Reference Committee C

Report(s) of the Council on Medical Education

01 Additional Pathways for International Medical Graduates

Resolutions

301 Preventing Sleep Deprivation and Supporting Medical Student Wellness

304 Systemic Exclusion of IMGs from Residency Programs

305 Paid Sick Leave and Flexible Work Arrangements for Caregivers of Individuals with Special Needs, Chronic Illness, or Elderly Parents

306 Support for Paid Prenatal Leave

307 Integrating Artificial Intelligence (AI) Literacy Into UME, GME, and CME

308 Enhancing the Pathway for Black Male Medical Students

311 Gender and URiM Disparities in Surgical Training Volumes

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 1-I-25

Subject: Additional Pathways for International Medical Graduates

Presented by: Kelly J. Caverzagie, MD, FACP, FHM

Referred to: Reference Committee C

American Medical Association (AMA) Policy D-255.971, "Alternative Pathways for International Medical Graduates," adopted at the 2024 Interim Meeting of the AMA House of Delegates (HOD) asks the following:

1. Our American Medical Association will provide an informational report about the ongoing work around alternate licensing pathways and currently introduced laws and regulations being introduced around the country and their status during the I-25 meeting.
2. Our AMA, following the conclusion of the work of the Advisory Commission on Alternate Licensing Models, will develop educational resources related to alternate licensing models for the AMA HOD and other interested parties.
3. Our AMA will widely distribute the Commission's report and relevant educational content to all AMA members.

This report is submitted to the HOD in response to the directive in the first clause. Since the 2024 Interim Meeting, the Advisory Commission changed its name from "Alternate" to "Additional" Licensing Models. For the purposes of this report, it will be referred to as the "Commission."

BACKGROUND

Inception and convening

On March 27, 2024, The Federation of State Medical Boards (FSMB), Intealth™, and the Accreditation Council for Graduate Medical Education (ACGME) announced the establishment of a new Advisory Commission on Alternate Licensing Models "to provide guidance on alternative pathways for state licensure of physicians who have completed training and/or practiced outside of the United States. These are physicians who have graduated from medical school in another country, have completed a post graduate training program substantially similar to those in the U.S., and (in most state requirements) have practiced for a certain period of time. The Commission uses the term "internationally trained physicians." Many of these physicians are international medical graduates (IMGs), encompassing both foreign nationals and U.S. citizens who completed their medical education and training outside the United States and Canada."[1] The intent was to create recommendations to guide state medical boards, legislatures, and policymakers considering state legislation to create additional pathways to licensure or those responsible for implementing legislation that has been enacted. These founding organizations held their first meeting on April 5, 2024, in Washington, D.C. The Commission convened as state legislative activity creating additional pathways to licensure is gaining momentum.

This Commission convened a one-day symposium on June 18, 2024, in Washington D.C., attended by more than 175 individuals representing members of the public, state medical licensing boards, and organizations involved with medical education, accreditation, and certification. The symposium "provided a forum for attendees to exchange ideas and discuss considerations for legislative, regulatory, and procedural implementation of such alternative pathways for medical licensure."[2]

A meeting on September 16, 2024, discussed a first set of recommendations. Those draft preliminary recommendations were then released on October 1, 2024, with a focus on eligibility requirements with an open comment period through December 6, 2024, via online survey.[3] The AMA provided comments, which are available on the AMA's Federal and State Correspondence Finder.

Commission Recommendations

On February 4, 2025, the Commission released its first set of nine recommendations informed by the feedback from the open comment period; the full document with recommendations is available on the FSMB website:

1. "Rulemaking authority should be delegated, and resources allocated, to the state medical board for implementing and evaluating any additional licensure pathways.
2. An offer of employment should be required for pathway eligibility. State medical boards should be authorized to define what is an appropriate clinical facility for the supervision and assessment of internationally trained physicians (ITPs) for their provisional licensure period.
3. Educational Commission for Foreign Medical Graduates (ECFMG) Certification and graduation from a duly recognized medical school should be required for pathway eligibility.
4. Completion of postgraduate training (graduate medical education) outside the United States should be required for pathway eligibility.
5. Possession of authorization from another country or jurisdiction to lawfully practice medicine in that country or jurisdiction, and at least three years of experience in medical practice should be required for pathway eligibility.
6. A limit on the physician's time "out of practice" that is consistent with that state's existing re-entry to practice requirements should be considered.
7. A successfully completed period of supervision and assessment by an employer should be required of ITPs to transition from provisional licensure to full licensure.
8. State medical boards should preserve their authority to assess each candidate for full and unrestricted licensure.
9. State medical boards implementing additional licensure pathways should collect and share data to evaluate the program's effectiveness."[4]

Following the publication of these recommendations, the Commission announced on May 22, 2025, a call for comments on new draft guidance recommendations specifically regarding the assessment and supervision of internationally-trained physicians seeking licensure in the U.S.[5,6] This second call for comment, open until July 11, 2025, offered eight recommendations addressing specific guidance for the consideration of state medical boards and other relevant parties. The feedback was collected via a survey tool. The AMA appreciates the Commission's efforts to ensure safe, structured pathways for internationally trained physicians. AMA feedback supported the intent of each recommendation while also addressing concerns (e.g., additional burdens put upon rural health care systems, supervising physicians, and small practices; lack of uniform standards

and institutional oversight; unintended consequences) and offering suggestions for improvement to best execute these recommendations.

In July 2025, the Annals of Internal Medicine published an opinion from the leaders of the Commission's founding organizations entitled "Licensing Internationally Trained Physicians: Advisory Commission Leaders Share Initial Progress."[7] An August 2025 press release provided the latest recommendations as well as a toolkit to inform the assessment and supervision of ITPs.[8]

Of note, these are recommendations and do not carry the force of law.

DISCUSSION

Founders of the Commission

The FSMB supports state medical boards within the U.S., its territories, and the District of Columbia in protection of the public's health, safety, and welfare. This involves oversight of proper medical regulation, licensing, and disciplining of physicians (as well as physician assistants and other health care professionals). This includes issues and concerns related to internationally trained physicians. As such, the FSMB serves as the primary convener for the Commission.

The Educational Commission for Foreign Medical Graduates (ECFMG) Certification assures the readiness of internationally trained physicians to enter graduate medical education in the U.S. Foundation for Advancement of International Medical Education (FAIMER®) promotes excellence in international health professions education through programmatic and research activities. They partner with other leaders in U.S. medical education to analyze data, develop policies, and create new tools for this audience. In 2021, ECFMG and FAIMER® were joined under the umbrella of Intealth.

The ACGME establishes and oversees the voluntary professional educational standards that are essential to preparing physicians (including those internationally trained) to provide safe and high-quality medical care. They also oversee the accreditation of residency and fellowship programs in the U.S.

AMA engagement

The AMA has been actively engaged in the Commission as an adviser since its inception. In addition, the AMA Advocacy and Medical Education business units, in collaboration with the Council on Medical Education and the International Medical Graduates (IMG) Section, has responded to each open comment period provided by the Commission.

The Council on Medical Education (CME) actively monitors issues related to IMGs and authors reports as directed by the House of Delegates. They have included:

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

Reports from all Councils are made available to members via the Council Report Finder. The Medical Education unit publishes issue briefs on a variety of timely topics. In 2022, an issue brief was released entitled "Support for IMGs practicing in the U.S."

The Advocacy unit closely monitors any communications or actions by the current Administration as it relates to IMGs. For example:

- They have issued letters of support for the Conrad 30 Waiver Program and the recent Doctors in our Borders Act, which would expand the number of Conrad 30 waivers a state or regional commission can receive from 30 to 100. Such letters and statements are made available to members in the AMA Federal and State Correspondence Finder.
- AMA's Advocacy Update e-newsletter provides timely information which may contain news relevant to IMGs.
- Advocacy also monitors state legislative activity to create additional pathways to licensure for internationally trained physicians. This activity is summarized in a recently updated AMA issue brief entitled "Additional State Licensure Pathways for Internationally Trained Physicians."

Federal immigration issues are not discussed in this report, given ongoing changes by the current administration.

The AMA's IMG Section addresses and advocates for issues that impact international medical graduate physicians. To help IMGs navigate the process of practicing medicine in the United States, the section recently developed a toolkit. The latest information and resources from the IMG Section are available on the AMA website.

News articles and podcasts related to IMGs are also available on the AMA website. Examples of information from as recent as April 2025 include:

- Immigration issues: Visas and green cards
- Starting physician residency as an IMG? 6 tips to ease transition
- Meet Your Match: Tips for IMGs entering U.S. residency with Ricardo Correa, MD

RELEVANT AMA POLICY

The following policies, available in the AMA Policy Finder, are of relevance to this report. Full policies are listed in the Appendix.

- Abolish Discrimination in Licensure of IMGs H-255.966
- Licensure for International Medical Graduates Practicing in U.S. Institutions with Restricted Medical Licenses D-255.977
- AMA Principles on International Medical Graduates H-255.988
- Alternatives to the Federation of State Medical Boards Recommendations on Licensure H-275.934
- International Medical Graduate Employment H-255.965
- Unfair Discrimination Against International Medical Graduates H-255.978

CONCLUSION

The AMA will continue to (1) participate in the Advisory Commission on Additional Licensing Models, (2) provide comment on future recommendations, and (3) engage with relevant parties in support of internationally trained physicians.

RECOMMENDATION

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

1. That the first clause of AMA Policy D-255.971, "Alternative Pathways for International Medical Graduates," be rescinded as having been accomplished by this report. (Rescind AMA Policy)

Fiscal note: Minimal

APPENDIX – RELEVANT AMA POLICIES

Abolish Discrimination in Licensure of IMGs H-255.966

1. Our American Medical Association supports the following principles related to medical licensure of international medical graduates (IMGs):
    a. State medical boards should ensure uniformity of licensure requirements for IMGs and graduates of U.S. and Canadian medical schools, including eliminating any disparity in the years of graduate medical education (GME) required for licensure and a uniform standard for the allowed number of administrations of licensure examinations.
    b. All physicians seeking licensure should be evaluated on the basis of their individual education, training, qualifications, skills, character, ethics, experience and past practice.
    c. Discrimination against physicians solely on the basis of national origin and/or the country in which they completed their medical education is inappropriate.
    d. U.S. states and territories retain the right and responsibility to determine the qualifications of individuals applying for licensure to practice medicine within their respective jurisdictions.
    e. State medical boards should be discouraged from a) using arbitrary and non-criteria-based lists of approved or unapproved foreign medical schools for licensure decisions and b) requiring an interview or oral examination prior to licensure endorsement. More effective methods for evaluating the quality of IMGs' undergraduate medical education should be pursued with the Federation of State Medical Boards (FSMB) and other relevant organizations. When available, the results should be a part of the determination of eligibility for licensure.
2. Our AMA will continue to work with the FSMB to encourage parity in licensure requirements for all physicians, whether U.S. medical school graduates or international medical graduates.
3. Our AMA will continue to work with the Educational Commission for Foreign Medical Graduates and other appropriate organizations in developing effective methods to evaluate the clinical skills of IMGs.
4. Our AMA will work with state medical societies in states with discriminatory licensure requirements between IMGs and graduates of U.S. and Canadian medical schools to advocate for parity in licensure requirements, using the AMA International Medical Graduate Section licensure parity model resolution as a resource.
5. Our AMA will:
    a. encourage states to study existing strategies to improve policies and processes to assist IMGs with credentialing and licensure to enable them to care for patients in underserved areas.
    b. encourage the FSMB and state medical boards to evaluate the progress of programs aimed at reducing barriers to licensure--including successes, failures, and barriers to implementation.

