AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: (Assigned by HOD)
(A-26)

Introduced by: Women Physicians Section

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

Referred to: Reference Committee (Assigned by HOD)

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.

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.

Fiscal Note: (Assigned by HOD)

Received: XX/XX/XX

REFERENCES

1. Klein R, Julian KA, Snyder ED, et al. Gender Bias in Resident Assessment in Graduate Medical Education: Review of the Literature. *J Gen Intern Med*. 2019;34(5):712-719. doi:10.1007/s11606-019-04884-0
2. Rojek AE, Khanna R, Yim JWL, et al. Differences in Narrative Language in Evaluations of Medical Students by Gender and Under-represented Minority Status. *J Gen Intern Med*. 2019;34(5):684-691. doi:10.1007/s11606-019-04889-9
3. Mueller AS, Jenkins TM, Osborne M, Dayal A, O'Connor DM, Arora VM. Gender Differences in Attending Physicians' Feedback to Residents: A Qualitative Analysis. *J Grad Med Educ*. 2017;9(5):577-585. doi:10.4300/JGME-D-17-00126.1
4. Boatright D, Anderson N, Kim JG, et al. Racial and Ethnic Differences in Internal Medicine Residency Assessments. *JAMA Netw Open*. 2022;5(12):e2247649. Published 2022 Dec 1. doi:10.1001/jamanetworkopen.2022.47649

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]