

Reference Committee C

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REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 1-I-26

Subject: Medical Education Program and Content

Presented by: Shannon M. Kilgore, MD, Chair

Referred to: Reference Committee C

Adopted at the 2024 American Medical Association (AMA) Interim meeting, AMA Policy D-295.299, “Updates to Recommendations for Future Directions for Medical Education,” called for the following:

“Our American Medical Association will study the restructuring of AMA Policy H-295.995, ‘Recommendations for Future Directions for Medical Education,’ to consolidate existing AMA policies in these areas where appropriate and to recommend new language for the future of medical education, in a series of seven future reports based on the topics of:

- Mission of medical education.
- Professional regulation.
- Entry into and transition through the medical education continuum.
- Medical education curricula.
- Physician as medical professional.
- Medical education systems.
- Obligations to students and trainees.”

This report addresses the theme of medical education curricula, referred to in this report as “medical education program and content.”

BACKGROUND

The above policy was initially introduced via the Council on Medical Education’s self-initiated report, CME 2-I-24, with the intention of proposing a framework to consolidate and modernize AMA medical education policy. During their research for the CME 2-I-24 report, the Council noted the breadth of medical education policies, including Policy H-295.995, “Recommendations for the Future Directions for Medical Education” that contains 33 clauses and had not been reassessed in its entirety since 1982. CME 2-I-24 provided the following commentary regarding “medical education curricula”:

“A vast number of technological changes have occurred since 1982, including but not limited to the advent of widely available internet access in the 1990s in addition to more specific technological shifts in medical education over time. Virtual education is now prominent. More recently, the increasing attention to generative artificial intelligence or augmented intelligence (AI) prompted the AMA to release ‘Principles for Augmented Intelligence Development, Deployment, and Use’ in November 2023. AI technology and its opportunities and challenges are increasingly woven into the field of medical education.

From 2013-2022, the AMA’s Accelerating Change in Medical Education Consortium [gave] \$30 million in grants to 32 medical schools to jumpstart curricular and process changes and disseminate ideas, and in 2019, AMA launched the Reimagining Residency initiative to support innovations to transform residency training. The consortium became ChangeMedEd in 2023, and lessons from ChangeMedEd are informing ideas on future directions in medical education as intended. Curricular innovations include health systems science, the Master Adaptive Learner model, and a renewed emphasis on equity and social determinants of health.”

Citations denoted above are provided in [CME 2-I-24](#).

In order to provide consistency across the seven reports, guardrails were established:

- Policies explored include the entirety of the medical education continuum, including pre-medical education, UME, GME, and CME.
- The scope of each report will focus on updating a selection of existing related policies for accuracy as well as consolidation.
- Though the reports seek to consolidate existing policy and improve accuracy of language only, the recommendations may also make note of areas where future reports might be warranted to develop additional AMA policy on important topics not currently represented.
- Each report utilizes the well-established Appendix table format as seen in the annual Sunset Review reports.

To begin the process of selecting relevant policies for the seven reports, [AMA Policy Finder](#) was utilized. Starting on the home page, the “Search” button was selected. It provided a list of “policy topics,” one of which was “medical education.” By selecting this filter, it identified a total of 244 relevant policies. Implemented in September 2025, this process generated a numerical, comprehensive list of 244 policies to be categorized across the seven reports. A single policy is not listed in more than one report. Among them, seven policies were deemed not for inclusion in these reports given their length and/or complexity; 237 policies remained for categorization.

Among the 237 policies, 50 of them were sorted into this report. They address policies related to pre-medical education, content and teaching of the whole continuum, curricular topics, program evaluation, faculty development, technology, AI, ChangeMedEd work, and precision education. This report does not address policies where the main point of the policy fell outside of the purview of “medical education program and content,” even if tangentially related. Such topics are addressed in the other six reports.

DISCUSSION

Policies considered

As mentioned earlier, 50 policies related to this theme were reviewed for this report. Among them, the Council determined that the following 28 policies remain relevant and should be retained:

- [Holocaust Remembrance D-295.300](#)
- [Telemedicine in Medical Education D-295.313](#)
- [Communication and Clinical Teaching Curricula D-295.329](#)
- [Clinical Skills Training in Medical Schools D-295.960](#)
- [Support for Standardized Interpreter Training D-300.976](#)
- [Increasing Access to Gender-Affirming Care Through Expanded Training and Equitable Coverage H-295.847](#)

- 1 • [Teaching and Assessing Osteopathic Manipulative Medicine and Osteopathic Principles and Practice H-295.848](#)
- 2
- 3 • [Representation of Dermatological Pathologies in Varying Skin Tones H-295.853](#)
- 4 • [Augmented Intelligence in Medical Education H-295.857](#)
- 5 • [Systems-Based Practice Education for Medical Students and Resident/Fellow Physicians H-295.864](#)
- 6
- 7 • [Supporting Two-Interval Grading Systems for Medical Education H-295.866](#)
- 8 • [Education in Disaster Medicine and Public Health Preparedness During Medical School and Residency Training H-295.868](#)
- 9
- 10 • [Medical School Language Electives in Medical School Curriculum H-295.870](#)
- 11 • [Educating Medical Students in the Social Determinants of Health and Cultural Competence H-295.874](#)
- 12
- 13 • [Medical Treatment of Prisoners of War and Detainees H-295.877](#)
- 14 • [Medical Education on Sleep and Sleep Disorders H-295.894](#)
- 15 • [Alternative Medicine H-295.902](#)
- 16 • [Education of Medical Students and Residents about Domestic Violence Screening H-295.912](#)
- 17 • [Medical Training and Termination of Pregnancy H-295.923](#)
- 18 • [Use of Animals in Medical Education H-295.957](#)
- 19 • [Departments of Family Medicine in all LCME-Accredited Medical Schools H-295.959](#)
- 20 • [Medicolegal, Political, Ethical and Economic Medical School Course H-295.961](#)
- 21 • [Education Regarding Prescribing Controlled Substances H-295.972](#)
- 22 • [Family Medicine as a Fundamental Subject in Medical Schools H-295.984](#)
- 23 • [Humanism in Graduate Medical Education H-295.985](#)
- 24 • [Scholarly Activity by Resident and Fellow Physicians H-310.905](#)
- 25 • [Improving Residency Training in the Treatment of Opioid Dependence H-310.906](#)
- 26 • [Graduate Medical Education Faculty Evaluations H-310.945](#)
- 27

28 The remaining 22 policies are listed in the appendices with recommended actions. They are:

- 29
- 30 • [Sex and Gender Based Medicine in Clinical Education D-295.310](#)
- 31 • [Update on the Uses of Simulation in Medical Education D-295.330](#)
- 32 • [Suggested Revision in ACCME Evaluations D-300.979](#)
- 33 • [Medical Education and Training in Women's Health H-295.890](#)
- 34 • [Proficiency of Physicians in Basic and Advanced Cardiac Life Support H-300.945](#)
- 35 • [Recognition of Those Who Practice Addiction Medicine H-300.962](#)
- 36 • [Resident Education in Laboratory Utilization H-310.960](#)
- 37 • [Senior Living Community Training for Medical Students and Residents D-295.305](#)
- 38 • [Geriatric and Palliative Care Training For Physicians D-295.969](#)
- 39 • [Palliative Care and End-of-Life Care H-295.875](#)
- 40 • [Geriatric Medicine H-295.981](#)
- 41 • [Management and Leadership for Physicians D-295.316](#)
- 42 • [Health Care Economics Education D-295.321](#)
- 43 • [Future Directions for Socioeconomic Education H-295.924](#)
- 44 • [Practice Options and Skills Curriculum in Medical Education H-310.953](#)
- 45 • [Curriculum Orientation of Medical Staff Membership in Teaching Programs H-310.994](#)
- 46 • [Integrating Content Related to Public Health and Preventive Medicine Across the Medical Education Continuum D-295.327](#)
- 47
- 48 • [Service Learning in Medical Education H-295.880](#)

- [Medical Student, Resident and Fellow Legislative Awareness H-295.953](#)
- [Increasing Education on Physician-Led Care and Advocacy in Residency Training H-310.898](#)

Gaps identified

This review process has illuminated opportunities where policies could be re-examined and reframed in the future to be more forward-thinking. For example, the Council identified the possible need for a policy supporting education on evidence-based care and principles across all topic areas, reducing the need for individual subject areas to be addressed in policies every time new medical literature and evidence arises. Other gap areas to address are precision education and adaptive expertise, entrustment in training, workplace-based assessment, telemedicine in medical education, and augmented intelligence in medical education. Such topics may be addressed in future reports, educational sessions, forums or other mechanisms as determined by this Council and/or the House of Delegates.

RELEVANT AMA POLICIES

There are multiple AMA policies impacted by this report:

Appendix A individually lists current policy language side-by-side with recommended actions (e.g., amend, rescind) related to that specific policy. These actions are collectively addressed in Recommendation 1 of this report.

Appendices B-F provide the language for related groups of current policy. Your Council recommends combining/consolidating these policies into alternate language for clarity and conciseness which is presented in Recommendations 2-6 of this report, respectively. The content of the original policies was maintained whenever possible, as was the spirit of the original policies.

CONCLUSION

This report reviewed 50 of the 237 policies originally identified and categorized as focusing on medical education and offered multiple recommendations for consideration. In this way, your Council is working to modernize and update our policy compendium as it relates to medical education and make it easier to identify and understand our policies moving forward.

RECOMMENDATIONS

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

1. The House of Delegates policies listed in Appendix A of this report be acted upon in the manner indicated. (Directive to Take Action)
2. That policies Senior Living Community Training for Medical Students and Residents D-295.305, Geriatric and Palliative Care Training For Physicians D-295.969, Palliative Care and End-of-Life Care H-295.875, and Geriatric Medicine H-295.981 (policy language available in Appendix B) be rescinded and the following policy be adopted:

GERIATRIC AND PALLIATIVE CARE TRAINING

- a) Our AMA recognizes that not all palliative care is related to geriatric care, though they significantly intersect.
 - b) Our AMA recognizes the critical need for geriatrics and palliative care training, including but not limited to geriatric pharmacotherapy training, for all physicians who care for older adults and/or terminally ill patients, across all specialties.
 - c) Our AMA encourages further education and research on aging and healthcare of the aged.
 - d) Our AMA encourages development of opportunities for medical students and resident/fellow physicians to train in senior living communities (for example, nursing homes and assisted living facilities), as appropriate to the educational objectives of the program.
 - e) Our AMA endorses the concept of affiliation between nursing home facilities for geriatric patients and residency/fellowship programs, where feasible, for the development of physicians' clinical experience in such facilities.
 - f) Our AMA encourages the inclusion of palliative medicine and geriatric medicine in the core curriculum of undergraduate, graduate, and continuing medical education.
 - g) Our AMA encourages the training of all healthcare professionals in the use of palliative care techniques and interdisciplinary team care.
 - h) Our AMA will continue its efforts in producing and distributing clinical CME programs on pain management and end-of-life care.
3. That policies Management and Leadership for Physicians D-295.316, Health Care Economics Education D-295.321, Future Directions for Socioeconomic Education H-295.924, Practice Options and Skills Curriculum in Medical Education H-310.953, and Curriculum Orientation of Medical Staff Membership in Teaching Programs H-310.994 (policy language available in Appendix C) be rescinded and the following policy be adopted:

MANAGEMENT AND LEADERSHIP FOR PHYSICIANS

Our AMA:

- a) supports and participates in the creation and promotion of management and leadership programs and curricula that emphasize experiential and active learning models to include knowledge, skills, and management techniques integral to achieving financial literacy and leading interprofessional healthcare teams;
- b) encourages the organizations responsible for the education of future physicians to implement programs throughout medical training to develop management and leadership competencies and financial literacy capabilities;
- c) encourages key interested parties to collect and analyze data on the effectiveness of management and leadership training and share such information with the medical education community;
- d) promotes the tenets of health systems science to prepare trainees for leadership roles and address prevalent challenges in the practice of medicine and public health;
- e) encourages medical schools and residencies to include basic content related to the structure and financing of the current healthcare system, including the organization of healthcare delivery, modes of practice, practice settings, cost effective use of diagnostic and treatment services, practice management, risk management, and utilization review/quality assurance;
- f) asks medical schools and residencies to ensure that content related to the environment and economics of medical practice in fee-for-service, managed care and other financing systems is presented at educationally appropriate times during undergraduate and graduate medical education;

- g) assists medical societies, medical schools, and residency programs in the development of model curricula regarding practice options and management skills, including information on CPT and ICD coding, as well as resource-based relative value scale (RBRVS) and the AMA/Specialty Society RVS Update Committee (RUC).
- h) believes that residency and fellowship programs should incorporate information on the privileges and responsibilities of medical staff membership into their education program's orientation materials.

4. That policies Integrating Content Related to Public Health and Preventive Medicine Across the Medical Education Continuum D-295.327 and Service Learning in Medical Education H-295.880 (policy language available in Appendix D) be rescinded and the following policy be adopted:

PUBLIC HEALTH AND SERVICE LEARNING IN MEDICAL EDUCATION

- a) Our American Medical Association encourages medical schools, schools of public health, graduate medical education programs, and key organizations to develop and implement longitudinal educational experiences in public health for medical students in the pre-clinical and clinical years and to provide both didactic and practice-based experiences in public health for residents in all specialties including public health and preventive medicine.
- b) Our AMA encourages the Liaison Committee on Medical Education and the Accreditation Council for Graduate Medical Education to examine their standards to assure that public health-related content and skills are included and integrated as appropriate in the curriculum.
- c) Our AMA actively encourages the development of innovative models to integrate public health content across undergraduate, graduate, and continuing medical education.
- d) Our AMA supports legislative efforts to fund preventive medicine and public health training programs for graduate medical residents.
- e) Our AMA will urge the Centers for Medicare and Medicaid Services to include resident education in public health graduate medical education funding in the Medicare Program and encourage other public and private funding for graduate medical education in prevention and public health for all specialties.
- f) Our AMA will support the concept of service learning as a key component in medical school and residency curricula, and that these experiences should include student and resident collaboration with a community partner to improve the health of the population.

5. That policies Improving Sexual History Curriculum in the Medical School H-295.879 and Clinical Training in Sexually Transmitted Infections H-295.980 (policy language available in Appendix E) be rescinded and the following policy be adopted:

IMPROVING SEXUAL HISTORY AND STI TRAINING IN MEDICAL EDUCATION

Our AMA:

- a) encourages all medical schools to train medical students to be able to take a thorough and nonjudgmental sexual history in a manner that is sensitive to the personal attitudes and behaviors of patients in order to decrease anxiety and personal difficulty with sexual aspects of healthcare;
- b) urges medical schools to provide supervised training for sexually transmitted infections for all medical students and physicians in training;
- c) supports public messaging that encourages patients to discuss concerns related to sexual health with their physician and reinforces its commitment to helping patients maintain sexual health and well-being.

- 1 6. That policies Medical Student, Resident and Fellow Legislative Awareness H-295.953 and
2 Increasing Education on Physician-Led Care and Advocacy in Residency Training H-310.898
3 (policy language available in Appendix F) be rescinded and the following policy be adopted:
4

5 LEGISLATIVE AWARENESS AND ADVOCACY IN MEDICAL EDUCATION
6

- 7 a) Our AMA strongly encourages state medical associations to work in conjunction with
8 medical schools to implement programs to educate medical students concerning legislative
9 issues facing physicians and medical students.
10 b) Our AMA will advocate that political science classes which facilitate understanding of the
11 legislative process be offered as an elective option in the medical school curriculum.
12 c) Our AMA will establish health policy and advocacy elective rotations based in Washington,
13 DC for medical students, residents, and fellows.
14 d) Our AMA will support and encourage institutional, state, and specialty organizations to offer
15 real-world health policy and advocacy opportunities at local, state, and/or national levels for
16 medical students, residents, and fellows.
17 e) Our AMA will develop, provide, expand upon, and promote the educational resources in the
18 AMA GME Competency Education Program, as well as toolkits and workshops that
19 residency programs can implement to teach residents about physician-led care, advocacy
20 strategies, and how to effectively engage with healthcare policymakers and organizations.

Fiscal Note: Minimal

APPENDIX A: RECOMMENDATION 1 POLICIES AND RECOMMENDED ACTIONS

Title and Policy Number	Text and Timeline	Recommendation
Sex and Gender Based Medicine in Clinical Education D-295.310	1. Our AMA will collaborate with Accreditation Council for Graduate Medical Education, Liaison Committee on Medical Education, Commission on Osteopathic College Accreditation, Association of American Medical Colleges, and Accreditation Council for Continuing Medical Education to disseminate the work produced by medical schools participating in the Accelerating Change in Medical Education consortium and distribute pertinent information and a comprehensive bibliography about the influence that sex and gender have upon clinical medicine. 2. Our AMA will work collaboratively with the Liaison Committee on Medical Education and other interested organizations for the inclusion of sex- and gender-based differences within the curricular content for medical school accreditation. Res. 958, I-17 Appended: Res. 306, A-18	Rescind policy D-295.310. <i>Rationale: Clause 1 accomplished and available on AMA website. Clause 2 already reflected within existing policy, such as Medical Education and Training in Women's Health H-295.890.</i>
Update on the Uses of Simulation in Medical Education D-295.330	Our AMA will: 1. continue to advocate for additional funding for research in curriculum development, pedagogy, and outcomes to further assess the effectiveness of simulation and to implement effective approaches to the use of simulation in both teaching and assessment; 2. continue to work with and review, at five-year intervals, the accreditation requirements of the Liaison Committee on Medical Education (LCME), the Accreditation Council for Graduate Medical Education (ACGME), and the Accreditation Council for Continuing Medical Education (ACCME) to assure that program requirements reflect appropriate use and assessment of simulation in education programs;	Amend policy D-295.330 with a change in title as follows: UPDATE ON THE USES OF SIMULATION IN MEDICAL EDUCATION Our AMA will: 1. continue to advocate for additional funding for research in curriculum development, pedagogy, and outcomes to further assess the effectiveness of simulation and to implement effective approaches to the use of simulation in both teaching and assessment; 2. continue to work with and review, at five-year intervals, the accreditation requirements of the Liaison Committee on Medical Education (LCME), the Accreditation Council for Graduate

Title and Policy Number	Text and Timeline	Recommendation
	3. encourage medical education institutions that do not have accessible resources for simulation-based teaching to use the resources available at off-site simulation centers, such as online simulated assessment tools and simulated program development assistance; 4. monitor the use of simulation in high-stakes examinations administered for licensure and certification as the use of new simulation technology expands; 5. further evaluate the appropriate use of simulation in interprofessional education and clinical team building; and 6. work with the LCME, the ACGME, and other stakeholder organizations and institutions to further identify appropriate uses for simulation resources in the medical curriculum. CME Rep. 8, A-09 Reaffirmed: CME Rep. 01, A-19	Medical Education (ACGME), and the Accreditation Council for Continuing Medical Education (ACCME) to assure that program requirements reflect appropriate use and assessment of simulation in education programs; 3. encourage medical education institutions that do not have accessible resources for simulation-based teaching to use the resources available at off-site simulation centers, such as online simulated assessment tools and simulated program development assistance; 4. monitor the use of simulation in high-stakes examinations administered for licensure and certification as the use of new simulation technology expands; 5. further evaluate the appropriate use of simulation in interprofessional education and clinical team building; and 6. work with the LCME, the ACGME, and other stakeholder organizations and institutions to further identify appropriate uses for simulation resources in the medical curriculum. <i>Rationale: Simulation is effectively ubiquitous, though advocacy for funding and research remains important. Some of these policy items are outdated and no longer relevant.</i>
Suggested Revision in ACCME Evaluations D-300.979	Our American Medical Association will: communicate to the Accreditation Council for Continuing Medical Education that programs on the history of medicine have relevance for improvements in physicians' knowledge and competence. Sub. Res. 310, A-10 Appended: Res. 320, A-11 Modified: CME Rep. 1, A-21	Rescind policy D-300.979. <i>Rationale: Accomplished.</i>
Medical Education and Training in Women's Health H-295.890	Our American Medical Association encourages the coordination and synthesis of the knowledge, skills, and attitudinal objectives related to women's health/gender-based biology that have	Amend Clause 1 of policy H-295.890 as follows: Our American Medical Association encourages the coordination and

Title and Policy Number	Text and Timeline	Recommendation
	been developed for use in the medical school curriculum. Medical schools should include attention to women's health throughout the basic science and clinical phases of the curriculum. Our AMA does not support the designation of women's health as a distinct new specialty. Our AMA supports that each specialty should define objectives for residency training in women's health, based on the nature of practice and the characteristics of the patient population served. Our AMA supports surveys of undergraduate and graduate medical education, conducted by the AMA and other groups, should periodically collect data on the inclusion of women's health in medical school and residency training. Our AMA encourages the development of a curriculum inventory and database in women's health for use by medical schools and residency programs. Our AMA encourages physicians to include continuing education in women's health/gender-based biology as part of their continuing professional development. Our AMA encourages its representatives to the Liaison Committee on Medical Education, the Accreditation Council for Graduate Medical Education (ACGME), and the various ACGME Review Committees to promote attention to women's health in accreditation standards. Our AMA will work with the ACGME to protect patient access to important reproductive health services by advocating for all family medicine residencies to provide comprehensive women's health, including training in contraceptive counseling, family planning, and counseling for unintended pregnancy.	synthesis of the knowledge, skills, and attitudinal objectives related to women's health/gender-based biology that have been developed for use in the medical school curriculum. Medical schools should include attention to women's health throughout the basic science and clinical phases of the curriculum. Amend Clause 6 as follows: Our AMA encourages physicians to include continuing education in women's health/gender-based biology as part of their continuing professional development. <i>Rationale: Clarify language.</i>

Title and Policy Number	Text and Timeline	Recommendation
	Our AMA encourages the ACGME to ensure clarity when making revisions to the educational requirements and expectations of family medicine residents in comprehensive women's health topics. Jt. Rep. CME and CSA, A-99 Reaffirmed: CME Rep. 2, A-09 Reaffirmed: CME Rep. 01, A-19 Appended: CME Rep. 01, A-23	
Proficiency of Physicians in Basic and Advanced Cardiac Life Support H-300.945	Our American Medical Association believes that all licensed physicians should become proficient in basic CPR and in advanced cardiac life support commensurate with their responsibilities in critical care areas. Our AMA recommends to state and county medical associations that programs be undertaken to make the entire physician population, regardless of specialty or subspecialty interests, proficient in basic CPR. Our AMA encourages training of cardiopulmonary resuscitation and basic life support be funded by medical schools and provided to first-year medical students, preferably during the first term and or prior to clinical clerkships. CCB/CLRPD Rep. 3, A-14 Modified: CME Rep. 1, A-22	Amend Clause 3 of policy H-300.945 as follows: Our AMA encourages <u>that</u> training of cardiopulmonary resuscitation and basic life support be funded by medical schools and provided to first-year medical students, preferably during the first term and or prior to clinical clerkships. <i>Rationale: Important to encourage this to occur prior to clinical clerkships.</i>
Recognition of Those Who Practice Addiction Medicine H-300.962	1. It is the policy of the AMA to: (a) encourage all physicians, particularly those in primary care fields, to undertake education in treatment of substance abuse; (b) direct its representatives to appropriate Residency Review Committees (RRCs) to ask the committees on which they serve to consider requiring instruction in the recognition and management of substance abuse. Those RRCs that already require such instruction should consider greater emphasis for this subject. (c) encourage treatment of substance abuse as a subject for continuing medical education; and (d) affirm that many physicians in fields other than psychiatry have graduate education and experience appropriate for the treatment of substance abuse, and for utilization review, and for other evaluation	Amend policy H-300.962 with a change in title as follows: RECOGNITION OF THOSE WHO PRACTICE ADDICTION MEDICINE <u>PHYSICIAN EDUCATION FOR SUBSTANCE USE DISORDERS</u> 1. <u>Our</u> AMA: (a) encourages all physicians, particularly those in primary care fields, to undertake education in treatment of substance <u>use disorders</u> abuse; (b) directs its representatives to appropriate Residency Review Committees (RRCs) to ask the committees on which they serve to consider requiring instruction in the recognition and management of substance <u>use disorders</u> abuse. Those