Licensure for International Medical Graduates Practicing in U.S. Institutions with Restricted Medical Licenses D-255.977

Our American Medical Association will advocate that qualified international medical graduates have a pathway for licensure by encouraging state medical licensing boards and the member boards of the American Board of Medical Specialties to develop criteria that allow:

1. Completion of medical school and residency training outside the U.S.
2. Extensive U.S. medical practice.
3. Evidence of good standing within the local medical community to serve as a substitute for U.S. graduate medical education requirement for physicians seeking full unrestricted licensure and board certification.

AMA Principles on International Medical Graduates H-255.988

1. Our American Medical Association supports current U.S. visa and immigration requirements applicable to foreign national physicians who are graduates of medical schools other than those in the United States and Canada.
2. Our AMA supports current regulations governing the issuance of exchange visitor visas to foreign national IMGs, including the requirements for successful completion of the USMLE.
3. Our AMA reaffirms its policy that the U.S. and Canada medical schools be accredited by a nongovernmental accrediting body.
4. Our AMA supports cooperation in the collection and analysis of information on medical schools in nations other than the U.S. and Canada.
5. Our AMA supports continued cooperation with the ECFMG and other appropriate organizations to disseminate information to prospective and current students in foreign medical schools. An AMA member, who is an IMG, should be appointed regularly as one of the AMA's representatives to the ECFMG Board of Trustees.
6. Our AMA supports working with the Accreditation Council for Graduate Medical Education (ACGME) and the Federation of State Medical Boards (FSMB) to assure that institutions offering accredited residencies, residency program directors, and U.S. licensing authorities do not deviate from established standards when evaluating graduates of foreign medical schools.
7. In cooperation with the ACGME and the FSMB, our AMA supports only those modifications in established graduate medical education or licensing standards designed to enhance the quality of medical education and patient care.
8. Our AMA continues to support the activities of the ECFMG related to verification of education credentials and testing of IMGs.
9. Our AMA supports that special consideration be given to the limited number of IMGs who are refugees from foreign governments that refuse to provide pertinent information usually required to establish eligibility for residency training or licensure.
10. Our AMA supports that accreditation standards enhance the quality of patient care and medical education and not be used for purposes of regulating physician manpower.
11. Our AMA representatives to the ACGME, residency review committees and to the ECFMG should support AMA policy opposing discrimination. Medical school admissions officers and directors of residency programs should select applicants on the basis of merit, without considering status as an IMG or an ethnic name as a negative factor.
12. Our AMA supports the requirement that all medical school graduates complete at least one year of graduate medical education in an accredited U.S. program in order to qualify for full and unrestricted licensure. State medical licensing boards are encouraged to allow an alternate set of criteria for granting licensure in lieu of this requirement:
    a. completion of medical school and residency training outside the U.S.;
    b. extensive U.S. medical practice; and
    c. evidence of good standing within the local medical community.
13. Our AMA supports publicizing existing policy concerning the granting of staff and clinical privileges in hospitals and other health facilities.
14. Our AMA supports the participation of all physicians, including graduates of foreign as well as U.S. and Canadian medical schools, in organized medicine. Our AMA offers encouragement and assistance to state, county, and specialty medical societies in fostering greater membership among

IMGs and their participation in leadership positions at all levels of organized medicine, including AMA committees and councils, the Accreditation Council for Graduate Medical Education and its review committees, the American Board of Medical Specialties and its specialty boards, and state boards of medicine, by providing guidelines and non-financial incentives, such as recognition for outstanding achievements by either individuals or organizations in promoting leadership among IMGs.

15. Our AMA supports studying the feasibility of conducting peer-to-peer membership recruitment efforts aimed at IMGs who are not AMA members.
16. Our AMA membership outreach to IMGs to include
    a. using its existing publications to highlight policies and activities of interest to IMGs, stressing the common concerns of all physicians;
    b. publicizing its many relevant resources to all physicians, especially to nonmember IMGs;
    c. identifying and publicizing AMA resources to respond to inquiries from IMGs; and
    d. expansion of its efforts to prepare and disseminate information about requirements for admission to accredited residency programs, the availability of positions, and the problems of becoming licensed and entering full and unrestricted medical practice in the U.S. that face IMGs. This information should be addressed to college students, high school and college advisors, and students in foreign medical schools.
17. Our AMA supports recognition of the common aims and goals of all physicians, particularly those practicing in the U.S., and support for including all physicians who are permanent residents of the U.S. in the mainstream of American medicine.
18. Our AMA supports its leadership role to promote the international exchange of medical knowledge as well as cultural understanding between the U.S. and other nations.
19. Our AMA supports institutions that sponsor exchange visitor programs in medical education, clinical medicine and public health to tailor programs for the individual visiting scholar that will meet the needs of the scholar, the institution, and the nation to which he will return.
20. Our AMA supports informing foreign national IMGs that the availability of training and practice opportunities in the U.S. is limited by the availability of fiscal and human resources to maintain the quality of medical education and patient care in the U.S., and that those IMGs who plan to return to their country of origin have the opportunity to obtain GME in the United States.
21. Our AMA supports U.S. medical schools offering admission with advanced standing, within the capabilities determined by each institution, to international medical students who satisfy the requirements of the institution for matriculation.
22. Our AMA supports the Federation of State Medical Boards, its member boards, and the ECFMG in their willingness to adjust their administrative procedures in processing IMG applications so that original documents do not have to be recertified in home countries when physicians apply for licenses in a second state.
23. Our AMA supports continued efforts to protect the rights and privileges of all physicians duly licensed in the U.S. regardless of ethnic or educational background and opposes any legislative efforts to discriminate against duly licensed physicians on the basis of ethnic or educational background.
24. Our AMA supports continued study of challenges and issues pertinent to IMGs as they affect our country's health care system and our physician workforce.
25. Our AMA supports advocacy to Congress to fund studies through appropriate agencies, such as the Department of Health and Human Services, to examine issues and experiences of IMGs and make recommendations for improvements.

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

Our American Medical Association adopts the following principles:

1. Ideally, all medical students should successfully complete Steps 1 and 2 of the United States Medical Licensing Examination (USMLE) or Levels 1 and 2 of the Comprehensive Osteopathic Medical Licensing Examination (COMLEX USA) prior to entry into residency training. At a minimum, individuals entering residency training must have successfully completed Step 1 of the USMLE or Level 1 of COMLEX USA. There should be provision made for students who have not completed Step 2 of the USMLE or Level 2 of the COMLEX USA to do so during the first year of residency training.

2. All applicants for full and unrestricted licensure, whether graduates of U.S. medical schools or international medical graduates, must have completed one year of accredited graduate medical education (GME) in the U.S., have passed all state-required licensing examinations (USMLE or COMLEX USA), and must be certified by their residency program director as ready to advance to the next year of GME and to obtain a full and unrestricted license to practice medicine. State medical licensing boards are encouraged to allow an alternate set of criteria for granting licensure in lieu of this requirement for completing one year of accredited GME in the U.S.: (a) completion of medical school and residency training outside the U.S.; (b) extensive U.S. medical practice; and (c) evidence of good standing within the local medical community.
3. There should be a training permit/educational license for all resident physicians who do not yet have a full and unrestricted license to practice medicine. To be eligible for an initial training permit/educational license, the resident must have completed Step 1 of the USMLE or Level 1 of COMLEX USA.
4. Residency program directors shall report only those actions to state medical licensing boards that are reported for all licensed physicians.
5. Residency program directors should receive training to ensure that they understand the process for taking disciplinary action against resident physicians, and are aware of procedures for dismissal of residents and for due process. This requirement for residency program directors should be enforced through Accreditation Council for Graduate Medical Education accreditation requirements.
6. There should be no reporting of actions against medical students to state medical licensing boards.
7. Medical schools are responsible for identifying and remediating and/or disciplining medical student unprofessional behavior, problems with substance abuse, and other behavioral problems. as well as gaps in student knowledge and skills.
8. The Dean's Letter of Evaluation should be strengthened and standardized, to serve as a better source of information to residency programs about applicants.

International Medical Graduate Employment H-255.965
Our American Medical Association will support federal legislation that reduces the administrative burden and streamlines the process of hiring International Medical Graduates.

Unfair Discrimination Against International Medical Graduates H-255.978
It is the policy of the AMA to take appropriate action, legal or legislative, against implementation of Section 4752(d) of the OBRA of 1990 that requires international medical graduates, in order to obtain a Medicaid UPN number, to have held a license in one or more states continuously since 1958, or pass the Foreign Medical Graduate Examination in Medical Sciences (FMGEMS), or pass the Educational Commission for Foreign Medical Graduates (ECFMG) Examination, or be certified by ECFMG.

REFERENCES

1. Accreditation Council for Graduate Medical Education (ACGME). FSMB, Intealth, ACGME Establish Advisory Commission to Guide Alternate Pathways for State Licensure of International Medical Graduates. March 27, 2024. Accessed March 12, 2025. https://www.acgme.org/newsroom/2024/3/fsmb-intealth-acgme-establish-advisory-commission-to-guide-alternate-pathways-for-state-licensure-of-international-medical-graduates/

2. Accreditation Council for Graduate Medical Education (ACGME). Advisory Commission on Alternate Licensing Models Hosts Symposium to Discuss Pathways to Licensure for Fully-Trained International Physicians. June 21, 2024. Accessed March 13, 2025. https://www.acgme.org/newsroom/2024/6/advisory-commission-on-alternate-licensing-models-hosts-symposium-to-discuss-pathways-to-licensure-for-fully-trained-international-physicians/

3. Federation of State Medical Boards (FSMB). Advisory Commission Opens Public Comment Period on Draft Recommendations. Accessed March 13, 2025. https://www.fsmb.org/advisory-commission-on-additional-licensing-models/

4. Federation of State Medical Boards (FSMB). Advisory Commission Releases Recommendations to Inform Legislation on Licensing Internationally-Trained Physicians. February 4, 2025. Accessed March 3, 2025. https://www.fsmb.org/advocacy/news-releases/advisory-commission-releases-recommendations/

5. Federation of State Medical Boards (FSMB). Advisory Commission on Additional Licensing Models Releases Second Set of Draft Preliminary Recommendations for Public Comment. Accessed May 24, 2025. https://www.fsmb.org/advisory-commission-comment-period/

6. Accreditation Council for Graduate Medical Education (ACGME). Advisory Commission on Additional Licensing Models Releases Second Set of Draft Recommendations. May 22, 2025. Accessed May 29, 2025. https://www.acgme.org/newsroom/2025/5/advisory-commission-on-additional-licensing-models-releases-second-set-of-recommendations/

7. Chaudhry HJ, Combes JR, Holmboe ES, et al. Licensing Internationally Trained Physicians: Advisory Commission Leaders Share Initial Progress. *Ann Intern Med*. 2025;178:1187-1189. [Epub 1 July 2025]. doi:10.7326/ANNALS-25-00936

8. Federation of State Medical Boards (FSMB). Advisory Commission Releases Recommendations and Toolkit to Inform Assessment and Supervision of Internationally Trained Physicians. Accessed August 29, 2025. https://www.fsmb.org/advocacy/news-releases/advisory-commission-releases-recommendations-and-toolkit/

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 301
(I-25)

Introduced by: Michigan

Subject: Preventing Sleep Deprivation and Supporting Medical Student Wellness

Referred to: Reference Committee C

Whereas, state studies recommend how much sleep adults need to function well. Experts recommend that adults receive 7-9 hours of sleep per night; and

Whereas, studies have found that sleeping less than 7 hours can lead to adverse health outcomes such as impaired immune function, increased pain, decreased performance, and an increased risk of accidents; and

Whereas, medical students and residents who receive less than 7 hours of sleep per night experience higher rates of burnout, decreased motivation for learning, and increased risk of anxiety, depression, and alcohol abuse; and

Whereas, sleep deprivation and extended wakefulness can lead to impaired attention, slowed response time, and increased risk of errors, accidents, and injuries. In addition, studies show that cognitive function is most impaired during the first night of night shift work; and

