DISCLAIMER

The following is a preliminary report of actions taken by the House of Delegates at its 2026 Interim Meeting and should not be considered final. Only the Official Proceedings of the House of Delegates reflect official policy of the Association.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (I-26)

Final Report of Reference Committee C

Tate Hinkle, MD, Chair

RECOMMENDED FOR ADOPTION

1. Council on Medical Education Report 2 – Medical Education Systems

2. Council on Medical Education Report 4 – Physician as Medical Professional

3. Council on Medical Education Report 5 – Entry Into and Transition Through the Medical Education Continuum

4. Council on Medical Education Report 8 – Hardship for International Medical Graduates in Humanitarian Crisis or Conflict

5. Resolution 309 - Stronger Recognition and Promotion of Accommodations for Neurodivergent Learners

RECOMMENDED FOR ADOPTION AS AMENDED

6. Council on Medical Education Report 1 – Medical Education Programs and Content

7. Council on Medical Education Report 3 – Professional Regulation of Physicians

8. Council on Medical Education Report 6 – Obligations to Students and Trainees

9. Council on Medical Education Report 7 – Mission of Medical Education

10. Resolution 301 - Missing Indigenous People Crisis in Medical Education

11. Resolution 302 – Augmented Intelligence Use in Assessment Development During Medical Education

12. Resolution 303 - Transparent Visiting Rotation Fee Disclosure

13. Resolution 304 – Transparency in AI-Assisted Admissions

14. Resolution 306 – Fee Parity for International Medical Graduates Taking USMLE Examinations Outside the United States

RECOMMENDED FOR REFERRAL

15. Resolution 305 – Certification for Hospice Medical Directors

RECOMMENDED FOR REFERRAL FOR DECISION

16. Resolution 311 - Ensuring Flexible Testing Dates by the USMLE and Appropriate Stakeholder Engagement

RECOMMENDED FOR ADOPTION

(1) COUNCIL ON MEDICAL EDUCATION REPORT 2 - MEDICAL EDUCATION SYSTEMS

RECOMMENDATION:

Your Reference Committee recommends that Council on Medical Education Report 2 be adopted and the remainder of the report be filed.

HOD ACTION: Council on Medical Education Report 2 adopted and the remainder of the report filed.

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 the Appendix of this report be acted upon in the manner indicated and the remainder of this report be filed. (Directive to Take Action)

2) The AMA will study AMA Policy D-305.967, The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education, to update its contents (Directive to Take Action).

Your Reference Committee received supportive online testimony. One testimony noted concern regarding Policy D-305.984, "Reduction in Student Loan Interest Rates," which is listed in the report appendix and addresses the federal Graduate PLUS loan program. Your Reference Committee acknowledges the recent changes to this federal program, as noted in testimony. Your Reference Committee believes this GME issue and others can be addressed via study of Policy D-305.967 per Recommendation 2. Therefore, your Reference Committee recommends that CME Report 2 be adopted.

(2) COUNCIL ON MEDICAL EDUCATION REPORT 4 - PHYSICIAN AS MEDICAL PROFESSIONAL

RECOMMENDATION:

Your Reference Committee recommends that Council on Medical Education Report 4 be adopted and the remainder of the report be filed.

HOD ACTION: Council on Medical Education Report 4 adopted and the remainder of the report filed.

The Council on Medical Education recommends that the following be adopted and the remainder of the report be filed:
The House of Delegates policies listed in the Appendix of this report be acted upon in the manner indicated and the remainder of this report be filed. (Directive to Take Action)

Your Reference Committee received supportive online testimony. Therefore, your Refence Committee recommends that CME Report 4 be adopted.

(3) COUNCIL ON MEDICAL EDUCATION REPORT 5 - ENTRY INTO AND TRANSITION THROUGH THE MEDICAL EDUCATION CONTINUUM

RECOMMENDATION:

Your Reference Committee recommends that Council on Medical Education Report 5 be adopted and the remainder of the report be filed.

HOD ACTION: Council on Medical Education Report 5 adopted and the remainder of the report filed.

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

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

Your Reference Committee received supportive online testimony. One testimony questioned policy D-295.988 in the report appendix that addresses the United States Medical Licensing Examination (USMLE) and wondered if clauses should be amended instead of rescinded. Your Reference Committee reviewed the policy and agreed with the rescission. Your Reference Committee recommends that CME Report 5 be adopted.

(4) COUNCIL ON MEDICAL EDUCATION REPORT 8 - HARDSHIP FOR INTERNATIONAL MEDICAL GRADUATES IN HUMANITARIAN CRISIS OR CONFLICT

RECOMMENDATION:

Your Reference Committee recommends that Council on Medical Education Report 8 be adopted and the remainder of the report be filed.

