to support the following:

Pipeline programs to prepare and motivate members of underrepresented groups to enter medical school.

Diversity or minority affairs offices at medical schools.

Financial aid programs for students from groups that are underrepresented in medicine.

Financial support programs to recruit and develop faculty members from underrepresented groups.

Our AMA will work to obtain full restoration and protection of federal Title VII funding, and similar state funding programs, for the Centers of Excellence Program, Health Careers Opportunity Program, Area Health Education Centers, and other programs that support physician training, recruitment, and retention in geographically-underserved areas.

Our AMA will take a leadership role in efforts to enhance diversity in the physician workforce, including engaging in broad-based efforts that involve partners within and beyond the medical profession and medical education community.

Our AMA will encourage the Liaison Committee on Medical Education to assure that medical schools demonstrate compliance with its requirements for a diverse student body and faculty.

Our AMA will develop an internal education program for its members on the issues and possibilities involved in creating a diverse physician population.

Our AMA will provide on-line educational materials for its membership that address diversity issues in patient care including, but not limited to, culture, religion, race and ethnicity.

Our AMA will create and support programs that introduce elementary through high school students, especially those from groups that are underrepresented in medicine (URM), to healthcare careers.

Our AMA will create and support pipeline programs and encourage support services for URM college students that will support them as they move through college, medical school and residency programs.

Our AMA will recommend that medical school admissions committees and residency/fellowship programs use holistic assessments of applicants that take into account the diversity of preparation and the variety of talents that applicants bring to their education with the goal of improving health care for all communities.

Our AMA will advocate for the tracking and reporting to interested stakeholders of demographic information pertaining to URM status collected from Electronic Residency Application Service (ERAS) applications through the National Resident Matching Program (NRMP).

Our AMA will continue the research, advocacy, collaborative partnerships and other work that was initiated by the Commission to End Health Care Disparities.

Our AMA unequivocally opposes legislation that would dissolve affirmative action or punish institutions for properly employing race-conscious admissions as a measure of affirmative action in order to promote a diverse student population.

Our AMA will work with the AAMC and other stakeholders to create a question for the AAMC electronic medical school application to identify previous pipeline program (also known as pathway program) participation and create a plan to analyze the data in order to determine the effectiveness of pipeline programs.

CME Rep. 1, I-06 Reaffirmation I-10 Reaffirmation A-13 Modified: CCB/CLRPD Rep. 2, A-14 Reaffirmation: A-16 Appended: Res. 313, A-17 Appended: Res. 314, A-17 Modified: CME Rep. 01, A-18 Appended: Res. 207, I-18 Reaffirmation: A-19 Appended: Res. 304, A-19 Appended: Res. 319, A-19 Modified: CME Rep. 5, A-21 Modified: CME Rep. 02, I-22 Modified: Res. 320, A-23 Reaffirmed: CME Rep. 06, A-25

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

Our AMA will encourage medical schools, medical honor societies, and residency/fellowship programs to work toward ethical, equitable, and transparent recruiting processes, which are made available to all applicants.

Our AMA will advocate for residency and fellowship programs to avoid using objective criteria available in the Electronic Residency Application Service (ERAS) application process as the sole determinant for deciding which applicants to offer interviews.

Our AMA will advocate to remove membership in medical honor societies as a mandated field of entry on the Electronic Residency Application Service (ERAS)—thereby limiting its use as an automated screening

mechanism—and encourage applicants to share this information within other aspects of the ERAS application.
Our AMA will advocate for and support innovation in the undergraduate medical education to graduate medical education transition, especially focusing on the efforts of the Accelerating Change in Medical Education initiative, to include pilot efforts to optimize the residency/fellowship application and matching process and encourage the study of the impact of using filters in the Electronic Residency Application Service (ERAS) by program directors on the diversity of entrants into residency.
Our AMA will encourage caution among medical schools and residency/fellowship programs when utilizing novel online assessments for sampling personal characteristics for the purpose of admissions or selection and monitor use and validity of these tools.
CME Rep. 02, I-22 Reaffirmed: CME Rep. 05, A-25