Whereas, sleep deprivation and its negative effects on performance cannot be overcome by willing oneself to stay awake, nor by motivation, training, or experience. Thus, adequate rest is a necessary prerequisite for effective medical training; and

Whereas, research from the National Heart, Lung and Blood Institute underscores that sleep deprivation cannot simply be repaid through short sleeping periods. Multiple studies have shown that a full night of sleep (7-9 hours) is needed to restore memory and hippocampal-memory association function after one night of total sleep loss; and

Whereas, the Liaison Committee on Medical Education (LCME) works to ensure that every medical school has an effective system of counseling services to encourage medical student wellness; however, there are no guidelines in the LCME Functions and Structure of a Medical School: Standards for Accreditation of Medical Education Programs Leading to the MD Degree on how medical schools should manage student working hours and prevent sleep deprivation; and

Whereas, the Accreditation Council for Graduate Medical Education (ACGME) limits residents work hours to 80 hours per week (averaged over a 4-week period); and

Whereas, duty hour limits include at least 10 hours of rest between duty periods and no more than 24 hours of continuous scheduled clinical assignments (Note: 6-hour extension is permitted for patient continuity and education.); and

Whereas, ACGME also states that residents must have at least 14 hours free of clinical work and education after 24 hours of in-house call; therefore be it

RESOLVED, that our American Medical Association support the development of national standards to act as the official guideline for medical student work-hour limits, time off after a 24-hour shift, and work-hour guidelines. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Received: 9/3/25

REFERENCES

1. 2025-26-Functions-and-Structure_2024-08-01. (n.d.). https://lcme.org/publications/ ACGME Common Program Requirements (Residency). (n.d.). Retrieved February 24, 2025, from https://www.acgme.org/globalassets/pfassets/programrequirements/2025-prs/cprresidency_2025.pdf
2. Ahmed, N., Sadat, M., & Cukor, D. (2017). Sleep Knowledge and Behaviors in Medical Students: Results of a Single Center Survey. Academic psychiatry : the journal of the American Association of Directors of Psychiatric Residency Training and the Association for Academic Psychiatry, 41(5), 674â€“678. https://doi.org/10.1007/s40596-016-0655-3
3. Caruso CC. Negative impacts of shiftwork and long work hours. Rehabil Nurs. 2014 Jan-Feb;39(1):16-25. doi: 10.1002/rnj.107. Epub 2013 Jun 18. PMID: 23780784; PMCID: PMC4629843.
4. Chai, Y., Fang, Z., Yang, F.N. et al. Two nights of recovery sleep restores hippocampal connectivity but not episodic memory after total sleep deprivation. Sci Rep 10, 8774 (2020). https://doi.org/10.1038/s41598-020-65086-x
5. Kalkanis, A., Demolder, S., Papadopoulos, D., Testelmans, D., & Buyse, B. (2023). Recovery from shift work. Frontiers in neurology, 14, 1270043. https://doi.org/10.3389/fneur.2023.1270043
6. Lamond, N. and Dawson, D. (1999), Quantifying the performance impairment associated with fatigue. Journal of Sleep Research, 8: 255-262. https://doi.org/10.1046/j.1365-2869.1999.00167.x
7. Santhi N, Horowitz TS, Duffy JF, Czeisler CA (2007) Acute Sleep Deprivation and Circadian Misalignment Associated with Transition onto the First Night of Work Impairs Visual Selective Attention. PLoS ONE 2(11): e1233. https://doi.org/10.1371/journal.pone.0001233
8. Watson, N. F., Badr, M. S., Belenky, G., Bliwise, D. L., Buxton, O. M., Buysse, D., Dinges, D. F., Gangwisch, J., Grandner, M. A., Kushida, C., Malhotra, R. K., Martin, J. L., Patel, S. R., Quan, S. F., & Tasali, E. (2015). Recommended Amount of Sleep for a Healthy Adult: A Joint Consensus Statement of the American Academy of Sleep Medicine and Sleep Research Society. Sleep, 38(6), 843â€“844. https://doi.org/10.5665/sleep.4716
9. Wilson MR. The New ACGME Resident Duty Hours: Big Changes, Bigger Challenges. Ochsner J. 2003 Spring;5(2):3-5. PMID: 22826676; PMCID: PMC3399327.

RELEVANT AMA POLICY

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.

Resident/Fellow Clinical and Educational Work Hours H-310.907
Our American Medical Association adopts the following Principles of Resident/Fellow Clinical and Educational Work Hours, Patient Safety, and Quality of Physician Training:

1. Our AMA supports the 2017 Accreditation Council for Graduate Medical Education (ACGME) standards for clinical and educational work hours (previously referred to as “duty hours”).
2. Our AMA will continue to monitor the enforcement and impact of clinical and educational work hour standards, in the context of the larger issues of patient safety and the optimal learning environment for residents.
3. Our AMA encourages publication and supports dissemination of studies in peer-reviewed publications and educational sessions about all aspects of clinical and educational work hours, to include such topics as extended work shifts, handoffs, in-house call and at-home call, level of supervision by attending physicians, workload and growing service demands, moonlighting, protected sleep periods, sleep deprivation and fatigue, patient safety, medical error, continuity of care, resident well-being and burnout, development of professionalism, resident learning outcomes, and preparation for independent practice.
4. Our AMA endorses the study of innovative models of clinical and educational work hour requirements and, pending the outcomes of ongoing and future research, should consider the evolution of

specialty- and rotation-specific requirements that are evidence-based and will optimize patient safety and competency-based learning opportunities.

5. Our AMA encourages the ACGME to:
   a. Decrease the barriers to reporting of both clinical and educational work hour violations and resident intimidation.
   b. Ensure that readily accessible, timely and accurate information about clinical and educational work hours is not constrained by the cycle of ACGME survey visits.
   c. Use, where possible, recommendations from respective specialty societies and evidence-based approaches to any future revision or introduction of clinical and educational work hour rules.
   d. Broadly disseminate aggregate data from the annual ACGME survey on the educational environment of resident physicians, encompassing all aspects of clinical and educational work hours.
6. Our AMA recognizes the ACGME for its work in ensuring an appropriate balance between resident education and patient safety, and encourages the ACGME to continue to:
   a. Offer incentives to programs/institutions to ensure compliance with clinical and educational work hour standards.
   b. Ensure that site visits include meetings with peer-selected or randomly selected residents and that residents who are not interviewed during site visits have the opportunity to provide information directly to the site visitor.
   c. Collect data on at-home call from both program directors and resident/fellow physicians; release these aggregate data annually; and develop standards to ensure that appropriate education and supervision are maintained, whether the setting is in-house or at-home.
   d. Ensure that resident/fellow physicians receive education on sleep deprivation and fatigue.
7. Our AMA supports the following statements related to clinical and educational work hours:
   a. Total clinical and educational work hours must not exceed 80 hours per week, averaged over a four-week period (Note: “Total clinical and educational work hours” includes providing direct patient care or supervised patient care that contributes to meeting educational goals; participating in formal educational activities; providing administrative and patient care services of limited or no educational value; and time needed to transfer the care of patients).
   b. Scheduled on-call assignments should not exceed 24 hours. Residents may remain on-duty for an additional 4 hours to complete the transfer of care, patient follow-up, and education; however, residents may not be assigned new patients, cross-coverage of other providers’ patients, or continuity clinic during that time.
   c. Time spent in the hospital by residents on at-home call must count towards the 80-hour maximum weekly hour limit, and on-call frequency must not exceed every third night averaged over four weeks. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one-day-in-seven free of duty, when averaged over four weeks.
   d. At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident.
   e. Residents are permitted to return to the hospital while on at-home call to care for new or established patients. Each episode of this type of care, while it must be included in the 80-hour weekly maximum, will not initiate a new “off-duty period.”
   f. Given the different education and patient care needs of the various specialties and changes in resident responsibility as training progresses, clinical and educational work hour requirements should allow for flexibility for different disciplines and different training levels to ensure appropriate resident education and patient safety; for example, allowing exceptions for certain disciplines, as appropriate, or allowing a limited increase to the total number of clinical and educational work hours when need is demonstrated.
   g. Resident physicians should be ensured a sufficient duty-free interval prior to returning to duty.
   h. Clinical and educational work hour limits must not adversely impact resident physician participation in organized educational activities. Formal educational activities must be scheduled and available within total clinical and educational work hour limits for all resident physicians.
   i. Scheduled time providing patient care services of limited or no educational value should be minimized.
   j. Accurate, honest, and complete reporting of clinical and educational work hours is an essential element of medical professionalism and ethics.
   k. The medical profession maintains the right and responsibility for self-regulation (one of the key tenets of professionalism) through the ACGME and its purview over graduate medical education,

and categorically rejects involvement by the Centers for Medicare & Medicaid Services, The Joint Commission, Occupational Safety and Health Administration, and any other federal or state government bodies in the monitoring and enforcement of clinical and educational work hour regulations, and opposes any regulatory or legislative proposals to limit the work hours of practicing physicians.

l. Increased financial assistance for residents/fellows, such as subsidized child care, loan deferment, debt forgiveness, and tax credits, may help mitigate the need for moonlighting. At the same time, resident/fellow physicians in good standing with their programs should be afforded the opportunity for internal and external moonlighting that complies with ACGME policy.

m. Program directors should establish guidelines for scheduled work outside of the residency program, such as moonlighting, and must approve and monitor that work such that it does not interfere with the ability of the resident to achieve the goals and objectives of the educational program.

n. The costs of clinical and educational work hour limits should be borne by all health care payers. Individual resident compensation and benefits must not be compromised or decreased as a result of changes in the graduate medical education system.

o. The general public should be made aware of the many contributions of resident/fellow physicians to high-quality patient care and the importance of trainees' realizing their limits (under proper supervision) so that they will be able to competently and independently practice under real-world medical situations.

8. Our AMA is in full support of the collaborative partnership between allopathic and osteopathic professional and accrediting bodies in developing a unified system of residency/fellowship accreditation for all residents and fellows, with the overall goal of ensuring patient safety.

9. Our AMA will actively participate in ongoing efforts to monitor the impact of clinical and educational work hour limitations to ensure that patient safety and physician well-being are not jeopardized by excessive demands on post-residency physicians, including program directors and attending physicians.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 304
(I-25)

Introduced by: International Medical Graduates Section

Subject: Systemic Exclusion of IMGs from Residency Programs

Referred to: Reference Committee C

Whereas, international medical graduates (IMGs) represent nearly 25% of the U.S. physician workforce and provide essential care in primary care, rural, and underserved communities; and

Whereas, categorical exclusion of IMGs from residency application processes persists despite longstanding AMA policy opposing discrimination in medical education and training, including AMA Policy H-255.988 (“Support for International Medical Graduates”), which affirms that IMGs should be evaluated on the basis of individual merit rather than place of medical education; and

Whereas, AMA policy also opposes discrimination in graduate medical education based on school of graduation, citizenship, or immigration status, yet some programs continue to employ blanket exclusions; and

Whereas, such exclusion limits workforce diversity, exacerbates physician shortages, and denies patients access to qualified physicians trained and certified through rigorous international and U.S. standards; and

Whereas, many residency programs fail to provide transparent information about IMG eligibility, leading applicants to waste limited financial and personal resources while discouraging participation in the Match process; and

Whereas, fair, competency-based evaluation of residency applicants, rather than categorical exclusion, aligns with the principles of equity, diversity, and inclusion and strengthens the physician workforce; and

Whereas, graduate medical education (GME) positions are funded substantially by federal and state tax dollars, and programs receiving public funds should adhere to non-discrimination principles in admitting qualified applicants; therefore be it

RESOLVED, that our American Medical Association reaffirm its commitment to opposing discrimination against IMGs in all aspects of medical education and training (New HOD Policy); and be it further

RESOLVED, that our AMA, through its Council on Medical Education, work with the Accreditation Council for Graduate Medical Education, the National Resident Matching Program, and Intealth to prohibit categorical exclusion of IMGs from residency applications; (Directive to Take Action); and be it further