HOD ACTION: Council on Medical Education Report 8 adopted and the remainder of the report filed.

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)
3) Reaffirm AMA policy D-65.993, "War Crimes as a Threat to Physicians' Humanitarian Responsibilities" (Reaffirm HOD Policy)

4) Reaffirm AMA policy H-520.985, "Protection of Healthcare and Humanitarian Aid Workers in all Areas of Armed Conflict" (Reaffirm HOD Policy)

5) Reaffirm AMA policy D-275.989, "Credentialing Issues" (Reaffirm HOD Policy)

6) Reaffirm AMA policy H-515.982, "Violent Acts Against Physicians" (Reaffirm HOD Policy)

Your Reference Committee received support for the inclusive nature of this report in addressing access to postgraduate training for IMGs. One individual testified both online and in-person to suggest extending these updates to also modernize policy D-65.984 in a similar fashion. Your Reference Committee supports the spirit of aiding refugees from many areas and appreciates this testimony's point that modifying additional AMA policies could be procedurally possible within this report. However, no other testimony spoke in support of this amendment, and all other testimony supported adopting the report as is, including the original authors of the studied resolution. Other AMA policy already offers broad support for refugees in policies such as D-345.982 and H-350.957, and amending D-65.984 may become more complex than anticipated in the nuances of language. Therefore, Your Reference Committee felt that it would be best to prioritize addressing the educational access concerns, and not risk unintended consequences by amending an additional policy the Council did not initially consider in detail in their report. Your Reference Committee recommends that CME Report 8 be adopted.

(5) RESOLUTION 309 - STRONGER RECOGNITION AND PROMOTION OF ACCOMMODATIONS FOR NEURODIVERGENT LEARNERS

RECOMMENDATION:

Your Reference Committee recommends that Resolution 309 be adopted.

HOD ACTION: Resolution 309 adopted.

RESOLVED, that our American Medical Association support efforts to improve accessibility and transparency of accommodation processes for neurodivergent learners in medical training by:

(1) Encouraging residency and fellowship programs to provide clear guidance regarding procedures for requesting educational accommodations;
(2) Promoting faculty education and educational resources on teaching, supervising, and evaluating neurodivergent learners; and
(3) Encouraging collaboration between graduate medical education programs and institutional disability resource professionals and related specialists to support individualized accommodation planning for neurodivergent learners in medical training. (New HOD Policy)

Your Reference Committee received supportive in-person testimony for this resolution. Therefore, your Reference Committee recommends that Resolution 309 be adopted.

RECOMMENDED FOR ADOPTION AS AMENDED

(6) COUNCIL ON MEDICAL EDUCATION REPORT 1 - MEDICAL EDUCATION PROGRAM AND CONTENT

RECOMMENDATION A:

Your Reference Committee recommends that Recommendation 2 of Council on Medical Education Report 1 be amended by addition and deletion to read as follows:

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 CARE TRAINING 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 training and palliative care training, including but not limited to geriatric and palliative 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~~ long-term care and assisted living facilities), as appropriate to the educational objectives of the program.
e) Our AMA endorses the concept of affiliation between ~~nursing home~~ care facilities for geriatric and/or hospice 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.~~

RECOMMENDATION B:

Your Reference Committee recommends that Council on Medical Education Report 1 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Council on Medical Education Report 1 adopted as amended and the remainder of the report filed.

Adopted language in Recommendation 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, and "Geriatric Medicine" H-295.981 (policy language available in Appendix B) be rescinded and the following policy be adopted:

GERIATRIC CARE TRAINING 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 training and palliative care training, including but not limited to geriatric and palliative 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, long-term care and assisted living facilities), as appropriate to the educational objectives of the program.
e) Our AMA endorses the concept of affiliation between care facilities for geriatric and/or hospice patients, and residency/fellowship programs, where feasible, for the development of physicians' clinical experience in such facilities.
f) Our AMA encourages the inclusion of geriatric medicine in the core curriculum of undergraduate, graduate, and continuing medical education.

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.

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

LEGISLATIVE AWARENESS AND ADVOCACY IN MEDICAL EDUCATION

a) Our AMA strongly encourages 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.
b) 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.
c) Our AMA will establish health policy and advocacy elective rotations based in Washington, DC for medical students, residents, and fellows.
d) Our AMA will support and encourage institutional, state, and specialty organizations to offer real-world health policy and advocacy opportunities at local, state, and/or national levels for medical students, residents, and fellows.
e) 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 healthcare policymakers and organizations.