Title and Policy Number	Text and Timeline	Recommendation
	of such treatment, and should be entitled to compensation. 2. Our AMA commends the American Board of Preventive Medicine (ABPM) for its successful application to the American Board of Medical Specialties (ABMS) to establish the new ABMS-approved multispecialty subspecialty of addiction medicine, which will be able to offer certification to qualified physicians who are diplomates of any of the 24 ABMS member boards. 3. Our AMA recognizes the ABPM for developing and providing pathways for all qualified physicians to obtain ABMS-approved certification in the new ABPM subspecialty of addiction medicine, in order to improve access to care for patients with substance use disorder. 4. Our AMA recognizes the American Osteopathic Association Bureau of Osteopathic Specialists for developing and providing a pathway for all qualified physicians to obtain subspecialty certification in addiction medicine, in order to improve access to care for patients with substance use disorder. 5. Our AMA recognizes the American Osteopathic Association (AOA) for developing and providing a pathway for qualified physicians (DOs and MDs) with an active primary AOA board certification in any specialty to obtain subspecialty certification in Addiction Medicine, in order to improve access to care for patients with substance use disorder. CME Rep. I-93-5 Reaffirmed: CME Rep. 10, I-98 Reaffirmed: CME Rep. 11, A-07 Appended: Res. 314, A-16 Modified and Appended: CME Rep. 4, I-19	RRCs that already require such instruction should consider greater emphasis for this subject; (c) encourages treatment of substance <u>use disorders</u> abuse as a subject for continuing medical education; and (d) affirms that many physicians in fields other than psychiatry have graduate education and experience appropriate for the treatment of substance <u>use disorders</u> abuse, and for utilization review, and for other evaluation of such treatment, and should be entitled to compensation. 2. Our AMA commends the American Board of Preventive Medicine (ABPM) for its successful application to the American Board of Medical Specialties (ABMS) to establish the new ABMS-approved multispecialty subspecialty of addiction medicine, which will be able to offer certification to qualified physicians who are diplomates of any of the 24 ABMS member boards. 3. Our AMA recognizes the ABPM for developing and providing pathways for all qualified physicians to obtain ABMS-approved certification in the new ABPM subspecialty of addiction medicine, in order to improve access to care for patients with substance use disorder. 4. Our AMA recognizes the American Osteopathic Association Bureau of Osteopathic Specialists for developing and providing a pathway for all qualified physicians to obtain subspecialty certification in addiction medicine, in order to improve access to care for patients with substance use disorder. 5. Our AMA recognizes the American Osteopathic Association (AOA) for developing and providing a pathway for qualified physicians (DOs and MDs) with an active primary AOA board certification in any specialty to obtain subspecialty certification in Addiction Medicine, in order to improve access to

Title and Policy Number	Text and Timeline	Recommendation
		care for patients with substance use disorder. <i>Rationale: Update language to align with existing AMA policy Destigmatizing the Language of Addiction H-95.917, and to correct other out-of-date language. Removing specific recognition statements as accomplished since original policy from 1993. No need to indicate specific parties while retaining statements of overall AMA values.</i>
Resident Education in Laboratory Utilization H-310.960	Our American Medical Association endorses the concept of practicing physicians devoting time with medical students and resident physicians for chart reviews focusing on appropriate test ordering in patient care. Res. 84, A-91 Reaffirmed: Sunset Report, I-01 Reaffirmed: CME Rep. 2, A-11 Reaffirmed: CME Rep. 1, A-21	Rescind policy H-310.960 and amend policy Support for the Concepts of the Choosing Wisely Program D-155.988 to add an additional clause to read as follows: <u>Our American Medical Association endorses the concept of practicing physicians devoting time with medical students and resident physicians for chart reviews focusing on appropriate test ordering in patient care.</u> <i>Rationale: Policy consolidation.</i>

APPENDIX B: CURRENT TEXT OF GERIATRIC AND PALLIATIVE POLICIES
RECOMMENDED FOR REVISION

Senior Living Community Training for Medical Students and Residents D-295.305

Our American Medical Association encourages development of opportunities for medical students and resident/fellow physicians to train in senior living communities (for example, nursing homes and assisted living facilities), as appropriate to the educational objectives of the program.

Res. 319, A-22

Geriatric and Palliative Care Training For Physicians D-295.969

Our American Medical Association encourages geriatrics and palliative care training for physicians caring for elderly and terminally ill patients in long-term care facilities.

Our AMA endorses the concept of affiliation between nursing home facilities for geriatric patients and residency/fellowship programs, where feasible, for the development of physicians' clinical experience in such facilities.

Res. 305, A-02 Reaffirmed: CCB/CLRPD Rep. 4, A-12 Reaffirmed: BOT Rep. 05, I-16 Modified:
CME Rep. 01, A-20 Reaffirmed: BOT Rep. 18, I-24

Palliative Care and End-of-Life Care H-295.875

Our AMA:

1. Reaffirms the Council on Medical Education's support of palliative medicine as a medical subspecialty with certification recognized by the American Board of Medical Specialties, and also encourages the inclusion of palliative medicine in the core curriculum of undergraduate and graduate medical education.
2. Encourages the training of all allied health workers in the use of palliative care techniques and interdisciplinary team care.
3. Will continue its efforts in producing and distributing clinical CME programs on pain management and end-of-life care.
4. Our AMA will work with relevant national medical specialty organizations to petition the American Board of Medical Specialties and relevant specialty boards to support development of innovative fellowship models that would qualify physicians for board certification in the fields of hospice and palliative medicine as well as geriatrics.

BOT Rep. 5, A-06 Appended: Res. 322, A-14 Reaffirmed: BOT Rep. 05, I-16 Reaffirmed: BOT Rep. 18, I-24

Geriatric Medicine H-295.981

1. Our AMA reaffirms its support for: (a) the incorporation of geriatric medicine into the curricula of medical school departments and its encouragement for further education and research on the problems of aging and health care of the aged at the medical school, graduate and continuing medical education levels; and (b) increased training in geriatric pharmacotherapy at the medical student and residency level for all relevant specialties and encourages the Accreditation Council for Graduate Medical Education and the appropriate Residency Review Committees to find ways to incorporate geriatric pharmacotherapy into their current programs.

2. Our AMA recognizes the critical need to ensure that all physicians who care for older adults, across all specialties, are competent in geriatric care, and encourages all appropriate specialty societies to identify and implement the most expedient and effective means to ensure adequate education in geriatrics at the medical school, graduate, and continuing medical education levels for all relevant specialties.

Res. 137, A-85 Reaffirmed by CLRPD Rep. 2, I-95 Appended: CSA Rep. 5, A-02 Appended: Res. 301, A-10 Reaffirmed: BOT Rep. 05, I-16

APPENDIX C: CURRENT TEXT OF ECONOMICS AND LEADERSHIP POLICIES RECOMMENDED FOR REVISION

Management and Leadership for Physicians D-295.316

Our American Medical Association supports collaborative programs among medical schools, residency programs, and related schools of business and management to give physicians the opportunity to assume administrative, financial, and leadership responsibilities in medical management.

Our AMA:

- a. supports and participates in the creation and promotion of management and leadership programs and curricula that emphasize experiential and active learning models to include knowledge, skills, and management techniques integral to achieving financial literacy and leading interprofessional health care teams.
- b. encourages the organizations responsible for the education of future physicians to implement programs throughout medical training to develop management and leadership competencies and financial literacy capabilities.
- c. encourages key stakeholders to collect and analyze data on the effectiveness of management and leadership training and share such information with the medical education community.

Our AMA will expand efforts to promote the tenets of health systems science to prepare trainees for leadership roles and address prevalent challenges in the practice of medicine and public health.

Our AMA will create a central online directory of its management and leadership resources that is searchable on our AMA website and promote the directory and these resources to AMA members and the medical education community.

Sub. Res. 918, I-14 Appended: Res. 306, I-16 Reaffirmed in lieu of: Res. 307, A-17 Modified: Res. 313, A-18 Appended: Res. 327, A-22 Reaffirmation: A-23 Modified: CME Rep. 07, A-23

Health Care Economics Education D-295.321

Our AMA, along with the Association of American Medical Colleges, Accreditation Council for Graduate Medical Education, and other entities, will work to encourage education in health care economics during the continuum of a physician's professional life, including undergraduate medical education, graduate medical education and continuing medical education.

Res. 320, A-09 Reaffirmation I-15 Modified: CEJA Rep. 01, A-20

Future Directions for Socioeconomic Education H-295.924

The AMA:

- (1) asks medical schools and residencies to encourage that basic content related to the structure and financing of the current health care system, including the organization of health care delivery, modes of practice, practice settings, cost effective use of diagnostic and treatment services, practice management, risk management, and utilization review/quality assurance, is included in the curriculum;
- (2) asks medical schools and residencies to ensure that content related to the environment and economics of medical practice in fee-for-service, managed care and other financing systems is

presented at educationally appropriate times during undergraduate and graduate medical education; and (3) will encourage the Liaison Committee on Medical Education (LCME) to ensure that survey teams pay close attention during the accreditation process to the degree to which ‘socioeconomic’ subjects are covered in the medical curriculum.

CME Rep. 1-I-94 Reaffirmed and Modified: CME Rep. 2, A-04 Reaffirmation A-12 Reaffirmation I-15 Reaffirmed in lieu of: Res. 307, A-17 Modified: CME Rep. 2, I-19

Practice Options and Skills Curriculum in Medical Education H-310.953

Our American Medical Association will assist medical societies, medical schools, and residency programs in the development of model curricula regarding practice options and management skills, including information on CPT and ICD coding, as well as RBRVS and RUC.

Sub. Res. 311, I-92 Reaffirmed: CME Rep. 2, A-03 Reaffirmed: CME Rep. 2, A-13 Modified: CME Rep. 01, A-20

Curriculum Orientation of Medical Staff Membership in Teaching Programs H-310.994

Our AMA believes that teaching programs in hospitals with residencies throughout the US should incorporate information on the privileges and responsibilities of medical staff membership into their education program’s orientation materials.

Res. 142, A-83 Reaffirmed: CLRPD Rep. 1, I-93 Reaffirmed: CME Rep. 2, A-05 Reaffirmed: CME Rep. 1, A-15 Reaffirmed: CME Rep. 01, A-25

APPENDIX D: CURRENT TEXT OF PUBLIC HEALTH POLICIES RECOMMENDED FOR REVISION

Integrating Content Related to Public Health and Preventive Medicine Across the Medical Education Continuum D-295.327

1. Our American Medical Association encourages medical schools, schools of public health, graduate medical education programs, and key stakeholder organizations to develop and implement longitudinal educational experiences in public health for medical students in the pre-clinical and clinical years and to provide both didactic and practice-based experiences in public health for residents in all specialties including public health and preventive medicine.
2. Our AMA encourages the Liaison Committee on Medical Education and the Accreditation Council for Graduate Medical Education to examine their standards to assure that public health-related content and skills are included and integrated as appropriate in the curriculum.
3. Our AMA actively encourages the development of innovative models to integrate public health content across undergraduate, graduate, and continuing medical education.
4. Our AMA, through the Initiative to Transform Medical Education (ITME), will work to share effective models of integrated public health content.
5. Our AMA supports legislative efforts to fund preventive medicine and public health training programs for graduate medical residents.
6. Our AMA will urge the Centers for Medicare and Medicaid Services to include resident education in public health graduate medical education funding in the Medicare Program and encourage other public and private funding for graduate medical education in prevention and public health for all specialties.

CME Rep. 11, A-09 Reaffirmed: CME Rep. 03, I-18 Reaffirmed: CSAPH Rep. 2, I-21

Service Learning in Medical Education H-295.880

Our American Medical Association will support the concept of service learning as a key component in medical school and residency curricula, and that these experiences should include student and resident collaboration with a community partner to improve the health of the population.

Res. 321, A-04 Reaffirmed: CME Rep. 2, A-14 Reaffirmed: CME Rep. 01, A-24

APPENDIX E: CURRENT TEXT OF SEXUAL HEALTH POLICIES RECOMMENDED FOR REVISION

Improving Sexual History Curriculum in the Medical School H-295.879

Our AMA (1) encourages all medical schools to train medical students to be able to take a thorough and nonjudgmental sexual history in a manner that is sensitive to the personal attitudes and behaviors of patients in order to decrease anxiety and personal difficulty with sexual aspects of health care; and (2) supports public messaging that encourages patients to discuss concerns related to sexual health with their physician and reinforces its commitment to helping patients maintain sexual health and well-being.

Res. 314, A-05 Modified: CME Rep. 1, A-15 Reaffirmed: CSAPH Rep. 01, A-25

Clinical Training in Sexually Transmitted Infections H-295.980

Our AMA urges medical schools to provide supervised training in sexually transmitted infections for all medical students and physicians in training.

Sub. Res. 88, A-85 Reaffirmed by CLRPD Rep. 2, I-95 Reaffirmed: CME Rep. 2, A-05 Reaffirmed: CME Rep. 1, A-15 Modified: CME Rep. 01, A-25

APPENDIX F: CURRENT TEXT OF ADVOCACY POLICIES RECOMMENDED FOR REVISION

Medical Student, Resident and Fellow Legislative Awareness H-295.953

1. Our AMA strongly encourages the state medical associations to work in conjunction with medical schools to implement programs to educate medical students concerning legislative issues facing physicians and medical students.
2. Our AMA will advocate that political science classes which facilitate understanding of the legislative process be offered as an elective option in the medical school curriculum.
3. Our AMA will establish health policy and advocacy elective rotations based in Washington, DC for medical students, residents, and fellows.
4. Our AMA will support and encourage institutional, state, and specialty organizations to offer health policy and advocacy opportunities for medical students, residents, and fellows.

Res. 14, A-91 Reaffirmed: Sunset Report, I-01 Appended: Res. 317, A-10 Appended: Res. 307, A-15 Reaffirmed: CME Rep. 01, A-25

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

Our AMA will develop, provide, expand upon, and promote the educational resources in the AMA GME Competency Education Program, as well as toolkits and workshops that residency programs can implement to teach residents about physician-led care, advocacy strategies, and how to effectively engage with health care policymakers and organizations.

Our AMA encourages residency programs to promote opportunities for residents and trainees to engage in real-world advocacy efforts at the local, state, and national levels, in collaboration with state societies and other medical organizations.

Res. 309, A-25

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 2-I-26

Subject: Medical Education Systems

Presented by: Shannon Kilgore, MD, FAAN, FANA, Chair

Referred to: Reference Committee C

Adopted at the 2024 Interim Meeting, AMA Policy D-295.299, “Updates to Recommendations for Future Directions for Medical Education,” calls for the following:

“Our American Medical Association will study the restructuring of AMA Policy H-295.995, ‘Recommendations for Future Directions for Medical Education,’ to consolidate existing AMA policies in these areas where appropriate and to recommend new language for the future of medical education, in a series of seven future reports based on the topics of:

- Mission of medical education.
- Professional regulation.
- Entry into and transition through the medical education continuum.
- Medical education curricula.
- Physician as medical professional.
- Medical education systems.
- Obligations to students and trainees.”

This report addresses the theme of “medical education systems.”

BACKGROUND

The above policy was initially introduced via the Council on Medical Education’s self-initiated report, CME 2-I-24, with the intention of proposing a framework to consolidate and modernize AMA medical education policy. During their research for the CME 2-I-24 report, the Council noted the breadth of medical education policies, including Policy H-295.995, “Recommendations for the Future Directions for Medical Education,” that contains 33 clauses and had not been reassessed in its entirety since 1982. CME 2-I-24 provided the following commentary regarding “medical education systems”:

“The overall role of the physician and the practice of medicine in U.S. society has shifted. There has been a shift away from independent practice, influenced by economic, administrative, and regulatory burdens.⁴⁸ Due to the increasing complexity of health systems, in 1999, systems-based practice was introduced as one of the core competencies⁴⁹ endorsed by the ACGME and the ABMS, with Milestones introduced in 2013 as a developmental framework related to competencies and harmonized across specialties in 2017. There have been other updates since then.⁴⁹ Challenges continue to emerge in the clinical learning environment, requiring new approaches.⁴⁰ There are increasing concerns about the impact of corporate interests and private equity, as discussed in Council on Medical Education Reports 01-I-22, “The Impact of Private Equity on Medical Training,”⁵⁰ and 01-I-20, “Graduate Medical Education and the Corporate Practice of Medicine.”⁵¹ Other systems factors also influence medical education, such as high demand for clinical placements⁵², physician

workforce disparities⁵³, and scope of practice concerns, the latter of which led to the formation of the AMA's Scope of Practice Partnership in 2006.^{54"}

Citations denoted above are provided in CME 2-I-24.

In order to provide consistency across the seven reports, guardrails were established:

- Policies explored include the entirety of the medical education continuum, including pre-medical education, UME, GME, and CME.
- The scope of each report will focus on updating a selection of existing related policies for accuracy as well as consolidation.
- Though the reports seek to consolidate existing policy and improve accuracy of language only, the recommendations may also make note of areas where future reports might be warranted to develop additional AMA policy on important topics not currently represented.
- Each report utilizes the well-established Appendix table format as seen in the annual Sunset Review reports.

To begin the process of selecting relevant policies for the seven reports, AMA Policy Finder was utilized. Starting on the home page, the "Search" button was selected. It provided a list of "policy topics," one of which was "medical education." By selecting this filter, it identified a total of 244 relevant policies. Implemented in September 2025, this process generated a numerical, comprehensive list of 244 policies to be categorized across the seven reports. A single policy is not listed in more than one report. Among them, seven policies were deemed not for inclusion in these reports given their length and/or complexity; 237 policies remained for categorization.

Among the 237 policies, 37 of them were sorted into this report. They address policies related to scope of practice, GME funding (including funds from the Centers for Medicare & Medicaid Services), external groups outside medical education, systems-based practice, corporate interest, private equity, burdens to training (economic, administrative, regulatory), and the wider social environment. This report does not address policies where the main point of the policy fell outside of the purview of "medical education systems," even if tangentially related. Such topics are addressed in the other six reports.

DISCUSSION

Policies considered

As mentioned earlier, 37 policies related to this theme were reviewed for this report. Among them, the Council determined that the following 26 policies remain relevant and should be retained:

- Promoting and Reaffirming Domestic Medical School Clerkship Education D-295.309
- Encouragement of Interprofessional Education Among Health Care Professions Students D-295.934
- Attendance of Non-Physicians at Courses Teaching Complex Diagnostic, Therapeutic or Surgical Procedures D-300.998
- Preserving the Specialty of Occupational and Environmental Medicine D-305.947
- Promote Awareness of Federal Gainful Employment Regulations and Transparency Provisions D-305.948
- Increase in Children's Hospital Graduate Medical Education Funding D-305.949
- CMS to Pay for Residents? Vacation and Sick Leave D-305.968
- Strategies to Combat Mid-year and Retroactive Tuition Increases D-305.983
- Accounting for GME Funding D-305.992
- Coding for Services Involving Teaching Activity D-305.996

- Timely Issuance of Social Security Number D-310.960
- Promoting Transparency in Medical Education and Access to Training H-295.860
- Improving Medical School/Community Practice H-295.916
- Faculty/Staff Appointments at More Than One Medical School H-295.929
- Medical School Affiliations With Veterans Affairs (VA) Medical Centers H-295.933
- Principles of and Actions to Address Medical Education Costs and Student Debt H-305.925
- Payment Cuts to Teaching Programs H-305.927
- The Ecology of Medical Education: The Infrastructure for Clinical Education H-305.942
- Fairness in Publication of Names of Loan Defaulters H-305.950
- Financing of Medical Education Programs D-305.973
- Cost and Financing of Medical Education and Availability of First-Year Residency Positions H-305.988
- The Impact of Private Equity on Medical Training H-310.901
- Graduate Medical Education and the Corporate Practice of Medicine H-310.904
- Securing Funding for Graduate Medical Education H-310.917
- Training Physicians in Non-Traditional Sites H-310.946
- Residency Interview Costs H-310.966

During the drafting of this report, one of the policies reviewed was rescinded via the sunset report (CME 1-A-26) adopted at the 2026 Annual Meeting. It has therefore been removed from this report.

Nine policies are listed in the Appendix with recommended actions. They are:

- Medication Reconciliation Education D-300.973
- Implications of the “Stark II” Regulations for Continuing Medical Education D-300.988
- Medical Education Debt Cancellation in the Face of a Physician Shortage During the COVID-19 Pandemic D-305.951
- Cares Act Equity and Loan Forgiveness in the Medicare Accelerated Payment Program D-305.953
- Funding for Teaching Health Center Graduate Medical Education Program D-305.955
- Support for the Epidemic Intelligence Service (EIS) Program and Preventive Medicine Residency Expansion D-305.964
- Funding for Preventive Medicine Residencies D-305.974
- Reduction in Student Loan Interest Rates D-305.984
- Corporate Compliance Consolidation H-300.944

Gaps identified

This review process has illuminated opportunities where policies could be re-examined and reframed in the future to be more forward-thinking. For example, Policies D-305.973 and H-305.925 listed above, both extensive, could benefit from review given the brevity and evolving nature of the financing of medical education and impact on student debt. Also, the Council will consider a study of the role that the AMA and the Council play within the medical education community. This topic may be addressed in a future report, educational session, forum, or other mechanism as determined by this Council and/or the House of Delegates.

Upon further review of the issues raised in The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education D-305.967, the Council determined that it should be studied to reshape its content to offer clearer guidance and a more future-oriented perspective as well as to update language and outdated references. Thus, the Council has added a recommendation to this report regarding such study.

1 RELEVANT AMA POLICIES

2
3 See the bulleted list above as well as policies in the Appendix.

4
5 CONCLUSION

6
7 This report reviewed 37 policies out of the 237 policies originally identified and categorized. The
8 Appendix offers recommended actions for the remaining policies addressing “medical education
9 systems.”

10
11 RECOMMENDATIONS

12
13 The Council on Medical Education recommends that the following be adopted and the remainder of
14 the report be filed:

- 15
16 1. The House of Delegates policies listed in the Appendix of this report be acted upon in the
17 manner indicated and the remainder of this report be filed. (Directive to Take Action)
18
19 2. The AMA will study AMA Policy D-305.967, The Preservation, Stability and Expansion of
20 Full Funding for Graduate Medical Education, to update its contents (Directive to Take
21 Action).