Ensuring Equity in Interview Processes for Entry to Undergraduate and Graduate Medical Education H-295.844
Our American Medical Association will encourage interested parties to study the impact of different interview formats on applicants, programs, and institutions.
Our AMA will continue to monitor the impact of different interview formats for medical school and graduate medical education programs and their effect upon equity, access, monetary cost, and time burden along with the potential downstream effects upon on applicants, programs, and institutions.
Our AMA recommends that individual medical schools use the same interview format for all applicants to the same class at their institution to promote equity and fairness while allowing for accommodations for individuals with disabilities.
Our AMA recommends that individual graduate medical education programs use the same interview format for all applicants to the same program to promote equity and fairness while allowing for accommodations for individuals with disabilities.
CME Rep. 03, I-23

Educating Competent and Caring Health Professionals H-295.975
(1) Programs of health professions education should foster educational strategies that encourage students to be independent learners and problem-solvers. Faculty of programs of education for the health professions should ensure that the mission statements of the institutions in which they teach include as an objective the education of practitioners who are both competent and compassionate.
(2) Admission to a program of health professions education should be based on more than grade point average and performance on admissions tests. Interviews, applicant essays, and references should continue to be part of the application process in spite of difficulties inherent in evaluating them. Admissions committees should review applicants' extra-curricular activities and employment records for indications of suitability for health professions education. Admissions committees should be carefully prepared for their responsibilities, and efforts should be made to standardize interview procedures and to evaluate the information gathered during interviews. Research should continue to focus on improving admissions procedures. Particular attention should be paid to improving evaluations of subjective personal qualities.
(3) Faculty of programs of education for the health professions must continue to emphasis than they have in the past on educating practitioners who are skilled in communications, interviewing and listening techniques, and who are compassionate and technically competent. Faculty of health professions education should be attentive to the environment in which education is provided; students should learn in a setting where respect and concern are demonstrated. The faculty and administration of programs of health professions education must ensure that students are provided with appropriate role models; whether a faculty member serves as an appropriate role model should be considered when review for promotion or tenure occurs. Efforts should be made by the faculty to evaluate the attitudes of students toward patients. Where these attitudes are found lacking, students should be counseled. Provisions for dismissing students who clearly indicate personality characteristics inappropriate to practice should be enforced.
(4) In spite of the high degree of specialization in health care, faculty of programs of education for the health professions must prepare students to provide integrated patient care; programs of education should promote an interdisciplinary experience for their students.
BOT Rep. NN, A-87 Modified: Sunset Report, I-97 Reaffirmed: CME Rep. 2, A-07 Reaffirmed: CME Rep. 01, A-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 314
(A-26)

Introduced by: Medical Student Section, LGBTQ+ Section

Subject: Promoting Sex- and Gender-Inclusive Diagnostic Practices, Language, and Patient Education

Referred to: Reference Committee C

Whereas, current medical literature demonstrates robust evidence of systemic disparities in diagnostic and treatment delays for female patients compared to their male counterparts across multiple areas of medicine; and

Whereas, in GI medicine, women with IBD have significantly longer diagnostic delays and higher rates of misdiagnosis compared to men despite similar clinical presentations associated with worse patient outcomes[1,2]; and

Whereas, in rheumatology, women have higher rates of misdiagnosis and diagnostic delays when presenting with spondyloarthritis associated with higher rates of disability and more advanced disease, with recent evidence suggesting clinician expectations and documentation biases may contribute to this disparity[3,4]; and

Whereas, in neurology, women hospitalized due to ischemic stroke were less likely to receive standard diagnostic testing/imaging and less likely to be evaluated by a stroke specialist[5]; and

Whereas, cardiology is the field with the most notable differences in diagnostic timeline and treatment interventions for women compared to men, with women more likely to have a missed angina diagnosis despite similar symptoms [8,9]; and