RESOLVED, that our AMA, through its Council on Medical Education, advocate for mandatory transparency in residency program eligibility requirements, including IMG eligibility, published in a standardized and accessible format. (Directive to Take Action)

Fiscal Note: Minimal – less than $1,000

Received: 9/25/25

RELEVANT AMA POLICY

AMA Principles on International Medical Graduates – H-255.988

1. Our AMA supports current U.S. visa and immigration requirements applicable to foreign national physicians who are graduates of medical schools other than those in the United States and Canada.
2. Our AMA supports current regulations governing the issuance of exchange visitor visas to foreign national IMGs, including the requirements for successful completion of the USMLE.
3. Our AMA reaffirms its policy that the U.S. and Canada medical schools be accredited by a nongovernmental accrediting body.
4. Our AMA supports cooperation in the collection and analysis of information on medical schools in nations other than the U.S. and Canada.
5. Our AMA supports continued cooperation with the ECFMG and other appropriate organizations to disseminate information to prospective and current students in foreign medical schools. An AMA member, who is an IMG, should be appointed regularly as one of the AMA's representatives to the ECFMG Board of Trustees.
6. Our AMA supports working with the Accreditation Council for Graduate Medical Education (ACGME) and the Federation of State Medical Boards (FSMB) to assure that institutions offering accredited residencies, residency program directors, and U.S. licensing authorities do not deviate from established standards when evaluating graduates of foreign medical schools.
7. In cooperation with the ACGME and the FSMB, our AMA supports only those modifications in established graduate medical education or licensing standards designed to enhance the quality of medical education and patient care.
8. Our AMA continues to support the activities of the ECFMG related to verification of education credentials and testing of IMGs.
9. Our AMA supports that special consideration be given to the limited number of IMGs who are refugees from foreign governments that refuse to provide pertinent information usually required to establish eligibility for residency training or licensure.
10. Our AMA supports that accreditation standards enhance the quality of patient care and medical education and not be used for purposes of regulating physician manpower.
11. Our AMA representatives to the ACGME, residency review committees and to the ECFMG should support AMA policy opposing discrimination. Medical school admissions officers and directors of residency programs should select applicants on the basis of merit, without considering status as an IMG or an ethnic name as a negative factor.
12. Our AMA supports the requirement that all medical school graduates complete at least one year of graduate medical education in an accredited U.S. program in order to qualify for full and unrestricted licensure. State medical licensing boards are encouraged to allow an alternate set of criteria for granting licensure in lieu of this requirement:
    a. completion of medical school and residency training outside the U.S.;
    b. extensive U.S. medical practice; and
    c. evidence of good standing within the local medical community.
13. Our AMA supports publicizing existing policy concerning the granting of staff and clinical privileges in hospitals and other health facilities.
14. Our AMA supports the participation of all physicians, including graduates of foreign as well as U.S. and Canadian medical schools, in organized medicine. Our AMA offers encouragement and assistance to state, county, and specialty medical societies in fostering greater membership among IMGs and their participation in leadership positions at all levels of organized medicine, including AMA committees and councils, the Accreditation Council for Graduate Medical Education and its review committees, the American Board of Medical Specialties and its specialty boards, and state boards of medicine, by providing guidelines and non-financial incentives, such

as recognition for outstanding achievements by either individuals or organizations in promoting leadership among IMGs.

15. Our AMA supports studying the feasibility of conducting peer-to-peer membership recruitment efforts aimed at IMGs who are not AMA members.
16. Our AMA membership outreach to IMGs to include
    a. using its existing publications to highlight policies and activities of interest to IMGs, stressing the common concerns of all physicians;
    b. publicizing its many relevant resources to all physicians, especially to nonmember IMGs;
    c. identifying and publicizing AMA resources to respond to inquiries from IMGs; and
    d. expansion of its efforts to prepare and disseminate information about requirements for admission to accredited residency programs, the availability of positions, and the problems of becoming licensed and entering full and unrestricted medical practice in the U.S. that face IMGs. This information should be addressed to college students, high school and college advisors, and students in foreign medical schools.
17. Our AMA supports recognition of the common aims and goals of all physicians, particularly those practicing in the U.S., and support for including all physicians who are permanent residents of the U.S. in the mainstream of American medicine.
18. Our AMA supports its leadership role to promote the international exchange of medical knowledge as well as cultural understanding between the U.S. and other nations.
19. Our AMA supports institutions that sponsor exchange visitor programs in medical education, clinical medicine and public health to tailor programs for the individual visiting scholar that will meet the needs of the scholar, the institution, and the nation to which he will return.
20. Our AMA supports informing foreign national IMGs that the availability of training and practice opportunities in the U.S. is limited by the availability of fiscal and human resources to maintain the quality of medical education and patient care in the U.S., and that those IMGs who plan to return to their country of origin have the opportunity to obtain GME in the United States.
21. Our AMA supports U.S. medical schools offering admission with advanced standing, within the capabilities determined by each institution, to international medical students who satisfy the requirements of the institution for matriculation.
22. Our AMA supports the Federation of State Medical Boards, its member boards, and the ECFMG in their willingness to adjust their administrative procedures in processing IMG applications so that original documents do not have to be recertified in home countries when physicians apply for licenses in a second state.
23. Our AMA supports continued efforts to protect the rights and privileges of all physicians duly licensed in the U.S. regardless of ethnic or educational background and opposes any legislative efforts to discriminate against duly licensed physicians on the basis of ethnic or educational background.
24. Our AMA supports continued study of challenges and issues pertinent to IMGs as they affect our country's health care system and our physician workforce.
25. Our AMA supports advocacy to Congress to fund studies through appropriate agencies, such as the Department of Health and Human Services, to examine issues and experiences of IMGs and make recommendations for improvements.

BOT Rep. Z, A-8 Reaffirmed: Res. 312, I-93 Modified: CME Rep. 2, A-03 Reaffirmation I-11 Reaffirmed: CME Rep. 1, I-1 3 Modified: BOT Rep. 25, A-15 Modified: CME Rep. 01, A-16 Appended: Res. 304, A-17 Modified: CME Rep. 01, I-17 Reaffirmation: A-19 Modified: CME Rep. 2, A-21 Modified: CME Rep. 1, A-22 Modified: CCB/CLRPD Rep. 1, A-22 Reaffirmed: CME Rep. 03, A-23 Reaffirmed: Res. 312, A-25 Reaffirmed in lieu of the first resolve: Res. 234, A-2 Reaffirmed: Res. 241, A-25

Impact of Immigration Barriers on the Nation's Health D-255.980

1. Our American Medical Association recognizes the valuable contributions and affirms our support of international medical students and international medical graduates and their participation in U.S. medical schools, residency and fellowship training programs and in the practice of medicine.
2. Our AMA will oppose laws and regulations that would broadly deny entry or re-entry to the United States of persons who currently have legal visas, including permanent resident status (green card) and student visas, based on their country of origin and/or religion.

3. Our AMA will oppose policies that would broadly deny issuance of legal visas to persons based on their country of origin and/or religion.
4. Our AMA will advocate for the immediate reinstatement of premium processing of H-1B visas for physicians and trainees to prevent any negative impact on patient care.
5. Our AMA will advocate for the timely processing of visas for all physicians, including residents, fellows, and physicians in independent practice.
6. Our AMA will work with other stakeholders to study the current impact of immigration reform efforts on residency and fellowship programs, physician supply, and timely access of patients to health care throughout the U.S.

Alt. Res. 308, A-17 Modified: CME Rep. 01, A-18 Reaffirmation: A-19 Reaffirmed: CME Rep. 4, A-21 Reaffirmed: Res. 234, A-22 Reaffirmed: Res. 210, A-23

Filtering International Medical Graduates During Residency or Fellowship Applications H-255.963
1. Our American Medical Association recognizes the exclusion of certain residency applicants from consideration, such as international medical graduates.
2. Our AMA opposes discriminatory use of filters designed to inequitably screen applicants, including international medical graduates, using the Electronic Residency Application Service® (ERAS®) system.
Res. 313, A-23

National Resident Matching Program Reform D-310.977
1. Our AMA will work with the National Resident Matching Program (NRMP) to develop and distribute educational programs to better inform applicants about the NRMP matching process, including the existing NRMP waiver and violations review policies.
2. Our AMA will actively participate in the evaluation of, and provide timely comments about, all proposals to modify the NRMP Match.
3. Our AMA will request that the NRMP explore the possibility of including the Osteopathic Match in the NRMP Match.
4. Our AMA will continue to review the NRMP's policies and procedures and make recommendations for improvements as the need arises, to include making the conditions of the Match agreement more transparent while assuring the confidentiality of the match.
5. Our AMA will work with the Accreditation Council for Graduate Medical Education (ACGME) and other appropriate agencies to assure that the terms of employment for resident physicians are fair and equitable and reflect the unique and extensive amount of education and experience acquired by physicians.
6. Our AMA does not support the current the "All-In" policy for the Main Residency Match to the extent that it eliminates flexibility within the match process.
7. Our AMA will work with the NRMP, and other residency match programs, in revising Match policy, including the secondary match or scramble process to create more standardized rules for all candidates including application timelines and requirements.
8. Our AMA will work with the NRMP and other external bodies to develop mechanisms that limit disparities within the residency application process and allow both flexibility and standard rules for applicants.
9. Our AMA encourages the National Resident Matching Program to study and publish the effects of implementation of the Supplemental Offer and Acceptance Program on the number of residency spots not filled through the Main Residency Match and include stratified analysis by specialty and other relevant areas.
10. Our AMA will work with the NRMP and ACGME to evaluate the challenges in moving from a time-based education framework toward a competency-based system, including:
    a. Analysis of time-based implications of the ACGME milestones for residency programs.
    b. The impact on the NRMP and entry into residency programs if medical education programs offer variable time lengths based on acquisition of competencies.
    c. The impact on financial aid for medical students with variable time lengths of medical education programs.
    d. The implications for interprofessional education and rewarding teamwork.
    e. The implications for residents and students who achieve milestones earlier or later than their peers.

11. Our AMA will work with the Association of American Medical Colleges (AAMC), American Osteopathic Association (AOA), American Association of Colleges of Osteopathic Medicine (AACOM), and National Resident Matching Program (NRMP) to evaluate the current available data or propose new studies that would help us learn how many students graduating from US medical schools each year do not enter into a US residency program; how many never enter into a US residency program; whether there is disproportionate impact on individuals of minority racial and ethnic groups; and what careers are pursued by those with an MD or DO degree who do not enter residency programs.
12. Our AMA will work with the AAMC, AOA, AACOM and appropriate licensing boards to study whether US medical school graduates and international medical graduates who do not enter residency programs may be able to serve unmet national health care needs;
13. Our AMA will work with the AAMC, AOA, AACOM and the NRMP to evaluate the feasibility of a national tracking system for US medical students who do not initially match into a categorical residency program.
14. Our AMA will discuss with the National Resident Matching Program, Association of American Medical Colleges, American Osteopathic Association, Liaison Committee on Medical Education, Accreditation Council for Graduate Medical Education, and other interested bodies potential pathways for reengagement in medicine following an unsuccessful match and report back on the results of those discussions.
15. Our AMA encourages the Association of American Medical Colleges to work with U.S. medical schools to identify best practices, including career counseling, used by medical schools to facilitate successful matches for medical school seniors, and reduce the number who do not match.
16. Our AMA supports the movement toward a unified and standardized residency application and match system for all non-military residencies.
17. Our AMA encourages the Educational Commission for Foreign Medical Graduates (ECFMG) and other interested stakeholders to study the personal and financial consequences of ECFMG-certified U.S. IMGs who do not match in the National Resident Matching Program and are therefore unable to get a residency or practice medicine.
18. Our AMA encourages the AAMC, AACOM, NRMP, and other key stakeholders to jointly create a no-fee, easily accessible clearinghouse of reliable and valid advice and tools for residency program applicants seeking cost-effective methods for applying to and successfully matching into residency.
19. Our AMA will work with appropriate stakeholders to study options for improving transparency in the resident application process.
20. Our AMA encourages the piloting of innovations to the residency application process with aims to reduce application numbers per applicant, focus applicants on programs with reciprocal interest, and maximize residency placement. With support from the medical education community, successful pilots should be expanded to enhance the standardized process.
21. Our AMA will continue to engage the National Resident Matching Program® (NRMP®) and other matching organizations on behalf of residents and medical students to further develop ongoing relationships, improve communications, and seek additional opportunities to collaborate including the submission of suitable nominees for their governing bodies as appropriate.