Fiscal Note: Minimal

APPENDIX: POLICIES AND RECOMMENDED ACTIONS

Title and Policy Number	Current Policy Text and Timeline	Recommendation
<u>Medication Reconciliation</u> <u>Education D-300.973</u>	Our American Medical Association encourages the study of current medication reconciliation practices across transitions of care to evaluate the impact on patient safety and quality of care, including when there are dissimilar electronic health records, and to develop strategies, including the potential need for additional training, to reduce medical errors and ensure patient safety and quality of care. Policy Timeline: Res. 805, I-23	Append policy D-300.973 to policy <u>D-120.965</u>, “Medication Reconciliation to Improve Patient Safety.” Rescind policy D-300.973. <i>Rationale: Policy consolidation.</i>
<u>Implications of the “Stark II” Regulations for Continuing Medical Education D-300.988</u>	Our American Medical Association will monitor the impact of the Section 1877 (Stark II) regulations on the ability of health care institutions to provide continuing medical education to their medical staffs. Policy Timeline: CME Rep. 6, I-04; Reaffirmed: CME Rep. 2, A-14; Modified: CME Rep. 01, A-24	Append policy D-300.988 to policy <u>H-300.883</u>, “Community Hospital Continuing Medical Education.” Rescind policy D-300.988. <i>Rationale: Policy consolidation.</i>
<u>Medical Education Debt Cancellation in the Face of a Physician Shortage During the COVID-19 Pandemic D-305.951</u>	Our American Medical Association will study the issue of medical education debt cancellation and consider the opportunities for integration of this into a broader solution addressing debt for all medical students and physicians. Policy Timeline: Res. 301, A-22	Rescind D-305.951. <i>Rationale: Accomplished in Council on Medical Education reports “Medical Student Debt and Career Choice” (CME 04-I-21) and “Financing Medical Education” (CME 02-A-22).</i>
<u>Cares Act Equity and Loan Forgiveness in the Medicare Accelerated Payment Program D-305.953</u>	In the setting of the COVID-19 pandemic, our AMA will advocate for additional financial relief for physicians to reduce medical school educational debt. Policy Timeline: Res. 202, I-20	Rescind policy D-305.953. <i>Rationale: No longer necessary. AMA has policy in support of financial relief for physicians related to educational debt.</i>
<u>Funding for Teaching Health Center Graduate Medical Education Program D-305.955</u>	Our American Medical Association will encourage Congress to reauthorize the Teaching Health Center Graduate Medical Educational Program to its full and ongoing funding needs to continue the training of primary providers in community-based health centers in underserved areas to assure a continuing supply of primary providers and dentists for the underserved populations. Policy Timeline: Res. 214, A-15; Reaffirmed: BOT Rep. 09, A-25	Append policy D-305.955 to policy <u>D-305.967</u>, “The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education.” Rescind policy D-305.955. <i>Rationale: Policy consolidation.</i>

<u>Support for the Epidemic Intelligence Service (EIS) Program and Preventive Medicine Residency Expansion D-305.964</u>	Our American Medical Association will work to support increased federal funding for training of public health physicians through the Epidemic Intelligence Service program and work to support increased federal funding for preventive medicine residency training programs. Policy Timeline: Res. 301, A-08; Reaffirmed: CME Rep. 01, A-18; Reaffirmed: CME Rep. 03, I-18; Reaffirmed: CSAPH Rep. 2, I-21	Append policy D-305.964 to policy <u>D-305.974</u>, “Funding for Preventive Medicine Residencies” (see next row). Rescind policy D-305.964. <i>Rationale: Policy consolidation.</i>
<u>Funding for Preventive Medicine Residencies D-305.974</u>	Our American Medical Association will work with the American College of Preventive Medicine, other preventive medicine specialty societies, and other allied partners, to formally support legislative efforts to fund preventive medicine training programs. Policy Timeline: Res. 324, A-05; Reaffirmed: CME Rep. 8, A-08; Reaffirmation I-14; Reaffirmed: CME Rep. 03, I-18; Reaffirmed: CSAPH Rep. 2, I-21	Amend policy D-305.974 by addition to read as follows: <u>Our American Medical Association will work to support increased federal funding for training of public health physicians through the Epidemic Intelligence Service program and work to support increased federal funding for preventive medicine residency training programs.</u> <i>Rationale: Policy consolidation.</i>
<u>Reduction in Student Loan Interest Rates D-305.984</u>	1. Our American Medical Association will actively lobby for legislation aimed at establishing an affordable student loan structure with a variable interest rate capped at no more than 5.0%. 2. Our AMA will work in collaboration with other health profession organizations to advocate for a reduction of the fixed interest rate of the Stafford student loan program and the Graduate PLUS loan program. 3. Our AMA will consider the total cost of loans including loan origination fees and benefits of federal loans such as tax deductibility or loan forgiveness when advocating for a reduction in student loan interest rates. 4. Our AMA will advocate for policies which lead to equal or less expensive loans (in terms of loan benefits, origination fees, and interest rates) for Grad-PLUS loans as this would change the status quo of high-borrowers paying higher interest rates and fees in addition to having a higher overall loan burden.	Append policy D-305.984 to policy <u>H-305.925</u>, “Principles of and Actions to Address Medical Education Costs and Student Debt.” Rescind policy D-305.984. <i>Rationale: Policy consolidation.</i>

	Policy Timeline: Res. 316, A-03; Reaffirmed: BOT Rep. 28, A-13; Appended: Res. 302, A-13; Modified and Appended: 301, A-16; Modified: CME Rep. 02, A-23; Reaffirmed in lieu of: Res. 224, A-25	
<u>Corporate Compliance Consolidation H-300.944</u>	Our American Medical Association encourages reciprocity for corporate compliance curricula between institutions to minimize duplicate training and assessment of physicians. Policy Timeline: Res. 321, A-23	Rescind policy H-300.944. <i>Rationale: Addressed by more recent policy <u>H-270.949</u>.</i>

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 3-I-26

Subject: Professional Regulation of Physicians

Presented by: Shannon M. Kilgore, MD, Chair

Referred to: Reference Committee C

Adopted at the 2024 American Medical Association (AMA) Interim meeting, AMA Policy D-295.299, “Updates to Recommendations for Future Directions for Medical Education,” states:

“Our American Medical Association will study the restructuring of AMA Policy H-295.995, ‘Recommendations for Future Directions for Medical Education,’ to consolidate existing AMA policies in these areas where appropriate and to recommend new language for the future of medical education, in a series of seven future reports based on the topics of:

- Mission of medical education.
- Professional regulation.
- Entry into and transition through the medical education continuum.
- Medical education curricula.
- Physician as medical professional.
- Medical education systems.
- Obligations to students and trainees.”

This report addresses the theme of professional regulation, referred to in this report as “professional regulation of physicians.”

BACKGROUND

The above policy was initially introduced via the Council on Medical Education’s self-initiated report, CME 2-I-24, with the intention of proposing a framework to consolidate and modernize AMA medical education policy. During their research for the CME 2-I-24 report, the Council noted the breadth of medical education policies, including Policy H-295.995, “Recommendations for the Future Directions for Medical Education” that contains 33 clauses and had not been reassessed in its entirety since 1982. CME 2-I-24 provided the following commentary regarding “professional regulation of physicians”:

“Medical education maintains commitment to the concept that the regulation of the medical profession should be guided by physicians. A 2015 memorandum of understanding between the Accreditation Council for Graduate Medical Education (ACGME), American Osteopathic Association, and American Association of Colleges of Osteopathic Medicine began a five-year transition to single U.S. graduate medical education (GME) accreditation, which finalized in 2020, though some express concerns. AMA policy currently supports work toward a single licensure exam ([Single Licensing Exam Series for Osteopathic and Allopathic Medical Students D-275.947](#)), and inequities between Doctors of Osteopathic Medicine (DOs) and Doctors of Medicine (MDs) continue to be addressed.

Significant overall shifts in how standardized assessments are designed and discussed have also taken place since the 1980s. This includes the notion of competence as actual competencies linked to patient outcomes rather than personality traits, an understanding that did not develop until the late 1990s and early 2000s, with awareness of assessor bias and the limitations of assessments emerging in scholarly literature even later. In 2021, the United States Medical Licensing Examination (USMLE) Step 2 Clinical Skills (CS) was permanently discontinued after a COVID-19 related 2020 suspension. In 2022, the USMLE Step 1 exam converted from numeric to pass-fail.”

Citations denoted above are provided in [CME 2-I-24](#).

In order to provide consistency across the seven reports, guardrails were established:

- Policies explored include the entirety of the medical education continuum, including pre-medical education, UME, GME, and CME.
- The scope of each report will focus on updating a selection of existing related policies for accuracy as well as consolidation.
- Though the reports seek to consolidate existing policy and improve accuracy of language only, the recommendations may also make note of areas where future reports might be warranted to develop additional AMA policy on important topics not currently represented.
- Each report utilizes the well-established Appendix table format as seen in the annual Sunset Review reports.

To begin the process of selecting relevant policies for the seven reports, [AMA Policy Finder](#) was utilized. Starting on the home page, the “Search” button was selected. It provided a list of “policy topics,” one of which was “medical education.” By selecting this filter, it identified a total of 244 relevant policies. Implemented in September 2025, this process generated a numerical, comprehensive list of 244 policies to be categorized across the seven reports. A single policy is not listed in more than one report. Among them, seven policies were deemed not for inclusion in these reports given their length and/or complexity; 237 policies remained for categorization.

Of the 237 policies, 26 were sorted into this report. They address policies related to regulatory bodies, competency linked to patient care, self-regulation (non-interference), accreditations, credentialing, assessments (i.e., USMLE/COMLEX), and the process of developing standards/requirements. This report does not address policies where the main point of the policy fell outside of the purview of “professional regulation of physicians,” even if tangentially related. Such topics are addressed in the other six reports.

DISCUSSION

Policies considered

As mentioned earlier, 26 policies related to this theme were reviewed for this report. Among them, the Council determined that the following 17 policies remain relevant and should be retained:

- [Remediation Programs for Physicians D-295.325](#)
- [Update on Development of Branch Campuses of International Medical Schools D-295.996](#)
- [Physician Reentry D-300.984](#)
- [Reporting of Total Attempts of USMLE Step 1 and COMLEX-USA Level 1 Examinations H-295.841](#)
- [Physician Participation in the AMA Physician's Recognition Award H-300.959](#)
- [Residency Review Committee Representation and Requirements H-310.972](#)

- [Accreditation of Graduate Medical Education Programs H-310.997](#)
- [Disclosure of Compliance Issues Related to Joint ProvidersHIP D-300.974](#)
- [Reduced Continuing Medical Education \(CME\) Fees for Retired Physicians D-300.994](#)
- [Registration of Accredited CME Sponsors D-300.999](#)
- [Dissemination of Information Regarding CME Activities H-300.952](#)
- [Inappropriate Use of Social Security Numbers in CME Accreditation H-300.946](#)
- [Restructuring of Continuing Medical Education Credits H-300.955](#)
- [Protocol for Recognition of State Medical Society Accreditation Programs H-300.968](#)
- [Unification of Continuing Education Credits H-300.974](#)
- [Community Hospital Continuing Medical Education H-300.983](#)
- [National Accreditation of AMA as Provider of Continuing Medical Education H-300.992](#)

One policy reviewed, [Residency Program Responsibility for Resident Education H-295.915](#), was rescinded by the A-26 Sunset report during the process of writing this report and therefore no longer needs to be acted upon in this report.

The remaining policies are listed in the appendices with recommended actions. They are:

- [Independent Regulation of Physician Licensing Exams D-295.939](#)
- [Opposition to Increased CME Provider Fees D-300.980](#)
- [Proposed Fee Increase by the Accreditation Council for Continuing Medical Education D-300.981](#)
- [Evaluation of Increasing Resident Review Committee Requirements D-310.962](#)
- [Unification of Education Credits H-300.976](#)
- [Restoring Integrity to Continuing Medical Education H-300.988](#)
- [Federal Intervention in the Setting of Educational Standards H-295.921](#)
- [Legislative Threats to the Voluntary Accreditation Process H-295.947](#)

Gaps identified

This review process has illuminated opportunities where policies could be re-examined and reframed in the future to be more forward-thinking. For example, the Council identified the possible need for a policy related to physician reentry as well as further study on how legislative restrictions and government regulatory agencies impact AMA efforts. Such topics may be addressed in future reports, educational sessions, or other mechanisms as determined by this Council and/or the HOD.

RELEVANT AMA POLICIES

There are multiple AMA policies impacted by this report:

Appendix A individually lists current policy language side-by-side with recommended actions (e.g., amend, rescind) related to that specific policy. These actions are collectively addressed in Recommendation 1 of this report.

Appendix B provides the language for related groups of current policy. Your Council recommends combining/consolidating these policies into alternate language for clarity and conciseness which is presented in Recommendation 2 of this report. The content of the original policies was maintained whenever possible, as was the spirit of the original policies.

1 CONCLUSION

2
3 This report reviewed 26 of the 237 policies originally identified and categorized as focusing on
4 medical education and offered multiple recommendations for consideration. In this way, your Council
5 is working to modernize and update our policy compendium as it relates to medical education and
6 make it easier to identify and understand our policies moving forward.
7

8 RECOMMENDATIONS

9
10 The Council on Medical Education recommends that the following be adopted and the remainder of
11 the report be filed:
12

- 13 1. The House of Delegates policies listed in Appendix A of this report be acted upon in the manner
14 indicated and the remainder of this report be filed. (Directive to Take Action)
- 15 2. That policies Federal Intervention in the Setting of Educational Standards H-295.921 and
16 Legislative Threats to the Voluntary Accreditation Process H-295.947 (policy language available
17 in Appendix B) be rescinded and the following policy be adopted:
18

19 LEGISLATIVE THREATS TO MEDICAL EDUCATION STANDARDS

20
21 The AMA strongly opposes:

- 22 a) federal intervention, through legislative restrictions, that would limit the authority of
23 professional accrediting bodies to design and implement appropriate educational standards for the
24 training of physicians;
- 25 b) infringements and mandates on medical school curricular requirements through state and
26 federal legislative efforts, and recommends that state medical societies should carefully monitor
27 such activities and notify the AMA when such intrusions take place;
- 28 c) legislation that would dismantle national accrediting agencies and that would substitute state
29 standards for a uniform level of national standards in medical education, and
- 30 d) legislation that would limit professional participation in the setting and evaluation of quality
31 standards in medical education.

Fiscal Note: Minimal

APPENDIX A: POLICIES AND RECOMMENDED ACTIONS

Title and Policy Number	Text and Timeline	Recommendation
Independent Regulation of Physician Licensing Exams D-295.939	1. Our American Medical Association will continue to work with the National Board of Medical Examiners to ensure that the AMA is given appropriate advance notice of any major potential changes in the examination system. 2. Our AMA will continue to collaborate with the organizations who create, validate, monitor, and administer the United States Medical Licensing Examination. 3. Our AMA will continue to promote and disseminate the rules governing USMLE in its publications. 4. Our AMA will continue its dialog with and be supportive of the process of the Committee to Evaluate the USMLE Program (CEUP). 5. Our AMA will work with American Osteopathic Association and National Board of Osteopathic Medical Examiners to stay apprised of any major potential changes in the Comprehensive Osteopathic Medical Licensing Examination (COMLEX). CME Rep. 10, A-08 Modified: CME Rep. 01, A-18 Reaffirmation: A-22	Amend policy D-295.939 by addition and deletion to read as follows: 1. Our American Medical Association will continue to work with the National Board of Medical Examiners <u>relevant organizations</u> to ensure that the AMA is given appropriate advance notice of any major potential changes in the <u>United States Medical Licensing Examination (USMLE) and Comprehensive Osteopathic Medical Licensing Examination (COMLEX-USA)</u> examination systems. 2. Our AMA will continue to collaborate with the organizations who create, validate, monitor, and administer the United States Medical Licensing Examination. 3. Our AMA will continue to promote and disseminate the rules governing USMLE in its publications. 4. Our AMA will continue its dialog with and be supportive of the process of the Committee to Evaluate the USMLE Program (CEUP). 5. Our AMA will work with American Osteopathic Association and National Board of Osteopathic Medical Examiners to stay apprised of any major potential changes in the Comprehensive Osteopathic Medical Licensing Examination (COMLEX). <i>Rationale: Amendment to clause 1 makes clauses 2 and 5 redundant. Clauses 3 and 4 are no longer relevant as the Committee to Evaluate the USMLE Program (CEUP) was disbanded.</i>

Title and Policy Number	Text and Timeline	Recommendation
<u>Opposition to Increased CME Provider Fees D-300.980</u>	1. Our American Medical Association will: a. continue to work with the ACCME to: i. Reduce the financial burden of institutional accreditation and state recognition. ii. Reduce bureaucracy in these processes. iii. Improve continuing medical education. iv. Encourage the ACCME to show that accreditation criteria improve patient care. b. continue to work with the ACCME to i. Mandate meaningful involvement of state medical societies in the policies that affect recognition. ii. Reconsider the fee increases to be paid by the state-accredited providers to ACCME. 2. Our AMA will continue to work with the ACCME to accomplish the directives in policy D-300.980, "Opposition to Increased Continuing Medical Education (CME) Provider Fees." CME Rep. 14, A-10 Appended: CME Rep. 9, A-11 Modified: CCB/CLRPD Rep. 4, A-12 Modified: CCB/CLRPD Rep. 2, A-14 Appended: Res. 302, A-17 Modified: CME Rep. 1, A-21	Amend policy D-300.980 by addition and deletion with a change in title to read as follows: OPPOSITION TO INCREASED CME PROVIDER FEES<u>CONTINUING MEDICAL EDUCATION</u> <u>ACCREDITATION</u> 1. Our American Medical Association will: a. continue to work with the ACCME to: i. Reduce the financial burden of institutional accreditation and state recognition. ii. Reduce bureaucracy in these processes. iii. Improve continuing medical education. iv. Encourage the ACCME to show that accreditation criteria improve patient care. b. continue to work with the ACCME to i. Mandate meaningful involvement of state medical societies in the policies that affect recognition. ii. Reconsider the fee increases to be paid by the state-accredited providers to ACCME. 2. Our AMA will continue to work with the ACCME to accomplish the directives in policy D-300.980, "Opposition to Increased Continuing Medical Education (CME) Provider Fees." <u>Our AMA will investigate and recommend ways by which physicians may receive appropriate, accredited continuing medical education other than through ACCME-accredited activities.</u> <i>Rationale: Clause b(ii) is outside the purview of the AMA. Clause 2 is redundant. Addition is consolidated from D-300.981 below.</i>

Title and Policy Number	Text and Timeline	Recommendation
Proposed Fee Increase by the Accreditation Council for Continuing Medical Education D-300.981	Our AMA will strongly urge the Accreditation Council for Continuing Medical Education (ACCME) to reconsider the proposed fee increase and, if the ACCME refuses to reconsider the proposed fee increase, our AMA will investigate and recommend ways by which physicians may receive appropriate, accredited continuing medical education other than through ACCME-accredited activities. Res. 312, A-09 Reaffirmed: CME Rep. 01, A-19	Rescind policy D-300.981. <i>Rationale: First part of policy was accomplished by notifying the ACCME of this adopted policy. Second part of policy is recommended to be appended to D-300.980 above.</i>
Evaluation of Increasing Resident Review Committee Requirements D-310.962	Our American Medical Association will work with and monitor the Accreditation Council for Graduate Medical Education and American Osteopathic Association in studying residency/fellowship documentation requirements for program accreditation and the impact of these documentation requirements on program directors and residents with recommendations for improvement. Res. 315, A-08 Reaffirmed: CME Rep. 01, A-18	Amend policy D-310.962 by addition and deletion to read as follows: Our American Medical Association will <u>collaborate</u> work with and monitor the Accreditation Council for Graduate Medical Education and American Osteopathic Association in <u>evaluating</u> residency/fellowship documentation requirements for program accreditation and the impact of these documentation requirements on program directors and residents with recommendations for improvement <u>as needed</u>. <i>Rationale: The AMA is in communication with ACGME on this and related matters. AOA is no longer the appropriate organization to list here. AMA does not monitor ACGME.</i>
Unification of Education Credits H-300.976	It is the policy of the AMA to develop, in cooperation with national specialty organizations and state medical associations, uniform nationwide standards for continuing medical education credits recognized by all medical associations and specialty societies. Policy Timeline: Res. 102, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CME Rep. 2, A-10; Reaffirmed: CME Rep. 01, A-20	Amend policy H-300.976 by addition and deletion to read as follows: It is the policy of the AMA <u>will</u> develop, in cooperation with national specialty organizations and state medical associations, uniform nationwide standards for continuing medical education credits recognized by all medical associations and specialty societies. <i>Rationale: Cleaner phrasing.</i>

Title and Policy Number	Text and Timeline	Recommendation
Restoring Integrity to Continuing Medical Education H-300.988	1. Our American Medical Association supports retention of the definitions of continuing medical education in the Physicians' Recognition Award ("Continuing medical education consists of educational activities which serve to maintain, develop, or increase the knowledge, skills, and professional performance and relationships that a physician uses to provide services for patients, the public, or the profession. The content of CME is that body of knowledge and skills generally recognized and accepted by the profession as within the basic medical sciences, the discipline of clinical medicine, and the provision of health care to the public."). 2. Our AMA urges members of the medical profession to be attentive to the distinction between continuing medical education and continuing education which is not related directly to their professional activities. 3. Our AMA believes that accredited sponsors should designate as continuing medical education only those continuing education activities which meet the definition of continuing medical education. 4. Our AMA encourages the ACCME and state medical associations on the state level to weigh seriously, in considering the sponsor's continued accreditation, instances where an accredited sponsor identifies non-continuing medical education activities as continuing medical education. 5. Our AMA encourages state medical boards to accept for credit continuing education which relates directly to the professional activities of physicians, although each state with mandatory continuing medical education for reregistration of license has the	Amend policy H-300.988, Clause 4 by addition and deletion, with a change in title, to read as follows: INTEGRITY IN CONTINUING MEDICAL EDUCATION RESTORING INTEGRITY TO CONTINUING MEDICAL EDUCATION 4. Our AMA encourages the ACCME and state medical associations on the state level to weigh seriously, in considering the sponsor's continued accreditation, <u>oversight bodies to monitor instances where an accredited sponsor identifies non-continuing medical education activities as continuing medical education and intervene accordingly.</u> <i>Rationale: Cleaner phrasing.</i>

Title and Policy Number	Text and Timeline	Recommendation
	prerogative of defining the continuing education it will accept for credit. Policy Timeline: CME Rep. A, A-82; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmed: CME Rep. 2, A-03; Modified: CME Rep. 2, A-13; Reaffirmation: A-22	

APPENDIX B: CURRENT TEXT OF LEGISLATIVE POLICIES RECOMMENDED FOR REVISION

Federal Intervention in the Setting of Educational Standards H-295.921

The AMA strongly opposes federal intervention, through legislative restrictions, that would limit the authority of professional accrediting bodies to design and implement appropriate educational standards for the training of physicians. The AMA strongly opposes infringements and mandates on medical school curricular requirements through state and federal legislative efforts, and also recommends that state medical societies should carefully monitor such activities and notify the AMA when such intrusions take place.

Res. 323, A-95 Appended: CME Rep. 4, I-97 Reaffirmed: CME Rep. 2, A-07 Reaffirmed: CME Rep. 01, A-17

Legislative Threats to the Voluntary Accreditation Process H-295.947

It is the policy of our American Medical Association to strongly oppose legislation which would:

1. Dismantle national accrediting agencies and which would substitute state standards for a uniform level of national standards in medical education.
2. Limit professional participation in the setting and evaluation of quality standards in medical education.

Res. 225, I-91 Modified: Sunset Report, I-01 Reaffirmed: BOT Rep. 22, A-11 Reaffirmed: BOT Rep. 7, A-21

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 4-I-26

Subject: Physician as Medical Professional

Presented by: Shannon Kilgore, MD, FAAN, FANA, Chair

Referred to: Reference Committee C

Adopted at the 2024 Interim Meeting, AMA Policy D-295.299, “Updates to Recommendations for Future Directions for Medical Education,” calls for the following:

“Our American Medical Association will study the restructuring of AMA Policy H-295.995, ‘Recommendations for Future Directions for Medical Education,’ to consolidate existing AMA policies in these areas where appropriate and to recommend new language for the future of medical education, in a series of seven future reports based on the topics of:

- Mission of medical education.
- Professional regulation.
- Entry into and transition through the medical education continuum.
- Medical education curricula.
- Physician as medical professional.
- Medical education systems.
- Obligations to students and trainees.”

This report addresses the theme of “physician as medical professional.”

BACKGROUND

The above policy was initially introduced via the Council on Medical Education’s self-initiated report, CME 2-I-24, with the intention of proposing a framework to consolidate and modernize AMA medical education policy. During their research for the CME 2-I-24 report, the Council noted the breadth of medical education policies, including Policy H-295.995, “Recommendations for the Future Directions for Medical Education,” that contains 33 clauses and had not been reassessed in its entirety since 1982. CME 2-I-24 provided the following commentary regarding “physician as medical professional”:

“Due in part to the rapid growth of managed care in health insurance in the late 1980s and early 1990s, a much larger proportion of physicians began seeking board certification.⁴² Rapid changes in medicine and the exponential growth of medical knowledge also caused shifts in patient and payer concerns about physician knowledge.⁴³ In 1990, internal medicine board certification became time-limited rather than one-time, and in 2002, all member boards of the American Board of Medical Specialties agreed on recertification requirements and evaluation of performance in practice.⁴² These changes led to continuous assessment programs called maintenance of certification (MOC)⁴³ in the early 2000s, which offered both benefits and challenges, and translated to varying options for continuing board certification depending on specialty, such as a longitudinal knowledge assessment pathway for the American Board of Internal Medicine (ABIM) in 2022.⁴³”

With regard to physician lifelong learning, the Accreditation Council for Continuing Medical Education was still new when the 1982 report was written, having been established in 1981, and has evolved over time.⁴⁴ AMA's own Physician Recognition Award (PRA) Credit System also shifted over time, including official booklet updates in 2017 and in-progress changes since then.⁴⁵ Many factors related to lifelong learning have also emerged into greater awareness, such as ageism and principles to guide physician competence assessment at any age⁴⁶ and substance use disorder destigmatization and interventions.⁴⁷

Citations denoted above are provided in CME 2-I-24.

In order to provide consistency across the seven reports, guardrails were established:

- Policies explored include the entirety of the medical education continuum, including pre-medical education, UME, GME, and CME.
- The scope of each report will focus on updating a selection of existing related policies for accuracy as well as consolidation.
- Though the reports seek to consolidate existing policy and improve accuracy of language only, the recommendations may also make note of areas where future reports might be warranted to develop additional AMA policy on important topics not currently represented.
- Each report utilizes the well-established Appendix table format as seen in the annual Sunset Review reports.

To begin the process of selecting relevant policies for the seven reports, AMA Policy Finder was utilized. Starting on the home page, the "Search" button was selected. It provided a list of "policy topics," one of which was "medical education." By selecting this filter, it identified a total of 244 relevant policies. Implemented in September 2025, this process generated a numerical, comprehensive list of 244 policies to be categorized across the seven reports. A single policy is not listed in more than one report. Among them, seven policies were deemed not for inclusion in these reports given their length and/or complexity; 237 policies remained for categorization.