Whereas, women experiencing Acute coronary syndrome (ACS) are more likely to have delays in diagnosis after hospital presentation, are less likely to receive evidence based medication therapy, are less likely to be treated with cardiac catheterization and receive timely reperfusion, are more likely to experience prolonged “door-to-balloon” times, and have increased rates of in-hospital mortality, repeat MI, stroke, and major bleeding[10-14]; and

Whereas, despite coronary heart disease being a leading cause of morbidity and mortality amongst American women, common signs/symptoms that women present with are often described as ‘atypical’[15,16]; and

Whereas, multiple studies have found that describing common female presentations as ‘atypical’ likely contributes to diagnostic and treatment delays, suggesting that this term should be retired from medical education and literature[17-20]; therefore be it

RESOLVED, that our American Medical Association supports discontinuing use of the term ‘atypical’ to describe sex- and gender-based differences in symptomatic presentations in medical education curriculum and reference materials. (New HOD Policy)

Fiscal Note: Minimal – less than $5,000

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RELEVANT AMA POLICY

H-410.946 Decreasing Sex and Gender Disparities in Health Outcomes

Our AMA: (1) supports the use of decision support tools that aim to mitigate gender bias in diagnosis and treatment; and (2) encourages the use of guidelines, treatment protocols, and decision support tools specific to biological sex for conditions in which physiologic and pathophysiologic differences exist between sexes. [Res. 005, A-18]

H-295.890 Medical Education and Training in Women's Health

1. Our American Medical Association encourages the coordination and synthesis of the knowledge, skills, and attitudinal objectives related to women's health/gender-based biology that have been developed for use in the medical school curriculum. Medical schools should include attention to women's health throughout the basic science and clinical phases of the curriculum.
2. Our AMA does not support the designation of women's health as a distinct new specialty.
3. Our AMA supports that each specialty should define objectives for residency training in women's health, based on the nature of practice and the characteristics of the patient population served.
4. Our AMA supports surveys of undergraduate and graduate medical education, conducted by the AMA and other groups, should periodically collect data on the inclusion of women's health in medical school and residency training.
5. Our AMA encourages the development of a curriculum inventory and database in women's health for use by medical schools and residency programs.
6. Our AMA encourages physicians to include continuing education in women's health/gender-based biology as part of their continuing professional development.
7. Our AMA encourages its representatives to the Liaison Committee on Medical Education, the Accreditation Council for Graduate Medical Education (ACGME), and the various ACGME Review Committees to promote attention to women's health in accreditation standards.
8. Our AMA will work with the ACGME to protect patient access to important reproductive health services by advocating for all family medicine residencies to provide comprehensive women's health, including training in contraceptive counseling, family planning, and counseling for unintended pregnancy.
9. Our AMA encourages the ACGME to ensure clarity when making revisions to the educational requirements and expectations of family medicine residents in comprehensive women's health topics.

[Jt. Rep. CME and CSA, A-99; Reaffirmed: CME Rep. 2, A-09; Reaffirmed: CME Rep. 01, A-19; Appended: CME Rep. 01, A-23]

H-180.944 Plan for Continued Progress Toward Health Equity

Health equity, defined as optimal health for all, is a goal toward which our American Medical Association will work by advocating for health care access, research, and data collection; promoting equity in care; increasing health workforce diversity; influencing determinants of health; and voicing and modeling commitment to health equity. [BOT Rep. 33, A-18; Reaffirmed: CMS Rep. 5, 1-21; Reaffirmed: CMS Rep. 1, 1-23; Reaffirmed: BOT Rep. 30, A-24]

H-525.988 Sex and Gender Differences in Medical Research,

Our AMA:

(1) reaffirms that gender and sex exclusion in broad medical studies questions the validity of the studies' impact on the health care of society at large;

(2) affirms the need to include people of all sexes and gender identities and expressions in studies that involve the health of society at large and publicize its policies;

(3) supports increased funding into areas of women's health and sexual and gender minority health research;

(4) supports increased research on women's health and sexual and gender minority health and the participation of women and sexual and gender minority communities in clinical trials, the results of which will permit development of evidence-based prevention and treatment strategies for all women and sexual and gender minority individuals from diverse cultural and ethnic groups, geographic locations, and socioeconomic status;