CME Rep. 4, A-05 Appended: Res. 330, A-11Appended: Res. 920, I-11Appended: Res. 311, A-14Appended: Res. 312, A-14 Appended: Res. 304, A-15 Appended: CME Rep. 03, A-16 Reaffirmation: A-16 Appended: CME Rep. 06, A-17Appended: Res. 306, A-17 Modified: Speakers Rep. 01, A-17 Appended: CME Rep. 3, A-21Modified: CME Rep. 1, A-22 Appended: Res. 328, A-22 Modified: CME Rep. 02, A-24 Reaffirmed: CME Rep. 03, A-25

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 305
(I-25)

Introduced by: Women Physicians Section

Subject: Paid Sick Leave and Flexible Work Arrangements for Caregivers of Individuals with Special Needs, Chronic Illness, or Elderly Parents

Referred to: Reference Committee C

Whereas, there is no standardized or universal structure in place for laws related to paid sick leave across the United States[1,2]; and

Whereas, as more than 14 million children in the U.S. have been reported to have special needs, it is essential to expand on sick leave and flexible work arrangements for physician mothers who are also caregivers[3,4]; and

Whereas, in a 2019 JAMA Internal Medicine survey, 45% of physician mothers as caregivers reported being burnout and 40% of physician mothers with reported extra caregiving obligations also identified with having mood and anxiety disorder[5]; and

Whereas, physician mothers with caregiving obligations can reduce higher physician burnout, secondary traumatic stress, and compassion fatigue if their sick child or elderly sick parent receives prompt and timely care[6]; and

Whereas, the American with Disabilities Act (ADA) requires reasonable accommodations for employees with disabilities but does not mandate accommodations for caregivers, therefore accommodation for physician mothers who are also caregivers of child(ren) with special needs, disability, chronic illness or elderly sick parent(s) should be provided[7]; and

Whereas, the Family Medical Leave Act (FMLA) provides at least 12 weeks of unpaid leave for family/medical reasons, it does not mandate paid leave, hence it would be beneficial to provide financial compensation (partial or complete) for employee medical leave which can help to reduce the financial and mental distress of the employee (physician mother)[8,9] and

Whereas, the implementation and addition of backup child-care and elderly-care such as hospital based employer-provided care facilities or community-based respite programs, especially for situations where an elderly or child may be sick or require special in-person assisted care can benefit both the caregiver by reducing work disruptions and stress as well as having necessary support for their child or elderly parent; and

Whereas, provision of well-trained and well-equipped daycare centers that can provide care for children (with special needs or chronic health issues) or elderly parents (with health issues) can improve the work-life balance of physician mothers and reduce caregiver responsibilities; and

Whereas, flexible work arrangements such as flexible work hours, remote telework, or adjusted work schedules can help accommodate physician mothers who are also caregivers and may need to be physically present to attend the needs of their child(ren) (with special needs, disability, or chronic illness) or their elderly sick parent(s)[10,11,12]; therefore be it

RESOLVED, that our American Medical Association amend H-420.979, "AMA Statement on Family, Medical, and Safe Leave", by addition as follows:

Our American Medical Association supports policies that provide employees with reasonable job security and continued availability of health plan benefits in the event leave by an employee becomes necessary due to documented medical conditions, caregiving obligations, or reasons related to personal safety. Such policies should provide for reasonable periods of paid or unpaid:

1. Medical leave for the employee, including pregnancy, abortion, and stillbirth.
2. Maternity and paternity leave for the employee.
3. Leave if medically appropriate to care for a member of the employee's immediate family, i.e., a spouse, children, or elderly parents
4. Leave for adoption or for foster care leading to adoption.
5. Safe leave provisions for those experiencing any instances of violence, including but not limited to intimate partner violence, sexual violence or coercion, and stalking.
6. Flexible work arrangements such as flexible work hours and the ability to work remotely,

Such periods of leave may differ with respect to each of the foregoing classifications and may vary with reasonable categories of employers. Such policies should encourage voluntary programs by employers and may provide for appropriate legislation (with or without financial assistance from government). Any legislative proposals will be reviewed through the Association's normal legislative process for appropriateness, taking into consideration all elements therein, including classifications of employees and employers, reasons for the leave, periods of leave recognized (whether paid or unpaid), obligations on return from leave, and other factors involved in order to achieve reasonable objectives recognizing the legitimate needs of employees and employers. Our AMA recognizes the positive impact of paid safe leave on public health outcomes and supports legislation that offers safe leave;

(Modify Current HOD Policy); and be it further

RESOLVED, that our AMA supports physician mothers who are caregivers to alleviate physician burnout. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Received: 9/25/25

REFERENCES

1. Mitchell, Sophia. *STATE PAID SICK LEAVE LAWS* . Department of Labor- Women's Bureau, Sept. 2024.
2. U.S Bureau of Labor Statistics. "Paid Sick Leave: What Is Available to Workers?" *Www.bls.gov*, 19 Sept. 2024, www.bls.gov/ebs/factsheets/paid-sick-leave.htm.
3. *Children and Youth with Special Health Care Needs* . Health Resources and Services Administration Maternal and Child Health Bureau, 2022.
4. Child and Adolescent Health Measurement Initiative. 2021-2022 National Survey of Children's Health (NSCH) data query. Data Resource Center for Child and Adolescent Health supported by the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB). Retrieved [mm/dd/yy] from [www.childhealthdata.org]
5. Yank, Veronica, et al. "Behavioral Health and Burnout among Physician Mothers Who Care for a Person with a Serious Health Problem, Long-Term Illness, or Disability." *JAMA Internal Medicine*, vol. 179, no. 4, 1 Apr. 2019, p. 571, https://doi.org/10.1001/jamainternmed.2018.6411. Accessed 1 Feb. 2022.
6. Albert Henry, Tanya. "Higher Physician Burnout Risk for Moms in "Sandwich Generation."" *American Medical Association*, 3 June 2019, www.ama-assn.org/practice-management/physician-health/higher-physician-burnout-risk-moms-sandwich-generation.

7. *The ADA and Caregivers: Frequently Asked Questions*. ADA National Network, 2015, adata.org/factsheet/ada-and-caregivers.
8. U.S. Department of Labor. “Fact Sheet #28: The Family and Medical Leave Act.” *Www.dol.gov*, U.S Department of Labor, Feb. 2023, www.dol.gov/agencies/whd/fact-sheets/28-fmla.
9. “Paid Family and Medical Leave (PFML) Overview and Benefits.” *Mass.gov*, Department of Family and Medical Leave, 2024, www.mass.gov/info-details/paid-family-and-medical-leave-pfml-overview-and-benefits?_gl=1. Accessed 18 Sept. 2025.
10. Semere W, Ponce AN, Linos E, Jagsi R, Mangurian C, Halley MC. "Learning from those who know the system inside and out": Experiences of physician mothers who are informal caregivers. Fam Syst Health. 2025 Jun;43(2):386-393. doi: 10.1037/fsh0000945. Epub 2024 Dec 12. PMID: 39666478; PMCID: PMC12159254.
11. Minkove, Judy F. *Addressing Caregiver Strain among Faculty*. Johns Hopkins Medicine, 4 Oct. 2021, www.hopkinsmedicine.org/news/articles/2021/10/addressing-caregiver-strain-among-faculty. Accessed 18 Sept. 2025.
12. Wisenberg Brin, Dinah. *Working Mom, MD: Always on Call*. AAMC, 2017, www.aamc.org/news/working-mom-md-always-call. Accessed 18 Sept. 2025.

RELEVANT AMA POLICY

H-405.960 Increasing Practice Viability for Physicians Through Increased Employer And Employee Awareness of Protected Leave Policies

Our American Medical Association adopts as policy the following guidelines for, and encourages the implementation of, Parental, Family and Medical Necessity Leave for Medical Students and Physicians:

1. Our AMA urges residency training programs, medical specialty boards, the Accreditation Council for Graduate Medical Education, and medical group practices to incorporate and/or encourage development of leave policies, including parental, family, and medical leave policies, as part of the physician's standard benefit agreement.
2. Recommended components of parental leave policies for physicians include:
    a. duration of leave allowed before and after delivery;
    b. category of leave credited;
    c. whether leave is paid or unpaid;
    d. whether provision is made for continuation of insurance benefits during leave, and who pays the premium;
    e. whether sick leave and vacation time may be accrued from year to year or used in advance;
    f. how much time must be made up in order to be considered board eligible;
    g. whether make-up time will be paid;
    h. whether schedule accommodations are allowed; and
    i. leave policy for adoption.
3. Our AMA policy is expanded to include physicians in practice, reading as follows:
    a. residency program directors and group practice administrators should review federal law concerning maternity leave for guidance in developing policies to assure that pregnant physicians are allowed the same sick leave or disability benefits as those physicians who are ill or disabled;
    b. staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in other physicians' workloads, particularly in residency programs; and
    c. physicians should be able to return to their practices or training programs after taking parental leave without the loss of status.
4. Our AMA recommends that medical practices, departments and training programs strive to provide 12 weeks of paid parental, family and medical necessity leave in a 12-month period for their attending and trainee physicians as needed, with the understanding that no parent be required to take a minimum leave, and with eligibility beginning at the start of employment without a waiting period.
5. Residency program directors should review federal and state law for guidance in developing policies for parental, family, and medical leave.
6. Medical students and physicians who are unable to work because of pregnancy, childbirth, abortion or stillbirth, and other related medical conditions should be entitled to such leave and other benefits on the same basis as other physicians who are temporarily unable to work for other medical reasons.

7. Residency programs should develop written policies on leave for physicians. Such written policies should include the following elements:
    a. leave policy for birth or adoption;
    b. duration of leave allowed before and after delivery;
    c. duration of leave allowed after abortion or stillbirth;
    d. category of leave credited (e.g., sick, vacation, parental, unpaid leave, short term disability);
    e. whether leave is paid or unpaid;
    f. whether provision is made for continuation of insurance benefits during leave and who pays for premiums; (g) whether sick leave and vacation time may be accrued from year to year or used in advance;
    g. extended leave for resident physicians with extraordinary and long-term personal or family medical tragedies for periods of up to one year, without loss of previously accepted residency positions, for devastating conditions such as terminal illness, permanent disability, or complications of pregnancy that threaten maternal or fetal life;
    h. how time can be made up in order for a resident physician to be considered board eligible;
    i. what period of leave would result in a resident physician being required to complete an extra or delayed year of training;
    j. whether time spent in making up a leave will be paid; and
    k. whether schedule accommodations are allowed, such as reduced hours, no night call, modified rotation schedules, and permanent part-time scheduling.
8. Medical schools should develop written policies on parental leave, family leave, and medical leave for medical students. Such written policies should include the following elements:
    a. leave policy for birth or adoption;
    b. duration of leave allowed before and after delivery;
    c. extended leave for medical students with extraordinary and long-term personal or family medical tragedies, without loss of previously accepted medical school seats, for devastating conditions such as terminal illness, permanent disability, or complications of pregnancy that threaten maternal or fetal life;
    d. how time can be made up in order for a medical students to be eligible for graduation with minimal or no delays;
    e. what period of leave would result in a medical student being required to complete an extra or delayed year of training; and
    f. whether schedule accommodations are allowed, such as modified rotation schedules, no night duties, and flexibility with academic testing schedules.
9. Our AMA endorses the concept of equal parental leave for birth and adoption as a benefit for resident physicians, medical students, and physicians in practice regardless of gender or gender identity.
10. Staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in the workloads of other physicians, particularly those in residency programs.
11. Physicians should be able to return to their practices or training programs after taking parental leave, family leave, or medical leave without the loss of status.
12. Residency program directors must assist residents in identifying their specific requirements (for example, the number of months to be made up) because of leave for eligibility for board certification and must notify residents on leave if they are in danger of falling below minimal requirements for board eligibility. Program directors must give these residents a complete list of requirements to be completed in order to retain board eligibility.
13. Our AMA encourages flexibility in residency programs and medical schools incorporating parental leave and alternative schedules for pregnant trainees.
14. In order to accommodate leave protected by the federal Family and Medical Leave Act, our AMA encourages all specialties within the American Board of Medical Specialties (ABMS) to allow graduating residents to extend training after the traditional residency completion date while still maintaining board eligibility, in the event of leave beyond six weeks. Our AMA encourages specialty boards to develop flexible policies for board certification for those physicians who take leave beyond the minimum of six weeks of family or medical leave (per ABMS policy) and

whose residency programs are able to certify that residents meet appropriate competencies for program completion.