Among the 237 policies, 28 of them were sorted into this report. They address policies related to professionalism, burnout, lifelong learning, board certification, PRA operations, and continuing medical education. This report does not address policies where the main point of the policy fell outside of the purview of "physician as medical professional," even if tangentially related. Such topics are addressed in the other six reports.

DISCUSSION

Policies considered

As mentioned earlier, 28 policies related to this theme were reviewed for this report. Among them, the Council determined that the following 24 policies remain relevant and should be retained:

- Promoting Physician Lifelong Learning D-295.328
- Criminal Background Checks for Medical Students D-295.949
- Continuing Medical Education Resources for Preceptorship D-300.972
- Increased Credit for Continuing Medical Education Preparation D-300.975
- Alternative Funding for Continuing Medical Education D-305.965
- Physician and Medical Student Burnout D-310.968
- Protections for Trainees, Faculty, and Staff Experiencing Retaliation in Medical Education H-295.837
- Curricular Structure Reform to Support Physician and Trainee Well-Being H-295.838
- Addressing Professionalism Standards in Medical Training H-295.839
- The Impact of Midlevel Providers on Medical Education H-295.849
- Conscience Clause: Final Report H-295.896
- Continuing Medical Education Activities for Procedural Skills H-300.948

- 1 • Credit for Reading Medical Journals H-300.951
- 2 • Content-Specific CME Mandated for Licensure H-300.953
- 3 • Support for Continuing Medical Education H-300.958
- 4 • Medical Ethics and Continuing Medical Education H-300.964
- 5 • Promoting Quality Assurance, Peer Review, and Continuing Medical Education H-300.973
- 6 • Fraudulent/Legitimate Continuing Medical Education Activities H-300.975
- 7 • Focused Continuing Education Programs for Enhanced Clinical Competence H-300.980
- 8 • Community Hospital Continuing Medical Education H-300.983
- 9 • National Accreditation of AMA as Provider of Continuing Medical Education H-300.992
- 10 • Support of Voluntary Continuing Medical Education H-300.994
- 11 • Reaffirmation of Support for Continuing Medical Education H-300.996
- 12 • ACGME Allotted Time Off for Health Care Advocacy and Health Policy Activities H-
- 13 310.911

14
15 The remaining four policies are listed in the Appendix with recommended actions. They are:

- 16 • Fostering Professionalism During Medical School and Residency Training D-295.983
- 17 • Continuing Medical Education for Physicians in the Hospital Setting H-300.966
- 18 • Revisions to the Physician's Recognition Award H-300.977
- 19 • "Medical Education" Travel H-300.997

20 21 *Gaps identified*

22
23 Upon review of the 28 policies, the Council identified important topics that could be further
24 illuminated in AMA policy. They include physician wellness, augmented intelligence (AI)/emerging
25 technologies and the future of medical education, competency-based medical education (CBME) in
26 continuing medical education, and principles related to physician re-entry into clinical practice. Such
27 topics may be addressed in future reports, educational sessions, forums, or other mechanisms as
28 determined by this Council and/or the House of Delegates.

29 30 RELEVANT AMA POLICIES

31
32 See the bulleted list above as well as policies in the Appendix.

33 34 CONCLUSION

35
36 This report reviewed 28 policies out of the 237 policies originally identified and categorized. It offers
37 recommended actions for four of those policies addressing "physician as medical professional."

38 39 RECOMMENDATIONS

40
41 The Council on Medical Education recommends that the following be adopted and the remainder of
42 the report be filed:

- 43
44 1. The House of Delegates policies listed in the Appendix of this report be acted upon in the
45 manner indicated and the remainder of this report be filed. (Directive to Take Action)

Fiscal Note: Minimal

APPENDIX: POLICIES AND RECOMMENDED ACTIONS

Title and Policy Number	Text and Timeline	Recommendation
<u>Fostering Professionalism During Medical School and Residency Training D-295.983</u>	(1) Our AMA, in consultation with other relevant medical organizations and associations, will work to develop a framework for fostering professionalism during medical school and residency training. This planning effort should include the following elements: (a) Synthesize existing goals and outcomes for professionalism into a practice-based educational framework, such as provided by the AMA's Principles of Medical Ethics. (b) Examine and suggest revisions to the content of the medical curriculum, based on the desired goals and outcomes for teaching professionalism. (c) Identify methods for teaching professionalism and those changes in the educational environment, including the use of role models and mentoring, which would support trainees' acquisition of professionalism. (d) Create means to incorporate ongoing collection of feedback from trainees about factors that support and inhibit their development of professionalism. (2) Our AMA, along with other interested groups, will continue to study the clinical training environment to identify the best methods and practices used by medical schools and residency programs to fostering the development of professionalism, to include an evaluation of professional behavior, carried out at regular intervals and employing methods shown to be valuable in adding to the information that can be obtained from observational reports. An ideal system would utilize multiple evaluation formats and would build upon educational experiences that are already in place. The results of such evaluations should be used both for timely feedback and appropriate interventions for medical students and resident physicians aimed at improving their performance and for summative decisions about progression in training. Policy Timeline: CME Rep. 3, A-01; Reaffirmation I-09; Reaffirmed: CME Rep. 01, A-19; Modified: CME Rep. 01, A-20	Amend policy clause (2) of D-295.983 by addition and deletion to read as follows: (2) Our AMA, along with other interested groups, will continue to study the clinical training environment to identify the best methods and practices used by medical schools and residency programs to fostering the development of professionalism, to <u>Methods should include an evaluation of professional behavior, to be</u> carried out at regular intervals and employing methods shown to be valuable in adding to the information that can be obtained from observational reports. An ideal system would utilize multiple evaluation formats and would build upon educational experiences that are already in place. The results of such evaluations should be used both for timely feedback and appropriate interventions for medical students and resident/fellow physicians aimed at improving their performance and for summative decisions about progression in training. <i>Rationale: Amended to provide clarity.</i>

<u>Continuing Medical Education for Physicians in the Hospital Setting H-300.966</u>	It is the policy of our American Medical Association that the continuing medical educational programs offered physicians in the hospital setting be the responsibility of the hospital medical staff and directed by the medical staff as defined in the hospital bylaws. Policy Timeline: Res. 318, A-92; Reaffirmed: CME Rep. 2, A-03; Reaffirmed: CME Rep. 2, A-13; Reaffirmed: CME Rep. 01, A-23	Amend policy H-300.966 to read as follows: It is the policy of oOur American Medical Association that the encourages continuing medical educational programs offered to physicians in the hospital setting be <u>created collaboratively the</u> responsibility of the hospital medical staff and directed by <u>with</u> the medical staff as defined in the hospital bylaws. <i>Rationale: Policy implied that only the medical staff office can offer continuing medical education. For large organizations, this policy could be prohibitive and burdensome. Amended language provides broader educational opportunities.</i>
<u>Revisions to the Physician's Recognition Award H-300.977</u>	Our American Medical Association has adopted the following changes in the Physician's Recognition Award: 1. To accept recertification by an AMA-recognized specialty board in satisfaction of requirements for a three-year PRA certificate. 2. To allow credit for international conferences when these have been approved by the AMA prior to the event. 3. To allow credit for teaching to be reported for <i>AMA PRA Category 2 Credit™</i> toward the award. Policy Timeline: CME Rep. D, I-90; Reaffirmed: Sunset Report, I-00; Modified and reaffirmed: CME Rep. 2, A-06; Reaffirmed: CME Rep. 01, A-16; Reaffirmation: A-22	Rescind policy H-300.977. <i>Rationale: Changes listed in clauses 1-4 were accomplished. For more information, see <u>AMA PRA Booklet</u>.</i>

<u>“Medical Education”</u> <u>Travel H-300.997</u> 1	Our AMA (1) deploras excessive charges for continuing medical education programs which exploit physicians or distort the real purposes of education programs; (2) encourages state society accrediting agencies to consider the impact of the cost of the accreditation process on program charges; and (3) supports making a concentrated effort to acquaint physicians with programs that will help them meet their particular educational needs at a reasonable cost. Policy Timeline: Sub. Res. 84, A-79; Reaffirmed: CLRPD Rep. B, I-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CME Rep. 2, A-10; Reaffirmed: CME Rep. 01, A-20	Amend policy H-300.997 by addition and deletion with a change in title to read as follows: CONTINUING MEDICAL EDUCATION FEES Our AMA (1) deploras <u>opposes</u> excessive charges for continuing medical education <u>(CME)</u> programs which that exploit physicians or distort the real purposes of education programs; (2) encourages state society accrediting agencies to consider the impact of the cost of the accreditation process on program charges; and (3) supports making a concentrated efforts to acquaint physicians with programs that will help them meet their particular educational needs at a reasonable cost. <i>Rationale: Amended to provide clarity and accuracy.</i>
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REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 5-I-26

Subject: Entry into and transition through the medical education continuum

Presented by: Shannon Kilgore, MD, FAAN, FANA, Chair

Referred to: Reference Committee C

Adopted at the 2024 Interim Meeting, AMA Policy D-295.299, “Updates to Recommendations for Future Directions for Medical Education,” calls for the following:

“Our American Medical Association will study the restructuring of AMA Policy H-295.995, ‘Recommendations for Future Directions for Medical Education,’ to consolidate existing AMA policies in these areas where appropriate and to recommend new language for the future of medical education, in a series of seven future reports based on the topics of:

- Mission of medical education.
- Professional regulation.
- Entry into and transition through the medical education continuum.
- Medical education curricula.
- Physician as medical professional.
- Medical education systems.
- Obligations to students and trainees.”

This report addresses the theme of “entry into and transition through the medical education continuum.”

BACKGROUND

The above policy was initially introduced via the Council on Medical Education’s self-initiated report, CME 2-I-24, with the intention of proposing a framework to consolidate and modernize AMA medical education policy. During their research for the CME 2-I-24 report, the Council noted the breadth of medical education policies, including Policy H-295.995, “Recommendations for the Future Directions for Medical Education,” that contains 33 clauses and had not been reassessed in its entirety since 1982. CME 2-I-24 provided the following commentary regarding “entry into and transition through the medical education continuum”:

“Application and selection processes have also changed over time. In 1995, the Association of American Medical Colleges (AAMC) developed the Electronic Residency Application Service (ERAS), replacing cumbersome paper mail residency applications with newer technology—first floppy disks, followed by web-based services.¹⁸ In more recent years, specialties have considered and tested alternatives to ERAS, such as the obstetrics and gynecology (OB/GYN) specialty’s shift to the Residency Centralized Application Service in 2024.¹⁹ This new platform will still work in conjunction with the National Resident Matching Program (NRMP) for the Match. Although the NRMP was established in 1952,²⁰ significant changes have also taken place over the years to modernize infrastructure and shift strategic priorities in response to modern needs.²¹ The NRMP formalized its Specialty Matching

Service and conducted its first fellowship Match in 1984.²² A single Match for DOs and MDs began in 2020.⁶

The COVID-19 pandemic, declared officially in 2020, sparked both a major crisis within medical education and devastation for many within society at large, prompting opportunities for transformations of existing systems²³ in both education and patient care.²⁴ AAMC now recommends virtual interviewing for all residency and fellowship programs.²⁵ On the heels of COVID-19 related upheaval, the Coalition for Physician Accountability commissioned an independent body to review the UME-to-GME transition and provide recommendations. The Undergraduate Medical Education to Graduate Medical Education Review Committee (UGRC) released a report with 34 recommendations in August 2021.²⁶

For international medical graduates, the Educational Commission for Foreign Medical Graduates (ECFMG) established the Foundation for Advancement of International Medical Education and Research (FAIMER) in 2000,²⁷ launched electronic verification of medical credentials in 2012,²⁸ developed certification Pathways in 2020 following the suspension of USMLE Step 2,²⁹ and in 2023, ECFMG and FAIMER became divisions of a private nonprofit organization, Intealth.²⁹ In 2024, the Federation of State Medical Boards (FSMB), Intealth, and the ACGME established an 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,’ with work in progress at the time of this writing.³⁰

Citations denoted above are provided in CME 2-I-24.

In order to provide consistency across the seven reports, guardrails were established:

- Policies explored include the entirety of the medical education continuum, including pre-medical education, UME, GME, and CME.
- The scope of each report will focus on updating a selection of existing related policies for accuracy as well as consolidation.
- Though the reports seek to consolidate existing policy and improve accuracy of language only, the recommendations may also make note of areas where future reports might be warranted to develop additional AMA policy on important topics not currently represented.
- Each report utilizes the well-established Appendix table format as seen in the annual Sunset Review reports.

To begin the process of selecting relevant policies for the seven reports, AMA Policy Finder was utilized. Starting on the home page, the “Search” button was selected. It provided a list of “policy topics,” one of which was “medical education.” By selecting this filter, it identified a total of 244 relevant policies. Implemented in September 2025, this process generated a numerical, comprehensive list of 244 policies to be categorized across the seven reports. A single policy is not listed in more than one report. Among them, seven policies were deemed not for inclusion in these reports given their length and/or complexity; 237 policies remained for categorization.

Among the 237 policies, 21 of them were sorted into this report. They address policies related to application and selection processes, match processes, demonstrating readiness to progress, ERAS, and Intealth. This report does not address policies where the main point of the policy fell outside of the purview of “entry into and transition through the medical education continuum,” even if tangentially related. Such topics are addressed in the other six reports.

DISCUSSION

Policies considered

As mentioned earlier, 21 policies related to this theme were reviewed for this report. Among them, the Council determined that the following 19 policies remain relevant and should be retained:

- Modifying Financial Assistance Eligibility Criteria for Medical School Applicants D-305.950
- Mitigating Demographic and Socioeconomic Inequities in the Residency and Fellowship Selection Process D-310.945
- Fellowship Application Reform D-310.958
- Ensuring Equity in Interview Processes for Entry to Undergraduate and Graduate Medical Education H-295.844
- Decreasing Bias in Assessments of Medical Student Clinical Clerkship Performance H-295.851
- Increase Awareness Among Residency, Fellowship, and Academic Programs on the United States-Puerto Rico Relationship Status H-295.854
- Extramural Clerkships and Early Career Decisions H-295.983
- Progress in Medical Education: Structuring the Fourth Year of Medical School H-295.895
- The Ecology of Medical Education: Physician Self-Directed Learning and Continuing Medical Education H-300.949
- Discrimination Against Resident Candidates Based on Graduate Medical Education Medicare Funding H-305.971
- Transparency and Access to Medical Training Program Unionization Status, Including Creation of a FREIDA Unionization Filter H-310.897
- Unmatched Graduating Physicians H-310.899
- Resident and Fellow Physicians Seeking to Transfer GME Program H-310.900
- Preliminary Year Program Placement H-310.910
- 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 H-310.919
- Medical Student Involvement and Validation of the Standardized Video Interview Implementation D-310.949
- In-Service Training Examinations - Final Report H-310.959
- Reevaluation of Residency Selection Process H-310.982
- Residency Positions for Sale H-310.983

The remaining two policies are listed in the Appendix with recommended actions. They are:

- Clinical Skills Assessment During Medical School D-295.988
- Tools to Support Achievement of Competencies Across Learning Continuum H-295.862

Gaps identified

This review process has illuminated opportunities where policies could be re-examined and reframed in the future to be more forward-thinking. For example, efforts in the medical education community are currently focused on the transition from UME to GME (and GME into practice). These efforts provide an opportunity to leverage early lessons learned from competency-based medical education, precision education, and other initiatives to revisit policies like H-295.895 (listed above). Also, the Council may consider future study of the transitions that occur throughout the course of medical training. This complex topic could be addressed in a future report, educational session, forum, or other mechanism as determined by this Council and/or the House of Delegates.

1 RELEVANT AMA POLICIES

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3 See bulleted list above as well as policies in the Appendix.

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5 CONCLUSION

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7 This report reviewed 21 policies out of the 237 policies originally identified and categorized. The
8 Appendix offers recommended actions for the two remaining policies that address “entry into and
9 transition through the medical education continuum.”

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11 RECOMMENDATIONS

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

- 15
16 1. The House of Delegates policies listed in the Appendix of this report be acted upon in the
17 manner indicated and the remainder of this report be filed. (Directive to Take Action)

Fiscal Note: Minimal

APPENDIX: POLICIES AND RECOMMENDED ACTIONS

Title and Policy Number	Text and Timeline	Recommendation
<u>Clinical Skills Assessment During Medical School D-295.988</u>	1. Our American Medical Association will encourage its representatives to the Liaison Committee on Medical Education (LCME) to ask the LCME to determine and disseminate to medical schools a description of what constitutes appropriate compliance with the accreditation standard that schools should “develop a system of assessment” to assure that students have acquired and can demonstrate core clinical skills. 2. Our AMA will work with the Federation of State Medical Boards, National Board of Medical Examiners, state medical societies, state medical boards, and other key stakeholders to pursue the transition from and replacement for the current United States Medical Licensing Examination (USMLE) Step 2 Clinical Skills (CS) examination and the Comprehensive Osteopathic Medical Licensing Examination (COMLEX) Level 2-Performance Examination (PE) with a requirement to pass a Liaison Committee on Medical Education-accredited or Commission on Osteopathic College Accreditation-accredited medical school-administered, clinical skills examination. 3. Our AMA will work to: a. ensure rapid yet carefully considered changes to the current examination process to reduce costs, including travel expenses, as well as time away from educational pursuits, through immediate steps by the Federation of State Medical Boards and National Board of Medical Examiners. b. encourage a significant and expeditious increase in the number of available testing sites. c. allow international students and graduates to take the same examination at any available testing site.	Amend policy D-295.988 by addition and deletion to read as follows: 1. Our American Medical Association will encourage its representatives to the Liaison Committee on Medical Education (LCME) to ask the LCME to determine and disseminate to medical schools a description of what constitutes appropriate compliance with the accreditation standard that schools should "develop a system of assessment" to assure that students have acquired and can demonstrate core clinical skills. 2. Our AMA will work with the Federation of State Medical Boards, National Board of Medical Examiners, state medical societies, state medical boards, and other key stakeholders to pursue the transition from and replacement for the current United States Medical Licensing Examination (USMLE) Step 2 Clinical Skills (CS) examination and the Comprehensive Osteopathic Medical Licensing Examination (COMLEX) Level 2-Performance Examination (PE) with a requirement to pass a Liaison Committee on Medical Education-accredited or Commission on Osteopathic College Accreditation-accredited medical school-administered, clinical skills examination. 3. Our AMA will work to: a. ensure rapid yet carefully considered changes to the current examination process to reduce costs, including travel expenses, as well as time away from educational pursuits, through immediate steps by the Federation of State Medical Boards and National Board of Medical Examiners. b. encourage a significant and expeditious increase in the number of available testing sites. c. allow international students and graduates to take the same examination at any available testing site.

	d. engage in a transparent evaluation of basing this examination within our nation's medical schools, rather than administered by an external organization. e. include active participation by faculty leaders and assessment experts from U.S. medical schools, as they work to develop new and improved methods of assessing medical student competence for advancement into residency. 4. Our AMA is committed to assuring that all medical school graduates entering graduate medical education programs have demonstrated competence in clinical skills. 5. Our AMA will continue to work with appropriate stakeholders to assure the processes for assessing clinical skills are evidence-based and most efficiently use the time and financial resources of those being assessed. 6. Our AMA encourages development of a post-examination feedback system for all USMLE test-takers that would: - Identify areas of satisfactory or better performance. - Identify areas of suboptimal performance. - Give students who fail the exam insight into the areas of unsatisfactory performance on the examination. 7. Our AMA, through the Council on Medical Education, will continue to monitor relevant data and engage with stakeholders as necessary should updates to this policy become necessary. Policy Timeline: CME Rep. 7, I-99; Reaffirmed: CME Rep. 2, A-09; Appended: Alt. Res. 311, A-16; Appended: CME Rep. 9, A-17; Reaffirmation: I-19; Reaffirmed: Res. 306, I-20; Reaffirmed in lieu of: Res. 308, A-21	d. engage in a transparent evaluation of basing this examination within our nation's medical schools, rather than administered by an external organization. e. include active participation by faculty leaders and assessment experts from U.S. medical schools, as they work to develop new and improved methods of assessing medical student competence for advancement into residency. 4. Our AMA is committed to assuring that all medical school graduates entering graduate medical education programs have demonstrated competence in clinical skills. 5. Our AMA will continue to work with appropriate stakeholders <u>parties</u> to assure <u>ensure</u> the processes for assessing clinical skills are evidence-based and most efficiently use the time and financial resources of those being assessed. 6. Our AMA encourages development of a post-examination feedback system for all USMLE <u>and COMLEX-USA</u> test-takers that would: - Identify areas of satisfactory or better performance. - Identify areas of suboptimal performance. - Give students who fail the exam insight into the areas of unsatisfactory performance on the examination. 7. Our AMA, through the Council on Medical Education, will continue to monitor relevant data and engage with stakeholders <u>relevant parties</u> as necessary should updates to this policy become necessary. <i>Rationale: Retain clause 4. Clauses 1-3 are no longer relevant. Updated clause 6 to include DO students. Updated terminology in clauses 5 and 7.</i>
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<u>Tools to Support Achievement of Competencies Across Learning Continuum H-295.862</u>	Our AMA supports the development and implementation of tools (e.g., longitudinal learner portfolios) to track learners' progress in achieving the defined competencies across the continuum. Policy Timeline: CME Rep. 4, A-14; Appended: CME Rep. 10, A-15; Modified: CME Rep. 01, A-25	Append policy H-295.862 to policy <u>D-295.317</u>, "Competency Based Medical Education Across the Continuum of Education and Practice." Rescind policy H-295.862. <i>Rationale: Policy consolidation.</i>
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REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 6-I-26

Subject: Obligations to Students and Trainees

Presented by: Shannon Kilgore, MD, FAAN, FANA,, Chair

Referred to: Reference Committee C

Adopted at the 2024 Interim Meeting, AMA Policy [D-295.299](#), “Updates to Recommendations for Future Directions for Medical Education,” calls for the following:

“Our American Medical Association will study the restructuring of AMA Policy [H-295.995](#), ‘[Recommendations for Future Directions for Medical Education](#),’ to consolidate existing AMA policies in these areas where appropriate and to recommend new language for the future of medical education, in a series of seven future reports based on the topics of:

- Mission of medical education.
- Professional regulation.
- Entry into and transition through the medical education continuum.
- Medical education curricula.
- Physician as medical professional.
- Medical education systems.
- Obligations to students and trainees.”

This report addresses the theme of “obligations to students and trainees.”

BACKGROUND

The above policy was initially introduced via the Council on Medical Education’s self-initiated report, [CME 2-I-24](#), with the intention of proposing a framework to consolidate and modernize AMA medical education policy. During their research for the CME 2-I-24 report, the Council noted the breadth of medical education policies, including Policy [H-295.995](#), “Recommendations for the Future Directions for Medical Education,” that contains 33 clauses and had not been reassessed in its entirety since 1982. CME 2-I-24 provided the following commentary regarding “obligations to students and trainees”:

“Since 1982, there has been increased attention to the needs of students and trainees, in a variety of forms. Student well-being is now better researched, and a variety of interventions have been tested⁵⁰ and implemented on an ongoing basis.⁵⁵ Resident working conditions and duty hours have become major issues in GME, particularly after the Libby Zion case in 1984⁵⁶ and adoption of ACGME duty hour standards.⁵⁷ In 2011, the AMA released the Residents and Fellows’ Bill of Rights H-2 31.912, last updated in 2023, and there is increasing awareness of the need to address growing stressors and burnout within medical education, both for learners⁵⁸ and faculty.⁵⁹ Research is ongoing on how other aspects of the medical education field have shifted over time and how these changes may impact learners and public health.⁶⁰”

Citations denoted above are provided in [CME 2-I-24](#).

In order to provide consistency across the seven reports, guardrails were established:

- Policies explored include the entirety of the medical education continuum, including pre-medical education, UME, GME, and CME.
- The scope of each report will focus on updating a selection of existing related policies for accuracy as well as consolidation.
- Though the reports seek to consolidate existing policy and improve accuracy of language only, the recommendations may also make note of areas where future reports might be warranted to develop additional AMA policy on important topics not currently represented.
- Each report utilizes the well-established Appendix table format as seen in the annual Sunset Review reports.