(5) recommends that all medical/scientific journal editors require, where appropriate, a sex-based and gender-based analysis of data, even if such comparisons are negative; and

(6) recommends that medical and scientific journals diversify their review processes to better represent women and sexual and gender minority individuals;

(7) supports the FDA's requirement of actionable clinical trial diversity action plans from drug and device sponsors that include women and sexual and gender minority populations;

(8) supports the FDA's efforts in conditioning drug and device approvals on post-marketing studies which evaluate the efficacy and safety of those products in women and sexual and gender minority populations when those groups were not adequately represented in clinical trials; and

(9) supports and encourages the National Institutes of Health and other grant-making entities to fund

post-market research investigating pharmacodynamics and pharmacokinetics for generic drugs that did not adequately enroll women and sexual and gender minority populations in their clinical trials, prioritizing instances when those populations represent a significant portion of patients or reported adverse drug events. [Res. 80, A-91Appended: CSA Rep. 4, I-00Modified: CSAPH Rep. 1, A-10Reaffirmed: CSAPH Rep. 05, A-16Modified: Res. 004, A-23Modified: CSAPH Rep. 04, A-24]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 315
(A-26)

Introduced by: Medical Student Section, Underrepresented in Medicine Advocacy Section, Hawaii, Washington, Oregon

Subject: Expanding the Native Hawaiian Health Scholarship Program Eligibility

Referred to: Reference Committee C

Whereas, the federal U.S. government has a legal trust obligation to provide quality health care to American Indian and Alaska Native (AI/AN) and Native Hawaiian (NH) populations, as affirmed through treaties, statutes, and executive orders [1-3]; and

Whereas, despite the federal obligation to improve NH health, NH continue to experience disproportionately high rates of chronic disease, including diabetes, cardiovascular disease, and cancer, requiring co-management across specialties, as well as significantly lower life expectancy compared to non-Native populations [4-20]; and

Whereas, data show that NH representation is declining across multiple medical specialties and there are current specialty gaps in Hawai'i's physician workforce [21-22]; and

Whereas, research indicates that racial/ethnic concordance between NH patients and their physicians has been associated with improvements in patient-physician communication, greater time spent with physicians, improved shared decision-making, improved patient understanding of disease risk, improved medication adherence, decreased wait times for treatment, improved preventive health screenings, and decreased implicit bias from clinicians [23-24]; and

Whereas, Native Hawaiian and Pacific Islanders (NHPI) are critically underrepresented in the medical workforce and among medical trainees, with NHPI medical students representing the smallest proportion of any racial/ethnic group in U.S. medical schools (0.4%)[8-9, 21, 25-28]; and

Whereas, to fulfill federal trust obligations and workforce shortages, the Native Hawaiian Health Scholarship Program (NHHSP) was implemented as a part of the Native Hawaiian Health Care System and has been effective in increasing the number of NH primary care health professionals serving NH communities in Hawai'i [29]; and

Whereas, the current eligibility for NHHSP and comparable service scholarships such as the IHS Scholarship exclude NH healthcare trainees planning to pursue primary care who serve diaspora NHs, as well as NH healthcare trainees pursuing specialized fields such as oncology, cardiology, nephrology, and psychiatry, who serve NH patients [10, 27, 29-30]; therefore be it

RESOLVED, that our American Medical Association support expanded funding and eligibility requirements for the Native Hawaiian Health Scholarship Program (NHHSP), or an equivalent program, to include Native Hawaiian trainees who provide specialized healthcare services. (New HOD Policy)

Fiscal Note: Minimal – less than $5,000

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RELEVANT AMA POLICY

H-270.950 Indian Health Service Licensing Exemptions
Our American Medical Association will work with interested parties to evaluate existing regulatory and licensure opportunities and barriers to physician participation in health care services for Native Americans, Alaska Natives, and Native Hawaiians. [Res. 312, A-23.]