15. Our AMA will work with appropriate stakeholders to encourage that residency programs annually publish and share with FREIDA and other appropriate stakeholders, self-identified and other demographic data, including but not limited to the composition of their program over the last 5 years by age; historically marginalized, minoritized, or excluded status; sexual orientation and gender identity.
16. Our AMA will encourage the Accreditation Council for Graduate Medical Education and other relevant stakeholders to annually collect data on childbirth and parenthood from all accredited US residency programs and publish this data with disaggregation by gender identity and specialty.
17. These policies as above should be freely available online through FREIDA and in writing to all current trainees and applicants to medical school, residency or fellowship.
18. Medical schools are encouraged to develop clear, equitable parental leave policies and determine how a 12-week parental, family, or medical leave may be incorporated with alternative, timely means of completing missed curriculum while still meeting competency requirements necessary to complete a medical degree.
19. Our AMA opposes any discrimination related to physicians taking protected leave during training and/or medical practice for medical, religious, and/or family reasons.
20. Our AMA will encourage relevant stakeholders to survey physicians and medical students who have taken family leave, in an effort to learn about the experiences of various demographic groups and identify potential disparities in career progression trends. [CCB/CLRPD Rep. 4, A-13; Modified: Res. 305, A-14; Modified: Res. 904, I-14; Modified: Res. 307, A-22; Modified: Res. 302, I-22; Modified: Res. 312, I-22; Modified: CME Rep. 01 and Res. 306, I-23; Modified: Res. 302, I-24]

H-405.947 Compassionate Leave for Physicians, Medical Students, Medical Trainees, and Physician Residents and Fellows

1. Our American Medical Association urges:
    a. medical schools, and the Liaison Committee on Medical Education and Commission on Osteopathic College Accreditation to incorporate and/or encourage development of compassionate leave policies. Such compassionate leave policies should consider inclusion of extensive travel and events impacting family planning, pregnancy, or fertility (including pregnancy loss, an unsuccessful round of intrauterine insemination or of an assisted reproductive technology procedure, a failed adoption arrangement, or a failed surrogacy arrangement). These policies should determine how compassionate leave may be incorporated with alternative, timely means of achieving curricular goals when absent from curricular components and to meet competency requirements necessary to complete a medical degree.
    b. residency and fellowship training programs, their sponsoring institutions, and Accreditation Council for Graduate Medical Education to incorporate and/or encourage development of compassionate leave policies as part of the physician's standard benefit agreement. Such compassionate leave policies should consider appropriateness of coverage during extensive travel and events impacting family planning, pregnancy, or fertility (including pregnancy loss, an unsuccessful round of intrauterine insemination or of an assisted reproductive technology procedure, a failed adoption arrangement, or a failed surrogacy arrangement). These policies should also include whether the leave is paid or unpaid, outline what obligations and absences must be made up, and determine how compassionate leave may be incorporated with alternative, timely means of achieving curricular goals when absent from curricular components and to meet competency requirements necessary to achieve independent practice and board eligibility for their specialty.
    c. medical group practices to incorporate and/or encourage development of compassionate leave policies as part of the physician's standard benefit agreement. Such compassionate leave policies should consider appropriateness of coverage during extensive travel and events impacting family planning, pregnancy, or fertility (including pregnancy loss, an unsuccessful round of intrauterine insemination or of an assisted

reproductive technology procedure, a failed adoption arrangement, or a failed surrogacy arrangement). These policies should also include whether the leave is paid or unpaid and what obligations and absences must be made up.

2. Our AMA encourages medical schools, residency and fellowship programs, specialty boards, specialty societies and medical group practices to incorporate into their compassionate leave policies a three-day minimum leave, with the understanding that no medical student or physician should be required to take a minimum leave.
3. Medical students and physicians who are unable to work beyond the defined compassionate leave period because of physical or psychological stress, medical complications of pregnancy loss, or another related reason should refer to their institution's sick leave policy, family and medical leave policy, and other benefits on the same basis as other physicians who are temporarily unable to work for other reasons.
4. Our AMA supports the concept of equal compassionate leave for bereavement due to death or loss (e.g., pregnancy loss and other such events impacting fertility in a physician or their partner) as a benefit for physicians, medical students, medical trainees, and physician residents and fellows, regardless of gender or gender identity.
5. Staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in the workloads of other physicians, particularly those in residency programs.
6. These guidelines as above should be freely available online and in writing to all applicants to medical school, residency, or fellowship. [Res. 309, I-22; Modified: CME Rep. 01, I-23]

H-405.954 Parental Leave
Our American Medical Association encourages the study of the health implications among patients if the United States were to modify one or more of the following aspects of the Family and Medical Leave Act (FMLA): a reduction in the number of employees from 50 employees; an increase in the number of covered weeks from 12 weeks; and creating a new benefit of paid parental leave.

1. Our AMA will study the effects of FMLA expansion on physicians in varied practice environments.
2. Our AMA:
    a. encourages employers to offer and/or expand paid parental leave policies.
    b. encourages state medical associations to work with their state legislatures to establish and promote paid parental leave policies.
    c. advocates for improved social and economic support for paid family leave to care for newborns, infants and young children.
    d. advocates for federal tax incentives to support early child care and unpaid child care by extended family members.
3. Our AMA:
    a. encourages key stakeholders to implement policies and programs that help protect against parental discrimination and promote work-life integration for physician parents, which should encompass prenatal parental care, equal parental leave for birthing and non-birthing parents, and flexibility for childcare.
    b. urges key stakeholders to include physicians and frontline workers in legislation that provides protections and considerations for paid parental leave for issues of health and childcare. [Res. 215, I-16; Appended BOT Rep. 11, A-19; Appended: Res. 403, A-22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 306
(I-25)

Introduced by: Women Physicians Section

Subject: Support for Paid Prenatal Leave

Referred to: Reference Committee C

Whereas, prenatal care utilization is significantly associated with maternal and infant health outcomes, with lower utilization associated with increased maternal morbidity and mortality[1–7]; and

Whereas, lower socioeconomic status is associated with higher risk of severe maternal morbidity and lower utilization of prenatal care[8–14]; and

Whereas, pregnant people working low wage jobs are less likely to access prenatal care than pregnant people working high wage jobs and pregnant people in two-income households, with financial strain often cited as a reason for missing prenatal care appointments[10,15–21]; and

Whereas, on January 1, 2025 New York became the first state to enact paid prenatal leave, which guarantees an additional 20 hours of paid sick leave for prenatal care in addition to existing sick leave for all privately-employed pregnant workers in New York[22]; and

Whereas, many people can't afford to take unpaid leave, and about 44% of U.S. workers don't qualify for benefits through FMLA, which excludes smaller employers and many part-time workers[23]; and

Whereas, Americans who currently have access to paid leave are much more likely to be affluent, well-educated, and white[24–26], and

Whereas, people who currently do not have access to paid leave would likely experience the most improved outcomes from gaining access to paid prenatal leave, including fewer preterm births, lower infant mortality, decreased risk of poverty, and reduced intimate partner violence[23,27–30]; therefore be it

RESOLVED, that our American Medical Association supports policies that provide employees, particularly larger organizations and those with the capacity and resources, with paid leave for prenatal care or any medical care related to pregnancy in addition to other existing forms of leave (New HOD Policy); and be it further

RESOLVED, that our AMA supports the creation of state sponsored programs that cover family and medical leave. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Date Received: 9/25/25