Your Reference Committee received primarily supportive online testimony, though some testimony noted concerns that Recommendation 2 may unintentionally conflate Geriatric Medicine with Palliative Medicine. This testimony asked that H-295.875, "Palliative Care and End-of-Life Care", be removed from this report so that it is retained as it currently is within existing AMA policy, rather than moving its language into the report's proposed consolidated policy. Your Reference Committee concurs with the feedback provided and removed H-295.875's language from this report to retain it as is in existing policy. Changes were also made to modernize language when referring to care facilities and to further distinguish between elder care and palliative care. Additional in-person testimony expressed concerns about the consolidation of the two policies in Recommendation 4, noting that they would like to amend one of these policies at A-27. Instead, it was

requested to leave them separated rather than consolidating at this time. However, consolidation simply moves the exact policy language into a single page rather than two, removes outdated language referring to what is now ChangeMedEd, and does not prevent future amendments as desired. The topics are also directly related as both policies discuss education on the health of communities across all specialties. Therefore, Your Reference Committee concurred with the Council's original proposal for Recommendation 4. Your Reference Committee recommends that CME Report 1 be adopted as amended.

(7) COUNCIL ON MEDICAL EDUCATION REPORT 3 - PROFESSIONAL REGULATION OF PHYSICIANS

RECOMMENDATION A:

Your Reference Committee recommends that Recommendation 2 of Council on Medical Education Report 3 be amended by addition and deletion to read as follows:

That policies "Federal Intervention in the Setting of Educational Standards" H-295.921 and "Legislative Threats to the Voluntary Accreditation Process" H-295.947 (policy language available in Appendix B) be rescinded and the following policy be adopted:

~~LEGISLATIVE~~ GOVERNMENTAL THREATS TO MEDICAL EDUCATION STANDARDS

The AMA strongly opposes:

a) ~~federal~~ governmental 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;

b) infringements and mandates on medical school curricular requirements through any governmental efforts~~state and federal legislative efforts~~, and recommends that state medical societies should carefully monitor such activities and notify the AMA when such intrusions take place;

c) ~~legislation~~ governmental action that would dismantle national accrediting agencies and that would substitute state standards for a uniform level of national standards in medical education, and

d) ~~legislation~~ governmental action that would limit professional participation in the setting and evaluation of quality standards in medical education.

RECOMMENDATION B:

Your Reference Committee recommends that Council on Medical Education Report 3 be adopted as amended and that the remainder of the report be filed.

HOD ACTION: Council on Medical Education Report 3 adopted as amended and the remainder of the report filed.

Adopted language in Recommendation 2:

That policies "Federal Intervention in the Setting of Educational Standards" H-295.921 and "Legislative Threats to the Voluntary Accreditation Process" H-295.947 (policy language available in Appendix B) be rescinded and the following policy be adopted:

GOVERNMENTAL THREATS TO MEDICAL EDUCATION STANDARDS

The AMA strongly opposes:

a) governmental intervention that would limit the authority of professional accrediting bodies to design and implement appropriate educational standards for the training of physicians;

b) infringements and mandates on medical school curricular requirements through any governmental efforts, and recommends that state medical societies should carefully monitor such activities and notify the AMA when such intrusions take place;

c) governmental action that would dismantle national accrediting agencies and that would substitute state standards for a uniform level of national standards in medical education, and

d) governmental action that would limit professional participation in the setting and evaluation of quality standards in medical education.

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 and the remainder of this report be filed. (Directive to Take Action)

2. That policies "Federal Intervention in the Setting of Educational Standards" H-295.921 and "Legislative Threats to the Voluntary Accreditation Process" H-295.947 (policy language available in Appendix B) be rescinded and the following policy be adopted:

LEGISLATIVE THREATS TO MEDICAL EDUCATION STANDARDS

The AMA strongly opposes:
a) 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;
b) infringements and mandates on medical school curricular requirements through state and federal legislative efforts, and recommends that state medical societies should carefully monitor such activities and notify the AMA when such intrusions take place;
c) legislation that would dismantle national accrediting agencies and that would substitute state standards for a uniform level of national standards in medical education, and
d) legislation that would limit professional participation in the setting and evaluation of quality standards in medical education.

Your Reference Committee received supportive overall testimony, with amendments. One amendment suggested adding the word “state” to part A of the second recommendation, in addition to the discussion of federal intervention, as state legislative restrictions also impact medical education. Another amendment suggested broadening the language to “governmental,” and your Reference Committee concurs. Therefore, your Reference Committee therefore recommends CME Report 3 be adopted as amended.