To begin the process of selecting relevant policies for the seven reports, AMA Policy Finder was utilized. Starting on the home page, the “Search” button was selected. It provided a list of “policy topics,” one of which was “medical education.” By selecting this filter, it identified a total of 244 relevant policies. Implemented in September 2025, this process generated a numerical, comprehensive list of 244 policies to be categorized across the seven reports. A single policy is not listed in more than one report. Among them, seven policies were deemed not for inclusion in these reports given their length and/or complexity; 237 policies remained for categorization.

Among the 237 policies, 42 of them were sorted into this report. They address policies related to protection of learners, well-being, needs of learners, resident working conditions, duty hours, bill of rights, burnout/stress, and equity in access for DOs. This report does not address policies where the main point of the policy fell outside of the purview of “obligations to students and trainees,” even if tangentially related. Such topics are addressed in the other six reports.

DISCUSSION

Policies considered

As mentioned earlier, 42 policies related to this theme were reviewed for this report. Among them, the Council determined that the following 25 policies remain relevant and should be retained:

- Accreditation Standards to Address Sexual Harassment in Medical Training Programs D-295.304
- Decreasing Bias in Evaluations of Medical Student Performance D-295.307
- Parental Leave and Planning Resources for Medical Students D-295.308
- Facilitating Access to Health Care Facilities for Training D-295.941
- Pharmaceutical Federal Regulations -- Protecting Resident Interests D-295.964
- Increased Education and Access to Fertility Resources for U.S. Medical Students H-295.846
- Support for Institutional Policies for Personal Days for Undergraduate Medical Students H-295.850
- Support for the Study of the Timing and Causes for Leave of Absence and Withdrawal from United States Allopathic and Osteopathic Medical Undergraduate and Graduate Education Programs H-295.856
- Access to Confidential Health Services for Medical Students and Physicians H-295.858
- Equal Fees for Osteopathic and Allopathic Medical Students H-295.876
- Color Blindness H-295.889
- Protection of Medical Students in the Event of Medical School Closure or Reduction in Enrollment H-295.908
- Protecting Medical Trainees from Hazardous Exposure H-295.939

- 1 • Issues Regarding Patient and/or Donor Transports by Resident Physicians and Medical
- 2 Students H-295.943
- 3 • Teacher-Learner Relationship in Medical Education H-295.955
- 4 • Inclusion of Medical Students and Residents in Medical Society Impaired Physician
- 5 Programs H-295.993
- 6 • Psychological Testing Without Informed Consent H-295.996
- 7 • Due Process H-295.998
- 8 • Recognizing Dependent Care Expenses in Determining Medical Education Financial Aid H-
- 9 305.941
- 10 • Taxation of Federal Student Aid H-305.962
- 11 • Resident/Fellow Clinical and Educational Work Hours H-310.907
- 12 • Physician Extenders H-310.913
- 13 • Eliminating Religious and Cultural Discrimination from Residency and Fellowship Programs
- 14 and Medical Schools H-310.923
- 15 • Shared Residency Positions H-310.990
- 16 • Resident Participation on Hospital Committees H-310.993

17
18 Sixteen policies are listed in Appendix A with recommended actions. They are:

- 19 • HIV Postexposure Prophylaxis for Medical Students During Electives Abroad D-295.970
- 20 • Reimbursement for Post-Exposure Protocol for Needlestick Injuries H-295.855
- 21 • The Effect of the COVID-19 Pandemic on Graduate Medical Education D-310.946
- 22 • Protecting Trainees' Breastfeeding Rights D-310.950
- 23 • Accommodating Lactating Individuals Taking Medical Examinations H-295.861
- 24 • Resident Pay During Orientation D-310.967
- 25 • Impairment Prevention and Treatment in the Training Years H-295.863
- 26 • Expanding the Visiting Students Application Service for Visiting Student Electives in the
- 27 Fourth Year H-295.867
- 28 • Eliminating Benefits Waiting Periods for Residents and Fellows H-295.873
- 29 • Insurance Coverage for Medical Students and Resident Physicians H-295.942
- 30 • Residents' Salaries H-305.930
- 31 • Resident and Fellow Access to Fertility Preservation H-310.902
- 32 • Financial Protections for Doctors in Training H-310.903
- 33 • Funding to Support Training of the Health Care Workforce H-310.916
- 34 • The Educational and Work Environment of Resident Physicians H-310.935
- 35 • Anonymity for Resident Inquiries to Residency Review Committees H-310.995

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37 *Gaps identified*

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39 This review process has illuminated opportunities where policies could be re-examined and reframed
40 in the future to be more forward-thinking. For example, Policy H-295.955 addresses an important and
41 complex topic that could be further explored in terms of the evolving learning environment in medical
42 education.

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44 Review of these 42 policies also illuminated for the Council the opportunity to investigate how
45 undergraduate, graduate, and continuing medical education must innovate with augmented
46 intelligence (AI) as well as other emerging technologies to fulfill medical education's obligations to
47 students and trainees. This topic may be addressed in future reports, educational sessions, forums or
48 other mechanisms as determined by this Council and/or the House of Delegates.

Upon further review of the issues raised in the Residents and Fellows' Bill of Rights H-310.912, the Council determined that it should be studied. This policy has grown significantly over time. Such review provides an opportunity to reshape its content to offer clearer guidance, reduce redundancies, and a more future-oriented perspective as well as to update language and outdated references. Thus, the Council has added a recommendation to this report regarding such study. Of note, it also raises consideration for the possibility of a bill of rights for medical students.

RELEVANT AMA POLICIES

See bulleted list above as well as policies in Appendix A. Also, Appendix B lists current language for two policies the Council has recommended for rescission as a themed grouping. Rescission does not mean the topic is no longer relevant. Rather, the topics and language from Appendix B policies have been used to create new consolidated language in the report recommendations, for clarity and conciseness. The Council's intention is to make it easier to find and understand AMA's stance on specific topics, rather than having similar policies scattered in many areas of Policy Finder.

CONCLUSION

This report reviewed 42 policies out of the 237 policies originally identified and categorized. It offers recommended actions for four of those policies addressing "obligations to students and trainees."

RECOMMENDATIONS

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

1. The House of Delegates policies listed in Appendix A of this report be acted upon in the manner indicated. (Directive to Take Action)
2. The AMA will study Policy H-310.912, Residents and Fellows' Bill of Rights, to update its contents (Directive to Take Action).
3. That Policies D-310.948, Protection of Resident and Fellow Training in the Case of Hospital or Training Program Closure, and H-310.943, Closing of Residency Programs, (policy language available in Appendix B) be rescinded and the following policy be adopted:

PROTECTIONS IN THE CASE OF HOSPITAL OR TRAINING PROGRAM CLOSURE

1. Our American Medical Association (AMA) opposes the closure of residency/fellowship programs or reductions in the number of current positions in programs as a result of changes in graduate medical education (GME) funding.
2. Our AMA encourages residency programs and teaching hospitals to:
 - a. Uphold their contractual responsibilities to the residents.
 - b. Undergo monitoring by the applicable Review Committees to ensure that reductions in resident and fellow numbers do not unduly burden remaining residents and fellows through adverse effects on work hours or working conditions, consistent with Review Committee requirements.

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3. Our AMA encourages the Centers for Medicare & Medicaid Services (CMS) to:
 - a. Stipulate in its regulations that residency slots are not assets that belong to the teaching institution.
 - b. Establish regulations that protect residents and fellows impacted by program or hospital closure, which may include recommendations for:
 - i. Notice by the training hospital intending to file for bankruptcy within 30 days to all residents and fellows primarily associated with the training hospital as well as those contractually matched at that training institution who may not yet have matriculated of its intention to close, along with provision of reasonable and appropriate procedures to assist current and matched residents and fellows to find and obtain alternative training positions that minimize undue financial and professional consequences, including but not limited to maintenance of specialty choice, length of training, initial expected time of graduation, location and reallocation of funding, and coverage of tail medical malpractice insurance that would have been offered had the program or hospital not closed.
 - ii. Revise the current CMS guidelines that may prohibit transfer of funding prior to formal financial closure of a teaching institution.
 - iii. Improve provisions regarding transfer of GME funding for displaced residents and fellows for the duration of their training in the event of program closure at a training institution.
 - iv. Protect against the discrimination of displaced residents and fellows consistent with [“Nondiscrimination Toward Residency Applicants H-295.969.”](#)
4. Our AMA encourages the Accreditation Council for Graduate Medical Education (ACGME) to:
 - a. Address the problem of non-educational closing or downsizing of residency training programs.
 - b. Include in its Institutional Requirements that sponsoring institutions provide:
 - i. Professional liability coverage for residents in the event of an institution or program closure.
 - ii. Information regarding the financial health of the institution, such as its credit rating, or if it has recently been part of an acquisition or merger by sponsoring institutions to residents/fellows and applicants.
5. Our AMA encourages the American Board of Medical Specialties (ABMS) and its member boards to develop a mechanism to accommodate the discontinuities in training that arise from residency closures, regardless of cause, including waiving continuity of care requirements and granting residents credit for partial years of training.
6. Our AMA encourages relevant organizations to:
 - a. Develop a process similar to the Supplemental Offer and Acceptance Program (SOAP) that could be used in the event of a sudden teaching institution or program closure.
 - b. Develop a stepwise algorithm for designated institutional officials and program directors to assist residents and fellows with finding and obtaining alternative training positions.
 - c. Create a centralized, regulated process for displaced residents and fellows to obtain new training positions.
 - d. Develop pathways that ensure closing and accepting institutions provide liability insurance coverage to residents, at no cost to residents.
 - e. Identify a process by which displaced residents and fellows may be directly represented in proceedings surrounding the closure of a training hospital or program.

- 1 f. Monitor issues, collect data, and share information related to training programs run by
- 2 nonprofit and for-profit entities and their effect on medical education.
- 3 g. Advocate for the development and implementation of effective policies to permit
- 4 graduate medical education funding to follow the resident physician from a closing to
- 5 the receiving residency program (including waivers of CMS caps) in the event of
- 6 temporary or permanent residency program closure.
- 7 h. Coordinate and collaborate on the communication with sponsoring institutions,
- 8 residency programs, and resident physicians in the event of a sudden institution or
- 9 program closure to minimize confusion, reduce misinformation, and increase clarity.

Fiscal Note: Minimal

APPENDIX A: POLICIES AND RECOMMENDED ACTIONS

Title and Policy Number	Current Policy Text and Timeline	Recommendation
HIV Postexposure Prophylaxis for Medical Students During Electives Abroad D-295.970	1. Our American Medical Association recommends that US medical schools ensure that medical students who engage in clinical rotations abroad have immediate access to HIV postexposure prophylaxis. 2. Our AMA encourages medical schools to provide information to medical students regarding the potential health risks of completing a medical rotation abroad, and on the appropriate precautions to take to minimize such risks. Policy Timeline: Res. 303, A-02; Reaffirmed: CCB/CLRPD Rep. 4, A-12; Modified: CME Rep. 1, A-22	Amend policy D-295.970 by change in title to read as follows: HEALTH RISKS FOR MEDICAL STUDENTS DURING ELECTIVES ABROAD <i>Rationale: Title should be broader to encompass clause (2).</i>
Reimbursement for Post-Exposure Protocol for Needlestick Injuries H-295.855	Our AMA will encourage medical schools to have policies in place addressing diagnosis, treatment, and follow-up at no cost to medical students exposed to an infectious or environmental hazard in the course of their medical student duties. Policy Timeline: Res. 801, I-19	Amend policy H-295.855 by addition to read as follows: Our AMA will encourage medical schools to have policies in place addressing diagnosis, treatment, and follow-up at no cost to medical students exposed to an infectious or environmental hazard in the course of their medical student duties, <u>including when abroad</u>. Append amended policy H-295.855 to policy D-295.970. Rescind policy H-295.855. <i>Rationale: Addition makes policy more comprehensive. Appendage allows for policy consolidation.</i>
The Effect of the COVID-19 Pandemic on Graduate Medical Education D-310.946	Our AMA will: (1) work with relevant stakeholders to advocate for equitable compensation and benefits for residents and fellows who are redeployed to fulfill service needs that may be outside the scope of their specialty training; and (2) urge the Accreditation Council for Graduate Medical Education (ACGME) and specialty boards to consider reducing case numbers and clinic visits with revised holistic measures to recognize resident/fellow learning, given the	Amend policy D-310.946 by addition and deletion with a change in title to read as follows: THE EFFECT OF NATIONAL CRISES ON GRADUATE MEDICAL EDUCATION Our AMA will: (1) work with relevant stakeholders <u>parties</u> to advocate for equitable compensation and benefits for residents and fellows who are redeployed to fulfill service needs that may be outside the scope of their

	drastic educational barriers confronted during the COVID-19 pandemic. Policy Timeline: Res. 319, A-21	specialty training; and (2) urge the Accreditation Council for Graduate Medical Education (ACGME) and specialty boards to consider reducing case numbers and clinic visits with revised holistic measures to recognize resident/fellow learning, given the drastic educational barriers confronted during the COVID-19 pandemic <u>during national crises, which have a significant impact on graduate medical education such as pandemics.</u> <i>Rationale: Policy should be broader to apply to other national crises.</i>
Protecting Trainees' Breastfeeding Rights D-310.950	1. Our American Medical Association will work with appropriate bodies, such as the Accreditation Council for Graduate Medical Education (ACGME) and the Liaison Committee on Medical Education (LCME), to include language in housestaff manuals or similar policy references of all training programs regarding protected times and locations for milk expression and secure storage of breast milk. 2. Our AMA will work with appropriate bodies, such as the LCME, ACGME, and Association of American Medical Colleges (AAMC), to include language related to the learning and work environments for breastfeeding people in regular program reviews. Policy Timeline: Res. 302, I-16; Modified: Speakers Rep. 02, I-24	Amend policy D-310.950 by addition and deletion with change in title to read as follows: PROTECTIONS FOR LACTATING INDIVIDUALS 1. Our American Medical Association will work with appropriate bodies, such as the Accreditation Council for Graduate Medical Education (ACGME) and the Liaison Committee on Medical Education (LCME), to include language in housestaff manuals or similar policy references of all training programs regarding protected times and locations for milk expression and secure storage of breast <u>human</u> milk. 2. Our AMA will work with appropriate bodies, such as the LCME, ACGME, and Association of American Medical Colleges (AAMC), to include language related to the learning and work environments for breastfeeding people <u>lactating individuals</u> in regular program reviews. <i>Rationale: Policy should use inclusive language in accordance with Policy D-65.969, "Use of Inclusive Language in AMA Policy."</i>

Accommodating Lactating Individuals Taking Medical Examinations H-295.861	1. Our American Medical Association urges all medical licensing, certification and board examination agencies, and all board proctoring centers, to grant special requests to give breastfeeding individuals additional break time and a suitable environment during examinations to express milk. 2. Our AMA encourages that such accommodations to breastfeeding individuals include necessary time per exam day, in addition to the standard pool of scheduled break time found in the specific exam, as well as access to a private, non-bathroom location on the testing center site with an electrical outlet for individuals to breast pump. Policy Timeline: Sub. Res. 903, I-14; Modified: Res. 310, A-17; Modified: Speakers Rep. 02, I-24	Amend policy H-295.861 by addition and deletion to read as follows: 1. Our American Medical Association urges all medical licensing, certification and board examination agencies, and all board proctoring centers, to grant special requests to give breastfeeding <u>lactating</u> individuals additional break time and a suitable environment during examinations to express milk. 2. Our AMA encourages that such accommodations to breastfeeding <u>lactating</u> individuals include necessary time per exam day, in addition to the standard pool of scheduled break time found in the specific exam, as well as access to a private, non-bathroom location on the testing center site with an electrical outlet for individuals to breast pump. Append amended policy H-295.861 to policy D-310.950. Rescind policy H-295.861. <i>Rationale: Policy should use inclusive language in accordance with Policy D-65.969, "Use of Inclusive Language in AMA Policy." Appendage allows for policy consolidation.</i>
Resident Pay During Orientation D-310.967	Our American Medical Association will advocate that all resident and fellow physicians should be compensated, and receive benefits, at a level commensurate with the pay that they will receive while in their training program, for all days spent in required orientation activities prior to the onset of their contractual responsibilities. Policy Timeline: Res. 302, A-07; Modified: CCB/CLRPD Rep. 2, A-14; Reaffirmed: CME Rep. 01, A-24	Append policy D-310.967 to policy H-310.912, "Residents and Fellows' Bill of Rights." Rescind policy D-310.967. <i>Rationale: Appendage allows for policy consolidation.</i>
Impairment Prevention and Treatment in the Training Years H-295.863	1. Our American Medical Association affirms the importance of preventing and treating psychiatric illness, alcoholism, and substance use in medical students, residents, and fellows.	Append policy H-295.863 to policy H-295.858, "Access to Confidential Health Services for Medical Students and Physicians." Rescind policy H-295.863.

	2. Our AMA encourages medical schools and teaching hospitals to develop and maintain impairment prevention and treatment programs with confidential services for medical students, residents, and fellows. 3. Our AMA urges medical schools, hospitals with graduate medical education programs, and state and county medical societies to initiate active liaison with local impaired physician committees in order to more effectively diagnose and treat medical student and resident substance use. 4. Our AMA advocates: . further study (and continued monitoring of other studies) concerning the problem of substance use among students, residents, and faculty in U.S. medical schools; and . development of model policy and programmatic guidelines which might assist in the establishment of programs for medical students, residents, and faculty and which could significantly impact this problem and potentially reduce the risk of future impairment among physicians. Policy Timeline: CCB/CLRPD Rep. 3, A-14; Modified: CME Rep. 01, A-24	<i>Rationale: Appendage allows for policy consolidation.</i>
Expanding the Visiting Students Application Service for Visiting Student Electives in the Fourth Year H-295.867	1. Our American Medical Association strongly encourages the Association of American Medical Colleges (AAMC) to expand eligibility for the Visiting Students Application Service (VSAS) to medical students from Commission on Osteopathic College Accreditation (COCA)-accredited medical schools. 2. Our AMA supports and encourages the AAMC in its efforts to increase the number of members and non-member programs in the VSAS, such as medical schools accredited by COCA and teaching institutions not affiliated with a medical school.	Rescind policy H-295.867. <i>Rationale: Policy is no longer necessary since start of Visiting Student Learning Opportunities™ (VSLO®) program.</i>

	3. Our AMA encourages the AAMC to ensure that member institutions that previously accepted both allopathic and osteopathic applications for fourth year clerkships prior to VSAS implementation continue to have a mechanism for accepting such applications of osteopathic medical students. Policy Timeline: Res. 910, I-09; Reaffirmed: CME Rep. 01, A-19	
Eliminating Benefits Waiting Periods for Residents and Fellows H-295.873	Our AMA: (1) supports the elimination of benefits waiting periods imposed by employers of resident and fellow physicians-in-training; (2) will strongly encourage the Accreditation Council for Graduate Medical Education (ACGME) to require programs to make insurance for health care, dental care, vision care, life, and disability available to their resident and fellow physicians on the trainees' first date of employment and to aggressively enforce this requirement; and (3) will work with the ACGME and with the Liaison Committee on Medical Education (LCME) to develop policies that provide continuous hospital, health, and disability insurance coverage during a traditional transition from medical school into graduate medical education. (4) encourages the Accreditation Council for Graduate Medical Education to request that sponsoring institutions offer to residents and fellows a range of comparable medical insurance plans no less favorable than those offered to other institution employees. Policy Timeline: BOT Action in response to referred for decision Res. 318, A-06; Appended: CME Rep. 5, A-10; Reaffirmed: CME Rep. 01, A-20	Amend clause (3) of policy H-295.873 by addition and deletion to read as follows: (3) will work with the ACGME, and with the Liaison Committee on Medical Education (LCME), and Commission on Osteopathic College Accreditation to develop policies that provide continuous hospital, health, and disability insurance coverage during a traditional transition from medical school into graduate medical education. Append amended policy H-295.873 to policy H-310.912, "Residents and Fellows' Bill of Rights." Rescind policy H-295.873. <i>Rationale: Policy should be inclusive of DO students. Appendage allows for policy consolidation.</i>
Insurance Coverage for Medical Students and Resident Physicians H-295.942	1. Our American Medical Association urges 1. all medical schools to pay for or offer affordable policy options and, assuming the rates are appropriate, require enrollment in disability insurance plans by all medical students.	Amend policy H-295.942 by deletion to read as follows: 1. Our American Medical Association urges —3. medical schools and residency training programs to pay for or offer comprehensive

	2. all residency programs to pay for or offer affordable policy options for disability insurance, and strongly encourage the enrollment of all residents in such plans. 3. medical schools and residency training programs to pay for or offer comprehensive and affordable health insurance coverage, including but not limited to medical, dental, and vision care, to medical students and residents which provides no less than the minimum benefits currently recommended by the AMA for employer-provided health insurance and to require enrollment in such insurance. 4. carriers offering disability insurance to: - offer a range of disability policies for medical students and residents that provide sufficient monthly disability benefits to defray any educational loan repayments, other living expenses, and an amount sufficient to continue payment for health insurance providing the minimum benefits recommended by our AMA for employer-provided health insurance. - include in all such policies a rollover provision allowing continuation of student disability coverage into the residency period without medical underwriting. 5. Our AMA: - actively encourages medical schools, residency programs, and fellowship programs to provide access to portable group health and disability insurance, including human immunodeficiency virus positive indemnity insurance, for all medical students and resident and fellow physicians. - will work with the ACGME and the LCME, and other interested state medical societies or specialty organizations, to develop strategies and policies to ensure access to the provision of portable health and disability insurance coverage, including human immunodeficiency virus positive indemnity insurance, for all	and affordable health insurance coverage, including but not limited to medical, dental, and vision care, to medical students and residents which provides no less than the minimum benefits currently recommended by the AMA for employer-provided health insurance and to require enrollment in such insurance. 5. Our AMA: - actively encourages medical schools, residency programs, and fellowship programs to provide access to portable group health and disability insurance, including human immunodeficiency virus positive indemnity insurance, for all medical students and resident and fellow physicians. - will work with the ACGME and the LCME, and other interested state medical societies or specialty organizations, to develop strategies and policies to ensure access to the provision of portable health and disability insurance coverage, including human immunodeficiency virus positive indemnity insurance, for all medical students, resident and fellow physicians. 3. Our AMA supports the continuation of comprehensive medical insurance benefits for inactive students taking an approved leave of absence during their time of degree completion and encourage medical schools to publicize their policies regarding the continuation of insurance benefits during leaves of absence. Append amended clause (1.2) to policy H-310.912, “Residents and Fellows’ Bill of Rights.” <i>Rationale for deletions:</i> • <i>Clause (1.3): This is already addressed in H-310.912, “Residents and Fellows’ Bill of Rights.”</i> • <i>Clause (1.5): Modern policies now cover HIV-related illnesses.</i> • <i>Clause (3): Coverage over leaves of absences is often tied to federal loan funding.</i>
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	medical students, resident and fellow physicians. c. will prepare informational material designed to inform medical students and residents concerning the need for both disability and health insurance and describing the available coverage and characteristics of such insurance. 2. Our AMA encourages medical schools to allow students and their families who qualify for and enroll in health insurance plans other than the institutionally offered health insurance plans, to be exempt from an otherwise mandatory student health insurance plan requirement, provided that the alternative plan has comparable care coverage and is accepted at the primary geographic locations of training. 3. Our AMA supports the continuation of comprehensive medical insurance benefits for inactive students taking an approved leave of absence during their time of degree completion and encourage medical schools to publicize their policies regarding the continuation of insurance benefits during leaves of absence. Policy Timeline: BOT Rep. W, I-91; Reaffirmed: BOT Rep. 14, I-93; Appended: Res. 311, I-98; Modified: Res. 306, A-04; Modified: CME Rep. 2, A-14; Appended: Res. 304, I-23	<i>Rationale: Appendage allows for policy consolidation.</i>
Residents' Salaries H-305.930	Our American Medical Association supports appropriate increases in resident salaries. Policy Timeline: Res. 307, A-05; Reaffirmed: CME Rep. 1, A-15; Reaffirmed in lieu of: Res. 307, I-22	Append policy H-305.930 to policy H-310.912, "Residents and Fellows' Bill of Rights." Rescind policy H-305.930. <i>Rationale: Appendage allows for policy consolidation.</i>
Resident and Fellow Access to Fertility Preservation H-310.902	1. Our American Medical Association encourages insurance coverage for fertility preservation and infertility treatment within health insurance benefits for residents and fellows offered through graduate medical education programs. 2. Our AMA supports the accommodation of residents and fellows who elect to pursue fertility preservation and infertility	Append policy H-310.902 to policy H-310.912, "Residents and Fellows' Bill of Rights." Rescind policy H-310.902. <i>Rationale: Appendage allows for policy consolidation.</i>

	treatment, including but not limited to, the need to attend medical visits to complete the gamete preservation process and to administer medications in a time-sensitive fashion. Policy Timeline: Res. 302, A-22	
Financial Protections for Doctors in Training H-310.903	Our American Medical Association supports the availability of retirement plans for residents and fellows at all teaching institutions that are no less favorable than those offered to other institution employees. Policy Timeline: BOT Rep. 18, I-21	Append policy H-310.903 to policy H-310.912, “Residents and Fellows’ Bill of Rights.” Rescind policy H-310.903. <i>Rationale: Appendage allows for policy consolidation.</i>
Funding to Support Training of the Health Care Workforce H-310.916	1. Our American Medical Association will insist that any new GME funding to support graduate medical education positions be available only to Accreditation Council for Graduate Medical Education (ACGME) and/or American Osteopathic Association (AOA) accredited residency programs, and believes that funding made available to support the training of health care providers not be made at the expense of ACGME and/or AOA accredited residency programs. 2. Our AMA strongly advocates that: a. There be no decreases in the current funding of MD and DO graduate medical education while there is a concurrent increase in funding of graduate medical education (GME) in other professions. b. There be at least proportional increases in the current funding of MD and DO graduate medical education similar to increases in funding of GME in other professions. 3. Our AMA will advocate to appropriate federal agencies, and other relevant stakeholders to oppose the diversion of direct and indirect funding away from ACGME-accredited graduate medical education programs.	Amend policy H-310.916 by deletion to read as follows: 1. Our American Medical Association will insist that any new GME funding to support graduate medical education positions be available only to Accreditation Council for Graduate Medical Education (ACGME) and/or American Osteopathic Association (AOA) accredited residency programs, and believes that funding made available to support the training of health care providers not be made at the expense of ACGME and/or AOA accredited residency programs. 2. Our AMA strongly advocates that: a. There be no decreases in the current funding of MD and DO graduate medical education while there is a concurrent increase in funding of graduate medical education (GME) in other professions. b. There be at least proportional increases in the current funding of MD and DO graduate medical education similar to increases in funding of GME in other professions. 3. Our AMA will advocate to appropriate federal agencies, and other relevant stakeholders to oppose the diversion of direct and indirect funding away from ACGME-accredited graduate medical education programs.