REFERENCES

1. Perez MT, Bucholz E, Asimacopoulos E, et al. Impact of maternal social vulnerability and timing of prenatal care on outcome of prenatally detected congenital heart disease. *Ultrasound Obstet Gynecol*. 2022;60(3):346-358. doi:10.1002/uog.24863
2. Champion ML, Bushman ET, Martin KD, et al. Reevaluating Associations between Prenatal Care Utilization and Current Trends in Preterm Birth. *Am J Perinatol*. 2024;41(13):1880-1886. doi:10.1055/a-2295-6524
3. Yan J. The Effects of Prenatal Care Utilization on Maternal Health and Health Behaviors. *Health Econ*. 2017;26(8):1001-1018. doi:10.1002/hec.3380
4. Peahl AF, Pennathur H, Zacharek N, et al. Retrospective Use of Patients' Characteristics to Assess Variation in Prenatal Care Utilization. *Am J Perinatol*. 2024;41(S 01):e2529-e2538. doi:10.1055/s-0043-1771505
5. Castelló A, Río I, Martinez E, et al. Differences in Preterm and Low Birth Weight Deliveries Between Spanish and Immigrant Women: Influence of the Prenatal Care Received. *Ann Epidemiol*. 2012;22(3):175-182. doi:10.1016/j.annepidem.2011.12.005
6. Coley SL, Aronson RE. Exploring Birth Outcome Disparities and the Impact of Prenatal Care Utilization Among North Carolina Teen Mothers. *Womens Health Issues*. 2013;23(5):e287-e294. doi:10.1016/j.whi.2013.06.004
7. Gadson A, Akpovi E, Mehta PK. Exploring the social determinants of racial/ethnic disparities in prenatal care utilization and maternal outcome. *Semin Perinatol*. 2017;41(5):308-317. doi:10.1053/j.semperi.2017.04.008
8. Wolf ER, Donahue E, Sabo RT, Nelson BB, Krist AH. Barriers to Attendance of Prenatal and Well-Child Visits. *Acad Pediatr*. 2021;21(6):955-960. doi:10.1016/j.acap.2020.11.025
9. Bellerose M, Collin L, Daw JR. The ACA Medicaid Expansion And Perinatal Insurance, Health Care Use, And Health Outcomes: A Systematic Review. *Health Aff (Millwood)*. 2022;41(1):60-68. doi:10.1377/hlthaff.2021.01150
10. Bellerose M, Rodriguez M, Vivier PM. A systematic review of the qualitative literature on barriers to high-quality prenatal and postpartum care among low-income women. *Health Serv Res*. 2022;57(4):775-785. doi:10.1111/1475-6773.14008
11. Yapundich M, Jeffries RS, Moore JB, Mayfield AM, Namak SY. Evaluating Prenatal Care Compliance and Barriers to Prenatal Care Among Pregnant Individuals in Forsyth County, North Carolina. *N C Med J*. 2024;85(6). doi:10.18043/001c.121419
12. Kaur A, Hornberger LK, Fruitman D, Ngwezi D, Eckersley LG. Impact of rural residence and low socioeconomic status on rate and timing of prenatal detection of major congenital heart disease in a jurisdiction of universal health coverage. *Ultrasound Obstet Gynecol*. 2022;60(3):359-366. doi:10.1002/uog.26030
13. Krishnan A, Jacobs MB, Morris SA, et al. Impact of Socioeconomic Status, Race and Ethnicity, and Geography on Prenatal Detection of Hypoplastic Left Heart Syndrome and Transposition of the Great Arteries. *Circulation*. 2021;143(21):2049-2060. doi:10.1161/CIRCULATIONAHA.120.053062
14. Wang E, Glazer KB, Howell EA, Janevic TM. Social Determinants of Pregnancy-Related Mortality and Morbidity in the United States: A Systematic Review. *Obstet Gynecol*. 2020;135(4):896-915. doi:10.1097/AOG.0000000000003762
15. Testa A, Jackson DB. Incarceration Exposure and Barriers to Prenatal Care in the United States: Findings from the Pregnancy Risk Assessment Monitoring System. *Int J Environ Res Public Health*. 2020;17(19):7331. doi:10.3390/ijerph17197331
16. Testa A, Jackson DB. Barriers to Prenatal Care Among Food-Insufficient Women: Findings from the Pregnancy Risk Assessment Monitoring System. *J Womens Health*. 2021;30(9):1268-1277. doi:10.1089/jwh.2020.8712
17. Testa A, Lee J, Semenza DC, Jackson DB, Ganson KT, Nagata JM. Intimate partner violence and barriers to prenatal care. *Soc Sci Med*. 2023;320:115700. doi:10.1016/j.socscimed.2023.115700
18. Care I of M (US) C to SO for P, Brown SS. Barriers to the Use of Prenatal Care. In: *Prenatal Care: Reaching Mothers, Reaching Infants*. National Academies Press (US); 1988. Accessed January 19, 2025. https://www.ncbi.nlm.nih.gov/books/NBK217704/
19. Fryer K, Munoz MC, Rahangdale L, Stuebe AM. Multiparous Black and Latinx Women Face More Barriers to Prenatal Care than White Women. *J Racial Ethn Health Disparities*. 2021;8(1):80-87. doi:10.1007/s40615-020-00759-x
20. Bebbington M. Barriers to accessing care: challenges in early prenatal diagnosis of congenital anomalies. *Ultrasound Obstet Gynecol*. 2022;60(3):307-308. doi:10.1002/uog.26040
21. Campbell MJ, Lorch S, Rychik J, Quartermain MD, Passarella M, Groeneveld PW. Socioeconomic barriers to prenatal diagnosis of critical congenital heart disease. *Prenat Diagn*. 2021;41(3):341-346. doi:10.1002/pd.5864
22. New York State Paid Prenatal Leave. Accessed January 19, 2025. https://www.ny.gov/programs/new-york-state-paid-prenatal-leave
23. The urgent necessity for paid parental leave. https://www.apa.org. Accessed January 19, 2025. https://www.apa.org/monitor/2022/04/feature-parental-leave
24. A National Paid Leave Program Would Help Workers, Families | Center on Budget and Policy Priorities. April 27, 2021. Accessed January 19, 2025. https://www.cbpp.org/research/economy/a-national-paid-leave-program-would-help-workers-families
25. J.;Waldfogel,Jane B Ann P ;Kim,Soohyun;Nam,Jaehyun;Rossin Slater,Maya;Ruhm,Christopher. Racial and ethnic disparities in access to and use of paid family and medical leave: evidence from four nationally representative datasets. Bureau of Labor Statistics. Accessed January 19, 2025. https://www.bls.gov/opub/mlr/2019/article/racial-and-ethnic-disparities-in-access-to-and-use-of-paid-family-and-medical-leave.htm
26. Goodman JM, Williams C, Dow WH. Racial/Ethnic Inequities in Paid Parental Leave Access. *Health Equity*. 2021;5(1):738-749. doi:10.1089/heq.2021.0001
27. Khan MS. Paid family leave and children health outcomes in OECD countries. *Child Youth Serv Rev*. 2020;116:105259. doi:10.1016/j.childyouth.2020.105259
28. D'Inverno AS, Reidy DE, Kearns MC. Preventing intimate partner violence through paid parental leave policies. *Prev Med*. 2018;114:18-23. doi:10.1016/j.ypmed.2018.05.024
29. Stanczyk AB. Does Paid Family Leave Improve Household Economic Security Following a Birth? Evidence from

California. *Soc Serv Rev*. 2019;93(2):262-304. doi:10.1086/703138
30. Stearns J. The effects of paid maternity leave: Evidence from Temporary Disability Insurance. *J Health Econ*. 2015;43:85-102. doi:10.1016/j.jhealeco.2015.04.005

RELEVANT AMA POLICY

AMA Statement on Family, Medical, and Safe Leave H-420.979

Our American Medical Association supports policies that provide employees with reasonable job security and continued availability of health plan benefits in the event leave by an employee becomes necessary due to documented medical conditions. Such policies should provide for reasonable periods of paid or unpaid:

1. Medical leave for the employee, including pregnancy, abortion, and stillbirth.
2. Maternity leave for the employee-mother.
3. Leave if medically appropriate to care for a member of the employee's immediate family, i.e., a spouse or children.
4. Leave for adoption or for foster care leading to adoption.
5. Safe leave provisions for those experiencing any instances of violence, including but not limited to intimate partner violence, sexual violence or coercion, and stalking.

Such periods of leave may differ with respect to each of the foregoing classifications and may vary with reasonable categories of employers. Such policies should encourage voluntary programs by employers and may provide for appropriate legislation (with or without financial assistance from government). Any legislative proposals will be reviewed through the Association's normal legislative process for appropriateness, taking into consideration all elements therein, including classifications of employees and employers, reasons for the leave, periods of leave recognized (whether paid or unpaid), obligations on return from leave, and other factors involved in order to achieve reasonable objectives recognizing the legitimate needs of employees and employers.

Our AMA recognizes the positive impact of paid safe leave on public health outcomes and supports legislation that offers safe leave

[BOT Rep. A, A-88 Reaffirmed: Sunset Report, I-98 Reaffirmed: CLRPD Rep. 1, A-08 Reaffirmation A-12 Reaffirmed: CMS Rep.03, A-16 Modified: Res. 302, I-22 Appended: Res. 413, A-23 Modified: Res. 424, A-23 Modified: Speakers Rep. 01, I-24]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 307
(I-25)

Introduced by: New Jersey

Subject: Integrating Artificial Intelligence (AI) Literacy Into UME, GME, and CME

Referred to: Reference Committee C

Whereas, the American Medical Association (AMA) has established policy on Augmented Intelligence in Health Care and has issued principles to guide trustworthy AI development, deployment, and use in clinical settings, including calls for education of physicians and trainees about AI's promises and limits; and

Whereas, peer-reviewed studies and surveys across specialties show trainees are already using AI tools, believe AI will play a current/future role in care, and desire formal training that includes ethics, equity, bias mitigation, evaluation, and safe workflow integration; and

Whereas, medical schools in New Jersey currently lack standardized AI curricula, despite the integration of AI-driven tools in affiliated teaching hospitals; and

Whereas, New Jersey's leading health systems are already deploying AI in radiology, oncology, cardiology, and predictive analytics for patient flow, demonstrating that resident physicians in NJ are encountering AI-enabled environments without structured training; and

Whereas, the State of New Jersey has recently launched initiatives positioning NJ as a hub for AI and life sciences innovation, further underscoring the importance of preparing NJ's physician workforce with AI literacy to align with state priorities; therefore be it

RESOLVED, that our American Medical Association support developing and disseminating model AI learning objectives and curricular toolkits aligned with existing AMA policy and AAMC principles (New HOD Policy); and be it further

RESOLVED, that our AMA collaborate with LCME and ACGME to recognize AI literacy elements within accreditation and program requirements where appropriate (Directive to Take Action); and be it further

RESOLVED, that our AMA support CME offerings to upskill the current workforce (New HOD Policy); and be it further

RESOLVED, that our AMA advocate for funding and faculty-development resources to implement and evaluate such training initiatives (Directive to Take Action); and be it further

RESOLVED, that our AMA report back on progress, including uptake metrics, learner outcomes, and best practices for equitable implementation across diverse institutions. (Directive to Take Action)

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

Received: 9/26/25

REFERENCES

1. University of Miami, Cincinnati, Minnesota, UC Irvine AI curricula pilots (AAMC News).
   RSNA Imaging AI Certificate Program; ACR AI-LAB residency modules.
2. STFM AiM-PC (Artificial Intelligence & Machine Learning for Primary Care) Curriculum.
   Surveys of resident/faculty attitudes toward AI education (Academic Radiology, 2024).
   Rowan University AI resources and Edison Patent Award recognition (Rowan News, Rowan SOM LibGuide).
3. Rutgers NJMS Distinction in AI in Medicine.
4. Hackensack Meridian Health AI innovations (Google Cloud AI deployment, AI-powered primary care, AI-driven cardiology tools).
5. NJ Economic Development Authority & Governor Murphy's AI research/innovation hub initiatives (NJ Business Magazine).

RELEVANT AMA POLICY

AMA Policy on Augmented Intelligence in Health Care (H-480.940).
AMA Principles for AI in Healthcare (2023-2025 updates).
AAMC Principles for Responsible AI in Academic Medicine.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 308
(I-25)

Introduced by: New York

Subject: Enhancing the Pathway for Black Male Medical Students

Referred to: Reference Committee C

Whereas, the rate of Black male medical student matriculation rate is decreasing; and

Whereas, systemic barriers, including implicit bias, lack of mentorship, financial constraints, and institutional policies, contribute to the academic challenges faced by Black male medical students; and

Whereas, increasing diversity in the physician workforce has been linked to improved patient outcomes, particularly in underserved communities where Black physicians play a critical role in reducing health disparities; and therefore; therefore be it

RESOLVED, that, consistent with applicable laws, our American Medical Association support the development and funding of comprehensive mentorship programs connecting Black male pre-medical students with physician mentors, guiding academic preparation, MCAT preparation, the medical school application process, and career development (New HOD Policy); and be it further

RESOLVED, that, consistent with applicable laws, our AMA promote the expansion of loan repayment programs specifically designed to incentivize physicians to practice in underserved communities, where Black male populations are often concentrated (Directive to Take Action); and be it further

RESOLVED, that, consistent with applicable laws, our AMA develop faculty to promote unbiased assessment of the performance of medical learners to reduce disparities in medical school matriculation (Directive to Take Action); and be it further

RESOLVED, that, consistent with applicable laws, our AMA support the development of leadership training programs for Black male physicians, equipping them with the skills and knowledge to assume leadership roles in academic medicine, healthcare administration, and public health (New HOD Policy); and be it further

RESOLVED, that our AMA encourage collaboration between our AMA, medical schools, HBCUs, and community organizations. (New HOD Policy)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 9/26/25

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 311
(I-25)

Introduced by: American Academy of Ophthalmology

Subject: Gender and URiM Disparities in Surgical Training Volumes

Referred to: Reference Committee C

Whereas, a 2018-2019 retrospective review of case logs from 133 vitreoretinal surgery fellows found a consistent trend for female fellows to report fewer total procedures than male fellows at the completion of training, with significantly fewer key procedures including endolaser (P = .018), internal limiting membrane peel (P = .042); and cyroretinopexy (P = .002); and

Whereas, a longitudinal analysis of 1,271 ophthalmology resident from 24 U.S. programs (2005-2017) found that female residents performed 15 fewer cataract surgeries and 58 fewer total procedures on average than men (P<.001), with disparities widening over time despite increases in overall surgical volume; and

Whereas, a national cohort study of 4,811 ophthalmology residents (2014–2023) confirmed these patterns, showing women performed 4.4% fewer cataract surgeries and 7.4% fewer total procedures than men (P < .001), and URiM residents performed 5.3% fewer total procedures than non-URiM peers (P = .02), disparities consistent across a decade of training data; and