(8) COUNCIL ON MEDICAL EDUCATION REPORT 6 - OBLIGATIONS TO STUDENTS AND TRAINEES

RECOMMENDATION A:

Your Reference Committee recommends that the first recommendation in Council on Medical Education Report 6 be amended by addition to read as follows:

The House of Delegates policies listed in Appendix A of this report be acted upon in the manner indicated, with the following changes as noted in the third column below:

Policy Text and Timeline	CME Report 6 Recommendation	Ref Com C Recommendation
H-295.942, "Insurance Coverage for Medical Students and Resident Physicians"		
1.3. 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. 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	~~1.3. 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.~~ ~~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.~~	1.3. Reject the proposed deletion and retain original policy as written. 3. Reject the proposed deletion and retain original policy as written.

Policy Text and Timeline	CME Report 6 Recommendation	Ref Com C Recommendation
H-310.995, "Anonymity for Resident Inquiries to Residency Review Committees"		
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. 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.	Our AMA ~~supports~~ encourages ~~a detailed~~ procedures ~~to guarantee~~ that support the 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~~ Such procedures should include~~s~~ a mechanism for the resident who elects to forward a complaint to the ~~residency~~ review committee (~~R~~RC), outline~~s~~ options for ~~R~~RC action~~;~~, and identify~~ies~~ possible final actions open to the ~~R~~RC.	Our AMA supports ~~a~~ detailed procedures to guarantee ~~that support the~~ anonymity, to the extent possible, 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~~ Such procedures should include~~s~~ a mechanism for the resident who elects to forward a complaint to the ~~residency~~ review committee (~~R~~RC), outline~~s~~ options for ~~R~~RC action~~;~~, and identify~~ies~~ possible final actions open to the ~~R~~RC.

RECOMMENDATION B:

Your Reference Committee recommends that Council on Medical Education Report 6 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Council on Medical Education Report 6 adopted as amended and the remainder of the report filed.

Retained language in H-295.942 clauses (1.3) and (3):

1.3. 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.

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.

Adopted language in H-310.995:

Our AMA supports detailed procedures to guarantee anonymity, to the extent possible, of a resident physician who initiates an inquiry by a review committee into the conduct of a residency program, to protect residents from reprisals and program directors from unfounded complaints.

Such procedures should include a mechanism for the resident who elects to forward a complaint to the review committee (RC), outline options for RC action, and identify possible final actions open to the RC.

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.

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.

f. Monitor issues, collect data, and share information related to training programs run by nonprofit and for-profit entities and their effect on medical education.
g. 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.
h. 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.

Your Reference Committee received supportive online and in-person testimony that included several suggested amendments.
Policy H-295.942, "Insurance Coverage for Medical Students and Resident Physicians," is listed in the report appendix. The report recommends that clause (1.3) be rescinded due to redundancy with policy H-310.912; however, testimony clarified that medical students' access to health coverage is not included in that policy. Further testimony noted the importance of clause (3). Your Reference Committee agrees and recommends retaining clause (1.3) and (3).

Policy H-310.916, "Funding to Support Training of the Health Care Workforce," is listed in the report appendix and recommends rescission of clauses (1) and (2). The Council wrote that clause (3) adequately covers the intent of clauses (1) and (2). Other testimony opposed rescission of clauses (1) and (2). Upon additional review, your Reference Committee maintains agreement with the Council, finding that clause (3) is actually broader and gives the AMA more agency than clauses (1) and (2). Thus, your Reference Committee recommends rescinding clauses (1) and (2) as recommended by the Council in the report.

Policy H-310.995, "Anonymity for Resident Inquiries to Residency Review Committees," is listed in the report appendix. The Council recommended it be amended by addition and deletion as stated in the table above. However, testimony noted concern that the amendments to the first sentence could weaken the clause. In the Preliminary Report, your Reference Committee offered amendments to the first sentence, but in-person testimony suggested existing language was strong enough. Your Reference Committee offered a new amendment adding "to the extent possible," acknowledging that a definitive guarantee is not always possible. Therefore, your Reference Committee recommends that CME Report 6 be adopted as amended.