D-200.982 Diversity in the Physician Workforce and Access to Care
1. Our American Medical Association will continue to advocate for programs that promote diversity in the US medical workforce, such as pipeline programs to medical schools.
2. Our AMA will continue to advocate for adequate funding for federal and state programs that promote interest in practice in underserved areas, such as those under Title VII of the Public Health Service Act, scholarship and loan repayment programs under the National Health Services Corps and state programs, state Area Health Education Centers, and Conrad 30, and also encourage the development of a centralized database of scholarship and loan repayment programs.
3. Our AMA will continue to study the factors that support and those that act against the choice to practice in an underserved area, and report the findings and solutions at the 2008 Interim Meeting.

[CME Rep. 7, A-08Reaffirmation A-13Reaffirmation: A-16Reaffirmed: CME Rep. 5, A-21Reaffirmation: Res. 240, A-24Reaffirmed: Res. 308, I-25]

H-295.871 Accelerating Change in Medical Education: Strategies for Medical Education Reform
Our AMA continues to recognize the need for transformation of medical education across the continuum from premedical preparation through continuing physician professional development and the need to involve multiple stakeholders in the transformation process, while taking an appropriate leadership and coordinating role. [CME Rep. 13, A-07Reaffirmed: CME Rep. 01, A-17]

D-180.981 Plan for Continued Progress Toward Health Equity
Our AMA will develop an organizational unit, e.g., a Center or its equivalent, to facilitate, coordinate, initiate, and track AMA health equity activities. The Board will provide an annual report to the House of Delegates regarding AMA's health equity activities and achievements. [BOT Rep. 33, A-18]

H-305.925 Principles of and Actions to Address Medical Education Costs and Student Debt
The costs of medical education should never be a barrier to the pursuit of a career in medicine nor to the decision to practice in a given specialty. To help address this issue, our American Medical Association (AMA) will: Collaborate with members of the Federation and the medical education community, and with other interested organizations, to address the cost of medical education and medical student debt through public- and private-sector advocacy. Vigorously advocate for and support expansion of and adequate funding for federal scholarship and loan repayment programs--such as those from the National Health Service Corps, Indian Health Service, Armed Forces, and Department of Veterans Affairs, and for comparable programs from states and the private sector--to promote practice in underserved areas, the military, and academic medicine or clinical research. Advocate for increased funding for the National Health Service Corps Loan Repayment Program to assure adequate funding of primary care within the National Health Service Corps, as well as to permit: inclusion of all medical specialties in need, and service in clinical settings that care for the underserved but are not necessarily located in health professions shortage areas...Support and encourage state medical societies to support further expansion of state loan repayment programs, particularly those that encompass physicians in non-primary care specialties...[CME Report 05, I-18; Appended: Res. 953, I-18; Reaffirmation: A-19; Appended: Res. 316, A-19; Appended: Res. 226, A-21; Reaffirmed in lieu of: Res. 311, A-21; Modified: CME Rep. 4, I-21; Reaffirmation: A-22; Appended: CME Rep. 02, A-23; Appended: Res. 311, A-23; Reaffirmed: Res. 314, A-24; Reaffirmed: Res. 215, I-24; Reaffirmed: BOT Rep. 07, I-24 Reaffirmed in lieu of: Res. 224, A-25Reaffirmed: Res. 308, I-25].

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

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.

[CLRPD Rep. 3, I-98Reaffirmed: Res. 221, A-07Reaffirmation A-12Reaffirmed: Res. 233, A-13Reaffirmed: BOT Rep. 09, A-23Modified: CMS Rep. 03, A-24Reaffirmed: Res. 244, A-24]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 316
(A-26)

Introduced by: Resident and Fellow Section

Subject: Addressing Transitions Within GME Regarding Orientation Standards

Referred to: Reference Committee C

Whereas, in 2025, thousands of new trainees entered categorical residency, started advanced residency, and started fellowship; and

Whereas, the official start date of most ACGME programs is July 1 or August 1; and

Whereas, sometimes residents and fellows are unable to start on the official start date including due to visa delays; and