	Policy Timeline: Sub. Res. 913, I-09; Appended: Res. 917, I-15; Appended: Res. 309, I-20; Reaffirmed: Res. 305, A-21	<i>Rationale:</i> • <i>Clauses (1) and (2) are out of date given single accreditation.</i> • <i>Clause (2a) use of “GME” outside of MD/DO training is problematic.</i> • <i>Clause (3) adequately addresses intent of policy.</i>
The Educational and Work Environment of Resident Physicians H-310.935	AMA policy is that there should be resident organizations in place at institutions that sponsor graduate medical education programs to facilitate the ability of residents to negotiate about issues related to their working environment. Policy Timeline: CME Rep. 11, A-98; Reaffirmed: CME Rep. 2, A-08; Reaffirmed: CME Rep. 01, A-18	Rescind policy H-310.935. <i>Rationale: Policy already addressed in H-310.912, “Residents and Fellows’ Bill of Rights.”</i>
Anonymity for Resident Inquiries to Residency Review Committees H-310.995	Our AMA supports a detailed procedure to guarantee anonymity of a resident physician who initiates an inquiry by a residency review committee into the conduct of a residency program, to protect residents from reprisals and program directors from unfounded complaints. The procedure includes a mechanism for the resident who elects to forward a complaint to the residency review committee (RRC), outlines options for RRC action; and identifies possible final actions open to the RRC. Policy Timeline: CME Rep. C, A-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: CME Rep. 2, A-05; Reaffirmed: CME Rep. 1, A-15; Reaffirmed: CME Rep. 01, A-25	Amend policy H-310.995 by addition and deletion to read as follows: Our AMA supports <u>encourages a detailed procedures to guarantee that support the</u> anonymity of a resident physician who initiates an inquiry by a residency review committee into the conduct of a residency program, to protect residents from reprisals and program directors from unfounded complaints. The <u>Such procedures should</u> includes a mechanism for the resident who elects to forward a complaint to the residency review committee (RRC), outlines options for RRC action; and identifies possible final actions open to the RRC. <i>Rationale: While it is not possible to guarantee anonymity in this situation, reports should be confidential and protected. Review Committees use the abbreviation “RC.”</i>

APPENDIX B: CURRENT TEXT OF RESIDENCY PROGRAM CLOSURE POLICIES
RECOMMENDED FOR RECISSION (SEE RECOMMENDATION 3 OF REPORT)

Closing of Residency Programs H-310.943

1. 1. Our American Medical Association:
 - a. encourages the Accreditation Council for Graduate Medical Education (ACGME) to address the problem of non-educational closing or downsizing of residency training programs.
 - b. reminds all institutions involved in educating residents of their contractual responsibilities to the resident.
 - c. encourages the ACGME and the various Residency Review Committees to reexamine requirements for "years of continuous training" to determine the need for implementing waivers to accommodate residents affected by non-educational closure or downsizing.
 - d. will work with the American Board of Medical Specialties Member Boards to encourage all its member boards to develop a mechanism to accommodate the discontinuities in training that arise from residency closures, regardless of cause, including waiving continuity care requirements and granting residents credit for partial years of training.
 - e. urges residency programs and teaching hospitals be monitored by the applicable Residency Review Committees to ensure that decreases in resident numbers do not place undue stress on remaining residents by affecting work hours or working conditions, as specified in Residency Review Committee requirements.
 - f. opposes the closure of residency/fellowship programs or reductions in the number of current positions in programs as a result of changes in GME funding.
 - g. will work with the Centers for Medicare and Medicaid Services (CMS), ACGME, and other appropriate organizations to advocate for the development and implementation of effective policies to permit graduate medical education funding to follow the resident physician from a closing to the receiving residency program (including waivers of CMS caps), in the event of temporary or permanent residency program closure.
2. Our AMA will work with the Centers for Medicare and Medicaid Services (CMS) to establish regulations that protect residents and fellows impacted by program or hospital closure, which may include recommendations for:
 - a. Notice by the training hospital, intending to file for bankruptcy within 30 days, to all residents and fellows primarily associated with the training hospital, as well as those contractually matched at that training institution who may not yet have matriculated, of its intention to close, along with provision of reasonable and appropriate procedures to assist current and matched residents and fellows to find and obtain alternative training positions that minimize undue financial and professional consequences, including but not limited to maintenance of specialty choice, length of training, initial expected time of graduation, location and reallocation of funding, and coverage of tail medical malpractice insurance that would have been offered had the program or hospital not closed.
 - b. Revision of the current CMS guidelines that may prohibit transfer of funding prior to formal financial closure of a teaching institution.
 - c. Improved provisions regarding transfer of GME funding for displaced residents and fellows for the duration of their training in the event of program closure at a training institution.
 - d. Protections against the discrimination of displaced residents and fellows consistent with H-295.969.

3. Our AMA will work with the Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, National Resident Matching Program, Educational Commission for Foreign Medical Graduates, Centers for Medicare and Medicaid Services, and other relevant stakeholders to identify a process by which displaced residents and fellows may be directly represented in proceedings surrounding the closure of a training hospital or program.
4. Our AMA will work with the Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, National Resident Matching Program, Educational Commission for Foreign Medical Graduates, Centers for Medicare and Medicaid Services, and other relevant stakeholders to:
 - a. Develop a stepwise algorithm for designated institutional officials and program directors to assist residents and fellows with finding and obtaining alternative training positions;
 - b. Create a centralized, regulated process for displaced residents and fellows to obtain new training positions; and
 - c. Develop pathways that ensure that closing and accepting institutions provide liability insurance coverage to residents, at no cost to residents.

Policy Timeline: Sub. Res. 328, A-94; Appended by CME Rep. 11, A-98; Reaffirmed: CME Rep. 7, A-06; Appended: Res. 926, I-12; Modified: CME Rep. 1, A-15; Appended: Res. 310, I-19; Modified: CME Rep. 3, I-20; Reaffirmed: CME Rep. 01, I-22

Protection of Resident and Fellow Training in the Case of Hospital or Training Program Closure D-310.948

1. Our American Medical Association will ask the Centers for Medicare & Medicaid Services (CMS) to stipulate in its regulations that residency slots are not assets that belong to the teaching institution.
2. Our AMA will encourage the Association of American Medical Colleges (AAMC), American Association of Colleges of Osteopathic Medicine (AACOM), and National Resident Matching Program (NRMP) to develop a process similar to the Supplemental Offer and Acceptance Program (SOAP) that could be used in the event of a sudden teaching institution or program closure.
3. Our AMA will encourage the Accreditation Council for Graduate Medical Education (ACGME) to specify in its Institutional Requirements that sponsoring institutions are to provide residents and residency applicants information regarding the financial health of the institution, such as its credit rating, or if it has recently been part of an acquisition or merger.
4. Our AMA will work with AAMC, AACOM, ACGME, and relevant state and specialty societies to coordinate and collaborate on the communication with sponsoring institutions, residency programs, and resident physicians in the event of a sudden institution or program closure to minimize confusion, reduce misinformation, and increase clarity.
5. Our AMA will encourage ACGME to revise its Institutional Requirements, under section IV.E., Professional Liability Insurance, to state that sponsoring institutions must create and maintain a fund that will ensure professional liability coverage for residents in the event of an institution or program closure.
6. Our AMA will continue to work with ACGME, interested specialty societies, and others to monitor issues, collect data, and share information related to training programs run by nonprofit and for-profit entities and their effect on medical education.

Policy Timeline: CME Rep. 3, I-20; Modified: CME Rep. 01, I-22; Modified: Res. 301, I-23

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 7-I-26

Subject: Mission of Medical Education

Presented by: Shannon M. Kilgore, MD, Chair

Referred to: Reference Committee C

Adopted at the 2024 American Medical Association (AMA) Interim meeting, AMA Policy D-295.299, “Updates to Recommendations for Future Directions for Medical Education,” called for the following:

“Our American Medical Association will study the restructuring of AMA Policy H-295.995, ‘Recommendations for Future Directions for Medical Education,’ to consolidate existing AMA policies in these areas where appropriate and to recommend new language for the future of medical education, in a series of seven future reports based on the topics of:

- Mission of medical education.
- Professional regulation.
- Entry into and transition through the medical education continuum.
- Medical education curricula.
- Physician as medical professional.
- Medical education systems.
- Obligations to students and trainees.”

This report addresses the theme of workforce and medical education values, referred to in this report as the “mission of medical education.”

BACKGROUND

The above policy was initially introduced via the Council on Medical Education’s self-initiated report, CME 2-I-24, with the intention of proposing a framework to consolidate and modernize AMA medical education policy. During their research for the CME 2-I-24 report, the Council noted the breadth of medical education policies, including Policy H-295.995, “Recommendations for the Future Directions for Medical Education” that contains 33 clauses and had not been reassessed in its entirety since 1982. CME 2-I-24 provided the following commentary regarding the “mission of medical education”:

“Medical education’s mission is to train a competent physician workforce that meets the needs of patients and populations. Though efforts by groups and individuals have been made throughout history to improve conditions for the most marginalized, a heightened awareness of equity concerns within medical education has emerged over the past few decades. In the context of the AMA, since the original 1982 Council report on the future of medical education, the Minority Affairs Consortium was created in 1992, the Commission to End Health Care Disparities began in 2004, and in 2008, the AMA officially apologized for its history of harms against Black physicians and patients. The AMA’s Center for Health Equity was launched in 2019, with the AMA’s strategic plan to embed racial justice and advance health equity released in 2021. Council

on Medical Education Report 05-J-21, ‘Promising Practices Among Pathway Programs to Increase Diversity in Medicine’ discussed the harms of the 1910 Flexner Report and called for an external study focused on reimagining the future of health equity and racial justice in medical education, which was published in 2024. In the greater U.S., milestones such as the 1990 Americans with Disabilities Act (ADA), the 2008 ADA Amendments Act, and the 2015 legalization of same-sex marriage via the *Obergefell v. Hodge* Supreme Court decision have also drawn attention to disability and lesbian, gay, bisexual, transgender, queer, and more (LGBTQ+) rights within medical education.

In recent years, there is an unprecedented demand for health care, with increasing physician workforce shortages nationally as well as in certain underserved areas. There are also current and pending shortages in specific specialties, such as urology. Many of these shortages may be attributed to maldistribution, rather than purely insufficient numbers of physicians nationwide, with certain areas remaining underserved, particularly rural areas, with medical education playing a major role in influencing physicians to meet these needs. The transition toward competency-based medical education (CBME) is one of the most pivotal shifts in medical education in recent years and one of AMA’s ChangeMedEd 2023 areas of strategic focus, alongside equity, diversity, and belonging; precision education; and transitions across the continuum.”

Citations denoted above are provided in [CME 2-I-24](#).

In order to provide consistency across the seven reports, guardrails were established:

- Policies explored include the entirety of the medical education continuum, including pre-medical education, UME, GME, and CME.
- The scope of each report will focus on updating a selection of existing related policies for accuracy as well as consolidation.
- Though the reports seek to consolidate existing policy and improve accuracy of language only, the recommendations may also make note of areas where future reports might be warranted to develop additional AMA policy on important topics not currently represented.
- Each report utilizes the well-established Appendix table format as seen in the annual Sunset Review reports.

To begin the process of selecting relevant policies for the seven reports, [AMA Policy Finder](#) was utilized. Starting on the home page, the “Search” button was selected. It provided a list of “policy topics,” one of which was “medical education.” By selecting this filter, it identified a total of 244 relevant policies. Implemented in September 2025, this process generated a numerical, comprehensive list of 244 policies to be categorized across the seven reports. A single policy is not listed in more than one report. Among them, seven policies were deemed not for inclusion in these reports given their length and/or complexity; 237 policies remained for categorization.

Among the 237 policies, 28 of them were sorted into this report. They address policies related to workforce, competency-based medical education, philosophical stances on diversity, equity and inclusion, and training competent physicians. This report does not address policies where the main point of the policy fell outside of the purview of the “mission of medical education,” even if tangentially related. Such topics are addressed in the other six reports.

DISCUSSION

Policies considered

As mentioned earlier, 28 policies related to this theme were reviewed for this report. Among them, the Council determined that the following 19 policies remain relevant and should be retained:

- [Recommendations for Future Directions for Medical Education H-295.995](#)
- [Increased Inclusivity and Admission Policies Clarification for DACA-Eligible Medical School and Residency Applicants D-295.302](#)
- [Competency Based Medical Education Across the Continuum of Education and Practice D-295.317](#)
- [Medical Student Debt and Career Choice D-305.952](#)
- [Increasing Graduate Medical Education Positions as a Component to any Federal Health Care Reform Policy D-305.958](#)
- [Title VII Funding D-305.972](#)
- [Support for the Establishment of Indigenous-Led Medical Schools in the United States H-295.840](#)
- [International Applicants to U.S. Medical Schools H-295.842](#)
- [Humanism in Anatomical Medical Education H-295.843](#)
- [Against Legacy Preferences as a Factor in Medical School Admissions H-295.845](#)
- [Strengthening Interview Guidelines for American Indian and Alaska Native Medical School, Residency, and Fellowship Applicants H-295.852](#)
- [Guidelines for Students Shadowing Physicians H-295.859](#)
- [Discrimination Against Patients by Medical Students H-295.865](#)
- [Accelerating Change in Medical Education: Strategies for Medical Education Reform H-295.871](#)
- [Recruiting Students of Medicine at the Elementary and High School Levels H-295.940](#)
- [Nondiscrimination Toward Residency Applicants H-295.969](#)
- [Financial Aid to Medical Students H-305.999](#)
- [Preserving Accreditation Standards on Diversity, Equity, and Inclusion H-310.896](#)
- [Gender-Based Questioning in Residency Interviews H-310.976](#)

The remaining policies are listed in the Appendix with recommended actions. They are:

- [Providing Transparent and Accurate Data Regarding Students and Faculty at Medical Schools D-295.306](#)
- [Competency-Based Portfolio Assessment of Medical Students D-295.318](#)
- [Increasing Medical School Class Sizes D-295.938](#)
- [Continued Support for Diversity in Medical Education D-295.963](#)
- [Eliminating Health Disparities - Promoting Awareness and Education of Sexual Orientation and Gender Identity Health Issues in Medical Education H-295.878](#)
- [Enhancing the Cultural Competence of Physicians H-295.897](#)
- [Educating Competent and Caring Health Professionals H-295.975](#)
- [Maintaining Competence of Health Professionals H-300.982](#)
- [Proposed Revisions to AMA Policy on the Financing of Medical Education Programs H-305.929](#)

1 *Gaps identified*

2
3 This review process has illuminated opportunities where policies could be re-examined and reframed
4 in the future to be more forward-thinking. For example, the Council identified that there may be a
5 benefit to further study on increasing diverse representation in medical schools. Such a topic may be
6 addressed in future reports, educational sessions, forums or other mechanisms as determined by this
7 Council and/or the House of Delegates.

8
9 RELEVANT AMA POLICIES

10
11 There are multiple AMA policies impacted by this report:

12
13 The Appendix individually lists current policy language side-by-side with recommended actions (e.g.,
14 amend, rescind) related to that specific policy. These actions are collectively addressed in
15 Recommendation 1 of this report.

16
17 Recommendation 2 highlights one policy that requires study for additional consolidation.

18
19 CONCLUSION

20
21 This report reviewed 28 of the 237 policies originally identified and categorized as focusing on
22 medical education and offered multiple recommendations for consideration. In this way, your Council
23 is working to modernize and update our policy compendium as it relates to medical education and
24 make it easier to identify and understand our policies moving forward.

25
26 RECOMMENDATIONS

27
28 The Council on Medical Education recommends that the following be adopted and the remainder of
29 the report be filed:

- 30
31 1. The House of Delegates policies listed in the Appendix of this report be acted upon in the manner
32 indicated and the remainder of this report be filed. (Directive to Take Action)
33 2. Our AMA study Recommendations for Future Directions for Medical Education H-295.995 for
34 further modernization and consolidation. (Directive to Take Action)
35

Fiscal Note: Minimal

APPENDIX: POLICIES AND RECOMMENDED ACTIONS

Title and Policy Number	Text and Timeline	Recommendation
Providing Transparent and Accurate Data Regarding Students and Faculty at Medical Schools D-295.306	Our American Medical Association will work with the Liaison Committee on Medical Education and Commission on Osteopathic College Accreditation to encourage their respective accredited medical schools to make publicly available without charge transparent and accurately reported race and ethnicity demographic data regarding students and faculty. Res. 316, A-22	Amend policy D-295.306 to read as follows: Our American Medical Association will work with the Liaison Committee on Medical Education and Commission on Osteopathic College Accreditation to encourage their respective accredited medical schools to make publicly available without charge transparent and accurately reported race and ethnicity demographic data regarding students and faculty <u>when collection of such data is legal</u>. <i>Rationale: States may have different laws in place regarding this.</i>
Competency-Based Portfolio Assessment of Medical Students D-295.318	Our American Medical Association will work with the Association of American Medical Colleges, the American Osteopathic Association and the Accreditation Council for Graduate Medical Education, and other organizations to examine new and emerging approaches to medical student evaluation, including competency-based portfolio assessment. Our AMA will work with the NRMP, ACGME and the 11 schools in the AMA's Accelerating Change in Medical Education consortium to develop pilot projects to study the impact of competency-based frameworks on student graduation, the residency match process and off-cycle entry into residency programs. Res. 314, A-10 Appended: Res. 311, A-14 Reaffirmed: CME Rep. 04, A-23	Rescind clause 2 of policy D-295.318. <i>Rationale: Accomplished and now out of date.</i>
Increasing Medical School Class Sizes D-295.938	Our AMA supports increasing the number of medical students, provided that such expansion would not jeopardize the quality of medical education. Res. 309, A-08 Reaffirmed: CME Rep. 01, A-18	Amend policy D-295.938 by addition and deletion to read as follows: Our AMA supports increasing the number of medical students, provided that such expansion would not jeopardize appropriate

Title and Policy Number	Text and Timeline	Recommendation
		<u>medical student class sizes that contribute to the</u> quality of medical education. <i>Rationale: This policy was retained in the 2018 sunset report as “still relevant” with no further notes. Currently, Council feedback notes that there is no clear goal articulated for increasing class size which may not be effective to increase workforce and may have the opposite effect, such as in the case of innovations involving 3-year medical schools. Schools may also require a particular class size for an endowment, which will ultimately attract more students to the school and assist medical students.</i>
Continued Support for Diversity in Medical Education D-295.963	1. 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. 2. 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. 3. 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. 4. 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	Amend policy D-295.963 clause 2 to read as follows: 2. Our AMA will encourages the Liaison Committee on Medical Education to regularly share <u>relevant diversity statistics, if any, related to compliance with accreditation standards IS-16 and MS-8</u> with medical schools and with other <u>interested parties stakeholder groups</u>. Rescind clauses 3 and 9. <i>Rationale: Updating for accuracy and current legal environment. Clause 3 is accomplished.</i>

Title and Policy Number	Text and Timeline	Recommendation
	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. 5. 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. 6. 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. 7. Our AMA will investigate the impacts of state legislation regarding DEI-related efforts on the education and careers of students, trainees, and faculty. 8. Our AMA will recognize the disproportionate efforts by and additional responsibilities placed on minoritized individuals to engage in diversity, equity, and inclusion efforts. 9. 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. 10. Our AMA will prioritize our organization's efforts to bolster diversity, equity, and inclusion across the medical education continuum, including but not limited to supporting structural pathways, culturally responsive curricula, and accountability mechanisms that strengthen recruitment, retention, and advancement of historically marginalized groups in medicine. Policy Timeline: 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	

Title and Policy Number	Text and Timeline	Recommendation
Eliminating Health Disparities - Promoting Awareness and Education of Sexual Orientation and Gender Identity Health Issues in Medical Education H-295.878	Our AMA: (1) supports the right of medical students and residents to form groups and meet on-site to further their medical education or enhance patient care without regard to their gender, gender identity, sexual orientation, race, religion, disability, ethnic origin, national origin or age; (2) supports students and residents who wish to conduct on-site educational seminars and workshops on health issues related to sexual orientation and gender identity; and (3) encourages medical education accreditation bodies to both continue to encourage and periodically reassess education on health issues related to sexual orientation and gender identity in the basic science, clinical care, and cultural competency curricula in undergraduate and graduate medical education. Res. 323, A-05 Modified in lieu of Res. 906, I-10 Reaffirmation A-11 Reaffirmation A-12 Reaffirmation A-16 Modified: Res. 16, A-18 Modified: Res. 302, I-19	Amend policy H-295.878 clause 1 and 2 to read as follows: Our AMA: (1) supports the right of medical students and residents to form groups and meet on-site to further their medical education or enhance patient care without regard to their gender, gender identity, sexual orientation, race, religion, disability, ethnic origin, national origin or age; (2) supports students and residents who wish to conduct on-site educational seminars and workshops on health issues related to sexual orientation and gender identity; and <i>Rationale: AMA cannot specify policies certain private locations may have about activities they allow on their grounds.</i>
Enhancing the Cultural Competence of Physicians H-295.897	1. Our American Medical Association continues to inform medical schools and residency program directors about activities and resources related to assisting physicians in providing culturally competent care to patients throughout their life span and encourage them to include the topic of culturally effective health care in their curricula. 2. Our AMA continues to support research into the need for and effectiveness of training in cultural competence and cultural humility, using existing mechanisms such as the annual medical education surveys. 3. Our AMA will assist physicians in obtaining information about and/or training in culturally effective health care through dissemination of currently available resources from the AMA and other relevant organizations. 4. Our AMA encourages training opportunities for students and residents, as members of the physician-led team, to learn cultural competency	Amend policy H-295.897 by addition and deletion to read as follows: 1. Our American Medical Association continues to inform medical schools and residency program directors about activities and resources related to assisting physicians in providing <u>humble, culturally</u> structurally competent care to patients throughout their life span and encourage them to include the topic of culturally effective health care in their curricula. 2. Our AMA continues to support research into the need for and effectiveness of training in cultural <u>structural</u> competence and cultural humility, using existing