(9) COUNCIL ON MEDICAL EDUCATION REPORT 7 - MISSION OF MEDICAL EDUCATION

RECOMMENDATION A:

Your Reference Committee recommends that the first recommendation in Council on Medical Education Report 7 be amended by addition to read as follows:

The House of Delegates policies listed in the Appendix of this report be acted upon in the manner indicated and the remainder of the report be filed, with the following changes as noted in the third column below:

Policy Text and Timeline	CME Report 7 Recommendation	Ref Com C Recommendation
H-305.929, "Proposed Revisions to AMA Policy on the Financing of Medical Education Programs"		
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. 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.	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.~~ Clear value should be consistently ascribed to medical education.	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. ~~Clear value should be consistently ascribed to medical education.~~

RECOMMENDATION B:

Your Reference Committee recommends that Council on Medical Education Report 7 be adopted as amended and that the remainder of the report be filed.

HOD ACTION: Council on Medical Education Report 7 adopted as amended and the remainder of the report filed.

Adopted language in H-305-929 clause D:

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 a medical school's missions.

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 the Appendix of this report be acted upon in the manner indicated and the remainder of this report be filed. (Directive to Take Action)

2) Our AMA study Recommendations for Future Directions for Medical Education H-295.995 for further modernization and consolidation. (Directive to Take Action)

Your Reference Committee received primarily supportive online testimony. One amendment was proffered to clarify language in clause (1D) of Policy H-305.929, "Proposed Revisions to AMA Policy on the Financing of Medical Education Programs". Your Reference Committee concurred that the proposed amendment would retain the Council's intent more clearly and therefore recommends that CME Report 7 be adopted as amended.

(10) RESOLUTION 301 - MISSING INDIGENOUS PEOPLE CRISIS IN MEDICAL EDUCATION

RECOMMENDATION A:

Your Reference Committee recommends that Resolution 301 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association ~~will collaborate~~encourages ~~with~~ the American Association of Medical Colleges and American Association of Colleges of Osteopathic Medicine to ~~encourage~~promote ~~medical schools to integrate~~the integration of education on the Missing and Murdered Indigenous Persons (MMIP) crisis, trauma-informed care for Indigenous populations, violence screening protocols, and recognition of human trafficking indicators in medical schools ~~into medical education curricula~~. (New HOD Policy)

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 301 be adopted as amended.

RECOMMENDATION C:

Your Reference Committee recommends a change in title to read as follows:

MEDICAL EDUCATION ON THE MISSING INDIGENOUS PEOPLE CRISIS

HOD ACTION: Resolution 301 adopted as amended.

Adopted language:

RESOLVED, that our American Medical Association encourages the American Association of Medical Colleges and American Association of Colleges of Osteopathic Medicine to promote the integration of education on the Missing and Murdered Indigenous Persons (MMIP) crisis, trauma-informed care for Indigenous populations, violence screening protocols, and recognition of human trafficking indicators in medical schools.

RESOLVED, that our American Medical Association will collaborate with the American Association of Medical Colleges and American Association of Colleges of Osteopathic Medicine to encourage medical schools to integrate education on the Missing and Murdered Indigenous Persons (MMIP) crisis, trauma-informed care for Indigenous populations, violence screening protocols, and recognition of human trafficking indicators into medical education curricula. (New HOD Policy)

Your Reference Committee received supportive in-person testimony for the spirit of the resolution. Testimony highlighted the unique positions that physicians and trainees have, which enables them to take steps to address the crisis and supported opportunities to provide the necessary knowledge and skills. There was testimony to express that human trafficking extends beyond Indigenous communities and asked that the policy be broadened, however there was also testimony requesting specification of this community due to the disproportionate impact of trauma on Indigenous people. The Council on Medical Education, while supportive of the intent of the resolution, testified to the significant amount of work being done in this area which is publicly accessible and advised amending to avoid a curricular mandate. Your Reference Committee agrees with the testimony and supports increasing access to education on the subject of missing Indigenous people while upholding the Council's position of opposing curricular mandates. Therefore, your Reference Committee recommends that Resolution 301 be adopted as amended.

(11) RESOLUTION 302 - AUGMENTED INTELLIGENCE USE IN ASSESSMENT DEVELOPMENT DURING MEDICAL EDUCATION

RECOMMENDATION A:

Your Reference Committee recommends that Resolution 302 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association supports ~~disclosure to students along~~ risk-proportionate transparency on the use of generative augmented intelligence (AI) and meaningful human review in the development and utilization of assessments for learners across the medical education continuum ~~regarding the use of generative augmented intelligence (AI) in the development and evaluation of performance on assessments~~ (including medical students, resident and fellow physicians, and practicing physicians participating in continuing medical education and continuing board certification). (New HOD Policy)

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 302 be adopted as amended.

HOD ACTION: Resolution 302 adopted as amended.