Whereas, incoming fellows are often required to utilize vacation time to go to orientation at the end of their residency; and

Whereas, many incoming fellows are contractually obligated to provide coverage up until June 30th of their last day of residency; and

Whereas, these transitions in training often lead to gaps in salary and necessary benefits for trainees, including but not limited to health insurance; and

Whereas, students who enroll in the school-sponsored health insurance plan at medical colleges such as NYU Grossman School of Medicine, Northwestern University, Emory University School of Medicine and the University of Rochester extend health insurance coverage through the end of June or later of the respective graduate year to accommodate coverage gaps caused by transitions in training; and

Whereas, these logistical challenges create difficulty in transitioning in graduate medical education, especially for those who need to relocate for training; and

Whereas, creating a staggered start date to fellowship following the end of residency would lead to improved transitions between residency and fellowship by allowing incoming fellows adequate time to relocate and onboard at their new institution; therefore be it

RESOLVED, that our American Medical Association study mechanisms for training programs to provide residents and fellows with necessary benefits, including but not limited to health insurance, during transitions in undergraduate and graduate medical education (Directive to Take Action); and be it further

RESOLVED, that our AMA study the benefits of flexible start dates as it relates to reducing logistical and financial burdens on trainees, including but not limited to the following transitions: (1) from medical school to residency; (2) from a transitional or preliminary year to residency; and (3) from residency into fellowship. (Directive to Take Action)

Fiscal Note: Minimal – less than $5,000

Received: 4/21/26

RELEVANT AMA POLICY

Residents and Fellows' Bill of Rights H-310.912
1. Our American Medical Association continues to advocate for improvements in the ACGME Institutional and Common Program Requirements that support AMA policies as follows:

a. Adequate financial support for and guaranteed leave to attend professional meetings.
b. Submission of training verification information to requesting agencies within 30 days of the request.
c. Adequate compensation with consideration to local cost-of-living factors and years of training, and to include the orientation period.
d. Health insurance benefits to include dental and vision services.
e. Paid leave for all purposes (family, educational, vacation, sick) to be no less than six weeks per year.
f. Stronger due process guidelines. […]

[CME Rep. 8, A-11; Appended: Res. 303, A-14; Reaffirmed: Res. 915, I-15; Appended: CME Rep. 04, A-16; Modified: CME Rep. 06, I-18; Appended: Res. 324, A-19; Modified: Res. 304, A-21; Modified: Res. 305, A-21; Modified: BOT Rep. 18, I-21; Reaffirmation: A-22; Reaffirmed in lieu of: Res. 307, I-22; Modified: CME Rep. 05, I-23; Reaffirmed: CME Rep. 02, A-24; Modified: Res. 304, I-24]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 317
(A-26)

Introduced by: Resident and Fellow Section

Subject: Support for Intern, Resident, and Fellow Jeopardy Pay and Additional Compensation for Gaps in Trainee Coverage

Referred to: Reference Committee C

Whereas, interns, residents, and fellows serve in frontline roles that are critical to patient care, including last-minute coverage of inpatient services, consults, rounding, clinics, overnight call, home call, and operating room time when colleagues are unavailable due to unexpected leave, illness, or emergencies; and

Whereas, this coverage system, often referred to as “jeopardy,” typically relies on interns, residents, and fellows from elective rotations to absorb colleagues’ clinical responsibilities, thereby adding significant unplanned workload and stress; and

Whereas, surgical trainees, in particular, may bear a disproportionate jeopardy burden compared to non-surgical trainees due to limited backup and operative coverage, often having to manage additional patients on service while simultaneously covering operative responsibilities, amplifying risk to both trainees and patients; and

Whereas, jeopardy coverage among interns, residents, and fellows may also be utilized to accommodate increased patient volume; and

Whereas, an analysis of 31 institutions found that hospital medicine jeopardy systems contribute to physician dissatisfaction due to their unpredictability, highlighting the potential of equitable compensation models as a solution[1]; and