Title and Policy Number	Text and Timeline	Recommendation
	from community health workers, when this exposure can be integrated into existing rotation and service assignments. 5. Our AMA supports initiatives for medical schools to incorporate diversity in their Standardized Patient programs as a means of combining knowledge of health disparities and practice of cultural competence with clinical skills. 6. Our AMA will encourage the inclusion of peer-facilitated intergroup dialogue in medical education programs nationwide. 7. Our AMA supports the development of national standards for cultural humility training in the medical school curricula. CME Rep. 5, A-98 Reaffirmed: Res. 221, A-07 Reaffirmation A-11 Appended: Res. 304, I-16 Modified: CME Rep. 01, A-17 Appended: Res. 320, A-17 Reaffirmed: CMS Rep. 02, I-17 Appended: Res. 315, A-18 Modified: Res. 322, A-22	mechanisms such as the annual medical education surveys. 3. Our AMA will assist physicians in obtaining information about and/or training in <u>promotes resources on</u> culturally effective health care through dissemination of currently available resources from the AMA and other relevant organizations. 4. Our AMA encourages training opportunities for students and residents, as members of the physician-led team, to learn <u>structural competence and cultural humility competency</u> from community health workers, when this exposure can be integrated into existing rotation and service assignments. 5. Our AMA supports initiatives for medical schools to incorporate diversity in their Standardized Patient programs as a means of combining knowledge of health disparities and practice of cultural <u>humility competence</u> with clinical skills. 6. Our AMA will encourage the inclusion of peer-facilitated intergroup dialogue in medical education programs nationwide. 7. Our AMA supports the development of national standards for cultural humility training in the medical school curricula. Amend title as follows: Enhancing the <u>Structural Competence</u> and Cultural <u>Humility Competence</u> of Physicians

Title and Policy Number	Text and Timeline	Recommendation
		<i>Rationale: This is a subject that should be approached from the perspective of continual opportunity for growth, and therefore, cultural humility is a better term. The competence component relates to structural awareness, and skills navigating these systems, as referenced here.</i>
Educating Competent and Caring Health Professionals H-295.975	(1) Programs of health professions education should foster educational strategies that encourage students to be independent learners and problem-solvers. Faculty of programs of education for the health professions should ensure that the mission statements of the institutions in which they teach include as an objective the education of practitioners who are both competent and compassionate. (2) Admission to a program of health professions education should be based on more than grade point average and performance on admissions tests. Interviews, applicant essays, and references should continue to be part of the application process in spite of difficulties inherent in evaluating them. Admissions committees should review applicants' extra-curricular activities and employment records for indications of suitability for health professions education. Admissions committees should be carefully prepared for their responsibilities, and efforts should be made to standardize interview procedures and to evaluate the information gathered during interviews. Research should continue to focus on improving admissions procedures. Particular attention should be paid to improving evaluations of subjective personal qualities. (3) Faculty of programs of education for the health professions must continue to emphasize that they have in the past on educating practitioners who are skilled in communications, interviewing and listening techniques, and who are compassionate and technically competent. Faculty of health professions education should be attentive to the environment in which education is provided; students should learn in a setting where respect and concern are	Rescind policy H-295.975. <i>Rationale: This policy was created in 1987 and is accomplished. Language use throughout policy is substantially different 40 years later, and other AMA policies cover similar topics.</i>

Title and Policy Number	Text and Timeline	Recommendation
	demonstrated. The faculty and administration of programs of health professions education must ensure that students are provided with appropriate role models; whether a faculty member serves as an appropriate role model should be considered when review for promotion or tenure occurs. Efforts should be made by the faculty to evaluate the attitudes of students toward patients. Where these attitudes are found lacking, students should be counseled. Provisions for dismissing students who clearly indicate personality characteristics inappropriate to practice should be enforced. (4) In spite of the high degree of specialization in health care, faculty of programs of education for the health professions must prepare students to provide integrated patient care; programs of education should promote an interdisciplinary experience for their students. BOT Rep. NN, A-87 Modified: Sunset Report, I-97 Reaffirmed: CME Rep. 2, A-07 Reaffirmed: CME Rep. 01, A-17	
Maintaining Competence of Health Professionals H-300.982	(1) Health professionals are individually responsible for maintaining their competence and for participating in continuing education; all health professionals should be engaged in self-selected programs of continuing education. In the absence of other financial support, individual health professionals should be responsible for the cost of their own continuing education. (2) Professional schools and health professions organizations should develop additional continuing education self-assessment programs, should prepare guides to continuing education programs to be taken by practitioners throughout their careers, and should make efforts to ensure that acceptable programs of continuing education are available to practitioners. (3) Health professions organizations and faculty of programs of health professions education should develop standards of competence. Such standards should be reviewed and revised periodically. (4) When reliable and cost-effective means of assessing continuing competence are developed, they should be required for continued practice.	Amend policy H-300.982 clause 2 by addition and deletion to read as follows: (2) Professional schools and health professions organizations should develop additional continuing education self-assessment programs, should prepare guides to continuing education programs to be taken by practitioners <u>professionals</u> throughout their careers, and should make efforts to ensure that acceptable programs of continuing education are available to professionals-practitioners. <i>Rationale: Though policy discusses all health professionals, not just physicians, practitioners is not the appropriate umbrella term when physicians are included in the statement.</i>

Title and Policy Number	Text and Timeline	Recommendation
	(5) Patient relations and ethics are appropriate subjects for continuing education; educational providers should increase the offering in these fields. BOT Rep. NN, A-87 Reaffirmed: Sunset Report, I-97 Reaffirmed: BOT Rep. 17, A-04 Reaffirmed in lieu of Res. 313, A-12 Reaffirmed: BOT Rep. 13, A-19	
Proposed Revisions to AMA Policy on the Financing of Medical Education Programs H-305.929	1. It is AMA policy that: A. Since quality medical education directly benefits the American people, there should be public support for medical schools and graduate medical education programs and for the teaching institutions in which medical education occurs. Such support is required to ensure that there is a continuing supply of well-educated, competent physicians to care for the American public. B. Planning to modify health system organization or financing should include consideration of the effects on medical education, with the goal of preserving and enhancing the quality of medical education and the quality of and access to care in teaching institutions are preserved. C. Adequate and stable funding should be available to support quality undergraduate and graduate medical education programs. Our AMA and the federation should advocate for medical education funding. D. Diversified sources of funding should be available to support medical schools' multiple missions, including education, research, and clinical service. Reliance on any particular revenue source should not jeopardize the balance among a medical school's missions. E. All payers for health care, including the federal government, the states, and private payers, benefit from graduate medical education and should directly contribute to its funding.	Amend policy H-305.929 clause 1A by addition and deletion to read as follows: 1. It is AMA policy that: <u>Our AMA supports the following:</u> A. Since quality medical education directly benefits the American people, there should be public support for medical schools and graduate medical education programs and for the teaching institutions in which medical education occurs. Such support is required to ensure that there is a continuing supply of well-educated, competent physicians to care for the American public. Amend Clause 1B by deletion to read as follows: B. Planning to modify health system organization or financing should include consideration of the effects on medical education, with the goal of preserving and enhancing the quality of medical education and the quality of and access to care in teaching institutions are preserved. Amend Clause 1C by addition to read as follows: C. Adequate and stable funding should be available to support quality undergraduate and graduate medical education programs

Title and Policy Number	Text and Timeline	Recommendation
	F. Full Medicare direct medical education funding should be available for the number of years required for initial board certification. For combined residency programs, funding should be available for the longest of the individual programs plus one additional year. There should be opportunities to extend the period of full funding for specialties or subspecialties where there is a documented need, including a physician shortage. G. Medical schools should develop systems to explicitly document and reimburse faculty teaching activity, so as to facilitate faculty participation in medical student and resident physician education and training. H. Funding for graduate medical education should support the training of resident physicians in both hospital and non-hospital (ambulatory) settings. Federal and state funding formulas must take into account the resources, including volunteer faculty time and practice expenses, needed for training residents in all specialties in non-hospital, ambulatory settings. Funding for GME should be allocated to the sites where teaching occurs. I. New funding should be available to support increases in the number of medical school and residency training positions, preferably in or adjacent to physician shortage/underserved areas and in undersupplied specialties. 2. Our AMA endorses the following principles of social accountability and promotes their application to GME funding: (a) Adequate and diverse workforce development; (b) Primary care and specialty practice workforce distribution; (c) Geographic workforce distribution; and (d) Service to the local community and the public at large. 3. Our AMA encourages transparency of GME funding through models that are both feasible and fair for training sites, affiliated medical schools and trainees.	<u>regardless of external funding uncertainties.</u> Our AMA and the federation should advocate for medical education funding. Amend Clause 1D by addition and deletion to read as follows: D. Diversified sources of funding should be available to support medical schools' multiple missions, including education, research, and clinical service. Reliance on any particular revenue source should not jeopardize the balance among a medical school's missions. <u>Clear value should be consistently ascribed to medical education.</u> F. Full Medicare direct medical education funding should be available for the number of years required for initial board certification <u>eligibility</u>. For combined residency programs, funding should be available for the longest of the individual programs plus one additional year. There should be opportunities to extend the period of full funding for specialties or subspecialties where there is a documented need, including a physician shortage. <i>Rationale: Edits for clarity. Emphasize importance of funding even during challenges. Balance is difficult to measure and therefore wording clarified slightly. The number of years between a resident finishing residency and taking boards to become certified could be up to 7 years, and new language eliminates confusion regarding coverage.</i>

Title and Policy Number	Text and Timeline	Recommendation
	4. Our AMA believes that financial transparency is essential to the sustainable future of GME funding and therefore, regardless of the method or source of payment for GME or the number of funding streams, institutions should publicly report the aggregate value of GME payments received as well as what these payments are used for, including: (a) Resident salary and benefits; (b) Administrative support for graduate medical education; (c) Salary reimbursement for teaching staff; (d) Direct educational costs for residents and fellows; and (e) Institutional overhead. 5. Our AMA supports specialty-specific enhancements to GME funding that neither directly nor indirectly reduce funding levels for any other specialty. CME Rep. 7, A-05 Reaffirmation I-06 Reaffirmed: Sub. Res. 314, A-07 Reaffirmation I-07 Reaffirmed: CME Rep. 4, I-08 Reaffirmed: Sub. Res. 314, A-09 Reaffirmed: CME Rep. 3, I-09 Reaffirmed: CME Rep. 15, A-10 Reaffirmation A-11 Reaffirmation A-13 Reaffirmed: CME Rep. 5, A-13 Appended: CME 05, A-16 Appended: Res. 319, A-16 Reaffirmation A-16 Reaffirmed: Res. 310, A-24	

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 8-I-26

Subject: Hardship for International Medical Graduates in Humanitarian Crisis or Conflict

Presented by: Shannon M. Kilgore, MD, Chair

Referred to: Reference Committee C

1 Resolution 313-I-25, “Hardship for International Medical Graduates from Palestine,” was introduced
2 at the American Medical Association (AMA) 2025 Interim meeting and was referred. The resolution
3 asked the following:

4
5 RESOLVED, that our American Medical Association (AMA) advocate with relevant
6 stakeholders that advise state medical boards to develop alternative pathways such as a hardship
7 waiver for primary source verification of medical education for all licensing requirements for
8 physicians who graduated from medical schools in Palestine until the current humanitarian crisis
9 in Palestine is resolved; and be it further

10
11 RESOLVED, that our AMA advocate with relevant stakeholders to consider waiving the
12 requirement that the Statement of Need for visa application come directly from a federal/central
13 Ministry of Health office for Palestinian physicians who matched to the residency or fellowship
14 in the U.S. until the resolution of the current humanitarian crisis in Palestine.

15 16 BACKGROUND

17 18 *AMA Deliberations at the I-25 House of Delegates Meeting*

19
20 The language of this resolution’s resolve one mirrors existing AMA policy D-255.974, “Hardship for
21 International Medical Graduates from Ukraine.” Testimony was mixed, though all supported the spirit
22 of the resolution and acknowledged the moral imperative to support those experiencing hardships
23 from humanitarian crises. Additional testimony noted that AMA policy has precedent for naming
24 specific groups, such as Ukraine in past policy, and emphasized the significant challenges
25 experienced by Palestinian physicians, including the U.S. federal government’s suspension of visas
26 for Palestinians specifically.

27
28 Some testimony expressed concerns about varying definitions of Palestine, though Council on
29 Medical Education testimony noted that the Educational Commission for Foreign Medical Graduates
30 (ECFMG) maintains a definition for Palestine relevant to their verification work. One amendment,
31 supported by the resolution author, was offered to recognize hardships for Palestinian physicians
32 while not limiting policy to this group. The Council noted that advocacy on these matters should not
33 be limited by the end of an immediate humanitarian crisis, as even after crises are resolved there may
34 still be hardships with verification. Additionally, normal verification processes may resume even
35 amidst crises. Discussions also focused on balancing the immediate needs of this specific group with
36 policy that stays evergreen in future situations. After additional concerns that other groups in need,
37 such as those in Sudan, were not directly referenced, Resolution 313 was referred.

Context of the Original Resolution

In 2024 and 2025, the only two medical schools in Gaza, Al Azhar University-Gaza (AUG) and the Islamic University of Gaza (IUG), were destroyed.¹ These were once considered ECFMG-eligible schools, previously listed under Pathway 3, which is a “Medical School Accredited by Agency Recognized by World Federation for Medical Education (WFME)”² and approximately 2,500 medical students had been enrolled as of October 2023.³ Furthermore, Al-Israa University, which had just announced the formation of a medical school, and Gaza’s largest hospital, Al-Shifa, which housed the most extensive medical library used for training, were also destroyed in 2023 and 2024.⁴

Additionally, in 2025, the U.S. State Department suspended all visas for people with Palestinian passports, regardless of their physical residence.⁵ This is not in agreement with AMA policy H-255.966, “Abolish Discrimination in Licensure of IMGs,” which states, “Discrimination against physicians solely on the basis of national origin and/or the country in which they completed their medical education is inappropriate.”

Of note, the healthcare system in Gaza has significantly relied on graduates from AUG and IUG.⁶ As these graduates advance in their careers and pursue specialization, they typically follow one of two pathways: enrolling in local specialty training programs or seeking international postgraduate training opportunities, including in the United States. Those who pursue international training acquire advanced qualifications in their respective specialties and often return to Gaza to work, thereby addressing critical gaps in specialized medical care and strengthening the overall healthcare infrastructure.⁷

It is important to recognize that even if international medical graduates (IMGs) leave after training in the U.S., IMGs nonetheless contribute substantially to the physician workforce within the U.S.⁸ They also add value to the U.S. healthcare system, including in leadership, mentorship, new cultural perspectives, and improved quality of care.⁹

DISCUSSION

How the System Usually Works and Noted Exceptions

[Council on Medical Education Report 08-A-23, “Challenges to Primary Source Verification of International Medical Graduates Resulting from International Conflict,”](#) previously studied the topic of primary source verification issues in a different context, that of Russia and Belarus. This report describes in detail the role that the ECFMG, a member of Intealth, serves in verifying qualifications of IMGs pursuing U.S. graduate medical education (GME) and in credentialing practicing IMGs seeking to practice medicine in the U.S.

The Council report from 2023 states that: “ECFMG staff also indicated that the ECFMG pursues alternative options if the customary primary source verification process is not workable—for example, when there is international conflict or the medical school or ministry of health in a given country is not responding to ECFMG queries. Through one alternative option, the applicant for ECFMG certification can request that three medical school classmates or faculty who are now practicing in the U.S. swear on their U.S. medical license that the applicant did indeed graduate. This process requires completion of a notarized form and submission of a letter describing the facts of the matter. The ECFMG tries to assist individual applicants throughout the certification process (while maintaining the integrity of its procedures), to include postponement of examinations and refunding fees, where appropriate.”¹⁰

1 This specific alternative option is particularly challenging for learners from Gaza seeking to verify
 2 their medical education credentials in the face of widespread destruction: many classmates, academic
 3 faculty, and health professionals who would verify attendance and graduation were casualties of
 4 conflict.¹¹

6 *Well-Established Intealth Processes*

8 During the writing of this report, AMA staff engaged in conversations with Intealth's Senior Vice
 9 President and ECFMG's Executive Director on primary source verification and the Senior Vice
 10 President, Regulatory Affairs, and Chief Communications Officer on visas. Intealth noted sensitivity
 11 to distressing situations of humanitarian crisis and emphasized long-standing, flexible processes in
 12 place that work even in unusual and challenging circumstances. Primary source verification and,
 13 when needed, rigorous alternate processes have been safely established at Intealth since 1986. Intealth
 14 is also engaged in addressing visa issues.

16 Discussions with Intealth, as well as House of Delegates testimony, revealed that there are a wide
 17 variety of locations around the world facing humanitarian crisis. Therefore, Intealth does not maintain
 18 country-specific policies, but rather treats each situation seriously and individually. Intealth does not
 19 request additional AMA support other than in educating the medical education community that these
 20 resources already exist. Intealth prefers to broadly and flexibly respond to any given situation,
 21 whether a widespread crisis or one individual's situation: this may be an entire cohort, on any or all
 22 "sides" of a conflict, or even one specific person who is politically targeted or experiences other
 23 safety issues.

25 A dedicated team assists these individuals; regions and crises change rapidly, but the process is
 26 rigorous yet flexible enough to address these situations. The Intealth intake process identifies needs
 27 and directs people to necessary resources. In fact, less than 1% of those who work with Intealth need
 28 alternate processes. For those who cannot meet ECFMG's primary-source verification requirement
 29 through regular means or established alternate processes, a subcommittee of the Intealth Board of
 30 Trustees reviews these applications. The subcommittee considers the safety of both IMGs seeking
 31 verification and the U.S. public, including patients.

33 Intealth also works on issues related to visa and entry restrictions and sponsors J-1 visas for
 34 physicians. At the Council on Medical Education's Forum on "Impacts of H1-B Visa Restrictions on
 35 Medical Education" in June 2026, which included Intealth leadership, discussion also occurred
 36 around wider visa issues, noting the impact of travel bans. Intealth released [resources](#) for those
 37 impacted and continues to work extensively to exempt physicians from these restrictions, as IMGs are
 38 well-vetted, necessary, and serve the U.S. national interest.¹² However, Intealth also noted challenges
 39 even when physicians are exempted—for instance, a physician who is not able to reunite with a
 40 spouse and infant child due to a travel ban. According to data presented at the Forum, in 2025, 98%
 41 of IMGs were able to join their programs in the U.S., though some joined late. Typically, this number
 42 is 99%. Data from 2026 has not yet been determined, and Intealth is monitoring closely to review the
 43 impact. Intealth continues extensive advocacy efforts as well as work with individuals who need
 44 assistance.

46 Regarding the visa issues discussed above, at the time of this writing (August 2026), the Council
 47 noted publicly available testimonies of Palestinian physicians who matched into U.S. residency
 48 programs and whose J-1 visas have been delayed in administrative processing by the U.S. Department
 49 of State since June 2026, disrupting their GME training, though ongoing advocacy efforts are
 50 underway to urge processing speed.¹³ Organizations, such as the Hanoon Foundation, also assist

displaced learners with fundraising, such that their medical educations can continue, and, unrelated to the main topics of the proposed resolution, there are continued needs in this area.¹⁴

RELEVANT AMA POLICY

AMA has several policies related to credentialing, visas, support for IMGs, support for Intealth's work, and protection of education and lives within humanitarian crises. These are listed in Appendix A.

CONCLUSION

AMA's existing policy D-255.974, "Hardship for International Medical Graduates from Ukraine," referred Resolution 313-I-25, and CME Report 08-A-23, refer to medical education events in specific locations of humanitarian crises. The Council recognizes the pain and frustration, underscored in House of Delegates testimony, when some crises are more widely discussed than others or are more explicitly stated in policy. Resolution 313-I-25, "Hardship for International Medical Graduates from Palestine," sought to acknowledge the real suffering of Palestinian physicians, using AMA's past policy on Ukraine as a model. HOD testimony also expressed the need to acknowledge many other groups, such as those in crisis in Sudan¹⁵ and likely many others. Other existing AMA policy H-255.988, "AMA Principles on International Medical Graduates," emphasizes that AMA "continues to support the activities of the ECFMG related to verification of education credentials and testing of IMGs." As the organization most involved for decades in assisting international physicians and learners during crises, the AMA should continue to support Intealth/ECFMG's processes. Intealth does not request additional AMA support other than in educating the medical education community that these resources already exist.

Therefore, striving for fairness as well as effective policy stewardship and support for ECFMG, AMA policy should therefore be broad enough to support every learner experiencing war or a humanitarian crisis. Proposed changes below do not reflect a removal of support from any one group, but rather a widening of support as deemed appropriate by Intealth, the expert in addressing these challenges.

RECOMMENDATIONS

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

1. Amend AMA policy D-255.974 "Hardship for International Medical Graduates from Ukraine" by addition and deletion to read as follows:

Hardship for International Medical Graduates from Ukraine in Humanitarian Crisis or Conflict

Our American Medical Association will advocate with relevant stakeholders that advise supports Intealth's processes for primary source verification, state medical boards to grant hardship waiver for including, when needed, alternatives to primary source verification of medical education for all licensing requirements for physicians who graduated from medical schools in Ukraine until the current humanitarian crisis in Ukraine is resolved areas of humanitarian conflict or crisis. (Modify HOD Policy)

2. Reaffirm AMA policy H-255.988, "AMA Principles on International Medical Graduates" (Reaffirm HOD Policy)

- 1 3. Reaffirm AMA policy D-65.993, “War Crimes as a Threat to Physicians' Humanitarian
- 2 Responsibilities” (Reaffirm HOD Policy)
- 3 4. Reaffirm AMA policy H-520.985, “Protection of Healthcare and Humanitarian Aid Workers
- 4 in all Areas of Armed Conflict” (Reaffirm HOD Policy)
- 5 5. Reaffirm AMA policy D-275.989, “Credentialing Issues” (Reaffirm HOD Policy)
- 6 6. Reaffirm AMA policy H-515.982, “Violent Acts Against Physicians” (Reaffirm HOD Policy)

Fiscal note: Minimal

APPENDIX A: RELEVANT AMA POLICY

Humanitarian and Medical Aid Support to Ukraine D-65.984

1. Our American Medical Association will advocate for continuous support of organizations providing humanitarian missions and medical care to Ukrainian refugees in Ukraine, at the Polish-Ukrainian border, in nearby countries, and/or in the US.
2. Our AMA will advocate for an early implementation of mental health measures, including suicide prevention efforts, and address war-related trauma and post-traumatic stress disorder when dealing with Ukrainian refugees with special attention to vulnerable populations including but not limited to young children, their parents, pregnant people, and the elderly.
3. Our AMA will advocate for educational measures to enhance the understanding of war-related trauma in war survivors and promote broad protective factors (e.g., financial, employment, housing, and food stability) that can improve adjustment and outcomes for war-affected people, particularly when applied to vulnerable categories of people.

Expedited H-1B Pathways for International Medical Graduate Physicians in the USA H-255.961

Our American Medical Association supports the continuance of premium processing and other mechanisms that expedite H-1B visa applications and renewals for International Medical Graduate physicians.

Support for International Medical Graduates from Countries Facing Major Humanitarian Crises H-255.962

1. Our American Medical Association affirms its support and will advocate for immigrant physicians and trainees working in the United States when their country of origin faces major humanitarian crises, regardless of their country's political alignment, to promote an understanding of the challenges specific to immigrant physicians.
2. Our AMA will support the development and implementation of channels of communication for immigrant physicians to share their personal and professional journey when facing severe destruction, humanitarian crises, or personal losses in their country of origin, contributing therefore to improving the understanding of the difficulties faced by immigrant physicians.

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.

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.

Hardship for International Medical Graduates from Ukraine D-255.97

Our American Medical Association will advocate with relevant stakeholders that advise state medical boards to grant hardship waiver for primary source verification of medical education for all licensing requirements for physicians who graduated from medical schools in Ukraine until the current humanitarian crisis in Ukraine is resolved.

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.

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.
26. Our AMA will uphold its commitment to opposing discrimination against IMGs in all aspects of medical education and training.

Visa Complications for IMGs in GME D-255.991

1. Our American Medical Association will
 - a. work with the ECFMG to minimize delays in the visa process for International Medical Graduates applying for visas to enter the US for postgraduate medical training and/or medical practice.
 - b. promote regular communication between the Department of Homeland Security and AMA IMG representatives to address and discuss existing and evolving issues related

1 to the immigration and registration process required for International Medical
2 Graduates.

- 3 c. work through the appropriate channels to assist residency program directors, as a
4 group or individually, to establish effective contacts with the State Department and
5 the Department of Homeland Security, in order to prioritize and expedite the
6 necessary procedures for qualified residency applicants to reduce the uncertainty
7 associated with considering a non-citizen or permanent resident IMG for a residency
8 position.