Adopted language:

RESOLVED, that our American Medical Association supports risk-proportionate transparency on the use of generative augmented intelligence (AI) and meaningful human review in the development and utilization of assessments for learners across the medical education continuum (including medical students, resident and fellow physicians, and practicing physicians participating in continuing medical education and continuing board certification).

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

Your Reference Committee received supportive testimony for the intent of Resolution 302 emphasizing that as AI becomes increasingly integrated into medical education, transparency regarding its use in examination development and the evaluation of student performance is essential. Both the significant potential benefits and risks of AI use were presented. Given the substantial academic and career implications of assessments, proponents argued that learners should be informed when AI is used and that appropriate accountability and oversight mechanisms should accompany its implementation.

One testimony favored a study examining disclosure to students across the medical education continuum regarding the use of generative AI in the development of assessments and the evaluation of performance. The Council on Medical Education recommended combining Resolutions 302 and 304 through a substitute resolution which was supported by a coalition and section council. The alternate language expressed

support for risk-proportionate transparency, meaningful human review, and applicant due process. The language also included access to human reevaluation and avenues to appeal or contest decisions influenced by the use of generative AI.

Your Reference Committee acknowledges that this is a complicated issue and thinks the amended statement aligns with the will of the testimony while demonstrating support for transparency and accountability of generative AI use without being overly prescriptive while being inclusive of learners across the medical education continuum. Your Reference Committee also appreciates the interest to have unique policies that specifically address systems issues related to both the admissions and selections process as well as the assessment process. Therefore, your Reference Committee recommends that Resolution 302 be adopted as amended.

(12) RESOLUTION 303 - TRANSPARENT VISITING ROTATION FEE DISCLOSURE

RECOMMENDATION A:

Your Reference Committee recommends that Resolution 303 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association supports ~~efforts to ensure transparent preapplication~~ public disclosure, by the host institution, of all requirements, mandatory fees, and anticipated expenses ~~associated with~~ for visiting student rotations, prior to application submission. ~~including fees assessed through centralized application platforms and by host institutions, such that those fees and expenses are specific, well-defined, and available to applicants before application submission.~~ (New HOD Policy)

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 303 be adopted as amended.

HOD ACTION: Resolution 303 adopted as amended.

Adopted language:

RESOLVED, that our American Medical Association supports public disclosure, by the host institution, of all requirements, mandatory fees, and anticipated expenses for visiting student rotations, prior to application submission.

RESOLVED, that our American Medical Association supports efforts to ensure transparent preapplication disclosure of all mandatory fees and expenses associated with visiting student rotations, including fees assessed through centralized application platforms and by host institutions, such that those fees and expenses are specific, well-defined, and available to applicants before application submission. (New HOD Policy)

Your Reference Committee heard supportive testimony for this item, noting significant undisclosed financial burdens as well as DO/MD disparities in fees. The Council offered an amendment clarifying mandatory fees versus other expenses that may be difficult to estimate. Your Reference Committee discussed mandatory expenses that are not necessarily fees and offered amended language for clarity. Your Reference Committee recommends that Resolution 303 be adopted as amended.

(13) RESOLUTION 304 - TRANSPARENCY IN AI-ASSISTED ADMISSIONS

RECOMMENDATION A:

Your Reference Committee recommends that the first resolved clause of Resolution 304 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association study and report back on guiding principles for the ethical, equitable, and transparent use of augmented intelligence (AI) in the application, admission, and selection ~~medical school and residency application~~ review processes for medical school, residency, and fellowships, including access to human reevaluation and avenues to appeal or contest decisions. ~~including potential standards for notice, disclosure, and explanation of AI involvement to applicants, including but not limited to, what stage AI is involved and to what extent.~~

RECOMMENDATION B:

Your Reference Committee recommends that the second resolved clause of Resolution 304 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association support approaches to promote fairness, accountability, and applicant due process~~, including access to human reevaluation and avenues to appeal or contest decisions influenced by such systems~~ related to the use of augmented intelligence (AI) in the application processes for medical school, residency, and fellowships.

RECOMMENDATION C:

Your Reference Committee recommends that Resolution 304 be adopted as amended.

HOD ACTION: Resolution 304 adopted as amended.

Adopted language:

RESOLVED, that our American Medical Association study and report back on guiding principles for the ethical, equitable, and transparent use of augmented intelligence (AI) in the application, admission, and selection review processes for medical school, residency, and fellowships, including access to human reevaluation and avenues to appeal or contest decisions.

RESOLVED, that our American Medical Association support approaches to promote fairness, accountability, and applicant due process related to the use of augmented intelligence (AI) in the application processes for medical school, residency, and fellowships.