Whereas, certain residency and fellowship programs require shift “payback” for jeopardy coverage (such as using days off and/or vacation to compensate for sick leave), a practice that exacerbates burnout by discouraging appropriate use of sick time, incentivizing physicians to work while ill, and risking violations of duty hour regulations, thereby undermining physician well-being and patient safety in direct conflict with Accreditation Council for Graduate Medical Education (ACGME) policy 6.14.b[2]; and

Whereas, jeopardy assignments impose additional burdens on interns, residents, and fellows, disrupting essential rest and recovery, limiting time for family and personal health needs, and undermining overall well-being and work-life integration due to unpredictability of call-ins; and

Whereas, there is precedent for jeopardy pay, such as at the University of California, San Francisco Department of Surgery, where jeopardized residents are compensated at the standard moonlighting rate, and at the Stanford Department of Medicine, where internal

medicine residents receive $2,500 for a day shift and $3,000 for a night shift related to patient-volume jeopardy;[3] and

Whereas, the ACGME has increasingly emphasized physician well-being, yet current compensation structures fail to recognize the additional professional, personal, and familial strain associated with jeopardy assignments;[2,4] and

Whereas, ACGME policy 6.14.a. states, "the program must have policies and procedures in place to ensure coverage of patient care and ensure continuity of patient care," but does not require equitable compensation; and

Whereas, a fair and equitable system would provide monetary compensation to interns, residents, and fellows for being "jeopardized" to cover essential shifts, recognizing that the costs of burnout, fatigue, and potential patient safety risks far outweigh the financial impact of jeopardy pay; therefore be it

RESOLVED, that our American Medical Association supports standardized compensation ("jeopardy pay"), provided in addition to base salary and benefits, for interns, residents, and fellows who are required to cover unscheduled ("jeopardy") shifts or additional duties, and encourages programs to adopt transparent and equitable compensation structures that account for specialty-specific burdens. (New HOD Policy)

Fiscal Note: Minimal – less than $5,000

Received: 4/21/26

REFERENCES

1. Kangelaris KN, Keniston A, Auerbach AD, et al. A multi-institutional multi-methods analysis of jeopardy systems in academic hospital medicine. *J Hosp Med*. 2025;20(9):953-962. doi:10.1002/jhm.70045
2. Accreditation Council for Graduate Medical Education. Common Program Requirements (Residency). Published September 3, 2025. Accessed September 8, 2025. https://www.acgme.org/globalassets/pfassets/programrequirements/2025-reformatted-requirements/cprresidency_2025_reformatted.pdf
3. UCSF Department of Surgery Resident Portal. https://surgeryresidentportal.ucsf.edu/resident-jeopardy-policy-guidelines
4. Accreditation Council for Graduate Medical Education. ACGME Answers: ACGME's Commitment to the Health and Well-Being of Health Care Professionals. ACGME. Published February 15, 2023. Accessed September 8, 2025. https://www.acgme.org/newsroom/blog/2023/acgme-answers-acgmes-commitment-to-the-health-and-well-being-of-health-care-professionals/

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Principles for Graduate Medical Education H-310.929
COMPENSATION OF RESIDENT PHYSICIANS. All residents should be compensated. Residents should receive fringe benefits, including, but not limited to, health, disability, and professional liability insurance and parental leave and should have access to other benefits offered by the institution. Residents must be

informed of employment policies and fringe benefits, and their access to them. Restrictive covenants must not be required of residents or applicants for residency education.
[CME Rep. 9, A-99; Reaffirmed: CME Rep. 2, A-09; Reaffirmed: CME Rep. 14, A-09; Modified: CME Rep. 06, I-18; Reaffirmed: CME Rep. 01, I-22]

Factors Causing Burnout H-405.948
Our American Medical Association recognizes that medical students, resident physicians, and fellows face unique challenges that contribute to burnout during medical school and residency training, such as debt burden, inequitable compensation, discrimination, limited organizational or institutional support, stress, depression, suicide, childcare needs, mistreatment, long work and study hours, among others, and that such factors be included as metrics when measuring physician well-being, particularly for this population of physicians. [Res. 208, I-22]