- 9 2. Our AMA International Medical Graduates Section will continue to monitor any H-1B visa
10 denials as they relate to IMGs inability to complete accredited GME programs.
11 3. Our AMA will study, in collaboration with the Educational Commission on Foreign Medical
12 Graduates and the Accreditation Council for Graduate Medical Education, the frequency of
13 such J-1 Visa reentry denials and its impact on patient care and residency training.
14 4. Our AMA will, in collaboration with other stakeholders, advocate for unfettered travel for
15 IMGs for the duration of their legal stay in the US in order to complete their residency or
16 fellowship training to prevent disruption of patient care.
17

18 Credentialing Issues D-275.989

19 Our American Medical Association encourages state medical licensing boards, the Federation of State
20 Medical Boards, and other credentialing entities to accept certification by the Educational
21 Commission for Foreign Medical Graduates (a member of Intealth) as proof of primary source
22 verification of an IMG's international medical education credentials.
23

24 Protection of Healthcare and Humanitarian Aid Workers in all Areas of Armed Conflict H-520.985

- 25 1. Our American Medical Association supports peace in the world in order to protect civilian
26 lives and healthcare personnel.
27 2. Our AMA supports the safety of healthcare and humanitarian aid workers along with safe
28 access to healthcare, healthcare facilities, and humanitarian aid for all civilians in areas of
29 armed conflict.
30 3. Our AMA condemns targeting, detention, or attack of non-combatant healthcare workers and
31 humanitarian personnel; and our AMA also condemns the use of healthcare workers,
32 humanitarian personnel, and healthcare institutions for military purposes or as shields for
33 military operations.
34 4. Our AMA recognizes the deliberate targeting of non-combatant healthcare workers, medical
35 students, and healthcare facilities in all areas of conflict as a violation of medical neutrality
36 and AMA policy.
37 5. Our AMA supports efforts to protect, release, and provide restitution to detained non-
38 combatant healthcare workers in all areas of conflict.
39

40 Medical Neutrality H-520.998

41 Our American Medical Association supports medical neutrality, under the principles of the Geneva
42 Convention, for all health care workers and the sick and wounded in all countries.

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 302
(I-26)

Introduced by: Medical Student Section

Subject: Augmented Intelligence Use in Assessment Development During Medical Education

Referred to: Reference Committee C

1 Whereas, AI has a growing presence in medical education both within medical school and post-
2 graduate education¹; and
3

4 Whereas, a greater number of schools have turned their focus to the use of AI in examinations,
5 for generating multiple-choice questions and developing machine learning to analyze student
6 performance in Objective Structured Clinical Examinations (OSCEs)²; and
7

8 Whereas, the use of generative AI has the potential to increase the speed by which new
9 question banks are created, it has also been found to include errors related to “inaccurate
10 terminology, age-sensitive inaccuracies, and geographically insensitive inaccuracies” in up to
11 15% of questions^{3,4}; and
12

13 Whereas, despite strong performance on multiple-choice benchmarks, AI models show an
14 average drop of 39.43% in performance when assessed via free-response questions, requiring
15 rigorous inspection to ensure that AI-generated content genuinely integrates knowledge with
16 clinical reasoning rather than replicating surface-level patterns⁵; and
17

18 Whereas, medical schools utilizing AI-driven grading have identified that generative AI models
19 lack transparency and the underlying processes by which GPT-4 applies grading rubrics are
20 unknown beyond the prompt and rubric which is provided⁶; and
21

22 Whereas, newer studies in higher education outside of medicine have shown students’ distrust
23 of an over-reliance on AI autograders by teachers and a preference for human graders⁷; and
24

25 Whereas, AI assessment tools in higher education outside of medicine have shown that even
26 with high-accuracy autograders, there is significant misalignment between how AI is used and
27 how students perceive it is used, which may contribute to suboptimal answer development
28 amongst students⁸; and
29

30 Whereas, research on implementation of AI-tool-based grading in higher education outside of
31 medicine has shown that a transparency statement on the use of AI in grading of exams led to
32 students finding an AI autograder significantly more accurate, suggesting that explaining the use
33 of AI and its past accuracy may help students better understand its use and view it as a helpful
34 tool⁷; and
35

36 Whereas, major institutions such as the United States Medical Licensing Examination (USMLE)
37 are now investigating AI-driven adaptive testing, where algorithms could modify questions in
38 real time⁹; and

1 Whereas, prior American Medical Association policies emphasize physician oversight and
2 responsible AI use, these expectations are not specifically outlined for AI use in medical
3 assessment creation and learner performance evaluation; therefore be it
4

5 RESOLVED, that our American Medical Association supports disclosure to students along the
6 medical education continuum regarding the use of generative augmented intelligence (AI) in the
7 development and evaluation of performance on assessments. (New HOD Policy)

Fiscal Note: Minimal – less than \$5,000

Date Received: 9/3/26

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RELEVANT [AMA POLICY](#)

Augmented Intelligence in Medical Education H-295.857

Our AMA will: (a) encourage accrediting and licensing bodies to study how artificial intelligence should be most appropriately addressed in accrediting and licensing standards; (b) encourage medical specialty societies and boards to consider the development of specialty-specific educational modules related to artificial intelligence; (c) support research regarding the effectiveness of artificial intelligence instruction in medical education on learning and clinical outcomes; (d) encourage institutions and programs to be deliberative in determining when artificial intelligence–assisted technologies should be taught, including consideration of established evidence-based curricula and what existing curricular content may need to be modified or removed to accommodate new training modules; (e) support stakeholders in providing educational materials to help learners guard against inadvertent dissemination of bias that may be inherent in artificial intelligence systems; (f) support the study of how differences in institutional access to artificial intelligence may impact disparities in medical education for students at schools with fewer resources and less access to artificial intelligence technologies; (g) support enhanced training across the continuum of medical education regarding the assessment, interpretation, and application of data in patient care; (h) support the study of how disparities in access to artificial intelligence educational resources may impact health care disparities for patients in communities with fewer resources and less access to artificial intelligence technologies; (i) encourage institutional leaders and academic deans to proactively include nonclinician experts, such as data scientists and engineers, on faculty rosters to assist learners in understanding and using artificial intelligence; and (j) support close collaboration with and oversight by practicing physicians in the development and implementation of artificial intelligence applications in medical education. [CME Rep. 04, A-19; Appended: Res. 307, I-25]

Explainability of Artificial/Augmented Intelligence and Machine Learning Algorithms D-480.954

To maximize the impact and trustworthiness **of** augmented intelligence and machine-learning (AI/ML) tools in clinical settings, our AMA recognizes that: (a) Explainable AI with safety and efficacy data should be the expected form **of** AI tools for clinical applications, and exceptions should be rare and justified and require at minimum safety and efficacy data prior to their adoption or regulatory approval; (b) To be considered "explainable," an AI device's explanation **of** how it arrived at its output must be interpretable and actionable by a qualified human. Claims that an algorithm is explainable should be adjudicated only by independent third parties, such as regulatory agencies or appropriate specialty societies, rather than by declaration from its developer; [CSAPH Rep. 08, A-25]

Assessing the Intersection Between AI and Health Care H-480.931

(1)General Governance (a)Health care AI must be designed, developed, and deployed in a manner which is ethical, equitable, responsible, accurate, transparent, and evidence-based...(2) Decisions regarding transparency and disclosure of the use of AI should be based upon a risk- and impact-based approach that considers the unique circumstance of AI and its use case. The need for transparency and disclosure is greater where the performance of an AI-enabled technology has a greater risk of causing harm to a patient. [BOT Rep. 01, I-24; Reaffirmed: CSAPH Rep. 08, A-25; Reaffirmed in lieu of the first resolve: Res. 226, A-25]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 304
(I-26)

Introduced by: Medical Student Section, Underrepresented in Medicine Advocacy Section,
Resident and Fellow Section

Subject: Transparency in AI-Assisted Admissions

Referred to: Reference Committee C

Whereas, artificial intelligence (AI) involvement, referring to algorithmic or machine learning-based tools that influence applicant screening, scoring, ranking, summarization, or evaluation decisions, is increasingly being integrated into medical school and residency application review processes, including holistic file analysis, interview evaluation, and predictive ranking systems used to assist admissions committees and residency selection programs¹; and

Whereas, proponents of AI-assisted review systems argue that such tools may improve administrative efficiency and help manage the growing volume of applications submitted through centralized systems such as the American Medical College Application Service (AMCAS) and the Electronic Residency Application Service (ERAS)¹; and

Whereas, broader evidence from high-stakes decision-making systems demonstrates that artificial intelligence may perpetuate bias if not carefully designed and evaluated, and that standardized frameworks for assessing and reporting fairness remain incompletely developed as these technologies are increasingly adopted in selection processes²⁻⁵; and

Whereas, access to medical education and residency training represents a critical pathway into the physician workforce, and the use of artificial intelligence–assisted selection systems may influence not only individual admissions outcomes but also the composition, diversity, and equity of the future physician workforce, making fairness, transparency, and accountability in these systems essential⁵; and

Whereas, existing American Medical Association policy, including Augmented Intelligence in Health Care (H-480.940), Assessing the Intersection Between AI and Health Care (H-480.931), Augmented Intelligence in Medical Education (H-295.857), and Health Equity (H-180.944), supports responsible and transparent development and implementation of augmented intelligence technologies and emphasizes addressing systemic bias and advancing equity in health systems and decision-making processes⁷⁻¹⁰; and

Whereas, establishing transparent governance standards for AI-assisted admissions processes presents an opportunity to ensure that technological innovation supports equitable access to medical education while maintaining public trust in the integrity of the physician training pipeline^{5,6}; therefore be it

RESOLVED, that our American Medical Association study and report back on the ethical, equitable, and transparent use of augmented intelligence (AI) in medical school and residency application review processes, including potential standards for notice, disclosure, and

1 explanation of AI involvement to applicants, including but not limited to, what stage AI is
2 involved and to what extent (Directive to Take Action); and be it further
3
4 RESOLVED, that our AMA support approaches to promote fairness, accountability, and
5 applicant due process, including access to human reevaluation and avenues to appeal or
6 contest decisions influenced by such systems. (New HOD Policy)

Fiscal Note: Minimal – less than \$5,000

Date Received: 9/3/26

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RELEVANT [AMA POLICY](#)

H-480.940 Augmented Intelligence in Health Care

Our AMA supports the responsible, ethical, and transparent development and deployment of augmented intelligence (AI) technologies in health care, including safeguards to address bias, ensure accountability, and maintain appropriate physician oversight. (Res. 214, A-18; Reaffirmed: BOT Rep. 28, A-19)

H-480.931 Assessing the Intersection Between AI and Health Care

Our AMA encourages ongoing evaluation of the benefits, risks, and ethical implications of artificial intelligence technologies in health care to guide policy development and ensure safe, equitable, and effective implementation. (Res. 214, A-18; Reaffirmed: BOT Rep. 28, A-19)

H-295.857 Augmented Intelligence in Medical Education

Our AMA supports the thoughtful integration of artificial intelligence technologies into medical education, including the need for transparency, appropriate oversight, and the protection of educational equity in their use. (CME Rep. 1, A-19)

H-180.944 Health Equity

Our AMA supports efforts to identify and eliminate systemic bias and inequities in health systems and decision-making processes and to promote equitable access to care, medical education, and health outcomes. (BOT Rep. 8, I-18)

E-1.2.11 Ethics of Health Information Technology

Physicians and health systems should ensure that digital health technologies, including automated decision systems, are used in a manner that promotes transparency, accountability, patient safety, and safeguards against bias and unintended harm. (AMA Code of Medical Ethics)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 305
(I-26)

Introduced by: American Academy of Hospice and Palliative Medicine

Subject: Certification for Hospice Medical Directors

Referred to: Reference Committee C

1 Whereas, hospice medical directors provide clinical leadership, interdisciplinary team support
2 and oversight of quality care, for seriously ill patients and their families; and
3

4 Whereas, while Hospice and Palliative Medicine (HPM) board certification requires fellowship
5 training, Hospice Medical Director Certification (HMDC) allows multiple pathways to certification
6 eligibility, including an experiential pathway with a minimum of 400 hours of broad hospice-
7 related activities and 2 years of hospice work experience during the prior 5 years; and
8

9 Whereas, HPM board certification and the HMDC credential demonstrate specialized
10 knowledge and competency in the care of patients with serious illness, symptom management,
11 communication, hospice regulations and end of life care; and
12

13 Whereas, Centers for Medicare and Medicaid services requires hospice organizations to
14 designate a physician to serve as medical director who has responsibility for the medical
15 component of the hospice's patient care program; and
16

17 Whereas, the hospice medical director is not a category of medical practice but a position a
18 hospice must designate under Medicare conditions of participation, in which a physician
19 assumes on behalf of a certified provider the statutory duty to certify terminal illness, a
20 determination that both authorizes federal payment and effects the beneficiary's waiver of
21 Medicare coverage for curative treatment of the terminal condition; and
22

23 Whereas, Medicare conditions of participation and coverage already establish certification-
24 based qualification standards for designated physician director positions, including 42 CFR
25 494.140(a)(1) for dialysis facility medical directors, with an alternative approval provision at 42
26 CFR 494.140(a)(2) where no qualified physician is available, and 42 CFR 493.1443 for
27 laboratory directors of high complexity testing, which provides multiple qualification pathways
28 and protection for incumbents; and
29

30 Whereas, our AMA advocates that coverage determinations affecting Medicare beneficiaries be
31 made by board-certified physicians with clinical expertise in the relevant field; and
32

33 Whereas, physician certification of terminal illness is the sole clinical gate to the Medicare
34 hospice benefit, and that gate is only as strong as the certifying physician's command of
35 prognostication, eligibility criteria, and hospice regulations; and
36

37 Whereas, ongoing federal enforcement actions involving hospice providers have demonstrated
38 vulnerabilities in hospice eligibility determinations and physician certifications of terminal illness;
39 and

Whereas, the majority of the >5,000 hospice organizations in the United States do not demonstrate evidence their hospice medical directors hold HPM certification or the HMDC credential; and

Whereas, our AMA has policy on physician-directed hospice care (H-85.955), modernizing the hospice benefit (D-330.895), and improving hospice program integrity (D-85.991); and

Whereas, an increasing number of patients receiving hospice care rely completely on the hospice physician to guide their care; and

Whereas, patients and families receiving hospice services deserve access to physician leadership that meets established standards of expertise and competency; and

Whereas, the increasing complexity of hospice care delivery, regulatory oversight, and quality reporting creates a need for specialized knowledge and qualifications and;

Whereas, physician board certification is correlated with better quality of patient care; therefore be it

RESOLVED, that our American Medical Association advocate for recognition of Hospice and Palliative Medicine board certification or Hospice Medical Director Certification as qualification standards for physicians designated as hospice medical directors with an implementation period sufficient to avoid reducing beneficiary access to hospice care, particularly in rural and underserved communities (Directive to Take Action); and be it further

RESOLVED, that our AMA support the principle that hospice medical directors should obtain board certification in Hospice and Palliative Medicine or Hospice Medical Director Certification, and encourage hospice agency employers to support the time and cost of certification (New HOD Policy); and be it further

RESOLVED, that our AMA study the workforce, access and regulatory implications of hospice medical director qualification standards, including Hospice and Palliative Medicine or Hospice Medical Director Certification, and report its findings to the House of Delegates (Directive to Take Action); and be it further

RESOLVED, that our AMA collaborate with relevant specialty societies, including but not limited to the American Academy of Hospice and Palliative Medicine, and accrediting organizations to promote standards supporting physician competency in hospice medical director roles. (Directive to Take Action)

Fiscal Note: Minimal – less than \$5,000

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RELEVANT AMA POLICY

Palliative Care and End-of-Life Care H-295.875

Our AMA:

1. Reaffirms the Council on Medical Education's support of palliative medicine as a medical subspecialty with certification recognized by the American Board of Medical Specialties, and also encourages the inclusion of palliative medicine in the core curriculum of undergraduate and graduate medical education.
2. Encourages the training of all allied health workers in the use of palliative care techniques and interdisciplinary team care.
3. Will continue its efforts in producing and distributing clinical CME programs on pain management and end-of-life care.

Hospice Care H-85.955

Our AMA will work with relevant national medical specialty organizations to petition the American Board of Medical Specialties and relevant specialty boards to support development of innovative fellowship models that would qualify physicians for board certification in the fields of hospice and palliative medicine as well as geriatrics.

Our American Medical Association approves of the physician-directed hospice concept to enable the terminally ill to die in a more homelike environment than the usual hospital; and urges that this position be widely publicized in order to encourage extension and third party coverage of this provision for terminal care.

Our AMA encourages physicians to be knowledgeable of patient eligibility criteria for hospice benefits and, realizing that prognostication is inexact, to make referrals based on their best clinical judgment.

Our AMA supports modification of hospice regulations so that it will be reasonable for organizations to qualify as hospice programs under Medicare.

Our AMA believes that each patient admitted to a hospice program should have their designated attending physician who, in order to provide continuity and quality patient care, is allowed and encouraged to continue to guide the care of the patient in the hospice program.

Our AMA supports changes in Medicaid regulation and reimbursement of palliative care and hospice services to broaden eligibility criteria concerning the length of expected survival for pediatric patients and others, to allow provision of concurrent life-prolonging and palliative care, and to provide respite care for family care givers.

Our AMA seeks amendment of the Medicare law to eliminate the six-month prognosis under the Medicare Hospice benefit and support identification of alternative criteria, meanwhile supporting extension of the prognosis requirement from 6 to 12 months as an interim measure.

Our AMA will advocate through all appropriate means to ensure that medications and other treatments used to stabilize palliative and hospice patients for pain, delirium, and related conditions in the hospital continue to be covered by pharmacy benefit management companies, health insurance companies, hospice programs, and other entities after patients are transitioned out of the hospital.

On-Site Physician Home Health Care H-210.981

Our AMA: (1) recognizes that timely access to physician care for the frail, chronically ill, disabled or low-income patient is a goal that can be met by an increase in physician house calls to this vulnerable, underserved population.

(2) strongly supports the role of interdisciplinary teams in providing direct care in the patient's own home, but recognizes that physician oversight of that care from a distance must sometimes be supplemented by on-site physician care through house calls.

(3) advocates that the physician who collaborates in a patient's plan of care for home health services should see that patient on a periodic basis.

(4) recognizes the value of the house call in establishing and enhancing the physician-patient and physician-family relationship and rapport, in assessing the effects of the social, functional and physical environment on the patient's illness, and in incorporating the knowledge gained into subsequent health care decisions.

(5) believes that physician on-site care through house calls is important when there is a change in condition that cannot be diagnosed over the telephone with the assistance of allied health personnel in the home and assisted transportation to the physician's office is costly, difficult to arrange, or detrimental to the patient's health.

(6) recognizes the importance of improving communication systems to integrate the activities of the disparate health professionals delivering home care to the same patient. Frequent and comprehensive communication between all team members is crucial to quality care, must be part of every care plan, and can occur via telephone, FAX, e-mail, video telemedicine and in person.

(7) recognizes the importance of removing economic, institutional and regulatory barriers to physician house calls, including the development of programs for low-income families and older adults.

(8) supports the requirement for a medical director for all home health agencies, comparable to the statutory requirements for medical directors for nursing homes and hospice.

(9) recommends that all specialty societies address the effect of dehospitalization on the patients that they care for and examine how their specialty is preparing its residents in-training to provide quality care in the home.

(10) encourages appropriate specialty societies to continue to develop educational programs for practicing physicians interested in expanding their involvement in home care.

(11) urges CMS to clarify and make more accessible to physicians information on standards for utilization of home health services, such as functional status, severity of illness, and socioeconomic status.

(12) urges CMS, in its efforts to redefine homebound, to consider the adoption of criteria and methods that will strengthen the physician's role in authorizing home health services, as well as how such criteria and methods can be implemented to reduce the paperwork burden on physicians.

Good Palliative Care H-70.915

Our American Medical Association: encourages all physicians to become skilled in palliative medicine.

Our AMA recognizes the importance of providing interdisciplinary palliative care for patients with disabling chronic or life-limiting illness to prevent and relieve suffering and to support the best possible quality of life for these patients and their families.

Our AMA encourages education programs for all appropriate health care professionals, and the public as well, in care of the dying patient; and the care of patients with disabling chronic or life-limiting illness.

Our AMA supports improved reimbursement for health care practices that are important in good care of the dying patient, such as the coordination and continuity of care, "maintenance" level services, counseling for patient and family, use of multidisciplinary teams, and effective palliation of symptoms.

Our AMA encourages physicians to become familiar with the use of current coding methods for reimbursement of hospice and palliative care services.

Our AMA advocates for reimbursement of Evaluation and Management (E/M) codes reflecting prolonged time spent on patients' care outside of the face-to-face encounter in non-hospital settings.

Our AMA continues to monitor the development and performance on the CMS 30-day mortality measures and enrollments in the Medicare hospice program and the VA hospice programs and continues to work to have CMS exclude palliative patients from mortality measures.

Our AMA supports efforts to clarify coding guidance or development of codes to capture "comfort care," "end-of-life care," and "hospice care;"

Our AMA encourages research in the field of palliative medicine to improve treatment of unpleasant symptoms that affect quality of life for patients.

Our AMA encourages research into the needs of dying patients and how the care system could better serve them.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 306
(I-26)

Introduced by: International Medical Graduates Section, Resident and Fellow Section

Subject: Fee Parity for International Medical Graduates Taking USMLE Examinations Outside the United States

Referred to: Reference Committee C

Whereas, International Medical Graduates (IMGs) represent a vital component of the United States healthcare workforce, helping address critical physician shortages, particularly in rural and medically underserved areas; and

Whereas, examinees taking the United States Medical Licensing Examination® (USMLE®) Step 1 and Step 2 Clinical Knowledge (CK) at testing centers outside the United States and Canada are assessed substantial international test delivery surcharges (\$210 for Step 1 and \$235 for Step 2 CK) in addition to baseline registration fees; and

Whereas, these regional surcharges create a severe, compounding financial barrier for international medical students and graduates seeking to enter the US healthcare system; and

Whereas, the transition toward fixed USMLE examination schedules and the planned expansion of testing center infrastructure globally streamlines capacity planning, stabilizes operational overhead, and lowers per-candidate delivery costs; and

Whereas, economies of scale achieved through expanding global test site networks should reduce operational costs across the board rather than placing an asymmetric financial burden on candidates testing abroad; and

Whereas, the American Medical Association is committed to advancing health equity, eliminating arbitrary workforce entry barriers, and supporting a diverse global physician pipeline; therefore, be it

RESOLVED, that our American Medical Association advocate with the National Board of Medical Examiners (NBME), the Federation of State Medical Boards (FSMB), and Intealth/ECFMG to establish fee parity between domestic and international test-takers for all USMLE examinations by eliminating geographic test delivery surcharges; (Directive to Take Action) and be it further

RESOLVED, that our AMA work with testing sponsors to ensure that any restructuring of examination scheduling—including fixed exam administration windows and international center expansion—is implemented with transparent, standardized cost structures that do not disproportionately penalize candidates testing outside the United States. (Directive to Take Action)

Fiscal Note: Minimal – less than \$5,000

Received: 9/16/26

References:

1. Intealth / Educational Commission for Foreign Medical Graduates. 2026 Information Booklet: Fees and Payment. ECFMG; 2026.
2. National Board of Medical Examiners, Federation of State Medical Boards. USMLE Bulletin of Information. NBME/

AMA RELEVANT 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.
 26. Our AMA will uphold its commitment to opposing discrimination against IMGs in all aspects of medical education and training.
- BOT Rep. Z, A-86 Reaffirmed: Res. 312, I-93 Modified: CME Rep. 2, A-03 Reaffirmation I-11 Reaffirmed: CME Rep. 1, I-13 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-25 Reaffirmed: Res. 241, A-25 Appended: Res. 304, I-25 Reaffirmed: Res. 226, A-26

Financial Burdens and Exam Fees for International Medical Graduates H-255.964

1. Our American Medical Association encourages key stakeholders, such as the National Board of Medical Examiners, Federation of State Medical Boards, Educational Commission for Foreign Medical Graduates (a member of Intealth), Cambridge Assessment English and Box Hill Institute, and others to (a) study the most equitable approach for achieving parity across U.S. MD

and DO trainees and international medical graduates with regard to application, exam, and licensing fees and related financial burdens; and (b) share this information with the medical education and IMG communities.

2. Our AMA encourages relevant stakeholders to work together to achieve cost equivalency for exams required of all medical students and trainees, including IMGs. CME Rep. 03, A-23