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 explanation of AI involvement to applicants, including but not limited to, what stage AI is involved and to what extent (Directive to Take Action); and be it further

RESOLVED, that our AMA support approaches to promote fairness, accountability, and applicant due process, including access to human reevaluation and avenues to appeal or contest decisions influenced by such systems. (New HOD Policy)

Your Reference Committee received supportive testimony both online and in-person for Resolution 304, emphasizing that the growing use of AI in medical school, residency, and fellowship admissions warrants greater transparency, accountability, and safeguards against bias. Testimony emphasized that applicants should be informed when AI influences admissions decisions and should have access to meaningful human review, reevaluation, and appeals processes to ensure fairness, due process, and equity.

There was also testimony in support of retaining the request for a study with a focus on ethical, equitable, and transparent use of AI in admissions and selections processes. The Council on Medical Education provided a recommendation online to combine Resolutions 302 and 304 through an alternate resolution that received support as well as opposition. In-person testimony also addressed the current administrative burdens for faculty and how AI has improved their capacity to address the high volume of applications received. Your Reference Committee respects the diversity of viewpoints expressed and thinks the amended language acknowledges the concerns raised while supporting learners and faculty. Therefore, your Reference Committee recommends that Resolution 304 be adopted as amended.

(14) RESOLUTION 306 - FEE PARITY FOR INTERNATIONAL MEDICAL GRADUATES TAKING USMLE EXAMINATIONS OUTSIDE THE UNITED STATES

RECOMMENDATION A:

Your Reference Committee recommends that the first resolved clause of Resolution 306 be deleted.

RECOMMENDATION B:

Your Reference Committee recommends that the second resolved clause of Resolution 306 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA work with testing sponsors to ensure that any restructuring of ~~examination~~ the United States Medical Licensing 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)

RECOMMENDATION C:

Your Reference Committee recommends that AMA Policy H-255.964, "Financial Burdens and Exam Fees for International Medical Graduates" be reaffirmed. (Reaffirm HOD Policy)

Recommendation D:

Your Reference Committee recommends Resolution 306 be adopted as amended.

HOD ACTION: Resolution 306 adopted as amended.

Adopted language in second resolved clause:

RESOLVED, that our AMA work with testing sponsors to ensure that any restructuring of the United States Medical Licensing 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.

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)

Online and in-person testimony was supportive of the intent of Resolution 306, with some testimony emphasizing that geographic testing surcharges create unnecessary financial barriers for international medical graduates (IMGs) pursuing U.S. licensure and training. Testimony noted that greater fee parity and transparency would advance equity, reduce financial burdens, and align with the AMA's longstanding commitment to supporting IMGs and reducing barriers to entry into the physician workforce. Testimony also highlighted the vital role that IMGs play in meeting healthcare workforce needs and stressed that examination costs should not vary based on testing location. The Council on Medical Education recommended reaffirmation of Policy H-255.964, "Financial Burden and Exam Fees for International Medical Graduates", in lieu of adopting Resolution 306. The Council noted that current AMA policy already promotes examination cost equivalency and equitable approaches to fees for IMGs. The Council explained that information provided by Intealth indicated that USMLE examination fees themselves are the same for U.S. and international examinees and that recent changes to the registration process have further reduced distinctions that may have contributed to perceptions of fee disparities. Additional testimony supported reaffirmation on the grounds that the resolution's objectives are substantially addressed by existing policy. Testimony included a proposed amendment to include the addition of the Comprehensive Osteopathic Medical Licensing Examination of the United States (COMLEX-USA) to promote inclusive pathways for all medical students. Your Reference Committee appreciates the intent of this proposal, however COMLEX is strictly designed for students and graduates of accredited colleges of osteopathic medicine and there are no accredited colleges of osteopathic medicine outside the United States so this amendment would not be appropriate in this instance. Additionally, your Reference Committee agrees that minimizing unnecessary financial barriers for IMGs remains an important objective. Policy H-255.964 addresses examination cost equivalency and equitable approaches to licensing-related costs for IMGs, which addresses the intent of the first resolved clause. Therefore, Your Reference Committee recommends Resolution 306 be adopted as amended.

RECOMMENDED FOR REFERRAL

(15) RESOLUTION 305 - CERTIFICATION FOR HOSPICE MEDICAL DIRECTORS

RECOMMENDATION:

Your Reference Committee recommends that Resolution 305 be referred.

HOD ACTION: Resolution 305 referred.

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)

Online testimony was supportive of the goal of ensuring high-quality, physician-led hospice care and substantial concern regarding the feasibility and potential consequences of establishing board certification or hospice medical director certification as an expected qualification standard for hospice medical directors.