Whereas, a cohort study of 2,544 graduating otolaryngology residents (2009–2017) found consistent gender-based differences in operative case volume, with male residents performing on average 34.8 more key indicator cases per year than female residents (P < .001), and 41.3 more cases when serving as primary surgeon or supervisor (P < .001), highlighting disparities in both operative exposure and leadership opportunities; and

Whereas, a multi-institutional study of 1,343 categorical general surgery graduates (2010–2020) from 20 ACGME-accredited programs found persistent gender disparities in operative experience, with female residents performing fewer total cases (1,140 vs. 1,177; P < .01) and less likely to be high-volume residents (27% vs. 36%, P < .01), though the gap showed signs of narrowing over time; and

Whereas, an analysis of orthopaedic surgery residency case logs from 2013–2022 demonstrated both gender- and race/ethnicity-based disparities, with early cohorts showing women reporting 33 fewer cases and URiM residents 29 fewer cases than peers, and while overall differences narrowed in later years, women continued to lag in several key case categories including anterior cruciate ligament reconstruction and total joint arthroplasty; and

Whereas, a national study of 3,335 urology residents from 145 ACGME-accredited programs (2013–2023) found persistent gender disparities, with women logging significantly fewer cases than men overall (1,374 vs. 1,423; P < .001), and men consistently performing more general urology, endoscopy, and oncology procedures; and

Whereas, the disparities in case distribution raise concerns about equity of opportunity, access to complex surgical experiences, and potential barriers to professional development; therefore be it

RESOLVED, that our American Medical Association recognize gender- and URiM-based disparities in surgical training volumes as an equity issue in graduate medical education, distinct from resident competency (New HOD Policy); and be it further

RESOLVED, that our AMA advocate for the Accreditation Council for Graduate Medical Education (ACGME) and specialty boards to collect and publish aggregate, de-identified surgical case volume data stratified by gender and URiM status (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate that surgical residency and fellowship programs implement monitoring mechanisms to promote equitable case allocation, while reaffirming that all graduates meet established training requirements (Directive to Take Action); and be it further

RESOLVED, that our AMA support the development and dissemination of best practices—including mentorship initiatives, equitable case distribution systems, and supportive leave policies—to ensure fairness in operative experience across all surgical specialties (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Received: 9/30/25

REFERENCES

1. Maffei JB, Johny A, Park YS, Holmboe E, Hogan SO, Badalato GM, Kraft KH, Mayer WA. The Effect of Gender on Case Log Volumes for Urology Residents: An 11 Year National Study. J Surg Educ. 2025 Jun;82(6):103515. doi: 10.1016/j.jsurg.2025.103515. Epub 2025 May 2. PMID: 40318562. https://www.sciencedirect.com/science/article/abs/pii/S1931720425000959?via%3Dihub
2. Culican SM, Syed MF, Park YS, Hogan SO. Gender Differences in Case Volume Among Ophthalmology Resident Graduates, 2014-2023. JAMA Ophthalmol. 2025 Jun 1;143(6):490-497. doi: 10.1001/jamaophthalmol.2025.0935. PMID: 40310612; PMCID: PMC12046517. https://jamanetwork.com/journals/jamaophthalmology/fullarticle/2833393
3. Shoga P, Van Heest A, Ames SE, Hogan SO, Holmboe E, Klingensmith M, Park YS, Parker C, Solberg E, Templeton K. Does Resident Gender or Race/Ethnicity Affect Orthopaedic Surgery Case Volume During Residency Training? JB JS Open Access. 2025 Feb 3;10(1):e24.00146. doi: 10.2106/JBJS.OA.24.00146. PMID: 39901939; PMCID: PMC11778099. https://pmc.ncbi.nlm.nih.gov/articles/PMC11778099/
4. Shoga P, Van Heest A, Ames SE, Hogan SO, Holmboe E, Klingensmith M, Park YS, Parker C, Solberg E, Templeton K. Does Resident Gender or Race/Ethnicity Affect Orthopaedic Surgery Case Volume During Residency Training? JB JS Open Access. 2025 Feb 3;10(1):e24.00146. doi: 10.2106/JBJS.OA.24.00146. PMID: 39901939; PMCID: PMC11778099. https://pmc.ncbi.nlm.nih.gov/articles/PMC11778099/
5. Winer LK, Kader S, Abelson JS, Hammaker AC, Eruchalu CN, Etheridge JC, Cho NL, Foote DC, Ivascu FA, Smith S, Postlewait LM, Greenwell K, Meister KM, Montgomery KB, Zmijewski P, Byrd SE, Kimbrough MK, Stopenski SJ, Nahmias JT, Harvey J, Farr D, Callahan ZM, Marks JA, Stahl CC, Al Yafi M, Sutton JM, Elsaadi A, Campbell SJ, Dodwad SM, Adams SD, Woeste MR, Martin RCG, Patel P, Anstadt MJ, Nasim BW, Willis RE, Patel JA, Newcomb MR, George BC, Quillin RC 3rd, Cortez AR. Disparities in the Operative Experience Between Female and Male General Surgery Residents: A Multi-institutional Study From the US ROPE Consortium. Ann Surg. 2023 Jul 1;278(1):1-7. doi: 10.1097/SLA.0000000000005847. Epub 2023 Mar 30. PMID: 36994704; PMCID: PMC10896185. https://pmc.ncbi.nlm.nih.gov/articles/PMC10896185/
6. Reyes-Capo DP, Yannuzzi NA, Chan RVP, Murray TG, Berrocal AM, Sridhar J. GENDER DIFFERENCES IN SELF-REPORTED PROCEDURAL VOLUME AMONG VITREORETINAL FELLOWS. Retina. 2021 Apr 1;41(4):867-871. doi: 10.1097/IAE.0000000000002942. PMID: 32796443. https://journals.lww.com/retinajournal/abstract/2021/04000/gender_differences_in_self_reported_procedural.27.aspx
7. Gurgel RK, Cardon BR, Allen CM, Presson AP, Kelly BC, Hopf HW, Choi SS, Miller RH. Evaluating gender parity in operative experience for otolaryngology residencies in the United States. Laryngoscope. 2020 Jul;130(7):1651-1656. doi: 10.1002/lary.28306. Epub 2019 Sep 18. PMID: 31532842. https://onlinelibrary.wiley.com/doi/10.1002/lary.28306
8. Gong D, Winn BJ, Beal CJ, Blomquist PH, Chen RW, Culican SM, Dagi Glass LR, Domeracki GF, Goshe JM, Jones JK, Khouri AS, Legault GL, Martin TJ, Mitchell KT, Naseri A, Oetting TA, Olson JH, Pettey JH, Reinoso MA, Reynolds AL, Siatkowski RM, SooHoo JR, Sun G, Syed MF, Tao JP, Taravati P, WuDunn D, Al-Aswad LA. Gender Differences in Case Volume Among Ophthalmology Residents. JAMA Ophthalmol. 2019 Sep 1;137(9):1015-1020. doi: 10.1001/jamaophthalmol.2019.2427. PMID: 31318390; PMCID: PMC6646997. https://jamanetwork.com/journals/jamaophthalmology/fullarticle/2738409

RELEVANT AMA POLICY

D-295.963 Continued Support for Diversity in Medical Education
Our American Medical Association will publicly state and reaffirm its support for diversity in medical education and acknowledge the incorporation of DEI efforts as a vital aspect of medical training.
1. Our AMA will request that the Liaison Committee on Medical Education regularly share statistics related to compliance with accreditation standards IS-16 and MS-8 with medical schools and with other stakeholder groups.
2. Our AMA will work with appropriate stakeholders to commission and enact the recommendations of a forward-looking, cross-continuum, external study of 21st century medical education focused on reimagining the future of health equity and racial justice in medical education, improving the diversity of the health workforce, and ameliorating inequitable outcomes among minoritized and marginalized patient populations.
3. Our AMA will advocate for funding to support the creation and sustainability of Historically Black College and University (HBCU), Hispanic-Serving Institution (HSI), and Tribal College and University (TCU) affiliated medical schools and residency programs, with the goal of achieving a physician workforce that is proportional to the racial, ethnic, and gender composition of the United States population.
4. Our AMA will directly oppose any local, state, or federal actions that aim to limit diversity, equity, and inclusion initiatives, curriculum requirements, or funding in medical education.
5. Our AMA will advocate for resources to establish and maintain DEI offices at medical schools that are staff-managed and student- and physician-guided as well as committed to longitudinal community engagement.
6. Our AMA will investigate the impacts of state legislation regarding DEI-related efforts on the education and careers of students, trainees, and faculty.
7. Our AMA will recognize the disproportionate efforts by and additional responsibilities placed on minoritized individuals to engage in diversity, equity, and inclusion efforts.
8. Our AMA will collaborate with the Association of American Medical Colleges, the Liaison Committee on Medical Education, and relevant stakeholders to encourage academic institutions to utilize Diversity, Equity, and Inclusion activities and community engagement as criteria for faculty and staff promotion and tenure. [Res. 325, A-03 Appended CME Rep. 6, A-11 Modified: CME Rep. 3, A-13; Appended: CME Rep. 5, A-21; Modified: CME Rep.02, I-22; Appended: Res 319, A-22; Modified: Res. 319, A-23; reaffirmed: BOT Rep. 31, A-24]

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."
Our AMA:
1. opposes questioning residency or fellowship applicants regarding marital status, dependents, plans for marriage or children, sexual orientation, gender identity, age, race, national origin, and religion;
2. will work with the Accreditation Council for Graduate Medical Education, the National Residency Matching Program, and other interested parties to eliminate questioning about or discrimination based on marital and dependent status, future plans for marriage or children, sexual orientation, age, race, national origin, and religion during the residency and fellowship application process;
3. will continue to support efforts to enhance racial and ethnic diversity in medicine. Information regarding race and ethnicity may be voluntarily provided by residency and fellowship applicants;
4, encourages the Association of American Medical Colleges (AAMC) and its Electronic Residency Application Service (ERAS) Advisory Committee to develop steps to minimize bias in the ERAS and the residency training selection process; and
5. will advocate that modifications in the ERAS Residency Application to minimize bias consider the effects these changes may have on efforts to increase diversity in residency programs. [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]

H-310.919 Eliminating Questions Regarding Marital Status, Dependents, Plans for Marriage or Children, Sexual Orientation, Gender Identity, Age, Race, National Origin and Religion During the Residency and Fellowship Application Process
Our AMA:
1. opposes questioning residency or fellowship applicants regarding marital status, dependents, plans for marriage or children, sexual orientation, gender identity, age, race, national origin, and religion;
2. will work with the Accreditation Council for Graduate Medical Education, the National Residency Matching Program, and other interested parties to eliminate questioning about or discrimination based on marital and dependent status, future plans for marriage or children, sexual orientation, age, race, national origin, and religion during the residency and fellowship application process;
3. will continue to support efforts to enhance racial and ethnic diversity in medicine. Information regarding race and ethnicity may be voluntarily provided by residency and fellowship applicants;
4. encourages the Association of American Medical Colleges (AAMC) and its Electronic Residency Application Service (ERAS) Advisory Committee to develop steps to minimize bias in the ERAS and the residency training selection process; and
5. will advocate that modifications in the ERAS Residency Application to minimize bias consider the effects these changes may have on efforts to increase diversity in residency programs. [Res 307, A-09; Appended: Res 955, I-17]

H-310.976 Gender-Based Questioning in Residency Interviews
Our American Medical Association opposes gender-based questioning during residency interviews in both public and private institutions for the purpose of sexual discrimination. [Res.124, I-88; Reaffirmed: Sunset Report, I-98; Modified and Reaffirmed: CME Rep. 2, A-08; Reaffirmed: CCB/CLRPD Rep. 3. A-13; Modified: CME Rep. 01, A-23]