Some testimony highlighted concerns about hospice quality, regulatory complexity, fraud prevention, and the value of specialized training and certification in hospice and palliative medicine. However, other testimony noted that requiring additional credentials could reduce the pool of qualified physicians; limit patient access to hospice services; create unintended workforce challenges, particularly in rural and underserved areas; and establish standards without sufficient evidence of improved outcomes.

There was testimony that supported referral, citing the need to better understand the complexity of factors that would be impacted if this resolution were adopted. The Council on Medical Education expressed concerns that the first three resolved clauses were not feasible at this time and recommended not adopting them, while supporting collaboration with relevant organizations to develop standards that promote physician competence in hospice care. Your Reference Committee agrees that the intent of promoting physician competence and high-quality hospice care is important but finds that the proposed certification-based qualification standards warrant further evaluation given the concerns expressed. Therefore, your Reference Committee recommends that Resolution 305 be referred for study.

RECOMMENDED FOR REFERRAL FOR DECISION

(16) RESOLUTION 311 - ENSURING FLEXIBLE TESTING DATES BY THE USMLE AND APPROPRIATE STAKEHOLDER ENGAGEMENT

RECOMMENDATION:

Your Reference Committee recommends that Resolution 311 be referred for decision.

HOD ACTION: Alternate Resolution 311 adopted in lieu of original Resolution 311.

Adopted language:

RESOLVED, that our American Medical Association support flexible and frequent testing dates for medical school admission and licensing examinations, including the United States Medical Licensing Examination (USMLE) and the Comprehensive Osteopathic Medical Licensing Examination of the United States (COMLEX-USA), to accommodate variations in medical school curricula and residency training schedules, as well as unforeseen personal circumstances; and be it further

RESOLVED, that our AMA support early stakeholder engagement, public comment periods, and disclosure of both the rationale for and the impacts of any future changes to testing date availability for medical school admission and licensing examinations, including impacts on examination access, examinee costs, residency application timelines, and students from historically marginalized backgrounds; and be it further

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RESOLVED, that our American Medical Association support:

a. a broad distribution of flexible testing dates throughout the year for each United States Medical Licensing Examination (USMLE) Step examination to accommodate diverse medical school and residency program curricula and unforeseen personal emergencies & circumstances, to ensure examinees can test when they are adequately prepared without undue stress; and
b. a defied emergency and hardship rescheduling process, distinct from the standard testing calendar, especially but not limited to when USMLE testing dates are limited in number or availability, to accommodate illness, disability-related needs, and unforeseen personal circumstances (New HOD Policy); and be it further

RESOLVED, that our AMA support and encourage the USMLE program and its sponsoring organizations, the Federation of State Medical Boards, and the National Board of Medical Examiners, with extensive involvement, review, and feedback by affected stakeholders, to comprehensively study, evaluate, and report, both prior to and following any implementation of the USMLE Designated Testing Dates model or any future alternative models:

a. The educational, logistical, financial, and workforce impacts, examination access, scheduling delays, travel burden, costs of examinees, residency application timelines, and
b. Differential impacts on students from historically marginalized or disadvantaged backgrounds, and
c. Assessment of its effects on medical students, residents, residency programs, and state medical licensing processes (Directive to Take Action)

Your Reference Committee heard supportive in-person testimony for the intent of this resolution. Your Reference Committee acknowledges the challenges faced by students regarding proposed USMLE testing date changes, as well as the recent announcement by the USMLE that they have deferred implementation of changes until January 2029. The Council on Medical Education recommended referral for decision given that the AMA is already actively engaged with this issue. Further, the Council explained that referral for decision may lead to amplification of current efforts supporting the intent of the resolution. For example, your Reference Committee was informed that that AMA hosted a virtual forum with NBME regarding the testing changes on August 26, 2026, in collaboration with the MSS. It was noted that AMA Policy H-295.841, "Reporting of Total Attempts of USMLE Step 1 and COMLEX-USA Level 1 Examinations" supports flexibility, which relates to this issue. Considering the prolixity of the resolution as well as the rationale provided by the Council, your Reference Committee recommends that Resolution 311 be referred for decision.

This concludes the report of Reference Committee C. I would like to thank Neil Datta, MD, Rajneet Lamba, MD, Parneeta Mohapatra, Katrina Saba, MD, Rachel Whynott, MD, and David Winchester, MD, as well as AMA staff persons Amber Ryan, Tanya Lopez, and Lee Selke-Collazo, and all those who testified before the Committee.

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